Proposing and Applying an Anti-Harassment Policy Tool

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Abstract

Introduction: Harassment of medical trainees is a widely documented and pervasive problem that needs to be addressed by higher education institutions and governing bodies. Canadian universities are required to provide harassment policies to students and employees. However, under-reporting of harassment is still a major area of concern. At this time, there is no standardized criteria employed to ensure that all Canadian medical university policies are comprehensive, accessible, and clear. Chapter 1 of this thesis provides an overview of the harassment definitions and the current prevalence of medical trainee harassment documented across Canadian and top international medical universities. In Chapter 2, I introduce the barriers to reporting harassment and the issue of under-reporting and present an organizational framework, and ways that this tool can be applied to inform harassment policy development and also introduce the policy evaluation manuscript. In Chapter 3 I will discuss the organizational structure and culture of medical training. In Chapter 4, I outline the objectives and hypothesis for this thesis. Chapter 5 includes the policy evaluation manuscript. Here, I will discuss a set of adapted and extended criteria used to assess the comprehensiveness of the 17 Canadian medical universities' and the top 10 QS-ranked universities' harassment policies.

Methods: In chapter 5, I adapted a policy evaluation criteria to evaluate the harassment policies of the 17 Canadian medical universities and the top 10 QS-ranked universities. A total of 35 Canadian and 16 top 10 QS-ranked universities' workplace and university harassment policies were evaluated, scored, and analyzed for strengths and weaknesses based on the adapted and extended criteria.

Results: Our evaluation show areas of strength for Canadian universities, such as distinct harassment definitions and mentioning of harassment training for staff and students, and room

for improvements such as a lack of detail in the informal complaint procedures and few policies mentioning the availability of an ombudsperson or student representative. This adapted criterion can be used for future policy assessment and development across Canadian medical universities. **Conclusions**: Chapter 6 discusses conclusions, areas for improvement among Canadian university harassment policies and discusses future directions for this research, such as the application of this criteria in future policy development.

Keywords: Harassment, Canadian medical university harassment policies, medical trainee

Resume

Introduction: Le harcèlement des stagiaires en médecine est un problème largement documenté et omniprésent qui doit être abordé par les établissements d'enseignement supérieur et les organes directeurs. Les universités canadiennes sont tenues de fournir des politiques sur le harcèlement aux étudiants et aux employés, cependant, la sous-déclaration du harcèlement reste un sujet de préoccupation majeur. En ce moment, aucun critère normalisé n'est utilisé pour garantir que toutes les politiques des universités de médecine canadiennes sont complètes, accessibles et claires. Le chapitre 1 de cette thèse donne un aperçu des définitions du harcèlement et de la prévalence actually du harcèlement des stagiaires en médecine documentée dans les universités de médecine canadiennes et internationales. Dans le chapitre 2, je présente les obstacles au signalement du harcèlement et le problème de la sous-déclaration, ainsi qu'un cadre organisationnel et façons dont cet outil des moyens de l'appliquer pour éclairer l'élaboration de la politique sur le harcèlement et présenter le manuscrit de l'évaluation de la politique. Dans le chapitre 3, je décris le processus que j'ai utilisé pour adapter les critères que j'ai utilisés pour l'évaluation de la politique. Le chapitre 4 présente les objectifs et les hypothèses de cette thèse. Le chapitre 5 comprendra le manuscrit de l'évaluation des politiques. Ici, je discuter un ensemble de critères adaptés et étendus utilisés pour évaluer l'exhaustivité de ces politiques sur le harcèlement.

Méthodes : Au chapitre 5, j'ai adapté un critères d'évaluation des politiques pour évaluer les politiques sur le harcèlement des 17 universités médicales canadiennes et des 10 meilleures universités classées QS. Au total, 35 politiques canadiennes et 16 des 10 meilleures universités classées QS sur le harcèlement en milieu de travail et dans les universités ont été évaluées, notées et analysées pour leurs forces et leurs faiblesses en fonction des critères adaptés et étendus.

Resultats: Notre évaluation montre les points forts des universités canadiennes, tels que des définitions distinctes du harcèlement et la mention de la formation sur le harcèlement pour le personnel et les étudiants, et des possibilités d'amélioration telles qu'un manque de détails dans les procédures de plainte informelles et la mention d'un ombudsman ou de représentants des étudiants disponibles . Ce critère adapté peut être utilisé pour l'évaluation et l'élaboration de politiques futures dans les universités de médecine canadiennes.

Conclusions: Le chapitre 6 discute des conclusions, des domaines à améliorer parmi les politiques universitaires canadiennes sur le harcèlement et présente les orientations futures de cette recherche, telles que l'application de ce critère dans les futures réunions d'élaboration de politiques.

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Preface and Contributions of Authors

Dr. Jason Harley (J.M.H) supervised the entire thesis and was involved in every step of the process. My name, Hannah Olivia Peters will be denoted as (H.O.P). Dr. Nigel Mantou Lou (N.L.), and Byunghoon (Tony) Ahn (B.T.A) were involved throughout the whole process and contributed to the conception, and development of Chapter 5. Alison Yang (A.Y.) also contributed to Chapter 5.

Chapter 1

Chapter 1 was written by H.O.P and J.M.H reviewed and edited the section.

Chapter 2

Chapter 2 was written by H.O.P and J.M.H reviewed and edited the section.

Chapter 3

Chapter 3 was written by H.O.P and J.M.H reviewed and edited the section.

Chapter 4

Chapter 4 was written by H.O.P and J.M.H reviewed and edited the section.

Chapter 5

Chapter 5 is a presented manuscript soon to be submitted to the Canadian Medical Journal of Education. H.O.P led all aspects of the manuscript, including: the conception of the project, the background literature review, the development of the policy criteria table, the evaluation, screening, and scoring of 35 Canadian workplace and academic harassment policies and 16 top 10 ranked universities workplace and academic harassment policies, manuscript drafting and submission. N.L. supported all aspects of the manuscript, including: the conception of the project, the development of the policy criteria table, the evaluation, screening, and scoring of the 35 Canadian workplace and academic harassment policies and the 16 top 10 QS-ranked universities workplace and academic harassment policies, the writing of the introduction, results, discussion and conclusions sections of the manuscript, manuscript edits and approval for submission. B.T.A. supported: the conception of the project, the development of the policy criteria table, the evaluation of scoring of the 35 Canadian workplace and academic harassment policies and the 16 top 10 QS-ranked universities workplace and academic harassment policies, the writing of the introduction, results, discussion and conclusions sections of the manuscript,

and manuscript edits. J.M.H. supported and supervised: the conception of the project, the development of the policy criteria table, the writing of the introduction, results, discussion and conclusions sections of the manuscript, manuscript edits and approval for submission and submission of the article to the Canadian Medical Education Journal. A.Y. provided her translation services for three of the Canadian university policies that were originally published in French. She ensured that the Google translated document (from English to French) were clear and accurate.

Chapter 6

Chapter 6 was written by H.O.P and J.M.H reviewed and edited the section.

List of abbreviations

Medical trainee: a medical student, resident or any medical student at the undergraduate or post graduate level.

CAUT: The Canadian Association of University Teachers

RDoC: Resident Doctors of Canada

PGY: Post-graduate year or residency year

Chapter 1: Introduction to harassment in medical training

Medical trainee harassment is a pervasive problem that has been a widely recognized and publicized issue for decades. Despite increased recognition by academic medical institutions and organizations, medical student and resident harassment is still a serious, widespread and global issue. [1] A meta-analysis including multiple countries reported the overall pooled prevalence of intimidation, harassment, and discrimination among medical students and trainees was 64%. [2] Similarly, a study conducted across medical students in the United Kingdom found that 63% of survey respondents experienced harassment during their medical school training, and 56.4% had witnessed at least one form of harassment or discrimination. [3] Additionally, a recent study conducted in Germany found that among 623 medical students, over half (58.9%) were exposed to sexual harassment behaviours. [4] This issue is not just at the undergraduate level but also affects medical trainees in hospital settings. A national survey of Canadian residents found that more than three-quarters of residents had experienced at least one form of harassment and intimidation in the previous year. [5] These findings collectively illustrate the high prevalence of medical trainee harassment and highlight that it is an important, global issue that needs to be addressed across all levels of medical training and contexts.

Forms and definitions of harassment

Research focusing on medical trainee harassment has recognized the importance of defining harassment and the forms it can take in order to provide a clear way forward for many years. [6] Harassment, as defined by the Royal College of Physicians and Surgeons of Canada, "is a form of discrimination. [1] It involves any unwanted physical or verbal behavior that offends or humiliates. [1] Generally, harassment is a behavior that persists over time. However, one single incident, if sufficiently serious, can constitute harassment". [1] Defining harassment is difficult, and the terminology can often be interchangeable with terms such as mistreatment, discrimination and bullying. [1] As recommended by the Royal College of Physicians and Surgeons of Canada, the term mistreatment can be considered an umbrella term, which encompasses many forms of harmful behavior, including bullying, discrimination, harassment, and racism. [1] Some of the articles in our literature review, and manuscript, will use the terms mistreatment, discrimination, and intimidation. However, for the purposes of this thesis, we focus on the following five definitions of harassment provided by the Royal College of

Physicians and Surgeons of Canada: harassment, personal harassment, sexual harassment, workplace harassment and discrimination. We chose to focus on these definitions because the majority of the policies across Canadian medical universities prioritize these terms, or a combination of one or all of them, to define harassment as part of their harassment policies. Furthermore, the Royal College of Physicians and Surgeons of Canada, which is one of the most influential medical associations in Canada, included these definitions as a part of an online publication on their website titled: Creating a Positive Work Environment. [1] In the following paragraphs, I will introduce the prevalence of harassment across the five distinct definitions mentioned, further validating the need for all five individual definitions.

Harassment can take many forms, such as sexual, personal, workplace and discrimination, to name a few. A cross-sectional survey of 7,409 U.S. general surgery residents conducted in 2018 cited three main forms of harassment: physical abuse, sexual harassment, and pregnancy or childcare discrimination. [7] Additionally, a meta-analysis conducted between multiple countries found the most common forms of harassment and intimidation were verbal, physical, and sexual. [3] Focusing primarily on personal and workplace harassment, a study conducted across the United Kingdom asked nursing and medical students to provide context regarding the forms of harassment they experienced in the workplace. [8] Multiple respondents reported the following personal accounts "derogatory comments, outright bullying, and being told that I didn't know anything by my superior". [8] Many of the accounts of harassment reported were in the form of stereotypes, including joking about an individual's ethnicity, gender, religion, social group belonging, race, language and sexuality. [8] These findings justify including specific and distinct personal and workplace harassment definitions, as the literature exemplifies that there is both personal and workplace harassment occuring in the medical training environment.

Sexual harassment is an area of recent focus among medical trainee harassment research after numerous articles have cited the high prevalence. [6, 7] In 2016, the American Medical College (AAMC) graduation questionnaire (GQ) found that 3.8% of the 13,897 respondents reported experiencing unwanted sexual advances, 12.9% had experienced sexist remarks, and 0.2% experienced being offered grades or awards in exchange for sexual favors. [9] Additionally, a Canadian survey distributed across 2016 found that out of 807 incidents of sexual harassment, the most common form and source was inappropriate remarks, which were made by patients,

followed by peers and then faculty and staff. [10] Furthermore, a survey that was distributed to 524 medical students across the United States found that 36.6% of respondents reported sexual harassment by faculty/staff members and 38.5% reported harassment by another student. [11] Sexual harassment is important to characterize because the definition creates an important reference for trainees to be able to understand, recognize and report inappropriate behavior before it continues indefinitely.

Discrimination, as defined by the Royal College of Physicians and Surgeons of Canada can have "11 grounds that are protected under the *Canadian Human Rights Act:* Race, National or Ethnic Origin, Color, Religion, Age, Sex, Sexual orientation, Marital status, Family status, Disability, and a conviction for which a pardon has been granted or a record suspension has been ordered." [1] A cross-sectional survey across American Surgical residents in 2018, which was completed by 99.3% of the residents, 31.9% reported experiencing discrimination based on their self-identified gender, and 16.6% reported experiencing racial discrimination. [9] Furthermore, a survey completed by 259 medical students across the United Kingdom found that well over half, 63.3%, had experienced harassment during their medical school training, and 56.4% had witnessed at least one type of discrimination or harassment. [3] Generalized, personal, workplace and sexual harassment, and discrimination are all forms of harassment that are prevalent in the medical trainee harassment literature and important areas to define and explore and address. Although there is some overlap in the scope of these definitions, there are also important distinctions that justify including unique definitions and examples of each form of harassment.

Sources of harassment

Medical trainee harassment can come from a variety of people. A recent meta-analysis found that the most common sources of intimidation, harassment, and discrimination towards medical trainees were from staff physicians, residents, medical students, patients, relatives of patients, nurses, and other staff. [7] There is, evidently, a vast range of sources that harassment can come from. However, an important source to further investigate is senior physicians or instructors, due to the implicit power differential and their role in shaping the knowledge of medical trainees, including modeling of professional behavior. A survey conducted across the United States including 7,409 medical residents found that approximately 20% of harassment that students experienced was from an attending physician (a senior physician). [7] Additionally, a

survey of medical programs in the United States found that 36.6% of respondents reported sexual harassment by faculty or staff members in their programs. [11] An anonymous electronic survey sent to general surgery trainees at Yale University found the most common source of harassment differed between gender. [12] Female residents reported being most frequently harassed by attending physicians (72.9%) compared to male residents, who were more commonly harassed by nurses (70.5)%. [12]

Chapter 2: Why is there a problem?

Medical students and residents are in a novice position, and as such, can often feel disempowered to report experienced or suspected harassment. This feeling of disempowerment. coupled with the unique workplace environment in which medicine operates, leaves medical trainees vulnerable to harassment in its many forms. The Government of Canada published a list of workplace factors that can contribute to an environment with above average levels of harassment and violence, and two particular factors illuminated critical areas of consideration that apply to the medical training environment: work activity/culture and job factors. [13] Some of the factors they listed under work activity/culture, which create a potential risk to encounter harassment in the workplace, include working with the public and working with volatile persons. [13] This factor which is especially important to recognize as a potential risk factor for medical trainees, due to the emotional, high-stakes environment that providing medical care can create between physicians and their patients.

A few of the job factors listed above are particularly important to consider when examining the medical training environment: a lack of control of how work is done, excessive workload, and ambiguous or complicated reporting structures.[13] The lack of confidence trainees feel in their reporting structures puts them in a vulnerable and difficult position when deciding whether they should feel empowered to report harassment. [14] Furthermore, the factors mentioned above can be exacerbated by a fear of being excluded from opportunities as a result of reporting. [14] An article that was published in 2016 in the Sydney Herald stated multiple reasons that may preclude a medical trainee from reporting harassment, including being "stamped for life" as difficult to work with. [14] The cumulative effect of these job factors, coupled with the fear of being labelled as difficult to work with, can lead to numerous downstream effects, including fatigue, extreme anxiety and burnout. [15-18] Multiple studies have investigated the relationship between the learning/work environment and burnout among residents, citing similar reasons as above, and including factors that are unique to a career in medicine such as uncertainty about the future, and a high level of work-home interference. [15-18] All of the previously listed job factors are critical to consider when evaluating the work-life balance and culture of medical training, particularly when pertaining to downstream effects such as burnout and under-reporting of harassment.

An interview with the Australian Medical Students Association discussed this ingrained culture of unchallenged bullying and sex discrimination in the medical field.[14] One of the statements, from the student's perspective, was that abuse is beneficial because "if you can't make it, you aren't tough enough for the field of medicine". [14] This example illustrates the culture that medical training has adopted, which is one of pain and sacrifice, often at the expense of the student/trainee. [14] The workplace activity/culture and job risk factors previously listed above, and their applicability to the medical training environment, illuminate why medicine is an area where harassment is consistently under-reported. Important factors to consider are how harassment reporting affects trainees, and how both the structure of reporting, and the ingrained culture of medical trainee, result in a lower rate of reported harassment than is truly representative. Taken together, this research showcases the need for a strong support system in place to counter some of these difficult to control environmental and job factors.

Introducing the problem

Although harassment in academic institutions occurs across all disciplines, certain aspects of medical training, as previously stated above, can make it particularly vulnerable to harassment. A critical consideration is how undergraduate and postgraduate medical training is traditionally taught. Medical training has been grounded in the apprenticeship model for hundreds of years. [19] An apprentice, defined by the Oxford dictionary, is "a learner of a craft, bound to serve, and entitled to instruction from his or her employer for a specified period". [19] The skills and professional qualities that a future physician must embody are extensive, and this model has been successful at imparting this knowledge. [19] However, it is important to understand that this model creates a clear delineation of seniority, which can lend itself to students or residents fearing the repercussion of voicing their opinions or offending their superiors.[20] Therefore, it is critical that this training structure, and the power differential it creates, are closely considered when evaluating medical university harassment policies and training.

An important way for universities, and organizations to support medical trainees is by providing accessible and clear institutional harassment policies and training for students and staff. This has long been recognized as a critical way for post-secondary institutions to support their students and empower them to report harassment. The Canadian Association of University Teachers (CAUT) publicized a statement committing to creating a safe learning environment free

of sexual harassment for post-secondary university students in 1989. [21] This article outlined a universal five-stage reporting process: stage one, harassment is reported to a counselor or official contact, stage two, the report is written and formalized, stage three, mediation is encouraged before a hearing, and stage four, the university hearing committee investigates the complaint, actions, and consequences are exercised, and stage five, an appeal stage. [21] Notably, these processes and steps do not differ drastically from the procedures in place today, nearly 40 years later. Yet, the issue of clarity of harassment guidelines, and subsequently under-reporting of harassment, is still a critical problem today. [22]

Despite the fact that every Canadian medical university has a set of harassment reporting policies in place, there are fundamental barriers that prevent students and trainees from feeling protected and empowered to report harassment. [23] The Canadian Federation of Medical Students released a position paper in March of 2019 that cited the barriers to reporting harassment. Two of the primary barriers were the fear of reprisal and the belief that this disclosure would damage their relationship with their mentors and teachers. [23] A Canadian medical student survey in 2016 found that the primary reasons students did not report harassment was because they felt that no effective action would be taken and that reporting may even pose personal risk or harm. [23] These findings touch on a critical consideration, which was previously mentioned, for harassment reporting across medical training, which is the fear repercussions, specifically the fear that reporting would negatively impact the future advancement of one's career. [20] If universities fail to acknowledge and create policies that protect the confidentiality of their students and trainees when reporting harassment, the issue of under-reporting could continue indefinitely. At the same time, it is important to recognize that there are barriers that are created by having anonymous reporting procedures. Notably, the limited ability to provide feedback to those involved can lead to inappropriate labelling and bullying of the accused, which can exacerbate potentially already existent bias towards the senior physician. [7]

Under-Reporting

A recent survey conducted by the Department of Surgery at Yale University found that 7.6% of respondents who had experienced harassment reported the incident, meaning that 93.4% of those who experienced harassment did not report it. [12] Some of the reasons that they did not report the harassment incident was that it was perceived as "harmless" (62.1%), they believed

that reporting would be a waste of time (47.7%), and they felt they were too busy to file the complaint (37.9%). [12] A similar qualitative survey study was administered to graduating medical students between 1992-1996. [26] When asked why they did not report experienced harassment, 39.5% of the respondents felt that the mistreatment was not serious enough to warrant reporting, and 31.6% did not feel reporting would be effective. [26] These findings bring to light the fact that many of the reasons stated above have not significantly improved over the past 30 years. A qualitative review of medical students' experience of harassment was conducted in Sydney, Australia, focused on personal interviewing, where 10 medical students' shared their experiences as students and trainees. [20] The respondents were asked to highlight some aspects of their training that posed a potential barrier to students and trainees feeling empowered to report harassment. [20] Four major themes were highlighted: hierarchy, a culture of self-sacrifice, a cultural practice of deference to more senior doctors, and the idea of 'imposter syndrome', meaning they did not want to appear unknowledgeable. [20] Taken together, these conclusions showcase a multitude of barriers that prevent students and trainees from feeling empowered to report harassment, many of which surround uncertainty regarding whether an event was serious enough to be considered mistreatment. [12, 26] An important area of focus is how these factors and barriers could be incorporated into the creation of harassment policies to reduce some of the barriers trainees face in reporting harassment.

Another crucial area of exploration is the definitions and formalized grievance procedures outlined in harassment policies. Freedman-Weiss and colleagues' (2020) qualitative review found that the most cited reason residents did not report experienced harassment was that they felt unsure if what was occurring was defined as sexual harassment. [12] This finding illuminates the importance, and responsibility, that universities must provide clear and explicit definitions of harassment as a part of their policies. A qualitative exploration of barriers to reporting harassment conducted across Sydney Australia corroborated these conclusions, as they found that seven out of ten respondents felt when it came to reporting harassment, and their impression of the avenues of recourse, there was "insufficient assurance of confidentiality, lack of clarity regarding whether incidents fell under the university or hospital's purview, grievance policies were unclear and outcomes characterized were inadequate." [20] This research suggests that there may be an overall feeling of mistrust and lack of clarity from the trainees perspective's

in their universities' policies and grievance procedures. [20] Taken together, these findings put into perspective a critical question: are there ways to improve the current harassment policies to ensure they are transparent, timely and accessible?

Shortcomings of the current policies

The lack of clarity, inaccessibility and feelings of overall mistrust in medical universities' harassment policies is an area of concern at the undergraduate and post-graduate level. A national survey conducted by the Resident Doctors of Canada in 2018 found that when asked if their medical school or program had a policy to address harassment, one-fifth of respondents stated that they were unsure. [5] Additionally, of the individuals who reported an experience of harassment, only a little over 10% accessed and used their institution's policies and resources. [5] When the residents that did use their institutions policies to report harassment and intimidation were asked about the policies effectiveness, over half (62.1%) rated these resources as inadequate. [5] It is clear that future development would benefit from a greater focus on ways to improve existing Canadian medical universities harassment policies to help ensure medical trainees feel supported and empowered to report harassment.

Many articles, position papers, and organizations have proposed recommendations to improve university and hospital harassment policies.[22-24] These recommendations include measures to protect those experiencing harassment, including confidential reporting, mandatory harassment training, and adopting a zero-tolerance approach. [22-24, 27] Although these elements are more routinely incorporated into harassment policies, under-reporting of harassment is still a critical issue. At this time, there is no single standardized criteria by which all Canadian medical harassment universities must adhere to ensure that they are inclusive, comprehensive, and provide all of the adequate elements necessary to support their students and residents. Furthermore, without a criteria and comparison measure, it becomes challenging to situate where and how Canadian harassment policies can improve to help support students and reduce the prevalence of harassment among medical students and residents.

As evidenced from our background literature review, medical trainee harassment is a prevalent issue across Canada, Europe, the United States and the United Kingdom.[2-8]There is a clear disconnect between the prevalence of harassment occurring and the number of incidents reported. Universities have an obligation to provide clear, and supportive harassment reporting

procedures in order to provide trainees with knowledge and information necessary to report harassment. However, as it stands, there is no clear and available criteria or system in place to ensure that these policies meet this standard. The first step towards accomplishing this is the creation of a set of criteria which can be used to evaluate university harassment policies and identify areas for strength and weaknesses. With this goal in mind, together as a team, we adapted and extended a harassment policy evaluation criterion that can be used to evaluate university harassment policies, which will be introduced in the following chapter.

Although the focus of our evaluation is on Canadian medical university policies, it is important to understand if other countries, with similar prevalence rates, are also encountering these same issues. Therefore, our evaluation will includes the top 10-QS ranked universities. There are multiple sources that rank universities including the Times Higher Education (THE) ranking, Leiden Ranking, and Webometrics, to name a few. [28] Each one of these systems weights different aspects, such as research productivity and publications, differently and assign more or less weight based on their ranking system. [28] We decided to use the QS-ranking system due to it's accessibility and focus on hard data outcomes. [24] Although this rating system is subject to survey fluctuations and error, we felt it was a strong set of ranking criteria to employ. [28] If there are critical areas of overlap, or areas where certain countries are excelling, this could help identify areas for improvement within Canadian medical university harassment policies. Likewise, if Canadian universities and top international universities are missing key elements, this could help inform future policy development and highlight areas for improvement. This review was not systematic in nature, and primarily focused on North America, Europe and the United Kingdom whose policies were in either English and French, which the reviewers could read and have translated very easily. Therefore, while it is likely that these issues are globally pervasive, this review only focuses on policies written in English or French. Moreover, we decided to adapt a criteria from a sexual harassment policy evaluation conducted across universities in South Africa, due to its clear parallels with our goal and intentions, to help create a meaningful comparison between Canadian medical universities, and the top 10 QS-ranked international universities policies. We will introduce the development and rationale of this evaluation in the following chapter 3.

Chapter 3: Addressing the problem

The medical training environment is a unique hybrid between a university and workplace setting. Nonetheless, this enviornment should be treated as both. An important area to explore is the factors that create or perpetuate an environment where harassment is tolerated and dismissed. Medical trainees have a vast range of responsibilities, including clinical placements, exams, research projects, and studying, leaving minimal time for personal or social engagements. [29] These duties, and the associated workloads, have become a part of the expectations that universities have of medical trainees and can lead to a multitude of downstream effects, leaving trainees to feel unsupported by their academic institutions. The expectations, and the sacrifices physicians make contribute to the culture of medicine, which is grounded in self-sacrifice, hours of work and a belonging to a competitive and prestigious career. The term culture of medicine is cited, however, the literature lacks a formal definition. For the purposes of this thesis, we will refer to the culture of medicine as an all encompassing collective experience, beginning in medical school, and following a clear trajectory of seniority throughout one's medical career. In order to address the culture and the expectations of organizations of medical trainees and physicians, it is essential to understand the relationships between an organization's expectations and the effectiveness of harassment training and policies to appropriately address the problem.

A conceptual framework proposed by Roehling and Huang (2018) explored the primary factors influencing the effectiveness of sexual harassment training. [30] A critical area for consideration is a variable they described as the "organizational context," which pertains to the work environment and situational characteristics that can impact the effectiveness of sexual harassment training. [30] This variable includes the following subcategories, which can all impact the effectiveness of sexual harassment training and are important to consider: "aligned policies/practices, leadership support, climate and culture, organizational tolerance of sexual harassment and diversity value." [30] It is imperative to recognize that sexual harassment training can be affected by other external varibles, which this framework further outline: training objectives, such as the extent that the sexual harassment training was communicated, training design and delivery, such as the delivery method including online video or recording, and trainee characteristics, such as the trainee's personal tolerance of sexual harassment. [30] This framework uniquely highlights how variables, such as the environment, policies, and leadership, can

ultimately impact whether issues such as sexual harassment and their training are effective within an organization.

Two critical aspects outlined by Roehling and Huang (2018) that are particularly important to consider in the medical training environment are leadership support and "aligned" policies/practices. [30] If leadership, such as hospital and university administration, do not support trainees or medical students to feel empowered to report harassment, or provide them with adequate harassment training or policies, then the perpetuation of trainee mistreatment could continue indefinitely. This framework illustrates the clear relationship between the organizational context, such as climate and culture, and the intermediate outcomes, including the prevalence of sexual harassment and other downstream effects including bullying and other forms of harassment. [30] Therefore, due to the applicability of Roehling and Huang's (2018) framework to our evaluation and harassment training in general, we decided to apply it to help guide and shape and development of our evaluation.

Organizations such as the Resident Doctors of Canada and the Royal College of Physicians and Surgeons have recognized the importance of gaining the trainees' perspective of harassment prevalence and issues in order to help improve the learning and work environment. After conducting surveys measuring the prevalence of intimidation and harassment among Canadian medical residents, the Resident Doctors of Canada began to publish position papers addressing intimidation and harassment as early as 1996.[24] Starting in 2012, the Resident Doctors of Canada released a position paper each year. In 2015, they published an article entitled "Optimizing a Positive Work Environment by Addressing Intimidation and Harassment". [25] In this paper, they proposed a set of recommendations to help promote a positive work environment and reduce the prevalence of harassment. [25] Their recommendations included: "promoting a positive work environment, faculties of medicine establishing and maintaining a culture that prioritizes and promotes well-being and a zero-tolerance approach to intimidation and harassment, post-graduate medical programs developing a free, open forum for resident doctors to safely report inappropriate behaviors when they occur, a process for administrators to examine and address events as they arise in a timely fashion, and lastly, for all programs to update their intimidation and harassment workplace policies and procedures regularly". [25]

Position papers and recommendations are critical, as they bring to light essential areas for improvement among Canadian university harassment policies. It is clear that this is an area where recommendations are being proposed, but the essential question is, how can we ensure that these recommendations are being incorporated or evaluated in future policies? Many of these recommendations are published by organizations that govern the Canadian medical system. However, there is still no guarantee or system in place that ensures that these recommendations are applied to future harassment policy iterations. This poses a critical question of how to monitor if these changes are being implemented, and importantly if these recommendations are helping to create supportive, accessible, and comprehensive policies for medical trainees. Policy evaluations, such as the one we conducted and reported in Chapter 5, will not solve all of these important issues alone, however, they are an important step towards ensuring that these criteria and recommendations are being implemented.

Chapter 4: Objectives and Hypothesis

Objectives:

1. Provide an understanding of the problem of harassment, and under-reporting of harassment in medical training (CH 1).
2. To discuss the barriers and organizational factors that contribute to under-reporting of harassment and future steps to address this important issue (CH 2).
3. To discuss attempts, opportunities, and challenges to address harassment (CH 3).
4. Propose a set of criteria which can be used to evaluate Canadian medical university harassment policies (CH 5).
5. Compare Canadian medical university harassment policies between Canadian regions and against the top 10 QS-ranked universities to address strengths, weaknesses and areas for future improvement (CH 5 and CH 6).

We hypothesized that the criteria we adapted would provide a meaningful comparison between Canadian medical university harassment policies, between regions, and the top 10 QS-ranked universities. Additionally, we hypothesized that the top 10 QS-ranked universities' harassment policies would be exemplary and create a strong reference for Canadian medical universities to be evaluated against.

Chapter 5: Manuscript

An exploration of anti-harassment policies across Canadian and international medical programs

Manuscript submitted for review to the Canadian Medical Education Journal (August 3, 2021) and to the American Education Research Association Annual Meeting [conference] (July 20, 2021).

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Conflict of interest statement:

Two SSHRC grants awarded to Dr. Jason Harley supported this research: "Defining and Combatting Harassment in Health Sciences Education (Harley, PI: ID 430-2020-00573) and "impacts: A multi-sector partnership to investigate and develop policy and practice models to dismantle rape culture in universities (Harley, PI of subaward, co-applicant of grant; Dr. Sharriff PI of grant: ID 895-2016-1026)." The authors declare that they have no known conflict of interest.

Abstract

Background:

Medical trainee harassment is a global issue that has led to a multitude of detrimental effects. An important area of consideration is whether harassment policies are clear and available to all medical trainees, both in Canada and internationally. We conducted a thematic policy evaluation of the 17 Canadian medical universities', and top 10 Quacquarelli Symonds (QS)-ranked international universities' workplace and university harassment policies using adapted and extended harassment policy evaluation criteria.

Methods:

We evaluated 35 workplace and university harassment policies from the 17 Canadian medical universities in 2020 and 16 workplace and university harassment policies from the top 10 QS-ranked universities. We assigned each university a score across three themes: theme (1) Policy definition, harassment definition and understanding harassment, (2) Informal and formal complaint procedures, and (3) Resolution, training, and implementation procedures.

Results:

Our findings showed areas of strength for Canadian universities, such as the explicit mention of harassment training and provision of definitions, and areas for improvement such as a lack of informal complaint procedures and mention of an ombudsperson or student representative. Furthermore, our results revealed important differences across universities regarding the three themes we evaluated: Canadian universities scored higher than international universities across themes 1 and 3, and international universities outperformed Canadian universities on theme 2.

Conclusions:

There is a need for improvement and standardization across Canadian medical university harassment policies. The presented criteria can be used for future policy assessment and development across Canadian medical universities, and hopefully in the future, international medical universities.

Keywords: Harassment, Policy, International, Canadian, Medical-Education

Abstract: 248/250

Word count: 4497 /450

Introduction and Background Literature

Harassment across medical training programs is a pervasive and global issue with widespread and detrimental consequences, such as poor health outcomes for students and trainees, performance decline, feelings of isolation, financial loss, and decreased productivity, to name just a few. [1] Studies throughout the years consistently report high incidences of harassment: A US-based 2016-2017 survey distributed to 27,504 graduating medical students revealed at least one episode of mistreatment from 40.9% of female students and 25.2% of male students; a 2018 survey distributed across 16 medical training programs found 30.8% and 70.8% of male and female trainees experienced sexual harassment, respectively; Canadian surveys spanning from 2012 to 2020 found that between 73% to 78.2% of Canadian residents experienced at least one instance of intimidation and harassment during their training. [34,2, 27, 5, 25] Studies from Australia and the United Kingdom echo similar findings: 54.3-57.5% of junior doctors in their first or second year of residency reported being bullied [35] while 63.3% of medical students have experienced at least one type of discrimination or harassment. [8] Taken together, these findings illustrate that harassment is a prevalent issue among Canadian and international medical training programs. It is critical to find ways that these programs can better support their students and residents, including helping them feel empowered to report experienced harassment.

Despite medical trainee harassment reports becoming increasingly more publicized, recent findings suggest that the number of harassment incidents reported is likely under representative of the actual number of harassment events occurring during medical training.[12] A survey conducted by the Department of Surgery at Yale University found that only 7.6% of residents who had experienced sexual harassment reported the incident, meaning that 93.4% of respondents did not report it. [12] The most cited reasons residents did not report experienced sexual harassment were: the incident was perceived as "harmless" (62.1%), they believed that reporting would be a waste of time (47.7%); they felt they were too busy to file the complaint (37.9%), or they felt unsure if what had happened was considered sexual harassment, (31.8%). [12] These rationales raise an important question: do medical trainees have access to clear and timely information that allows them to identify and feel empowered to report experienced harassment confidently?

University harassment policies are a key source of information for medical trainees to learn how to report harassment. However, if medical trainees are unaware of reporting policies, or if the policies are unclear or inaccessible, this may lead to under-reporting and increased tolerance of harassment indefinitely. [12] There is relatively little published literature evaluating the effectiveness and accessibility of harassment policies from medical trainees' perspectives. A position paper published in 2019 stated one of the primary concerns for Canadian medical student mistreatment is a lack of oversight from trainees surrounding harassment policy development. [23] To this end, a national survey conducted in 2018 found that when asked if their medical school or program had a policy to address harassment, one-fifth of residents stated that they did not know. [5] Additionally, of the individuals who reported an experience of harassment, only a little over 10% accessed and used their institution's policies and resources. [5] At this time, there is no known set of standardized or association-endorsed criteria used to evaluate Canadian medical university harassment policies to ensure that they are comprehensive and accessible to medical trainees across all levels of training. This existing research demonstrates the need to develop criteria that can be used to evaluate harassment policies and to determine if they are accessible, comprehensive, and supportive of their students and residents.

We reviewed 35 workplace and academic harassment policies from the 17 Canadian medical universities in 2020 and 16 workplace and academic harassment policies from the top 10 Quacquarelli Symonds (QS)-ranked universities to assess their harassment policies. [36] Our focus was on analyzing these policies for common and unique weaknesses and strengths to better understand areas that Canadian medical universities could improve their harassment policies. The top 10 QS-ranked universities are considered world-class institutions and are evaluated using four core criteria: academic reputation, employer reputation, research citations, and H-index (impact ranking for published work and research). [36] Because both academic and employer reputation is considered a part of their ranking criteria, we reasoned their harassment policies would create a strong reference for Canadian medical universities to be evaluated against. However, we recognize that the reliance on the QS ranking system is potentially problematic due to it’s use of subjective measurements such as surveys. This needs to be be taken into consideration when analyzing our results. [28] Overall, we believed that the criteria developed in this review could serve as a benchmarking tool to evaluate the accessibility and

comprehensiveness of Canadian medical universities' harassment guidelines and identify both areas for improvement and universities that might be looked to for examples of how to improve on specific criteria.

Rationale

Research into the theoretical understanding of harassment was diverse, including general, workplace, personal and sexual harassment, and discrimination literature, focusing on university harassment policies. In-depth searches beyond published journal articles suggest that there are varying approaches to studying harassment. A 2010 master's thesis, written by Justine Brisebois and submitted to the University of Manitoba, compared university harassment guidelines using three primary approaches: the respectful workplace approach, the legal-preventative approach, and the forerunner approach. [31] Additionally, a thesis published in 2008 by Marni Roberta Westerman also compared Canadian university harassment policies, electing to take an authoritarian, personal, historical, and neoliberal (pertaining to primarily economic and politics) approach to policy evaluation. [32] All of these approaches provided an enriched perspective; however, for our evaluation, we were looking to develop a comprehensive, nominal, set of criteria that would apply to the entire policy, and be amenable to quantitative evaluation to support comparisons. Additionally, we wanted to focus on the organizational structure of medical universities and training environments for our evaluation to help ensure it was universally applicable to both Canadian medical universities' and top international universities' harassment policies.

The theoretical lens through which this evaluation is framed is from a conceptual framework proposed by Roehling & Huang: Primary Factors for Influencing the Effectiveness of Sexual Harassment Training. [30] Our approach was grounded in this framework, which proposes that the organizational context (e.g., organization's tolerance of sexual harassment, leadership support, "aligned" policies/practices, climate, culture, and diversity value) directly impacts the intermediate outcomes (e.g., prevalence of sexual harassment) and environmental factors (e.g., a hospital environment). The framework posits that if an organization lacks aligned policies, such as including a different definition of sexual harassment in their policies than was provided to staff during their training, this disconnect could contribute to cases of sexual harassment being considered a "false positive". [30] This could result in cases being falsely dismissed by compliance

officers, even though the event was in fact sexual harassment, and could appear as though the organization tolerates and accepts harassment rather than opposes it. [13] This framework, and the focus on aligned policies and organizational tolerance as a predictor of an organization's tolerance of harassment, justified and motivated the development of our evaluation. Therefore, we predict that a comprehensive, accessible, and clear harassment policy can serve as an indicator of the organizations' tolerance, or lack of tolerance, of harassment and, in turn, empower students to report experienced harassment.

We adapted our criteria to evaluate the Canadian and top 10 QS ranked harassment policies, based on a policy review conducted by Wilken & Badenhorst (2003), which analyzed sexual harassment policies across higher education institutions in South Africa. [33] The elements assessed in their review, which we also included in ours were: (1) policy statement, (2) zero tolerance statement, (3) clear definitions of harassment, (4) workplace safety, (5) health regulations, (6) confidentiality laws, (7) reporting procedures including timelines, support, safety concerns, retaliation concerns, appeal measures, (8) disciplinary actions, (9) education and training provided to students and staff, (10) implementation and training of policies. [33]

We considered all these elements to be critical to include in our review criteria. Based on recommendations proposed by the Resident Doctors of Canada and our review of the policies, we added additional elements to our adapted criteria: understanding harassment, additional definitions, and more detailed, separate sections for informal and formal complaint reporting and resolutions (see Tables 1, 2 and 3).[1] For definitions, we used the five definitions provided by The Royal College of Physicians and Surgeons of Canada (see Table 1, Definitions of harassment). [1]

Methods

Sample size and characteristics

Two authors independently searched for and reviewed sexual violence policies, harassment policies, and harassment reporting guidelines from 17 Canadian medical programs. First, we categorized Canadian universities across the three major regions of Canada: Western Canada (The provinces of British Columbia, Alberta, Saskatchewan, and Manitoba), Atlantic (The provinces of Newfoundland and Labrador, Prince Edward Island, Nova Scotia, and New Brunswick), and Central Canada (The provinces of Ontario and Quebec). [37, 38] For this evaluation, we focused on these regions because they all had medical schools. [37, 38] Next, we

used the same method of searching to gather the harassment policies from the top 10 QS-ranked international universities (United States, 50%; United Kingdom, 40%; Sweden, 10%). In total, we reviewed 35 harassment policies from the 17 Canadian medical universities' and 16 harassment policies from the top 10 Quacquarelli Symonds (QS)-ranked universities to assess their harassment policies. For the purposes of this review, we will refer to the top 10 QS-ranked 2020 international universities as top international universities

Data organization

For evaluation and to provide a score, we divided our criteria into three separate themes. Theme 1 (Policy definition, harassment definition and understanding harassment) included 10 elements, which included for example, a definition of sexual harassment. Theme 2 (Informal and formal complaint procedures) included 10 elements, which included for example, when an investigation would occur after an informal complaint has been filed. Theme 3 (resolution, train- ing and implementation procedures) included 9 elements, which included for example, are disciplinary actions outlined to both the victim and the accused? We repeated this evaluation for both Canadian universities and top international universities. We constructed two tables (Table 1 and 2) with three main sections: theme 1, 2 and 3, one for the Canadian universities and one for the international universities. Please note that the number of elements evaluated are denoted as "n". Additionally, the number of universities that included an element are denoted as "N". For example, if you see n=10, this means that 10 elements were evaluated as a part of the theme. If you see N=3, that means that 3 out of 10 of the top international universities, or 3 out of 17 of the Canadian universities included this element in their policies.

Study protocol

Two independent raters reviewed each policy and recorded if an element was or was not present using a rating system (0 = missing, 1 = the element was present). We divided our criteria into three separate themes: (1) Policy definition, harassment definition and understanding harassment; (2) Informal and formal complaint procedures; and (3): Resolution, training, and implementation procedures. We recorded our findings by theme and for Canadian vs. top international universities (see Table 3). We further analyzed Canadian universities by region (Western, Central and Atlantic). To calculate percentages per each element by university, we employed an open coding approach, meaning we scored each element by summing the total

number of schools that scored a 1 on that element. [39,40] For example, to calculate the number of Canadian universities that included a zero-tolerance statement of harassment (element 1.1 in Table 2) we counted that there were 16 out of 17 Canadian universities that included this element in their policies, so the per centage of Canadian universities that included that element in their harassment policies was 94% (see Table 2). We repeated this same protocol for the international universities. Scores for each theme were calculated by adding up the number of 0's and 1's in each column and totalling them. For example, the University of British Columbia scored 90% on theme 1, meaning that there 9 out of the 10 elements we evaluated for across theme 1 were present in their policy. Neither of the raters were fluent in French. Therefore, Sherbrooke University, University of Montreal, and University Laval policies were translated using Google Translate and corrected by a French-English bilingual speaker who reviewed both the original English policy documents and Google Translated French ones.

Outcome measures and data analysis

After the initial review, the inter-rater agreement was calculated using SPSS version 24. The kappa score was 0.78, $p < .001$ for the 17 Canadian universities, and 0.82, $p < .001$, for the international universities. This is considered a substantial agreement score. [41] Next, the two independent authors discussed discrepancies and reached a 100% agreement.

Results

Comparison of Themes 1, 2 and 3 Between Western, Central and Atlantic Canadian Regions

Concerning theme 1, *Policy statement, harassment definition, and understanding of harassment*, the average policy scores were relatively strong with a mean of 82% of elements accounted for across the 17 Canadian universities (*SD*=.26). The average score for this subsection within the Central region was 80% (*SD*=.30 range; 60-100%, n=10). Notably, only two universities scored 100% on this theme: Memorial University, in the Atlantic region, and the Northern Ontario School of Medicine, in the Central region. The most observable difference between regions was found within theme 2, the *Informal and formal complaint procedures theme*. The average score for this subsection, across the Western regions of Canada was 62% (*SD*=.32; range;30-90%;range; n=10. The average score in the Central region was 55% (*SD*=.33; range; 30-70%, n=10) and the Atlantic region's average score was 75% (*SD*=.33, range: 60-90%;

n=10)). Lastly, when it came to comparing among regions by theme 3, the *Resolution, training implementation theme*, the average score in the Western region was 91%, (*SD*=.11; range; 66-100%, n=9) with three universities scoring 100% (the University of British Columbia, the University of Alberta, and the University of Manitoba). The Central region's average score was 89% (*SD*=.12; range; 66-100%, n=9). Notably, both universities we evaluated from the Atlantic region scored 100% on the *Resolution, training implementation* subsection (*SD*=.00, range;100-100%, n=9) (see Appendix A).

Comparing the Policy Themes between Top International and Canadian Universities

Theme 1: Policy, Definition, and Understanding of Harassment Theme

On average, Canadian universities scored higher than the international universities on *Policy, definition and understanding of harassmen*t subsection (theme 1) of our evaluation (Canadian, *M*=0.81, *SD*=.26, International, *M*=0.74, *SD*=.42). All the Canadian universities' and top international universities' policies included a policy statement and included both elements of the understanding harassment section: described whom harassment could occur between and referenced the legal definition of harassment regarding local governing bodies. The largest differences were in the definition sections of Canadian and top international universities' harassment policies. Most Canadian universities and top international universities included a definition of harassment (94%, n=16;90%, N=9) and sexual misconduct (94%, N=16; 100%, n=10). However, most Canadian, and top international universities did not define workplace harassment (35%,N=6; 0%; N=0) and personal harassment (35%, N=6; 0%, N=0). No single top international university scored above 80% on this section. In contrast, 7 Canadian universities did (see Table 3, Canadian Universities score by element and theme). Although the ranges in scores are similar, it is notable that Canadian universities were scored higher more frequently than the top international universities.

Theme 2: Informal and formal complaint procedures

When comparing the top international universities' and Canadian universities' scores on theme 2, *Informal and formal complaint procedures*, the greatest observable difference was on the informal complaint procedures subsection. Specifically, the timelines outlined for reporting a harassment incident and if there was support available to trainees, such as an ombudsperson. A higher percentage of top international universities outlined if there was an ombudsperson present

for these procedures as compared to Canadian universities' (International; 100%; N=10; Canadian; 88%; N=15) and when the resolution would be reached (International; 30%; N=3, Canadian;12%; N=2). When specifically examining the formal complaint procedures, two elements were seldom mentioned by Canadian universities: if there was a student representative, such as an ombudsperson, present for students to report harassment to (35%; N=6) and when the complaint would be reviewed in relation to when the complaint was filed (47%, N=8). In general, the top international universities scored higher than Canadian universities on theme 2, *the Informal and formal complaint procedures subsection* (Canadian, *M*=0.70; *SD*=.26; n=10; International, *M*=0.74; *SD*=.42; n=10). This finding may have been the case due to the question pertaining to when the resolution would be reached, which was more frequently outlined by international universities (Canadian, *M*=.18, International, *M*=.30). A notable difference can be observed between Canadian and top international universities, primarily under the element outlining if an investigation will occur under the formal investigation section. Most Canadian universities (88%; N=15) explicitly stated this, whereas only (60%; N=6) of top international universities mentioned this element.

Theme 3: The Resolution, Training Process, and Implementation

The most discernible difference between Canadian and top international universities was within theme 3, the *Resolution process, training, and implementation* subsection, particularly if there was mention of harassment training and if there was a commitment to reviewing harassment policies and updating them accordingly (elements 6.1-6.2, and 7.2). Most Canadian universities' (76%; N=13) policies mentioned providing training to students compared to 40% (N=4) of the top international universities' policies. Moreover, all the Canadian universities' harassment policies (100%; N=17) explicitly stated that there would be a review and revision process of harassment policies and stated a timeline (within 1 to 3 years), in comparison to 50%, (N=5) of top international universities. Lastly, when it came to disciplinary actions, 82% (N=14) of Canadian universities mentioned what the discipline for the perpetrator would look like, for instance, legal repercussions or expulsion, in their policies. This finding contrasted with the top international universities, which all mentioned the disciplinary actions (100%).

Discussion

The main objectives of this policy evaluation were to evaluate and compare Canadian medical universities' harassment policies between regions, and with top international universities to identify strengths, weaknesses, and areas for improvement. Overall, Canadian universities scored well on the criteria we analyzed and were considerably more comprehensive than the top international universities regarding the definitions, training, and implementation sections. However, noteworthy is that few Canadian institutions used all five definitions of harassment we included in our adapted criteria, as recommended by the Royal College of Physicians and Surgeons of Canada. As past literature has shown, harassment and mistreatment are often experienced in multiple forms, such as verbal and emotional. [9] Therefore, including separate and distinct definitions for harassment, including workplace, sexual harassment or misconduct, discrimination, and personal harassment, can serve as an important way to inform students and residents about the many forms of harassment that can occur. This understanding may allow medical trainees to feel more empowered to report experienced harassment.

An important finding when comparing across regions of Canada was the difference of scores across the *Informal and formal complaint procedures theme* (theme 2). The top international universities scored considerably higher than the Canadian universities across this theme. Additionally, the range of scores on theme 2 across the three regions of Canadian universities was broad, with the lowest and highest scores ranging between 30-90% (n=10). This sheds light on the issue of inconsistencies across the *Informal and formal complaint procedures*, even within a single country. The Canadian university harassment policies scored generally quite well across our criteria. However, the lack of clarity regarding how to formalize a complaint and whom to talk to could contribute to the under-reporting, and further perpetuation of harassment. Notably, when it comes to theme 3, *the Resolution, training process and implementation* theme, most universities within all regions of Canada scored extremely well, particularly the universities in the Atlantic Canadian region, which both scored 100% (n=9). An important area to focus on improving in terms of clarity is the resolution procedures. If they are unclear, or intimidating, this could explain why some trainees would feel like reporting harassment is hopeless. Having universities across Canada with exemplary scores across these sections will provide other Non-

Canadian universities with the opportunity to evaluate where they could improve their policies to ensure that they are as comprehensive and transparent as possible.

A crucial finding of this review was the difference between universities in the amount of detail provided for the informal complaint procedures. Specifically, there were considerable inconsistencies between Canadian universities concerning the reporting procedures, mention of support in place such as an ombudsperson, and timelines surrounding the informal complaint procedures. While some Canadian universities outlined all these components, many others included just one or two of these elements. Considering these findings from the *Primary Factors for Influencing the Effectiveness of Sexual Harassment Training framework*, if students do not feel like their organization provides clear harassment procedures and policies, they will not feel supported by their university or know how to identify harassment. [29] The informal complaint process is considered the first opportunity for students to identify, report and resolve harassment before it escalates to a formal complaint. If these procedures are unclear, or inconsistently defined, this could deter trainees from reporting this event, and future events of harassment. Findings such as Freedman-Weiss and colleagues' (2020) found that nearly 48% of students who did not report harassment thought it would be a waste of time, affirming the need for clear, accessible, informal complaint procedures and an organizational commitment to providing these for all medical trainees. [12] By having the informal complaint process clearly stated and accessible, trainees can feel empowered to report experienced harassment, and if needed, escalate their complaints to the formal complaint procedure.

A critical step towards reducing harassment is providing education and guidelines for medical trainees to access. Medical trainees learn and model the professional behaviour of senior physicians and staff, and thus training at the senior level is also critical to ensure that a cycle of abuse and mistreatment does not continue or become systematically entrenched within the institution or workplace. Most Canadian medical universities' policies mentioned providing harassment training to both staff and students, and far more Canadian policies mentioned this element when compared to top international universities. Ensuring that harassment training is provided to all students and staff affirms that stopping harassment is an individual and collective organizational effort.[29] Furthermore, providing harassment training allows for students and trainees to recognize the organization, in this case their universities, commitment to a

harassment-free environment.[29] This practice is a strength among Canadian medical universities, as education is essential in reducing harassment and providing learners with a safe environment to study, learn and work. Additionally, all the Canadian medical universities mentioned a commitment to reviewing and revising their harassment policies every few years, compared to only 50% of the top international universities. Despite these findings, the Resident Doctors of Canada, nonetheless, recently found that only a little over 10% of medical residents accessed and used their institution's policies and resources to report harassment.[5] It is therefore clear that there is considerable room for improvement in ensuring that these policies are current, accessible and that harassment training is provided to all students and staff.

Conclusion

Our review has brought to light critical areas of overlap and differences across Canadian and international universities' harassment policies and highlighted the lack of congruence, even within common regions of Canada. Articles and papers, such as the ones published by The Resident Doctors of Canada, and The Royal College of Physicians and Surgeons of Canada have proposed criteria to help improve harassment reporting procedures across Canada. [1, 25] Nevertheless, at this time, there is no known single established set of criteria to which all Canadian harassment policies are evaluated to ensure they are accessible, comprehensive, and supportive of their students and staff. We believe our proposed adapted criterion could help address the differences between Canadian medical universities' harassment policies and ensure that these policies are comprehensive and accessible. Furthermore, university policy developers could use this criterion to evaluate their harassment policies after each revision to ensure further future policies are complete, accessible, and comprehensive.

Limitations and future directions

One major limitation of this study was that universities often had multiple websites where these policies were published. Therefore, there is a possibility that the two independent reviewers missed some of the policy documents, which may have been embedded in other documents or not explicitly labelled as policy. Additionally, the criteria and subsequent tables created were based primarily on universities in Canada, The United States, The United Kingdom and Sweden. Therefore, representation from international universities was limited to North America and Europe, which only provides a few distinct legal and policy procedure perspectives for

comparison. Future inclusion of countries from more diverse areas across the world could be beneficial and help better illuminate areas of strength and areas for improvement across Canadian and top international universities' harassment policies. Additionally, the assignment of a nominal rating system, meaning either a score of 1 for the element being present or a score of 0 for the element not being present, by two independent raters was another limitation. Although this was useful for our purposes, some nuances may be missed if you employ a binary rating system. For example, two universities may both include a zero-tolerance policy statement, but these statements might not be equally helpful or accessible.

When considering the findings from this policy evaluation, two critical areas of future policy development include more distinct definitions of harassment and clarifying reporting guidelines. A possible solution could be creating a single resource where definitions and reporting resources and policies are accessible. For example, McGill University has a website offered by the Office for Mediation and Reporting entitled Straightforward Reporting.[42] This resource cites clear definitions for harassment, discrimination, and sexual violence and outlines, step by step, the reporting and resolution process and resources available to students in one location and creates a platform for students and trainees to access and reduces barriers to finding and reporting harassment events.[44] In the future, other Canadian institutions could draw on this website as a model to create a more accessible, single resource for students and trainees to learn about and feel supported and empowered to report harassment.

A future direction for the proposed criteria could be a small pilot study, where multiple Canadian medical university harassment policy development teams use this criterion to assess their current policies. If they can replicate our findings and utilize this criterion effectively to highlight areas of strengths and weakness, this could further serve as support for the applicability of this tool. A future follow-up study could provide the criteria to university policymakers and student representatives, such as an ombudsperson, to examine potential differences between their ratings on the policies. This information could be used to further adjust policies to ensure they are accessible, clear, and comprehensive from trainees' and policy developers' perspectives.

Contributions

Canadian medical universities can use this adapted criterion we developed in this study as a tool to evaluate their policies to ensure they are comprehensive and accessible to medical

trainees. Our findings across Canadian medical universities and top international universities, such as differences across the informal complaint procedures, illustrate the need for a standardized evaluation system. The universities we selected for comparison were useful. However, we hope that the proposed evaluation criteria can be applied to future comparisons with universities worldwide to help inform Canadian as well as international medical universities harassment policy development moving forward.

Tables

Table 1.

Definitions of harassment

All definitions came directly from the following source:

Creating a Positive Work Environment. (n.d.). [1] Retrieved April 21, 2021 from: https://www.royalcollege.ca/rcsite/about/creating-positive-work-environment

Term	Definition
Harassment	"Harassment is a form of discrimination. It involves any unwanted physical or verbal behavior that offends or humiliates. Generally, harassment is a behavior that persists over time. However, one single incident, if sufficiently serious, can constitute harassment." [1]
Personal harassment	"Engaging in a course of vexatious comments or conduct not related to a prohibited ground, which creates an intimidating, humiliating, hostile, or offensive work environment. Personal harassment can include spreading malicious rumors, gossip, or innuendo; Intimidating a person, verbal abuse, threats, belittling or humiliating a person; Yelling or using profanity or making jokes, that are offensive (written, verbal or graphic); Punishment; Tampering with a person's personal belongings or work equipment; Undermining or deliberately impeding a person's work; and Other objectionable behavior designed to torment, pester or abuse someone." [1]
Sexual harassment	**"**A specific form of discriminatory harassment related to the prohibited grounds of sex (gender) or sexual orientation. It is not possible to identify every act that constitutes sexual harassment. Sexual harassment can include unwelcome flirtations, advances, propositions, solicitation, requests for sexual favors, lewd or suggestive comments or other vocal activity such as catcalls, whistles, and kissing sounds; Vulgar or sexual jokes (oral, written, or graphic); Continuing to express sexual interest after becoming aware that the interest is unwelcome; Unwanted physical

	touching, blocking or impeding movements; Indecent exposure; and Sexual assault." [1]
Workplace harassment	"Engaging in a course of vexatious comments or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome." [1]
Discrimination	"An action or decision that results in the unfair or negative treatment of a person or group. There are 11 grounds of discrimination that are protected under the *Canadian Human Rights Act:* Race, National or Ethnic Origin, Color, Religion, Age, Sex, Sexual orientation, Marital status, Family status, Disability, A conviction for which a pardon has been granted or a record suspension has been ordered." [1]

Table 2.
The percentage of Canadian and Top international universities policies that included each element

1. Policy statement	**Canadian Universities**	**International Universities**
1.1 Zero tolerance/ harassment free statement included	94%	100%
1.2 Commitment to student safety included	100%	100%
1.3 Workplace safety, health regulations and confidentiality laws mentioned	94%	100%
2. Harassment Definition		
2.1 Defines harassment clearly: (As per the royal college of physicians & surgeons' definition): (1)	94%	90%
2.2 Sexual harassment/misconduct	94%	100%
2.3 Discrimination	88%	50%
2.4 Workplace harassment	35%	0%
2.5 Personal harassment	35%	0%
3. Understanding harassment		
3.1 Describes whom harassment can occur between (teachers, supervisors, students)	100%	100%
3.2 References to legal definition, e .g., references the human rights code/government protection act	100%	100%
4. Informal complaint procedures		
4.1.1 Is there a student representative, such as an ombudsperson, that students can report harassment to?	88%	100%
4.1.2 When an investigation will occur (1)	35%	30%
4.1.3 When the resolution will be reached (1)	12%	30%
4.1.4 Format: Instructions outlining the format of the complaint (i.e., written, verbal)?	41%	80%
4.2 Formal complaint procedures		
4.2.1 Is there a student representative, such as an ombudsperson, that students can report harassment to?	35%	90%
4.2.2 When the complaint will be reviewed in relation to when the complaint was filed (1)	47%	60%
4.2.3 If an investigation will occur (1)	88%	60%
4.2.4 When the resolution will be reached in relation to the time it was filed (1)	76%	70%
4.2.5 Format: Instructions outlining the format of the complaint (i.e., written, verbal)?	82%	90%
4.3 pre-cautions for the complaint process Is there safety precautions put in place to protect the student from retaliation?	82%	90%
5. Resolution process		

5.1. Is the resolution discussed with both the victim and the accused ?	100%	100%
5.2 Are disciplinary actions outlined to both the victim and the accused?	82%	100%
5.3 Is coordination with law enforcement discussed in the event the case needs to be escalated for the complainant?	100%	90%
5.4 Is there an opportunity for the accused to contest the complaint?	100%	90%
5.5 Is there a process in place for a reappeal/reconsideration clearly outlined for the victim to contest the outcome?	82%	80%
6. Training process		
6.1 Is there a training for students mentioned in the policy?	76%	40%
6.2 Is there a training for staff mentioned in the policy?	82%	60%
7. Implementation		
7.1 Is there an anti-harassment officer or organization at the university?	88%	80%
7.2 Does the university commit to reviewing and revising the policies? (**timelines**)	100%	50%

Table 3: Canadian Universities, score by element and theme

Theme		**UBC**	**UA**	**UC**	**US**	**UM**	**UO**	**MC**	**WU**	**UT**	**QU**	**NO**	**McG**	**SU**	**MtU**	**UL**	**MU**	**DU**
Theme 1: policy definition, harassment definition and understanding harassment	**1. Policy statement**																	
	1.1 Zero tolerance/ harassment free statement included	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	1.2 Commitment to student safety included	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	1.3 Workplace safety, health regulations and confidentiality laws mentioned	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0
	2.Harassment Definition																	
	2.1 Defines harassment clearly:(as per the royal college of physicians & surgeons' definition): (1)	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1
	2.2 Sexual harassment/ misconduct	1	1	1	1	1	1	1	1	1	1	1	0	1	1	0	1	1

	2.3 Discrimination	1	1	0	1	0	1	1	1	1	1	1	1	1	0	0	1	0
	2.4 Workplace harassment	1	0	0	1	0	1	1	0	0	0	1	0	0	0	0	1	0
	2.5 Personal harassment	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	1	1
	3.Understanding of Harassment																	
	3.1 Describes whom harassment can occur between (teachers, supervisors, students	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	3.2 References to legal definition, e .g., references the human rights code/government protection act	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Grade/percentage	9/10	8/10	7/10	9/10	8/10	9/10	9/10	9/10	8/10	8/10	10/10	7/10	8/10	6/10	6/10	10/10	7/10
Theme 2: Informal and formal complaint procedures	**4. Informal Complaint procedures:**																	
	4.1.1 Is there a student representative, such as an ombudsperson, that students can report harassment to?	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	0

	4.1.2 When an investigation will occur (1)	1	0	1	0	1	1	0	0	0	1	0	0	1	0	0	0	0
	4.1.3 When the resolution will be reached (1)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
	4.1.4 Format: Instructions outlining the format of the complaint (i.e., written, verbal)?	0	0	1	0	0	0	0	0	1	0	1	1	0	0	1	1	1
	4.2 Formal Complaint Procedures:																	
	4.2.1 Is there a student representative, such as an ombudsperson, that students can report harassment to?	0	0	1	0	0	1	1	0	0	0	0	1	1	0	0	1	0
	4.2.2 When it complaint will be reviewed in relation to when the complaint was filed (1)	0	1	1	1	1	0	1	0	0	0	0	0	1	0	0	1	1
	4.2.3 If an investigation will occur (1)	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	4.2.4 When the resolution will be reached in relation to the time it was filed (1)	1	1	0	1	1	1	1	1	1	0	1	1	0	0	1	1	1
	4.2.5 Format: Instructions	1	1	0	1	1	1	1	1	1	1	1	1	0	1	0	1	1

	outlining the format of the complaint (i.e., written, verbal)?																	
	4.3 pre-cautions for the complaint process Is their safety precautions put in place to protect the student from retaliation?	1	1	1	1	0	1	1	1	1	1	1	1	1	0	0	1	1
	Grade/percentage	6/10	5/10	7/10	6/10	6/10	7/10	7/10	4/10	7/10	5/10	6/10	7/10	6/10	3/10	4/10	9/10	6/10
Theme 3: resolution, training, and implementation procedures	**5.1** Is the resolution discussed with both the victim and the accused ?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	5.2 Are disciplinary actions outlined to both the victim and the accused?	1	1	1	0	1	1	1	1	1	1	1	1	1	0	0	1	1
	5.3 Is coordination with law enforcement discussed in the event the case needs to be escalated for the complainant ?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	5.4 Is there an opportunity for the accused to contest/appe	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

	al the complaint?																	
	5.5 Reappeal: Is there a process in place for a reappeal/reconsideration clearly outlined for the victim and the accused?	1	1	1	1	1	1	0	1	1	1	1	1	0	1		1	1
	6. Training process																	
	6.1 Is there a training module or in-person harassment training for all students and to take?	1	1	0	1	1	1	0	1	1	0	0	1	1	1	1	1	1
	6.2 Is there a training module or in-person harassment training for all staff to take?	1	1	1	0	1	1	1	0	1	1	0	1	1	1	1	1	1
	7. Implementation:																	
	7.1 Is there an harassment officer or organization at the university?	1	1	1	0	1	1	0	1	1	1	1	1	1	1	1	1	1
	7.2 Does the university commit to reviewing and revising the policies? (**timeline**)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Grade-percentage	9/9	9/9	8/9	6/9	9/9	9/9	6/9	8/9	9/9	8/9	7/9	9/9	8/9	8/9	7/9	9/9	9/9

Table 4: International Universities score by element and theme

		1	2	3	4	5	6	7	8	9	10
		HU	**OXU**	**UCam**	**SU**	**JHU**	**KI**	**ICL**	**UC**	**UCL**	**YU**
	Policy statement										
	1.1 Zero tolerance/ harassment free statement included	1	1	1	1	1	1	1	1	1	1
	1.2 Commitment to student safety included	1	1	1	1	1	1	1	1	1	1
	1.3 Workplace safety, health regulations and confidentiality laws mentioned	1	1	1	1	1	1	1	1	1	1
	Harassment Definition										
	2.1 Defines harassment clearly: **1.** (As per the royal college of physicians & surgeons' definition): (1)	0	1	1	1	1	1	1	1	1	1
	2.2 Sexual harassment/misconduct	1	1	1	1	1	1	1	1	1	1
	2.3 Discrimination	0	0	0	0	1	1	1	0	1	1
	2.4 Workplace harassment	0	0	0	0	0	0	0	0	0	0
	2.5 Personal harassment	0	0	0	0	0	0	0	0	0	0
	Understanding harassment										
	2. 3.1 Describes whom harassment can occur between (teachers, students)	1	1	1	1	1	1	1	1	1	1
	3.2 References to legal definition, e .g., references the human rights code/government protection act	1	1	1	1	1	1	1	1	1	1
	Grade/percentage	6/10	7/10	7/10	7/10	8/10	8/10	8/10	7/10	8/10	8/10
Theme 2: Informal and formal	**4. Informal complaint procedures**										

complaint procedures											
	4.1.1 Is there a student representative, such as an ombudsperson, that students can report harassment to?	1	1	1	1	1	1	1	1	1	1
	4.1.2 When an investigation will occur (1)	1	0	0	0	1	0	0	0	1	0
	4.1.3 When the resolution will be reached (1)	1	0	0	0	1	0	0	0	1	0
	4.1.4 Format: Instructions outlining the format of the complaint (i.e written, verbal)?	1	1	1	1	1	1	0	1	1	0
	4.2 Formal complaint procedures										
	4.2.1 Is there a student representative, such as an ombudsperson, that students can report harassment to?	1	0	1	1	1	1	1	1	1	1
	4.2.2 When the complaint will be reviewed in relation to when the complaint was filed (1)	1	0	1	1	0	0	1	0	1	1
	4.2.3 If an investigation will occur (1)	1	0	1	1	0	0	1	0	1	1
	4.2.4 When the resolution will be reached in relation to the time it was filed (1)	1	1	1	1	0	0	1	0	1	1
	4.2.5 Format: Instructions outlining the format of the complaint (i.e written, verbal)?	1	1	1	1	1	1	1	0	1	1
	4.3 pre-cautions for the complaint process Is there safety precautions put in place to protect the student from retaliation?	1	1	1	1	1	1	1	0	1	1

	Grade/percentage	10/10	5/10	8/10	7/10	7/10	5/10	7/10	3/10	10/10	7/10
Theme 3: resolution, training and implementation procedures	**5.1.** Is the resolution discussed with both the victim and the accused ?	1	1	1	1	1	1	1	1	1	1
	5.2 Are disciplinary actions outlined to both the victim and the accused?	1	1	1	1	1	1	1	1	1	1
	5.3 Is coordination with law enforcement discussed in the event the case needs to be escalated for the complainant?	1	0	1	1	1	1	1	1	1	1
	5.4 Is there an opportunity for the accused to contest the complaint?	1	1	1	1	1	0	1	1	1	1
	5.5 Is there a process in place for a reappeal/reconsideration clearly outlined for the victim to contest the outcome?	1	1	1	1	1	0	0	1	1	1
	6. Training process										
	6.1 Is there a training for students mentioned in the policy?	0	0	0	1	1	0	1	1	0	0
	6.2 Is there a training for staff mentioned in the policy?	0	0	0	1	1	0	1	1	1	1
	7. Implementation										
	7.1 Is there a harassment officer or organization at the university?	1	0	1	1	1	0	1	1	1	1
	7.2 Does the university commit to reviewing and revising the policies? (**timelines**)	0	1	0	0	1	0	1	1	1	0

Appendix

Appendix A. Descriptive Statistics

Canadian Universities by Region Descriptive Statistics: Themes 1, 2 and 3

Variable (region)	N	X	SD
Western (Theme 1)	10	.82	.26
Central (Theme 1)	10	.80	.30
Atlantic (Theme 1)	10	.85	.24
Western (Theme 2)	10	.62	.32
Central (Theme 2)	10	.55	.33
Atlantic (Theme 2)	10	.75	.35
Central (Theme 3)	9	.89	.12
Western (Theme 3)	9	.91	.11
Atlantic (Theme 3)	9	1.0	.00

Note: I have used abbreviations for the following variables: Number of elements evaluated (N), Mean (X), and Standard Deviation, SD.

Canadian and international universities by theme Descriptive Statistics: Theme 1, 2 and 3

Policy Cluster	**Variable**	**Western Region (5)**	**Central Region (10)**	**Atlantic Region (2)**	**Canadian Universities (17)**	**International Universities (10)**
Theme 1	N	10	10	10	10	10
	X	.82	.80	.85	.81	.74
	SD	.26	.30	.24	.26	.42
Theme 2	N	10	10	10	10	10
	X	.62	.55	.75	.59	.70
	SD	.33	.35	.12	.28	.25
Theme 3	N	9	9	9	9	9
	X	.91	.89	1.0	.91	.77
	SD	.11	.12	.00	.052	.22

Note: I have used abbreviations for the following variables: Number of elements evaluated (N), Mean (X), and Standard Deviation, SD. Policies from 17 Canadian Universities were evaluated: 5 from Western, 10 from Central, and 2 from Atlantic Canada.

Descriptive Statistics of the three Canadian regions by theme

Mean, Median and Standard Deviation of Theme 1: Policy definition, harassment definition and understanding harassment

Variable (region and number of universities)	N	X	SD
Western (Theme 1) (5)	10	.82	.26
Central (Theme 1) (10)	10	.80	.30
Atlantic (Theme 1) (2)	10	.85	.24

Note: I have used abbreviations for the following variables: Number of elements evaluated (N), Mean (X) and Standard Deviation, SD. Policies from 17 Canadian Universities were evaluated: 5 from Western, 10 from Central, and 2 from Atlantic Canada.

Mean, Median and Standard Deviation of Theme 2: Informal and formal complaint procedures

Variable (region)	N	X	SD
Western (Theme 2) (5)	10	.62	.32
Central (Theme 2) (10)	10	.55	.33
Atlantic (Theme 2) (2)	10	.75	.35

Note: I have used abbreviations for the following variables: Number of elements evaluated (N), Mean (X) and Standard Deviation, SD. Policies from 17 Canadian Universities were evaluated: 5 from Western, 10 from Central, and 2 from Atlantic Canada.

Mean, Median and Standard Deviation of Theme 3: Resolution process, training process and implementation

Variable (region)	N	X	SD
Western (Theme 3) (5)	9	.91	.11
Central (Theme 3) (10)	9	.89	.12
Atlantic (Theme 3) (2)	9	1.0	.00

Note: I have used abbreviations for the following variables: Number of elements evaluated (N), Mean (X) and Standard Deviation, SD. Policies from 17 Canadian Universities were evaluated: 5 from Western, 10 from Central, and 2 from Atlantic Canada.

Appendix B. Canadian and international universities policies

Canadian Medical University Policies

University name	Policies
1. University of British Columbia	1. University of British Columbia "Post Graduate Medical Education" Human Resources. 010-Health-and-Safety-of-Postgraduate-Medical-Trainees-PGME-Policies-and-Procedures.pdf (ubc.ca) 2. University of British Columbia "Professional Standard for Learners[1] and Faculty Members in the Faculties of Medicine and Dentistry at the University of British Columbia" Human Resources. https://med.ubc.ca/files/2012/02/Professional-Standards-for-the-Faculties-of-Medicine-and-Dentistry.pdf 3. University of British Columbia "Faculty of Medicine Postgraduate Medical Education Dean's Office Residents Policies and Procedures Manual 2018-2019" Human Resources. https://med-fom-pgme.sites.olt.ubc.ca/files/2019/02/Resident-Policies-and-Procedures-Manual_Feb262019.pdf 4. University of British Columbia "Policy and Processes to Address Unprofessional Behaviour https://med-fom-faculty.sites.olt.ubc.ca/files/2005/02/Process-to-Address-Mistreatment-and-Learning-Environment.pdf 5. University of British Columbia "Health and Safety of Postgraduate Medical Trainees" https://med-fom-pgme.sites.olt.ubc.ca/files/2019/03/010-Health-and-Safety-of-Postgraduate-Medical-Trainees-PGME-Policies-and-Procedures.pdf
2. University of Alberta	6. University of Alberta "Sexual Violence Policy" https://policiesonline.ualberta.ca/PoliciesProcedures/Policies/Sexual-Violence-Policy.pdf 7. University of Alberta "Student Concerns and Complaints Policy- Records and Privacy" https://policiesonline.ualberta.ca/policiesprocedures/policies/student-concerns-and-complaints-policy-records-and-privacy.pdf 8. University of Alberta " Collective Agreement Between the NASA Non Academic Staff Association and the University of Alberta" https://www.ualberta.ca/human-resources-health-safety-

	environment/media-library/my-employment/agreements/support-staff-agreement-common-provisions.pdf 9. University of Alberta "Discrimination, Harassment and Duty to Accommodate Policy" https://policiesonline.ualberta.ca/PoliciesProcedures/Policies/Discrimination-Harassment-and-Duty-to-Accommodate-Policy.pdf 10. University of Alberta "Student Concerns and Complaints – Procedure for Management of Documents" https://policiesonline.ualberta.ca/policiesprocedures/procedures/student-concerns-and-complaints-procedure-for-management-of-documents.pdf
3. University of Calgary	11. University of Calgary "Harassment Policy" https://www.ucalgary.ca/legal-services/sites/default/files/teams/1/Policies-Harassment-Policy.pdf
4. University of Saskatchewan	12. University of Saskatchewan "Policy procedures on Discrimination and Harassment" https://policies.usask.ca/policies/health-safety-and-environment/discrimination-and-harassment-prevention.php#Policy
5. University of Manitoba	13. University of Manitoba "Respectful Work Learning Environment" https://umanitoba.ca/admin/governance/media/Respectful_Work_and_Learning_Environment_RWLE_Policy_-_2020_09_29.pdf 14. University of Manitoba "Sexual Violence" https://umanitoba.ca/admin/governance/media/Respectful_Work_and_Learning_Environment_RWLE_Policy_-_2020_09_29.pdf
6. University of Ottawa	15. University of Ottawa "Disclosing/Reporting an Incident" https://www.uottawa.ca/sexual-violence-support-and-prevention/definitions 16. University of Ottawa "Policy 67a- Prevention of Harassment and Discrimination" https://www.uottawa.ca/administration-and-governance/policy-67a-prevention-of-harassment-and-discrimination 17. University of Ottawa "File a complaint" https://www.uottawa.ca/respect/en/complaints 18. University of Ottawa "Procedure 36-2 Complaints of Harassment/Discrimination initiated by employees" https://www.uottawa.ca/administration-and-governance/procedure-36-2-complaints-harassmentdiscrimination-initiated-employees 19. University of Ottawa "Procedure 36-1 Complaints of Harassment/Discrimination initiated by students" https://www.uottawa.ca/administration-and-governance/procedure-36-1-

	complaints-harassmentdiscrimination-initiated-students#:~:text=Procedure%2036%2D1%20%2D%20Complaints%20of%20Harassment%2FDiscrimination%20initiated%20by%20students,-Date%20effective%3A%202017&text=1.,to%20the%20University's%20Policy%20No. 20. University of Ottawa "Policy 67- Sexual Harassment" https://www.uottawa.ca/administration-and-governance/policy-67-sexual-harassment
7. McMaster University	21. McMaster University "Discrimination, Harassment & Sexual Harassment: Prevention and Response. https://www.mcmaster.ca/vpacademic/documents/Discrimination_Harassment_Sexual_Harassment-Prevention&Response.pdf 22. McMaster University "Sexual Violence Policy" https://secretariat.mcmaster.ca/app/uploads/Sexual-Violence-Policy.pdf
8. Western University	23. Western University "Non-discrimination/Harassment Policy" https://www.uwo.ca/univsec/pdf/policies_procedures/section1/mapp135.pdf
9. University of Toronto	24. University of Toronto "Guidelines for Addressing Intimidation, Harassment and Other Kinds of Unprofessional or Disruptive Behaviour in Postgraduate Medical Education" https://umanitoba.ca/admin/governance/media/Respectful_Work_and_Learning_Environment_RWLE_Policy_-_2020_09_29.pdf
10. Queens University	25. Queens University "Resident Harassment Policy Postgraduate Medical Education, Queen's University" https://meds.queensu.ca/sites/default/files/inlinefiles/FINAL_Resident_Harassment_Policy.pdf 26. Queens University " Policy on Sexual Violence Involving Queen's University Students" https://www.queensu.ca/secretariat/policies/board-policies/sexual-violence-involving-queen%E2%80%99s-university-students-policy 27. Queens University "Interim Workplace Harassment & Discrimination Policy" https://www.queensu.ca/secretariat/sites/webpublish.queensu.ca.uslcwww/files/files/policies/InterimWorkplaceHarassmentandDiscriminationPolicyfinal.pdf Queens University "Harassment/Discrimination Complaint Policy and Procedure" https://www.queensu.ca/secretariat/policies/senate/harassmentdiscrimination-complaint-policy-and-procedure#4

11. Northern Ontario School of Medicine	28. Northern Ontario School of Medicine "Responding to Resident Concerns of Mistreatment" https://www.nosm.ca/wp-content/uploads/2020/05/PGME200-ResidentMistreatment.pdf
12. McGill University	29. McGill University "Policy on harassment and discrimination" https://www.mcgill.ca/secretariat/files/secretariat/policy_on_harassment_and_discrimination.pdf
13. Sherbrook University	30. Sherbrook University "Policy on the promotion of fundamental human rights and the prevention of all forms of harassment and discrimination" https://www.usherbrooke.ca/a-propos/fileadmin/sites/a-propos/documents/direction/politiques/2500-015.pdf
14. Montreal University	31. Montreal University " Policy to Prevent And Combat Misconduct And Violence of a Natural Sexual" https://secretariatgeneral.umontreal.ca/public/secretariatgeneral/documents/doc_officiels/reglements/administration/adm10_57_politique_VACS.pdf
15. University of Laval	32. Laval University "Regulations to prevent and counter harassment at Laval University" https://www.ulaval.ca/sites/default/files/etudiants-actuels/Harc%C3%A8lemet/PDF/Reglement_pour_prevenir_et_contrer_le_harcelement_a_l_UL_2016-CA-2016_22.pdf
16. Memorial University	33. Memorial University "Policy on Intimidation and Harassment" https://www.ucalgary.ca/legal-services/sites/default/files/teams/1/Policies-Harassment-Policy.pdf 34. Memorial University "Sexual Harassment and Sexual Assault" https://www.mun.ca/policy/browse/policies/view.php?policy=321
17. Dalhousie University	35. Dalhousie University "Personal Harassment Policy for Post Graduate Medicine Trainees" https://cdn.dal.ca/content/dam/dalhousie/pdf/faculty/medicine/departments/core-units/postgrad/Personal%20Harassment%20Policy%20for%20Postgraduate%20Medical%20Education%20web%20Version.pdf

Top 10 QS ranked universities policies

University	Country	Policies
1. Harvard University	United States	1. Harvard University "Office for Dispute Resolution Investigative processes" https://odr.harvard.edu/processes 2. Harvard University "Sexual and Gender-Based Harassment Policy" https://titleix.harvard.edu/files/titleix/files/harvard_sexual_harassment_policy_021017_final.pdf?m=1599767247
2. Oxford University	United Kingdom	3. Oxford University "Harassment Procedure Flowchart for Students" https://www.rdm.ox.ac.uk/files/intranet/harrassment-procedure-flowchart-for-students.pdf 4. Oxford University "University Policy and Procedures on Harassment" https://edu.web.ox.ac.uk/files/harassmentpppdf
3. University of Cambridge	United Kingdom	5. University of Cambridge "Discipline Committee: Practice Statement" https://www.studentcomplaints.admin.cam.ac.uk/files/disc_practice_statement.pdf 6. University of Cambridge "Reporting harassment, bullying, discrimination or sexual misconduct" https://www.studentcomplaints.admin.cam.ac.uk/harassment-sexual-misconduct/i-want-know-more-about-universitys-policies/report-inappropriate 7. University of Cambridge "Informal Complaint Procedure" https://www.studentcomplaints.admin.cam.ac.uk/files/published_informal_complaint_procedure.pdf 8. University of Cambridge "Dignity at work" https://www.hr.admin.cam.ac.uk/files/dignity_at_work_policy_11.12.18.pdf
4. Stanford University	United States	9. Stanford University "Sexual Harassment" https://adminguide.stanford.edu/chapter-1/subchapter-7/policy-1-7-1 10. Stanford University " Title IX Procedure" https://news-media.stanford.edu/wp-

		content/uploads/2020/08/14175743/20200814-Title-IX-Procedure.pdf
5. John Hopkins University	United States	11. John Hopkins "The John Hopkins University Sexual Misconduct Policy and Procedures" https://sexualmisconduct.jhu.edu/policies-laws/SMPP%20Effective%208.1.19%20Through%208.13.20.pdf
6. Karolinska University	Sweden	12. Karolinska Institutet "Guidelines concerning discrimination, harassment and victimization" https://www.imperial.ac.uk/media/imperial-college/administration-and-support-services/hr/public/policies/harassmentbullying/Harassment_Bullying_and_Victimisation_Policy-(Nov-2020-version).pdf
7. University College of London	United Kingdom	13. University College of London "Prevention of Bullying, Harassment and Sexual Misconduct Policy" https://www.ucl.ac.uk/equality-diversity-inclusion/dignity-ucl/prevention-bullying-harassment-and-sexual-misconduct-policy
8. Yale University	United States	14. Yale University " Procedures of the University-Wide Committee on Sexual Misconduct" https://uwc.yale.edu/sites/default/files/files/uwc-procedures.pdf
9. Imperial College of London	United Kingdom	15. Imperial College of London "Harassment, Bullying and Victimization Policy" https://www.imperial.ac.uk/media/imperial-college/administration-and-support-services/hr/public/policies/harassmentbullying/Harassment_Bullying_and_Victimisation_Policy.pdf
10. University of California	United States	16. University of California "Discrimination, Harassment, and Affirmative Acton in the Workplace" https://policy.ucop.edu/doc/4000376/DiscHarassAffirmAction

Appendix C

Supplemental Material

This section outlines the process of developing the search strategy, the past policy evaluation literature, the extension and adaptation of the criteria, and the categorization of our adapted and extended criteria.

Extended evaluation table adaptation and development

The adapted evaluation criteria was developed by H.O.P, N.M.L., B.T.A., and J.M.H. We conducted preliminary research to understand if there were previously created harassment policy evaluation criteria or tables available to serve as a template for our criteria development. Our literature review was diverse, and included generalized harassment, discrimination, workplace harassment, personal harassment, and sexual harassment literature, from multiple countries, with a primary focus on university policy criteria. Additionally, the adapted evaluation criteria was informed by the review of harassment policies from both Canadian and international universities. After conducting a preliminary search on my own, H.O.P consulted Andrea Quaiattini, librarian at the Schulich Library of Physical Sciences, Life Sciences and Engineering at McGill University. Together, we created a search strategy targeting the prevalence of mistreatment and harassment across medical training in post-secondary institutions. We also looked for policy evaluations specifically analyzing post-secondary harassment guidelines as a template for our research design.

After surveying the policy evaluation literature, two primary theses helped inform the approach we took for our evaluation. The first thesis, written by Justine Brisebois and submitted to the University of Manitoba, proposed a set of criteria to evaluate harassment policies across 15 Canadian universities with doctoral programs in 2010. [30] This criteria was developed, and the policies were then evaluated using three primary approaches: the Respectful Workplace approach, the Legal-Preventative approach, and the Forerunner approach. [30] The criteria employed by Brisebois had a numeric tabulation approach, but also employed subjective terms, such as “may include” or “limits”.

The second thesis, which was published in 2008 by Marni Roberta Westerman also proposed a set of criteria to evaluate harassment policies, using four main approaches:

authoritarian, personal, historical, and neoliberal. [31] The criteria proposed by Westermann primarily focused on the policy title and statement inclusion. [31] Aspects of these approaches were important to our understanding, particularly when understanding the importance of framing our policy evaluation and criteria development; however, for our evaluation, we were looking to develop a more comprehensive and dichotomous (yes or no) score that would apply to the entire policy, be amenable to tabulated evaluation, and could be reliably applied by different raters. We felt this approach would create an easy comparison procedure that could be applied to future analyses and make this criteria universal despite it's obvious limitations. Additionally, we wanted to focus on the organizational structure of medical universities and training environments for our evaluation to help ensure it was universally applicable to both Canadian and top international policies.

We also adapted our criteria from an article published by Wilken & Badenhorst (2003), who compared sexual harassment policies across academic institutions in South Africa. [31] We ultimately decided to adapt their proposed criteria's design due to its clear organization and metric system. Wilken & Badenhorst (2003) designed a table, which included columns for each of the universities' policies that they were evaluating. The cells were organized by super-ordinate categories, such as policy statement, and corresponding subordinate categories, such as zero-tolerance policy. [33] Next to each category, or element, was an empty cell which could be filled in by a checkmark meaning that the element was present in the corresponding policies, or an x meaning that it was not, or text: minimal, vague and comprehensive. [33] When they conducted their evaluation of the policies, they focused on comparing universities based on the presence of an element, the absence of an element, or the level of detail of an element (minimal, vague and comprehensive). For example, one of their findings was that only two universities (25 %) described disciplinary actions or outcomes. [33]

Our approach to adapting and extending the policy evaluation criteria developed by Wilken & Badenhorst (2003) was to alter a few of the categories to specifically reflect the Canadian medical university harassment guidelines. We kept the following superordinate categories identical because they were applicable to our evaluation: policy statement, training and education and implementation. [33] The first iteration of the table was developed by H.O.P and included seven primary superordinate categories: policy statement, harassment definition,

understanding of harassment, informal complaint process, formal complaint process, resolution, training and education, and implementation. After meeting with N.M.L., B.T.A. and J.M.H, we went through three iterations of our criteria to ensure they were clear and decisive and ensure that the two independent raters could objectively use the adapted criteria.

We included four sections that were considerably different from the criteria published by Wilken & Badenhorst (2003): definitions of harassment, understanding of harassment, informal and formal complaint procedures, and resolution process. [33] We included the "understanding of harassment" section because we wanted to outline whom harassment could occur between (i.e., peer to peer or student to supervisor). We hoped that by adding this element, we would be able to better understand if harassment policies included elements needed to identify and understand whom harassment could occur between and what policies covered each form of harassment. Under the definition section, we added five separate definitions of harassment, which the Royal College of Physicians and Surgeons of Canada recommended in their statement, "Creating a Positive Work Environment": general harassment, personal harassment, sexual harassment, workplace harassment, and discrimination. [1] We included these five distinct definitions based on our literature review and our understanding of the diverse forms that harassment can take. [1]

Wilken & Badenhorst's (2003) criteria had one main section entitled procedures, where they included elements, such as reporting options, timelines, retaliation concerns, and appeal measures, to name a few. [33] When it came to reporting, we separated the informal and formal complaint procedures because we noticed that most Canadian medical universities' policies used a two-staged process for reporting (informal first, formal second). [33] First, students would have the opportunity to file an informal complaint, which routinely involved interpersonal conversations or strategies for parties to reach a common agreement. Although Wilken & Badenhorst's (2003) criteria did include a subordinate category "provision for formal and informal complaint," it did not go on to mention distinct policies or procedures of the complaint process. [33] This two stage process, first informal complaint and then formal, were distinctive and often came in order, starting with informal and later escalating to formal if a resolution was not reached at the informal stage; therefore, we decided it was important to ensure each reporting form was clearly outlined. Lastly, although many of our criteria included substantial overlap across the subordinate categories included in Wilken and Badenhorst's (2003) review, we also

included unique categories that were more specific to the policies we reviewed. Additionally, we decided to further separate the resolution process from the complaint filing process to provide a clear distinction between filing and resolutions. [33]

We made these modifications and added elements because we wanted to create an evaluation system primarily using numerical comparisons between Canadian regions and international universities. Therefore, we changed the grading system from checkmarks and x's to 0's and 1's, where 0 meant that the subordinate element was not present in the policy, and 1 indicated that it was. Wilken & Badenhorst (2003) primarily used a nominal system but also had the option to grade criteria using the following three terms: minimal, vague, and comprehensive. When analyzing the results, Wilken & Badenhorst (2003) compared across universities how many x's or checkmarks were present across each row. [33] For example, they cited that only two out of the eight universities included appeal measures in their policies. [33] However, when it came to timelines, they cited that one university had "vague" timelines instead of a checkmark or x. [33]

For our evaluation, we only included numeric scoring that we found to be feasible and effective. Additionally, after adapting one large evaluation table, much like Wilken and Badenhorst (2003) employed , we decided to separate our criteria into three separate subsections, or themes, in order to create three tables for easy comparison: theme 1: Policy definition, harassment definition, and understanding harassment, theme 2: Informal and Formal complaint procedures, and theme 3: Resolution, training and implementation section. We created these three subsections for ease of comparison and so that we could assign each theme with a numeric grade. We reasoned that by creating these tables and having a numerical score for each subsection of the policy, these results could inform universities about areas of strength and areas of weakness or room for improvement across specific areas of their policies. Our adapted and extended criteria can be found in tables 3 and 4.

Chapter 6: Conclusion and Future Directions

Summary

This thesis aims to provide a foundational understanding of medical trainee harassment and highlights the need for robust evaluation criteria to assess harassment policies across Canadian medical university programs. In addressing the first objective of this thesis, I provided an overview of the prevalence and forms of medical student and resident harassment across multiple countries. This information exemplifies how diverse and far-reaching harassment across medical training is and showcases the importance of further exploration into the root causes of this issue at the institutional policy level. In addressing the second objective of this thesis, I introduced some of the barriers that students and residents may face when deciding whether or not to report experienced harassment. Through this exploration, I touched on many themes that can affect under-reporting, specifically the fear of reprisal, based on the hierarchical nature of the medical training system. Importantly, I focused on the research needed to better understand how Canadian medical university harassment guidelines and resources can be designed to support trainees by reducing fear and empowering them to report harassment.

The third objective of this thesis was designed to provide a brief overview of the culture and organizational structure of medical training and how it can contribute to harassment tolerance. By focusing on the university and organizations context, we were able to approach our evaluation with an enriched understanding of harassment policy design. Next, the fifth objective was designed to propose an adapted and extended criteria which was designed to compare the Canadian medical university harassment policies against the top 10 QS-ranked universities to address strengths, weaknesses, and future areas for improvement. I accomplished this in chapter 5, with a policy evaluation I led. As part of this evaluation an adapted and extended tool was proposed, which can be used by medical universities across Canada to better understand where Canadian medical university policies are in comparison to the top 10 QS-ranked universities across the world, and to identify key areas for improvement and future development. Although our policy analysis only included 27 universities, 17 Canadian and 10 international, our findings illuminated critical differences among Canadian and international universities' harassment policies concerning the informal complaint procedures and definitions of harassment. At this

time, the issue of harassment policy consistency, and its effect on under-reporting, has seldom been explored. A lack of formal and clear definitions of harassment and informal complaint procedures could pose a significant barrier to reporting harassment. Clarity and distinction of harassment definitions and reporting procedures are essential in future iterations of Canadian and international medical universities' harassment policies and training.

The criteria proposed in our evaluation contributes to the existing literature, particularly, concerning Canadian medical university harassment policies. Our evaluation exemplified that there are inconsistencies among harassment definitions and reporting procedures across Canada. Moreover, there were considerable differences between international and Canadian medical university policies in terms of comprehensiveness, where Canadian universities were typically quite thorough. However, there is limited published literature exploring ways to evaluate these criteria and create important changes, such as more precise definitions of harassment and reporting guidelines. [8] Position papers, evaluations, and critiques have been published, however, there is no way to ensure that these recommendations are applied and utilized in the future without a set of policy evaluation criteria and a collective and individual sense of commitment and willingness among the community in which they are addressing. The first step is to ensure that Canadian medical university harassment policies are supportive, accessible, clear, updated, and comprehensive. I hope that this set of criteria can be used during future policy reviews and to inform policy development research to help combat the issue of under-reporting of harassment, and hopefully occurrence of harassment, across Canadian medical training.

Limitations and Future directions

An important factor to consider is that the two independent reviewers who assessed and rated these policies were not Canadian medical university students or trainees (e.g., medical residents or fellows). Future research having medical students and trainees complete a similar evaluation, using these criteria, could provide insight from the perspective of trainees in the medical field. Additionally, both of the two raters were involved in the the adaptation and extension of the policy evaluation criteria, which could potentially lead to them being more reliable using the criteria than other less experienced raters might be. Having more raters replicate these findings could help ensure that inexperienced raters can reliabily use the criteria.

The aggregate findings from this thesis illustrate that there is still a lot of work to be done to ensure that harassment policies, training, and interventions are accessible and useable to medical trainees across Canada. Our evaluation focused primarily on the elements present or absent in university harassment policies. However, it is clear that there needs to be more research into specifically which elements of these policies pose a barrier to students reporting harassment. This could be accomplished by conducting a qualitative pilot study, much like Colenbrander, Causer & Haire, 2020, and asking medical trainees to act as representatives from the 17 Canadian medical universities across Canada. [20] Each student could review the policy and identify barriers that these policies may pose to reporting harassment and identify elements they wished were present. These findings could help inform further policy evaluation criteria, which could inform harassment policy development and improvement across Canadian medical universities in the future.

Numerous future directions have been proposed in our manuscript and throughout this thesis. Our manuscript recommends using a more diverse cross-section of countries in future iterations and involving medical trainees in the evaluation of these policies. Additionally, our evaluation highlighted the usefulness of a single, electronic reporting structure, like the McGill Office for Mediation and Reporting website entitled “Straightforward Reporting Universities”. [42] Furthermore, this thesis exemplifies the need for a clearer understanding of whether trainees across both medical student training and residency are aware of where these policies are stored and how to access them. This could be accomplished through a multi-institutional survey designed to address whether medical students and residents know where to access their universities harassment policies. Additionally, another survey could be disseminated that aims to ask trainees to first use our proposed criteria to evaluate existing university harassment guidelines and then recommend any criterion, such as distinct definitions of harassment, that may make these policies more clear and supportive in the future. Additionally, a third future direction could be a Delphi study, where a panel of university policy staff and an ombudsperson or student representatives could take our adapted and extended criteria and evaluate current harassment policies to ensure that the criteria fit and that all of the essential and necessary elements are present. The results could be beneficial for situating areas for future improvement.

The evaluation of university policies using our adapted criteria, as proposed in this thesis, should be considered an important but preliminary rather than a final step in policy evaluation. An important future direction could be to include this criterion at the next policy evaluation meeting, or Resident Doctors of Canada organizational meeting, for all Canadian universities and to see if policy development teams could use these criteria to evaluate their policies. Aspects such as fear of reporting tie back to the organizational culture of medical training, specifically how it is grounded in a self-sacrifice model, where aspects such as excessively long work hours, sleep deprivation, and even harassment are tolerated.[20] Developing a more robust understanding of this model and how harassment policies and training could address these specific barriers could help create an environment that no longer tolerates this culture for their medical trainees. Lastly, a critical perspective could be a retrospective policy analysis, where past policies from five, ten, twenty, and thirty years ago were analyzed with the following criteria, taking into consideration of the societal norms during the decades. This could serve as an essential piece of information, as it could allow us to see how far Canadian institutions have progressed, or importantly, where we have not progressed with our policies and in doing so, identify clear areas for future development.

Appendices

Appendix A

Adapted Criteria used for policy evaluation

	School name (abbreviation)								
1. Policy statement	Score (0 or 1)								
1.1 Zero tolerance/ harassment free statement included									
1.2 Commitment to student safety included									
1.3 Workplace safety, health regulations and confidentiality laws mentioned									
2. Harassment Definition									
2.1 Defines harassment clearly: (As per the royal college of physicians & surgeons' definition): (1)									
2.2 Sexual harassment/misconduct									
2.3 Discrimination									
2.4 Workplace harassment									
2.5 Personal harassment									
3. Understanding harassment									
3.1 Describes whom harassment can occur between (teachers, supervisors, students)									
3.2 References to legal definition, e.g., references the human rights code/government protection act									

4. Informal complaint process:									
4.1.1 Is there a student representative, such as an ombudsperson, that students can report harassment to?									
4.1.2 When an investigation will occur (1)									
4.1.3 When the resolution will be reached (1)									
4.1.4 Format: Instructions outlining the format of the complaint (i.e., written, verbal)?									
4.2 Formal complaint process									
4.2.1 Is there a student representative, such as an ombudsperson, that students can report harassment to?									
4.2.2 When the complaint will be reviewed in relation to when the complaint was filed (1)									
4.2.3 If an investigation will occur (1)									
4.2.4 When the resolution will be reached in relation to the time it was filed (1)									
4.2.5 Format: Instructions outlining the format of the complaint (i.e., written, verbal)?									
4.3 pre-cautions for the complaint process Is there safety precautions put in place to protect the student from retaliation?									
5. Resolution process									
5.1. Is the resolution discussed with both the victim and the accused?									

5.2 Are disciplinary actions outlined to both the victim and the accused?									
5.3 Is coordination with law enforcement discussed in the event the case needs to be escalated for the complainant?									
5.4 Is there an opportunity for the accused to contest the complaint?									
5.5 Is there a process in place for a reappeal/reconsideration clearly outlined for the victim to contest the outcome?									
6. Training process									
6.1 Is there a training for students mentioned in the policy?									
6.2 Is there a training for staff mentioned in the policy?									
7. Implementation									
7.1 Is there an anti-harassment officer or organization at the university?									
7. 2 Does the university commit to reviewing and revising the policies? (**timelines**)									

Appendix B

Illustrative recreation of the original policy analysis, Table 1: Checklist and analysis of policies to gauge the scope and comprehensives of each policy. For full table, see article by Wilken & Badenhorst (2003). [33]

Element	UP	RAU	US	UCT	Natal	Rhodes
2. Procedures	x	x	√	x	**x**	√
2.1 Reporting Options	√	√	√	x	x	√
2.2 Neutral party	√	√	√	√	√	√
2.3 Provision for Formal and Informal Procedures	x	x	√	√	x	Vague
2.4 Timelines:	x	x	√	√	x	x
• File complaints	x	x	√	√	x	x
• Investigation commence	x	x	√	√	x	x
• Investigation conclude	x	x	√	x	x	x

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