A Better Culture

A Better Culture Curriculum

Acknowledgements

A Better Culture would like to acknowledge and pay our respects to the Traditional Owners of the lands across Australia and extend our gratitude for their contributions to health and healing. Our offices are located on the lands of the Wurundjeri people of the Kulin nation; we pay our respects to their Elders and ancestors past and present, and acknowledge that sovereignty was never ceded.

The project was commissioned by the Australian Government Department of Health, Disability and Ageing in December 2022 to address high rates of bullying, harassment, discrimination and racism experienced by doctors, and is hosted by the Royal Australasian College of Medical Administrators (RACMA).

The project team extends its sincere gratitude for the invaluable support provided by various associations and organisations, including the 16 specialist medical colleges, which have played a pivotal role in supporting the project and its working and reference groups.

Further Information and Support Services

Bullying, harassment, discrimination and racism are challenging issues. Reading this document may bring up strong feelings. Free and confidential 24-hour support services are available online and via telephone.

If you or someone else is in immediate danger, call emergency services on 000.

The National Sexual Assault, Domestic and Family Violence Counselling Service, 1800Respect, provides support for people who have experienced, or are at risk of experiencing, violence and abuse, including sexual violence. It also contains an online searchable database to locate services in your area. Call 1800 737 732 or visit www.1800respect.org.au.

For confidential and qualified advice over the phone for any doctor or medical student in Australia, call Drs4Drs on 1300 374 377 or visit www.drs4drs.com.au, available 24/7.

For crisis support or suicide prevention services, call Lifeline on 13 11 14 or visit www.lifeline.org.au. For non-crisis mental health support, call BeyondBlue on 1300 22 4636 or visit www.beyondblue.org.au for more information.

Safe Work Australia can be accessed at www.safeworkaustralia.gov.au for information about work health and safety and workers' compensation.

The Fair Work Ombudsman can be accessed at www.fairwork.gov.au to learn more about pay, leave and other entitlements and workplace protections or to report a workplace issue, including anonymously.

The Australian Human Rights Commission can be accessed at www.humanrights.gov.au for information about discrimination and human rights, including how to raise a complaint.

Accessibility

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1.0 Executive Summary

1.1 Executive Summary

Workplace culture will be a key determinant of the health sector's ability to navigate many challenges of our time including workforce sustainability, high-quality patient care and environmental resilience. Despite strong engagement and a huge amount of work from a wide array of healthcare organisations, progress has been hampered by a lack of shared conceptual understanding and common learning outcomes. This curriculum aims to address that gap.

The environmental scan across a wide range of healthcare stakeholders identified seven gaps:

- Existing curricula often assume a traditional career arc, which does not recognise the diversity of our current workforce
- The term 'Culture' is used with many different meanings in healthcare
- There are many resources for learning but few resources for assessment
- Culture is created collectively, but reporting systems focus on individuals
- Workplace culture and cultural safety are often presented in deficit discourse, rather than as opportunities or strengths
- There is very little consistency or asset-sharing between organisations
- In addition to learners and trainers, organisational leadership has a key role in establishing culture and should have equivalent curricular support

A recursive consultation process has been undertaken over 16 months to develop a unified curriculum. Consultation has included all levels of education from medical school to retirement, a wide array of clinical and non-clinical medical practice (patient care, education, administration, consultation, legal etc), all specialist medical college members of the CPMC, and all states and territories. Consultation has been additionally supported by subject matter experts and the project's reference groups.

The curriculum defines 10 outcome areas across the four AMC domains. Separate curricula apply to organisational leadership, trainers and learners. Each curriculum is further developed into levels one to three, reflecting novice, intermediate and expert performance. A resource list and possible assessment modes are also suggested.

Culture is a complex phenomenon. Although the challenges of curricular implementation cannot be fully anticipated, six likely barriers are examined. Each is accompanied by suggested strategies underpinned by scholarship drawn from education, neurobiology, sociology, business, and Aboriginal and Torres Strait Islander studies:

- Perceived threat to professional identity
- The neurobiology and social advantages of bias
- Assumption of non-diversity and fragmentation of efforts
- Sustainability of change

- Applying simple solutions to complex problems
- The lack of an operational model of cultural safety for the Aboriginal and Torres Strait Islander workforce in the Australian healthcare context

Poor culture continues to harm patients, staff and healthcare organisations, while good culture remains a largely under-recognised and untapped resource for substantial gains. A unified curriculum is an essential roadmap towards a better culture and better healthcare.

2.0
Gap Analysis

2.1 Gap Analysis

Existing curricula often assume a traditional career arc, equating seniority with both leadership and learnedness. This is inconsistent with the modern world, where doctors may have multiple arcs within their professional career, both simultaneously and sequentially. It is no longer unusual for doctors to have significant leadership roles early in their careers, to be simultaneously expert in one role while novice in another, or to take unconventional career pathways in favour of roles that better fit personal values. At the same time, there is increasing scrutiny of the assumption that becoming more 'senior' automatically means commensurate expertise in all relevant competencies, particularly competencies that are newly emerging. For example, being a senior clinician does not always indicate a senior level of cultural safety knowledge and practice, which has implications for expectations that they will assess the same knowledge and practice of learners under their supervision.

'Culture' is a term with a multiplicity of meanings. The most relevant to the work of A Better culture are cultural safety (pertaining to and defined by Aboriginal and Torres Strait Islander peoples), and workplace culture. The environmental scan showed that organisations often treat these two meanings separately instead of understanding and presenting them as significantly overlapping. Cultural safety education is often pitched at an introductory level that does not match the complexity of healthcare and often avoids challenging discussions about how to manage bullying, discrimination, racism or sexual harassment arising from impacts of colonisation and ongoing colonial practices. It also almost exclusively casts Aboriginal and Torres Strait Islander people as patients rather than trainees, peers or senior staff. 'Workplace culture' education about bullying, discrimination, racism or sexual harassment often focuses on formal definitions and reporting pathways, makes no mention of Cultural Safety, and fails to demonstrate the connection in the workplace experience of Aboriginal and Torres Strait Islander colleagues. These courses similarly often avoid challenging discussions about intersectionality and the possibility of multiple truths for the same behaviour when viewed through different cultural lenses, including Aboriginal and Torres Strait Islander cultures.

There are many resources delivering education about culture, but few resources for assessment of learning. Assessment is part of the education triad of curriculum, pedagogy and assessment. The environmental scan showed that many organisations have curricula, and some organisations are starting to develop pedagogy, but there are not yet resources to assess performance in workplace culture or cultural safety except for medical students (new AMC outcomes 2023), and postgraduate years (PGY) one and two (AMC prevocational program 2025). The lack of defined assessment outcomes compounds the problem of learners being assessed by trainers who may never have been required to demonstrate the required competence themselves. In the absence of assessment tools, organisations predominantly rely on 'tip of the iceberg' reporting to prompt responses to incidents signifying poor culture, such as bullying, discrimination, racism or sexual harassment. This surfaces only the most egregious behaviours, treating poor culture as an exception rather than the commonplace and intersectional phenomenon consistently demonstrated in detailed longitudinal data.

The need for valid assessment is even more apparent when considering cultural safety curricula. Cultural safety is not self-defined – it is determined by patients, communities and colleagues impacted by healthcare practices. Therefore, assessment tools must be co-designed and endorsed by Aboriginal and Torres Strait Islander communities to ensure they reflect real experiences, not institutional perspectives.

Reporting systems are targeted at individuals, but culture is created collectively. This has a twofold effect. Firstly, 'zero tolerance' approaches have proven ineffective when reporting mechanisms are designed to manage singular 'bad apples' instead of addressing systemic antecedents. Secondly, individuals act in ways to protect themselves from risk that are paradoxically counterproductive to progress towards a better culture. They might for example, choose not to speak up about a patient safety issue for fear of being seen as a bully, or they may choose not to research in gendered or Aboriginal and Torres Strait Islander health topics because the additional systemic challenges of doing so (and the consequences of falling short) are shouldered by an individual Principal Investigator[1].

Culture narrative is often a deficit narrative. There is much more literature, organisational effort and resources expended on poor culture than on good culture. This asymmetry is seen in curricular structures, where education about bullying or discrimination is often mandated while education about good culture, such as team building, healthy work practices and strengths-based leadership are discretionary. Similarly, reporting systems for poor behaviour are often formalised and systematic while positive reporting pathways are absent or serendipitous. The environmental scan shows many examples of organisational policies for managing reports of poor behaviour such as bullying, but not a single formal policy for managing reports of good behaviour, such as routine feedback to the person and their manager. A shift to a more balanced, aspirationally framed culture narrative will mirror important parallel shifts in safety and healthcare, for example from Safety I to Safety II framing[2] or from psychopathology to positive psychology[3].

An exemplar shift from deficit discourse to strengths-based approaches

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Historically, curricula on Aboriginal and Torres Strait Islander health often focused on a deficit discourse, emphasising disparities, poor health outcomes and systemic failures. While these realities remain important to acknowledge, this approach failed to recognise the strengths, resilience and innovations within Aboriginal and Torres Strait Islander communities. In recent years, there has been a deliberate shift in universities towards strengths-based approaches, which centre self-determination, community leadership and Indigenous knowledge systems in health education.

There is a vast array of training modules about culture, but very little consistency or asset-sharing between organisations. This leads to mismatch in understandings of core concepts and expected behaviours. This is also a missed opportunity to amplify learning, rather than duplicate it, because doctors end up doing similar modules at the same level of learning rather than advancing their understanding over time. The fragmentation of education delivery means generational differences in expectations from medical school to the end of the career remain unaddressed.

At an organisational level, it leads to poor vertical consistency in organisational hierarchies as well as poor horizontal consistency between organisations.

Organisations are not seen to be 'learning' in the same way as clinical staff and students. Students and trainees in medicine, nursing, and allied health have curricula and learning outcomes, with continued CPD as practitioners to the ends of their careers. This individual commitment stands in stark contrast to the lack of learning curricula or CPD for organisations as a whole, even though many organisations claim to be 'learning organisations'. Accreditation standards are insufficient, being static measures that do not recognise the baseline state (learning needs analysis), the local contexts and resources (learning environment) or the desired outcomes for each organisation (learning goals). Although organisations are 'structured groups of people with a particular purpose' rather than individuals, the mismatch between cultural expectations of doctors and the systems in which they are expected to work came up repeatedly in Working Group discussions as a source of significant moral distress. Organisations – which in practice means organisational leadership, both clinical and non-clinical – should expect to set learning goals and be assessed against them in the same way as clinical staff. This may have the added benefit of collectively avoiding duplication and wastage of efforts towards meeting standards that do not always recognise the diversity of organisations across Australia.

3.0 Curriculum Logic

3.1 Curriculum Logic

The volume of human knowledge is rapidly increasing, and expectations of learners – including organisations – are changing from 'what' is known to 'how' to perform in complex systems and towards the 'why' of desired endpoints. Additionally, the ability to apply critical thinking and discern 'which' data to trust is an emerging skill with the advent of artificial intelligence. Bloom's taxonomy, a staple of educators since the 1950s, is more important than ever, and learners must function at the higher levels to perform well. This has been built into the curriculum with a steady progression from outcomes describing or defining knowledge (recall) to outcomes interpreting existing knowledge (apply) or developing new knowledge (create).

This shift aligns with Aboriginal and Torres Strait Islander pedagogies, which emphasise learning as a relational, reflective and context-driven process. Aboriginal and Torres Strait Islander ways of knowing – such as deep listening, yarning-based learning and learning through Country – mirror contemporary educational shifts that prioritise systems thinking, lived experience and ethical decision-making.

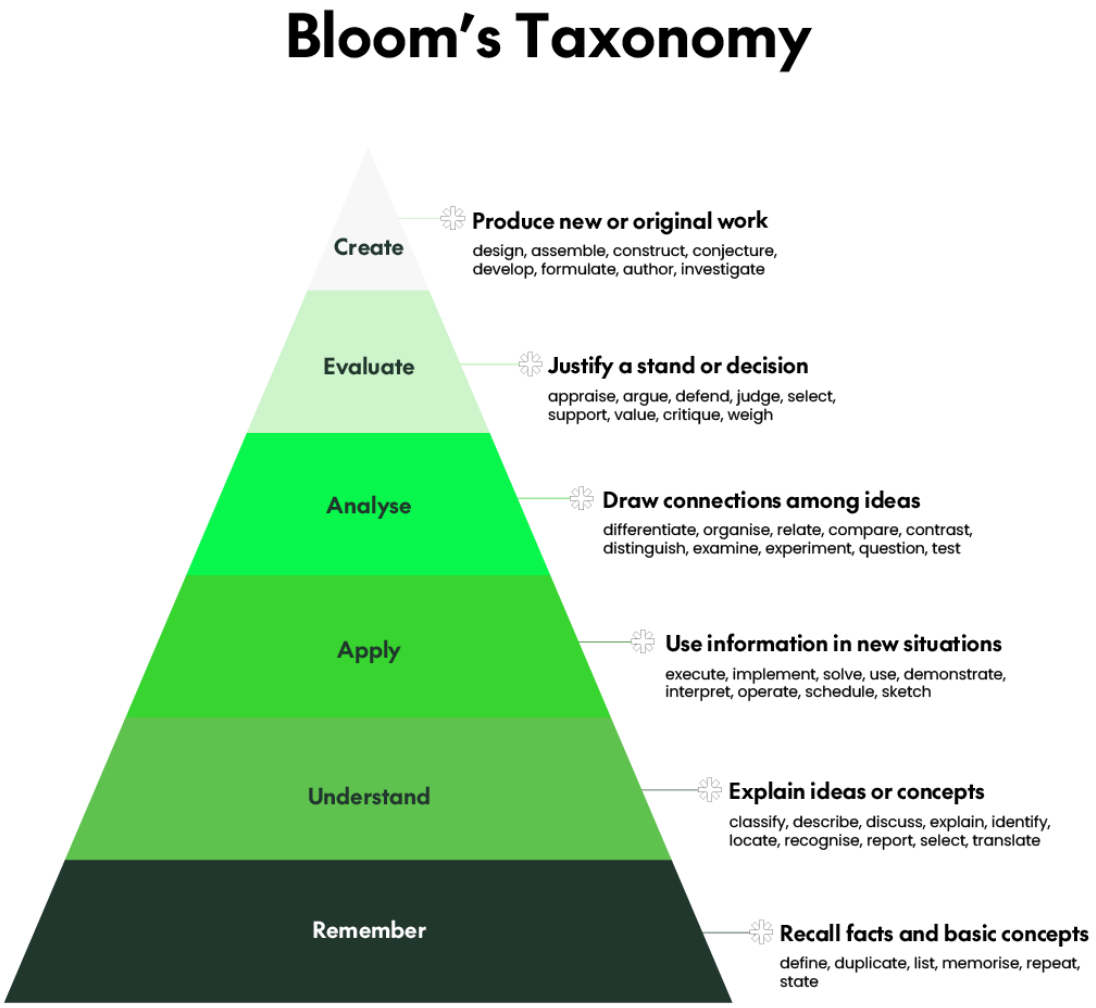

Figure 1: Blooms Taxonomy is a way of categorising learning outcomes by cognitive complexity. Trainers and learners in medicine should be competent at higher levels. Adapted from

https://www.researchgate.net/figure/Blooms-taxonomy-Vanderbilt-University-Centre-for-Teaching-and-Anderson-and-Krathwohls_fig1_357095596

The rapid increase of knowledge includes education theory and research. Considering the demanding nature of learning medicine and the consequences of not teaching it well, the expectations of professionalism in education should be higher, not lower. In this curriculum, core educational concepts are therefore used as a given; readers unfamiliar with these concepts are encouraged to utilise the resource list[4-6].

Teaching competence should not be assumed simply based on seniority but rather developed through structured learning and mentorship. This reflects Aboriginal and Torres Strait Islander pedagogical principles, where knowledge is shared through reciprocal learning, mentoring and community engagement rather than simply passed down in a hierarchical model.

The Working Group began with an early-mid-late career scaffold. This evolved into a junior-mid-senior scaffold with the aim of recognising that modern career arcs mean that being 'junior' can occur in late career, or vice versa. This evolved further into the current levels one to three, addressing unhelpful connotations associated with terms such as 'junior' or 'senior'.

True cultural change requires collective, long-term commitment rather than reliance on individual leaders. This aligns with Aboriginal and Torres Strait Islander governance models, which emphasise relational leadership, shared responsibility and long-term knowledge stewardship. By incorporating these principles, the curriculum recognises that leadership is not just about formal roles but about creating environments that support collective learning and change. While Learner and Trainer curricula are extended from existing curricula identified in the environmental scan, there were no equivalent curricula identified for organisations. The curriculum for organisations is therefore developed *de novo* based on existing accreditation standards and recursive rounds of consultation (modified Delphi process) involving the Working Group, the Supervisors and Educators Reference Group, and identified subject matter experts. Based on current socioecological models of personal development, the curricula are presented from system level to individual level, i.e. Organisational Leadership first, then Trainer, then Learner. This recognises the contextual and sociocultural nature of learning and makes clear that a suitable organisational environment is a prerequisite for expectations of Trainer or Learner performance.

To facilitate integration into existing programs, the curriculum uses the four AMC learning domains of Practitioner, Professional and Leader, Health Advocate, and Scientist and Scholar[7]. The choice of the AMC domain structure reflects the specific scope of A Better

Culture, namely, medical workforce. However, care has been taken to optimise the potential for adaptation to other health profession contexts and cohorts. Ten core competencies have been identified for this first curriculum and mapped to the four domains. While this necessarily omits some competencies, it is hoped that users will find the core curriculum a useful structure from which to develop additional outcomes to meet local needs or priority areas.

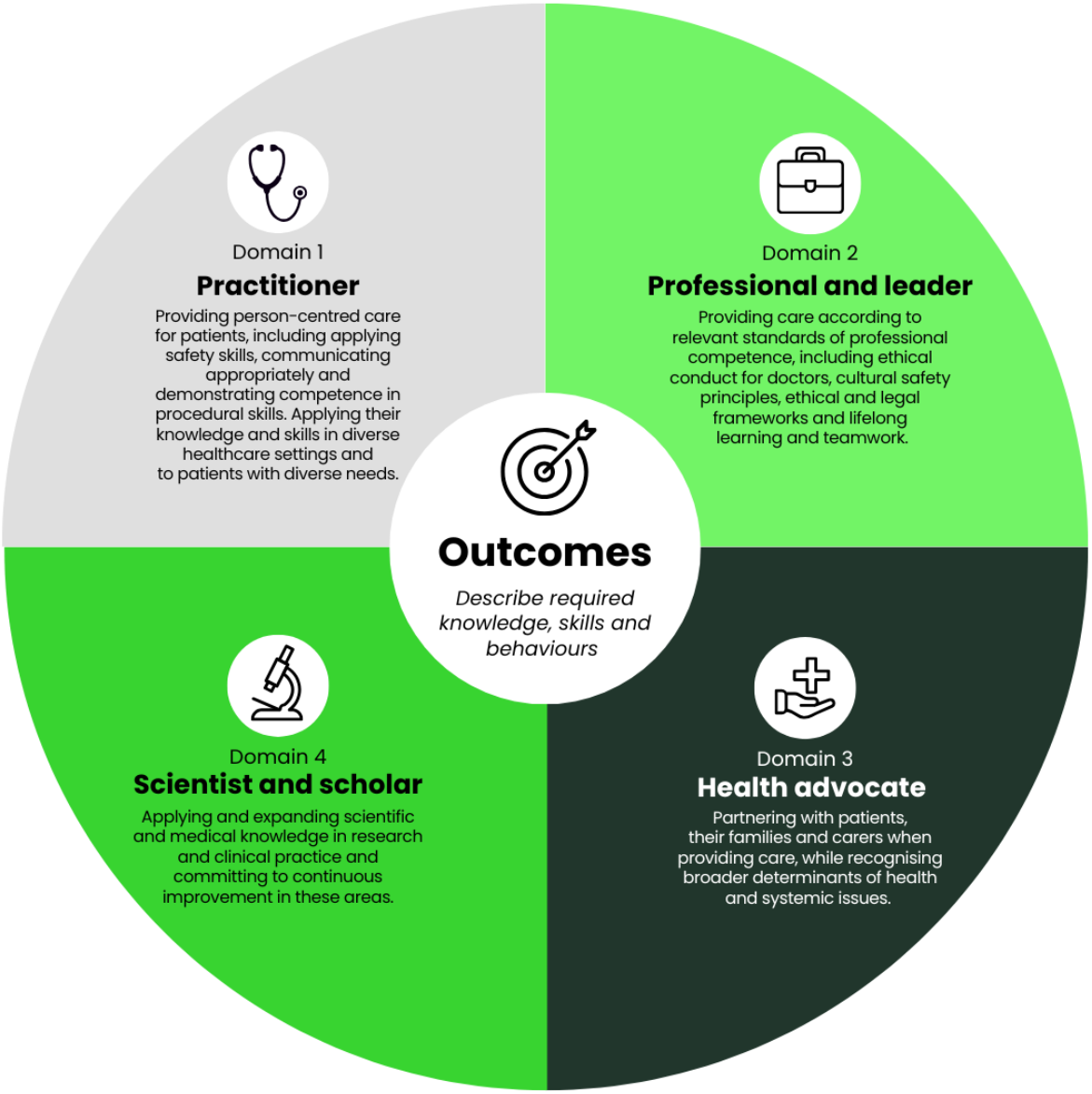

Figure 2:The four AMC curriculum domains required for accreditation of medical education programs. Adapted from https://www.amc.org.au/wp-content/uploads/2023/08/AMC-Medical_School_Standards-FINAL.pdf

Core Curriculum Outcome Mapping		
Domain	***Outcome suffix***	***Outcome descriptor***
Domain 1 **Practitioner**	.1 .2 .3	Self-awareness and behaviour Cultural safety Addressing bias and discrimination
Domain 2 **Professional and leader**	.4 .5 .6	Respectful workplace behaviour Establishing and sustaining psychological safety Intersectional approaches to diversity
Domain 3 **Health Advocate**	.7 .8 .9	Trauma-informed care Healthcare advocacy Working for equity in systems
Domain 4 **Scientist and Scholar**	.10	Evidence-based practice

Outcomes are defined at three levels reflecting novice (foundation), intermediate (application) and expert (sustainable) performance.

Levels are additive, not stand-alone. In other words, someone practising at level three should also be demonstrating levels one and two. Levels for learners are approximated to PGY to match AMC outcome statements but can apply to learners at any career stage based on learning needs. Trainer levels correspond to the Learners they are training or supervising.

- Level 1 maps to AMC graduate level - what is expected for a learner newly graduated from medical school or a rrainer of such a learner.
- Level 2 maps to entry to specialty training, nominally PGY 3-5, or a Trainer of such a learner.
- Level 3 maps to specialist consultancy and beyond, or a trainer of such a learner.

This definition of levels one to three proved to be insufficient for the organisational leadership curriculum, as this includes non-clinical leaders who may not follow a clinical career arc. The levels for organisations therefore follow a change program logic, which will aid organisations intending to develop internal learning plans or action rubrics.

- Level 1 outcomes are expected of organisational leaders in personal learning and performance.
- Level 2 outcomes are expected of organisational leaders interacting with systems in the organisation.
- Level 3 outcomes, at a high Bloom's level, are intended to drive innovative change. It is expected that few leaders will currently be performing at this level. This level is an aspirational roadmap, but in keeping with complexity theory it is also the level that holds the most potential for unanticipated change. This level should therefore be viewed as a living document that should continue to be adapted based on user feedback over successive implementation cycles.

The term 'patient' is used throughout the curriculum to reflect the patient-centred nature of healthcare but should be replaced with an appropriate term where organisational leadership, trainers or learners are non-patient facing, for example with 'students' for educational organisations or 'members' for professional colleges. Additionally, recognising that patients are *people* even when they are not in a patient role, the term 'patient' is used for role clarity (to avoid confusion with leaders, trainers, students or members who are also people) and encompasses holistic person-centred care.

As the first curriculum of this type, this can only be considered the starting point. The social environment is changing rapidly, often in unpredictable ways, and a curriculum is only useful for as long as it is being used at higher Bloom's levels itself – being recursively and responsively interpreted, appraised and re-developed. Feedback is welcomed and it is hoped that users will share their own efforts, successful or not, in a community of organisations, trainers and learners dedicated to creating a better culture.

Individuals and organisations who wish to provide feedback on the A Better Culture Curriculum should contact Cris Massis, CEO of RACMA, who will be continuing this work after the close of the project in June 2025.

3.2 Gaps this Curriculum Addresses

This curriculum aims to:

- Shift from a deficit narrative to a strengths-based, aspirational approach. While existing measures to address workplace issues – such as reporting systems – are essential, they alone do not create cultural change. This curriculum builds upon existing actions to foster a proactive, learning-oriented culture rather than focusing solely on remediation.
- Align expectations between organisational leadership, trainers and learners. This curriculum makes clear that workplace culture is shaped collectively, bridging the gap between the prevalence of poor behaviours and the discrepancy in formal reporting. While formal processes will always be necessary for serious misconduct, sustainable cultural change requires systemic learning at all levels of an organisation.
- Integrate Aboriginal and Torres Strait Islander cultural safety within workplace culture. Cultural safety of colleagues is not separate from workplace culture – it is the result of a workplace culture that is willing to embrace different ways of thinking, learning and doing. This curriculum promotes an everyday, organisation-wide commitment to cultural safety, rather than treating it as relevant only when working with Aboriginal and Torres Strait Islander patients. It also broadens workplace culture discussions to address the full spectrum of harmful behaviours, including those that may be subtle or unintentional when viewed through a dominant sociocultural lens.
- Provide a common framework for consistency and collaboration. A shared curriculum reduces duplication of efforts, encourages asset-sharing, and enables organisations to recognise prior learning. This approach supports progressive learning, ensuring that staff advance their understanding rather than repeating the same content at the same level. Additionally, although this curriculum is primarily designed for the medical workforce, it is also intended as a core reference for collaborative interprofessional work, such as with diversity and inclusion initiatives, educators, nursing and allied health.

3.3 Gaps this Curriculum does not Address

This curriculum does not:

- Provide specific resources for pedagogy or implementation. While useful resources have been identified in the environmental scan and through expert consultations, users are encouraged to map the curriculum against existing resources, identify learning gaps, and develop materials that suit their local needs, contexts and priorities. The curriculum provides a common language and framework to support resource-sharing and collaboration across sectors.
- Provide a fully developed assessment framework. Assessment is identified as a critical gap by the Working Group. While suggested assessment modes are included for each curriculum, it is recognised that organisations must tailor assessments to their existing structures and priorities. This curriculum provides a foundation for organisations to develop and embed their own cultural safety assessment tools.
- Substitute for proper consultation with relevant groups when developing curriculum-related resources. Additionally, where groups are under-represented, such as Aboriginal and Torres Strait Island peoples, the consultation process must centre and respect the additional labour.
- Define structures for governance, maintenance, reporting or accreditation of the curriculum. This will be necessary subsequent work and will be greatly enhanced if there is strong leadership and collaborative integration both vertically (organisational to collegial, state and federal) and horizontally (across organisational and collegial networks, and to interprofessional craft groups such as nursing and allied health). Additionally, it is recognised that organisations are currently at different stages of the culture journey, and a diverse range of approaches will be appropriate initially towards eventual curricular alignment.
- Specify an ongoing research program or the necessary evidence for demonstrating efficacy. Existing organisational reporting systems and quality assurance procedures may require further development to align with curricular implementation, especially with regard to addressing under-reporting and detecting unintended effects. Academic activity such as research and dissemination will also support curricular implementation, and will require necessary resourcing.

4.0 Anticipated Barriers and Suggested Strategies

4.1 Anticipated Barriers and Suggested Strategies

Perceived Threat to Professional Identity

The respect accorded to doctors and leaders has traditionally rested on specialised knowledge in their field. The goal was unconscious competence – the ability to perform expertly without apparent stress. While specialised knowledge and competence are still expected, the goal is now reflective competence[8,9] – a metacognitive concept encompassing humility, self-awareness of knowledge gaps and the skills to address identified gaps. This concept has been developed because unconscious competence embeds heuristics and behaviours based on unconscious biases, both good and bad. Heuristics are necessary for efficient performance during routine work (unconscious competence) but experts must also have a higher-level ability to recognise when emerging evidence requires conscious departure from heuristics in order to avoid cognitive errors (reflective competence). While experience allows clinicians to make quick decisions under pressure, it can also lead to assumptions and patterns of thinking that go unchallenged, which may result in errors or blind spots, particularly in areas like cultural safety and equity.

Doctors who have succeeded through long training programs requiring individual performance and an extensive knowledge base may perceive this as a challenge to their professional identity because it implies re-entering a novice state. It requires acknowledging knowledge gaps and being open to new ways of thinking and learning. The expectation is no longer just about what an individual knows but about how they adapt, collaborate, and make informed decisions within complex systems.

The expression of reflective competence from learners who may be better trained in metacognitive learning skills than previous generations may even be perceived as a threat to the medical profession. Examples include expressions such as ‘students these days don’t know enough’ or ‘back in my day we were expected to do this [skill] by internship’.

To address this barrier, healthcare culture must normalise the reality that no individual can ‘know it all’. Rather than expecting professionals to master all knowledge personally, the focus should be on:

- Recognising when additional expertise is needed and collaborating across disciplines
- Developing leadership skills in delegation, consultation and system-based decision-making
- Evolving CPD structures to explicitly value reflective competence alongside technical expertise

By embedding reflective competence into medical education and leadership frameworks, the health sector can create a learning culture that prioritises adaptability, inclusivity and ongoing self-assessment – all of which are fundamental to cultural safety and systemic change.

The Neurobiology and Social Advantages of Bias

The neurobiology of bias can act as a powerful barrier to culture change because it is encoded in areas of the brain that relate to survival, personal identity and emotion[10].

Humans hold negative biases towards those who are different to themselves, which are thought to have conferred an advantage in times when split-second recognition of 'the other' could mean the difference between survival or death[11]. In some modern-day circumstances, such as walking alone at night, these biases may still have a protective function by raising our alertness towards anyone unfamiliar.

By defining 'the other', and therefore what a person is not, biases are also thought to play an important part in the development of personal identity – a process which is thought to begin before the first birthday and continue through adulthood.

Cognitive biases are thought to be largely encoded in the amygdala at a subconscious level. Unless there is activation of the other areas of the brain such as the prefrontal cortex to cause awareness, bias against 'the other' can act in the workplace to cause differential treatment of others. This can occur even when the person believes they are 'treating everyone the same', because responses are reflexive and do not reach a person's consciousness. Social advantages such as power or belonging can then reinforce the action of cognitive bias, again often at a subconscious level. The double action of cognitive bias and social reinforcement acts to powerfully suppress actions that breach social norms, such as speaking up.

Because biases are encoded in the amygdala, they are also strongly tied to emotions. Anger, fear, defensiveness or guilt are common responses when personal biases are challenged.

Data showing evidence of differential treatment, such as disparities in recognition despite equivalent achievements, can be powerful external feedback to the effectiveness of bias correction. It is important to note that evidence of differential treatment is not problematic in itself, as there may be very reasonable justifications, such as addressing a historical inequity to better meet patient needs. However, negative biases that remain unconscious, when multiplied across groups of people holding similar biases, can result in specific groups experiencing structural oppression enacted through innumerable daily decisions such as who to share information with, who to allocate tasks to, and which characteristics are valued for recognition[12, 13].

Recognising and addressing bias is not about blame or guilt but about building self-awareness and fostering psychosocial and cultural safety in workplaces.

In healthcare, bias often manifests in who is seen as 'leadership material', whose voices are amplified in decision-making, and how patients are assessed and treated. Without intervention, subconscious bias influences daily decisions, from hiring practices to patient outcomes, contributing to inequitable experiences and access to care.

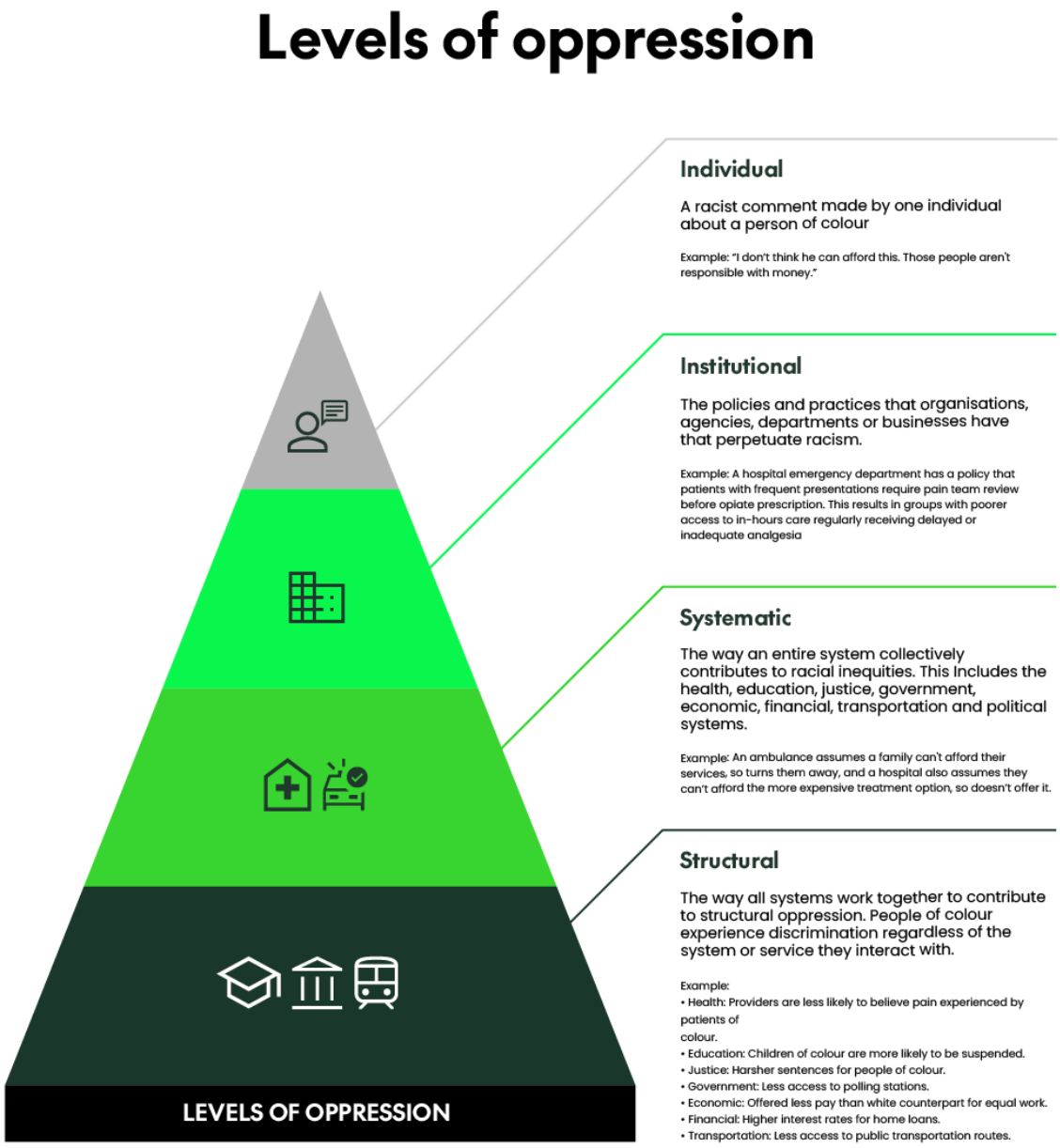

Figure 3: Oppression manifests at different levels: individual, institutional, systemic, and structural. Bias must be addressed at all levels because they are interconnected and reinforce each other. Adapted from https://ofm.wa.gov/sites/default/files/public/shr/Diversity/SubCommit/EquityLanguageGuide_Final.pdf

Correcting for individual bias therefore has three prerequisites: knowledge of ones' own biases, a conscious effort to overcome them, and sufficient emotional intelligence to recognise and manage concurrent emotional responses. Translating a collective change in individual biases into correction of structural bias additionally requires leadership actions to minimise powerful social disincentives to speaking up, while maximising moral, social or actual incentives to act, sufficient to overcome the sense of personal risk.

This in turn should lead to powerful adjustment in the design and implementation of workplace policies, leadership pathways and accountability structures, ensuring that bias correction is not left to individual effort but is a shared organisational commitment.

Assumption of Non-diversity and Fragmentation of Efforts

People who identify with a dominant group, such as being male, being white or speaking English, may feel that they have no diversity. This can cause disengagement with diversity efforts or a perception that they are being excluded from resources directed towards diversity.

People who identify with 'diverse' characteristics, such as being a woman, identifying as Aboriginal and Torres Strait Islander, or being neurodivergent, may act in ways that are strongly informed by their lived experience. This authenticity is valuable in healthcare but can cause fragmentation of efforts due to a combination of under-representation (insufficient critical mass to form effective networks and low visibility to leadership) and a perception of unique goals compared to other groups.

The mechanism underlying both challenges is in-group bias. In-group bias means that people prefer others they perceive to belong to their own group, cognitively associating members of that group by emphasising traits shared in common[14]. This can be socially adaptive, such as children preferring other children of similar age, or veterans of armed forces finding support from other veterans. In workplaces, this can lead to unintentional exclusion, where dominant groups have greater access to mentorship, leadership opportunities and informal networks of support. At the same time, underrepresented groups may struggle to build influence and visibility within leadership structures, reinforcing workplace disparities.

However, in-group bias relies on cognitively minimising differences within the group while magnifying differences between the 'in-group' and other groups (out-groups), which are similarly cognitively associated by emphasising shared out-group traits. This process of creating stereotypes of one's in-group and other out-groups decreases cognitive load but creates a perception that diversity between groups is much greater than the diversity within groups, when the reverse is true. For example, there is far more diversity between all the women in a workplace, than there is between women as a group and men as a group – and yet it is still common that organisational diversity efforts will focus more on the differences between genders than between individuals.

A suggested solution is to move towards an intersectional lens[15, 16]. While the original formulation of intersectionality in the 1980s focused on the two dimensions of race and gender, current concepts of intersectionality propose that everyone has diversity across many dimensions of diversity extending well beyond visible or legally protected characteristics[17].

An intersectional lens strengthens cultural safety by ensuring that diversity efforts are not siloed into isolated initiatives. While different groups have unique needs, an equity-focused approach recognises shared systemic barriers and works towards collective solutions.

This means embedding intersectionality into leadership development, workforce policy and accountability structures –not just diversity training or inclusion programs.

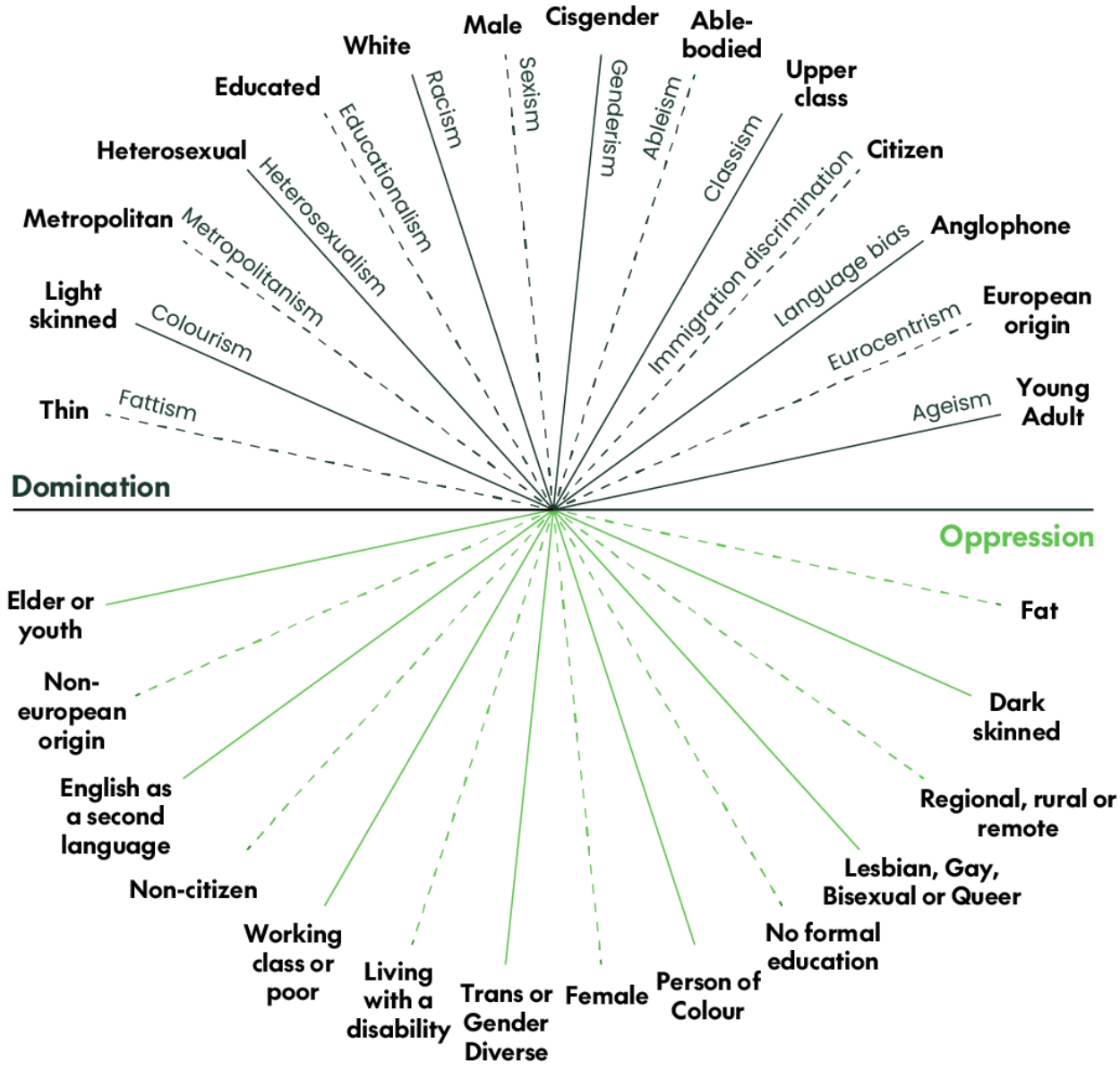

Figure 4: Each person will have a different 'heatmap' against the intersectionality wheel. Within the same team there may be individuals who predominantly experience domination, predominantly experience oppression, or a mix of both. 'Treating everyone the same' overlooks intersectionality and reproduces inequity. Workplaces are more equitable when they recognise and actively address intersectional disadvantage. Adapted from the Association for Women in Science https://awis.org/intersectionality/

An intersectional lens addresses assumption of non-diversity by showing how everyone has diversity and valuable insights to contribute to diversity work. An intersectional lens similarly avoids fragmentation of efforts by showing how oppression arising from different aspects of a person's identity overlap and interact. While there must always be attention to differing group-specific needs, the shared experience of oppression extends across multiple dimensions, providing a common basis from which to work together for equity.

Diversity and inclusion efforts in healthcare settings must therefore be framed within the broader commitment to intersectional diversity.

An intersectional lens recognises that workplace systems, leadership decisions and policies must be actively structured to support all staff, especially those from underrepresented backgrounds. This overarching approach does not replace the need for a specific focus on cultural safety, which is a First Nations-created concept and in Australia, applies to the distinct experiences of the Aboriginal and Torres Strait Islander people. However, a culture that respects diversity creates the environment where cultural safety may be more fully embedded and maximally impactful.

Sustainability of Change

Despite broad agreement about the benefit of culture change and high levels of leadership support, resource constraints remain a persistent barrier to sustaining required work.

Financial and material constraints are ubiquitous and will require careful and strategic prioritisation. Cognitive and labour constraints are less obvious. Change initiatives require vast amounts of cognitive effort – to conceptualise, to lead and to practise new ways of working until they become habitual. The resulting change fatigue leads to staff disengagement, and increased rates of burnout and staff turnover. The risk of change fatigue is higher in busy or stressful units due to insufficient available cognitive load (often colloquially termed 'limited bandwidth')[18, 19] which is often a 'new normal' state as population healthcare needs continue to increase relative to available resources.

Similarly, change requires large amounts of additional labour – for communication, planning, implementation and evaluation. In clinical environments there is evidence that the additional demands of change, when poorly supported, can increase patient error due to diversion of necessary cognitive space and labour. To avoid the potential harms of additional labour, it is therefore suggested that culture change efforts begin with decisions about what to stop or phase out. These may be hard decisions. Almost every healthcare organisation has by now grappled with the challenges of workplace culture, but where these efforts have been ineffective, there should be a willingness to innovate even if existing initiatives are strongly linked to organisational narratives and significant sunk cost.

The cognitive and labour requirements of culture change are often distributed unevenly with more demanded of the under-represented group, with a mismatch between these requirements and the allocation of financial and material support. It is not uncommon to find that a person contributing key cognitive expertise and labour, such as a consumer advocate or person with lived experience, is the least well remunerated person in the room (assuming they are in the room and remunerated to begin with, which is not always the case). This is a structural issue, not an individual oversight – and when leadership fails to properly resource and recognise these contributions, it erodes trust, reinforces exclusion, and makes long-term change unsustainable.

Strategies for organisational change abound – i.e. Lewin's change management model, McKinsey's 7-S framework, Kotter's eight steps for leading change and so on. The choice of change strategy will be determined by local context and expertise. However, the unique characteristics of changing culture – 'the way we do things around here' – adds three key considerations for success[20-23].

- Justice

  A perception of interpersonal justice predicts pro-change behaviour. This will be absent in environments where there is normalised disrespect, conveyed through interpersonal behaviour, or inequities of resource allocation, recognition or power. Pro-change behaviour is additionally mediated by organisational identification. It is not difficult to see how culture change can fail when detailed longitudinal data indicates a high baseline prevalence of disrespect and inequity, and where large portions of the medical workforce rotate from one organisation to another.

- Trust

  Trust is built through transparent decision-making, shared power and meaningful action. Many organisations promote ‘engagement’ and ‘socialisation’ of new cultural initiatives, yet real power over funding, policy and implementation often remains concentrated in existing leadership structures.
  In these circumstances, cultural reform initiatives risk being performative rather than transformational. Potential participants in culture change want to see evidence of change before engaging in followership, especially in low-trust contexts (arguably the majority of healthcare organisations, based on current prevalence data about disrespectful behaviours). Leaders should not be afraid of flattening or reversing hierarchy, distributing power and examining where usual ways of working may negatively impact trust.

- Time

  It goes without saying that prior behaviour counts. People with memories of a leader or colleague’s poor behaviour are unlikely to immediately trust newly changed behaviour, even when it is genuine. Similarly, it takes time to become aware of deeply held biases and to practise conscious correction until it becomes habitual. This is especially the case when biases rest on prior trauma, when awareness can be intensely painful and may require professional support. A common aphorism in culture change is ‘hurt people hurt people’ (i.e. people who have been hurt are more likely to hurt others). Reporting systems in organisations are often missing this trauma-informed lens, resulting in ongoing harm to both the enactor of the behaviour, whose causative trauma remains unaddressed, and the recipient (and future recipients) of the behaviour, who may not achieve resolution of their trauma and may indeed be retraumatised by the process of reporting. It is not difficult to see how poor culture can be intergenerationally transmitted and how much time is required to break this cycle. Organisations embarking on culture change need to be committed to it for at least as long as the training period of a new generation of specialists (years), if not as long as the career life cycle of existing specialists (decades).

Simple Approaches to Complex Problems

Simple, linear approaches to culture reform – such as one-off diversity training, mandated reporting policies or top-down interventions – often fail because they do not account for power imbalances, historical trauma or the lived experiences of those most affected by systemic inequities.

Sustainable cultural change requires an adaptive, complexity-informed approach, recognising that solutions must be contextual, community-led and responsive to ongoing feedback.

The RACS Building Respect project was launched in 2015 with the tenet 'the standard you walk past is the standard you accept', a phrase quoted in 2011 by then-Chief of Army David Morrison and attributed to then-Chief of the Defence Force David Hurley. In the first iteration of the project, this was explicitly linked to the concept of always speaking up when disrespectful behaviour was witnessed or experienced.

The initial 'speak up' model in the RACS Building Respect project failed to acknowledge differences in context, and especially how power, hierarchy and identity shape an individual's ability to act. It was an overly simplistic approach that caused disproportionate harm to doctors in training, leaving them with a Hobson's choice of speaking up and risking repercussions or not speaking up and being disbelieved later – "Well, why didn't you say something at the time?". For Aboriginal and Torres Strait Islander peoples, as well as other underrepresented staff, 'speaking up' often carries far greater professional and personal risk than for their senior or dominant-culture colleagues.

In response to this unintended harm, 'if you see something, you must speak up' has been updated to 'if you see something, you must act', with expectations for actions that differ between doctors at consultant and training levels. The higher-level Operating with Respect course[24] combines this with formal teaching about diversity, hierarchy and context as key modifiers of how behaviour is perceived. Additional considerations of change in complex adaptive systems in the Building Respect project include the 'system nudge' of training all surgical leaders to the higher level, and a learning mindset with regular reviews to integrate emerging scholarship and monitor for further unintended harms[25].

An expectation to 'act' must include systemic accountability – not just individual responsibility – ensuring that organisations actively protect and support those calling out unsafe behaviours.

Similar examples of harms arising from simple approaches to complex problems abound in healthcare – for example the discriminatory effects of criminalising marijuana use[26], or 'alarm fatigue' caused by too many automated alarms in monitoring equipment[27]. Zero-tolerance approaches to workplace culture may be another example, with the small amount of research so far showing excess reporting of women and non-white people[28, 29]. This would be consistent with the wider literature showing the harms of zero-tolerance approaches in education and law[30, 31]. The RACS Building Respect project chose to follow the lead of the successful Vanderbilt Center for Patient and Professional Advocacy by not using zero-tolerance language or approaches.

Increased complexity in healthcare highlights the limits of narrowly reductive approaches such as Randomised Control Trials (RCT) or Plan Do Study Act (PDSA) cycles, because single-factor interventions become ineffective within the interconnectedness of the larger system. In a similar way, attempts to standardise procedures or codify 'best practice' can become a point of brittleness, limiting the available solutions and especially the creativity and agility of responses to unexpected demands. In other words, the faster the pace of change, the greater the risk of failure in trying to apply fixed solutions to moving problems.

It is therefore not possible to prescribe 'solutions' to complex problems, only 'nudges'. However, there are guiding principles[33-37], a summary of which is presented in section 5.5, Guiding Principles of Effective Change in Complex Systems.

Some of these guiding principles are already intuitive to doctors because medicine is complex. Change is ever-present in patient care, and action is often required despite incomplete information. Other principles may pose a significant challenge to previous training, for example the decoupling of cause and effect. A necessary parallel development for this change will be training in research methodologies more appropriate to complex interventions[39], which may initially seem 'wrong' to clinicians trained in biomedical research paradigms designed to interrogate causality.

Furthermore, many of the principles of complexity science – such as adaptive problem-solving, relational accountability and recognising interconnected systems – are already embedded in Aboriginal and Torres Strait Islander knowledge systems. Cultural reform initiatives can draw on these Aboriginal and Torres Strait Islander ways of knowing, ensuring that change efforts reflect relational, iterative and community-driven approaches rather than rigid, one-size-fits-all policies.

Lack of an operational model of cultural safety for the Aboriginal and Torres Strait Islander workforce in the Australian healthcare context

The AHPRA definition of cultural safety is relatively narrow:

- Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.
- Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

The definition from Te Kaunihera Rata of Aotearoa (Medical Council of New Zealand) adds a requirement for practitioner acknowledgement of bias, makes explicit that expectations extend to non-clinical interactions as well as patient care, and does not limit the expectation of cultural safety to Indigenous peoples[39], consistent with some current scholarship[40]:

The Lowitja Institute has published a policy brief on Cultural Safety that explains why, in Australia, they do not support the broadening of the use of the term Cultural Safety to apply to other populations[41]. In particular, they note that whilst respecting the experiences and needs of culturally diverse peoples, this should not be conflated with the unique experiences and needs of Aboriginal and Torres Strait Islander peoples.

For this reason, and recognising that A Better Culture is funded by the Australian Government, whilst recognising the evolution in thinking represented by Curtis et al.[40], we continue to use cultural safety as a term that applies to Aboriginal and Torres Strait Islander peoples, and is defined solely by them.

Developing an operational model for workers rather than users of services, will require adequate and deep consultation with a sufficiently broad and culturally authoritative Aboriginal and Torres Strait Islander group, beyond what was achievable in the constraints of this project. Foundations for that discussion, including recommendations for governance are laid down in the report “Cultural Safety: From Compliance to Commitment”[42].

5.0
The Curriculum

5.1 The Curriculum

Organisational leadership

Domain	Level 1	Level 2	Level 3
Practitioner	O.1.1 Identify and manage personal triggers to maintain respectful behaviour towards others. Demonstrate actions that support others to maintain respectful behaviour. O1.2 Include cultural safety learning goals in appraisal and development plans of staff and peers. Use consistently culturally safe language in internal and external communications. O1.3 Provide resources for staff and peers to undertake self-assessment of implicit bias. Demonstrate how strengths-based diversity is considered in recruitment and promotion decision	O2.1 Demonstrate the effectiveness of systems that enable patients and staff to address workplace factors contributing to disrespectful behaviour in a timely manner. O2.2 Incorporate culturally safe practices in routine workflows in clinical and non-clinical workplaces. Demonstrate anti-racist actions and the centering of cultural expertise in engagement and practice. O2.3 Measure diversity work undertaken by staff and show how it is appropriately recognised as work. Consistently use strategies such as diversity matrices and equity lenses to inform planning and decision-making.	O3.1 Demonstrate behaviour modifications for culture and context. Evaluate performance in maintaining respectful team culture during events that challenge staff and system resilience. O3.2 Participate in a leadership community of practice that continuously updates organisational education, systems, and engagement to contemporary concepts of cultural safety. Integrate cultural safety measures into organisational reporting. O3.3 Assess markers of systemic bias in workforce inclusion data, including gender and race. Demonstrate strategies to address systemic bias and undertake audit cycles to assess their effectiveness.
Professional and leader	O1.4 Demonstrate learning activities to maintain current understandings about organisational culture. Show capability in upstander behaviour through leadership professional development plans or performance assessment. O1.5 Demonstrate understanding of psychological safety, and describe actions that have established a safe culture for disagreement from patients, their support networks, and members of staff. O1.6 Demonstrate reflection on personal intersectionality. Demonstrate skills to respectfully enquire about others' intersectionality and demonstrate how supporting intersectional strengths have improved team performance	O2.4 Assess and act on outcomes of processes for providing feedback about respectful and disrespectful behaviours to the individuals involved. Demonstrate behaviours that support processes to protect upstanders and notifiers. O2.5 Analyse organisational measures of psychological safety disaggregated to detect differences for specific groups, and lead improvement at unit or team level. O2.6. Show how intersectional considerations are integrated into planning and decision-making. Demonstrate actions taken to normalise non-stereotyped intersectional representation in organisational leadership and communications.	O3.4 Review methods used to assess respectful and disrespectful culture in the organisation and demonstrate changes made to reflect current understandings. O3.5 Demonstrate behaviours that maintain psychological safety for all participants in conflict management. Evaluate effectiveness of response to case-specific culture and context when addressing differing perceptions of psychological safety. O3.6 Design and evaluate innovations to support intersectional representation. Demonstrate how the innovation design recognises additional work and amplifies impact for intersectional contributors.
Health advocate	O1.7 Describe trauma-informed care and show how this is implemented through personal behaviours and staff support to improve patient outcomes. O1.8 Demonstrate respectful engagement with under-represented groups that improves representation at planning and decision-making level. O1.9 Include staff and patient equity metrics in leadership portfolios. Seek feedback and engage in reflective practice about leadership equity effectiveness.	2.7 Evaluate the effectiveness of systems for disclosing and managing trauma in staff and patients. Demonstrate planning and processes to manage the enhanced risks of trauma during exceptional events. O2.8 Review methods used for organisational data collection and reporting for ability to detect group specific trends. Evaluate the effectiveness of actions taken to reduce disparity. O2.9 Implement and assess pathways for patients to have equity-focused input into care delivery, and similarly implement and assess pathways for staff input into workplace processes.	3.7 Develop pathways to support trauma recovery and post-traumatic growth in staff and peers. Show how cultural and contextual considerations are incorporated to recognise the diverse range of trauma responses. O3.8 Demonstrate engagement with under-represented groups. Show how this informs anti-discrimination actions and integration of cultural understanding into organisational ways of working, caring, and evaluating. O3.9 Demonstrate capability for managing the ethical challenges of balancing equity requirements of different individuals and groups.
Scientist and scholar	O1.10 Continuously appraise current evidence about A Better Culture and show how this informs actions towards organisational culture change. Engage with Aboriginal and/or Torres Strait Islander communities to co-design education and assessment resources.	O2.10 Demonstrate facilitation of interprofessional, inter-organisational or inter-sectoral collaboration in culture projects to amplify efforts of under-represented contributors and accelerate industry-wide learning.	O3.10 Support resource and governance requirements for research towards A Better Culture. Demonstrate actions that increase cultural research capacity or cultural capability in the organisation.

Trainer

Domain	Level 1	Level 2	Level 3
Practitioner	T1.1. Implement strategies to maintain respectful behaviours towards learners, recognising the potential for the increased cognitive load of being a trainer to be a personal trigger for disrespectful behaviour. T1.2 Describe cultural differences in systems of knowledge and pedagogical traditions. Adapt educational practice to maintain cultural safety for a diverse range of learners. T1.3 Undertake bias self-assessment and develop strategies to address the potential impact of personal bias on training behaviours and assessment of learners.	T2.1 Guide learners to recognise their own triggers and to develop personal strategies to maintain respectful behaviour towards patients and team members. Provide opportunities for learners to practice conflict management. T2.2 Provide resources and facilitate opportunities that improve learners' capability to deliver culturally safe care. Incorporate learners' cultural identities into learning plans. T2.3 Provide feedback to learners about behaviours that may convey bias to patients and team members. Teach and model anti-discrimination actions in professional practice.	T3.1 Model and narrate professional behaviours to build learners' cultural knowledge. Demonstrate leadership to maintain respectful team behaviour in situations that may challenge learner resilience. T3.2 Build cultural safety and anti-discriminatory measures into education program design, including assessment. T3.3 Evaluate learner experience of bias and discrimination at unit level or higher, in ways that provide anonymity and safety for learners. Show what actions have been taken based on the results.
Professional and leader	T1.4 Describe how respectful and disrespectful behaviours influence learning, and define trainer actions that support respectful learning culture. T1.5 Describe how psychological safety supports effective teaching and learning. Apply strategies for gauging learner psychological safety. T1.6 Demonstrate self-awareness of intersectionality and how this may influence personal teaching practice. Use teaching and assessment strategies that support learner intersectionality that may differ from one's own.	T2.4 Model upstander behaviours when witnessing disrespectful educational interactions. Evaluate alternative choices of upstander behaviour for differing contexts and to maintain learner safety. T2.5. Explain how trainers and learners can have differing perceptions of psychological safety. Demonstrate teaching behaviours that encourage learner contributions and provide a safe culture for disagreement. T2.6 Seek feedback about the inclusiveness of personal teaching practice from intersectional peers and learners, using methods that respect their preferences regarding trust and safety	T3.4 Demonstrate leadership when made aware of disrespectful behaviour in educational settings. Identify when roles as clinician, trainer, assessor and employee result in conflicts of interest, and seek appropriate additional support. T3.5 Establish a safe learning culture by modelling vulnerability and narrating decision-making when there is uncertainty. Support learner admissions of error and guide learners to develop emotionally healthy ways of responding to error. T3.6 Audit the inclusion of intersectional perspectives in education materials used across the delivered curriculum. Centre intersectional voices in developing new material to address identified gaps.
Health advocate	T1.7 Describe the role of trauma in trainer and learner behaviours and define the aim of trauma-informed practice. Provide examples of trauma-informed practice in education. T1.8 Incorporate health inequity and the health effects of discrimination, including racism, into routine teaching by prompting learner reflection and discussion about under-represented groups. T1.9 Demonstrate strengths-based advocacy in assessment of learners, and skills in speaking up to prompting awareness of deficit-based narratives applied to learners.	T2.7 Demonstrate skills in respectfully enquiring about prior trauma in learners and education colleagues. Implement appropriate responses to disclosed trauma and show how training is modified to avoid retraumatisation. T2.8 Consistently model inclusive and anti-discriminatory behaviours as a trainer. Build learner capacity to advocate for patients from under-represented groups. T2.9 Identify where educational, social or physical resources are not inclusive, and implement actions to ensure access and equity for faculty and learners	T3.7 Identify educational contexts associated with increased risk of trauma. Develop strategies to minimise risk of learner trauma and detail measures taken to maintain faculty alertness for trauma. T3.8 Undertake mentorship, sponsorship, or coaching of learners from under-represented groups. Identify specific value that this has provided to their progression. T3.9 Evaluate faculty diversity and demonstrate actions taken to strengthen faculty performance through inclusion and representation.
Scientist and scholar	T1.10 Undertake professional development specific to education, recognising education as a competency for trainers that is distinct from practitioner competency.	T2.10 Articulate evidence linking respectful education cultures, learner performance, and patient outcomes. Incorporate evidence into personal reflective practice and workplace quality improvement.	3.10a (Clinical) Demonstrate leadership behaviours that communicate and reinforce evidence about respectful culture. T3.10b (Academic) Contribute or facilitate contributions to research and dissemination of research towards better cultures.

Learner

Domain	Level 1	Level 2	Level 3
Practitioner	L.1.1 Identify personal triggers that may result in disrespectful behaviours and apply strategies to maintain respectful behaviour. L.1.2 Use communication strategies that recognise diversity and establish a culture of inclusion in patient care and team interactions. Demonstrate understanding of Aboriginal and Torres Strait Islander knowledge systems and how they inform culturally safe care. L.1.3 Identify personal biases and describe their potential impact on clinical decision-making, team interactions, and patient care outcomes.	L.2.1 Determine the personal stressors of patients and members of their personal support networks. Implement strategies to maintain respectful behaviours, taking these stressors into account. L.2.2 Incorporate patients' cultural identities, beliefs, values, and preferences into treatment plans. Adapt communication strategies when using interpreters to achieve clarity, cultural sensitivity, and respect. L.2.3 Appraise behaviours that convey bias in self, patients, and team members. Demonstrate strategies to address negative impacts of bias on patient care.	L.3.1 Adapt personal behaviour by culture and context to meet differing expectations of respect to achieve optimal patient outcomes. L.3.2 Translate concepts of cultural capability, cultural humility, cultural diversity and cultural agility into personal behaviours that foster more inclusive team cultures. L.3.3 Evaluate systemic bias in routine workplace practices and demonstrate collaboration to establish or re-establish equitable workflows.
Professional and leader	L.1.4 Adhere to relevant Codes of Conduct, workplace health and safety, legislative and cultural safety policies relating to respectful workplace culture. L.1.5 Describe how psychological safety supports effective teamwork and patient safety. Demonstrate personal strategies for encouraging contributions from all members of a team. L.1.6 Demonstrate awareness of one's own beliefs, attitudes, and values, and how this shape personal professional practice. Provide examples of culturally safe and culturally unsafe healthcare behaviours.	L.2.4 Demonstrate behaviours that maintain respect in interactions with patients and team members, and initiate upstander actions, such as anti-racism actions, when witnessing disrespectful interactions. L.2.5 Articulate the role of productive conflict in psychological safety and act collaboratively to establish a safe culture for disagreement. L.2.6 Apply an equity lens to clinical decision-making, incorporating patients' cultural identities, values, and preferences into health interventions and treatment plans.	L.3.4 Implement routine workplace practices or structures that foster good team culture and normalise respect. Build team capability for supporting upstander actions. L.3.5. Assess indicators of psychological safety culture in teams. Demonstrate inclusive leadership when team members perceive a different level of psychological safety. L.3.6 Evaluate the effectiveness of equity actions through quality improvement or audit of personal practice.
Health advocate	L.1.7 Describe the principles of trauma-informed care, recognising the impact of trauma on individuals' physical, emotional, and cognitive states. L.1.8 Describe how specific needs and systemic barriers can contribute to health inequity for patients, including but also extending beyond those with legally protected characteristics. L.1.9 Describe deficit-based narratives and develop skills in respectfully prompting awareness of them during routine work	L.2.7 Demonstrate trauma-informed interactions with patients and workplace colleagues. Provide immediate support when patients or team members experience trauma, and identify where to seek additional help. L.2.8 Demonstrate behaviours that improve health by meeting specific needs of patients and their support networks. Define gaps in personal understanding and seek expert guidance when required. L.2.9 Demonstrate integration of cultural safety and equity into responses to non-routine demands such as high emergency demand or environmental event.	L.3.7 Compare exemplars of trauma-informed health interventions at group or population level to own system, and collaborate to develop improvement actions. L.3.8 Evaluate team diversity and demonstrate actions taken to strengthen team performance through inclusion and representation. L.3.9 Identify systemic inequity in healthcare delivery and implement collaborative actions for sustainable improvement at unit, organisation or population level.
Scientist and scholar	L.1.10 Define the importance of respectful workplace behaviours in enhancing team communication and patient safety.	L.2.10 Use reflective practice to implement personal learning plans that apply evidence linking respectful cultures, patient outcomes, and team performance.	L.3.10a (Clinical) Demonstrate leadership behaviours that communicate and reinforce evidence about respectful culture. L.3.10b (Academic) Contribute or facilitate contributions to research and dissemination of research towards better cultures.

5.2 Suggested Assessment Modes

Notes

- Portfolios comprising a variety of activities at multiple timepoints over the assessment period are more robust than any single assessment. This also embeds Aboriginal and Torres Strait Islander principles of iterative learning.
- Assessment should be as authentic as possible. This also embeds Aboriginal and Torres Strait Islander principles of relational and experiential learning. Assessment of actual work (e.g. project outcomes, changes to patient management, 360-degree assessment) reflects competency most accurately, followed by workplace-based assessment (e.g. case-based discussion, simulation, reflective activities), followed by non-workplace based assessment (e.g. written examinations, essays)
- All trainers and organisational leaders are also expected to be learners. The learner outcomes are considered core, with additional assessment modes suggested for those taking on trainer and organisational leadership roles.
- Assessment tools and standards are outside the scope of this curriculum, but current best practice centres the patient voice, especially from under-represented groups such as Aboriginal and Torres Strait Islander leaders and patients, in their development.

Organisational leadership	Trainers	Learners
All of learner assessment modes, plus **1. Direct observation:** - Behaviours that establish and maintain team culture - Leadership of a culture change project - Evidence of engagement with and action on behalf of community groups experiencing inequitable health outcomes - Culture-informed management of safety and risk, such as contribution and attribution analysis using just culture and safe feedback principles **2. Stakeholder feedback e.g. employee, patient, member, consumers, Aboriginal and Torres Strait Islander community.**	**All of learner assessment modes, plus** **1. Direct observation:** - Planning, preparation, and delivery of teaching - Ability to maintain a safe and effective learning environment - Identification of learning needs and engagement in respectful feedback conversations with learners - Conduct of assessment e.g. Exam, OSCE, viva - Recruitment and selection to education programs **2. Feedback from learners using a safe methodology, such as anonymised survey**	**1. Direct observation:** - Behaviour during clinical rotations or simulated scenarios, focusing on interactions with patients, families and colleagues. - Structured assessment tools like the mini linical Evaluation Exercise (mini-CEX) to assess professional conduct. **2. Standardised patient encounters**: - Use trained actors in Objective Structured Clinical Examinations (OSCEs) to simulate scenarios requiring discretion, compassion or empathy. Assess responses and communication skills.

3. Leadership performance review: - Markers of culture such as equitable behaviour, upstander interventions, team psychological safety - Evaluation of delivery and outcomes of culture change project **4. Evidence of leadership development in culture change e.g. courses, peer engagement, community of practice** **5. Contribution to strategy and planning towards organisational culture change**	**3. Education quality improvement activities:** - Gap analysis of curriculum or learning program - Implementation of teaching improvements and evaluation of outcomes **4. Educational leadership:** - Taking on leadership or champion roles - Design or delivery of education or assessment programs - Contributions to learning curriculum and content **5. Peer review, including through First Nations-led peer review models**	**3. Feedback from stakeholders:** - 360-degree feedback from patients, peers, supervisors and other healthcare team members to gauge respect, empathy and professionalism - Specific feedback from diverse or under-represented voices about respectful engagement and inclusion, including First Nations communities - Patient surveys **4. Audit of outcomes:** - Complete audit cycles at personal or unit level to assess markers of culture such as equity of prescribing or complaints data **5. Leadership and followership:** - E.g. roles in committees, working groups, selection panels, advocacy activities, policy consultation, digital communications **6. Case-based discussions:** - Review case scenarios where ethical dilemmas or professionalism issues arise, assessing the ability to navigate these situations appropriately - Consider First Nations pedagogies such as community-led clinical scenario discussions, yarning-based assessment, storytelling as reflective practice, or group consensus

		7. Reflective practice: - Write reflective statements or keep reflective journals to demonstrate self-awareness and critical thinking about ethical and professional challenges faced in practice - Consider First Nations pedagogies such as peer debriefing circles, Elder-guided reflections, and community storytelling as reflection **8. Evidence of learning** - Completion of further self-directed education e.g. workshops, courses, higher qualifications - Peer or near-peer education activities - Development of patient education materials - Participation in structured debriefing from critical incidents focused on culture or communication - Participation in journal club or community of practice focused on culture or communication - Academic activities such as research, publishing, presentation or peer review of manuscripts **9. Participation in, or provision of, structured supervision, mentoring or coaching**

5.3 Curriculum Resources

	Organisational leadership	Trainers	Learners
.1 Self awareness and behaviour	NHS Leadership Framework Self-Assessment Tool https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Framework-LeadershipFrameworkSelfAssessmentTool.pdf Faculty of Medical Leadership and Management. Leadership and management self-assessment tool for healthcare teams https://www.fmlm.ac.uk/sites/default/files/content/page/attachments/Self-assessment%20tool%20for%20healthcare%20teams.pdf American College of Healthcare Executives. 2025 Competencies Assessment Tool https://www.ache.org/-/media/ache/career-resource-center/cat-competencies-assessment-tool.pdf	American Institutes for Research. Self-Assessing Educator Social and Emotional Competencies. https://www.air.org/sites/default/files/2022-12/GTL-Educator-Self-Assessment-Refreshed-2014-508.pdf RACS Operating With Respect online module https://www.surgeons.org/Education/Professional-Development/Introduction-to-Operating-with-Respect Vahle-Hinz T, Baethge A, Van Dick R. Beyond one work day? A daily diary study on causal and reverse effects between experienced workplace incivility and behaving rude towards others. European Journal of Work and Organizational Psychology. 2019 Mar 4;28(2):272-85. https://doi.org/10.1080/1359432X.2019.1576633	QCOSS: Emotional and Social Intelligence Self-Assessment https://www-qcoss-org-au.webpkgcache.com/doc/-/s/www.qcoss.org.au/wp-content/uploads/2023/01/Emotional-and-Social-Intelligence-Self_Assessment.docx Charles Carver: The Brief COPE inventory https://heal.nih.gov/files/CDEs/2023-07/brief-cope-crf.docx Sattar R, Lawton R, Janes G, Elshehaly M, Heyhoe J, Hague I, Grindey C. A systematic review of workplace triggers of emotions in the healthcare environment, the emotions experienced, and the impact on patient safety. BMC health services research. 2024 May 9;24(1):603. https://doi.org/10.1186/s12913-024-11011-1 Gass R, Ansara J. Managing your triggers toolkit: A practice for being resilient in challenging circumstances. https://mediatorsbeyondborders.org/wp-content/uploads/2020/01/managing-your-triggers-toolkit.pdf

.2 Professional practice for cultural safety	Australian Human Rights Commission. Social Justice Report 2011. Chapter 4: Cultural safety and security: Tools to address lateral violence https://humanrights.gov.au/our-work/projects/chapter-4-cultural-safety-and-security-tools-address-lateral-violence-social NT Health. Aboriginal Cultural Security Framework 2016–2026 https://health.nt.gov.au/ data/assets/pdf_file/0010/1035496/aboriginal-cultural-security-framework-2016-2026.pdf Watego C, Singh D, Macoun A. Partnership for justice in health: Scoping paper on race, racism and the Australian health system. Melbourne: The Lowitja Institute. 2021 May 1. https://search.informit.org/doi/pdf/10.3316/informit.9781921889769	Pimentel J, García JC, Romero-Tapia AE, Zuluaga G, Correal C, Cockcroft A, Andersson N. Competency-Based Cultural Safety Training in Medical Education at La Sabana University, Colombia: A Roadmap of Curricular Modernization. Teaching and Learning in Medicine. 2025 Jan 1;37(1):127-36. https://pubmed.ncbi.nlm.nih.gov/37929697/	AIDA: Cultural Safety Training https://aida.org.au/cultural-safety-program/what-is-cultural-safety/ https://aida.org.au/cultural-safety-program/cultural-awareness-foundations-of-cultural-safety/ CICM: Statement on Racism in the Healthcare System https://cicm.org.au/common/Uploaded%20files/Assets/Professional%20Documents/IC-34-Statement-on-Racism-in-the-Healthcare-System.pdf

.3 Addressing bias and discrimination	Victorian Government: Template board skills and diversity matrix https://www.vic.gov.au/diversity-victorian-government-board-guidelines/template-board-skills-and-diversity-matrix UQ Guide to Planning Inclusive Events https://www.uq.edu.au/about/files/10857/UQ%20Guide%20to%20Planning%20an%20Inclusive%20Event.pdf Academy of Social Sciences (UK) EDI good practice for organising events https://acss.org.uk/esrc-project-equality-diversity-inclusion/edi-good-practice-for-organising-events/ Harvard School of Public Health Equity Lens for Decision Making. 2021. https://progov21.org/Download/Document/1D0S99	Averbuch T, Eliya Y, Van Spall HG. Systematic review of academic bullying in medical settings: Dynamics and consequences. BMJ open. 2021 Jul 1;11(7):e043256. https://bmjopen.bmj.com/content/11/7/e043256.abstract Teal CR, Gill AC, Green AR, Crandall S. Helping medical learners recognise and manage unconscious bias toward certain patient groups. Medical Education. 2012 Jan;46(1):80-8. https://asmepublications.onlinelibrary.wiley.com/doi/full/10.1111/j.1365-2923.2011.04101.x Bowen CN, Havercamp SM, Bowen SK, Nye G. A call to action: Preparing a disability-competent health care workforce. Disability and Health Journal. 2020 Oct 1;13(4):100941. https://www.sciencedirect.com/science/article/abs/pii/S1936657420300662	Project Implicit: Implicit Association Test https://implicit.harvard.edu/implicit/takeatest.html Willems J. Microaggressions in the general practice setting. Australian Journal of General Practice. 2023 Dec 1;52(12):836-40. https://www1.racgp.org.au/ajgp/2023/december/microaggressions-in-the-general-practice-setting Ehie O, Muse I, Hill L, Bastien A. Professionalism: Microaggression in the healthcare setting. Current Opinion in Anesthesiology. 2021 Apr 1;34(2):131-6. https://journals.lww.com/co-anesthesiology/pages/articleviewer.aspx?year=2021&issue=04000&article=00012&type=Fulltext de Oca EA, Deboel S, Van den Bosch L, Verspreet L. “Baby, you were born this way”: LGBTQI+ discrimination in healthcare communication between healthcare provider and patient. The British Student Doctor Journal. 2021 Apr 30;5(2):95-102. https://thebsdj.cardiffuniversitypress.org/articles/268/files/submission/proof/268-1-2115-1-10-20210430.pdf

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5.4 Curriculum Explanatory Notes

When determining who the curricula should apply to, the terminology of ‘learner’ was widely accepted and uncontroversial. The decision to use ‘trainer’ rather than ‘teacher’ or ‘educator’ conveys a focus on workplace performance and demonstration of competency, but the distinction between a trainer and a teacher/educator – someone who provides instruction that results in learning – is narrow. Regardless of the terminology, the curriculum takes a broad view of the roles of a trainer, which should include competency in teaching, mentorship and coaching.

The terminology ‘organisational leadership’ remains contested. The overall aim of the curriculum is that organisations embark on a learning journey and achieve a respectful culture that is stable regardless of changes in leadership personnel. However, there were Working Group and Reference Group concerns that a focus on a collective organisational end would not sufficiently convey the responsibility on organisational leaders to provide the means to achieve it. At the same time, specifying positional leadership such as ‘executives and boards’ does not sufficiently capture the diversity of health organisations, especially those that may not follow Western ethnocultural organisational structures. It also risks excluding the significant capabilities of leadership outside the executive and boards. ‘Organisational leadership’ should therefore be taken to include all non-clinical and clinical positional leaders within an organisation who have responsibility for the performance of others.

5.5 Guiding Principles of Effective Change in Complex Systems

Avoid thinking in terms of causes and effects. In complex systems, causes can be effects, and effects can be causes[33]. For example, bullying and poor performance at work can reinforce each other in a loop.

Act and reassess rapidly rather than waiting for complete information. Decisions often need to be made even when all the facts aren't available. This is because complete information is rare in complex systems, and systems themselves change constantly. An example is the rise of misinformation in the early COVID pandemic while health systems and government bodies waited for more complete or more accurate data to inform communications[34].

Don't plan too far in advance. Plans cannot be fully specified for a complex system since its reactions are unpredictable. Instead, monitor progress regularly to check for unexpected outcomes. This may be at odds with organisational processes such as research grants and implementation projects where a fully specified program is required to secure resources. Making use of a complexity lens such as the Cynefin Framework[35] can help communicate the value of complexity-informed change management, especially in inherently unstable healthcare settings such as disasters and emergencies.

Adapt for context. A solution that works well in one place may not work in another without adjustments. Complex systems are sensitive to even small differences, so local adaptation is essential[33]. For example, successful healthcare solutions from metropolitan areas may fail in rural areas without consideration of system complexity.

Embed goals, not processes. Processes are insensitive to changes in context, may have 'stop points' that prevent action when there is incomplete information, and may formalise cultural mismatch between process designers and users. For example, the Murdi Paaki COAG trials 2002–07 were able to successfully work with a highly complex federal-state governance structure across 16 Aboriginal communities in western and northwestern NSW by establishing new and flexible ways of working, and a 'well enough' governance philosophy. This was able to circumvent entrenched bureaucratic inertia arising from standardised processes, to release community energy towards more effective improvements in health and education[36].

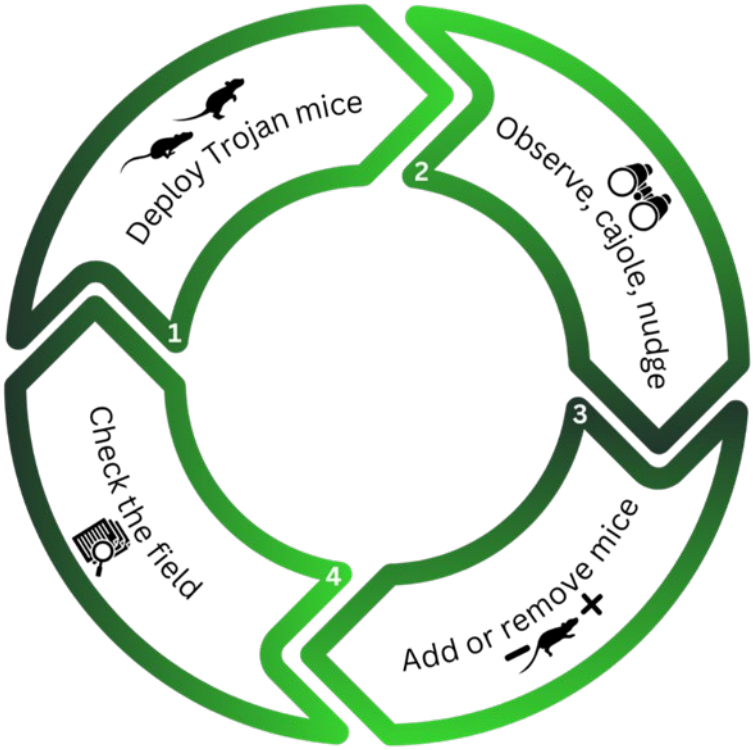

Figure 5: 'Trojan mice' diversify risk into smaller experiments to test hypotheses about how complex systems will respond. Multiple small interventions with close attention to unexpected effects are safer, less wasteful, and more effective than single large 'Trojan horse' projects. Adapted from: https://interactioninstitute.org/on-trojan-mice/

Start small. Begin with multiple small, low-risk projects instead of one big, high-risk 'Trojan horse' effort. Each small project, or 'Trojan mouse', acts as an experiment to see what works. Smaller projects are easier to change or stop if needed, and help identify factors that could be critical when scaling up[37]. In essence, the 'Trojan mouse' approach harnesses the multitude of small adaptations that healthcare staff make every day when working within complex systems, but surfaces them as good and useful, not surreptitious workarounds or 'non-compliance'. This establishes a culture where it is safe to innovate[3].

6.0 Appendices

6.1 Contributors

The Curriculum Design Working Group members represent all levels of education from medical school to retirement, a diversity of specialties, interprofessional and consumer representation, and clinical and non-clinical practice.

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Members of the following reference group participated in varying degrees according to their capacity and expertise. Their mention here is intended as an acknowledgement only, and does not imply personal or institutional endorsement of the curriculum.

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6.2 Curriculum Design Working Group Terms of Reference

Purpose and Scope

The Working Group is established to support the Advisory Board via provision of content expertise and design of a universal curriculum for training and skills development with specific content for all career stages, starting before graduation.

The working group will comprise educators and a broad range of reference group members to give perspectives across the career spectrum.

Responsibilities

The primary responsibility of the Working Group is to:

- Review mapping activities of the national strategic approach, and consider existing frameworks, training and requirements in the development of this curriculum for training and skills development.
- Review the list of current training programs offered across Specialist Medical Colleges and consider gap analysis.
- Propose the structure of a contemporary, fit-for-purpose curriculum.
- Draft program outcomes and learning objectives for all career stages.
- Provide advice on strategies for assessment and contribute to the development of assessments aligned with the defined program outcomes.

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