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GENERAL SCHOLARLY ARTICLE

The ANCHOR Framework:

Responding Compassionately to Suicidality in Health Practitioners Under Regulatory Investigation

Abstract

Suicide among health professionals under regulatory investigation is a deeply complex and under-addressed issue. Whereas regulatory processes are essential to assure and protect the public, they can unintentionally amplify practitioner distress, particularly when experienced as opaque, dehumanizing, or punitive. This paper proposes a structured, compassionate response to incidents of suicide and distress among health practitioners during or following a regulatory complaints process. It outlines a six-part framework that aims to strengthen psychological safety, promote reflective growth, and help cultivate a more humane, learning-oriented regulatory system.

Our intention is not to encourage a reduction in scrutiny or accountability, but to outline practical ways to embed emotional intelligence, humility, and compassion into regulatory practice. By listening to those with lived experiences, introducing structured reviews, and learning from them, regulators can remain sensitized to the lives behind the files, building a culture that protects the public while preserving practitioner wellbeing. Devised in Australia, the framework has wide reaching applicability across regulatory systems for health professionals in different jurisdictions.

Introduction

Suicide among health professionals is a critical yet under-addressed issue, with doctors, nurses, and other healthcare professionals experiencing significantly higher suicide rates than the general population.[1,2,3] The well-documented pressures of medical practice, including high workloads, moral distress, stigma around help-seeking, and access to lethal means, place this group at heightened risk.[4] Recent systematic reviews suggest women doctors, younger doctors, older doctors, and those experiencing career challenges are at heightened risk. [3,5] Suicide is multifactorial and rarely attributable to a single cause. Yet the role of the regulatory complaints process in suicidality should not be overlooked. Practitioners, particularly doctors and nurses, are at increased risk of suicide due to a unique confluence of factors which include organizational failures, professional isolation, high standards of self-expectation, loss of identity and meaning, stigma around seeking help and desensitization to pain and death.[5]

Among these risk factors, regulatory scrutiny has emerged as a potent source of distress. Practitioners undergoing investigations, regardless of the nature of the complaint, may experience profound anxiety, uncertainty, reputational damage, financial strain, and social isolation. In some cases, this distress contributes to suicidal ideation and, in rare instances, suicide.[6,7,8] Regulatory processes, though essential for ensuring public safety, can inadvertently magnify a practitioner's vulnerability, especially when the process is experienced as lengthy, opaque, punitive, or dehumanizing. Recently, Freiberg has advocated for a trauma-informed approach to regulation, drawing on the substantial body of work on trauma-informed approaches to health care and restorative justice.[9,10,11]

Health regulators must carry out their duties in a way that protects the public, yet they must also ensure their processes do not become a catalyst for further harm. Safeguarding lives does not have to be sacrificed in the safeguarding of standards. Yet the regulatory process, by its very nature, introduces threat to identity, livelihood, and belonging, pillars central to a health practitioner's sense of self. Drawing on Dietrich Bonhoeffer's distinction between cheap grace and costly grace, where cheap grace describes forgiveness without responsibility, absolution without truth, and mercy without consequence.[12] In a regulatory context, such an approach would be ethically indefensible and incompatible with public protection.

What we argue for instead is a form of costly grace: a way of exercising regulatory authority that retains rigor and consequence, while demanding greater moral effort from the system itself. Costly grace does not excuse failure or remove accountability, but it insists that accountability be explored with grace, proportionality, and care. In this sense, compassion is not an alternative to good regulation, but a more demanding form of it. Recognizing the emotional toll that regulatory processes could have on practitioners, the Australian Health Practitioner Regulation Agency (Ahpra) convened an Expert Advisory Group in 2021 to identify ways to reduce distress among those under investigation by Ahpra. This marked a significant shift in how regulatory impacts were being understood and addressed. The Group made 15 key recommendations and outlined 33 concrete actions, all of which have been accepted and are currently being implemented.[13]

These reforms include:

- The establishment of a dedicated Health Management Team to provide dedicated and compassionate support for practitioners with a health impairment and accelerate resolution of their cases, thereby reducing prolonged uncertainty and distress.
- Improvements in communication to provide practitioners with helpful information about their case progression.
- Targeted efforts to address misinformation, including myth-busting initiatives, public messaging campaigns, and partnerships with indemnity providers, professional associations, and mental health services.
- Encouragement of peer support networks and a proposed navigation service to guide at-risk practitioners through the complaints process.
- Suicide prevention and trauma-informed training for Ahpra staff and decision-makers to enhance sensitivity in communications and decision-making.
- Guidance for regulatory staff responding to, reporting, and reviewing incidents involving distressed practitioners and notifiers.

Together, these changes reflect an organization-wide approach to make the regulatory experience more humane, responsive, and compassionate for all, without compromising public safety. They represent significant progress in shifting the culture of regulation towards one that values psychological safety and emotional intelligence alongside procedural rigor and protection of the public.

Embedding compassion in regulation

Increasingly, regulatory bodies in the US, Canada, Ireland, and the UK, have begun to provide guidance on doctor wellbeing and burnout. Hengerer and colleagues led much of this work in the US, influencing regulators and professional associations worldwide.[14,15,16,17,18] Some now report annually on deaths proximal to investigations.[19] Our aim in this paper is to propose a potential review framework, aligned with what is already underway within Ahpra. Specifically, we describe the guiding principles behind embedding learning cultures in regulatory bodies and conclude with proposals on the need for system-wide strategies to reduce the risk of suicide. We focus on the use of a structured review process following incidents of serious distress or suicide among those involved in a regulatory process. To support this, we outline a six-part framework, summarized by the acronym ANCHOR (Table 1), that strengthens psychological safety, promotes reflective growth, and helps cultivate a more humane, learning-oriented regulatory system.

TABLE 1: ANCHOR: Six-part framework for structured reviews following an incident of serious distress or suicide

Letter	Theme	Description
A	Attune to Learning	Embed reflective learning cultures that center emotional and psychological safety. Encourage humility, not blame.
N	Nurture Compassionate Reviews	Establish structured, non-punitive reviews that explore how regulatory processes were experienced, without revisiting decisions.
C	Connect with Families	Engage bereaved families and survivors as partners in restorative listening, not litigation. Leadership can model this cultural responsibility.
H	Hold Space for Hindsight Bias	Protect staff from unfair retroactive judgement. Frame growth through contextualized, systems-focused reflection.
O	Organize Thematic Reviews	Conduct regular reviews to track systemic themes, monitor cultural traction, and reinforce 1% improvements.
R	Reinforce Sustainable Change	Build proactive strategies, peer support, and trauma-informed regulatory practices to prevent future distress and suicide.

1. A — Attune to learning: restorative orientation

Psychological safety is the soil in which all learning must grow. Attunement begins by acknowledging that people, whether regulators or health practitioners, come to work with the intention of doing good. To 'attune' is to slow down, notice distress, and create space for compassionate inquiry.

Earlier research suggests that embedding a reflective learning culture shifts the overall institutional posture in regulatory environments.[20,21] This means enriching adjudication and enforcement with formational practices toward compassion and reflectivity. A restorative orientation in the wake of harm asks about impacts,

the needs that come from them, and the resulting obligations for awareness and action on a range of people involved. The grace this process extends is costly, not cheap: it requires truthfulness, cooperation, sustained attention, and institutional willingness to change.[22] Results elsewhere show that it does not undermine accountability but enhances it by forward-looking commitments to improve systems and safeguard both public and practitioner well-being.[23,24,25,26]

The research tells us that internal psycho-social safety is foundational.[27] Regulatory staff must be encouraged to feel safe to reflect on their own role in complex or distressing cases. Leadership can model this by creating non-punitive spaces for debrief and reflection, and treating difficult outcomes not as personal failures, but as shared opportunities to learn.[28] In this, narrative humility matters. Learning cultures pay attention not just to what happened, but to how it was experienced.[29,30] Attunement is the mental equivalent of dropping anchor, taking time to understand the gravity of the work, and the impact it can have on people's lives.

2. N — Nurture compassionate reviews: opportunities for connection, not re-litigation

We propose a structured, compassionate review process focused on learning from incidents, including attempted or completed suicide and self-harm, by examining how the regulatory process was experienced by the practitioner. The review would be conducted by a small group of regulatory staff not involved in the practitioner's regulatory case. Those staff who were involved are invited to share feedback, including how they were able to manage distress within the system. This is not an avenue to re-litigate regulatory decisions, which are made through established legal and professional frameworks and must remain outside the scope of review. From a Bonhoefferian perspective, reviews that focus on learning represent costly grace in practice. They resist the ease of either denial ("nothing could have been done") or scapegoating ("someone must be blamed"). Instead, they hold the system accountable for how power was exercised, how distress was recognized, and how humanity was preserved under pressure.

The process around this is designed to reflect on the human elements of regulation: how decisions were communicated, how distress was managed, and whether moments of connection, empathy, or timely signposting to support were missed. Even within a formal system, opportunities for clarity, kindness, and compassion exist, especially at emotionally charged junctures like delivering adverse decisions. This form of accountability is more demanding than punitive reflexes because it requires the organization to look honestly at itself rather than locating failure solely in the individual.

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The review should follow a structured analysis that considers:

- **Most relevant chronology of events:** Complaints, investigations, communications, and outcomes.
- **Quality of interactions:** Timeliness, tone, and emotional attunement.
- **Sources of distress:** Including delay, uncertainty, financial strain, reputational threat, or isolation.
- **Connection to support:** Not whether the regulator provided the support, but whether staff recognized risk and offered or facilitated access to external supports.
- **Recognition of distress:** Whether signs of practitioner vulnerability were noticed, documented, and responded to appropriately.

Regulators do not have access to clinical information that a health service could access following a suicide. What we are proposing is a different kind of review, focusing solely on the regulatory journey: the emotional tone, procedural experience, and overall human impact of the regulatory complaints process. Its aim is not to replace other reviews but to complement them by identifying how regulation itself may have contributed to, or failed to buffer, practitioner distress. These reviews allow the system to see the human being behind the file, reflect on how power was exercised, and learn in order to improve.

3. C — Connect with families: listening as a leadership practice

A vital component of the review process involves the possibility of voluntary engagement with bereaved families following a practitioner suicide, or with individuals who have survived a significant suicide attempt during or following a regulatory process. This is often the hardest, and most human, part of the journey. Leaders may hesitate not out of indifference, but because it is emotionally confronting and logistically difficult. These conversations are not about determining liability, reviewing regulatory decisions, or addressing complaints. Rather, they are about bearing witness to, listening to, and learning from the human impact of the regulatory process from the perspective of those who have experienced its emotional toll most acutely.

When these meetings take place, they must be framed as part of a restorative and learning-focused culture, not a mechanism for defense or exculpation[28]. Not all practitioners or families will wish to engage, and participation must always be on their terms. But when they do, these conversations provide a unique window into how the process was lived, how it felt, and where there may have been missed opportunities for kindness, clarity, or connection. Importantly, this is not about revisiting or rewriting the regulatory decision, which sits outside the scope of such engagement, but about understanding how the process was experienced by a person who may have been frightened, isolated, or overwhelmed, and how that experience may have reverberated through their family, community, and profession.

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These engagements should be led by senior leadership, not frontline case managers. This is because leadership must carry the cultural responsibility and organizational accountability for embedding compassion into regulation. When leaders choose to listen to families and those with direct lived experience, it sends a powerful message across the organization: that these practitioners were not just case files, but fellow human beings with families and colleagues. In doing so, leaders stay connected to the human stakes of their system, and that emotional proximity can become the anchor for sustainable, values-driven change. [31]

Leaders who listen can also act as emotional buffers for the wider workforce. In absorbing the difficult truths that emerge, they are positioned to translate that feedback in ways the system can bear, passing it along gently, incrementally. When leadership models humility, courage, and compassion in these encounters, it creates the psychological safety necessary for change. In this way, the review process becomes not just a technical tool for analysis, but a cultural instrument for humanization. Kindness, warmth, and respect are not incompatible with rigor and safety. By creating a structured space where stories can be heard and honored, even when outcomes cannot be changed, regulatory bodies can continue to grow in empathy, maturity, and wisdom.

4. H — Hold Space for Hindsight Bias: Learn with Hindsight, Lead without Blame

One of the most significant risks to the integrity of a learning review is hindsight bias, the inclination to reinterpret actions as flawed simply because a bad outcome occurred. [32,33] Hindsight bias is inevitable but it need not be punitive.[34] In fact, recognizing and resisting hindsight bias is itself an expression of costly grace. It requires restraint, humility, and a refusal to convert tragic outcomes into moral certainty about past decisions. Such restraint does not excuse error, but it preserves fairness and psychological safety, without which meaningful learning is impossible.[35]

In the case of suicide, there is a danger that regulatory staff would feel unfairly judged, particularly if the same approach had previously caused no known harm in other cases. This section proposes a discipline of compassion and reflection on how decisions made sense at the time, while resisting the pull to judge them through the lens of what came later. This creates a delicate but essential balancing act: how to honor the seriousness of the outcome, without retroactively discrediting professional judgement

made in good faith. To protect against this, review processes must:

- Use contextualized reflection (eg: "What was knowable then?").
- Frame findings not as judgments, but as opportunities for 1% improvements.
- Emphasize that tragic outcomes rarely stem from bad processes or the actions of an individual alone, sometimes, despite kindness and professionalism, tragedy still occurs.
- Recognize that there is always room for improvement, regardless of outcome.

This approach also supports broader improvement: if, in hindsight, there were missed opportunities for compassion or connection in a case with a tragic outcome, it is likely the same omissions occurred in many other cases where harm simply did not manifest.[36] This tells the organization something systemic about itself. Suicide is rare, but its rarity should not become a false reassurance. The absence of a bad outcome does not confirm the presence of a good process.

Staff must be able to participate in honest reflection without fear of blame.[28,37] Reviews should support collective growth, not individual scrutiny, reinforcing a culture of kindness and care.

5. O — Organize thematic reviews: closing the loop and system accountability

Only by weaving themes together across time can we see the fabric of risk, resilience, and missed opportunities that go across multiple cases. To this end, we propose a regular thematic review, ideally involving an independent reviewer, a person with lived experience, and a senior staff member who collates and synthesizes the findings, lessons, and recommendations from all serious incident reviews conducted in, say, the preceding year. This thematic review could take place towards the end of each calendar year or early in the following year, for instance, each January, and would serve as both a reflective and forward-looking moment for the regulatory system. It would bring together:

- **Common themes** identified across individual reviews (eg: communication gaps, timing of complaints, lack of signposting)
- **Opportunities for improvement identified**
- **Recommendations made** and whether they were accepted and acted upon
- **Evidence of uptake** ie, whether previous recommendations have led to system changes, training updates, or shifts in communication practice
- **New insights** emerging from family or practitioner feedback that challenge or refine earlier approaches

The thematic review also tracks cultural traction. Are reforms embedded or beginning to erode? Are case managers experiencing greater psychological safety? Are regulatory practices more compassionate? Small, incremental improvements are made visible and measurable, reinforcing the idea that even in the absence of harm, refinement is always possible. This can prevent "review fatigue" or the idea of reflection as endpoint. The review process becomes a living loop: past experience informs future design, and cultural growth is not assumed but assessed.

Staff must be able to participate in honest reflection without fear of blame. Reviews should support collective growth, not individual scrutiny, reinforcing a culture of kindness and care.

By documenting what has changed, and what still needs to change, the thematic review serves as a form of regulatory self-awareness. It anchors regulatory commitment to compassionate regulation not in rhetoric, but in regular, transparent cycles of listening, learning, and doing. Institutional memory is built this way: systems become wiser and safer. By including voices of families and survivors in its synthesis, it honors the human experience as an essential source of intelligence.

6. R — Reinforce sustainable change: cultural and systemic

Culture change is a series of nudges, reinforcements, and reminders over time. [38] Whilst retrospective reviews are a crucial component of learning from practitioner suicides and incidents of serious distress, sustainable change requires a longer strategic vision.

This means building structures, practices, and norms that protect both public safety and practitioner well-being. It means moving beyond reactive responses to crisis and toward proactive strategies that anticipate distress, recognize vulnerability early, and reduce preventable harm (See Figure 2 for key components of a system side approach).

FIGURE 2: Key components of a system-wide approach

Early identification and support for at-risk practitioners
• Implement routine mental health check-ins for practitioners undergoing investigation, especially for those flagged as high-risk due to mental health histories or substance use concerns. • Train regulatory staff to recognize early warning signs of distress and ensure timely intervention.
Confidential peer support programs
• Expand peer-led mental health and mentoring networks, modelled on initiatives such as the Doctors' Support Network (UK) and the FSMB work (US). • Establish a confidential helpline or navigation service to assist practitioners through emotionally difficult regulatory processes.
Suicide awareness and mental health training for regulatory staff
• Ensure all case managers and decision-makers receive trauma-informed training that equips them to communicate clearly, sensitively, and with psychological insight. • Equip regulatory staff with basic crisis response capabilities to ensure distressed practitioners are met with compassion, not silence.
Reducing regulatory trauma through alternative investigation models
• Adopt rehabilitative and tailored models of regulation for practitioners with identified mental health or substance use issues. • Fast-track lower-risk complaints to reduce prolonged uncertainty, one of the most significant and preventable sources of distress.

This is not only about policies, but cultivating a regulatory environment where psychological safety, trauma awareness, and human connection are embedded in everyday practice. [9,21] Sustainable change requires constant checking of cultural traction: Are reforms still being lived out? Do staff feel safer, clearer, more empowered? Are case managers better equipped to meet both notifiers and practitioners with kindness and clarity, even in difficult circumstances? These initiatives align with mental health and suicide prevention frameworks, tailored to the unique pressures of regulatory scrutiny. A national strategy for health practitioner suicide prevention could one day unify these efforts across jurisdictions.

Dropping ANCHOR

When a serious incident or practitioner suicide occurs, it is not only a moment of tragedy, but also a moment to pause. These moments should prompt collective reflection, not reactive blame. They are the mental equivalent of dropping anchor, a deliberate slowing-down to acknowledge the gravity of the work regulators do. In such times, both leadership and frontline case managers are reminded that they are not just administering processes but engaging with people's lives. The weight of regulatory power must be carried with humility because its reach extends far beyond the file, into identity, well-being, and community.

The six-part ANCHOR framework proposed in this paper is designed to formalize that pause, to create space for safe, structured, and human-centered reflection. It provides a stabilizing force in turbulent moments, helping systems hold steady while learning, and protecting against the kind of institutional defensiveness that can stall growth. Meeting with families, hearing hard truths, and embedding these insights into small, cumulative changes are not easy tasks. But when embraced by leadership and modelled consistently, they ripple through the system as acts of cultural commitment. ANCHOR is not just an acronym. It is a philosophy of practice: to stay grounded, stay human, and stay open to change.

Conclusion

Regulatory processes, though essential to public protection, can contribute to profound practitioner distress. Our aim is not merely to improve processes, but to reframe the culture that surrounds them. By offering the ANCHOR framework in this discussion paper, we invite regulators into a shared conversation. This is a call to drop anchor: to pause, reflect, and rehumanize regulation.

The urgency of this cultural shift becomes clearest when we turn to the most devastating outcome that can occur during regulatory processes: suicide among health professionals under investigation. Suicide is a multifaceted and deeply human tragedy. Many contributing factors lie outside the regulator's control, but how the process is conducted

and how communication is framed can be improved. The regulator holds power not just over decisions, but over tone, pace, language, and emotional context. These elements matter deeply. They can amplify distress or ease it. They can isolate or reassure. And in rare but devastating cases, they can be part of a sequence that leads to catastrophic outcomes.

Regulatory processes, though essential to public protection, can contribute to profound practitioner distress.

We have outlined a multi-layered framework for refining regulatory practice in ways that are not only more compassionate, but also more emotionally intelligent, more sustainable, and ultimately more just. These are brought together under the ANCHOR framework, a principled and practical approach to embedding kindness, learning, and cultural responsibility at every level of the regulatory process. Crucially, we do not argue here that regulation should become soft or avoidant. Scrutiny, standards, and accountability must remain. But those can, and must, coexist with compassion, kindness, clarity, and emotional sensitivity.[7] The best regulatory systems are not those that never cause distress, but those that remain humane in the face of it, and adaptable in response to it. Bonhoeffer's warning against cheap grace remains highly relevant in contemporary regulation. Compassion that bypasses accountability is ethically weak and undermines public trust.

Yet the opposite error — a system that ostensibly protects standards at the cost of humanity — carries its own moral failure. What ANCHOR advances is a regulatory posture shaped by costly grace: one that preserves scrutiny while accepting the burden of exercising power with care. In this framing, compassion is not indulgence. It is moral seriousness, enacted through structures, language, and leadership choices that acknowledge the human weight of regulation without relinquishing its responsibility. To navigate the moral tension at the heart of health regulation, between protecting the public and preserving the lives of those being investigated, we propose that structured review becomes a cultural anchor. Not a once-off analysis, but a routine act of organizational humility. It is a mechanism that reminds the regulator to keep its eyes open, its systems reflective, and its people sensitized to the lives behind the files.

Ahpra is committed to evolving this culture through slow, steady, incremental improvement and involvement of those affected.[13] Listening to those most affected by regulatory processes, particularly after serious harm or loss, is not just compatible with regulatory professionalism, but essential to its evolution. In a high-responsibility, high-stakes profession like healthcare, regulation must remain robust and effective. But it must also remain compassionate. Because behind every complaint is a human being, with a life worth returning to. And the role of a compassionate regulator is not only to hold standards, but to help make that return possible.

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Funding/support: N/A

Other disclosures: SB and KE are employed by the Australian Health Practitioner Regulatory Agency. MKR and AvdG served on the Minimising Practitioner Distress Expert Advisory Group at Ahpra. MKR, SD, and AvdG received no remuneration for this paper.

Author contributions: MKR provided the first draft of the paper, SD, SB, KE, and AvdG all contributed equally to the manuscript, AvdG completed the final edits.

Acknowledgements: The authors acknowledge past and present members of the Minimising Practitioner Distress Expert Advisory Group at the Australian Health Practitioner Regulatory Agency (Ahpra). We thank Carly Smalley for her comments on the paper, and Tess Moloney and Kirsten Rawlings who have been instrumental to the approach we discuss in this paper. We would like to acknowledge those who have lost loved ones and recognize their enduring contribution to this work.

Keywords: Health practitioner distress, self-harm, suicide prevention, health professional regulation, complaints handling

Received: February 19, 2026; **revision received:** May 5, 2026; **accepted:** May 6, 2026