Medical complaints process in Australia

Senate Standing Committee on Community Affairs

beyondblue Submission

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Introduction

beyondblue welcomes the opportunity to make this submission to the Senate Standing Committee on Community Affairs on the medical complaints process in Australia.

beyondblue is committed to supporting all people in Australia to achieve their best possible mental health. As a national population mental health organisation, we have a range of integrated initiatives to prevent depression, anxiety and suicide and to support people who experience these conditions to get the right services and supports at the right time.

beyondblue's focus on prevention emphasises the need to reduce people's exposure to risk factors that can impact on their mental health and risk of suicide. Bullying and harassment are two such risk factors.

Research shows a clear link between bullying and harassment and the experience of depression and anxiety conditions. These conditions are potentially disabling, and associated with a wide range of adverse outcomes for affected individuals, including the risk of premature death by suicide. These conditions also impact on family, friends, workplace colleagues, and on society more broadly.

Bullying can lead to poor health and low morale, engagement and productivity among workers who witness bullying. In the medical profession the negative impacts of bullying and harassment have the potential to impact on patient care.

Bullying and harassment also impact on the workplace through lower productivity and reduced career longevity. They are associated with burnout, low job satisfaction, reduced organisational commitment, increased intentions to leave, absenteeism and presenteeism. Ultimately, they lead to higher rates of staff turnover and the associated costs of re-hiring and training new workers. They also take up time and resources in investigating and managing complaints and can lead to legal costs in defending claims or in compensation payments. The impact on the broader economy is also considerable. In 2010 the Productivity Commission estimated that the combined direct and indirect costs of workplace bullying was costing Australia between $6 billion and $36 billion annually.[1]

Given the personal and social costs, it is clear that workplace bullying and harassment cannot be ignored.

It is therefore of considerable concern that research and anecdotal evidence confirm that bullying and harassment continue to affect workers across all Australian workplaces. The 'caring and helping professions' including medical students and doctors, are not immune to experiencing or perpetrating bullying and harassment.

While it is difficult to determine the exact prevalence of bullying and harassment in the medical profession, these behaviours will affect thousands of medical students and doctors each year.

These are not just 'private issues' to be resolved between the individuals involved, but a public health issue which requires a shared and systematic approach to prevention and management.

Action on bullying and harassment is everyone's responsibility. Governments have a role through enacting legislation and funding relevant programs. Statutory authorities have a role in overseeing adherence to legislation through education, investigation of complaints, and the enforcement of laws and penalties. Employers are required by law to create an environment that protects the health and safety of their staff. Employees are obliged to follow the law and the lawful directions of their employers.

Despite these existing laws, regulatory bodies, codes of practice, and education initiatives, bullying and harassment continue to occur within the medical profession and the health profession more broadly. It is clear, that new approaches are required.

A number of professional bodies have already shown leadership and made a commitment to take action to the next level. For its own sake, and for the benefit of the broader community, the medical profession has an important role to play as a role model, and by making action on bullying and harassment a public health priority.

In line with our work on this issue, *beyondblue's* submission to this inquiry focuses primarily on medical students and doctors although we believe that the issues are similar among other health professionals, and

the proposed solutions should benefits these groups as well. We have also focused our attention on the broad issue of bullying and harassment, rather than to the particular issue of the possible vexatious use of the National Registration and Accreditation Scheme as a specific example of how bullying and harassment may occur.

It is our view that a global approach is required that focuses on all types of bullying and harassment. It is also our view that the most effective way to achieve this is by including bullying and harassment within a broader focus on creating a mentally healthy workplace and improving workplace culture, rather than treating these problems in isolation to broader workplace issues. It is particularly crucial to support the next generation of doctors and other health professionals as leaders in eradicating bullying and harassment, while also working with those already in the profession. Ultimately, the focus is on stopping the transgenerational 'acceptance' of bad behaviour by bringing the issue out into the open so that doctors start to expect better behaviour from themselves and their peers and colleagues and no longer feel powerless to speak out where they see bullying and harassment occurring.

Accordingly, *beyondblue* would like to make the following recommendations:

1. Action on bullying and harassment should be embedded within a focus on workplace mental health. It is therefore recommended that the Commonwealth government, in collaboration with State/Territory governments, works to address workplace bullying and harassment by supporting all public hospitals and funded health care services to introduce a whole of organisation workplace mental health strategy. *beyondblue* is currently in working in collaboration with several Victorian hospitals and other industry stakeholders to create a resource that provides guidance to hospitals on how to develop and implement a comprehensive mental health strategy that encompasses all hospital staff. Once developed and evaluated, this resource could be considered for national implementation.
2. Action on bullying and harassment should be based on a culture of respectful relationships. It is therefore recommended that the Commonwealth Government:
    a. work with the Medical Board of Australia and the Medical Colleges to include a specific reference to the importance of respectful relationships within the Code Of Conduct For Doctors in Australia and within each of the Colleges' codes of conduct
    b. work with the Australian Medical Council or other body to include a specific focus on respectful relationships within the curricula and expected competencies of all medical specialist training programs.
3. Action on bullying and harassment should be supported by incentives, particularly those targeted to future leaders in the medical profession. It is therefore recommended that the Commonwealth Government examine opportunities to:
    a. leverage existing awards programs (e.g. ComCare Work Health and Safety Awards) to recognise an individual or organisation's contribution to effective workplace anti-bullying and harassment approaches in healthcare settings
    b. work with the Medical Board of Australia, the AMA, Medical Colleges, and/or State/Territory governments to introduce awards for doctors in training which recognise individual leadership and action on workplace anti-bullying and harassment.
4. Action on bullying and harassment needs to be supported by ready access to reliable data to monitor the impact of anti-bullying and harassment interventions. It is therefore recommended that the Commonwealth government, in collaboration with State/Territory governments, consider the introduction of:
    a. a regular national prevalence survey of bullying and harassment within all public hospitals and funded health care services, with particular items relating to medical students and doctors, to monitor the prevalence of bullying and harassment

b. a centralised collection and reporting on data from all Commonwealth and State/Territory statutory authorities that receive complaints in relation to bullying and harassment and from State and Territory funded health services, in relation to reported incidents of bullying and harassment within the medical profession.

The public health context

Mental health conditions

Mental health conditions are common. The 2007 National Survey of Mental Health and Wellbeing found that in the year prior to the survey around 1 in 5 Australians aged 16 to 85 had experienced a mental health condition at some point. The survey also found that over their lifetime, around 45 per cent of Australians had experienced some sort of mental health condition.[2] Depression, anxiety and substance use conditions are the most prevalent mental health disorders in Australia. One in seven Australians are likely to experience depression in their lifetime and one quarter an anxiety condition.[3] Mental health conditions are associated with psychosocial disability, poor physical health and premature death, including by suicide. In 2015, 3,027 Australians died by suicide. The majority of people who suicide are in the prime of their life.[4]

The medical profession is not immune from mental health conditions and suicidal behaviours. In a systematic review of the international literature on the mental health of doctors Elliot et al. found that the prevalence of depression among doctors from various countries varied from 14 per cent to 60 per cent and the prevalence of anxiety conditions varied between 18 per cent and 55 per cent. The reviewers also found that suicide rates were higher among medical practitioners compared to the general community.[5]

In 2013 *beyondblue* commissioned Monash University to undertake the Australian National Mental Health Survey of Doctors and Medical Students.[6] The 42,942 doctors who participated in the survey, were found to report significantly greater levels of very high psychological distress compared to people in the general population and to people in other professionals (3.4% vs. 2.6% vs. 0.7% respectively). The survey also found that approximately 21 per cent of the doctors reported they had been diagnosed with, or treated for depression at some point in their lives and 6 per cent reported a current diagnosis. Additionally, around 9 per cent of doctors reported they had been diagnosed or treated with an anxiety disorder at some time, and approximately 4 per cent reported being currently diagnosed with, or treated for an anxiety disorder. With regards to suicidality, around a quarter of doctors reported having thoughts of taking their own life prior to the last 12 months and around 10 per cent reported they had had these thoughts within the last 12 months. Approximately 2 per cent of doctors reported they had attempted suicide at some point in their lives.[7] These rates of suicidal ideation and attempt are substantially higher than those reported by the general population and other professionals in the 2007 National Survey of Mental Health and Wellbeing.[8]

Medical students were also found to experience high rates of mental health issues. Levels of very high psychological distress were substantially higher among the 6,658 medical students who participated in the survey, than in the general population (9.2% and 3.1% respectively). In addition, around 18 per cent self-reported that they had been diagnosed with, or treated for depression at some point in their lives and 8 per cent reported currently experiencing depression. Just under 10 per cent reported ever having an anxiety condition, while slightly over 5 per cent reported currently experiencing an anxiety condition.[9] While these rates are higher than the Australian population, they are similar to those reported for Australian university students, however, the prevalence of suicidal ideation and suicide attempts was substantially higher among medical students.[10]

Preventing mental health conditions

While effective treatments are available for mental health conditions, increasing emphasis is being placed on finding ways to prevent these conditions from developing in the first place. There is no one single cause of depression or anxiety conditions. Rather these conditions develop through the complex interplay of individual and environmental risk and protective factors. While some of these factors are relatively fixed, such as genetic predisposition, many are malleable and open to influence. Public health prevention measures aim to identify and reduce the malleable risk factors and increase the protective factors that can lead to poor mental health. While doctors experience a range of risk factors for anxiety and depression including heavy workloads, long working hours, shift work, work-effort imbalance, and home/work stress,[11] there is some evidence to suggest that their exposure to bullying and harassment may be independently contributing to their risk of developing mental health conditions such as depression and anxiety conditions.

The importance of improving Australia's response to depression and anxiety conditions cannot be underestimated. It has recently been estimated that scaling up our response to the prevention and management of these conditions is likely to yield substantial return on investment – between 2.3-3.0 to 1 when economic benefits only are considered, and 3.3-5.7 to 1 when the value of health returns is also included.[12]

Summary of key points:

Mental health conditions are common, potentially disabling, and associated with the risk of premature death from suicide.

These conditions impact affected individuals, their families and friends and the wider community. The economic cost of mental health conditions is considerable.

While effective treatments and supports exist for most mental health conditions, increasing emphasis is being placed on preventing conditions from developing in the first place, through initiatives targeted to reduce key risks and to promote protective factors.

Exposure to bullying and harassment are risk factors for the development of common mental health conditions such as depression and anxiety conditions.

Preventing bullying and harassment may avert a significant number of incident cases as well as improving outcomes for people affected by these conditions.

The prevalence and impacts of bullying and harassment

Definitions

There is no single legal definition of workplace bullying and individual states and territories have developed their own definitions[13], however there is general agreement that a worker is bullied at work if: a person or group of people repeatedly act unreasonably towards them or a group of workers; and the behaviour creates a risk to health and safety.[14] The key feature of bullying is that it causes harm and is repetitive or occurs over a prolonged period of time.[15] The Fair Work Ombudsman defines bullying as:

> "Unreasonable behaviour includes victimising, humiliating, intimidating or threatening. Whether a behaviour is unreasonable can depend on whether a reasonable person might see the behaviour as unreasonable in the circumstances. Examples of bullying include: behaving aggressively; teasing or practical jokes; pressuring someone to behave inappropriately; excluding someone from work-related events; or unreasonable work demands."[16]

Other examples of bullying include: abusive, insulting or offensive language or comments; unjustified criticism or complaints; spreading misinformation or malicious rumours; withholding information that is vital for effective work performance; denying access to information, supervision, consultation or resources to the detriment of the worker; setting tasks that are unreasonably below or beyond a person's skill level; and changing work arrangements such as rosters and leave to deliberately inconvenience a particular worker or workers.[17] It has been suggested that bullying covers a spectrum of behaviour and that it may be quite intentional or occur through ignorance of its impact on others – either way it must be addressed. Bullying may also take the form of social exclusion.[18]

It is important to note that reasonable performance management that is carried out in a judicious way is not bullying.

As with bullying, no single legal definition of workplace harassment exists. Generally speaking, harassment is considered to be any unwelcome conduct that humiliates, offends or intimidates people.[19] In a recent report on bullying and harassment in the health system, the Victorian Auditor General defined harassment as:

> "…treating someone less favourably than another person or group because of a particular characteristic—such as ethnic origin, gender, age, disability or religion." [20]

Like bullying, harassment may include a range of behaviours such as: telling insulting jokes about particular racial groups; displaying racially offensive posters or screen savers; making derogatory comments or taunts about someone's race; or asking intrusive questions about someone's personal life.[21]

Sexual harassment is a specific form of harassment. It is defined as: "any unwanted or unwelcome sexual behaviour where a reasonable person would have anticipated the possibility that the person harassed would feel offended, humiliated or intimidated. It has nothing to do with mutual attraction or consensual behaviour."[22] Such behaviours may include: staring or leering; unnecessary familiarity, such as deliberately brushing up against you or unwelcome touching; suggestive comments or jokes; insults or taunts of a sexual nature; intrusive questions or statements about your private life; displaying posters, magazines or screen savers of a sexual nature; sending sexually explicit emails or text messages; inappropriate advances on social networking sites; accessing sexually explicit internet sites; requests for sex or repeated unwanted requests to go out on dates; behaviour that may also be considered to be an offence under criminal law, such as physical assault, indecent exposure, sexual assault, stalking or obscene communications.[23]

Unlike bullying, harassment, including sexual harassment only needs to involve a single incident rather than a repeated pattern of behaviour to be considered unlawful.

Prevalence of bullying and harassment in Australian workplaces

Estimates of the prevalence of bullying and harassment vary widely according to the definition used. In 2012, researchers from South Australia undertaking the Australian Workplace Barometer survey provided survey respondents with the following definition of bullying:

> "Bullying is a problem at some workplaces and for some workers. To label something, as bullying, the offensive behaviour has to occur repeatedly over a period of time, and the person confronted has to experience difficulties defending him or herself. The behaviour is not bullying if two parties of approximate equal "strength" are in conflict or the incident is an isolated event." [24]

Based on this definition, 6.8 per cent of the 5,743 respondents from a range of occupations and industries reported that they had experienced bullying in the last six months and of these approximately half (3.5 per cent of the total sample) reported experiencing bullying for longer than 6 months.[25] Other evidence suggests that nearly half of all Australian employees experience workplace bullying at some stage during their working life.[26]

Respondents in the Workplace Barometer survey were also asked about their experiences of harassment. Around 34 per cent reported being sworn at or yelled at while at work, 23 per cent said they had been humiliated in front of others, 19 per cent experienced discomfort because of sexual humour, around 10 per cent experienced unfair treatment due to their gender, and about 5 per cent had experienced unwanted sexual advances.[27] "Overall, females reported significantly higher levels of overall sexual harassment and bullying and experienced bullying for significantly longer periods of time than men."[28]

Sexual harassment at work is also a major problem, with females disproportionately affected.[29] In their 2012 national survey of sexual harassment in the workplace, the Australian Human Rights Commission found that sexual harassment occurred across a wide range of occupations, workplaces and industries. A quarter of women (25%) and one in six men (16%) aged 15 years and older reported that they had experienced sexual harassment in the workplace in the past five years. The most likely targets were women, in particular those less than 40 years of age. The most likely harassers were male co-workers, but also included bosses or employers.[30]

Prevalence of bullying and harassment in the medical profession

Bullying and harassment also occur in the medical profession although its exact prevalence is difficult to establish. In 2008, the Garling Report into Acute Care Services in NSW Public Hospitals noted widespread reports of bullying but did not provide an estimate of its prevalence.[31]

In 2015, ACT Health commissioned KPMG to undertake a review of the clinical training culture at the Canberra Hospital and Health Services. As part of the review, the consultants provided staff with the option of making a written submission. Seventy six per cent of the 28 people who provided a submission indicated they had observed/witnessed behaviours that would indicate a culture condoning/accepting bullying, discrimination and/or harassment. Allegations of bullying and harassment were also reported in the focus groups undertaken as part of the review. The review concluded that: "while there is evidence of issues relating to bullying, discrimination and/or harassment that need to be addressed by the hospital, participants in the review wanted to make it clear that this inappropriate behaviour was not widespread in every area of training specialty."[32] So, while bullying and harassment were clearly occurring, the review was not able to measure its exact extent, although it was likely to have occurred to a sizeable minority of staff.

The recent Victorian Government Auditor General's *Report into Bullying and Harassment in the Health Sector* cited a 2014 report by Monash University that found 40 per cent of Victorian nursing professionals who participated in a survey on occupational health and safety reported they had experienced bullying or harassment within the previous 12 months. The Victorian Auditor General's report also noted that Victorian

Public Sector Commission's People Matter survey showed that 25 per cent of health agency employees said they had experienced bullying.[33]

In the 2013 *beyondblue* commissioned survey on the mental health of doctors and medical students, respondents were asked to identify sources of stress in their lives. Around 10 per cent of the 42,942 doctors who participated cited difficult relations with senior colleagues as source of stress and 4.5 per cent specifically noted workplace bullying as a source of stress. There was considerable variability within the respondent sample on this issue. Around 22 per cent of doctors from an Aboriginal and/or Torres Strait Islander background reported being stressed by bullying. Doctors in non-patient roles (12.4%), imaging and pathology (6%), oncology (6%), surgery (5.5%), paediatrics (5.5%), obstetrics and gynaecology (5.3%) and mental health (4.8%) were also relatively high compared to the average. Concerns about bullying were also notably higher among females (5.3%) than males (4.0%).[34] The issue of sexual harassment was not directly assessed in the survey.

In 2012, Askew and colleagues analysed data from a cross sectional survey of doctors undertaken as part of a broader longitudinal study on the medical workforce. The survey included several questions relating to workplace bullying. Of the 747 doctors who responded to these questions, 25 per cent reported being bullied in the last 12 months.[35]

In 2015, the Royal Australasian College of Surgeons (RACS) commissioned an Expert Advisory Group (EAG) to investigate and advise the College on the prevalence of discrimination, bullying, harassment and sexual harassment in surgery in Australia and New Zealand. Overall, 3,516 individuals participated in the prevalence survey representing a 47.8 per cent response rate. Almost half of the respondents (49.2%) indicated that they had experienced discrimination, bullying, harassment and sexual harassment including some who had experienced multiple behaviours. This proportion was consistent across every specialty. Bullying was the most prevalent experience (39%), followed by harassment (19%), discrimination (18%) and sexual harassment (7%). The percentage of female respondents experiencing any of these behaviours was significantly higher than males.[36 37] The Expert Advisory Group concluded that: "discrimination, bullying and sexual harassment are pervasive and serious problems in the practice of surgery in Australia and New Zealand."[38]

Trainees appear to be particularly vulnerable to bullying and harassment. Of the 532 respondents in the RACS EAG prevalence study who identified themselves as surgical trainees, 468 (88%) reported that they had experienced one or more of the behaviours. More than half (54%) responded that they had been bullied, 24 per cent said they had experienced discrimination, 23 per cent harassment and 12 per cent they had experienced sexual harassment.[39 40] A 2014 systematic review and meta-analysis of harassment and discrimination in medical training, which reviewed 59 studies from a range of countries, found that around 63 per cent of trainee doctors had experienced some form of harassment, with verbal harassment being the most common type of abuse.[41]

Medical students also experience a range of poor behaviours. The 2014 systematic review and meta-analysis cited above also found that overall in the studies that were reviewed, just under 60 per cent of medical students had experienced some form of harassment, with verbal harassment being the most common type of abuse.[42] A recent study of 'teaching by humiliation' within the medical profession, found that among the 146 final-stage medical students from the University of Sydney and University of Melbourne who participated in the survey, 74 per cent had experienced 'teaching by humiliation' and around 84 per cent had witnessed it during their adult clinical rotations, while just under 29 per cent had experienced it and 45 per cent had witnessed teaching by humiliation during their paediatric rotation. Common behaviours included intimidating questioning, rudeness, hostility and belittling. More overt behaviours like yelling, or swearing were less common.[43] Sexual harassment also appears to be common among Australian medical students although the exact prevalence is not well established.[44] In a study of 293 medical students, over one third (38%) reported they had experienced some sort of sexual harassment during their undergraduate training. The prevalence was higher among female students and among students in the clinical years, compared to those in the pre-clinical years.[45]

In addition to these formal reviews and studies on bullying and harassment, there is also considerable anecdotal evidence of its existence. Some examples emerged in the Australian Broadcast Commission 4 Corners story – At their mercy[46] – which was aired shortly after comments made by Dr Gabrielle McMullin that sexual harassment was widespread in the surgical profession.[47] Bullying and harassment may well be under-reported. Under-reporting occurs for a range of reasons including a level of 'acceptance and normalisation of bullying', fear of career repercussions, and distrust of, or lack of confidence in complaints investigation and resolution processes.[48]

The impact of bullying and harassment

Individual impacts

Individuals who experience bullying and harassment are at risk of a range of poor physical health outcomes including headaches, hypertension, and chronic pain.[49] [50] Bullied individuals are also at increased risk of mental health conditions. In their meta-analysis of 137 cross-sectional studies, Nielsen and Einarsen found that exposure to bullying was associated with a range of mental health problems including depression.[51] A more recent systematic review and meta-analysis of cross sectional studies by Verkuil et al. also found a strong association between workplace bullying and depression, anxiety and stress-related psychological complaints.[52] A recent Australian cross-sectional study found that people who reported workplace bullying were 2.5 times more likely to experience depression, than those who had not experienced bullying. Drawing on these results the study estimated that bullying was responsible for around 5.2 per cent of the annual depression burden in Australia.[53]

The link between bullying and depression has also been found in longitudinal studies. In their study of the Norwegian workforce, Einarsen and Nielsen found that exposure to bullying at baseline was predictive of future psychological distress five years later, even after controlling for baseline levels of distress and stressful work situation.[54] Likewise, Loerbroks et al. found that among a group of 621 junior doctors in Germany who participated in a prospective cohort study, bullying at baseline was predictive of increased depressive symptoms at one year and three year follow up.[55] A meta-analysis of 13 longitudinal studies by Nielsen and Einarsen found that bullying at baseline was significantly predictive of future mental health conditions,[56] while a meta-analysis of longitudinal studies by Verkuil et al. found that baseline workplace bullying significantly predicted depression, anxiety and stress related psychological complaints. Both these meta-analysis studies also showed a bi-directional relationship with baseline anxiety and stress related psychological complaints predicting the experience of being bullied in the future.[57] [58]

Exposure to bullying is also associated with increased risk of suicide ideation and suicide behaviours.[59]

While exposure to bullying and harassment does not invariably lead to mental health conditions, nor are these the only risk factors that contribute to these conditions, they are certainly amenable to intervention.

Workplace, productivity and societal impacts

Bullying does not just impact on affected individuals but also those around them. Bullying can lead to poor health and low morale, engagement and productivity among workers who witness bullying.[60] In the medical profession the negative impacts of bullying and harassment have the potential to impact on patient care.[61]

Bullying and harassment impacts on the workplace through lower productivity and reduced career longevity. Bullying and harassment are associated with burnout, low job satisfaction, reduced organisational commitment, increased intentions to leave, absenteeism and presenteeism.[62] [63] [64] [65] In one study, doctors who reported being bullied were significantly less satisfied with their jobs, experienced higher levels of absenteeism in the last 12 months, were more likely to contemplate decreasing the number of hours worked in medicine in the next 12 months, or ceasing direct patient care in the next five years compared to those who had not experienced bullying.[66] Evidence also shows that medical students who experience humiliation, bullying or harassment may also consider dropping out of their course.[67] Of significant concern, there is some evidence that female medical students believe that their career path was negatively influenced by gender discrimination and sexual harassment considerations.[68] Ultimately, bullying and harassment lead to higher

rates of staff turnover and the associated costs of re-hiring and training new workers.[69] Bullying and harassment can also take up time and resources in investigating and managing complaints. There are also potential legal costs in defending claims or in compensation payments and significant reputational impacts.[70] [71] [72]

The impact on the broader economy is also considerable. In 2010, the Productivity Commission estimated that the combined direct and indirect costs of workplace bullying was costing Australia between $6 billion and $36 billion annually.[73]

Summary of key points:

Workplace bullying consists of repeated unreasonable acts by an individual or group of individuals against a co-worker and that these behaviours creates a risk to health and safety for the individual who experiences them.

Harassment is any unwelcome conduct that humiliates, offends or intimidates people. It can also involve treating someone less favourably than another person or group because of a particular characteristic—such as ethnic origin, gender, age, disability or religion.

Sexual harassment is defined as any unwanted or unwelcome sexual behaviour where a reasonable person would have anticipated the possibility that the person harassed would feel offended, humiliated or intimidated.

Anecdotal and empirical evidence, including some several reviews of bullying in health services and the medical profession commissioned by governments or statutory authorities, show that bullying and harassment is a chronic and endemic problem in the profession affecting a sizable minority of medical students and doctors.

Individuals who experience bullying and harassment are at risk of a range of poor physical health outcomes.

They are also at significantly increased risk of experiencing mental health conditions such as depression and anxiety.

Bullying does not just impact on affected individuals. It can lead to poor health and low morale, engagement and productivity among workers who witness bullying.

In the medical profession, the negative impacts of bullying and harassment have the potential to impact on patient care.

Bullying and harassment impacts on the workplace through lower productivity and reduced career longevity. Bullying and harassment are associated with burnout, low job satisfaction, reduced organisational commitment, increased intentions to leave, absenteeism and presenteeism.

Bullying and harassment can also take up time and resources in investigating and managing complaints. There are also potential legal costs in defending claims or in compensation payments and significant reputational impacts.

The impact on the broader economy is also considerable. In 2010 the Productivity Commission estimated that the combined direct and indirect costs of workplace bullying was costing Australia between $6 billion and $36 billion annually.

The legislative and regulatory environment

Commonwealth and State/Territory Legislation

The prevention and management of bullying and harassment involves a complex suite of legislation, regulatory frameworks and organisational practices and policies. Action is the shared responsibility of governments, regulators, employers and employees.

The twin issues of bullying and harassment are covered by a variety of different Commonwealth, State and Territory laws. These include the Fair Work Act 2009 (Cth) in sections 789FA-789FI,[74] the Work Health and Safety Act 2011 (Cth), the Sex Discrimination Act 1984 (Cth) and the various State and Territory WHS/OHS, anti-discrimination and equal opportunity laws.

Under the Fair Work Act 2009 (Cth) employers are required to ensure that workers are not bullied. The responsibility to prevent workplace bullying, harassment and discrimination is also covered in the Work Health and Safety Act 2011 by the duty to provide a healthy and safe working environment.

Under State and Territory WHS/OHS laws, employers and employees have a legal responsibility to ensure that, as far as reasonably practicable, they provide employees with a working environment that is safe and free from risks to their health and that employers behaviour or the behaviour of their employees does not adversely affect the health and safety of other workers.[75] Such behaviours include bullying and harassment.

While each State and Territory has its own OHS legislation, in 2008 through the COAG, all Australian governments endorsed the Inter-Governmental Agreement for Regulatory and Operational Reform in Occupational Health and Safety which aimed to harmonise the various State and Territory WHS/OHS laws through the development a model Act (the Work Health and Safety Act 2011), supported by model regulations, model codes of practice and a nationally consistent approach to compliance and enforcement policy.[76]

Sexual harassment in employment is unlawful under the Sex Discrimination Act 1984 (Cth) and also under state anti-discrimination or equal opportunity laws. Other forms of harassment may also be unlawful under Commonwealth and State/Territory laws where it involves a person being treated less favourably: "on the basis of certain personal characteristics, such as race, sex, pregnancy, marital status, breastfeeding, age, disability, sexual orientation, gender identity or intersex status."[77]

In Victoria, Brodie's Law makes serious bullying a criminal offence. This law covers workplace bullying, as well as bullying occurring in schools, sporting clubs, on social media or other contexts.[78] Certain forms of sexual harassment, such as sexual assault or stalking are also criminal offences.

Codes of practice

Some State and Territory WHS/OHS regulators have developed their own Code of Practice in relation to bullying (e.g. ACT and WA). These Codes provide employers with detailed information on how to manage workplace bullying as part of meeting their duties under the local WHS/OHS laws. These Codes do not replace WHS/OHS laws, but assist employers to understand what to do. Safe Work Australia has also developed a Code of Practice titled a *Guide to preventing and responding to workplace bullying* for employers and a companion document for employees titled *Dealing with workplace bullying - a worker's guide*.

Similarly, the Fair Work Commission, the Australian Human Rights Commission, and all the State and Territory based WHS/OHS regulators, equal opportunity and/or human rights commissions have produced extensive guidance materials for workplaces on bullying and harassment, including sexual harassment. Most these authorities also provide training either online or face-to-face to assist all employers and employees to understand their rights and their responsibilities.

Within the medical profession, professional colleges address harassment in their codes of conduct.[79]

Workplace strategies

A range of strategies are utilised by organisations to prevent and manage workplace bullying. These include:

- Individual level strategies which aim to influence employee attitudes and interaction styles, through education and training
- Job-level strategies which aim to modify the job characteristics or work environment as a way of preventing/managing bullying
- Organisational strategies which take a whole of organisation approach, such as policies/procedures, and strategies to address workplace culture
- Multi-level strategies which combine elements of more than one of the strategies above in order to comprehensively address bullying and prevent its recurrence.[80]

Complaints and enforcement

In most workplaces, an employee who is experiencing workplace bullying or harassment is encouraged to either discuss the issue with the perpetrator, object to the behaviour and to tell them to stop – if they feel safe to do so. Alternatively they may report the behaviour to their manager, human resources office, workplace health and safety (WHS)/occupational health and safety (OHS) officer or a union representative.[81]

An employee may also take their complaint about bullying and harassment to the relevant State or Territory based WHS/OHS regulator. These regulators have the power to launch investigations and enforce change through serving notices for the problem to be remedied or to launch court action to have an employer or employee a prosecuted for serious breaches. Where an employee experienced harassment, including sexual harassment, that contravenes local anti-discrimination or equal opportunity laws, they may take their complaint to the relevant State or Territory based equal opportunity or anti-discrimination authority.

Commonwealth authorities are another avenue. A person who believes that they are being bullied may also take action through the Fair Work Commission under the Fair Work Act 2009 (Cth) if they are employed within a constitutionally covered business. The Fair Work Commission has the powers to make orders to stop bullying. The Fair Work Ombudsman can assist in enforcing an order that has not been followed. A person can also make a complaint to the Australian Human Rights Commission in relation to bullying and harassment covered by anti-discrimination law. This includes bullying and harassment because of a person's race, sex, age, sexual orientation, religion or disability. A person who believes that they have been sexually harassed can make a complaint to the Australian Human Rights Commission.

Some types of workplace bullying and harassment are criminal offences and can be reported to the police.

Barriers to reporting bullying and harassment

It appears that many instances of bullying and harassment may go unreported.[82] Askew et al. found that around a third of doctors (31%), who had experienced bullying had not made a formal or informal complaint. Of the 69 per cent of doctors who had made either an informal or formal complaint only 24 per cent were satisfied with the outcome of their complaint.[83] Among the respondents to the RACS EAG survey, around 45 per cent who were bullied did not take any action to report it and just over 56 per cent of those who had experienced sexual harassment did not report it. There are also concerns that sexual harassment may be under-reported.[84]

A range of factors contribute to under-reporting including: not knowing how to make a complaint; a lack of a local complaints management system; lack of confidence or trust in the complaints process; perceived lack of action taken even after a complaint; fear of retribution, including through changes in rostering and opportunities; and concern about the impact on one's career.[85] [86] [87] The 2014 AMA specialist trainee report found that less than a third (30%) agreed or strongly agreed that their college has policies on dealing with bullying and harassment that are clear and readily accessible to trainees. In addition, only 12 per cent of respondents agreed or strongly agreed that their college responds in a timely and appropriate manner to cases of bullying and harassment.[88]

Concerns about the inadequacy of complaints systems and fears about the risk of reprisal are supported by the reported experiences of respondents in the RACS EAG prevalence survey who did report their experience of discrimination, bullying, harassment, or sexual harassment. Across the four behaviours between 22-33 per

cent of respondents stated that the report made no difference and the behaviour continued. Across the four behaviours between 5-15 per cent of respondents stated they were victimised for making a complaint and between 10-18 per cent reported that they left their job after making a report. Across the four behaviours, the behaviour stopped in only 10-30 per cent of cases, with the highest reported cessation being after a complaint about sexual harassment.[89]

The risk is that when other doctors or medical students hear about their peers' and colleagues' experiences of bullying and discrimination, particularly if it is not reported, investigated and stopped they are more likely to anticipate a negative reaction if they experience it and try to do something, and may stop themselves from taking positive action.

The Australian Health Practitioners Regulation Agency

The Australian Health Practitioners Regulation Agency (AHPRA) receives and manages complaints about registered health practitioners or students on behalf of the 14 National Boards, except in NSW and Queensland.[90] Under the National Scheme, a complaint about a registered health practitioner is called a 'notification'. Notifications may relate to professional conduct, performance or the health of registered practitioners.[91] Notifications may be made by patients or their families, other health practitioners, employers or representatives of statutory bodies. Notifications are managed according to legal requirements, including confidentiality, privacy and principles of procedural fairness.[92]

beyondblue acknowledges and supports the principle underpinning the complaints process as an important element for protecting the general community, however it is important that this process does not paradoxically contribute to harm for the persons involved. The process is stressful for all parties and needs to be managed with sensitivity, as well as with procedural integrity.

It is important that the complaints and investigation process be continuously reviewed and improved to reduce the stress on all parties involved, including where a complaint is being made against a doctor or medical student who may be potentially unwell. We consider the following elements to be important:

a) Ensure that all AHPRA personnel involved in receiving, investigating and managing complaints have training in basic mental health first aid skills in order to recognise and respond to emerging psychological distress and provide support to the relevant party/parties. There must be emphasis on compassion as well as transparency and natural justice for the benefit of all. AHPRA staff should also be supported in their work.
b) Ensure the manner in which a potentially impaired doctor is notified of the complaint or report is managed with care to ensure that the mental health of an already vulnerable person is protected and that support is offered and then followed up.
c) Ensure the timely investigation of a complaint, particularly where a doctor's practice may be limited, or reviewed because of illness. Delays and the inability to practice contribute significantly to stress. Emphasis should be given to supporting a potentially unwell doctor into treatment and rehabilitation, including transitioning back into work, by an agreement or process worked out between AHPRA, the Doctor's Health Service and the employer. This would align to how formal investigations into potential misconduct or redundancy or termination processes occur in any other workforce.
d) Ensure high quality and timely supports are available to protect the mental health of doctors who may subject to a complaints investigation process. This should be done in collaboration with other medical profession stakeholders (e.g. health services, training colleges).

beyondblue does note that some of these concerns about timeliness, procedural fairness and transparency were raised as part of The Independent Review of the National Registration and Accreditation Scheme for health professions conducted by Mr Kim Snowball on behalf of Australian Health Ministers' Advisory Council[93] The COAG Health Council meeting as the Australian Health Workforce Ministerial Council reviewed the 33 recommendations made in the Final Report by the Independent Reviewer, including recommendations on improving the operation of the complaints and notifications process, and that the Australian Health Ministers accepted 9 recommendations, accepted in principle 11 recommendations, did not accept 6 recommendations, and deferred decisions on 7 recommendations pending further advice.[94]

beyondblue welcomes all efforts by AHPRA to ensure that it has mechanisms in place to receive and respond to feedback and concerns about its practices, processes and systems on an ongoing basis and encourages AHPRA to report on the implementation of the relevant recommendations. The Independent Review of the National Registration and Accreditation Scheme and any other measures it takes to respond to community concerns.

Summary of key points:

Action to prevent and respond to bullying requires action by governments, regulators, employers and employees.

Bullying and harassment are proscribed by a variety of Commonwealth, State and Territory laws.

All jurisdictions have regulatory authorities responsible for the enforcement of relevant legislation. These authorities have developed codes of practice around bullying and harassment laws and provide information and education to employers and employees about their respective rights and responsibilities under relevant workplace laws.

All workplaces are required to have measures in place to prevent bullying and harassment and to effectively manage situations where they arise.

People who experience bullying and harassment have a number of different options for making a complaint against an alleged perpetrator. In the first instances, this may involve talking to the person about their behaviour and asking them to stop, or reporting the behaviour to the relevant internal line manager, human resource officer, work health safety (WHS)/occupational health safety (OHS) officer, or union representative.

People can also take complaints of bullying and harassment to a range of State/Territory or Commonwealth statutory authorities including WHS/OHS regulators, or equal opportunity, anti-discrimination and human rights commissions.

Within the medical profession, people may also potentially make a complaint about a doctor or medical student who is bullying or harassing them to the Australian Health Practitioners Regulation Agency (AHRPA).

Workplace bullying and harassment appears to be under-reported, including in the medical profession and strategies are therefore required to address barriers to reporting. These include: lack of knowledge, inadequate internal complaints management systems in workplaces, as well as fear of retribution or damage to one's career.

Creating a mentally healthy workplace

Why does bullying and harassment occur?

It is difficult to establish a single cause for bullying and harassment. Research on workplace bullying has tended to focus on the attributes of the target of bullying, the perpetrator, and of the organisational environment. While there is no uniform 'type' of person who experiences bullying, studies suggest that targets of bullying often appear sad and anxious and have higher levels of neuroticism and may also lack assertiveness or self-efficacy.[95] [96] Likewise while anyone can be a bully, perpetrators are more often male, may be narcissistic or have psychopathic traits.[97] Other research suggests that employees experiencing job insecurity, or work related stress (high demands and low control) are more likely to engage in bullying behaviours.[98]

Organisational factors are also very important. Workplace factors that contribute to bullying include poor leadership and management style (e.g. too authoritarian or too passive in resolving conflicts), overly hierarchical workplaces where power imbalances exist, a non-supportive organisational culture and non-ethical climate, an insufficient focus on and/or poorly developed, or implemented organisational policies and systems to combat bullying and situational factors such as high job stress, hot, noisy and cramped conditions, or reward structures that foster competition.[99] [100] [101]

The Victorian Auditor General found that bullying occurred in health services because of: lack of effective controls in place to prevent or reduce bullying and harassment; lack of an effective early intervention process or mechanisms to ensure managers are responding to issues brought to them effectively; inadequate formal complaints process affected by widespread under-reporting, and inadequate complaints management systems and practices; and a lack of collaboration between the Department, WorkSafe and Victorian Public Sector Commission.[102]

The issue of sexual harassment appears to be closely aligned with issues of gender inequality. From this perspective sexual harassment may arise from power imbalances between men and women as well as the degree to which rigid gender stereotypes are maintained within the culture of the workplace.[103]

Structural characteristics of work are also relevant, with sexual harassment more common among women in precarious employment (e.g. casual and fixed term positions).[104] Doctors in training are often employed on annual contracts. The precarious nature of contracts or advancement through their training program may also contribute to underreporting of unwanted or unwelcome sexual behaviour.

Causes of bullying and harassment within the medical profession

Some suggest the rigid hierarchical structure of the medical profession[105] particularly within hospitals, contributes to the situation, by creating, embedding and reinforcing power imbalances between individuals. Bullying and harassment is often experienced by those in lower positions of authority relative to the perpetrator. Askew et al. found that most doctors in their survey who had experienced bullying in the previous 12 months had experienced this behaviour from a more senior doctor (44%), or from managers, administrators and clerical staff (27%).[106] The systematic review and meta-analysis of harassment and discrimination in medical training by Fnais et al. found that consultants were the most commonly cited perpetrators.[107] In the RACS EAG prevalence survey, male surgical consultants were identified as the most likely perpetrators of discrimination, bullying or sexual harassment.[108] [109] The RACS EAG also noted that of the hospitals who participated in a separate survey conducted by the Group to ascertain the views of hospitals and educational organisations throughout Australia and New Zealand, around 71 per cent of the hospitals that participated reported instances of discrimination, bullying or sexual harassment by a surgeon in their hospital in the last five years. Bullying was the most frequently reported issue. Surgical directors or surgical consultants were by far the most frequently reported perpetrators (in 50% of hospitals).[110]

Clearly, however not all doctors in positions of authority exhibit or condone bullying and harassment and having a position of authority is not the only factor that may contribute to bullying. For example, O'Connor suggests that bullying in hospitals in part arises within the context of the resource constrained, pressurised and adversarial environment that exists within public hospitals, where people are stressed and competing against each other.[111] This is in line with the frustration/strain explanation of bullying.[112]

There is some concern however, that there may be a 'culture' that allows bullying and harassment to occur within the medical profession, and that this may be a transgenerational phenomenon ingrained in the profession.[113] Some doctors reproduce behaviours they have learned from role models from previous generations.[114] This is supported by evidence from Scott et al. who found that many students considered 'teaching by humiliation' as part of the culture of medicine and part of the process of toughening people up for a career in the profession.[115] The Victorian Auditor General noted a high degree of acceptance of bullying and harassment among junior doctors. "Such behaviour was explained as a 'training technique' that helped motivate them to work harder, or as unfortunate but an inevitable rite of passage and part of the 'old-school way."[116]

Ultimately, the report concluded bullying and harassment flourish where there is a lack of real commitment and the issue is not taken seriously and where there are no or inadequate systems in place to prevent and manage these behaviours in a systematic way. Many existing approaches appear tokenistic in that they are poorly documented, not sufficiently promoted to staff through education and training, under-resourced, not enforced, poorly monitored and not evaluated.[117]

Addressing bullying and harassment

Workplace bullying and harassment often tends to be regarded as a 'private' issue between individuals, however research suggests it is better to understand these problems as structural organisational issues.[118] This suggests that ending bullying and harassment requires a change in the 'culture' of a workplace and not just a change that focuses on selected individuals. According to the Victorian Auditor General: "Building positive and respectful workplace cultures is a key control for preventing inappropriate behaviour including bullying and harassment."[119] Despite this, at present, many of the interventions to prevent bullying and harassment are targeted at the individual level.[120] This needs to change.

A multi-level systems approach is required that focuses on changing individual knowledge, attitudes, beliefs and behaviours, as well as changing the internal and external social norms and the organisational processes, systems and culture that allow bullying and harassment to flourish. Importantly, action on bullying and harassment needs to be embedded within a far broader focus on creating a mentally healthy workplace rather than being a standalone focus.[121]

Mentally healthy workplaces are those which are friendly and supportive, promote a positive workplace culture, minimise workplace risks related to mental health, support people with mental health conditions, and prevent discrimination.[122] They have been demonstrated to provide better support and protect employee mental health, and be more productive.

A comprehensive and integrated workplace mental health program model is founded on three pillars.[123] These are:

1. Protect mental health by reducing work-related risk factors. Guidelines have been developed on how organisations can prevent common mental health problems in the workplace124,125 – this includes activities such as developing a positive work environment, balancing job demands with job control, appropriately rewarding employee efforts, creating a fair workplace, providing workplace supports, effectively managing performance issues, providing training to develop management and leadership skills, and having effective anti-bullying, sexual harassment and anti-discrimination policies, procedures and initiatives in place.
2. Promote mental health by developing the positive aspects of work and employee strengths and capacities. Workplace mental health promotion strategies adopt a strengths-based approach, which

focus on identifying and enhancing what is being done well, rather than fixing what is 'wrong' with individuals, groups or organisations. Positive outcomes include subjective wellbeing, psychological capital, positive mental health, employee engagement and positive organisational attributes (for example authentic leadership, supportive workplace culture, workplace social capital).126

3. Address mental health problems among workers. People experiencing depression or anxiety should be supported to access effective treatment options, and have a safe and supportive workplace environment which encourages disclosure of a mental health problem and is free from stigma and discrimination. Work is an important part of the recovery process for most people. Workplaces need to adopt good stay-at-work and return-to-work practices (e.g. maintaining contact when a worker is absent from work due to a mental health condition, addressing any workplace risk factors that contributed to a workplace injury). Workplaces have a duty to make reasonable adjustments to support ongoing participation at work.

While leadership from individuals in positions of organisational authority, such as Boards, CEOs, and senior management is critical, ultimately the creation of mentally healthy workplaces needs to be a shared responsibility between employers and employees. It is essential therefore that employees are involved in the design, implementation and evaluation of initiatives to prevent and manage workplace bullying and harassment.

The Victorian Auditor General's Report,[127] the recent Victorian Government's *Our pathway to change: eliminating bullying and harassment in healthcare* [128]and the *Final Report on Workplace Bullying in Australia*[129] provide significant guidance on what needs to occur. Collectively these documents emphasise the need to:

- Focus on creating a culture that promotes respectful relationships and challenges entrenched norms within the medical profession that ignore, accept or permit humiliation, bullying and harassment
- Emphasise commitment, leadership and accountability
- Engage and involve staff in creating solutions
- Apply a risk management approach to the prevention of and response to bullying and harassment
- Address the underlying risk factors relating to people's jobs and the work environment that contribute to the risk of bullying and harassment occurring
- Have clearly documented policies and procedures and ensure clear lines of responsibility and accountability for identifying and responding to bullying and harassment
- Resource, train and support staff responsible for oversight of policies and procedures
- Develop and implement mandatory, comprehensive training and support mechanisms for managers on preventing and responding to bullying and harassment, including developing positive workplace cultures and good management practices
- Develop and implement mandatory, targeted training and support mechanisms on the awareness of bullying and harassment and people's legal responsibilities and rights
- Monitor compliance by all staff with policies and procedures related to bullying and harassment
- Focus on early identification and de-escalation of inappropriate behaviour before bullying and harassment develop
- Have easy to follow and use complaints management systems, that take complaints seriously and investigate and manage them promptly, objectively, and with transparency
- Collect and report on data relevant to the prevention and management of workplace bullying and harassment, including financial costs, in order to monitor progress and identify areas for improvement.

All of these steps should be embedded within an overall framework for creating a mentally healthy workplace. The Heads Up program provides the evidence, strategies and tools for workplaces wanting to achieve this outcome.

Heads Up is an Australian-first initiative of *beyondblue* and the Mentally Healthy Workplace Alliance[1] launched in May 2014, which supports Australian employers and employees to create mentally healthy workplaces. Heads Up is funded by the Australian Government Department of Health and Ageing. Through Heads Up, employers can access a tool to develop a tailored and practical action plan for creating a mentally healthy workplace based on their specific needs. This interactive step-by-step guide helps employers to identify priority areas of action, implement strategies to address these priorities, and review and monitor the outcomes.

Heads Up is enabling workplaces to overcome many of the factors that negatively impact on people with depression and anxiety participating in the workforce, by improving employer understanding and attitudes about common mental health conditions, reducing the stigma and discrimination associated with depression and anxiety, ensuring that the workplace environment and culture promotes and supports mental health and wellbeing, and ensuring that people experiencing mental health conditions are recruited, supported and retained.

beyondblue also congratulates the Australian Medical Association, the Royal Australasian College of Surgeons, the Victorian State Government and others who are working to eradicate bullying and harassment in the medical profession including the directions that have been set out in the AMA Victoria Summit on this issue, the RACS EAG campaign on discrimination, bullying and sexual harassment and the Victorian Government's *Our pathway to change: eliminating bullying and harassment in healthcare* resources.

While bullying and harassment occur across every profession, workplace and industry, the medical profession has an important role to play as a role model, both in the health sector, and more broadly by making action on bullying and harassment a public health, and economic priority.

Summary of key points:

There is no one single cause for workplace bullying and harassment. Rather bullying and harassment result from the complex interplay of individual, interpersonal and organisational factors.

While some of the individual and interpersonal factors that contribute to bullying and harassment may not be amenable to change, almost all of the organisational factors potentially can be modified.

Key factors include: rigid hierarchies that allow significant power imbalances to occur; poor leadership and management style; a non-supportive organisational culture and non-ethical climate; an insufficient focus on and/or poorly developed, or implemented organisational policies and systems to combat bullying; inadequate early intervention processes and poor complaints management systems and practices; and situational factors such as hot, noisy and cramped conditions, or reward structures that foster competition.

The workplace is a key setting for the promotion of good mental health, protection of mental health and prevention of suicide.

People spend considerable periods of time at work. Work culture and environments have a considerable influence on mental health.

[1] The Mentally Healthy Workplace Alliance is a tripartite alliance of business, government and the mental health sector which is committed to improving the mental health of Australian workplaces. Founding Alliance members include the National Mental Health Commission, Australian Chamber of Commerce and Industry, Australian Psychological Society Ltd, *beyondblue*, Black Dog Institute, Business Council of Australia, Comcare, Council of Small Business Organisations of Australia, Mental Health Council of Australia, Safe Work Australia, SANE Australia, and University of New South Wales. The Alliance has since been joined by SuperFriend and the Australian Industry Group.

Conclusions

Bullying and harassment occur across a range of work sectors, including within the medical profession. The personal toll of bullying is considerable. Bullying is associated with poor physical health and a range of mental health conditions including depression and anxiety, and the risk of suicide. The workplace economic toll of bullying and harassment are also considerable. The psychological distress associated with bullying and harassment may lead to affected people taking time off from work, or being less productive even when they are at work. Bullying and harassment can also lead to poor job satisfaction and an increased risk of people leaving their job. The cost to the community of a medical student or doctor leaving the profession prematurely is considerable through reduced workforce availability.

Despite extensive efforts to impact on bullying and harassment through legislation, regulation and education, this submission highlights that bullying and harassment are still common, with a significant minority of medical students and doctors reporting they have been the subject of these negative behaviours.

It is unlikely that further legislation will resolve the problem, however, a tightening of the regulatory oversight and enforcement of existing laws may be beneficial. Primarily this should be achieved by way of incentives linked to accurate data on the prevalence of bullying and harassment within key medical training and clinical practice environments. Action should focus more broadly on creating a mentally healthy workplace, rather than be constrained to a focus on bullying and harassment alone.

Crucially, it is time to break the intergenerational cycle by supporting medical students and junior doctors to champion the need for new social norms and behaviours within the profession. This is not to say that bullying and harassment among current senior staff should be ignored, but rather that change is most likely to occur by supporting the current generation of students and junior doctors to lead the way.

Our recommendations therefore relate to three key principles:

- **Shift the focus from bullying and harassment to the creation of a mentally healthy workplace.** This will automatically include a focus on impacting on the antecedent factors that contribute to workplace bullying and harassment, as well as responses to these issues
- **Track the prevalence of bullying and harassment** through regular surveys and the collection of data relating to complaints, in order to monitor progress and evaluate the outcomes of specific initiative
- **Champion the role of medical students and junior doctors as future leaders**, in order to break the cycle of bad behaviour that has become ingrained in some sections of the medical profession

Recommendations

1. Action on bullying and harassment should be embedded within a focus on workplace mental health. It is therefore recommended that the Commonwealth government, in collaboration with State/Territory governments, works to address workplace bullying and harassment by supporting all public hospitals and funded health care services to introduce a whole of organisation workplace mental health strategy. *beyondblue* is currently in working in collaboration with several Victorian hospitals and other industry stakeholders to create a resource that provides guidance to hospitals on how to develop and implement a comprehensive mental health strategy that encompasses all hospital staff. Once developed and evaluated, this resource could be considered for national implementation.
2. Action on bullying and harassment should be based on a culture of respectful relationships. It is therefore recommended that the Commonwealth Government:
    a. work with the Medical Board of Australia and the Medical Colleges to include a specific reference to the importance of respectful relationships within the Code Of Conduct For Doctors in Australia and within each of the Colleges codes of conduct
    b. work with the Australian Medical Council or other body to include a specific focus on respectful relationships within the curricula and expected competencies of all medical specialist training programs.
3. Action on bullying and harassment should be supported by incentives, particularly those targeted to future leaders in the medical profession. It is therefore recommended that the Commonwealth Government examine opportunities to:
    a. leverage existing awards programs (e.g. ComCare Work Health and Safety Awards) to recognise an individual or organisation's contribution to effective workplace anti-bullying and harassment approaches in healthcare settings
    b. work with the Medical Board of Australia, the AMA, Medical Colleges, and/or State and Territory governments to introduce awards for doctors in training which recognise individual leadership and action on workplace anti-bullying and harassment.
4. Action on bullying and harassment needs to be supported by ready access to reliable data to monitor the impact of anti-bullying and harassment interventions. It is therefore recommended that the Commonwealth government, in collaboration with State/Territory governments, consider the introduction of:
    a. a regular national prevalence survey of bullying and harassment within all public hospitals and funded health care services, with particular items relating to medical students and doctors, to monitor the prevalence of bullying and harassment.
    b. the centralised collection and reporting on data from all Commonwealth and State and Territory statutory authorities that receive complaints in relation to bullying and harassment and from State and Territory funded health services, in relation to reported incidents of bullying and harassment within the medical profession

Appendix One: the *beyondblue* doctors and medical students mental health program

Since, 2009 *beyondblue* has taken a proactive approach to supporting the mental health of doctors through the *beyondblue* Doctors' Mental Health Program (bbDMHP). The aim of the bbDMHP is to address the prevalence of depression and anxiety in Australian medical students and doctors. Its key objectives are to:

- increase awareness of the issues affecting the mental health of doctors and medical students;
- reduce barriers to, and encourage, help-seeking; and
- promote existing services and support health service employers to protect the mental health of their employees.

A number of initiatives have occurred that have focused on increasing awareness, knowledge and action around doctor's mental health. These initiatives have been developed in consultation with key stakeholders including medical students, doctors, medical industry associations, medical training colleges, hospitals and government. At present, the program is currently targeted to doctors working in Victoria in an effort to develop a program model that can then be implemented across Australia. Initiatives to date are listed below.

Doctors mental health program

Systematic literature review

In 2010 beyondblue commissioned the Mental health of doctors: a systematic review of the literature to review the international literature on the prevalence of depression, anxiety and suicide among doctors and doctors' attitudes and behaviours in relation to these mental health conditions.

Keeping your grass greener

In 2011, beyondblue, in partnership with the Australian Medical Students' Association (AMSA) and the New Zealand Medical Students' Association (NZMSA) developed the original version of Keeping Your Grass Greener, a wellbeing guide for medical students. A hard copy was distributed to all first - and second-year medical students. A second version of the guide was released in 2014.

National mental health survey of doctors and medical students

In 2013, a national survey of Australian medical students and doctors was conducted by researchers as Monash University on behalf of beyondblue and its key partners. Results from the survey were released on 8 October 2013 at a launch held at the RACGP in Melbourne. Since launching the survey findings in October 2013, beyondblue has promoted the key findings through conferences and other events.

Roundtable: The mental health of doctors and medical students

In June 2014, beyondblue partnered with the AMA to stage a roundtable of leaders within the medical profession in Melbourne, to commence the development of an action plan to improve the mental health of the medical profession. The event aimed to encourage the medical profession to take a leadership role in this area.

The mental health of Victorian Doctors event

In June 2015 beyondblue hosted an event attended by leaders within the medical profession to discuss the mental health of Victorian doctors. Speakers at the event included The Hon. Jill Hennessy MP, The Hon. Jeff Kennett AC, Ms Georgie Harman, Dr Mukesh Haikerwal AO, Ms Shelly Park (Monash Health CEO), Ms Jessica Dean (past President of AMSA and *beyondblue* Director), Prof. David Clarke and Mr Graeme Campbell (Vice-President of Royal Australasian College of Surgeons). *beyondblue* highlighted the need for urgent, coordinated action to promote the mental health of doctors, and reduce their risk of suicide.

Victorian Hospitals Workshop on mentally healthy workplaces

In December 2015 beyondblue held a half-day workshop about creating mentally healthy workplaces specifically tailored for Victorian hospitals. The workshop was held at Austin Hospital and was attended by

leaders and relevant OH&S/HR staff from over 15 metropolitan and regional hospitals. The aim of the workshop was to identify practical actions Victorian hospitals can implement to address current challenges relating to mental health in the workplace, and to encourage further collaboration between hospitals and *beyondblue.* This program follows on from the joint RACGP/*beyondblue* projects 'Keeping the Doctor Alive' and the trial of a professional peer support model to increase awareness of depression and anxiety among the medical workforce.

Direct engagement with Victorian hospitals

beyondblue has met with leaders at hospitals across Victoria to discuss the challenges they are facing and help address their specific needs in relation to supporting the mental health of their doctors.

Hospital Grand Rounds

beyondblue has presented a mental health Grand Round at Austin Health, Peninsula Health and the Royal Brisbane and women's Hospital, with plans to present at the Alfred Hospital and Royal Melbourne Hospital in coming months. The feedback from the Grand Round Seminars conducted to date has been overwhelmingly positive. At both The Austin Hospital and Frankston hospital the event was a full house with standing room only and went overtime due to the high level of engagement from the audience during the Q&A component of the session.

Industry collaboration projects

- Worksafe Victoria have established a health practice team to implement the Hospital Intervention Program which is designed to work with hospital boards to improve safety outcomes around key issues such as occupational violence, bullying and harassment and linking worker and patient safety. *beyondblue* have been meeting regularly with Worksafe to provide our support and expertise to the relevant projects within this program.
- The Postgraduate Medical Council of Victoria (PMCV), together with representatives of AMA Victoria, beyondblue, the Victorian Doctors Health Program, the Victorian JMO Forum, the Australian Medical Students Association (AMSA) and the Royal Australasian College of Medical Administrators (RACMA) have established a Welfare Interest Group (WIG). The primary aim of the WIG is to help raise awareness about these issues and positively contribute to the welfare of high quality medical practitioners by collaborating to develop wide reaching education and awareness program and providing access to clear pathways of support.
- *beyondblue* has worked closely with Medical Defence Australia in the past to communicate information about doctors' mental health to its members. More recently, *MDA* has engaged *beyondblue to* support and provide insight into its Live Well, Work Well project, which features a number of short videos about specific issues concerning doctors mental health and wellbeing. The MDA have also agreed to work with *beyondblue* to publish four editorial pieces over the next 18 months, in their First Defence, Defence and Student updates.
- *beyondblue* has been working with the Royal Australasian College of Medical Administrators to feature doctors mental health in their professional development program. Including opportunities to conduct webinars, run workshops and provide training for their members.

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