A Better Culture

Individual Level Interventions & Reporting Pathways Working Group Report

Consultation Draft December 2024

Acknowledgements

A Better Culture acknowledges and pays 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, and 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 Commonwealth Department of Health and Aged Care in December 2022 to address high rates of bullying, discrimination, harassment, and racism (BDHR) experienced by doctors, and is hosted by the Royal Australasian College of Medical Administrators (RACMA).

The Advisory Board and the project team extend sincere gratitude to the Reference Group members for their tremendous efforts and valuable contributions since the project's inception. We also acknowledge 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 groups.

Disclaimer

These reports are consultation drafts developed based on discussions among the working group members. While the members represent diverse stakeholders within the healthcare sector, the reports, recommendations, and any views expressed are solely those of the working group and do not reflect the official positions or views of their respective organisations. The contents of these reports should not be attributed to any organisation.

Support Services

BDHR is a challenging issue. 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, 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, wages, leave and other entitlements or to report a workplace issue 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

If you speak a language other than English and need help understanding this document, you can contact the free Translating and Interpreting Service on 131 450. If you are deaf and/or find it hard hearing or speaking with people who use a phone, the National Relay Service (NRS) can help you. Please contact the NRS Helpdesk by calling 1800 555 660 or through your preferred call option.

Contents

1.0 Executive Summary

1.1 Executive Summary

This report by the Individual-Level Interventions and Reporting Pathways (ILIRP) Working Group examines the efficacy of the reporting and response arms of systems designed to address bullying, discrimination, harassment, and racism (BDHR).

The working group examined **reporting pathways** available to healthcare professionals, particularly early career doctors, who wish to escalate BDHR concerns, either formally (e.g. in a written complaint or via an online reporting system) or informally (e.g. in a conversation with a superordinate).

The working group also focused on **individual-level interventions** (ILIs) designed to address BDHR, namely:

- **professional accountability programs** designed to educate staff about BDHR, impart techniques for regulating behaviour, and encouraging positive workplace behaviour through awareness, self-reflection, and feedback; and

- **speaking up programs** designed to support employees who are the victims or bystanders of BDHR to raise or report their concerns.

Overall, the working group found that despite the implementation of strategies intended to reduce BDHR and establish effective reporting pathways in various hospital and health services (HHS), they appear to have met with limited success in terms of early career doctors. Those who participated in our research, some of whom were specialist trainees who were Post-graduate year 10+ , reported they and their colleagues routinely experience BDHR. For these participants, professional accountability programs designed to reduce BDHR have had little impact.

Speaking up programs also appear to have little effect: early career doctor participants considered voicing concerns about BDHR to be career-limiting or ineffective, responses that have been noted in literature on this theme and are supported by data from the national Medical Training Surveys conducted annually by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA). The perceived dangers and futility of speaking up meant many of the early career doctors also viewed reporting pathways as redundant and untrustworthy.

The working group recognises that cultural change is a long-term goal that could take a generation or more of sustained and comprehensive effort. This report, therefore, represents the start of a broader program of activity and acknowledges there is more work to be done. In the words of one group member, it "identifies the shining gold flecks in the pan; the strategies we recommend continue and can be augmented with other things we are learning are helpful in this space".

The report is timely. Willingness to tolerate BDHR is decreasing, not only among early career doctors and those working and researching in healthcare but in society more broadly – a reality increasingly enshrined in law. The recent National Health Practitioner Ombudsman report on accreditation processes has set out a clear expectation of collaboration between

employers and Colleges to address BDHR. The advent of legislation on psychosocial safety and sexual harassment at work and other developments means it is now incumbent on employers, educators, and stakeholders to find a way to create a better culture and eliminate BDHR for early career doctors and *all* healthcare workers. We trust it provides the necessary impetus for change.

Note the term “early career doctor” rather than “junior doctor” is used throughout this report. Many doctors in training are more than a decade post-graduation. Neither they, nor the responsibilities they carry, are adequately represented by a term that minimises their high levels of training, skill, and independent service delivery.

Recommendations

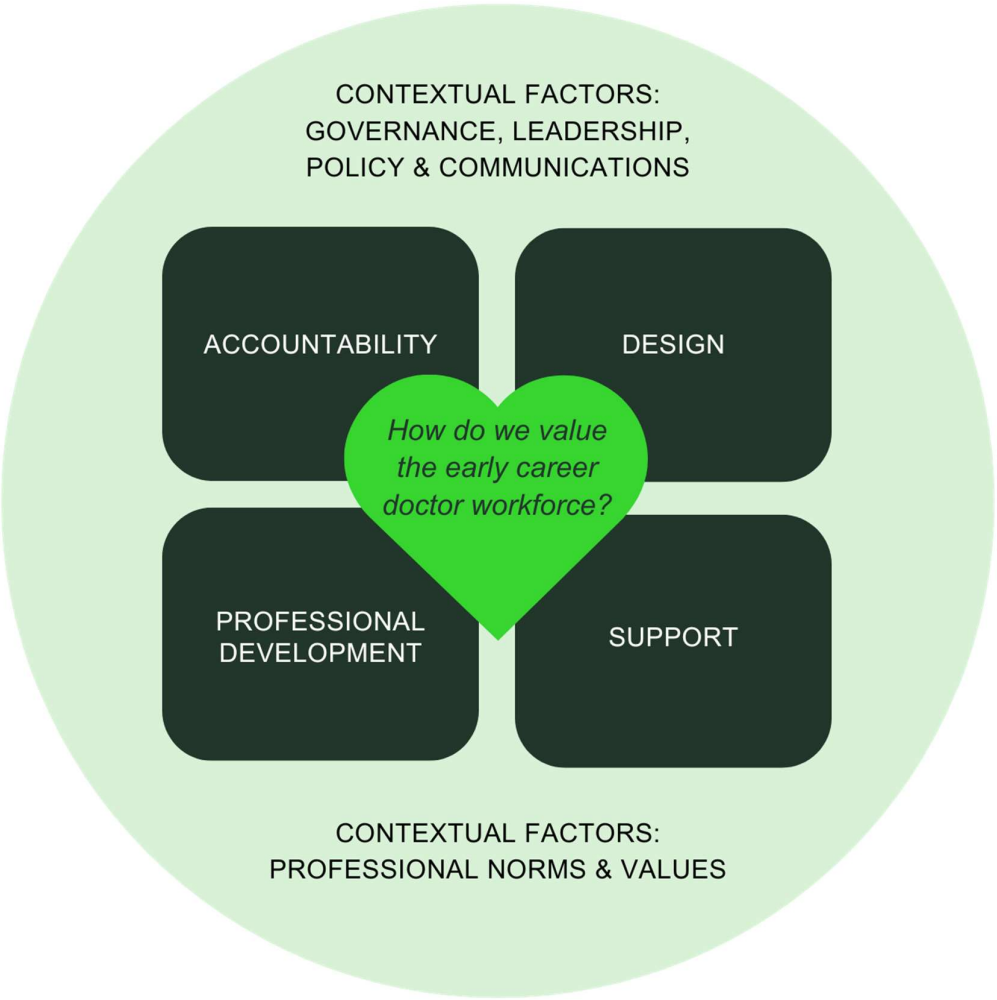
Overall, the working group found the strategies that have been used to mitigate BDHR are not enough to overcome entrenched, negative cultural practices in the medical profession and in healthcare generally. It was clear from the data that the question “How do we value the early career doctor workforce?” needed to be answered: literally, in terms of “What do we need to do to fix this?” and figuratively, in terms of “How will the profession demonstrate it truly values early career doctors?”

Four overarching themes emerged in response:

1. by increasing **accountability**
2. by revisiting the **design** of reporting pathways and individual-level interventions
3. by **developing** our medical professionals, and
4. by increasing the **support** available to early career doctors.

Recommendations related to each of these themes are summarised below. The insights that led to them are detailed thereafter.

Figure 1: Recommendations grouped by theme



Accountability

1. Employers and colleges should address and mitigate BDHR using a **risk-management approach** that ensures BDHR is treated as seriously as other workplace health and safety issues and that, where appropriate, BDHR offenders are held **accountable** using due process and a restorative justice framework.

2. Employers should ensure that the work to **implement recommendation 13 of the National Health Practitioner Ombudsman report on accreditation processes** is enhanced to benefit early career doctors who are not affiliated with any college, with particular focus on non-accredited registrars and international medical graduates (IMGs).

3. Governments should continue efforts to strengthen **levers in the broader environment** to support the eradication of BDHR (e.g., training accreditation, safety and quality accreditation, and workplace health and safety codes and legislation).

4. The Healthcare Workforce Taskforce (or other appropriate entity) should commission a review on the merit and costs of establishing an **independent, external reporting system** as a key element in an escalating scale of interventions (see Design Recommendation 5).

5. Accreditation bodies should require **transparency** in reporting mechanisms, processes, and outcomes for BDHR, including **improving the cycle of reporting**, so concerns are acted upon in a timely manner.

6. Employers and colleges should **reduce early career doctors' fear of reporting** by assertively discrediting and systematically dismantling the custom and practice of informal information exchange about trainees.

Design

1. The Commonwealth should fund healthcare-specific **adaptation, implementation, and evaluation of proven interventions** from health and other sectors, ensuring **segmented evaluation** so outcomes for early career doctors are visible.

2. Employers and colleges should develop a simple, easy-to-understand **reporting roadmap** that aligns the spectrum of BDHR behaviours with a continuum of informal to formal reporting options.

3. Employers and colleges should ensure reporting pathways and interventions are **inclusive** and **recognise the difficulties** faced by IMGs and other ultra-vulnerable groups in the early career doctor cohort and consider anonymous reporting options in those pathways.

4. Entities that receive and manage reports should increase **transparency** in the reporting process by ensuring progress and outcomes are communicated to complainants and alleged offenders to the extent permissible by law.

Professional Development

1. Universities, colleges and employers should start early and continue **education** on BDHR and professional conduct and communication throughout the career life cycle and ground education in an **understanding of the circumstances** that allow BDHR to flourish.

2. Education programs and workplaces should **address socialisation and cultural factors** that create organisational and individual tolerance of threats to healthcare workers' health and safety.

Support

1. Familiarise early career doctors with their environments and the reporting pathways available to them, ensuring **orientation** is provided in the first week and whenever a change of workplace occurs.

2. Provide **psychological support** to complainants and alleged offenders and reduce the psychological burden of reporting and responding by ensuring **prompt action**.

3. Support early career doctors at the individual and small-group levels via coaching and other, targeted **micro-interventions**.

2.0 Introduction

2.1 Overview

The A Better Culture Project

A Better Culture is a project commissioned by the Commonwealth Department of Health in December 2022 using unspent Specialist Training Program funds held by RACMA. It is a response to the Medical Training Survey, which has shown year on year that reported rates of bullying, discrimination, harassment and racism (BDHR) are disturbingly high, with a disproportionately worse experience among First Nations trainees.

At initiation, it was agreed that the project would generate:

- a multi-faceted engagement strategy, and
- a tangible, achievable approach able to be adopted by all key stakeholders.

An 11-member advisory board and 12 reference groups involving over 200 individuals were established to co-design the project's work program. Three key themes emerged:

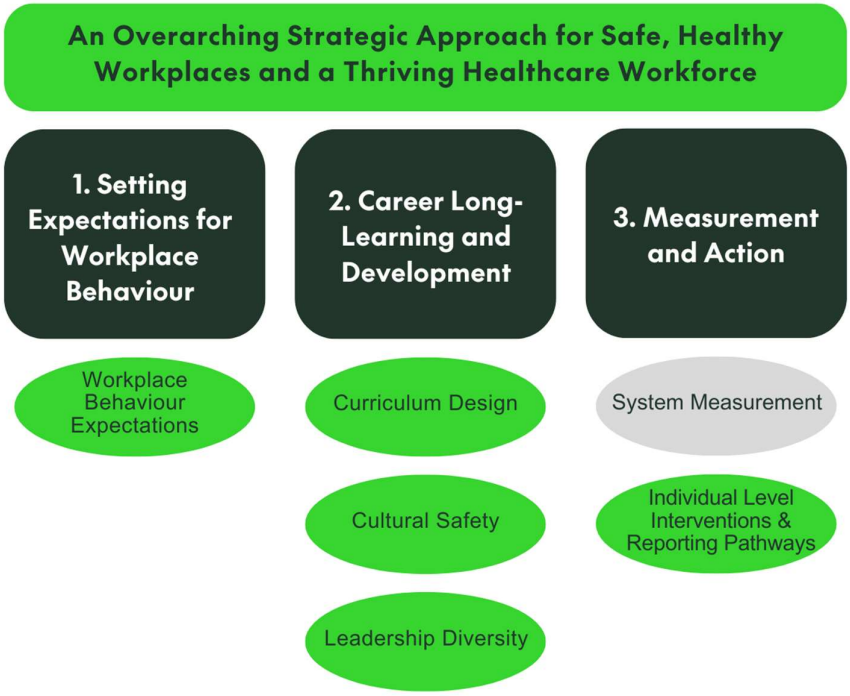
1. Workplace behaviour expectations
2. Career-long learning
3. Measurement and action

To advance work in these areas, five working groups were formed:

1. Workplace Behaviour Expectations Working Group
2. Curriculum Design Working Group
3. Healthcare Worker Cultural Safety Working Group
4. Individual Level Interventions and Reporting Pathways Working Group
5. Leadership Diversity Working Group

In addition to the five working groups, the project secretariat commissioned two additional pieces of work: a cultural measurement tool and an integrating, strategic approach to weave the strands of the project together.

Figure 2 - A Better Culture Project Deliverables



Individual Level Interventions and Reporting Pathways Working Group

The Individual Level Interventions and Reporting Pathways Working Group was established with the aim of addressing findings from successive Medical Training Surveys. For example, in the 2024 survey (Medical Board of Australia & AHPHRA, 2024), 85 per cent of early career doctors said that they knew how to report concerns about BDHR, and 78 per cent were confident that they would raise concerns.

However, when the survey questions turned to what happened in real situations, of those who witnessed one of the target behaviours, only 26 per cent reported it. Of those who experienced BDHR themselves, only 33 per cent reported. The key reasons for their silences were concern about repercussions, a belief that nothing would be done, and the perception that it was not accepted practice to report.

This gap between what trainees think they will do and what they actually do is reflective of the real-time evaluations affected early career doctors make of the personal risks and benefits of making a report.

To examine these issues, the Individual Level Interventions and Reporting Pathways Working group met six times throughout 2024, supported by Chair Michael Gorton (June–September) and subject matter experts (SMEs) Victoria Lister and Judy Finn.

The terms of reference for the working group are contained in Appendix A.

Table 1 List of Working Group Members

Name	Role
Mr Michael Gorton (Chair) *(June–September)*	Principal Consultant, Russell Kennedy Lawyers, and Chair, Clinical Governance Committee, Australian Commission on Safety and Quality in Health Care
Victoria Lister (SME)	Consultant and Early Career Researcher, Griffith University
Judy Finn (SME)	Executive Leader, Past Program Lead, Building Respect Improving Patient Safety Initiative, RACS
Dr Lynne McKinlay	Director, Medical Services, Clinical Governance, Sunshine Coast Hospital Health Service
Ms Jennifer Smith	Psychologist
Dr Dominique Lee	Radiation oncologist
Dr Suellyn Centauri	General surgeon
Dr Sarah Coll	Orthopaedic surgeon
Dr Lieu Chi Nguyen	Psychiatrist
Dr Amal Abou-Hamden	Neurosurgeon
Dr Marjorie Cross	General practitioner
Dr Clare Morgan	Healthcare consultant/Locum Acting Director Medical Services, The Wesley Hospital
Megan Crawford	Medical Advisory and Prevocational Accreditation Unit, Queensland Health
Danielle Clayman	Health and Wellbeing Practitioner, Melbourne Medical School
Ms Simone Perry	Master of Clinical Medicine Course Coordinator, University of Newcastle

2.2 Methods

Frameworks

The working group utilised a **just culture** frame of reference (Leape, 1997; Marx, 2001, Barkell & Snyder, 2020). An associated concept is **restorative justice**, a process that "brings people together to address the harm caused by crime" with the aim of "bringing hope and healing" to those most affected by it (Queensland Government, 2024). The working group also recognised the importance of a **trauma-informed** approach, in which efforts are made to ensure interventions "do not re-traumatise or blame victims" (NSW Health, 2022).

The concept of **psychosocial safety**, which is found in "job design, the organisation and management of work, and within the social and environmental contexts of the workplace" (Hall, Dollard & Coward, p. 354), was also paramount.

Note that psychosocial safety is distinct from **psychological safety**. In the healthcare context, psychological safety is often linked to speaking up for patient safety. In the context of this report, we believe it is incumbent on employers and other stakeholders to ensure healthcare workers are able to speak up for *practitioner* safety.

Approach

The working group: 1) investigated relevant literature on the topic of ILIs, reporting pathways, and early career doctors' experiences of BDHR and voice and silence at work; 2) consulted with industry experts, primarily on the topic of ILIs; 3) conducted focus groups and interviews with early career doctors and new consultants on reporting pathways; 4) polled early career and senior doctors working in rural and remote locations on reporting pathways; and 5) conducted focus group discussions with working group members on both topics. A consultant with expertise in early career doctors' silence at work assisted the group with the literature review, data collection and analysis, and report writing. The report discusses ILIs and reporting pathways in turn, integrating findings from the data and relevant literature.

Participants

Participants were recruited via email and social media from A Better Culture and working group members' networks and the consultant's networks. Participation was voluntary and confidential. Interviews and focus groups were between 30 to 60 minutes' and approximately 120 minutes' duration respectively and were audio-recorded, transcribed, and thematically analysed. One participant provided a written response. Nine industry experts and 12 early career doctors participated. The views of 27 rural and remote early career and senior doctors, mostly rural generalists and GPs, were also captured in a poll with open-ended questions. Relevant demographic details of all participants are presented as per the tables

in Appendix C. All data in the report has been de-identified. Note some participants declined to provide some demographic information. All participant and working group member quotes are in bolded italics. To ensure the confidentiality and anonymity of all participants — especially the early career doctor respondents — quotes have not been attributed.

Limitations

The limitations of this report are acknowledged. Compared to the 40,000+ early career doctors in Australia, the number sampled here was small. However, this is consistent with qualitative projects that aim to yield detailed information of a kind unable to be achieved in surveys.

The potential for self-selection bias is impossible to avoid in interview and focus group projects. Individuals volunteer to participate because they are interested in the topic, often have strong feelings about it, and believe it to be important (Saunders, 2012). Self-selection bias is mitigated by awareness of the possibility of it, and its effects on findings and generalisability (Robinson, 2014). These limitations also apply to the industry experts and working group members who participated in interviews and discussion groups.

No interviewees were service registrars — early career doctors who are not in a specialist training program (and are not seeking to be). As will be discussed elsewhere, service registrars — and unaccredited trainees who are seeking a place on a specialist training program — are recognised as the "*lost tribe of medicine"* and are difficult to recruit.

2.3 Existing Programs to Mitigate BDHR

The working group identified a range of ILIs and reporting pathways, summarised in the table at Appendix E. ILIs and reporting pathways nominated by early career doctor and industry expert interviewees were also included, as were advocacy, representation, and support programs, which had emerged as important in the data collected from the early career doctor and industry expert participants.

This identification of the programs designed to off-set BDHR is by no means comprehensive — a thorough investigation would require a program of research beyond the scope of this project. It does, however, provide a sense of the breadth and types of strategies that have been introduced to address BDHR in healthcare.

The main finding from the scan of BDHR programs was that most interventions are designed for all staff, relatively few are evaluated, and those that are evaluated do not segment their evaluations by staff groups. As a result, determining the extent to which they are effective for early career doctors is challenging. The working group observed, however, that early career doctors working in hospitals where ILIs were known to have occurred — and who are regularly surveyed by various groups (e.g. AHPRA., the Australian Medical Association) regarding BDHR and other working conditions issues — continue to report they experience unprofessional behaviours. While the validity and reliability of such surveys is difficult to ascertain, they suggest programs intended to address BDHR are not working for early career doctors and that tailored approaches and nuanced evaluations are required.

The views of many of the early career doctors — and industry experts — interviewed for this report lend credence to this suggestion. As will be described in the next section, on early career doctors and their experiences of reporting pathways, many interviewees were sceptical about the value of interventions in HHS where BDHR is allowed to flourish. It was also evident that the balance of power between early career doctors and the superordinates on whom their livelihoods depend is firmly weighted in favour of the latter. Speaking up about BDHR is a risk that few early career doctors are prepared to take, and uncertainty about safe and effective reporting ensures early career doctors remain predominately silent about their concerns.

This is not to say all interventions, pathways and programs are ineffectual — positive changes have occurred and there are aspects of existing strategies that can be adopted and adapted in future initiatives, including from organisations outside healthcare. For example, a work titled *Disrupting the system: Preventing and responding to sexual harassment in the workplace — Building confidence and trust in workplace responses to sexual harassment* offers “an example of how person-centred, trauma-informed, safe and fair reporting might work in practice” (Champions of Change Coalition, 2023). It includes a simple, non-linear model that resolves problems raised by the desire for anonymous reporting by providing different options. It also aims to ensure all elements related to support, reporting, resolution, and recovery are included.

The summary of the identified strategies is listed in Appendix E.

3.0 Early Career Doctors on Reporting Pathways

3.1 Early Career Doctors on Reporting Pathways

Experiences of Reporting BDHR

All of the 12 early career doctors who participated in this project had experienced or witnessed inappropriate behaviour, confirming BDHR is endemic in HHS — a view shared by the project's nine industry expert informants. Of the early career doctors interviewed, all but one had personally experienced BDHR and stated they had difficulties reporting about the BDHR they had experienced, or that they had declined to report. The participant who had not experienced BDHR noted the difficulties speaking up faced by her peers.

Congruent with research on early career doctors' silence in relation to their working conditions, including BDHR (Creese et al., 2021; Lister, 2024), participants cited fear and futility as their main motives for not speaking up. This correlates with the data from the recent Medical Training Survey (Medical Board of Australia & AHPRA, 2024), which listed fear of reprisal and a belief that nothing would be done as the main reasons for not reporting.

Reasons for fear were predominately related to perceived repercussions (further transgressions, reputational and relational harm, damage to career). Futility was the product of believing nothing would happen if they did speak up or that effective reporting options were not available to them.

The following quotes illustrate reasons — all of which were grounded in lived or observed experience — for early career doctors' feelings of fear and resignation:

"I never did go back and raise anything at the hospital level there because I didn't — like most people — feel that I was going to gain anything. For one, I'd already moved on. For another, I didn't think the hospital would be particularly receptive to it.

He said a few things that were — that I felt were quite disrespectful without really understanding where I was coming from and the level of experience that I had prior to coming to [the unit]. I feel like I would have been labelled as someone difficult if I had raised it. It's going to be really bad for you if you call it out ... You're usually better off to just go away quietly. There have been times I have not reported because I was scared I would be seen as difficult and that it would have repercussions on my reputation and future job prospects.

Reporting has damaged my relationships with senior administration in the hospital and they see me as a troublemaker now. If you get a reputation at one hospital and you're known to be difficult, the surgeon or consultant — they have friends at another. And they all talk amongst themselves."

Industry expert participants expressed similar views:

"Early career doctors can feel they're being bullied [by] a particular supervisor in a particular unit. And they feel sometimes reluctant to report that because that same supervisor then has to sign-off their term, or whatever assessment period they have to spend within that unit. Early career doctors don't want to say anything in their

organisation because of fear of reprisal ... [which] can come years after the fact. Many of these doctors have got long, long memories. There's certainly a power dynamic in terms of the ability for a supervisor to sign-off somewhat arbitrarily on the early career doctor's performance. "

Industry expert participants also noted that early career doctors can be sent to areas where there is limited ability to find alternative supervisors — ***where the head or the head consultant or the person who's controlling the training has formed a view about them***.

They also understood why early career doctors are silent about the BDHR they experience or witness:

"Obviously the con is nothing's going to get better if you do nothing. But the advantage [of not making a complaint] is you're not lifting your head above the [parapet] ready to have it chopped off."

Other Barriers to Reporting

Many other factors also impede early career doctors' ability to speak up. The factors in the data provided by the early career doctor and industry expert participants are listed below.

Job Mobility

Early career doctors are typically offered one-year employment contracts and often move hospitals or departments and, sometimes, jurisdictions; in their early years, they rotate between units. This transience leads many early career doctors to feel it is pointless raising BDHR concerns, and some cite it as a reason not to report: the early career doctor who stated ***"I'd already moved on"*** in the previous section on futility was alluding to the problem of mobility. Additionally, as an industry expert participant observed, early career doctor mobility might also give employers a reason not to act if concerns are raised.

Some early career doctors move to escape challenging situations. One early career doctor interviewee recalled being advised to quit their hospital by a consultant — the doctor running the interviewee's training program ***"had it in for [them]"*** and the consultant *"**didn't think it would be good for me to stay"**.* Recognising the wisdom of the advice, she moved interstate — ***"and I don't regret it for a second**."*

Internalisation of Abuse

Early career doctors report speaking up about the BDHR they experience can be impeded by a sense of shame that is endemic in medical culture and can be exacerbated by cultural norms. For example:

"If we found out that someone is struggling, we would stand up for them. But more often than not, people don't talk about it, because we're all Type-A personalities, we don't want to believe that we're being bullied. And if we are being bullied, we think it's because we are insufficient ... I was internalising the insults and I was thinking that there's something deficit in me. And then when I started talking to my co-residents, it turned out that everyone had the same experience."

For others, bullying leads to self-doubt. In one example, an early career doctor working in a regional hospital described:

"...getting told your treatments that you've decided on with the experts from [a city] are not appropriate for the patient — being demeaned so much in meetings there's that self-doubt. So I'll sit in the local consultant meetings, doubting what I'm choosing to do for patients, because I've been given grief. I feel more comfortable sitting in the meeting with the [city] experts because they don't tear shreds off me."

Focus on Clinical Issues

An industry expert participant observed early career doctors are **"*so focused on their clinical skills training and development that [it is difficult] actually getting them aside to even have a conversation about something that isn't specifically seen as a clinical issue.*"**

This concurred with the views of an early career doctor participant who stated:

"Honestly, a lot of times I don't even care ... about knowing what the reporting pathways are, because what is more important to me is knowing how I can order a chest X-ray for a patient. So that's where all my energy goes."

Another industry expert noted a similar phenomenon occurs at the senior staff/executive level when considering workplace health and safety (WHS) issues:

"I'll say to a group of directors 'How many hours did you sit around this table talking about COVID and what your business was going to do to keep everyone safe?' And they all go, 'Oh, yeah, hundreds of hours'. And then I say, 'Well, how many hours have you sat around here talking about what you're going to do to protect staff from sexual harassment?' And they look at me like, 'Why would we do that?' I'm like, 'Well, it's exactly the same thing.'"

Regional, Rural and Remote Settings

Comments from an industry expert participant highlighted the difficulties experienced by general practitioner (GP) registrars working in rural settings, observing that **"*there is at least a formal process of you go talk to this person and they should help you. That exists. The hospital has policy and protocol of this is what you should do.*"**

However, she also noted that ***"whether it's followed and supported is entirely different"*** and that for GP registrars in clinics ***"there's just no one to even go to for safety. If you're in a health service and you're on a surgical term, then you can go to the medical team and never see those people again, particularly if you're in a large centre. But if you're in general practice, there's nowhere to go."***

Other difficulties experienced by registrars (and senior doctors) working in rural and remote locations, and which prevent them from reporting BDHR, are discussed in section 3.2 and shown in the table in Appendix E.

Awareness of Reporting Pathways

In the Medical Training Survey data, 85 per cent of respondents stated they felt confident about *how* to make a report. However, the (much lower) percentage of those who actually report suggests a lack of awareness of reporting pathways could prevent early career doctors — particularly those working in hospital settings — from speaking up.

Interview data gathered for the current project support this suggestion. Unless they occupy leadership roles, are interested in medical administration, or are advanced trainees who have become familiar with the systems in which they are immersed, early career doctors working in hospitals have an incomplete or partial understanding of how to raise a concern or to whom — and may not appreciate that their understanding is incomplete until they need to report.

For example, although a broad spectrum of reporting pathways was mentioned, at the individual level, awareness of the options and how best to use them was low. Most of the reporting pathways nominated by early career doctors working in hospitals involved the direct, informal voicing of concerns to superordinates (e.g. registrars, peer managers, supervisors, line managers, management) rather than via formal means (e.g. human resources (HR) and risk-reporting systems). Indirect methods, such as early career doctor committees, were also identified as a way of raising issues.

Potential reporting pathways nominated by GPs in training were practice managers, general managers, CEOs, practice owners, senior GPs, clinic supervisors, training program managers, and risk reporting systems. For participants undertaking other kinds of specialist training, colleges were another option. For those not undertaking college-based training, the Postgraduate Medical Education Council was cited as a body that could receive a complaint. Some early career doctors nominated external bodies such as AHPRA as potential reporting pathways.

Lack of Clarity About Reporting Pathways

The interview data for this report also revealed that a reason hospital-based early career doctors experienced a lack of clarity about reporting pathways was **insufficient orientation to — and understanding of — reporting architecture**.

Commenting on staff use of a hospital's risk management system, one industry expert participant noted although individuals can use this system to report psychosocial hazards, this rarely happens — and when it does, it has often been used incorrectly.

Regarding orientation, one early career doctor participant commented that ***"[during] internship — first year and second year out — I think it's pretty well done. But after that, it's 'start the job and figure it out yourself'"***. Another respondent noted that early career doctor mobility means they are constantly learning about new environments in short timeframes, also without proper support.

This can lead to confusion about reporting pathways. For example, an industry expert participant described situations in which early career doctors report concerns to HR rather than managers, because ***"I don't think half of the staff even know who the next person up is from their line manager."*** Approaching HR was considered insufficient as "***quite often when somebody does speak up about an issue, be it with a manager or a colleague, [HR's] solution is to try mediation, which generally isn't super-effective. And the problem remains.***" Conversely, one early career doctor participant reported little sense of connection to HR: ***"to be honest, when I was working at that hospital, we didn't really know much about HR. We definitely knew about medical workforce, but medical workforce wasn't really as involved in our day-to-day structure."*** This indicates neither pathway was satisfactory.

These findings concur with those of a recent study that confirmed the opacity of reporting pathways in hospitals, finding that "although a plethora of formal voice structures existed, these were not always visible or accessible to staff, leading to confusion as to who to speak up to about which issues. Equally, other avenues which were not designated voice platforms were used by employees to get their voices heard" (Wilkinson et al., 2024, p. 1090).

Perceptions of Available Pathways

Many of the early career doctors interviewed were sceptical about the reporting pathways available to them, which acted as an additional barrier to speaking up. As one participant stated, ***"they do not give an avenue for early career doctors. Sure, you can go complain to your DMS [director of medical services]. It doesn't really get you very far."***

Another participant was blunter in their assessment of the situation:

"There's the exam answer. And then there's the real answer. So the exam answer is there are a multitude of reporting systems. Firstly, going to my consultants, my supervisors, the junior medical officer (JMO) support officer, the JMO complaints officer, the bullying advice line, human resources, the [professional accountability program]. The reality is, it was pretty clear that it was very much a kind of 'put up and shut up' type system ... The official systems are opaque and just rife with career-ending risk."

Lack of anonymity was also considered a major barrier to reporting, particularly for doctors in regional, rural, and remote settings (see the table in Appendix D).

One early career doctor interviewee provided a fictional example of the regional/rural dilemma, stating "***if you're the only ophthalmology trainee in e.g. Toowoomba, it'll be pretty easy to identify you — even if you've gone through the anonymous system"***. Although there was a great desire for more anonymity, participants simultaneously recognised that anonymous reporting lacks the detail needed to make reporting effective: ***"when the intimacy between people is lost, the nuance of the issues are lost."***

Another barrier was a lack of trust that such pathways would be sufficiently anonymous. As another early career doctor participant observed of an initiative that enabled training program directors to ask trainees for anonymous feedback, **"*most trainees don't trust the anonymity of this system".***

Advice and Support Seeking

The interview data revealed the reluctance to report instances of BDHR in-house — and the perception that speaking up is unsafe — leads early career doctors to seek advice from third parties, mainly medical defence organisations, unions, and professional associations. The data showed early career doctors also engage in a great deal of internal and external support seeking, indicating a need for additional means of assistance. Internal sources of support included dedicated early career doctor support staff, medical educators, speaking up champions, safety and wellbeing team members, mentors, peer meetings and mental health/psychiatric units. However, trust was an issue for some — it was observed by one early career doctor participant that internal sources of support ***"are still within the hospital power structure ... so let's not kid ourselves."*** The same participant described reporting to a speaking-up champion:

"I told him that one of his consultants was a sexual predator, in no uncertain terms. I was like, 'This man is a risk to women. I've seen him do things and I will go on record'. And what I was told was 'You and I both know that he's my boss as well. And that this is where this conversation ends'. And that was it."

Data from industry expert participants showed medical defence organisations (MDOs) are important external sources of moral support as well as advice on BDHR issues. Early career doctors perceive MDO staff as impartial and accessible. Non-college CPD (continuing professional development) home staff are also considered friendly, knowledgeable sources of support independent of the organisations in which early career doctors work. That early career doctors speak to CPD home staff about topics other than CPD highlights the deficiency in early career doctor support.

The Role of Colleges

Early career doctors undertaking specialist training recognised they can raise concerns about BDHR with their colleges. One participant experienced a positive outcome when she complained about her supervisor. Not only did she feel safer approaching the college, but it was also an anchor point in an otherwise shifting employment landscape:

"I never raised any concerns at the hospital level; [the issue I raised] was at the college level. And I know [...] the person that had been supervising me wasn't allowed to supervise for a while. I never did go back and raise anything at the hospital level because I didn't — like most people — feel that I was going to gain anything. For one, I'd already moved on. For another, I didn't think the hospital would be particularly receptive to it."

However, some of the early career doctors in training expressed frustration about the value of colleges as a reporting pathway, including the participant cited above who also had a negative college experience. As one of the industry expert participants commented, "***a college has no legislative mandate in terms of what happens in a workplace. [If it is] concerned about behaviours like bullying, discrimination, sexual harassment, it's very difficult for them to take action, because they're not the employer."*** Another agreed, stating colleges' separation from the employment relationship limits their ability to provide support. This "hands off" approach is noticed by early career doctors, who feel their colleges should do more.

These findings provide strong support for recent activity (triggered by recommendation 13 of the National Health Practitioner Ombudsman report into accreditation processes) to create collaborative models for colleges and employers to better jointly address concerns, as both have a duty of care under WHS laws.

Some early career doctors are also suspicious of the college apparatus. As another early career doctor observed, **"*there's no competition, there's no incentive. They can do whatever they want. They want to protect their own market. It's acting like a little buddy system or a little club, where they'll just let in whoever they want to, and usually males tend to succeed in that."***

One industry expert described a female trainee working up until 39 weeks gestation and returning to work two weeks after delivery. This was in spite of college efforts to improve the training environment for women.

An early career doctor participant also expanded on this theme, calling for colleges to appoint leaders who could do more to shift the culture away from bigotry and exclusion.

Proposed Solutions

Early career doctors were universal in their desire for more accountability and transparency in reporting pathways, particularly regarding transparency of reporting processes. Early career doctors wanted:

1. Policies that reinforce transparency and accountability
2. Effective leadership
3. Inclusive culture initiatives
4. More effective reporting pathways for IMGs and GP trainees
5. Robust funding to ensure longevity of programs
6. More advocates and sources of support, and
7. Changes to the ways their work is assessed to facilitate fairer and safer reporting such as independent or anonymous marking.

3.2 Reporting Pathways in Rural and Remote HHS

Twenty-seven doctors (early career and senior), mostly rural generalists and GPs, participated in a poll that captured their demographic details (see Appendix D), responses to a closed question, and a series of open-ended questions.

The poll revealed the nature of the reporting pathways issues experienced by doctors at all levels in rural and remote HHS. Concerningly, in answer to the closed question "Are reporting pathways safe?", nearly a quarter (24%) of respondents answered "No". Only seven per cent said "Yes". The majority (69%) responded "It depends".

The types of reporting pathways rural and remote doctors stated were available to them were similar to those described by the early career doctor interviewees. Statements made by poll respondents indicated most, like the interviewees, had an incomplete understanding of the avenues available to them. A difference between the two groups was that trust of reporting pathways appeared to be lower among the polled respondents. One nominated ***a close friend and colleague*** as their only reporting option, stating ***there are no systems above me that help realistically.*** Another included ***a friend*** as their first option; a third stated of the available reporting pathways there were ***none I could trust***.

Barriers to reporting stemmed from the difficulties working (and living) in a small or isolated community. The main barrier was lack of anonymity. As one respondent observed**, *if you're the one Aboriginal employee working in a workplace, you cannot report about an Aboriginal issue without them knowing who is reporting.*** Another observed that ***it's never going to be anonymous. It could go either way depending on the workforce culture, but you're more likely to know/predict what response you will get.***

Other impediments to reporting included potential breaches of confidentiality; lack of support; lack of staff trained to manage problems and fewer people to report to; limited alternative training or job prospects; and lack of accountability for alleged offenders in areas where staff are hard to find. For IMGs — many of whom are required to work in rural and remote services — the threat of deportation or inability to gain registration was a significant barrier.

One respondent nominated a potential benefit of working in a rural or remote setting, stating when making a complaint **"*there is potentially more leverage if you know they need you***." Conversely, another observed that perpetrators can more easily get a job in areas where there is no one else; another respondent stated that rural and remote HHS are **"*struggling to recruit doctors in the first place, so knowing that, despite their actions, the perpetrators won't be held accountable"***. A similar dichotomy was noted regarding administration in rural and remote HHS. As one respondent stated, **"*it's sometimes better as [there's] less bureaucracy bullshit. But sometimes [it's] worse as [it's] person dependent*."**

Suggestions for improvement to reporting pathways mostly related to the desire for greater anonymity, feedback, timeliness and transparency.

One respondent nominated the need for ***"an independent body to review complaints that is separate to the line management structure"*** to increase transparency; two respondents stated they wanted an independent reporting mechanism. Respondents also wanted more support post-reporting; more reporting options; to be able to trust the process and the people involved in it; and that raising a concern would not jeopardise their training or livelihoods.

The desire for an independent body aligns with the suggestions of Haskell et al. (2024) who examined the failure of colleges and employers to prevent BDHR among trainees. The authors suggest that "the logical solution is to create a permanent and truly independent complaints investigation service", noting that "a Commonwealth House of Representatives Standing Committee relating to workplace bullying recommended a 'single entry point to regulators'" to address BDHR (Haskell et al., 2024, p. 13). The need for the protection of an independent reporting pathway came up in the interviews conducted for the present report as well as in the poll. These are possibilities that need to be explored, along with the potential to expand the remit of an existing body or develop a national body that oversees employers' management of complaints.

Respondents' answers to the open poll questions are captured in a table (see Appendix D), noting not all respondents answered all questions.

4.0 Individual Level Interventions

4.1 Industry Experts on Individual Level Interventions

Industry expert participants (n=9) were involved in or had knowledge of various types of ILIs (professional accountability and speaking up interventions) and or services designed to support early career doctors or to which early career doctors turn to for informal and formal sources of advice and support. Some also had knowledge of reporting pathways. Others were HR professionals who had designed and implemented hospital-wide ILIs (including combinations of speaking up and professional accountability programs, reporting pathways, and individual psychosocial safety mechanisms). Some were senior doctors and consultants involved in the design of college-based ILIs. Others provided one-on-one support for early career doctors (e.g. coaching, education, advice) or had worked in settings where ILIs were implemented. Individual coaching for senior doctors to improve their professional awareness and development was another type of ILI aimed at improving professional accountability.

Overall, BDHR was acknowledged as ubiquitous in HHS and early career doctors were recognised as a significantly vulnerable group. Participants noted ILIs represented positive movements towards psychosocially safer workplaces. Large-scale initiatives were observed by those involved in their rollout to have been a contributing factor to positive cultural shifts in their organisation. One example included an initiative leading to the creation and normalisation of a direct pathway between senior and early career doctors to speak about personal safety issues. One reported broad support in their organisation for further funding and research on ILIs.

Those involved with the design of initiatives frequently nominated problems with the evaluation of ILIs, such as evaluations carried out by third parties, data not being available (or on hand), and difficulties in measurement and attribution of evaluation results, emphasising the need to segment data to identify outcomes for different groups. The need for evolving frameworks for ILIs was also identified.

The industry expert participants consistently noted strong resistance to cultural change by senior doctors, leadership, and executives as an impediment to ILIs and other initiatives. Although criticism varied, common themes included the superficial application of BDHR policies; ingrained unprofessional behaviour by long-time staff members (often described as racist and sexist); and a culture of covering up complaints to protect high-level staff rather than addressing issues.

It was also noticed by the industry expert participants that early career doctors are becoming more engaged in self-advocacy (albeit due to generational shifts rather than interventions). However, while an overall increase in self-advocacy was noted, industry experts observed the aversion to reporting remains strong among early career doctors — an observation supported by the data of actual reporting in the Medical Training Survey. Power imbalances between junior and senior doctors, subjectivity in assessment, and fear of reprisal were described as the major barriers to reporting. Multiple industry expert participants observed that rotation between units and hospitals is a barrier to speaking up, reporting that early career doctors are keen to avoid professional penalties for speaking up and often opt to “wait it out” instead of voicing concerns.

Industry experts confirmed IMGs experience unique roadblocks to reporting, particularly in small clinics where the ability to speak up can be impeded by a lack of reporting mechanisms, conflicts of interest, and the threat of poor performance evaluations jeopardising their ability to remain in the country. IMGs also experience racism — in the workplace and in the community.

Participants were overwhelmingly critical of a lack of transparency in current reporting systems, noting a lack of communication of outcomes to doctors who have made reports. Echoing the views of the poll respondents, the absence of anonymity in reporting was recognised as an extra barrier for early career doctors in small HHS. However, anonymised reporting was also acknowledged as problematic, as it prevents follow-up.

Professional Accountability Programs

Overall, industry expert participants who had been involved in or had observed professional accountability programs in their workplaces believed there was more to be done to improve them. Although there was some evidence of their value, others were critical of attempts to improve accountability, highlighting their potential for misuse and to obfuscate underlying issues.

Increased Awareness and Voice

The following vignette from a participant involved in the development of a professional accountability program demonstrates how such programs can raise behavioural awareness — and lead to speaking up. Describing a very senior colleague's unwanted touching (harassment), she observed that ***"he had very little understanding that his (non-sexual) touching was unwelcome. This was noted as common in other instances of unprofessional behaviour such as bullying, where in the first instance of a … reprimand, offenders have often never been told and are genuinely surprised to hear their behaviour is disturbing"***. She also noted that it was only with the advent of the program that someone actually said something about it. Highlighting the changes that occurred as result of the program, she added:

"[We] definitely think there's been a change and our own internal evaluation across the fellows and trainees shows that the egregiousness of the behaviour has decreased. So even though our prevalence data hasn't changed, nevertheless, there's a lot less of the kind of egregious end of things."

Conversations on professional behaviour and awareness of terms associated with psychological safety also increased, pointing to the utility of program language that ***"reminds people to moderate their own behaviour."***

More Accountability

However, the same participant affirmed the need for appropriate action when required:

"The other thing we've learned is that even though you can start very much framing [professional accountability] as an educational rather than punitive process from the outset, you do need that punitive kind of thing to give it teeth."

For example, after some individuals had failed to address their unprofessional behaviours despite experiencing their "third cup of coffee conversation" (peer messenger intervention), the program's designers realised that educational elements need to be coupled with strategies for escalation. Since then, she reported, ***"the official complaints process has been rejigged twice."***

Another participant commented on the effectiveness of the professional accountability program in the hospital she had worked at for many years, highlighting the demoralising effect when disciplinary action is not enforced, stating only ***"one time in the 17 years that I was at the hospital could you understand that disciplinary action had been taken because of the reports [that had been made]."***

Another industry expert participant observed professional accountability programs are sometimes not applied to senior doctors or are narrow in their focus — for example, targeting sexual harassment but not bullying. This highlights the difficulty in proving behaviours meet with the legal definition of bullying and suggests micro-aggressions could be a recommended threshold for pre-emptive action. Another was critical of programs that enforce "nice culture" in which speaking nicely to each other is enforced ***"... [placing] a specific kind of emphasis on civility and professionalism.*** This, they believed, ***"silences dissent and reinforces a very specific ethno-cultural background"*** that can disadvantage vulnerable staff.

Failure to Address Problematic Cultures

One industry expert participant was critical of professional accountability programs that focus on building respectful ways of working together rather than practical ways to speak up, believing they avoid dealing with deeply engrained cultural issues in organisations, and provide a cover for supervisors to deflect future issues:

"I just don't think that they are the solution. I think they create issues around organisational accountability because once they've run the program, "You should have just spoken up". They really don't hark back to the actual issue — that the behaviour should never have been tolerated or occurred. [Instead] the person you're talking to is just another person with their own stuff going on."

Another industry expert participant highlighted issues with an internal survey in which work units were ranked in terms of their "blame culture". Those ***"rated 'blame plus' get special support from the administration to try and improve their rating.*** "

However, the participant reported the initiative was potentially being used to exit staff who fail to assimilate to problematic cultures, improving unit scores but reinforcing underlying issues:

"Informally, I hear that the [aim] is basically to try to get the people who think [their unit] is in a blame plus culture to exit. So it's less about 'What can we do about that culture?' and more 'How can we decrease the reporting rate from this unit by getting rid of the noisy people?' ... Well, that seems to be essentially barking up the wrong tree."

Remarks of a similar nature, made by an early career doctor participant, are appropriate to include here. Referring to a professional accountability program implemented by their college, they commented it was initially ***"earth-shattering that [the college] would put their name on such a course."*** However, they believed over time, ***"the program has become less effective and that improper solutions can reinforce existing power structures or lead to shallow performativity that doesn't address issues."*** They also believed that **"*culture change officers and similar do not have ability to bring about change and are mostly performative."***

As an industry expert participant commented, organisations need to take responsibility to effect a cultural shift:

"It's [about defining what] behaviour is acceptable and not acceptable within the organisation. What kind of action is taken in response to people speaking up? Because if people think that it's futile or they think that it's dangerous, it's not going to happen. Whereas if the organisational culture is 'This behaviour is not acceptable and we will take swift action for anyone who behaves in this way', then that's what shifts things for all groups, including early career doctors."

Lack of Targeted Interventions

A participant involved in the rollout of a professional accountability program recalls it did not target early career doctors specifically — it was concerned with ***"issues around culture, around bullying, around harassment, discrimination, racism [that] are not doctor-specific — there was a very strong sense that we should be treating everyone the same."*** Concerns about broadscale approaches to the design and especially evaluation of ILIs were frequently raised by industry-expert participants (and working group members) who pointed to a lack of data regarding outcomes for early career doctors.

Addressing Medical Culture

One industry expert was involved in the design of a new online, college-based professional development program. As with most of the ILIs described in this report, it was designed for all doctors, **"*to basically teach [them] to be nice to each other*."** Holistic in its focus, it addressed the human factors and cultural issues in medicine at the individual level:

"The program starts with talking about the system, and the culture we work in, and then brings it down to our teams and our communication and our leadership styles, and then to individual factors — because it does revolve around developing some vulnerability and sharing that. It breaks it down over four weeks to give people time to feel safe and supported in the program. It has education on understanding your own emotions and how you can develop and grow emotional literacy and how that can affect your interactions and your ability to thrive in medicine.

As a culture of medicine, [we] take very young clinicians who haven't quite developed their own sense of self and put them into a culture that encourages them to depersonalise themselves and those around them — and that results in people being arseholes and thinking that that's appropriate. And then just perpetuating the same behaviour over and over and over, because 'That's what happened to me'. So you have to be tough and do X, Y, and Z to survive in medicine. [But] we've got so many other choices."

Teaching early career doctors about boundaries, a cornerstone of the participant's clinical work practice, was a key element in the program:

"I always find it really challenging [getting early career doctors to understand] the concept that they're allowed to say no. I'm like, 'How do you feel when your boundaries are respected?'. They're like, 'Oh, I feel really good'. And I'm like, 'Yeah. And how do you feel when you protect other people's boundaries?'. They're like, 'Oh, I feel really good'. 'Then why are we not saying no when something's inappropriate?' Whether 'That's my time and I don't want to do extra shifts' or 'That's not my job' or 'Don't talk to me like that'".

Speaking Up Programs

Overall, industry-expert participants reported less exposure to speaking up programs other than those designed to raise clinical (patient safety) concerns. One recalled working on the 'communicating for safety" portion of a national standards project in which there was investigation of culture and how to improve staff interaction with colleagues and patients but stated they had ***"never seen a speaking up for safety program succeed."*** Similarly, albeit referring to reporting pathways rather than speaking up programs, another industry-expert participant stated they ***"could not recall a hospital reporting system that was functional."***

Another industry expert advanced the case for not teaching early career doctors to speak up: ***"in the medical hierarchy, early career doctors are the most powerless — to train them to speak up, if it's done in a hostile environment, you're going to just make things worse."*** Referencing the well-known Vanderbilt methodology, used in many ILIs in Australian and globally (see the table in Appendix E), they noted:

"The Vanderbilt approach at that time was they don't even go near early career doctors.

They encourage their supervisors and other people in their workforce ... It was much better to [give everyone] a greater appreciation of the expectations around professional conduct in the health system as a whole, and the normalisation of speaking up as a whole, before you start to encourage early career doctors to speak up an isolated group. It was like, it's a bit premature to do that. Yes, it's probably got merit, but let's fix up a few other things first."

Proposed Solutions

Overall, the industry experts expressed that initiatives designed to minimise BDHR, improve psychosocial safety and professional accountability, and normalise speaking up are not enough to elicit the cultural change required to change the status quo. They pointed to a need for more work on individual-level interventions and reporting pathways, and a deeper acknowledgement of the organisational and leadership responsibilities of HHS leaders and executives.

5.0 Working Group Members on Individual Level Interventions & Reporting Pathways

5.1 Working Group Members on Individual Level Interventions and Reporting Pathways

The following observations were made by members of the ILIRP working group. Echoing the views of the industry expert interviewees, a key concern was that despite a plethora of programs and pathways designed to address BDHR, **"*nothing has significantly shifted the dial*"** — a perception supported by the data in successive annual Medical Training Surveys. Group members' perceptions about the reasons why change has been slow to occur are described next.

Early Career Doctor Vulnerability

Confirming the views of the early career doctor and industry expert-participants, working group members noted early career doctors are vulnerable in ways that prevent them from speaking up and using reporting pathways.

For example, early career doctors are subject to **reputational risk**. For example, those who are part of specialty training networks can benefit from an increased sense of belonging and camaraderie. However, the close-knit nature of these communities can ***"stifle their willingness to speak out — because they know that the label of being a troublemaker will follow them within their network."*** The same dynamic exists within the medical profession generally. Early career doctors vying for college positions are often subject to ***"whispers and judgment"*** — informal performance evaluations that can hinder career progression. These are also reputational judgements that can precede early career doctors' arrival to a new position or post and that can influence perceptions, expectations and future assessments.

More than any other group in healthcare, early career doctors are also vulnerable to **career disruption** by operational or training supervisors who decide to execute ***"quiet reputational sabotage***." As one group member noted, the culture of medical training, rather than discouraging and even reporting such behaviour, encourages it by reciprocity and endorsement:

"It is past time for "off the record" discussions about early career doctors to stop. Such conversations need to be clearly delineated as unacceptable, a breach of privacy legislation, and possible professional misconduct. Requests for such informal information-gathering must be refused, and unsolicited approaches to share such information should also be refused. Ideally, both should be reported to the relevant college and the medical professional lead of the employing healthcare facility."

Early career doctors also fear speaking up could trigger a **negative assessment** — they are also subject to formal performance evaluations and require referrals from supervisors and consultants. In the words of one group member, **"*they are so engrossed in the development of their identity as doctors in the specialty of their choice, or the career path of their choice, that they're not really willing to take risks with that.*"**

They are also immersed in environments where **deviant behaviours** are the norm and thus are part of the professionalisation process. As the group member quoted above explained:

"Because intense socialisation and identity development is happening, [along with] the normalisation of inappropriate behaviours in healthcare workplaces [where] nurses and other health professionals and even administrative staff exhibit these behaviours as well … it turns into this fetid pool of inappropriate behaviours that people then don't call out as inappropriate. The normalisation of deviance happens and it doesn't get reported."

Early career doctors also have high workloads with **high cognitive loads** and thus **"*lack the mental space to try and find some capacity to make a report*."** Those working in hospitals where overtime is now paid can be reluctant to use that time to report.

The normalisation of deviance in healthcare workplaces and the high cognitive loads experienced by doctors at all levels can result in them **failing to recognise instances of BDHR** when they occur. As one group member noted, **"*interventions require the person to be seasoned enough to recognise that something is inappropriate. It's only when they have a quiet moment to sit and think that they realise that a line was crossed*."** This can lead to further issues such as self-recrimination for not speaking up in the moment and delayed reporting. Lack of clarity around what is a reportable act, event, or behaviour can also result in uncertainty and shame.

Lack of information on the potential impacts on career, work responsibilities, and progression also leads to early career doctors delaying reporting until the end of clinical placements or terms. Early career doctors are also often unaware of who is responsible for them, particularly those outside the college system such as pre-vocational doctors. Their concerns about **confidentiality** mean they sometimes ask nursing staff to report on their behalf.

Early career doctors are also exceptionally **mobile**, changing roles, units, and hospitals frequently. This impedes their ability to fully participate in interventions, and to know who to report to or what reporting mechanisms are available. They also miss out on helpful training:

"The problem with offering organisationally driven education programs is that generally the early career doctors who are rotating around don't have time or get prioritised or get considered or get included in that, because they're only here for three months or they're only here for six months or they're only here for 12 months."

Lack of Ownership

The group observed that BDHR is **"*nobody's problem to fix.*"** Regulators, HHS, colleges, and employers can ignore BDHR issues when they arise and fail to take ownership of the entrenched problem of abusive behaviour towards early career doctors.

Some early career doctors are disadvantaged more than others:

"The early career doctors — at least [those on a] training program — have a college that has some interest in them.

The early career doctors ... that are outside the training programs — the cohort that are pre-vocational — are probably even more vulnerable because they wander around and [are] unsure about career pathways and who's actually looking after them ... [They're] the lost tribes of medicine."

Also known as principal house officers (PHOs), this group was acknowledged as particularly vulnerable in regional hospitals where:

"You might have three registrars on a training program, and then 12 not on a training program. They're all doing the same work [although the PHOs have] often been there longer ... [But] they are often treated like second-class citizens in some hospitals because they're not on the training program.

The Australian Medical Council are very concerned about this "lost tribe" and the fact that they are actually incredibly vulnerable because they're trying to get on to a training program. So they will eat anything that's in front of them. They're less likely to report. They don't have any support structure. And they're desperately trying to appease a powerful, potentially abusive leader so that they can get the reference to get on to the training program."

Early career doctors who have chosen not to undertake specialist training and have opted to be career medical officers were described as another "lost" group. Group members believed responsibility for these "lost tribes" of medicine ultimately rests with the employer. As one member stated:

"A board is responsible for the psychosocial culture of their organisation, and that's an opportunity to push down on to the shoulders of the various operational leads, whether that's the operational stream, or the executive directors of medical services. It requires a collaborative approach."

Picking up on this theme, another group member suggested that the role of good clinical and corporate governance in monitoring and addressing cultural issues in the workplace also needed to be emphasised under the quality and safety agenda.

Regarding the early career doctors who are members of the specialist colleges that train them in their HHS workplaces, one member stated:

"Colleges do, in fact, have a shared duty of care with employers in terms of the individual within a workplace education setting. Some colleges still don't acknowledge that. Where this often falls down is the communication between the hospitals and the college in terms of managing a complaint. Sometimes the complaint will come via the college, sometimes it'll come via the hospital. At the end of the day, both will ideally have an appropriate role in seeing how it's handled."

This concurs with recent research that concludes colleges, from a governance perspective, "appear to have significant responsibilities to address BDH involving their members" (Haskell et al., 2024, p. 3).

However, an audit of college policies (Haskell & Merridew, 2023) found policies vary widely and junior (and senior) doctors are working in environments in which "there may be 17 different applicable BDH policies — the employer's own BDH processes, plus the policies of up to 16 colleges" (Haskell et al., 2024, p. 4). Doctors who are not college affiliated also work in these environments and are impacted by the confusion.

Conflicts of interest within organisations also contribute to the perpetuation of BDHR, such as retaining staff who display questionable behaviours to meet service objectives, concerns about retaining college training accreditation, and the desire to minimise negative publicity.

For example, although colleges have the right to withdraw a trainee from a problematic post and, ultimately, withdraw a training post accreditation from a facility (steps acknowledged as being of last resort and highly disruptive), jurisdictions exert pressure on colleges not to take either course of action.

Lack of Targeted and Timely Approaches and Evaluations

Again, echoing the thoughts of the industry-expert participants, group members noted BDHR strategies designed to "***recognise the vulnerability of early career doctors are few and far between***." If all-staff strategies are implemented, these need to discern what different work groups have in common and what is unique. Furthermore, "***the outcomes of BDHR strategies are also evaluated globally".*** Group members recognised that major programs have made improvements, ***"…but we don't know if they've improved the experience of doctors in training ... those evaluations are virtually absent from the literature. We really are, in this conversation, making the case for specific evaluations."***

As has been noted throughout, external surveys of early career doctors at national (e.g. AHPRA, 2023) and state levels (e.g. AMA Queensland, 2024) yield some information about their experiences of BDHR. Colleges and health departments also survey early career doctors. The national Medical Training Surveys conducted by AHPRA indicate BDHR remains a persistent problem for early career doctors. However, an AMA Western Australia survey (AMA WA, 2023) suggested improvements had occurred across a hospital group where strategies to address BDHR were implemented (Government of Western Australia, 2022; Krishnasivum et al., 2024; North Metropolitan Health Service, 2022).

The extent to which external data can be used to extrapolate results was, however, acknowledged as questionable:

"Early career doctor participation in these surveys can also vary, and survey terminology can lead to imprecise meanings, potentially skewing results. As none use standard measures, they can't be benchmarked against one another. They can't be synthesised to give you an aggregation of what the whole system is doing."

Group members also noted surveys can be superficial and, to get a deep understanding of early career doctors' responses to BDHR strategies, ***"focus groups and interviews are really, really important."***

Timeliness of reporting processes and outcomes were also deemed critical as they affected complainants' willingness to raise a concern:

"Sometimes these investigation processes — should something get to that point — just drag on, drag on, drag on ... and then there's the increased risk to reputational damage ... and psychosocial harm while that's occurring. Especially if the trainee is only in that place for six months — a process that takes two years is simply not fit for purpose. People can be gone and so the impetus to act disappears if it takes ages. The psychological burden over that prolonged period is huge for all involved too."

Failure to provide feedback was also a problem:

"[If complainants] haven't heard back, or there is no transparency as to what happens after they reported, they feel like, 'All right, I made a great deal of effort, did the reporting, but then what? I might have compromised my identity in that process, but then I didn't gain anything back'. All systems and all parts need to work together."

Complex and Stressed Landscape

Group members were concerned about the increasing **fragmentation of visibility and responsibility**, noting that there are now parallel reporting pathways in hospitals – a professional stream and an operational stream. As **"*a lot of the junior medical staff don't know who their boss's boss is*"**, opaque reporting pathways were nominated as a potential system driver of some of the dysfunction.

System stress was also identified as problematic:

"You're more likely to have bad behaviour when a system is stressed. And I think the health system in general at the moment is very, very stressed. Education, mentoring — those things that nurture a better culture — are difficult to do when you're trying to run around and manage fires left, right, and centre."

The stresses that stem from working in a stressed system can also lead to unprofessional behaviours in people who ordinarily would not offend:

"There are some people who are recidivist, ongoing, and recalcitrant perpetrators. But we need to stop necessarily blaming people who come to work intending to do good and end up behaving in a way that even makes them ashamed."

Conversely, failure to address BDHR was also recognised as detrimental: "***if it goes on and on and on and nobody is prepared to address it, trainee after trainee after trainee is the subject of that poor behaviour."***

6.0 Recommendations

6.1 Recommendations

The working group recognised that isolated programs designed to reduce BDHR such as ILIs and reporting pathways "***are not [in and of themselves] the panacea for all ills***." However they can be effective if considered in terms of the underlying cultural issues and implemented in environments that support them:

"[Interventions] are most efficacious in the context of a workplace environment that supports the behaviours and the broader cultural change that we're looking for. A broader leadership, policy, and training environment that assists with promoting the behaviours that we want to see, as opposed to tolerating the ones we don't want to see. We need to keep revisiting that all the time because sometimes individual-level interventions are used as the bandaid. The cultural issues aren't addressed, but they'll send someone off to do a course or they'll expect that as a consequence of a peer-led conversation, a person's behaviour [will change] and the world will be fine again."

With this in mind, the group advanced a series of recommendations grouped around four themes: accountability, design, professional development, and support.

Accountability

1. Employers and colleges should address and mitigate BDHR using a **risk management approach** that ensures BDHR is treated as seriously as other workplace health and safety issues and that, where appropriate, BDHR offenders are held **accountable** using due process and a restorative justice framework.

2. Employers should ensure that the work to implement recommendation 13 of the National Health Practitioner Ombudsman report on accreditation processes is enhanced to benefit early career doctors who are not affiliated with a college, with particular focus on non-accredited registrars and IMGs.

3. Governments should continue efforts to strengthen **levers in the broader environment** to support the eradication of BDHR (e.g. training accreditation, safety and quality accreditation, and WHS codes and legislation).

4. The Healthcare Workforce Taskforce (or other appropriate entity) should commission a review on the merit and costs of establishing an **independent, external reporting system** as a key element in an escalating scale of interventions (see Design Recommendation 5).

5. Accreditation bodies should require **transparency** in reporting mechanisms, processes, and outcomes for BDHR, and improve the cycle of reporting so concerns are acted upon in a timely manner.

6. Employers and colleges should reduce early career doctors' fear of reporting by assertively discrediting and systematically dismantling the custom and practice of informal information exchange about trainees.

Design

1. The Commonwealth should fund healthcare specific adaptation, implementation, and evaluation of proven interventions from within health and other sectors, ensuring **segmented evaluation**, so outcomes for early career doctors are visible.

2. Employers and colleges should develop a simple, easy-to-understand **reporting roadmap** that aligns the spectrum of BDHR behaviours with a continuum of informal to formal reporting options.

3. Employers and colleges should ensure reporting pathways and interventions are **inclusive** and recognise the difficulties faced by IMGs and other ultra-vulnerable groups in the early career doctor cohort, and consider **anonymous reporting options** in those pathways.

4. Entities that receive and manage reports should increase **transparency** in the reporting process by ensuring progress and outcomes are communicated to complainants and alleged offenders to the extent permissible by law.

Professional Development

1. Universities, colleges, and employers should start early and continue **education** on BDHR and professional conduct and communication throughout the career life cycle and ground education in an **understanding of the circumstances** that allow BDHR to flourish.

2. Education programs and workplaces should address **socialisation and cultural factors** that create organisational and individual tolerance of threats to healthcare workers' health and safety.

Support

1. Familiarise early career doctors with their environments and the reporting pathways available to them, ensuring **orientation** is provided in the first week whenever a change of workplace occurs.

2. Provide **psychological support** to notifiers and alleged offenders and reduce the psychological burden of reporting and responding by ensuring **prompt action**.

3. Support early career doctors at the individual and small-group levels via coaching and other targeted, **micro-interventions**.

"I'm a living testament to the fact that it's possible to have a good internship experience, a good residency experience. And if it's never been done before, or never thought it was possible, I can attest to the fact that it's possible."

Early Career Doctor

7.0
Conclusion

7.1 Conclusion

Creating safe and respectful workplaces for early career doctors, and all healthcare professionals, requires a comprehensive and synergistic approach, and the ongoing commitment of regulators, universities, HHS, colleges, and private medical workplaces. It will also take time; the culture of the medical profession is historically slow to change, and the elements that perpetuate BDHR may resist transformation.

However, change can and does occur. As one industry expert participant observed, when she was an intern, ***it was very rare that someone took a break in training or did a locuming year, and now it's reasonably common to do that and in some areas, it's supported by colleges.***

This report represents a step in the right direction. More work is required to identify exactly what levers to pull, and how, at all levels — which aspects of existing interventions and reporting pathways are to be retained, and what can be revised or discarded.

8.0 Appendices

8.1 Appendix A: Individual Level Interventions and Reporting Pathways Terms of Reference

Purpose and Scope

These terms of reference establish the Individual Level Interventions Working Group for A Better Culture.

The working group is established to support the advisory board via provision of content expertise on individual level interventions and reporting pathways. The working group will define and promulgate mechanisms for individual-level intervention based on “just culture” concepts with clear delineation of blameworthy acts (e.g. criminal actions, intentional abuse, repeated recidivist behaviour).

The working group will be responsible for the following outputs:

- national and international review of individual level interventions
- specific engagement with doctors-in-training regarding reporting pathways
- identifying existing pathways for trainees to report concerns and develop recommendations for improvement.

The working group will comprise experts drawn from existing programs melded with health-industry specific knowledge from reference group members and inputs generated through the mapping activities of the national framework.

The Individual Level Interventions Working group will be time-limited and in place until the end of 2024, at which time it will be disbanded. Oversight will be provided by the advisory board until the project closes and hands over management of workplace culture reform to “business as usual” elements of various entities.

Responsibilities

The primary responsibility of the working group is to:

- undertake a brief national and international review of individual level interventions.
- undertake specific engagement with doctors-in-training regarding reporting pathways.
- define and promulgate mechanisms for individual-level intervention based on just culture concepts with clear delineation of blameworthy acts.
- identify principles of a good effective system to address trainee complaints.
- identify existing pathways for trainees to report concerns and develop recommendations for improvement.

8.2 Appendix B: Definitions

Term	Definition
Anti-racism	**Anti-racism** is an active process, unlike the passive stance of "non-racism" (Australian Human Rights Commission, 2022a). Anti-racism work requires consistent and targeted actions at systemic, institutional, interpersonal, and individual levels.
Belonging	Similar to inclusion, **belonging** is the feeling of security and support when there is a sense of acceptance, inclusion, and identity for a member of a certain group (Cornell University, 2023). It allows an individual to present their true self (at their workplace, school, etc.).
Bias	**Bias** is a tendency to favour one group over another. Unconscious bias, also known as implicit bias, is defined as "attitudes or stereotypes that unconsciously alter our perceptions or understanding of our experiences, thereby affecting behaviour, interactions, and decision-making" according to Marcelin et al. (2019).
Bullying	Repeated unreasonable behavior directed towards a worker or group of workers that creates a risk to health and safety (Safe Work Australia, n.d.). This includes bullying by workers, clients, patients, visitors, or others.
Bystander	A **bystander** is a person or group of people not directly involved as a target or perpetrator in an act of violence, discrimination, or other unacceptable behaviour (Marcelin et al., 2019).
Cultural safety	**Cultural safety** is determined by Aboriginal and Torres Strait Islander individuals, families, and communities, with culturally safe practice requiring ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours, and power differentials in delivering safe, accessible, and responsive healthcare free of racism (Australian Health Practitioner Regulation Agency, 2019).

Discrimination	**Discrimination** occurs when a person is treated badly or unfairly compared to another person because of their background or certain personal characteristics (Australian Human Rights Commission, 2022b). Federal discrimination laws protect people from discrimination on the basis of their race (including colour, national or ethnic origin or immigrant status), sex, pregnancy, marital status, family responsibilities or breastfeeding, age, disability, sexual orientation, gender identity, or intersex status.
Diversity	**Diversity** is about what makes each of us unique and includes our backgrounds, personality, life experiences, beliefs, and all the things that make us who we are (Victorian Government, 2023). It is also about recognising, respecting, and valuing differences based on ethnicity, gender, age, race, religion, disability, and sexual orientation. It can also include an infinite range of individual unique characteristics and experiences, such as communication style, career path, life experience, educational background, geographic location, income level, marital status, parental status, and other variables that influence personal perspectives.
Harassment	**Harassment** occurs when someone is treated less favourably due to personal characteristics such as age, disability, race, nationality, religion, political affiliation, sex, relationship status, family or carer responsibilities, sexual orientation, gender identity, or intersex status (Australian Human Rights Commission, 2022b).
Inclusion	**Inclusion** occurs when people feel valued and respected regardless of their personal characteristics or circumstances (Victorian Government, 2023). They should have the opportunity to fulfil their individual and combined potential according to their talents and perspectives, have access to opportunities and resources and bring their full selves to their jobs.
Leader	An individual who influences, guides and motivates others towards achieving goals (Jones, 2007).
Leadership	The concept of **leadership** has been defined as the ability to influence, guide, and direct others to achieve common goals (Northouse, 2021). It involves setting a vision, inspiring others, and effectively managing resources and relationships (Dubrin, 2023).

Lived and living experience	**Lived and/or living experience** is personal knowledge gained through direct, personal involvement in life events or circumstances. It also often refers to the insights and expertise of individuals who have experienced mental health issues, trauma, or other significant life challenges (Byrne et al., 2021).
Professional development	**Professional development** is achieved through continuous learning and skill enhancement activities that help individuals advance their careers and improve their professional competencies (Williams, 2022). It includes training, education, and experiential learning opportunities.
Psychological safety	**Psychological safety** refers to a work environment in which employees feel safe to express themselves and take risks without fear of negative consequences such as humiliation, punishment, or discrimination (Safety Australia Group, 2023). Psychological safety is essential in ensuring a safe and healthy work environment.
Psychosocial risk or hazard	**Psychosocial risks or hazards** refer to work-related factors that may have negative effects on an employee's mental health and wellbeing, such as excessive workloads, workplace conflict, exposure to traumatic events, etc. (Safety Australia Group, 2023).
Racism	**Racism** is the process by which systems, policies, actions, and attitudes create inequitable outcomes for people based on race (Australian Human Rights Commission, 2024). It extends beyond prejudice in thought or action, occurring when this prejudice — whether individual or institutional — is accompanied by the power to discriminate against, oppress, or limit the
Senior management	**Senior management** refers to a group of high-level executives (such as CEOs, COOs, and others) responsible for overseeing the overall operations and strategic direction of an organisation.

Sexual harassment	**Sexual harassment** is unwanted sexual behaviour that would cause a reasonable person to feel offended, humiliated or intimidated, and can include subjecting a person to unwelcome physical contact, sexually suggestive comments or jokes, comments, or questions of a sexual nature about a person's private life or the way they look, or unwanted displays of affection (Australian Human Rights Commission, 2022b).
Trauma awareness	**Trauma awareness** refers to the understanding and recognition of the impact that traumatic experiences (such as abuse, neglect, natural disasters, community events, etc.) can have on individuals' mental, emotional, and physical wellbeing (Brunzell, 2021).
Trauma informed	**A trauma informed** approach acknowledges the effects of trauma and integrates this understanding into policies, practices, and interactions (Bateman et al., 2014). It aims to create safe environments that support healing and recovery.
Upstander	An **upstander** is a person who chooses to take action when they are a bystander. Actions include aiming to stop the perpetrator, using de-escalation techniques, supporting a target, formally reporting the incident, or seeking assistance from others (Marcelin et al., 2019).
Workplace culture	**Workplace culture** is determined by the shared values and practices that characterise an organisation (Manley et al., 2011).
Workplace	A **workplace** is any place where work is carried out or where a worker goes, or is likely to be, while at work (Work Health and Safety Act 2011 (NSW) s.8).

8.3 Appendix C: Participant Details

+ Early career doctor participants (focus groups and interviews) (n=12)

Gender	Age	Location	Training classification	Work status	HHS	Current work location
M	35-44	—	Junior consultant and IMG	Full-time	Hospital	Regional
F	35-44	WA	Specialist trainee	Full-time	Hospital	Metro
F	—	ACT	Junior consultant	Full-time	—	—
F	35-44	VIC	Specialist trainee	Part-time	GP clinic	Metro
F	25-34	QLD	Pre-vocational trainee and IMG	Full-time	Hospital	Rural
M	35-44	TAS	Advanced trainee	Full-time	Hospital	Metro
F	35-44	TAS	Junior consultant	Part-time	Hospital	Metro
F	44-49	VIC	Specialist trainee	Full-time	Hospital	Metro
F	35-44	NSW	Specialist trainee	Locum	Hospital	Metro
F	35-44	NT	Pre-vocational trainee	Full-time	Hospital	Metro
F	—	QLD	—	—	—	—
M	35-44	NSW	Specialist trainee	Full-time	Hospital	Metro

+ Industry expert participants (interviews) (n=9)

Job Role	Organisation
Coach and educator	Medical professional association
GP specialist	General practice and public hospital
Senior manager	CPD home
Organisational psychologist (WHS and wellbeing)	Public hospital
Senior HR professional	Public hospital
Team manager	Medical defence organisation
Organisational consultant	Medical college
Specialist consultant	Public hospital
Legal adviser	Medical defence organisation

+ Junior and senior doctor poll participants (n=27)

Training/ role classification		Identify as		Age		Area of practice	
Pre-vocational trainee	4%	Male	48%	25-30	13%	Hospital	43%
Registrar	17%	Female	52%	31-35	22%	General practice	35%
Fellow	65%	Non-binary	0%	36-40	22%	Specialty practice	4%
Other - Doctor	4%	Aboriginal or Torres Strait Islander	4%	41-50	17%	Other healthcare	17%
Other (not a doctor)	9%	Neither Aboriginal nor Torres Strait Islander	96%	51-60	17%		
				61-70	9%		

8.4 Appendix D: Responses to the Open Poll Questions

What reporting pathways are available to you?	What makes/would make reporting pathways safe?	Does working rural/remote impact reporting?	If you are an IMG, does this impact reporting?	If you are an Aboriginal or Torres Strait Islander, does this impact reporting?
Line manager. Principal GP and practice manager. College may not feel like this is a training issue and it could be discerned as a contract issue/workplace culture and needs to be addressed by line manager even if perpetrator is line manager.	Independent auditing by users of the pathways.	Very much so ... as you need to socialise, have shared friends ... with colleague in conflict with.	IMG may have their family as dependents on the visa. Any action may affect the whole family.	Yes, if you're the one Aboriginal employee working in a workplace, you cannot report about an Aboriginal issue without them knowing who is reporting.
In practice follow the practice guidelines. If uncomfortable doing this, then try practice owners, senior GP. If in hospital, IMS or report through DMS or executive services.	Training for staff implementing pathways on consistency in responding, particularly on pastoral care/wellbeing after reporting.	Loss of any degrees of separation, and the overwhelming clinical imperative, distant manager intrusion, lack of respect and repeated failing to appreciate the clinical need.	Ability to get general registration, supervisor can dictate your ability to get gen reg and to delay it so that you can't move hospital. Also visa in general.	

What reporting pathways are available to you?	What makes/would make reporting pathways safe?	Does working rural/remote impact reporting?	If you are an IMG, does this impact reporting?	If you are an Aboriginal or Torres Strait Islander, does this impact reporting?
A close friend and colleague. Otherwise, there are no systems above me that help realistically.	Identifiable characteristics not shared where appropriate.	Worry about limiting training options.	I am no longer an IMG. If I lost my job in the past my visa would be cancelled, and I would be deported.	
Discuss with practice manager or CEO. Escalation could include legal avenues, health minister, journalist.	Confidence that this won't affect job prospects.	Next level of reporting is at a distance.	IMG here: I felt progressively safer when I gained permanent residency and then citizenship.	
GP — practice manager. Hospital — director of medical services.	Anonymous options (if in large enough organisation to actually make it anonymous). Knowing that there is a culture of follow-up of reports. Knowing that managers get professional development to support their responses to this.	Yes — the power that executive has over rural workforce. Lack of accountability with executive decision making.		
My friend. The applicable college or medical workforce. The locum agency. Their employer. My boss or the culprit's line manager. RiskMan system.	Transparency, immediate feedback.	Manager may be well known to you.		

What reporting pathways are available to you?	What makes/would make reporting pathways safe?	Does working rural/remote impact reporting?	If you are an IMG, does this impact reporting?	If you are an Aboriginal or Torres Strait Islander, does this impact reporting?
Exec, HR	Anonymity, trust and clarity like a most significant change process — see Davies and Dart.	Potentially more leverage if you know they need you.		
Practice manager.	Regular updates.	Don't shit where you eat.		
Have guidelines, policy, procedures in this to report as is likely a breach of code of conduct, make report to HR.	Confidentiality. When feedback is invited and scheduled so that those who aren't as courageous have the opportunity to speak out. Non-judgement. Assurance of follow-up.	Power imbalance with tertiary centres who controlled recruitment of our hospital.		
Complaints software platform. Line manager. Colleague. Anonymous feedback.	Putting the right people in positions of power.	Perpetrators can more easily get a job in areas where there is no one else.		
None that I trust.	Anonymous, at least initially.	Relationships within the locality.		
Supervisor. Medical educator. Consultant. Doctors in training committee. DMS/medical admin.	Having support person.	It's sometimes better, as less bureaucracy bullshit. But sometimes worse, as person-dependent.		
AMA/ASMOF.	Transparency, feedback, anonymity, etc.	Yes. Isolation, closer relationships with the perpetrator often. Fear of further isolation once reported.		

What reporting pathways are available to you?	What makes/would make reporting pathways safe?	Does working rural/remote impact reporting?	If you are an IMG, does this impact reporting?	If you are an Aboriginal or Torres Strait Islander, does this impact reporting?
In my AMS I would report to HR. On my hospital job to line manager.	Trust and integrity	Loyalty to community and workplace.		
Supervisor (head of department) Regional director. HR department.	Permissioning. A concept that reduces power difference.	Struggling to recruit doctors in the first place so knowing that despite their actions the perpetrators won't be held accountable.		
My seniors/supervisors. Early career doctors' committee. Mentors. DMS.	Anon. No fear of retribution. No fault. Feedback. Independent.	You are more likely to know the people you are reporting to and reporting about.		
My manager. People and culture. Safety team. Peer manager.	External/independent person.	Well, it's never going to be anonymous. It could go either way depending on the workforce culture, but you're more likely to know/predict what response you will get.		
General manager. Practice manager. Medical director. Board of the organisation.	Authority to escalate without losing my job.	Friendship circles. Impossible to be anonymous.		
Clinical colleagues senior to me.	Anonymity (if possible). Being able to be selective of where the report will go.	Hidden bullying, line managers not present, untrained managers, put up with bad staff to fill the roster.		

What reporting pathways are available to you?	What makes/would make reporting pathways safe?	Does working rural/remote impact reporting?	If you are an IMG, does this impact reporting?	If you are an Aboriginal or Torres Strait Islander, does this impact reporting?
Talk to supervisor. Talk to DMS (exec). Put in a RiskMan online form.	Timely response. Closed loop communication regarding outcomes.	The people in power above you don't know who you are, what you do, and care very little.		
RiskMan. Written or verbal report to manager. Written or verbal report to HR. Seek advice from ASMOF?	Actual outcomes after reporting	Yes. The hierarchical relationships are stronger.		
Inform boss.	Having a good relationship with the person you would report to.	It's harder to remain anonymous because of identifying features/data when reporting.		
Hospital DMS.	Good relationship, trust, ethical behaviour.	Limited alternative job prospects.		
Report to practice manager/owners. DMS for hospital.	Transparency that there is an independent body to review complaints that is separate to the line management structure.	There is no capacity to anonymously report and protect oneself from retribution.		
Designated officer. Direct to manager. Up the chain.	Anonymity. Any sense that there might be a positive outcome.	Lack of anonymity. Fewer people in line of "command".		
I have to look it up.	Independent person to report to.	Proximity. Isolation risk. Lack of anonymity.		

What reporting pathways are available to you?	What makes/would make reporting pathways safe?	Does working rural/remote impact reporting?	If you are an IMG, does this impact reporting?	If you are an Aboriginal or Torres Strait Islander, does this impact reporting?
IIMS. In-person report to facility manager or practice manager.	Certainty that the concern will be listened to, investigated, and feedback provided.	Can make anonymity much more difficult. Can make giving feedback more "personal".		
HCCC.	Evidence that concerns are acted upon and privacy is ensured.	Less anonymity and support.		
HR, a senior doctor.	Feedback loops.	Less anonymity, friendships.		
-	Knowing what happens within the black box.	Lack of anonymity.		

8.5 Appendix E: Summary of Individual Level Interventions, Reporting Pathways and Other Strategies

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
Vanderbilt and Derivative Programs (Often implemented via the Cognitive Institute)							
Vanderbilt Health Centre for Patient and Professional Advocacy, Vanderbilt University Medical Centre (Vanderbilt Health Centre for Patient and Professional Advocacy, 2024).	Encourages self-reflection and course correction among physicians engaging in unprofessional behaviour. Challenges the normalisation of unprofessional behaviour.	Capability training – delivers graded assertiveness training to encourage staff to speak up when they experience or witness behaviour that undermines patient safety. If staff are unable to speak up, they can provide feedback about unprofessional behaviour (Feedback for Reflection), or about positive behaviours that promote safety and quality (Feedback for Recognition) using an online messaging	Tiered model of intervention. Starts with informal, nonpunitive peer feedback for less severe behaviour (e.g., a cup of coffee conversation with a trained peer), and escalates in formality.		All staff	USA	Lowers the risk profile of physicians in terms of patient complaints. Sustained high levels of hand hygiene adherence when used as part of a wider behaviour change initiative.

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
		system with the option of staying anonymous.					
Cognitive Institute An independent provider of healthcare education (now a subsidiary of Medical Protection Society, UK). (Cognitive Institute/Medical Protection Society, 2024).	Whole-of-hospital programs in which clinical and non-clinical staff are empowered to speak up in the moment about unprofessional behaviour.	Speaking Up for Safety program. Provides a common language through the 'Safety C.O.D.E.' model to standardise communication when raising concerns. Balances patient safety with respect.	WeCare: An online messaging system used to report unprofessional behaviours or recognise staff who demonstrate the organisation's values. Reporters can choose to remain anonymous. Allows hospital staff to report co-worker behaviours (positive and negative). Submissions are triaged by a trained multidisciplinary team and then sent to a peer messenger or line manager who delivers the message.		All staff	Australia, NZ, Malaysia, Indonesia, Singapore & UK. See https://www.cognitiveinstitute.org/ and https://www.medicalprotection.org/uk/professional-development-courses	

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
Ethos (Medical Council of NSW, 2019)	Aims to change culture by addressing unprofessional behaviour and recognising behaviours that demonstrate professionalism (Churruca et al., 2023, p. 3). Middle managers play a crucial role in addressing these behaviours (Bagot et al., 2023, p. 1).	Similar educational programs focused on improving communication have also been effective in reducing adverse events and increasing incident reporting. These have led to improved staff attitudes and skills in speaking up, contributing to a safer and more respectful environment.	The Ethos program provides a confidential, non-punitive online system for reporting and peer messengers who provide feedback. (Bagot et al., 2023, Churruca et al., 2023).			8 hospitals in Australia (St Vincent's Hospitals, Mater Hospitals & The Royal Melbourne Hospital)	Following implementation there was a significant reduction in unprofessional behaviours, with incivility/bullying declining by 24% and extreme behaviours by 32% (Westbrook et al., 2021, p. 31).
CORS Program (Co-worker Observation Reporting System)	Addresses disrespectful and unsafe behaviours by physicians and advanced practice professionals who are reported by their co-workers (Webb, 2016, p. 149).				All staff	USA	3% of medical staff were associated with a pattern of CORS reports and 71% of recipients of pattern-related reports were not named in any subsequent report in a one-year follow-up. Follow-up surveillance indicates that the majority of professionals "self-regulate" after receiving CORS data (Webb, 2016, p. 149).

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
Safety Culture program (Safer Care Victoria, 2024)	Reducing unprofessional and unsafe behaviours, including disrespectful communication, intimidation, disruptive behaviour, working in a way that reduces safety such as failing to conduct patient risk assessments (McKenzie et al., 2019, pp. 694-705).	Increasing professional and safe behaviours such as, speaking up for safety, encouraging teamwork, completing safety-related processes such as practicing hand hygiene (McKenzie et al., 2019, pp. 694-705).	A graduated intervention process for addressing unprofessional staff behaviours. The process starts with informal peer-led conversations, progressing to formal disciplinary procedures if behaviour persists.	Adapted Vanderbilt model. Implemented via partnership with the Cognitive Institute. Appointed accredited Safety Champions to promote a safety culture and deliver speaking up for safety education sessions.	All clinical and non-clinical staff in a tertiary hospital.	Victoria, Australia	Strengthening safety culture remains an enduring challenge. Disruptive behaviours were sometimes emulated by impressionable individuals, suggesting junior staff might adopt the unprofessional behaviours of their senior colleagues, perpetuating a cycle of unprofessional conduct (McKenzie et al., 2019, p. 694).
Harvard / Simulation-Derived Programs (grounded in the simulation literature contributed to by the Harvard group and/or based on Harvard's Speaking with Good Judgement program)							
Patient Safety Net (Queensland Health, 2024)		Plans to integrate the High Value Conversations model (see entry below) have been announced.	Implemented as part of Queensland Health's Patient Safety Net as a response to the Mackay Base Hospital investigation. A reporting system focused on patient safety. Staff raise concerns internally to a designated patient safety steward, or		All staff	Implemented as part of Queensland Health's Patient Safety Net as a response to the Mackay Base Hospital investigation.	Pilot program evaluation was completed in July 2024. The exact outcomes are unknown, however the program will be rolled out across the state in 2025, indicating it the pilot was deemed successful.

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
			externally to a Queensland Health steward in the patient safety area of the Department of Health. The Patient Safety Net can be activated via phone, email, face-to-face or via an online portal. The safety steward receives, reviews and assess reports from staff. If the concern is not within the scope of the Net, the steward assists the reporter to access the appropriate pathway. (Queensland Health, 2024).			4 pilot Queensland Health HHS (Gold Coast, Townsville, Children's Health Queensland and Central Queensland)	
High Value Conversations / Speaking with Good Judgement		Aims to give staff skills to speak up in the moment. Includes all conversations healthcare workers have with colleagues (not only about patient safety).			All staff	Mater Queensland.	Evaluation involves cultural surveys and cultural safety surveys that examine willingness to speak up. There was a significant shift in Mater culture over the first year of the program where SWGJ language could be heard in corridors, meetings, theatre

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
(Mater Education, 2024).		Starts with the basic assumption that everyone wants to do the best job they can – there is no intent to harm or to make things difficult and uncomfortable for juniors and peers. A graded response system that commences with a 'nudge' from a peer messenger to encourage recipients to correct their behaviour. A second nudge might be required – a coaching conversation delivered by the peer messenger or supervisor or manager. A third, more formal level uses facilitators trained in HR principles to deliver intervention.					rooms and in debriefing processes.

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
		Also attempts to change the capability of the system and understand the root causes of key issues and address them.					
Advocacy Inquiry/ Cognitive Rehearsal (Centre for Medical Simulation, 2024).		A Harvard-derived, structured model for conducting challenging conversations. Used in simulation education and all settings. The PAAIL mnemonic is used to aid debriefers and others who engage in learning conversations: Preview: State what you'd like to talk about Advocacy 1: I saw – state what was observed, in objective terms Advocacy 2: I think – your perspective and the impact of the observed behaviour					Can be used with Cognitive Rehearsal, a primary prevention and intervention communication strategy used to address incivility in health care and educational settings. Working with a facilitator, participants practice addressing stressful situations in a non-threatening environment. The goal is to modify or enhance social or interpersonal skills by rehearsing effective strategies or behaviours to be used in future real-life situations.

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
		Inquiry: I wonder – ask the receiver what was on their mind at the time. Listen: To understand the frames behind the observed action.					
RACS (Royal Australasian College of Surgeons) Initiatives							
Building Respect, Improving Patient Safety (Royal Australasian College of Surgeons, 2024a).	A program designed by RACS (the Royal Australasian College of Surgeons) to reduce BDHR in surgical settings, where in 2016, 54% of trainees reported an experience of bullying.	See below.	A centralised complaints management office and support officer appointed; weekly triage and management of complaints raised: surgical advisors appointed to offer peer support to complainants and alleged offenders and to signpost complaints pathways outside the college where appropriate.	Focus on increasing the gender diversity in the surgical workforce; actions to support an increase in First Nations surgical trainees; adoption and support for cultural competence as the tenth surgical competency; inclusion of evidence-informed policy initiatives (e.g. flexible training) in hospital accreditation guidelines;	Surgical trainees, SIMGs and surgeons	Australia and NZ	Independent evaluation indicated: increasing awareness of RACS reporting pathways; preference for utilisation of RACS pathways compared with workplace reporting mechanisms. Barriers to reporting persist and are consistent with those found in the qualitative interview results in this report. (Royal Australasian College of Surgeons, 2024c)

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
			Development of information sharing protocol as part of accreditation of hospital training posts.	sustains communications and ongoing professional development options on sexual harassment, racism. (Royal Australasian College of Surgeons, 2024b)			
Operating With Respect (OWR) (Royal Australasian College of Surgeons, 2024d).	Training for senior doctors to improve their professional awareness and develop skills to address unprofessional conduct with their peers. OWR offers advanced, compulsory training for RACS members including surgical trainees and surgical IMGS so they can recognise, manage and prevent BDHR.	OWR includes training on speaking up. An OWR Speak-up app was launched in 2019.			Surgical supervisors	Australia and NZ	Surveys of 252 attendees revealed the face-to-face program was moderately effective in reducing BDHR in surgical workplaces. Respondents strongly agreed that bullying remains a problem, and improvement for employing organisations. (Gretton-Watson, 2024, p. 576).

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
	Training is online via e-learning modules; and in-person for surgical supervisors (Gretton-Watson, 2024, p. 576).						
TeamSTEPPS and Derivatives							
TeamSTEPPS Program **(Team Strategies and Tools to Enhance Performance and Patient Safety)** (Agency for Healthcare Research and Quality, 2024).		Provides training and tools to enhance collaboration, communication, leadership, situation monitoring and mutual support among team members. Founded by the Department of Defence (Aviation) and the Agency for Healthcare Research and Quality (AHRQ) in the USA. 8 steps to create a culture of safety, reduce medical errors and improve patient outcomes through effective team strategies (Rosenstein et al, 2017, p. 75).	An incident reporting system where each complaint is evaluated on its individual merit with recommendations for appropriate follow-up.		All staff. Designed for high-pressure and complex healthcare environments.	South Australia Health has partnered with AHRQ and implemented Team STEPPS.	After 1 year, results showed significant improvement in professional and organisation streams, including in communication, mutual support, situation monitoring, communication openness, patient safety and organisational learning and continuous improvement (Aaberg et al., 2021, p. 1).

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
EARRTH **(Early Awareness & Rapid Response Training in Hospitals)** (Nakatani et al., 2024)		An educational program aimed at improving communication for better teamwork to a reduce adverse events (AEs). Included 4 TeamSTEPPS tools. Did not target unprofessional behaviours but future iterations could. Did provide education for early career doctors.			General training targeted all employees. Practical training was an additional program for early career doctors and nurses (defined as having 5 years' experience or less in their roles). An interactive leadership training program for departmental safety officers and leaders (i.e., managers, directors and executives) was later developed.	A teaching hospital in Japan.	Following the intervention, early career doctors and nurses perceived fewer barriers to speaking up and had more positive attitudes towards voicing opinions as measured by a psychological scale. This suggests the intervention promoted staff willingness to speak up, which could lead to improved communication and decrease in AEs. Continuous increases in annual incident reports per employee following the interventions support these results.

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
Other Initiatives							
JMO Manifesto (Krishnasivam et al. 2024).			Incorporates a below-the-line behaviour reporting pathway – a process that includes peer supports to ensure that JMOs feel comfortable and safe using the pathway (North Metropolitan Health Service, 2022).	Strategies to resolve significant problems with recruitment and retention of early career doctors in a Western Australia hospital. The JMO Manifesto was developed with early career doctors to address issues they nominated as important, such as part-time opportunities and psychological safety. Actions arising from the Manifesto included optimising overtime processes, ensuring leave, instilling above and below the line behaviours, and streamlining the reporting of concerns.	Early career doctors.	A hospital group in Perth, Western Australia.	Actioned new processes for leave allocations, a centralised claiming system for overtime that removed hierarchical barries, new processes for reporting bullying claims, 24/7 medical workforce support and the redistribution of FTE to create part-time positions, reducing JMO vacancies from 92 to almost zero. The group was the WA employer of choice for JMOs and the highest ranking WA public health service in the 2023 AMA Hospital Health Check. (Post Graduate Medical Council of Western Australia, 2024).

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
CREW (Civility, Respect and Engagement in the Workforce) (Osatuke et al., 2009)		A group process with an interactive format (sharing concerns about relationships), role plays and structured exercises) designed to reset thresholds for civility and incivility (Leiter, 2011, 2012). A problem-solving format in which constructive relationships are the primary resource and employees are encouraged to take responsibility to address dysfunctional relationships. Focused on the '4As of civility': Acknowledgement, Appreciation, Acceptance and Accommodation. (Leiter, 2016).			All staff.	Canada	After one year civility improved and continued to steadily improve. Burnout and illness declined. (Leiter, 2016).

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
Guardian of Safe Working Hours (GOSW) (NHS Employers, 2021). **GOSW Junior Doctors Forum** (National Health Service, 2016).			Involves exception reporting, a mechanism early career doctors can use to report patient safety, rostering and training concerns. Access is given to all early career doctors at induction. The hospital trust has a quarterly meeting and produces quarterly reports of the findings of the exception report. One hospital also has a Junior Doctors Forum which meets monthly and is well attended.	Champions safe working hours for doctors in approved training programs. A complementary, internal monitoring system (with no focus on underlying causes). Safe working guardians are senior people independent of the organisation's management. They ensure issues of compliance with safe working hours are addressed as they arise.	Early career doctors.	NHS, UK.	
Promoting Professional Accountability (Cognitive Institute, 2019)	Aimed at fostering a culture of accountability and safety among staff, the program targeted doctors in private hospitals, and all		Ramsay Health worked with their IT department to design and install a custom-made, easy-to-use reporting tool.	Resistance to the program was overcome with regular open forums to answer questions and foster support.	Clinical staff.	Ramsay Health, Australia	The program is not effective in isolation and requires a full, top-down commitment to a 'no blink' approach.

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
	clinical staff in public and private facilities.					Ramsay adopted a two-stage approach for rollout, starting with a pilot involving 10,000 staff members before expanding the program across all 73 facilities.	Incorrect assumptions can derail the program; consistent communication is key – at the start the project team experienced resistance from doctors. Commitment was vital for success. The program requires the full commitment of board executive, and the medical advisory committee as well as the local working parties. National visibility and authority about what needed to happen and when was essential.
Helplines and support groups (various)				These are organisations to which early career doctors turn for support. Includes those offering confidential, peer-to-peer support for doctors (e.g. Hand-n-Hand), and those providing free health advisory and referral services, (e.g. Doctors4Doctors).	Doctors and other healthcare professionals	Australia	

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
Senior peer models				Chief Resident/ Senior Registrar/ Junior Consultant roles in which the most senior doctor still in (or just out of) training is able to advocate for early career doctors because their position is relatively secure. In NZ, the Chief House Officer is the early career doctor advocate. They work through roster and overtime issues, etc. and are endorsed by their facility as the representative voice for the House Officer cohort. Not a funded role – it has to be undertaken within the role allocation.	Early career doctors.	US, Australia and NZ.	
Speaking Up Support Scheme		A range of support for past and present NHS workers who have experienced a significant adverse	A post-speaking up support program. Formerly known as the Whistleblowers Support Scheme.		All staff.	England, UK.	All participants who completed the scheme reported increased levels of hope, self-belief, resilience, and optimism, with many attributing these

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
(NHS England, 2024).		impact on both their professional and personal lives to move forward following a formal speaking up process. Provides mostly psychological support.	Coaches and scheme managers provide: - health and wellbeing sessions - one-to-one psychological wellbeing support - career coaching - personal development group workshops - practical support through group sessions.				improvements directly to the scheme. Despite each participant's unique experience, common organisational themes emerged, including perceptions of HR and the misuse of hierarchical power by leaders. (NHS England, 2023).
Freedom to Speak Up (NHS England, 2024) **Freedom to Speak Up Training** (National Guardian's Office, 2024)		'Speak Up, Listen Up, Follow Up' is an online, structured program of support, including health and wellbeing, one-to-one psychological wellbeing support, career coaching, personal development workshops and a range of practical group sessions.	1000+ guardians to whom workers can speak up to openly, confidentially or anonymously.		All workers in NHS Trusts and other health organisations.	England, UK.	Evaluation of the FSUG program is difficult given the variability of implementation across England. A lack of available resources, especially time negatively and significantly impacted on their ability to effectively respond to concerns and collects and analyse speaking up data (Jones et al., 2021).

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
		(Delpino et al., 2023, pp. 4-6).					Barriers to speaking up included interdepartmental issues related to culture, context and the reactions and behaviours of others. Staff felt victimised or ostracised by senior management and colleagues, which hindered further raising of concerns. A widespread fear of speaking up for oneself or others due to the fear of reprisal was another barrier (Delpino et al, 2023, p. 4).
Sexual Harassment Contact Officers				Sexual Harassment Contact Officers – employees with no line management responsibilities identified as individuals able to advise about next steps.	Public service workers	Sectors outside healthcare in Australia	Could be adopted for healthcare. Comcare has provided a referral pathway guide to help navigate reporting sexual harassment. (Comcare, 2024). The Queensland Government directive 'Preventing and Responding to Workplace Sexual Harassment' supports staff to utilise the pathways set out in the directive. (Queensland Government, 2023).

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
Champions for Change Coalition (Champions of Change Coalition, 2023).			The Coalition's guide to preventing and responding to sexual harassment in the workplace (2023) is an example of existing policies and procedures that can be adapted and adopted to guide the formation of clear, nationally benchmarked BDHR reporting pathways.			Australia	The document outlines multiple reporting pathways for workplace sexual harassment to ensure a person-centred, trauma-informed, safe, and fair approach. For example, employees can report incidents in person, by phone, online or anonymously. They can also speak to a qualified person. Managers are equipped to receive and act on disclosures in a trauma-informed and person-centred manner. An anonymous reporting option helps remove the fear of retribution and allows organisations to identify potential hotspots and high-risk situations. Clear guidelines and support are provided for anonymous reports.
Health and Safety Representatives (HSR)			HSRs represent the health and safety interests of a work group	Employees in a work group can report to the HSR and raise any issues regarding their group.	All staff.	Legislated in Queensland and mandatory in all HHS.	There is no evidence of adherence to this legal requirement when it comes to early career doctors.

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
WorkSafe QLD **Work Health and Safety Officer (WHSO)** (Workplace Health and Safety Queensland, 2020).			and raise issues with their employer. They identify, report and investigate health and safety hazards, risks and incidents and establish educational and training programs on work health and safety.	HSR are usually confined to supporting their own work group, unless there is a serious risk to health and safety or a worker from another group asked for the HSR's assistance and the HSR from that work group is unavailable.			It might not be clear which group they belong to.
Junior doctor groups (various)				Committees of early career doctors who meet to share industry issues and challenges relevant to them, and advocate for change. The AMA Queensland Committee of Doctors in Training (CDT) is the peak advocacy group for early career doctors in Queensland.	Early career doctors.	Australia	

Strategy Name/Type	Professional Accountability Programs	Speaking Up Programs	Reporting Pathways	Advocacy/ Representation/ Support Models	Target Group(s)	Location	Outcomes/ Comments
				The Junior Doctor Advisory Committee is a national early career doctor advisory group auspiced by MDA National, a medical defence organisation. Committee members are early career doctors who represent their peers from internship to pre-fellowship.			

8.6 Appendix F: References

Aaberg, O. R., Hall-Lord, M. L., Husebø, S. I. E., & Ballangrud, R. (2021). A human factors intervention in a hospital – Evaluating the outcome of a TeamSTEPPS program in a surgical ward. *BMC Health Services Research, 21*(1), 1. https://doi.org/10.1186/s12913-021-06071-6

AMA Queensland (2024). *2024 Resident Hospital Health Check*. https://www.ama.com.au/qld/campaigns/resident-hospital-health-check

AMA Western Australia (2023). *Hospital Health Check 2023*. https://www.amawa.com.au/wp-content/uploads/2023/06/Hospital-Health-Check-2023-Report.pdf

Australian Health Practitioner Regulation Agency. (2019). *The national scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025*. In AHPRA (p. 9). Australian Health Practitioner Regulation Agency. https://www.AHPRA.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx

Australian Human Rights Commission. (2022). *Quick guide to discrimination law.* Australian Human Rights Commission. https://humanrights.gov.au/education/employers/quick-guide-discrimination-law

Australian Human Rights Commission. (2023). *Let's talk about equality and equity.* Australian Human Rights Commission. https://humanrights.gov.au/lets-talk-about-equality-and-equity

Australian Human Rights Commission. (2024). *Good practice guidelines for internal complaint processes*. https://humanrights.gov.au/our-work/employers/good-practice-guidelines-internal-complaint-processes

Australian Human Rights Commission. (2024). *Understanding racism.* Australian Human Rights Commission. https://humanrights.gov.au/understanding-racism

Australian Public Service Commission. (2023). *Psychosocial safety.* https://www.apsc.gov.au/initiatives-and-programs/aps-professional-streams/aps-human-resources-hr-profession/aps-hr-professional-news/psychosocial-safety#:~:text=Psychosocial%20hazards%20refer%20to%20aspects,reduce%20our%20ability%20to%20cope

Bagot, K. L., McInnes, E., Mannion, R., McMullan, R. D., Urwin, R., Churruca, K., Hibbert, P., & Westbrook, J.I. (2023). Middle manager responses to hospital co-workers' unprofessional behaviours within the context of a professional accountability culture change program: A qualitative analysis. *BMC Health Services Research, 23*(1012).

Barkell, N., & Snyder, S. (2021). Just culture in healthcare: An integrative review. In *Nursing Forum, 56*(1), 103-111. https://doi.org/10.1111/nuf.12525

Bateman, J., Henderson, C., & Kezelman, C. (2014). *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia — a national strategic direction.* Mental Health Coordinating Council. https://mhcc.org.au/wp-content/uploads/2018/05/nticp_strategic_direction_journal_article__vf4_-_jan_2014_.pdf

Brunzell, T. (2021). Trauma-Aware practice and positive education. In M. Kern & M. Wehmeyer (Eds.), *The Palgrave Handbook of Positive Education* (p. 207). Palgrave Macmillan Cham. https://doi.org/10.1007/978-3-030-64537-3_8

Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., & Saunders, M. (2021). *National Lived Experience Workforce Guidelines* (pp. 13–15). National Mental Health Commission. https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/national-lived-experience-peer-workforce-development-guidelines.pdf

Champions of Change Coalition (2023). *Disrupting the system: Preventing and responding to sexual harassment in the workplace — Building confidence and trust in workplace responses to sexual harassment.* https://championsofchangecoalition.org/wp-content/uploads/2023/11/Building-confidence-and-trust-in-workplace-responses-to-sexual-harassment-1.pdf

Churruca, K., Westbrook, J., Bagot, K. L., McMullan, R. D., Urwin, R., Cunningham, N., Mitchell, R., Hibbert, P., Sunderland, N., Loh, E., & Taylor, N. (2023). Retrospective analysis of factors influencing the implementation of a program to address unprofessional behaviour and improve culture in Australian hospitals. *BMC Health Services Research, 23*(584), 3. https://doi.org/10.1186/s12913-023-09614-1

Clinical Excellence Commission. (2016). *PREPARED model — A guide for clinicians for conversations about the last days of life.* https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0006/359277/PREPARED-model-for-difficult-conversations.PDF

Comcare. (2024). *Harassment including sexual harassment.* https://www.comcare.gov.au/safe-healthy-work/prevent-harm/psychosocial-hazards/harassment

Cornell University. (2023). *Sense of belonging.* Cornell University Diversity and Inclusion; Cornell University. https://diversity.cornell.edu/belonging/sense-belonging

Creese, J., Byrne, J., Matthews, A., McDermott, A., Conway, E., & Humphries, N. (2021). “I feel I have no voice”: Hospital doctors' workplace silence in Ireland. *Journal of Health Organization and Management, 35*(9), 178-194. https://doi.org/10.1108/JHOM-08-2020-0353

Delpino, R., Lees-Deutsch, L., & Solanki, B. (2023).‘Speaking Up’ for patient safety and staff wellbeing: a qualitative study. *BMJ Open Quality, 2023(12)* Article e002047, 4-6. https://doi.org/10.1136/bmjoq-2022-002047

Doctors4Doctors (n.d.). *About Doctors4Doctors*. https://www.drs4drs.com.au/about-us

Dollard, M. F., & Bakker, A. B. (2010). Psychosocial safety climate as a precursor to conducive work environments, psychological health problems, and employee engagement. *Journal of Occupational and Organisational Psychology, 83*(3), 579-599. https://doi.org/10.1348/096317909X470690

Dubrin, A. J. (2023). *Leadership: Research findings, practice, and skills.* (10th ed., p. 2). Cengage Learning.

Edmondson, A. (1999). Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly, 44*(2), 350-383. https://doi.org/10.2307/2666999

Government of Western Australia. (2022, December). *NMHS Junior Medical Officer Manifesto*. https://www.nmhs.health.wa.gov.au/News/2022/12/14/Junior-Medical-Officer-Manifesto

Gretton-Watson, P., Oakman, J., & Leggat, S. G. (2024). Evaluating anti-bullying training in surgery: surgeons' perceptions from Australia and Aotearoa New Zealand. *Australian Health Review, 48*(5), 576–584. https://doi.org/10.1071/ah24104

Hall, G., Dollard, M., & Coward, J. (2010). Psychosocial safety climate: Development of the PSC-12. *International Journal of Stress Management, 17*(4), 353. https://doi.org/10.1080/10615806.2012.700477

Hand-n-Hand (n.d.). *Hand-n-Hand Peer Support*. https://www.handnhand.org.au/

Haskell, T., Stankovich, J., & Merridew, N. (2024). A new framework for Australian specialty colleges and other healthcare leaders to address bullying, discrimination, and harassment that involves doctors. *The Lancet Regional Health — Western Pacific, 48* (101118). https://doi.org/10.1016/j.lanwpc.2024.101118

Hughes, H. (2019). Freedom to speak up – the role of freedom to speak up guardians and the National Guardian's Office in England. *Future Healthcare Journal, 6*(3), 186-189. https://doi:10.7861/fhj.2019-0031

Jones, A., Maben, J., Adams, M., Mannion, R., Banks, C., Blake, J., Job, K., & Kelly, D. (2021). A mixed methods evaluation of the implementation of "Freedom to Speak Up Guardians" in NHS England Acute Trusts and Mental Health Trusts. *NIHR Journals Library*. https://openresearch.surrey.ac.uk/esploro/outputs/report/A-mixed-methods-evaluation-of-the/99587023202346#file-0

Jones, M. (2007). *What is a leader, anyway?* Exchange, November/December. https://www.exchangepress.com/library/5017874.pdf

Krishnasivam, D., Eskander, G., & Osborough, A. (2024). *The NMHS JMO Manifesto.* https://racmaconference.com.au/the-nmhs-jmo-manifesto/

Leape, L., Shore, M., Dienstag, J., Mayer, R., Edgman-Levitan, S., Meyer, G., & Healy, G. (2012). Perspective: A culture of respect, Part 1: The nature and causes of disrespectful behaviour by physicians. *Academic Medicine, 87*(7), 845-852.

Leiter, M. P. (2016). *Improving civility contributes to wellbeing at work* [PowerPoint slide]. https://www.ohsu.edu/sites/default/files/2019-02/Michael-Leiter-2016-SummerInstitute-ImprovingCivility-Slides-OHWC.pdf

Leiter, M. P., Day, A., Laschinger, H. K. S., & Gilin-Oore, D. (2012). Getting better and staying better: Assessing civility, incivility, distress, and job attitudes one year after a civility intervention. *Journal of Occupational Health Psychology, 17*, 425-434. https://doi.org/10.1037/a0029540

Leiter, M. P., Laschinger, H. K. S., Day, A., & Gilin-Oore, D. (2011). The impact of civility interventions on employee social behavior, distress, and attitudes. *Journal of Applied Psychology, 96*, 1258-1274. https://doi.org/10.1037/a0024442

Lister, V. (2024). *Medical professional silence: Understanding the professional forces that prevent early career doctors from speaking up about their working conditions.* [PhD thesis in preparation.]

Manley, K., Sanders, K., Cardiff, S., & Webster, J. (2011). Effective workplace culture: The attributes, enabling factors and consequences of a new concept. *International Practice Development Journal, 1*(2). https://www.fons.org/wp-content/uploads/2024/03/IPDJ_0102_01.pdf

Marcelin, J., Siraj, D., Victor, R., Kotadia, S., & Maldonado, Y. (2019). The impact of unconscious bias in healthcare: How to recognize and mitigate it. *The Journal of Infectious Diseases, 220*(2), 62–73. https://doi.org/10.1093/infdis/jiz214

Marx, D. (2019). Patient safety and the just culture. *Obstetrics and Gynaecology Clinics of North America, 46*(2), 239–245. https://doi.org/10.1016/j.ogc.2019.01.003

McKenzie, L., Shaw, L., Jordan, J. E., Alexander, M., O'Brien, M., Singer, S. J., & Manias, E. (2019). Factors Influencing the Implementation of a Hospital-wide Intervention to Promote Professionalism and Build a Safety Culture: A Qualitative Study. *The Joint Commission Journal on Quality and Patient Safety, 45*(10), 694–705. https://doi.org/10.1016/j.jcjq.2019.07.005

Medical Board of Australia and AHPRA (2023). *Medical Training Survey 2023.* https://medicaltrainingsurvey.gov.au/Results/Reports-and-results

Medical Board of Australia and AHPRA (2024). *Medical Training Survey 2024.* https://www.medicaltrainingsurvey.gov.au/Download/2023/2023-Medical-training-survey-National%20report.pdf

National Health Service. (2016). *Junior doctors forum — guidance for employers.* https://www.nhsemployers.org/system/files/2021-06/junior-doctor-forum-guidance-nov2016.pdf

National Health Service. (2021). *Information for guardians of safe working hours.* https://www.nhsemployers.org/articles/information-guardians-safe-working-hours

NHS England. (2023). *Speaking Up Support Scheme evaluation report 2023.* https://www.england.nhs.uk/long-read/speaking-up-support-scheme-evaluation-report-2023/

NHS England. (n.d.). *Speaking Up support scheme.* https://www.england.nhs.uk/ourwork/freedom-to-speak-up/speaking-up-support-scheme/

North Metropolitan Health Service. (2022). *NMHS Junior Medical Officer Manifesto.* https://www.nmhs.health.wa.gov.au/News/2022/12/14/Junior-Medical-Officer-Manifesto

North Metropolitan Health Service. (2024). *JMO Wellbeing Guide 2024.* Post Graduate Medical Council of Western Australia. https://pmcwa.org.au/media/attachments/2024/01/12/pmcwa-jmo-wellbeing-guide-2024.pdf

Northouse, P. (2021). *Leadership: Theory and Practice* (9th ed., pp. 5–7). Sage Publications. https://books.google.com.au/books?id=HJ08DwAAQBAJ&pg=PT28&source=gbs_toc_r&cad=2#v=onepage&q&f=false

NSW Health. (2022). *What is trauma-informed care?* https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/trauma-informed.aspx

Queensland Government. (2023). *Preventing and responding to workplace sexual harassment (Directive 12/23)*. https://www.forgov.qld.gov.au/pay-benefits-and-policy/directives-policies-circulars-and-guidelines/preventing-and-responding-to-workplace-sexual-harassment-directive-1223

Queensland Government. (2024). *About adult restorative justice.* https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/settling-disputes-out-of-court/restorative-justice/about

Queensland Health. (2024). *Patient Safety Net*. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/patient-safety-staff-escalation

Ramsay Health Care. (2019). *Promoting Professional Accountability program in practice.* Cognitive Institute. 1-3. https://www.cognitiveinstitute.org/wp-content/uploads/Case-Study-RAMSAY-PPA-v1.4.pdf

Robinson, O. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology, 11*(1), 25-41. https://doi.org/10.1080/14780887.2013.801543

Rosenstein, A. (2017). Disruptive and Unprofessional Behaviours. *Physician Mental Health and Wellbeing, 75*. https://doi.org/10.1007/978-3-319-55583-6_3

Safe Work Australia. (2024). *Psychosocial hazards*. https://www.safeworkaustralia.gov.au/safety-topic/managing-health-and-safety/mental-health/psychosocial-hazards

Safe Work Australia. (n.d.). *Bullying*. Safe Work Australia. https://www.safeworkaustralia.gov.au/safety-topic/hazards/bullying

Safety Australia Group. (2023). *Understanding psychological safety and psychosocial risk.* Safety Australia Group. https://safetyaustraliagroup.com.au/understanding-psychological-safety-and-psychosocial-risk/

Saunders, M. N. (2012). Choosing research participants. *Qualitative organisational research: Core methods and current challenges*, 35-52. https://doi.org/10.4135/9781526435620.n3

The Systems Thinker. (2015). *Productive conversations: Using advocacy and inquiry effectively.* https://thesystemsthinker.com/productive-conversations-using-advocacy-and-inquiry-effectively/

Victorian Government. (2023). *What do we mean by diversity and inclusion?* Department of the Premier and Cabinet; Victorian Government. https://www.vic.gov.au/dpc-diversity-and-inclusion-strategy-2019-2021/what-do-we-mean-diversity-and-inclusion

Webb, L. E., Dmochowski, R. R., Moore, I. N., Pichert, J. W., Catron, T. F., Troyer, M., Martinez, W., Cooper, W. O., & Hickson, G. B. (2016). Using coworker observations to promote accountability for disrespectful and unsafe behaviours by physicians and advanced practice professionals. *The Joint Commission Journal on Quality and Patient Safety, 42*(4), 149. https://doi.org/10.1016/s1553-7250(16)42019-2

Westbrook, J., Sunderland, N., Li, L., Koyama, A., McMullan, R., Urwin, R., Churruca, K., Baysari, M. T., Jones, C., Loh, E., McInnes, E. C., Middleton, S., & Braithwaite, J. (2020). The prevalence and impact of unprofessional behaviour among hospital workers: a survey in seven Australian hospitals. The Medical Journal of Australia. 214(1), 31. https://doi.org/10.5694/mja2.50849

Westbrook, J.I. (2023). Middle manager responses to hospital co-workers' unprofessional behaviours within the context of a professional accountability culture change program: A qualitative analysis. *BMC Health Services Research, 23*(1012). https://doi.org/10.1186/s12913-023-09968-6

Wilkinson, A., Barry, M., Hague, L., Biggs, A., & Brough, P. (2024). A voice system or a voice maze? Navigating employee voice in a hospital setting. *Journal of Health Organization and Management. 38*(7), 1090-1107. https://doi:10.1108/JHOM-06-2023-0168

Williams, T. (2022). *What is CPD and why is it important?* UTS Open; University of Technology Sydney. https://open.uts.edu.au/insights/professional-development/what-is-cpd-and-why-is-it-important/

Work Health and Safety Act 2011 (NSW). https://classic.austlii.edu.au/au/legis/nsw/consol_act/whasa2011218/s7.html

Workplace Health and Safety Queensland. (2020). *Health and safety representatives and health and safety committees.* https://www.worksafe.qld.gov.au/safety-and-prevention/creating-safe-work/safety-roles-and-duties/health-and-safety-representatives-and-committees

A Better Culture