AMA(SA) – Statement to the Parliamentary Inquiry into Workplace Fatigue and Bullying in South Australian Hospitals and Health Services
13 September 2019

Introduction

- Good morning.
- Thank you for your invitation to the Australian Medical Association South Australia to present evidence to this inquiry.
- I would like to start by relating a stark example conveyed to me by a colleague of what bullying looks like on a day-to-day basis in SA hospitals.
- Dr A of one ward rings Dr B on another ward requesting him to assess a patient for possible admission to Doctor B's ward- to which Dr B says, 'fuck off' and puts the phone down.

Effects

- From this example you can extrapolate all the terrible consequences of bullying:
    1. Affects the psyche and mental health of the individual who is being bullied – and may, if repeated and viewed as normal and acceptable culture, even lead to the individual becoming a bully themselves one day
    2. Corrupts the morale, collegiality and teamwork of a unit – making it an unpleasant and inefficient workplace
    3. Most importantly, compromises patient care and safety – for where was the patient considered at all in this case?
    4. And finally, sadly, renders we, as doctors, as hypocritical as supposed healers of the bodies and minds of patients when we are the ones doing harm.
- Important in defining bullying to understand that this is repeated behaviour and not just someone having a bad day
- Statistics:
    - Royal Australian College of Surgeons evidence presented to you – showed that 70 per cent of trainee surgeons reported they had been bullied, and that 50 per cent of surgeons said they were 'being' bullied.
    - SASMOA – Junior Doctor Survey Results 2018 – 70% of junior doctors stated that bullying and harassment was a problem in their workplace.
- Particularly vulnerable are medical students and unaccredited registrars – reluctant to report because they may be afraid of the impacts of reporting abuse.

Causes

- What causes bullying? I would like to discuss four main levels of responsibility.

- The individual level:

    - Although people have differing perceptions of what constitutes bullying

    - Ultimately there are clear bullies and there is clear bullying behaviour – which the AMA cannot condone.

- I would like to submit the 'AMA Position on Workplace Bullying and Harassment', but more importantly the 'AMA Code of Ethics 2016':

    - *3.2.1 Treat your colleagues with respect and dignity.*

    - *3.2.4 Treat those under your supervision with respect, care and patience.*

- The professional level – which is the level the AMA(SA) can represent:

    - Although there may be traditional notions existing that 'teaching by humiliation' is effective, and that there is a need to 'harden up' medical students and junior doctors, on behalf of the profession, it is time to draw a line in the sand and say that bullying is NOT acceptable, no matter how senior of eminent you may be.

    - And I wish to apologise and say sorry for all the hurt that the bullying behaviour of doctors has caused.

- Another group which is often blamed are the medical colleges.

    - Groups like Royal Australian College of Surgeons have acknowledged the problem and have been proactive

    - But they can only do so much as they are not the employer and their one lever is a blunt one of not accrediting a teaching unit.

- Ultimately the major blame must rest with the workplace and the employer:

    - Firstly, for failure of leadership and accountability over many years – something that I will touch on later – but best exemplified by RAH which had the lost years of unstable leadership with CEOs changing every year while the NRAH was being built, which led to a particularly toxic culture being allowed to develop

    - Secondly, creating workplaces with unreasonable hours of work and under-resourcing leading to fatigue.

- In requesting input for this hearing, our members have emphasised the problems of workloads and lack of resources and given examples such as:

    - The paediatric specialist working in the country being on call for two to three days at a time, covering emergencies, sick kids as well as deliveries – and, if they finally get to

bed, they have been known to respond with inappropriate abuse to the person who does call them.

- A medical ward, where they doubled the size of a ward, but did not provide any more staff.

- Staff who are fatigued and experiencing cognitive overload will ultimately behave badly towards one another.

- So, these perennial staffing and resourcing issues are critical to a proper understanding of the problem of bullying.

- Too often, workforce decisions have been based on outmoded and inadequate data – for example, there is no measurement of input into clinical services or the time required for essential, non-clinical activities such as administrative duties, teaching and research.

Recommendations

- What should be done?

- Bullying occurs because the culture and the workload aren't right. Fix this and most of the bad behaviour goes away.

- We need a real commitment to a whole-of-system approach.

- Some tangible recommendations:

1. Consideration for implementation of the Royal Australasian College of Surgery's *Appropriate Working Hours for Surgical Trainees in Australia and New Zealand,* which endorses a 55-65-hour working week as one which is appropriate for trainees to gain the knowledge and experience required by the training program, but only if fatigue minimisation practices and safe rostering are employed.

2. Implementation of appropriate staffing and resourcing based on high-quality data and consideration of inputs.

3. Employment of occupational physicians with expertise in workplace stress, such as Professor Nikki Ellis.

4. For students and unaccredited registrars, who are vulnerable to bullying because their superiors hold such a level of power over them in being assessors, consideration of a policy for the use of independent processes for assessment.

5. Implementation of strategies to help doctors develop the skills to improve the performance of their more junior staff without permanently damaging them through bullying behaviour.

6. Embedding of reporting mechanisms which:

    - Are clear and known by all

    - Effective, including across siloes

- Are fair and incorporate due processes where concerns about bullying and fatigue can be raised without fear of retribution, and where all those involved – including those accused – have access to appropriate support

- Begin with the least threatening first and only escalate if required, with two examples being:

    - 360-degree feedback so doctors know how their behaviour is perceived by others and have an opportunity to change their behaviour

    - The 'supportive bystander model' advocated by the Australian Medical Students Association in which students and all staff look out for their peers, report incidences on others' behalf, and proactively prevent bullying behaviour.

7. Really important – developing and supporting positive leadership:

    - What happens now is that the job is usually given to the most senior, who may not be suited; that is, may not have the temperament to be positive or to make hard decisions. They are not trained or given skills in leadership and then they are expected to manage the entire unit on top of a full clinical load.

    - Leads to chaos – 'fish rots at the head' – and they are set up for failure

    - Must identify individuals with the right temperament and interest in leading, and give them the correct management/leadership skills and experience; give them the time to manage; and encourage them to lead units in a positive way with clear lines of reporting, responsibility, and accountability – so everyone knows where the buck stops.

8. Further along this line, we recommend implementation of the 'Mentally Healthy Workplaces Framework for the SA Public Sector', which is just coming out of consultation phase and which is a coherent plan with four components:

    1) Raise awareness – (normalising discussion on mental health and wellbeing)

    2) Build the positives – make the culture right – manage people well and design better jobs that are reasonable

    3) Prevent harm – systematically identify issues – fix bad jobs and support people doing hard jobs

    4) Intervene early – this is where well-known models like the Vanderbilt system come in. While these are good processes – doctors do focus too much on this intervention level, which is more like being the 'ambulance at the bottom of the cliff' because the bad behaviour has already occurred. If you get good leadership focussing on 1) & 2) and you get fewer events that require intervention.

    - Re: 3) – identification of issues – I would like to refer you to Associate Professor Michelle Tuckey's work (from University of SA) in developing an evidence-based 'Risk Audit Tool for Mentally Healthy Workplaces', which helps workplaces identify psychosocial risk but also what is causing this.

- It reinforces that if you give people reasonable hours, manage their performance respectfully (including bad behaviour) and provide positive leadership, the likelihood of bullying is reduced.

- The challenge, in this age of constrained budgets, will be for Government to commit with heart and soul to resourcing these initiatives – but to this the AMA would contend that doing so would return positive benefits in spades.

AMA(SA) Initiatives

- With respect to what the AMA(SA) will be doing in partnership with others:

1. Working to implement the AMA Safe Hours Audit in country health sites.

2. With respect to an initiative for the medical students, we are very pleased to announce an initiative with the support of the Dean of the University of Adelaide Medical School, Professor Ian Symonds, to commence a working group/committee to look at progressing strategies to reduce bullying of medical students – and which will involve the medical school, the Adelaide Medical Students Society, and AMA(SA).

3. Harking back to the long-standing feeling that 'the fish has been rotting from the head' with respect to SA Health.

    - We have been encouraged by the response of the Minister for Health, Stephen Wade, when we have implored him to understand that his staff are his greatest asset, and instead of treating them like a problem to be thrown under the bus at the first opportunity – as has been the case for many years – to lead them positively and to appreciate them.

    Which leads us to the significant announcement that the AMA(SA) will be holding a Culture and Bullying Summit, with the support of the Minister and involving other key stakeholders.

- The reason we are doing this is partly to act as a lightning rod to encourage progress with practical solutions to reducing bullying and fatigue.

- But the other reason was put to me by a colleague of mine:

    - He said that currently, initiatives to reduce bullying are already in motion.

    - But, if there is no genuine acknowledgement of the past – or a 'cathartic' moment – we will merely be in denial of many years of harm and hurt, and younger staff, in seeing this, may feel that bullying has just been temporarily swept under the carpet but that it is still ok and that it will return – and they may become the perpetrators.

    - He said, as have others, that we must have this 'line in the sand moment', where the profession takes ownership and says sorry, and where we say, for the sake of our patients and our colleagues: bullying is a cancer in our health system that has to be treated and we must all say, 'no more'. 'Bullying is not acceptable, and it has to stop.'

- Thank you.