INDEPENDENT REVIEW OF WORKPLACE CULTURE IN ACT PUBLIC HEALTHCARE SERVICES

AMA (ACT) SUBMISSION

'From inability to let well alone
From too much zeal for the new and contempt for what is old
From putting knowledge before wisdom, science before art, and
Cleverness before common sense;
From treating patients as cases;
And from making the cure of the disease more grievous than the
Endurance of the same, Good Lord, deliver us.' – ***Sir Robert Hutchison***

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Background and Approach

On 21 September 2018, the ACT Minister for Health, Meegan Fitzharris, announced an Independent Review into workplace culture within the ACT public healthcare services. Instrumental in the Minister's announcement was the considerable public pressure being brought to bear by AMA (ACT) regarding allegations of bullying, poor culture and sub-optimal administration.

AMA (ACT) proposed a 'Board of Inquiry' as the appropriate means of investigating workplace culture, primarily because of the protections for staff and community members making submissions were known, understood and regulated by the *Inquiries Act (ACT) 1991*. The Minister rejected this option.

The AMA (ACT) has repeatedly urged Minster Fitzharris to lead on the issue of effectively addressing the scourge of poor workplace culture in ACT public healthcare services. While we are pleased that an independent review has been established, this is by no means enough. The challenge will be for both the Review Panel members and the Minister to bring forward concrete, practical recommendations to address the systemic cultural problems in the ACT public healthcare services and accept and implement the recommendations without delay.

This submission focuses on issues directly involving medical practitioners employed by ACT Health or those who provide services to ACT public healthcare services. It does not deal with issues of how primary care or other services interact with the public hospital system or other publicly funded healthcare services.

However, there remains a challenge for the Review in that we know how important the interrelationship between primary care and public hospitals including and that is a key area where our public healthcare services – both in the ACT and elsewhere – can be improved.

A Challenge for the Review Panel

Given the limited powers granted to the Independent Review, the Review Panel members will be unable to ascertain with any specificity the extent of inappropriate conduct and behaviours in the relevant ACT workplaces. Nevertheless, we expect that the Review Panel members will be able to draw sufficient information from national and local experience and specific information provided by submitters that significant, adverse systemic issues exist within the relevant ACT workplaces.

In our view, to find otherwise would seriously undermine the credibility of both the Review and any recommendations that might be made by it.

Consequently, it is our expectation that the Review will make recommendations that include sweeping and comprehensive proposals for cultural change and broad-based change to complaints procedures, education, leadership, training, protections for staff and competencies in dealing with such issues together with legislative change and implementation of recommendations.

On too many occasions, to the AMA (ACT)'s knowledge, the hopes and expectations of junior and senior doctors have been dashed by either a refusal to acknowledge problems, an inability to deal with problems even if they are acknowledged or a desire to chase a 'fix' rather than a solution.

We strongly urge the Review Panel members not to repeat the errors and disappointments of the past.

The Legal Framework and Ethical Guides

The Independent Review will make recommendations that must account for the special obligations Canberra Health Service (CHS) and Calvary Public Hospital (Calvary) have as employers and as entities engaging contractors, as health services that care for patients and clients, as operators of facilities where members of the community attend as visitors, guests and volunteers and that are publicly funded.

In our view, CHS and Calvary also have special obligations to not only adhere to their legal responsibilities in regard to the groups and individuals referred to above, but to set a higher standard and to show community leadership in the manner in which they deal and interact with employees, contractors, patients, clients, visitors, guests and volunteers.

The Legal Framework

The following summary of relevant law deals with the obligations an employer has and the implications for that employer if those legal obligations are not properly discharged. Of course, the public implications of failing to discharge legal obligations are another matter entirely and have the potential to adversely impact on public confidence in healthcare in the ACT. The community often finds it difficult to distinguish between technical legal matters and the standard of care being delivered.

In passing we also provide an example of deficiencies in current legislation and associated poor workplace culture.

The *Work Health and Safety Act 2011 (ACT)* deals with bullying and harassment through an employer requirement to take all reasonably practicable steps to manage health and safety risks in their workplaces. A health service taking 'reasonable steps' to prevent the conduct is not enough. Instead, the employer must take '**all** reasonable steps' to have a competent

defense against allegations their workplace is unsafe. This test effectively mandates the following minimum steps:

- having a plan to identify and address unacceptable behaviour
- informing through training what is and what is not acceptable behaviour and what behaviour is acceptable or valued (includes likely consequences for wrong behaviour)
- having a bullying policy and procedures to address workplace bullying in the workplace
- having processes for managing complaints (both informal and investigative) that are procedurally fair, timely and allow for external, impartial providers of mediation / investigation

The *Public Interest Disclosures Act 2012 (ACT)* (PID Act) establishes a legal framework for a person to make a disclosure or a complaint about conduct that could amount to a criminal offence, give grounds for disciplinary action or activities that could amount to a serious malfeasance in public office in regard to an ACT public sector entity or employee or anyone performing a function on behalf of the ACT Government using public funds.

A disclosure or a complaint lodged by an ACT Government employee or relevant contractor in good faith attracts certain protections from reprisals for the discloser.

A further submission is made at confidential **Schedule 1** to this submission in regard to shortcomings of the PID Act. This is particularly relevant as all of the ACT Chief Minister, Minister for Health and Minister for Mental Health have publicly stated that the PID Act provides a viable means for reporting bullying and harassment in ACT Health.

The *Discrimination Act 1991 (ACT)* prohibits discrimination against a person based on their gender, sexual orientation, religion, race. professional associations, disability, marital or parental status, pregnancy, breastfeeding, age and a range of other personal attributes in the workplace.

The *Public Sector Management Act 1994 (ACT)* sets conduct standards for public sector employees (including bullying being unacceptable) and makes managers accountable for ensuring a safe work place with direct reference to the *Work Health and Safety (ACT) Act 2011.*

The *Fair Work Act 2009 (Cth)* (FW Act) *provides for a '*general protections' regime (sometimes referred to as adverse action) permitting an employee to seek uncapped financial damages in circumstances where they have suffered a negative effect in their employment after having sought to exercise a workplace right.

A right to a safe workplace free from bullying and harassment, and likewise free from physical or mental health impacts of bullying and harassment, is a fundamental protection provided by this part of the FW Act.

In additional, the FW Act now provides for an anti-bullying jurisdiction where the Fair Work Commission can issue prescriptive orders to stop behaviour and systems that have been found to cause bullying.

The *Safety, Rehabilitation and Compensation Act 1988 (Cth)* creates employer liability for reimbursement of time off work as well as medical costs associated with medical conditions arising from, for example, the psychological injury occasioned by bullying that can be attributable to the workplace.

AMA Code of Ethics and MBA Code of Conduct

By way of completeness and to indicate other standards of conduct and obligations relevant for medical practitioners, we note the following documents:

- AMA Code of Ethics 2004. Editorially Revised 2006. Revised 2016. We particularly refer to Part 3 – the Doctor and the Profession
- Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia

AMA Position Statements

The following are selected parts of the AMA's major policies (called 'Position Statements') as endorsed by the AMA Federal Council. It is noteworthy that AMA's policy timing and nature of response is consistent with general community expectation and is a leading voice for change to prevailing medical culture norms. For the full text of these Position Statements please refer to **Schedule 2** to this submission**.**

AMA Positions Statement - Workplace Bullying and Harassment 2009 [Revised 2015]

Medical students, doctors in training, female colleagues and international medical graduates have been identified as the most likely targets of bullying and harassment with more senior trainees most likely to be reported as the perpetrator. Other factors which increase the risk of workplace bullying and harassment include the presence of work stressors, leadership styles, systems of work, work relationships and workforce characteristics.

Incidences of bullying and harassment are often not reported because of fear of reprisal, lack of confidence in the reporting process, fear of impact on career, and/or cultural minimisation of the problem.

Workplace bullying contributes to poor employee health including the physical and psychological manifestations of stress and depression.

Appropriate management and leadership training must be provided and should be a requirement for those in leadership or supervisory roles. This includes education on

performance management, providing constructive feedback, communicating about difficult issues, and effective complaint management to prevent issues escalating where possible.

AMA Positions Statement - Sexual Harassment 1999 [Revised 2015]

While all doctors are at risk of sexual harassment, female doctors report a higher incidence. Gender inequity has a proven causal relationship with the incidence sexual harassment of female employees. This is particularly relevant for medicine where significant gender imbalances emerge in the majority of specialties despite female medical students and trainees slightly outnumbering their male counterparts.

The impact of sexual harassment is profound. It effects physical and mental health and undermines performance and collegiality in the workplace. Sexual harassment can influence career choice and career progression, and ultimately has the power to impact on the availability of female role models in medicine.

There is no place for sexual harassment in any workplace, including in medicine. All members of the medical workforce have a right to be treated with respect, dignity and as equals.
The medical profession must play a leadership role in tackling sexual harassment, modifying professional culture and modelling appropriate behaviour. This must include senior members of the profession making it clear that sexual harassment is unacceptable.

AMA Positions Statement - Equal Opportunity in the Medical Workforce 2016

It is important that the medical profession and workplace embraces the professional, economic and social contribution of doctors from diverse backgrounds and makes the most of the extensive skills, perspectives and networks that a diverse medical workforce will bring to the medical work and training environment. This will lead to a more productive, responsive and empathetic medical workforce, well equipped to deliver and advocate for the best health outcomes for patients and the broader community.

The AMA recognises the current under-representation in leadership positions of women and supports developing targets to address this.

Fair and transparent processes should be applied in assessing the capacity of a person to perform the job-related requirements of a position, having regard to the person's knowledge, skills, qualifications and experience and their potential for future development.

Giving Names to Behaviour

In many instances of inappropriate conduct and behaviour in the workplace, many doctors cannot necessarily define the problem other than feeling unhappy or distressed. This is supported by the fact that 38% of junior doctor respondents to a survey in relation to ACT

Health policy, protocols and frameworks, reported they have a poor or very poor understanding of their content[1].

By way of explanation, the most common reason why women do not complain after having been sexually harassed in an Australian workplace is because they believe it to have 'not (been) serious enough'. The next most common reason is that the behaviour is common place or accepted and that the behaviour was 'meant to be a joke'. It seems that there needs to be extreme offence taken to cause any form of reaction by the recipient of the behaviour[2].

From a legal and workplace policy perspective, these reasons seemed flawed in both logic and awareness and it's for these reasons we believe that definitions are important. Definitions raise awareness, create legitimacy and aid understanding of an experience and, importantly, provide a starting point to navigate solutions and make choices about what to do.

In our view, development, promulgation, education and use of definitions and language is an important part of cultural change but not sufficient on their own.

Some Definitions

Prevailing Culture is a set of basic assumptions and shared solutions as to 'how' to survive and remain part of the group, evolved over time. This does not suggest some intent of design nor suggest norms are legitimate because they exist.

With leadership the culture is capable of change; simply because culture exists does not create a reason to protect it from change.

Inappropriate Conduct and Behaviours is conduct and behaviours not suitable or proper in the circumstances in a workplace. These behaviours can occur by verbal, electronic or physical means and may also be a criminal offence requiring hospital reporting

Inappropriate conduct and behaviours do not mean reasonable action or a decision by an employer to direct, performance manage or discipline an employee.

Bullying is unreasonable and inappropriate behaviour that creates a risk to health and safety. Bullying behaviour has one or more of the following or similar characteristics:

- sarcasm and other forms of demeaning language;
- threats, abuse or shouting;
- physical contact;
- coercion;
- isolation;

[1] ACT Health's *Review of Clinical Training Culture – TCH and HS* [September 2015] p21

[2] *Everyone's Business: Fourth national survey on sexual harassment in Australian workplaces – Australian Human Rights Commission 2018*

- inappropriate blaming;
- 'ganging up';
- constant unconstructive criticism;
- deliberately withholding information or equipment that a person needs to do their job or access their entitlements; and/or
- unreasonable refusal of requests for leave, training or other condition arising under an agreement or policy.

Bullying can be a repeated set of behaviours or a single incidence where the behaviour is of sufficient magnitude.

Sexual Harassment is unwelcome behaviour which a reasonable person would anticipate, in the circumstances, that the person to whom the behavior is directed would find humiliating, offensive or intimidating.

Whether the behaviour is unwelcome is a subjective test; the issue is how the conduct in question was perceived and experienced by the recipient rather than the intention behind it. Whether the behaviour was offensive, humiliating or intimidating is an objective test; whether a reasonable person would have anticipated that the behaviour would have this effect.

Other Useful Terms and Concepts

Equality and **Equity -** the distinction between individuals being factually on the same level and the fair apportionment of outcomes so that individuals' differing needs are met. Gender equity, means justness, fairness and impartiality based on differing needs of women and men.

In the medical workplace and training environment, the operation of systems is fundamental to the delivery of equity.

Victim – on balance we prefer the use of the term '**Recipient** of the perpetrators conduct' or a similar formulation. This is because it is the perpetrator who choses their target, the recipient has no say and the recipient does not act 'attract' the conduct.

The Consequences of Inappropriate Conduct and Behaviour

'Unprofessional behaviour is sufficiently widespread in the Australian health care system that it could be considered endemic . . . [b]ullying, discrimination and harassment are just the tip of the iceberg. Unprofessional and disruptive behaviour encompasses a wide spectrum that includes conduct that more subtly interferes with team functioning, such as poor communication, passive aggression, lack of responsiveness, public criticism of colleagues and

'humour' at the expense of others. Although unprofessional behaviour is common, the true prevalence is likely to be significantly underestimated, with wide spread under-reporting.'[3]

The data provided later in this submission points to the fact that there is every reason to believe the ACT experience is consistent with the national and international experience. The incentives to challenge bullying behaviour or make a complaint about discrimination or harassment are outweighed by the incentives to remain silent, hence an aggressive culture is perpetuated which selects people who can survive it and these people may then become role models for future generations of bullies.[15]

There is ample evidence to suggest that the issue of bullying and harassment is a significant problem. Surveys have found that over 50 percent of Australian junior doctors experienced bullying in their clinical attachments, with the bullying most likely to be from a supervisor[4].

The culture of workplace bullying and harassment is not unique to the Australian health sector. International studies, in particular in the United States and United Kingdom, suggest disturbingly high levels of bullying, discrimination and mistreatment at all levels in the medical profession from application to medical school to examination success, job application, and the allocation of distinction awards to consultants[5].

The impacts of inappropriate conduct and behaviours are felt by:

- Patients, linked to safety and errors including increased surgical complications, hospital acquired infections, medication errors and adverse outcomes.
- Staff, through turnover and retention and associated recruitment costs, reduced productivity through poor morale and demands on management time, WH&S, training impact, resetting career goals and suppression of innovation
- Institutions, through the stifling of potential, adversely affecting operational efficiency and revenues, significant legal costs, reputational damage, economic cost and propagation of poor culture[6]

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[3] *Endemic unprofessional behaviour in health care: the mandate for a change in approach* - Johanna Westbrook, Neroli Sunderland, Victoria Atkinson, Catherine Jones and Jeffrey Braithwaite Med J Aust 2018; 209 (9): 380-381.

[4] Rutherford, A and Rissel, C. (2004) A survey of workplace bullying in a health sector organisation, Australian Health Review, vol. 28, no. 1; Scott, J., Blanshard, C. and Child, S. (2008) Workplace bullying of junior doctors: a cross-sectional questionnaire survey, NZMJ Digest, Vol. 121, No. 1282.

[5] The Japan Institute for Labour Policy and Training (2013) Workplace Bullying and Harassment: JILPT Seminar on Workplace Bullying and Harassment; Quine, L. (2002) Workplace bullying in junior doctors: questionnaire survey, BMJ 2002; 324; Woodrow, S.I., Gilmer-Hill, H. and Rutka, J.T. (2006) The Neurosurgical Workforce in North America: A Critical Review of Gender Issues, Neurosurgery, vol. 59, no. 4.

[6] *The Ethos Program: Re-defining Normal* - Dr Victoria Atkinson Group Chief Medical Officer Group General Manager Clinical Governance Cardiothoracic Surgeon

Often, where inappropriate conduct and behaviours occur, they are directed towards doctors from those outside the profession such as hospital administration or nursing staff. It is well recognised that continued exposure to bullying can cause both psychological harm and physical illness[7].

Workplaces where staff are happier are associated with better patient outcomes, improved quality and reduced adverse events[8].

Data on the National and ACT Experience

National

In 2018, the AMA (with the co-operation of the Australian Salaried Medical Officers Federation in some jurisdictions) conducted a Hospital Health Check Survey with junior doctors. The following outlines the relevant results from various jurisdictions:

NSW

Amongst all NSW doctor-in-training survey respondents,

- **42 percent** have **experienced bullying** or **harassment**
- **53 percent** have **witnessed** a colleague being bullied or harassed
- The **majority** perceived bullying issues had not been **not adequately dealt with**
- **66 percent feared negative consequences** of reporting inappropriate workplace behaviours
- **68 percent** have **felt unsafe** at work due to verbal or physical intimidation or threats from staff (or patients)
- **66 percent** were **concerned** there might be **negative consequences** in their workplace **if they report**ed inappropriate workplace behaviours[9]

Victoria

Amongst all Victorian doctor-in-training survey respondents,

- **45 percent** reported that they have **experienced bullying** or **harassment**
- **63 percent witnessed** unacceptable workplace behaviors
- **74 percent did not report** witnessed unacceptable behaviour
- **71 percent reported fear of career damage** was a reason to **not report** their experience

[7] Hutchinson, M., Vickers, M., Jackson, D., and Wilkes, L. (2006). Workplace bullying in nursing: towards a more critical organisational perspective. Nursing inquiry, 13(2), 118-126.

[8] Schwartz, Richard W., and Thomas F. Tumblin. "The power of servant leadership to transform health care organizations for the 21st-century economy." Archives of Surgery 137, no. 12 (2002)

[9] *Alliance New South Wales Hospital Health Check Survey 20187 (AMA New South Wales and Australian Salaried Medical Officers' Federation New South Wales)*

- **20 percent** of respondents described being **asked inappropriate questions during an interview** such as marriage plans or sexual orientation[10]

Queensland

Amongst all QLD doctor-in-training survey respondents,

- **37.9 percent** had **personally experienced** bullying, harassment or discrimination
- **72.9 percent** had **witnessed** a colleague experience bullying, harassment or discrimination
- Of those saying they have **experienced or witnessed** bullying, harassment or discrimination, **60.9 percent felt there was nothing they could do about it** [11]

Western Australia

Amongst all **WA** doctor-in-training survey respondents,

- in the previous 12 months **40 percent report experiencing bullying**
- 5 percent report experiencing sexual harassment[12]
- **a third of WA doctor** respondents said had **experienced sexual harassment** in their workplace[13]
- **20 percent** reported an **inappropriate question at interview**
- **74 percent** said they had **not reported witnessed** unacceptable behaviour[14].

Other National Survey Work

Arising from the recent National workplace sexual harassment survey[15] close to half of sexual harassment events in past five years occurred in four industries (retail, education, accommodation and food, and health). Useful in the Independent Review's context are the following survey findings:

- **Bystander inaction** was reported to be, in part, because "didn't know what to do" and "not their responsibility" with more men than women stating this reason.
- **Seeking advice** – 60 percent report they approached friends and family rather than professional associations or other external organisation for advice and representation
- **Reason why not making report:** others thinking *"overreaction*" (49%) *"easier to keep quiet"* (51%) *"I would if I thought things would change"* (43%) (noting 55% said no change after complaint)
- degree of perceived seriousness of the intimidation or offence correlates to the probability of complaint.

Australian Capital Territory

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[10] *2018 Hospital Health Check Survey* (AMA Victoria)

[11] *2018 Resident Hospital Health Check Survey* (AMA Queensland)

[12] *2018 Hospital Health Check* (AMA Western Australia)

[13] *Medicus* AMA(WA) [April 2016]

[14] AMA Victoria - Hospital Health Check Survey [18 January – 3 February 2018]

[15] *Everyone's Business: Fourth national survey on sexual harassment in Australian workplaces – Australian Human Rights Commission 2018*

AMA (ACT) 2018 Hospital Health Check Survey
The survey was administered in the latter part of 2018 with a closing date of 15 October 2018.

The Canberra Hospital
Amongst all Canberra Hospital doctor-in-training survey respondents,

- **42 percent** have experienced bullying or harassment
- **39 percent** have witnessed a colleague being bullied or harassed
- **68 percent** feared negative consequences of reporting inappropriate workplace behaviours
- **58 percent** rated staff morale as fair while **39 percent** rated it poor or very poor
- **54 percent** rated the workplace culture as fair while **29 percent** rated it poor or very poor

For a more detailed summary of the AMA (ACT) 2018 Hospital Health Check Survey please refer to confidential **Schedule 3** to this submission.

Medical Practitioner Testimonials

In this section we have collated a sample of comments and experiences provided to the AMA (ACT) either through the AMA (ACT) 2018 Hospital Health Check Survey or by individual practitioners.

AMA (ACT) 2018 Hospital Health Check Survey

- *'There are a number of Consultants that are known for bullying/and or inappropriate behaviour and comments. It is alarming that this behaviour is allowed to go on unchecked. The impression I have is that there is no point complaining to the administration because they won't do anything about it.'*

- *'Morale is really poor and culture is very poor and that is why I am leaving.'*

- *'The dysfunctional behaviours described have reached a level and frequency that patients and staff (medical, including some of the senior doctors, nursing and support staff) are at risk.'*

- *'Take bullying reports seriously. There are a number of Consultants who have unreal expectations of JMOs and bully and harass them. However many times these Doctors are reported, nothing happens.'*

- *'The concerns have been raised informally with senior doctors in and beyond the department in the past; there is therefore some broader knowledge of the problems raised.'*

For a more detailed summary of the AMA (ACT) 2018 Hospital Health Check Survey please refer to confidential **Schedule 3** to this submission.

Medical Practitioners

A selection of testimonials from Medical Practitioners is contained in confidential **Schedule 4 Parts 1 and 2** to this submission. **Schedule 4 Part 1** contains further information from junior medical staff while **Schedule 4 Part 2** contains information from senior staff.

Models for Cultural Change

Evidence indicates that:

- Early intervention can prevent minor inappropriate behaviours from escalating into bullying and harassment.
- Cultural change is created through conversations[16]

An additional challenge for the Review Panel is come up with practical recommendations that ACT Health and Calvary can implement to bring about cultural change and effectively respond to workplace bullying and harassment.

Two of the most often cited programs to bring about cultural change and reform in the workplace are the Vanderbilt Accountability Pyramid and the Ethos Program at St Vincent's Health Australia.

The Vanderbilt Accountability Pyramid / Melbourne Health Response 2016[17]

The Vanderbilt Pyramid is built on the premise that:

- most staff are good people, doing the right thing for the right reasons
- rewards should exist for people who are behaving well (includes acting as leadership symbols)
- based on peer accountability, peer messaging and peer comparison
- create micro / macro environments to intervene early and often
- data and safety driven interventions
- systems enable the right culture

The Pyramid is built on a structure of escalated communication as patterns of unprofessional behaviour develop but is based on the concept that the vast majority of professionals conduct

[16] *The Ethos Program: Re-defining Normal* - Dr Victoria Atkinson Group Chief Medical Officer Group General Manager Clinical Governance Cardiothoracic Surgeon

[17] The Vanderbilt Centre for Patient and Professional Advocacy

themselves in exemplary ways. All health professionals and administrators are subject to lapses and may engage in what appear to represent single "acts" of unprofessional conduct. Individuals who exhibit recurrent patterns of unprofessional conduct genuinely represent an anomaly, and therefore need to have their behaviour addressed. When a pattern of unprofessional conduct appears to exist, individuals need varying levels of intervention.

'Dotted lines' are used to separate various levels of intervention i.e. they are not solid. Rather, they reflect the importance of professional judgment and differences among organizations in deciding when to use each level. Research reveals that for those who exhibit patterns of unprofessional conduct, most respond to an awareness intervention. Unfortunately, some individuals will not or cannot respond at the 'Awareness' level and need a more directive approach higher in the pyramid. The conversations establish a structure of escalated communication, and everyone needs a supported plan for responding to reactions to conversations.

Melbourne Health introduced a similar system in 2016. Volunteer and respected specialist doctors, as required and in response to, for example, confidential intranet staff reporting, are authorised to speak privately with a peer who is observed to be exhibiting negative behaviour.

The idea is that a person would prefer to 'know' because often the behaviour is unconscious. It is a 'third way' to prevent behaviour escalating and informally managing it.

Where there is a risk that the Health Service's duty of care could be compromised if it maintained confidentiality and did not become more interventionist, there are carefully designed systems that come into operation. AMA (ACT) has been informed that persons who have been spoken too via this system are grateful for the insights offered and tend to quickly change their behaviour.

St Vincent's Health Australia (SVHA) Ethos Program[18]

The Ethos program looks beyond bullying and harassment to redefine the broader question of what 'normal' behaviour in healthcare has become.

Over time, healthcare has acquiesced to seemingly 'less sinister' behaviours that, while being more subtle in effect, still impact adversely on positive cultural change. These include behaviours that interfere with team work, contribute to ineffective communication and create risk. Less obvious examples include a lack of responsiveness, poor or ambiguous communication, publicly criticising members of the team, refusing to follow established best practice, learning by humiliation, intimidation, ignoring, isolating and laughing at other's expense.

[18] The following from Catholic Healthcare publication *The Sector Speaks – "The Ethos Program: Re-defining normal"* - Dr Victoria Atkinson, Group Chief Medical Officer St Vincent's Health Australia

SVHA Ethos program pillars:

- We feel safe
- We feel welcome
- We feel valued

The SVHA Ethos program principles are:

- All staff are entitled to a safe workplace
- Personal courage is not required to live our values
- We will encourage, acknowledge and reward behaviours that reflect our values
- Our response to behaviour that undermines patient or staff wellbeing will be consistent, transparent and equitable
- Our staff are enabled and empowered to speak up. If they cannot, we will provide them with a safe voice
- Our staff are given an opportunity for reflection and self-regulation where appropriate
- Particular attention will be paid to vulnerable groups such as trainees and junior staff
- Diversity and gender equity are central to organisational strength

The Ethos program highlights that while addressing this disruptive element is critical, on its own it is insufficient, representing only the tip of an iceberg with far larger hazards sitting below the waterline. Whilst it is essential to create a system that equitably holds destructive staff to account, the cultural change required is more far reaching and daunting than a handful of people demonstrating very poor behaviour.

Consistent with this, an organisation should seek to understand how the remaining 98 percent of staff are interacting; it is these many conversations that define the organisation and serve to encourage or extinguish the worst behaviours.

Addressing the Problems and Shifting the Culture

In our submission, a series of steps need to be taken that act together to shift workplace culture in the ACT public healthcare services. The steps are:

- Improved leadership competency in medicine
- Establish measurable objectives and goals for improving workplace culture
- Improve confidence in systems dealing with complaints
- Adoption of improved employment terms

These steps, when implemented, move the workplace culture through four key stages to deliver real change:

1. ***REGULATION AND LEADERSHIP****: applying good enforceable rules consistently and fairly, combined with leadership setting the right standard and acting as an example*

   Leaders, armed with good rules, set the standard and can then ensure -

2. ***VISIBILITY****: raising awareness of complaint processes and definitions of behaviours, regular reporting on 'where change is at' through survey work and information about organisational steps to combat inappropriate behaviours*

   With the organisation learning what the new standards are, through being shown what to do, how to do it and seeing evidence that the whole organisation is pushing in the same direction, what arises is -

3. ***LEGITIMACY****: differences arising from the diversity of style, background and/or gender become accepted. Recruitment to leadership positions are undertaken through recruitment processes free from cultural or gender bias*

   The legitimacy of difference leads to the transformational goal of -

4. ***RESPECT****: the standard is set and properly reinforced, difference is embraced and valued and unacceptable workplace behaviours are significantly reduced. The workplace culture breeds respect and not contempt.*

Improved Leadership Competency in Medicine

In our view, leadership is a key part of building a stronger workplace culture in ACT public healthcare services. Positive work environments are supportive and encouraging for staff, can lead to increased effectiveness and productivity while improving overall staff morale. In healthcare settings, this can lead to reduced risk, lower adverse events and better overall patient outcomes[19].

Where an organisation's leaders are insensitive, of poor standard, inconsistent, unfair, stale or not transparent and/or where its people are not aware of their rights and how to enforce

[19] Künzle, B., Kolbe, M., and Grote, G. (2010). Ensuring patient safety through effective leadership behaviour: a literature review. Safety Science, 48(1), 1-17.

them safely, the opportunity to enhance clinical team efficiency, maintain quality and develop employer of choice characteristics is reduced.

Leaders stand as symbols and good leaders should be equipped with the professional competencies to:

- regulate emotions
- manage through self-awareness
- develop trust by being reliable and consistent

The AMA training presentation, *Medical Leadership – Achieving Workplace Professionalism and Understanding Non-clinical risk – 'Is it good enough to just be a good doctor?'* sets out what we should expect from workplace leaders:

- To listen
- To modify original thoughts, impressions and objectives based on received information
- To set clear and fair boundaries and expectations
- To clearly communicate what the boundaries and expectations are
- To reward compliance and act against non-compliance
- To reward those who choose not to be by-standers
- To consistently apply rewards and negative consequences

Building leadership competency in medicine in line with the abilities set out in this part should form part of the process towards cultural change.

Establish measurable objectives and goals for improving workplace culture

Collecting data, analysis, developing plans and goals and measuring outcomes against the achievement of goals is fundamental to cultural change.

Collecting good, meaningful data is necessary to understanding what problems exist. Change in that data over time can then be used to identify recurring issues or trends, make improvements to systems and processes and allow services to improve their reputation.

Analysis of complaints should be done regularly and report on:

- Volumes and trends over time
- The types of issues being raised and their impact
- Complaint outcomes
- The actions taken in response
- The systemic issues identified
- The demographics of the people making complaints

Robust reporting, as set out above, builds visibility and confidence in the legitimacy of raising issues that, in turn increases confidence in the ACT healthcare services' willingness to make change through honest acknowledgement of the issues

Of recent times, the work done by the Royal Australasian College of Surgeons (RACS), through their Expert Advisory Group, supported such an approach. To their credit, RACS have moved well beyond the earlier data collection and analysis stages and have established targets in particular areas, notably gender equity.

While the overall goals include increasing the representation of women in surgical education and training and on college bodies, the specific targets are:[20]

- Increasing the representation of women in Surgical Education and Training to 40% by 2021
- Increasing the representation of women on RACS Boards and Committees to 20% by 2018 and 40% by 2020.

These decisions by RACS indicate that the College recognises there are structural and hierarchical impediments holding women back in access to surgical training and representation on boards and committees.

The benefits of setting targets include[21]:

- **commitment:** creates disciplined focus and clarifies accountabilities to improve gender balance
- **competition:** implies reportable measures that create a competitive market between organisations' encouraging improvement and showing value as an employer of choice
- **capability:** delivers improved talent pool, succession planning options and from that genuine merit-based selection and enhanced organisation brand value

Despite these benefits, targets still need to be part of a broad suite of change agendas because any gain for one group is often perceived as a loss for another group, leading that other group, in this case men, to potentially perceive unfairness. There may also be a perceived negative representation of women because 'women need help'[22].

Improve confidence in systems dealing with complaints

Improving confidence in complaints management processes is another key element in bringing about change in workplace culture. In the work RACS has undertaken, the College recognised this fact by setting a goal to revise and strengthen their complaints management

[20] RACS Diversity and Inclusion Program [November 2016]
[21] *Achieving gender diversity in Australia: the ugly, the bad and the good* [April 2015] Workplace Gender Equality Agency
[22] *Gender and the Economy* (University of Toronto) – He J. and Kaplan S.

processes, increase external scrutiny and demonstrate best-practice complaints management that is transparent, robust and fair[23].

The AMA (ACT) endorses this goal and likewise endorses the actions proposed to be taken by RACS as suitable for adaptation and implementation by ACT public healthcare services:

- revise Code of Conduct and sanctions policy to incorporate clear expectations about the management of complaints, including clear consequences for adverse findings, and to support professionalism.
- incorporate principles helping prevent victimisation and increase/ensure protection for those who make complaints.
- establish and provide external, expert and independent review and oversight of complaint processes including reviewing processes and recommending actions when processes are not followed or are inadequate
- strengthened confidentiality processes
- requirements to report information about complaints
- enable external expert mediation for complaints
- annual and public reporting on aggregated outcomes of complaints

While it is necessary to have policies and practices, it's also key to have medical practitioners educated to understand their workplace obligations, rights and responsibilities as senior employees (and contractors in the case of Visiting Medical Officers).

Put another way, it is unrealistic to expect a doctor to navigate employment law and human resources complexity, particularly when there is a lack of trust in the processes. As referred to earlier, limited workplace knowledge may be made worse where the recipient of unwelcome conduct does not fully understand or know:

- what fair treatment is
- how to trust or unpack and navigate redress schemes
- how to properly define then express what the problem is. When you're 'in it' you might think it's normal, or think it is something other than what it objectively is.

A further complicating factor can be that the expertise of a clinician may be seen as so valuable that inappropriate conduct and behaviours are ignored or categorised at the lower end of the scale in deference to a perceived greater good.

Whatever the complicating factors, an essential part of the solution is for doctors to better understand the workplace obligations that apply to them, whether as employees or contractors. The tendency to try and 'sort things out' using informal 'club' rules, while often well-meaning, can be fraught with risks. In the end, what's required are doctors with a better

[23] Goal 8 – 3. Complaints Management - *Building Respect, Improving Patient Safety - RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery*

understanding of workplace obligations together with workplaces that have good processes with clear, consistent and transparent formulae consistent with procedural fairness and legal rights, obligations and duties.

Adoption of Improved Employment Terms

AMA has established a national bargaining framework, including model clauses, as a reference tool for all jurisdictions when engaged in enterprise bargaining on behalf of hospital doctors. Explanation as to the rationale, the problem seeking to be solved and objectives in each area are set out below.

In the AMA (ACT)'s submission the model clauses set out below should be incorporated into the ACT Public Hospitals Medical Practitioners Enterprise Agreement to the extent agreed by the relevant employee and employer parties.

The areas dealt with are:

- Professional Management of Conduct or Performance
- Bullying, Discrimination and Harassment
- Family Friendly Arrangements
- Child Care Facilities
- Child Care Reimbursement

The Bargaining Framework and model clauses have been extensively informed by the AMA Position Statements contained in **Schedule 2** to this submission.

The AMA Model Clauses are set out in **Schedule 5** to this submission**.**

<u>AMA Model Clauses</u>

General rationale

- maximise regulation judged against fairness, justice, current deficits/needs gaps and emerging community trends and expectations;
- reinforcing the legitimacy of women having children by regulating family related rights in the workplace. This acts as a cultural change device by recognising and valuing gender diversity and consequent reduction of inappropriate conduct and behaviours;
- statement of clear and express rights, process steps, responsibilities, accountabilities and consequences;
- encourage managerial and leadership competency and skills within medicine; leaving no doubt as to what steps to take to ensure compliance;
- enhance prospect of compliance and/or enforcement through a comprehensive clause drafting approach; and
- streamline access to conciliation then arbitration by identifying the issues in dispute.

Professional Management of Conduct or Performance

Problems sought to be solved

- Lack of procedural fairness or administrative/managerial professionalism
- Responsibility between hospital and Learned College can be confused
- Doctor participating without representation

Objectives of clause

- If in the "course of employment", Learned College conduct is deemed a hospital liability
- Right of ASMOF or AMA representation
- Specifics in writing, opportunity to respond and right of appeal
- Ensure no 'knee jerk' hospital actions and confidentiality maintained

Bullying, Discrimination and Harassment

Problems sought to be solved

- Cease damaging health and career effects to recipient of perpetrator's behaviour
- Eliminate responsibility shifting between hospital and Learned College
- Doctors not trusting there is a safe, confidential and streamlined process to raise concerns and have concerns properly resolved without prejudice

Objectives of clause

- Removes concept of victim and replaces with term 'recipient' of destructive conduct by another
- Cultural change, both individual and organisation, through education and training
- Minimise potential for reprisal against recipient
- Enhance transparency and visibility as to how to raise concerns
- Create clear management obligations and accountabilities to intervene and fix
- Defines what the behaviours are
- Streamlined access to dispute resolution

Family Friendly Arrangements

Objective of clause

Shifting culture to accept the legitimacy and reality that women give birth and represent over 50 percent of graduating medical practitioners and have equivalent career expectations. This likely enhances respect and understanding thus reducing inappropriate conduct and behaviours.

Child Care Facilities

Problem sought to be solved

- Lack of child care facilities
- Lack breast feeding / breast milk storage facilities

Objective of clause

- Require hospital to take steps to introduce child care supports

➢ Child Care Reimbursement

Problem sought to be solved

- There is imbalance between work and family obligations and supports. This is unhealthy for sustainable clinical practice, society and individuals.

Objectives of clause

- Incentive for roster-posting compliance
- Compensation to doctor for unreasonable disruption to planned child care arrangements

Recommendations

AMA (ACT) proposes the following recommendations:

1 1.1 A clear and public commitment to be made by the Minister for Health, Minister for Mental Health, ACT Health and Calvary Public Hospital and representative organisations to ongoing cultural change across the ACT public healthcare services.

1.2 The commitment to be based on continuous improvement by organisations and individuals in regard to gender equity, diversity, education and training.

1.3 The content of the commitment to be developed with ACT Health, Calvary Public Hospital, AMA (ACT), ASMOF ACT and other health unions and the Council of Presidents of Medical Colleges.

1.4 The commitment to be contained in a public agreement between the Minister for Health, Minister for Mental Health, ACT Health and Calvary Public Hospital and AMA (ACT), unions and the Council of Presidents of Medical Colleges.

2 Identify and recommend a suitable model for cultural change to be implemented across the ACT public healthcare services for <u>salaried and contracted medical practitioners</u> such as the Vanderbilt/MHS or SVHA Ethos programs.

3 3.1 That ACT Health and Calvary Public Hospital review AMA National Bargaining Framework Model Clauses and initiate a joint process with AMA (ACT) and ASMOF ACT to incorporate the relevant clauses into the ACT Public Sector Medical Practitioners Enterprise Agreement (MPEA) within 12 months of the date of the Minister for Health accepting this recommendation.

3.2 Failure of the parties to agree on the clauses to be inserted into the MPEA within the 12-month timeframe, should see the matters referred to the Fair Work Commission for private arbitration.

4 In line with expectations under the contract of employment or contract for services, explicitly state obligations for senior medical practitioners to intervene and resolve inappropriate conduct and behaviours.

5 Establish processes to encourage intervention by by-standers when they witness inappropriate conduct and behaviours. The processes should include, but not be limited to, rewarding and protecting interveners.

6 Enhancing transparency and visibility as to what steps to take and where to obtain professional and independent advice when seeking to raise concerns regarding inappropriate conduct and behaviours.

7 Streamlined access to early dispute resolution that is speedy, expert, independent and creates incentives for changing workplace culture.

8 Minimise or eliminate the potential for reprisals against either a recipient of inappropriate conduct or behaviours or person seeking to raise concerns or positively intervene in regard to inappropriate conduct or behaviours. This should be achieved by means that include complaint systems that are confidential, objective and professional.

9 In line with AMA model clauses, cease the use of the word '<u>victim</u>' (a person is the 'recipient' of destructive conduct by the 'perpetrator') and replace with the word '<u>recipient</u>' where appropriate.

10 10.1 The Minster for Health and Minster for Mental Health establish a 'Culture Review Implementation Committee' to oversight the implementation of the Independent Review's recommendations.

10.2 The Culture Review Implementation Committee should be comprised of representatives from the ACT Government, ACT Health and Calvary Public Hospital nominees from AMA (ACT), ASMOF ACT and other health unions, a

nominee of the Council of Presidents of Medical Colleges and an independent chair.

10.3 The Culture Review Implementation Committee should be constituted so that, in addition to the independent chair, there are equal numbers between ACT Government, ACT Health and Calvary Public Hospital representatives and other stakeholder representatives.

11 The ACT Government amend the *Public Interest Disclosure Act* 2012 (the Act) so as to provide that:

11.1 From the time that the discloser makes the disclosure under the terms of the Act, the information is deemed to be a public interest disclosure and the relevant protections apply to the discloser.

11.2 Provide a maximum six-month period for undertaking both an initial assessment of a disclosure and a final determination of the issues raised in the disclosure to be made.