Building Respect, Improving Patient Safety

RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery

Royal Australasian College of Surgeons

Statement from the President and Vice President

The report of the Expert Advisory Group (EAG) into discrimination, bullying and sexual harassment represents a watershed for the College.

Drawing on the experiences of our own Fellows, Trainees and International Medical Graduates, the EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. These behaviours are bad for individuals, impair teams and put patient care and patient safety at risk.

The EAG report set the College some serious challenges. The EAG report said:

'...there must be a profound shift in the culture of surgery and an unwavering commitment to achieving this. Long-established traditions that have been inherited and have normalised unprofessional, and sometimes illegal, behaviours must be relinquished. Gender inequity must be addressed. Discrimination, bullying and sexual harassment must become problems of the past...'

This Action Plan is our response to the problems identified. It will bring significant, but necessary, changes to the culture of the health workplace and surgical training. There must be no tolerance of inappropriate behaviours that result from lack of respect for others. Some of these behaviours are unlawful, as well as being unethical, disrespectful and contrary to workplace safety. They have no place in the future of our proud profession.

When the EAG report was published, the College Council accepted the EAG recommendations in full and we issued an apology to everyone who had suffered from discrimination, bullying and sexual harassment. Council has committed RACS to countering and driving out these behaviours from surgical practice and surgical training.

This Action Plan outlines how we will do this. The work detailed in it is extensive, and will need to be sustained long-term. We have set goals to monitor our progress and make sure that our actions make a difference. We will be transparent about what we plan and what we do, and our work will be subject to external scrutiny.

RACS has established a dedicated project team, including external advisers, to support our efforts. The College Council has committed to resourcing this work.

The EAG challenged us to be bolder, more transparent and more accountable. We are a medical college with a long history of upholding high surgical standards and making positive contributions to the profession and the community. This Action Plan outlines how we will promote respect, and counter discrimination, bullying and sexual harassment.

We will need to work hard to close the gap between where we are now and where we want to be. We must do some things differently; deal with the behaviours we have said we will not tolerate and champion those that will help build a respectful, collaborative culture. We must make it safe for victims and bystanders to speak up. There must be clear consequences for those whose behaviour is unacceptable.

To be successful we will need to work effectively with many organisations – public and private hospitals, other medical colleges, universities, regulators and jurisdictions. We will need to establish agreed processes to share information; improve how we manage complaints; and demonstrate the respect for our colleagues, Trainees, teams and patients that they deserve.

Together, we are confident we can translate the recommendations of the EAG into action. We can meet the challenges facing our profession at this pivotal moment and build a safer, more respectful workplace. This will result in better standards of surgical training, and higher quality patient care.

Professor David Watters OBE
President

Mr Graeme Campbell
Vice President

RACS Commitment

The College has committed to action. This Action Plan outlines what we will do to address each of the EAG recommendations. Our work will lead to change in the three key areas identified by the EAG: *Cultural change and leadership, surgical education and complaints management*.

This program of work is comprehensive and long-term. It will be prioritised and phased. Each individual action forms part of an integrated whole. We will be reporting publicly each year on what we have done, and what has been achieved.

Two core principles underpin the work we will do: respect and collaboration. The College will work with others – including employers, universities, health departments, governments and regulators – to ensure our approaches are aligned and support successful change. We will not succeed on our own, but together we must deal effectively with discrimination, bullying and sexual harassment.

RACS Goals and Program of Work

RACS has set goals to help it meet these challenges and has developed a detailed, multi-year Action Plan to guide and focus our work. The goals respond to the EAG's *Recommendations at a glance* and the actions show what we will do to reach our goals. Appendix 1 details our response to each specific EAG recommendation.

We expect to adapt the Action Plan over time, to reflect both our progress and emerging challenges. Publishing our goals will enable us to be transparent about our activity, and also about our progress over time in making a difference. We will report in more detail in future about the prioritisation and sequencing of our work.

The RACS Vice President will lead this program of work for the College. Governance will be provided through the Council Executive, whose portfolios span all areas of College activity.

1 Cultural Change and Leadership

Goal 1

Build a culture of respect and collaboration in surgical practice and education

Action

Establish a multi-year program of work across three core areas: improved complaints management with external oversight and clear sanctions; targeted compulsory and regular training across the Fellowship in discrimination, bullying and sexual harassment (DBSH); and regular improved training for all Fellows who are involved with surgical education.[1.1]

Develop models of collaboration that align with RACS values developed from the principles in the Vanderbilt model (see Appendix 2). These principles will provide a foundation for joint approaches with important groups including public hospitals, private hospitals, ministries and departments of health, universities and medical colleges as well as surgical specialty societies.

The models will include:

- commitment to addressing DBSH and accepting new standards
- development of joint or aligned processes, where appropriate, to deal with DBSH
- regular communication and information sharing
- joint or aligned approaches to complaints management, sanctions, education and cultural change programs.[1.5, 1.8, 1.13, 3.6]

Work with the Royal Australasian College of Surgeons Trainees Association (RACSTA) to be involved in implementing the EAG recommendations.[2.20]

Goal 2

Respecting the rich history of the surgical profession, advance the culture of surgical practice so there is no place for discrimination, bullying and sexual harassment (DBSH)

Action

Establish training in DBSH as a mandatory component of continuing professional development and in Surgical Education and Training (SET) by 2017. Provide advanced training in DBSH to all members of Training Boards and other major committees of RACS, including surgical, IMG and research supervisors/assessors.[2.1, 2.2]

Improve education and support for individual surgeons in behavioural change by:

- clearly stating and holding Fellows to account against identified standards of behaviour [1.2]
- establishing processes for providing individual coaching for behavioural change in conjunction with RACS and employer educational programs [1.10, 2.6]
- working with hospitals/ employers to share knowledge and expertise and value of coaching interventions [2.6]
- investigating establishment of a confidential mentoring support system for Fellows, Trainees and IMGs [2.3]
- providing individual support to offenders to encourage behavioural change
- profiling RACS Support Program [3.1]

Goal 3

Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and their agencies in all jurisdictions

Action

Work with employers and regulators to agree and publish principles that clarify respective roles and responsibilities. Develop shared commitment to collaboration or aligned approaches to dealing with DBSH and information sharing in the public interest, within the law.[1.9, 2.7, 3.6]

Work with hospitals on initiatives to address DBSH issues by surgeons by:

- piloting different approaches
- improving accreditation arrangements with hospitals to better deal with issues of DBSH [2.7]
- evaluating pilots, identifying effective strategies and progressively extending successful models to other hospitals and employers, with involvement of the RACS Surgical Directors Section and Regional Committees [1.4]
- ensuring surgical appointments are merit based [2.18]

Work with hospitals and Surgical Directors to develop criteria for selection of heads of departments and other senior positions, incorporating leadership on DBSH [2.8]

Goal 4

Embrace diversity and foster gender equity.

Action

Develop and publish a Diversity Plan for RACS, including gender equity, to set expectations for all aspects of College activity.[1.15]

Review other Colleges' training programs with particular emphasis on flexibility and less than full-time training, to identify features that can be introduced into surgical training programs and improve RACS communications with Trainees about the availability of less than full-time training.[2.19]

Work with universities and medical schools to encourage surgery as a career.[2.21]

Better promote gender equity in surgery by:

- establishing targets for the involvement of female surgeons in leadership positions such as on Training Boards and as examiners [2.21]
- monitoring the application rates of women into surgical training to identify and address barriers to women and others considering applying for surgical training [2.21]
- monitoring rates of selection of women into surgical training to ensure that there are no barriers based on gender [2.21]
- reviewing and monitoring the attrition rates of women from surgical training, and address issues and barriers.[2.21]

Goal 5

Increase transparency, independent scrutiny and external accountability in College activities

Action

Enhance external input and scrutiny of RACS activities by:

- publishing Annual Reports and Activities Reports and provide to health ministers and regulators [1.3, 2.10, 2.14]
- repeating DBSH prevalence surveys in five years [1.11, 1.14]
- providing independent review for all Trainees placed on probation, to ensure all educational and cultural issues are being addressed; survey and report on Trainee issues [2.11, 2.12]
- revising selection/appointment processes for members of training boards
- revising terms of reference for training boards to ensure diversity: include external representatives, access to medical educational experts, female surgeons, and Trainees [2.13, 2.14, 2.15]
- reviewing assessment process for IMGs including appropriate composition of assessment panels and ensuring independent review mechanisms are in place.[2.16]


Together, we are confident we can translate the recommendations of the EAG into action. We can meet the challenges facing our profession at this pivotal moment and build a safer, more respectful workplace.

2 Surgical Education

Goal 6

Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism

Action

Review the selection criteria for all supervisors to include training as educators, how to give performance feedback, understanding of DBSH and how to deal with allegations. [2.8]

Using the RACS Foundation Skills for Surgical Educators course as the basis - renew, identify and accredit training for all surgeons involved in education in the following areas:

- adult education principles
- effective assessment and constructive feedback
- explicit content on discrimination, bullying and sexual harassment
- teamwork, leadership and other non-technical skills

Develop and establish explicit standards for all surgeons involved in education and supervision of research [1.8, 2.2, 2.3]

Identify underperforming supervisors (through Trainee feedback/multi-source feedback (MSF)/complaints mechanisms) and provide them with a remedial education plan to improve skills.

Training Boards to review all supervisors to ensure this is achieved over two years.[2.8]

Goal 7

Train all Fellows, Trainees and International Medical Graduates to build and consolidate professionalism including:

- fostering respect and good behaviour
- understanding DBSH: legal obligations and liabilities
- 'calling it out'/not walking past bad behaviour
- resilience in maintaining professional behaviour

Action

Revise accreditation standards for surgical training posts, ensuring DBSH standards and agreed complaints-resolution mechanisms for the local workplace are included, working with RACS and Specialty Training Boards as needed.[1.9]

Develop and implement effective multi-source feedback (MSF) by:

- establishing clear criteria for successful introduction of MSF that appropriately includes DBSH [2.9]
- introducing and including MSF in reviews of all Trainees, supervisors, surgical department heads [2.9]
- establishing systems to ensure feedback is recorded, acknowledged and used to improve quality [2.4]
- establishing an independent review process for all Trainees and IMGs placed on probation to ensure all educational and cultural issues are being addressed; this can also be triggered separately by Fellows, Trainees and IMGs [2.11]
- developing and rolling out a program for Trainees to engage constructively with feedback [2.4]

Ensure the surgical education training (SET) program includes guidelines in building resilience and managing stress.[2.5]

Review, identify and appropriately accredit:

- existing RACS courses and available external courses that provide training in non-technical skills (NTS) and link these to RACS-approved curriculum framework [2.10]
- potential external suppliers and external resources to provide suitable DBSH programs or courses [2.1]
- available resources, courses, including external support mechanisms as reference points for individual support and skills improvement [2.1, 2.5]

Build into all accreditation processes sessions with previous and/or current Trainees, an assessment of the functioning of the unit in a broad sense and specifically include assessment and review of issues of DBSH.[2.7]

3 Complaints Management

Goal 8

Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust and fair

Action

Revise RACS Code of Conduct and sanctions policy to incorporate clear expectations about the management of DBSH, including clear consequences for adverse findings, and to support professionalism.[1.6, 3.1]

Incorporate principles recommended by the EAG into the current RACS complaints approach and, recognising the limitations of the College's powers, work with other agencies to more effectively deal with discrimination, bullying and sexual harassment. This includes helping prevent victimisation and increase/ensure protection for those who make complaints.[3.1]

Establish and provide:

- external, expert and independent review and oversight of RACS complaint processes including reviewing College processes and recommending actions when processes are not followed or are inadequate [3.1, 3.4]
- strengthened confidentiality processes [3.2, 3.4]
- training accreditation guidelines that include requirements to report and share information about surgical practice related complaints [3.3]
- information for all Trainees and Fellows about changes made and incorporate into agreements with hospitals [3.3]
- external expert mediation for complaints [3.1]
- support for investigations [3.1]
- restorative justice options for complaints [3.1, 3.2]
- central recording of all complaints across all training, education and Fellowship activities, with independent oversight [3.2]
- annual and public reporting on aggregated outcomes of complaints.[1.12, 3.5]

Shaping the Future

This Action Plan shows our commitment to dealing with unacceptable behaviours; strengthening surgical education and training; and reshaping the culture of surgery on foundations of collaboration and respect. With long-term and comprehensive action, we will improve patient safety in the practice of surgery. We will do this out of respect for our patients, our colleagues and our teams, and because it is the right thing to do.

The College Council, the Speciality Societies and the Training Boards are committed to action. We look forward to working together effectively, and with all Fellows, Trainees and International Medical Graduates, to create a future free of discrimination, bullying and sexual harassment.

Council Executive

- **Prof David Watters OBE,** President (Chair)
- **Mr Graeme Campbell,** Vice President
- **Prof Marianne Vonau OAM,** Treasurer
- **Mr Philip Truskett AM,** Censor in Chief
- **Prof Julian Smith,** Chair Professional Development and Standards Board
- **Prof Spencer Beasley,** Member appointed by Council
- **Dr Cathy Ferguson,** Member appointed by Council
- **Mr Lawrie Malisano,** Member appointed by Council

Appendix 1

EAG Recommendations to the College

There is no place for discrimination, bullying and sexual harassment in the practice of surgery.

1 Cultural Change and Leadership: Take a stand

Area for action	Recommendations	Key Actions
1.1	Take the lead role with Fellows, Specialty Societies and Training Boards to ensure an effective, consistent and centrally coordinated approach to addressing discrimination, bullying and sexual harassment and provide a safe environment for 'speaking out'.	Executive of College form main leadership group to champion the DBSH program. Vice President to be main sponsor. Develop an ongoing internal and external Communications Plan linked to induction, training, CME, and regular College communications methods. Anticipate a three-year program of improved, complaints management process with external oversight, across Fellowship training in DBSH and continuing improved training for all Fellows involved with education. Includes articles, booklets, posters and electronic delivery.
1.2	Demonstrate a new approach to dealing with discrimination, bullying and sexual harassment and publish a statement that includes a strong commitment to change and a clear purpose, against which the College can be held to account.	Clear articulation of required standards following on from Apology by RACS President. Updating of Code of Conduct and associated policies. Revised complaints process.
1.3	Commit to and publish an action plan that responds to these recommendations to address and prevent discrimination, bullying and sexual harassment, and report annually on progress to the public, health ministers and College Fellows.	Action Plan to be completed by November 2015 with direction having been endorsed by October Council and Surgical Leaders Forum. Reports to be prepared annually and included in Activities and Annual reports and other methods to Ministers of Health and for public release.
1.4	Work with hospitals (public and private sector), to ensure they will not tolerate surgeons who subject others to discrimination, bullying and sexual harassment and will support bystanders who speak out about it.	Establish piloting approach to ensure key requirements from hospitals are in place. Develop principles of partnering and hospital MoU to drive partnership approach. Devise accreditation arrangement with hospital/s. Having piloted then progressively roll out. Under oversight of Section of Surgical Directors but having strong ownership by Regional Committees.

1.5	Work with employers, Medical Colleges and governments (bi-nationally, State and Commonwealth) to foster partnerships and develop joint approaches to ensure these issues are addressed and standards are upheld.	Develop partnering models that will enable joint approach with important groups that include public hospitals, private hospitals, Ministries and Departments of health, Universities and Medical Colleges, as well as Specialty Surgical Societies. Include: • Commitment to address DBSH and acceptance of new standards • Development of joint processes, where appropriate, to deal with DBSH • Regular communication and information sharing. Joint approaches to include complaints mechanisms, sanctions, education and cultural change programs. Will need to be supported through all Regional committees, Surgical Directors group, Governance and Advocacy Committee.
1.6	Ensure the College is able and willing to remove Fellowship from surgeons who do not meet the required standards in relation to discrimination, bullying and sexual harassment.	Revised Code of Conduct and Sanctions policy to ensure all expectations around DBSH are incorporated. Update all complaints methodologies to reflect this and also clearly link to revised Sanctions policy.
1.7	College Council to ensure that a senior office-bearer is explicitly responsible for overseeing the change-management program required to address discrimination, bullying and sexual harassment and is appropriately resourced and supported by senior staff. These responsibilities should be attached to a role not an individual and continue until this cultural change has been achieved.	Vice-President to be the senior office-bearer as champion but ownership by entire Council Executive. Develop a governance and management structure. At management level, recruit senior manager who is skilled in policy development, developing partnerships, liaising with government and other educational bodies and can oversee the delivery of a multi-year cultural change-management and educational program. Create a group of senior Fellows experienced in issues of professionalism and course delivery to oversee the educational programs required for cultural change, including: • what is DBSH • skills of resilience in maintaining professional behaviour • skills of 'calling it out'/not walking past bad behaviour • organisational change to nurture respect and good behaviour. Also at management level, recruit an experienced medical educator with skills in cultural change-management and issues around professionalism. Resource Academy of Surgical Educators/Professional Development/Skills course area to make available training opportunities for all educators to undertake Foundation course for educators as well as the training in DBSH (refer 2). Develop a Diversity policy for the College, including gender equity, to set expectations for all aspects of College activity.

Area for action	Recommendations	Key Actions
1.8	**Set standards:** Set, promote, uphold and publish clear and consistent standards in relation to discrimination, bullying and sexual harassment, including a review of existing policies.	Develop RACS standards document upon which educational resources can be reviewed, updated or developed and incorporated into RACS policy and existing educational resources. The standards are to be clearly incorporated into the Code of Conduct and all teaching material of RACS such as Guidelines for handling bullying and harassment. Develop appropriate J-Doc material to support the standards. All relevant policies and existing educational resources of RACS updated to reflect these standards.
1.9	Review all policies and work with employers to actively promote and enforce standards/expectations of professional behaviour in surgical practice, including through agreements with hospitals.	Revise accreditation standards for surgical training posts to ensure standards are included, as well as agreed mechanisms to see this dealt with in the local workplace with the assistance of RACS and Specialty Training Boards as needed. Seek clarity of legal obligations for the workplace and work with appropriate regulators to co-ordinate pathways for appropriate legal redress.
1.10	Support individual Fellows to change their behaviour and lead behaviour change in others by establishing mentoring and coaching programs at the College, and working with hospitals to support and share knowledge and expertise about these programs in the workplace.	Educational programs include coaching for behavioural change, which is available through RACS and hospitals.
1.11	**Increase external input and scrutiny:** Integrate independent, external (i.e. non-RACS) oversight across College activities and in committees, Training Boards and Specialty Societies and: a. Appoint an Ombudsman to provide independent, external scrutiny and accountability, and an alternative pathway to address issues of concern b. Commit to a further review in five years by an external, independent committee (e.g. EAG) and report publicly.	Medical Educators or other external people included in all Training Boards and educational activities. Increase resources within EDRD, Dean of Education areas to facilitate this. External reviewer appointed to oversee all complaints handling. Ombudsman appointed to have broad remit to review College processes affecting the rights of individuals. Annual reporting via annual reports/activities reports. EAG-type surveys repeated in five years under oversight of independent committee.
1.12	Increase transparency by continuing and increasing public reporting – of data, of progress against commitments, about complaints, etc.	Annual reporting of all complaints within annual report/ activities report, presented in a de-identified manner. Reporting or publishing of complaints to be included within sanctions policy.

1.13	Review contractual agreements between the College and Specialty Societies to align responsibility and authority for addressing these issues, embed information sharing and support best practice complaints management.	Work with Specialty Societies to gain common commitment to implement these recommendations. Identify components of best practice complaints management and information sharing that is required. Create an additional appendix to the agreements between RACS/Societies.
1.14	**Foster diversity:** Ensure diversity of representation on College committees, the Specialty Societies and Training Boards, by including female surgeons, independent non-medical members, educational experts, surgical Trainees and jurisdictional representatives.	Confirm committees of College such as the Training Boards as well as the Specialty Societies have appropriate representation. Ensure achievement over a two-year period.
1.15	Identify and address barriers to gender equity and diversity in surgery and support change by: a. Reviewing the features that will increase the appeal of surgery to more diverse groups including women (e.g. by providing workplace and training flexibility). b. Setting targets, monitoring and reporting on numbers of women attracted to surgery and their successful completion of or attrition from surgical training. c. Developing a strategy to encourage women to take on leadership roles in surgery – on Training Boards, Specialty Societies and throughout College hierarchy. d. Identifying champions to celebrate and support cultural change. e. Using social media and other mechanisms to support and encourage mentoring across specialties.	Create Diversity Action Plan, in a similar way to Indigenous health plan, to focus activities and to foster or encourage those who are interested. RACS and Specialty Societies become advocates with all hospitals for increased flexibility in training posts. This is 'built into' the accreditation guidelines. RACS explore the flexibility of the RANZCOG and other programs and progressively introduce key features. Targets for training program to be developed annually, incrementally. Targets could include increase in percentage of female applications and increase in success rate by female applicants. Regular monitoring and reporting. Further targets to be established on Training Board, Court of Examiners and Council. Ensure the President of all Societies for next three years have this initiative as major requirement and that all mechanisms including the use of social media are utilised to make progress.

2 **Surgical education:** Strengthen and focus on DBSH

Area for action	Recommendations	Key Actions
2.1	Develop and implement an education program on discrimination, bullying and sexual harassment that is mandatory for all Fellows through Continuing Professional Development (CPD) and for all Trainees and International Medical Graduates.	Review external resources to identify suitable DBSH programs, as per 1.4. Development of multi-level program including: • what is DBSH, what is its legal obligation and liability • skills of resilience in maintaining professional behaviour • skills of 'calling it out'/not walking past bad behaviour • organisational change to nurture respect and good behaviour. Program has multiple modalities: face to face; workshops; paper-based productions; electronic delivery; posters. Identification and 'accreditation' of potential external suppliers of training and education and accreditation in DBSH programs or courses. Provide program under the oversight of a committee of Fellows with strong interest in professionalism recognising that some components are mandatory for Fellows, Trainees and IMGs. Other components e.g. organisational change. May be more focused on Surgical Directors group. Training in DBSH to be a mandatory component of CPD by 2017. DBSH competency standards included in the SET curriculum.
2.2	Provide additional mandatory training about discrimination, bullying and sexual harassment for all College office-bearers including those in the Specialty Societies, Training Boards, and supervisors.	Intensive training around DBSH provided to all Training Boards and committees of RACS (such as Regional Committees) Similar to model delivered to Council in June. Intensive training also provided to Research supervisors. Consider making courses compulsory prior to appointment to committee. Resources identified to manage rollout.
2.3	**Educate the educators:** Mandatory training for educators in surgical practice in: a. Adult education principles b. Effective assessment and constructive feedback c. Explicit content on discrimination, bullying and sexual harassment d. Teamwork, leadership and other non-technical skills.	Develop explicit standards for educators and research supervisors. Develop a structured and linked program for each level of educator involvement identifying multiple available resources which will require accreditation. Using the Foundation course for Educators as the basis, mandate and appropriately resource to ensure its availability over a two-year timeframe. Establish a confidential mentoring support system for F/T/IMGs.

2.4	Equip all surgical educators and supervisors to teach and provide constructive, clear and timely feedback.	Specific courses at providing feedback and handling the poorly performing training are mandatory for all Fellows involved with surgical training. Develop systems to ensure feedback is recorded, acknowledged and revised for quality. Develop program for Trainees to accept constructive criticism.
2.5	Provide training in resilience and stress management as a component of surgical training.	Develop a framework of available resources, courses, including external support mechanisms e.g. Beyond Blue, self-assessment tools, as reference point for individualised skills improvement. External courses appropriately accredited. Course in building resilience and receiving and using feedback developed and made compulsory within SET program. Consider making core component on J-Doc programs.
2.6	Provide coaching and mentoring services for educators who seek additional support.	Educational programs include coaching for behavioural change, which is available through RACS and hospitals.
2.7	**Trainers and training posts**: Accreditation of training posts: establish generic and consistent mandatory requirements for the accreditation of training posts for surgical education, considering implications for resourcing and timeframes for implementation of no more than three years.	Accreditation guidelines are updated ensuring DBSH is highlighted as an issue that the local employer (hospital) has the skills to manage. MoU with hospitals to include legal and other mutual obligations to empower hospitals and the College to give proper effect. All accreditation to include sessions with previous/current Trainees to look at the functioning of the unit in a broad sense but to specifically include issues of DBSH. All Fellows involved with educational activities must have training in education, DBSH and its handling, and performance feedback. This includes multi-source feedback. The hospital needs to provide the resources/time to ensure this happens.
2.8	Establish central and consistent selection, appointment and review processes for surgical supervisors, heads of department and Training Board surgical members.	Review selection criteria for all supervisors, with mandatory completion of training in education, DBSH and its handling, and performance feedback as prerequisites. Identified underperforming supervisors (via Trainee feedback/ MSF/complaints mechanisms) are provided with a remedial education plan to improve skills. Training Boards to undertake review of all supervisors to ensure this is achieved over a two-year time frame. Work with hospitals and Surgical Directors to develop criteria for heads of departments and other senior positions.
2.9	Introduce mandatory multi-sourced feedback (MSF) for: a. Trainees b. Supervisors c. Surgical department heads d. Surgical units.	Establish clear criteria for successful introduction of MSF that appropriately profiles DBSH. MSF to be included in annual reviews of all Trainees, supervisors, surgical department head as a compulsory component of CPD. Encourage hospitals to have regular MSF of all surgeons.

Area for action	Recommendations	Key Actions
2.10	**Increase external input and scrutiny:** Include external, independent participation in training and assessment of non-technical skills.	Identify existing RACS courses and available external courses that provide training in NTS; linked to curriculum framework. Independent Medical Educators to be appointed to all Training Board with focus on non-technical skills training.
2.11	Establish a process for the independent review of training rotations that can be triggered by a Trainee, supervisor, or International Medical Graduate.	Develop regulations for swift Independent review process, with oversight by CIC and training Boards. Creation of a 'team' of educators/Fellows interested in education who will review training rotations as required. Close scrutiny and support for all research grant recipients for consideration of similar independent review model. It is anticipated that this independent review will happen for all Trainees placed on probation to ensure all educational issues and culture issues are being addressed. Similar to ANZCA model.
2.12	Undertake an annual survey of training positions and publish the results to improve transparency of decision-making and make visible the underlying culture of the unit, working with RACSTA to address concerns about identification of Trainees.	Annual survey by RACSTA already undertaken. To be resourced more thoroughly with appropriate reporting of survey to College Council/Training Boards/ Ministers of Health.
2.13	Review processes for selection into surgical training to support diversity and ensure independent, external non-College and non-medical membership of selection and recruitment panels.	Selection criteria to be reviewed independently, externally for 'objectivity' and support of diversity. Selection panels to include non-medical membership. Regular review of outcomes of selection processes to monitor commitment to diversity.
2.14	Appoint independent educational experts to all Training Boards.	Independent Medical Educators or other independent educational experts appointed to all Training Boards, with them providing reports on an annual basis for review by Health Ministers/Regulators.
2.15	Introduce explicit requirements for the membership of Training Boards – women surgeons, independent (non-medical) person, educational experts, surgical Trainees and jurisdictional representatives.	Terms of reference for training boards to be reviewed to include external educational experts, women surgeons, Trainees and jurisdictional representatives. Determine process for selection/appointment.
2.16	Increase neutral and independent oversight of IMG assessment, through external, independent participation in training and assessment.	Review assessment process for IMGs. Include appropriate independent people on assessment panels. Ensure independent review mechanism in place.

2.17	Consider use of video/audio recorded assessments in the workplace and examinations.	Undertake study around the feasibility of using video or audio recorded assessments in workplace/examinations.
2.18	Support hospitals to ensure transparent hospital appointment processes.	Clarify role of RACS and Fellows of RACS in credentialing/ appointment process. Develop 'model' for credentialing that includes natural justice and feedback that is then published/ distributed to all hospitals (public and private). Monitor hospital appointments to ensure commitment to diversity and merit.
2.19	**Foster diversity:** Foster diversity by aiming to become the industry leader in providing flexible training opportunities (considering working hours and arrangements, family-friendly practices, learning from the approach of the College of Obstetricians and Gynaecologists).	Review RANZCOG and other College's training programs with particular emphasis on flexibility to identify issues to be introduced into surgical training programs. Particularly review ability for leave within terms without disadvantage. Enhance communication between Trainees about availability.
2.20	Work with the Royal Australasian College of Surgeons Trainees Association (RACSTA) to better understand what resources would help RACSTA to effectively support and advocate for Trainees.	Agreed to ensure RACSTA is able to contribute fully to the implementation of these recommendations.
2.21	Improve gender equity in surgery by: a. removing barriers to participation b. providing flexible training options c. promoting diversity and d. having targets for the number of women on Training Boards and in College leadership roles.	Monitor application rate of women and identify barriers to females and others from considering an application for training. Work with Universities/medical schools to encourage surgery as a career. Ensure that female Trainees are selected at a greater percentage than their application rate. Create targets for involvement in leadership positions within Training Board, Examiners, other leadership roles. Adjust CPD requirements to suit part-time work more fully.

3 **Complaints:** Fair, timely, transparent.

Area for action	Recommendations	Key Actions
3.1	Introduce best practice complaints management built on the following principles: a. Visibility and accessibility of complaint mechanisms – processes should be well publicised and information made available about avenues for making complaints and options for resolution. b. Responsiveness with a focus on early intervention. This requires immediate acknowledgement of complaints and prompt responsiveness in addressing them, relative to their seriousness and impact. c. Restorative approaches to resolution of disputes, focusing on the impact of behaviours in the workplace and on others (such as colleagues and patients), and aimed at improving insight of participants and behaviour change. d. Processes should include elements of independence and objectivity to build confidence and integrity and ensure complaints are addressed in an equitable, objective and unbiased manner. e. Confidentiality of the process is essential and should be guaranteed. Confidentiality of complainants should be respected where possible, with investigations focused on the nature of the allegations with specific identifiable information only provided when needed. Confidentiality should not be treated as secrecy and complaint outcomes should be appropriately communicated to participants in the process. f. Established framework of accountability for taking, and reporting on, the actions and outcomes arising from complaints to participants in the process. g. Monitoring of complaint issues/trends, resolution rates and user satisfaction should be a feature and used to inform continuous improvement and assess the quality and effectiveness of complaint mechanisms and further interventions. h. Centralised, anonymous, accessible and detailed information about making complaints e.g. clarity of enquiry, registering, lodgement, progressing and ongoing reporting of all complaints, applying to all types of complaints; formal and informal, options, requirements. i. protection for those who make complaints (within the limited powers of the College), and prevention of victimisation.	Review Code of Conduct to strengthen DBSH and professionalism issues. Provide support to offenders to ensure behavioural change. Review of complaints approach/ methodology to ensure all these principles are incorporated. Arrange review and oversight by external expert in complaints handling. Establish role of ombudsman/ external reviewer on an ongoing basis. Ensure prevention of victimisation and protection for those who make complaints (within the limited powers of the College), and prevention of victimisation. Provide external expert mediation for complaints. Provide support for investigations, where mediation fails. Allow restorative justice systems for complaints system rather than legalistic response. Requires comprehensive internal and external communications plan. Profile presence of RACS Support Program.

3.2	Build trust and confidence in complaints-handling process by introducing centralised lodgement, assessment, co-ordination and ongoing oversight of complaints across all specialities of the College, including complaints about surgical practice, education and behaviour.	All complaints across all training, education and Fellowship activities to be recorded centrally with oversight by the In-House Counsel. Strengthen confidentiality processes. Oversight by independent review.
3.3	Accredited training posts in hospitals required to have mechanisms in place and share all information with the College about surgical practice-related complaints at that post, through explicit agreements between workplaces and the College.	Accreditation guidelines reviewed to include requirement about reporting and sharing information about surgical practice-related complaints. All Trainees and Fellows to be informed about this. Build into MoU with hospitals.
3.4	Appoint independent and external surgical Ombudsman role to: a. provide complaints oversight and a pathway for review of College actions to address and prevent discrimination, bullying and sexual harassment and b. make sure concerns can be raised and issues addressed fairly, without fear of reprisal or retribution.	External ombudsman appointed to oversee complaints and to review College processes and make recommendations where processes not followed or are inadequate.
3.5	Ensure public reporting of complaints, trends, and data including annual report on progress against actions taken to address discrimination, bullying and sexual harassment.	Complaints and their outcomes are reported on publically including Activities reports, Annual report and to the AHMC. Needs to appropriately handle privacy and confidentiality concerns.
3.6	Work proactively with hospitals to: a. develop a commonly understood approach to sanctions, including mechanisms for identifying, preventing and eliminating illegal and inappropriate behaviour and reporting surgeons as needed. b. commit to cultural and organisational changes that will help to end bystander and collective silence about discrimination, bullying and sexual misconduct. c. support cultural change including by improving transparency about the underlying culture of a unit, unprofessional behaviour and actions taken to address breaches. d. address the consequences of inappropriate behaviour, introducing both restorative and punitive mechanisms that protect those who seek to implement positive change the workplace (locally in teams and by hospital management).	Create partnerships with hospitals that will enable this. Pilot initially with private and public hospitals that are willing to undertake this and then progressively 'roll out'. Investigate Vanderbilt University model and its applicability across the health sector for Australia and New Zealand.

Appendix 2

Principles of engagement in partnering or collaborating to prevent discrimination, bullying and sexual harassment (DBSH)

Preamble

Every healthcare worker has a right to a workplace free of DBSH and every student/Trainee has a right to an education free of DBSH.

Patient safety should be the absolute and common priority in the workplace. Teams work together effectively respecting the skills, experience and contribution of each member. The success of work-based teams is measured by the safety of the workplace and the educational environment and by the extent to which all team members recognise that what they achieve together is more valuable than anything they can achieve on their own.

From this, there is a commitment to every patient in having the right to expect that their healthcare is not compromised by DBSH. The following principles are developed from the Vanderbilt Model (Hickson 2007).

Principles

1. There is an absolute commitment by the leadership of the organisations to preventing DBSH.

- DBSH is not accepted and is clearly regarded as actionable behaviour
- Leadership shows absolute willingness to act to the point that if DBSH continues that the Fellowship of the College is removed and employment will cease
- Clear pathways and access to leaders of the organisation and the College to ensure commitment to prevention of DBSH is maintained

2. The mission, goals and core values of the College and the organisation support respectful clinical and educational activities. These are supplemented by supportive and clear policies

- The policies demonstrate clear pathways for all employees and Trainees to ensure that DBSH is confronted and prevented
- The policies of the College and the organisation recognise the importance of privacy and natural justice

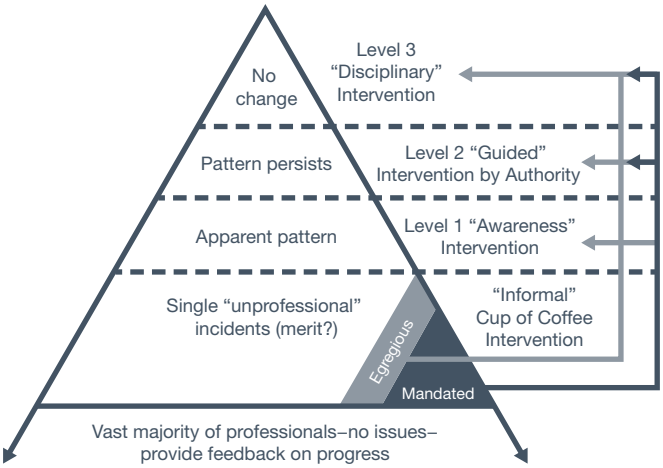
3. Surveillance tools are in place and capture observations and reports about the behaviours within the educational and clinical areas

- Open feedback from students/Trainees within each rotation
- Regular sources of feedback (such as multi-source feedback) and reviews are undertaken across the organisation

4. Processes are in place both within the College and the organisation to review the observations and reports

5. Model to guide graduated interventions is in place, such as the Vanderbilt graduated process (Hickson 2007)

- Minor breaches are dealt with on the spot
- Mediation is used early
- Progressive hierarchy to guided interventions



Adapted from reference 1.
Used with permission.

6. Multi-level professional and leader training is available and is essential as both as an employee and educator/Trainee

- Foundation course for Educators that includes feedback and training in identifying and supporting flexible training
- Training in communication and conflict resolution
- Training about DBSH that has at least four components
    i. What is DBSH
    ii. How do you maintain proper/professional behaviour when under stress
    iii. How do you speak out against, push back against, not walk past inappropriate behaviour
    iv. How do you influence and improve your organisation to push back against DBSH, and nurture professionalism

7. Resources are available to help address the causes of unnecessary variation in performance (both individual and systemic)

- Whenever RACS has issues of Trainee under-performance, the employer is aware and RACS manages the process
- Whenever a surgeon is being investigated about DBSH, RACS is aware and the hospital manages
- If the DBSH involves Trainees and supervision both are to manage
- Resources made available to address issues such as work-life balance, full support of flexible training, such as access to parental leave
- Resources made available for attendance at compulsory training in remediation (e.g. communication courses)

8. Resources to help those affected (psychological or physical harm)

- Support programs such as the RACS Support program
- Availability of designated support people within the organisation

i. Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Acad Med. 2007 Nov;82(11):1040-8.

For more information contact

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