A Better Culture

The Pathway to 'Better'

Reflections and recommendations for action from A Better Culture working groups

Contents

Foreword

It gives me great pleasure to present this final report of A Better Culture.

When this project was initiated, many stakeholders believed that the 'solution' lay in producing 'tools', 'training' and/or processes to increase accountability. While all of these are helpful, none of them is the solution.

Our early work, conducted in 2023, confirmed several key factors that influenced subsequent direction:

1. Culture is not changed by tools, training and punishment.
2. Healthcare workplace culture is shaped by the behaviours of everyone, from health ministers to the new graduate.
3. Systemic factors that enable and sustain bullying, harassment, racism, and discrimination must be understood and addressed.

We have observed that the key elements for success - required in any large system reform - are currently missing. These are:

1. Leadership
2. Collaboration
3. Implementation authority
4. Resourcing

In addition to the four key elements noted above, a fifth critical element emerged as a learning of the internal operations of the project – cultural governance. This fifth element is required when managing issues that relate to Aboriginal and Torres Strait Islander peoples – and for this project, that was its entirety. I acknowledge here the deficits in that governance as it related to the various streams of work where, despite our best efforts to include Aboriginal and Torres Strait Islander voices in every working group, it was not sufficient to deliver the vision of governance that is outlined in the Cultural Safety: From Compliance to Commitment Report.

We have formed a strong view that it is not sufficient for those who hold the fiscal and policy power over Australia's healthcare system to abrogate responsibility for this work, leaving the burden to advocacy and peak bodies and unions - as is now the case. Clear leadership intent and long-term vision – backed by resourcing, accountability, a requirement for collaboration and the authority to drive change (and not just advocate for it) – is missing.

Meaningful reform will require deliberate, coordinated, accountable action — not just a hopeful scatter of small, uncoordinated projects.

With workforce being by far the most expensive element of the healthcare system, a deliberate, intentional and focussed attempt to address the issues at the core of A Better Culture must be prioritised for action.

We identified deficits and drivers in the healthcare system that have resulted in our current predicament – where all healthcare professionals (not just doctors) suffer from work environments that are often quite unsafe.

And so, we unapologetically disappoint those who thought that the result of this project would be a training course or a 'how to fix the culture' manual – because improving the culture of healthcare workplaces is going to be a complex, difficult, protracted effort. It is going to require changes to things that some parts of the system desperately want to hold in stasis.

In these pages and in the accompanying curriculum framework and cultural safety report, along with the proposal for a national strategy to reform healthcare workplace culture, we have mapped a pathway to A Better Culture. It should never be forgotten that healthcare workers have a choice to continue their career or diversify. Retaining them, protecting them and helping them flourish is not only the right thing to do in and of itself, but will potentially save a healthcare system where the human element is already under severe strain.

I know that in reading the following pages, healthcare leaders will experience some discomfort, but I hope also for a sense that there are so many things we can do, especially if we work together.

Dr Jillann Farmer
CEO, A Better Culture

Recommendations

Address the vacuum at the top: Issues in governance, leadership and accountability

1. That health ministers require boards and directors general/secretaries for health to provide regular reporting on processes and outcomes for bullying, discrimination, harassment, sexual harassment and racism.

2. That the Australian Government Department of Health, Disability and Ageing (DHDA), in discussion with the jurisdictions, fund the sufficient development of implementation resources to allow pilot sites to adopt the Culture in Healthcare Assessment Tool, and further invest in scale-up once efficacy of the tool is established.

3. a. That the AMC, the CPMC, specialist medical colleges and employers incorporate the evidence-based curriculum framework developed by A Better Culture into the future development of training products.

   b. That DHDA fund the development of a standardised set of learning modules and tools based on the aforementioned curriculum, to scale up implementation efficiently and minimise duplication and waste.

4. a. That DHDA develop a national program for measurement and reporting of workforce and leadership diversity in health care, with specific focus on re-examining and challenging existing stereotypes of leadership.

   b. That workforce strategies and plans use this information to identify fall-off points in the career development pipeline and provide targeted interventions to diverse employees, enhancing their access to career opportunities.

5. That the Minister for Health consult with the Minister for Indigenous Affairs to develop approaches to evaluating and improving the cultural safety of the Indigenous workforce, noting that cultural safety focus to date has been on patients.

New perspectives on workplace health and safety

6. That all healthcare leaders and stakeholders recognise that staff health and safety is as important as patient health and safety, and that the two are inextricably connected.

7. That evidence-based workplace wellbeing programs that explicitly address occupational health, safety and system level issues in healthcare organisations be supported and funded accordingly.

8. That healthcare employers recognise that without effective demand-management strategies, the healthcare workforce is exposed to increasing levels of psychosocial risk. Implementation of productivity and efficiency initiatives must include occupational health measures to protect staff.

9. That governments, through their workplace health and safety regulators, give clear indications to duty holders of their obligation to protect healthcare worker safety by taking appropriate responsive regulatory actions.

10. That the AMC consider, in the current accreditation review of specialist medical colleges, a requirement that occupational health and safety relevant to the risks of each specialty form part of the assessable syllabus for specialist training programs, so that trainees can more effectively manage their own risks, and once qualified, are competent in supervision for safety.

11. That duty holders and workplace health and safety regulators seek and use competent WHS experts of seniority appropriate to the high level of risk, and with the capability to engage clinical staff and unions in meaningful analysis, collaboration and management of the risks of clinical work.

A multifaceted response

12. That employers and training bodies actively promote, support and monitor the provision and receipt of constructive feedback as a key indicator of positive workplace culture, where giving and receiving feedback is safe, normalised and expected as part of professional communication. 'Speaking up' programs may be effective in delivering constructive feedback.

13. That all office bearers and officers of specialist medical colleges acknowledge and act on their responsibilities as concurrent duty holders in relation to the provision of training and associated activities. This extends to consultants and those in private practice.

14. That Ahpra, in consultation with the national health practitioner boards, develop a consistent, evidence-informed national code of conduct for all healthcare workers, applicable across the public and private sectors, reflecting the following areas of focus: healthy and safe work, workplace behaviours, person centred practices, effective communication, positive workplace relationships and a just and learning culture.

Making reporting a safe, viable option

15. That employers and training bodies provide explicit confirmation that off-the-record conversations about individual early-career/trainee doctors are a breach of professional standards, may breach privacy legislation, are not supported, and may not be indemnified.

16. That employers and educational institutions review reporting pathways for characteristics of best practice issues and complaints management, including trauma-informed and culturally safe lenses, with provision for anonymous complaints and access to psychological support.

17. a. That accessible issue resolution options, which serve to normalise help seeking, be included in a graduated scale of interventions, ranging from confidential support and advice, progressing through to formal reporting as end-stage issue resolution.

b. That education about these approaches to both formal and informal reporting and complaints handling should form part of intern induction content, with ongoing brief reinforcing interventions delivered throughout PGY 1-2 and incorporated as part of clinical teaching sessions.

18. That employers ensure that the work to implement recommendation 13[1] of the National Health Practitioner Ombudsman report *Processes for progress, part one* is enhanced to benefit doctors who are not affiliated with any specialty training program or specialist medical college.

19. a. That DHDA establish an independent and nation-wide external assistance system, that can be accessed anonymously, and that directs healthcare workers to the most appropriate support and response mechanisms.

    b. That data from this system be made publicly available, including the volume of reports, the nature of issues and the advice given.

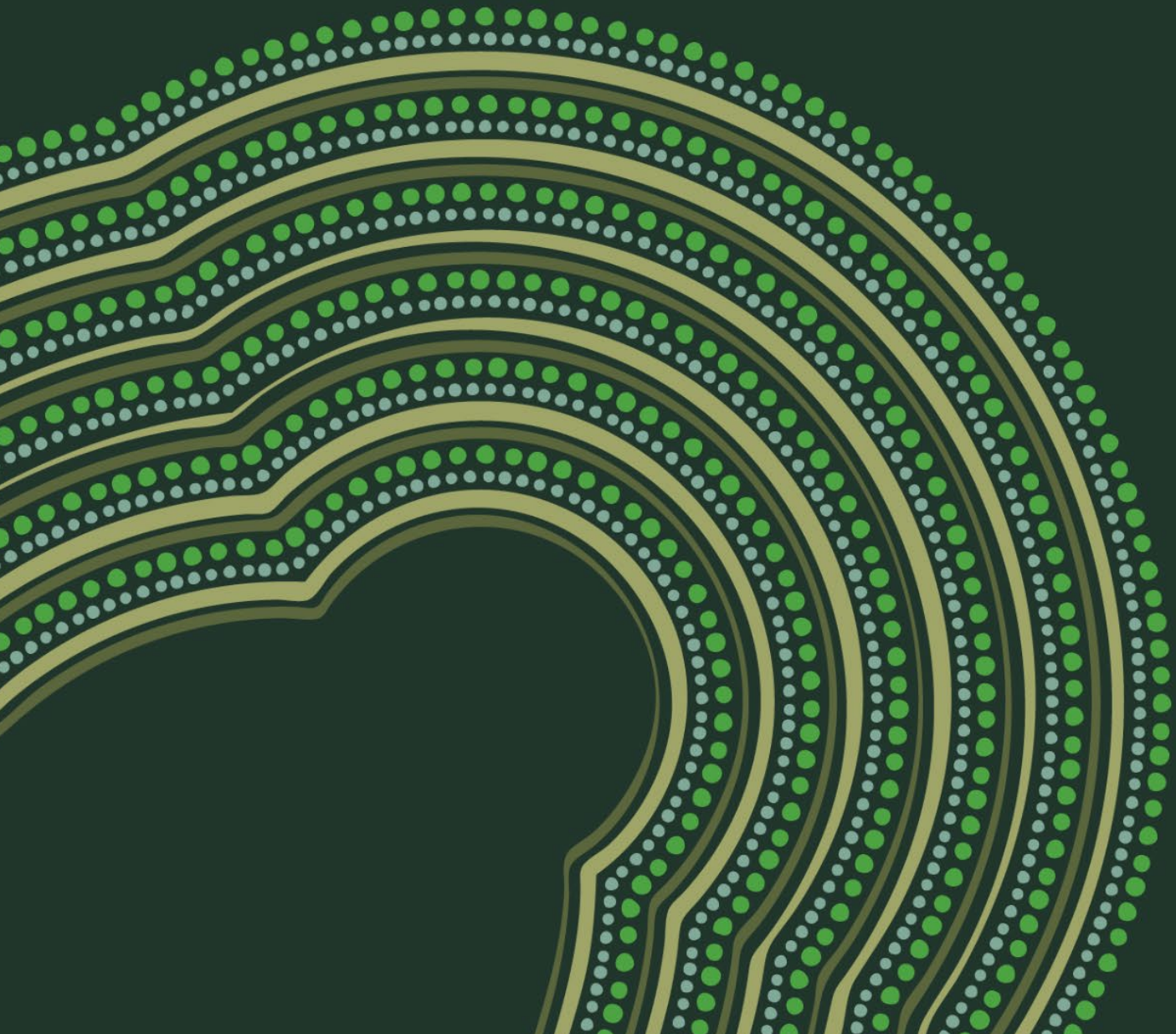
20. That the Rural Health Commissioner undertake a review of reporting pathways available to healthcare workers in rural and remote settings and make recommendations to achieve safe reporting for vulnerable groups, with anonymous reporting options included in those pathways.

Data, monitoring and evaluation – an ongoing need

21. That nationally consistent data collection be prioritised in a strategic approach to driving culture change across healthcare, as the basis for ongoing monitoring, evaluation, comparability and data-driven decision making.

[1] "The AMC should work with the colleges and other relevant stakeholders to develop a framework for managing concerns about accredited specialist medical training sites. (a) The framework should clarify how concerns related to bullying, harassment, racism and discrimination should be assessed and managed based on agreed and articulated roles and responsibilities. (b) The framework should also clarify how concerns about health practitioner performance or misconduct at an accredited specialist medical training site should be assessed and managed, including relevant referral and escalation pathways. (c) Once developed, the framework should be made publicly available and implemented with appropriate staff training" (NHPO, 2023).

1.0 Introduction



Introduction

A Better Culture was conceived in response to results from successive Medical Training Surveys (MTS), conducted by the Medical Board of Australia. These results have consistently shown that reported rates of bullying, harassment, discrimination, and racism are disturbingly high, with a disproportionately worse experience among Aboriginal and Torres Strait early career doctors. They also show significant differences between male, female and non-binary trainees.

The original project deliverable, approved by the Australian Government Department of Health, Disability and Ageing (DHDA), was to design and develop a multi-faceted engagement strategy to address the long-standing issues in the culture of medicine, in collaboration with all key stakeholders. To ensure impartiality and sector-wide credibility, A Better Culture established a governance structure independent of any one specialist medical college, including an advisory board and 12 reference groups, initially involving over 200 individuals. Outcomes from this process resulted in agreement regarding three key themes and the focus of five working groups.

This report synthesises the insights arising from an extensive consultation process, the findings of four of the five targeted working groups, and further stakeholder feedback received during a final round based on consultation drafts. One report - curriculum design - was developed with recursive consultation with senior educators during the build and has undergone a final round of consultation with a more diverse group of stakeholders.

This report seeks to integrate, refine and prioritise actionable recommendations, that give form and impact to the comprehensive work undertaken over the past 2 years. It should be read in conjunction with the consultation draft reports of the contributing working groups.

The culture of medicine operates in an ecosystem of healthcare subcultures, including, among many, nursing, allied health and administrative subcultures. Further, healthcare culture is critically acknowledged as "unique to each healthcare organisation and at a more micro level, to teams within each organisation" (Steople Australia, 2025, p. 11).

For Aboriginal and Torres Strait Islander healthcare workers, culturally unsafe environments often result in exclusion, professional isolation and compromised opportunities for success.

It has become starkly apparent that a multi-faceted engagement strategy as conceived in the original brief, however comprehensive, will not deliver the reforms needed to address "long-standing issues in the culture of medicine" referred to in the initial project proposal. Furthermore, it is disingenuous to conceive reform that benefits only doctors. All healthcare disciplines experience the adverse effects of poor workplace culture, and reforms must benefit all accordingly. Early in the project life, A Better Culture recognised this and sought endorsement of expanded scope to shape a multidisciplinary approach. Unfortunately, this was not supported by the funders. As a result, the work that has been produced is medically centred.

We remain of the view that a systemic, sector-wide and sustained, strategic approach is required to implement reform to address the drivers of workplace culture for all healthcare workers, not just those in medicine.

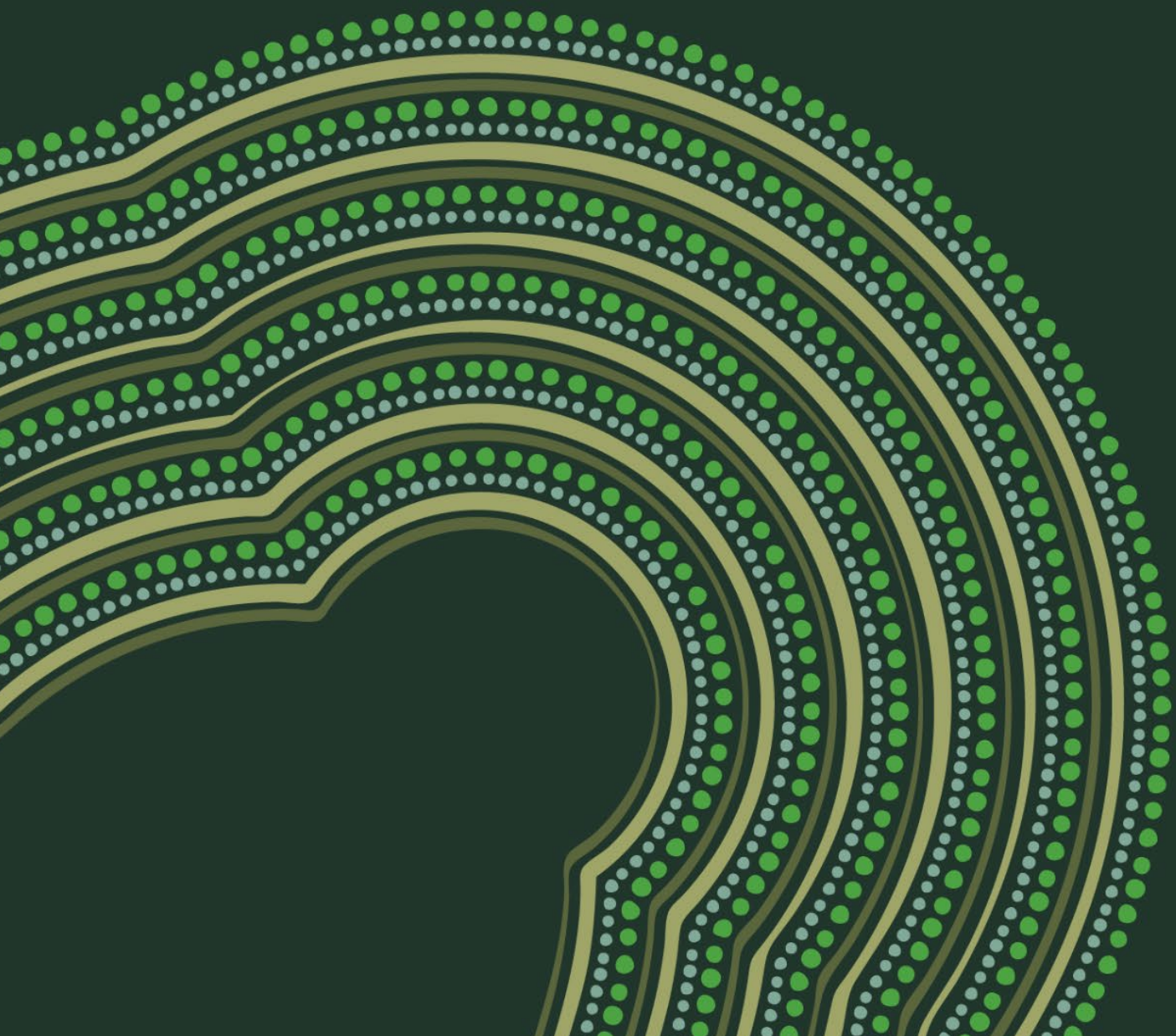
This will require collaboration: governments at all levels, policy makers, regulators, employers, all healthcare disciplines, health service unions, medical colleges, universities and other training providers.

At present, there is no clear leadership structure or accountability that makes such reform conceivable. federal-state relations, interprofessional rivalries, funding constraints, industrial tensions and political pressures all present barriers that would need to be overcome.

Unprecedented levels of determination, cooperation and collaboration will be necessary, in order to achieve change of the magnitude demanded. This makes the challenge seem insurmountable, but the groundswell of support demonstrated by the participants in this project gives hope that change is possible.

Only in this way can A Better Culture remain true to its original mandate: to impact positively on the experience of doctors-in-training across Australia.

2.0 Background



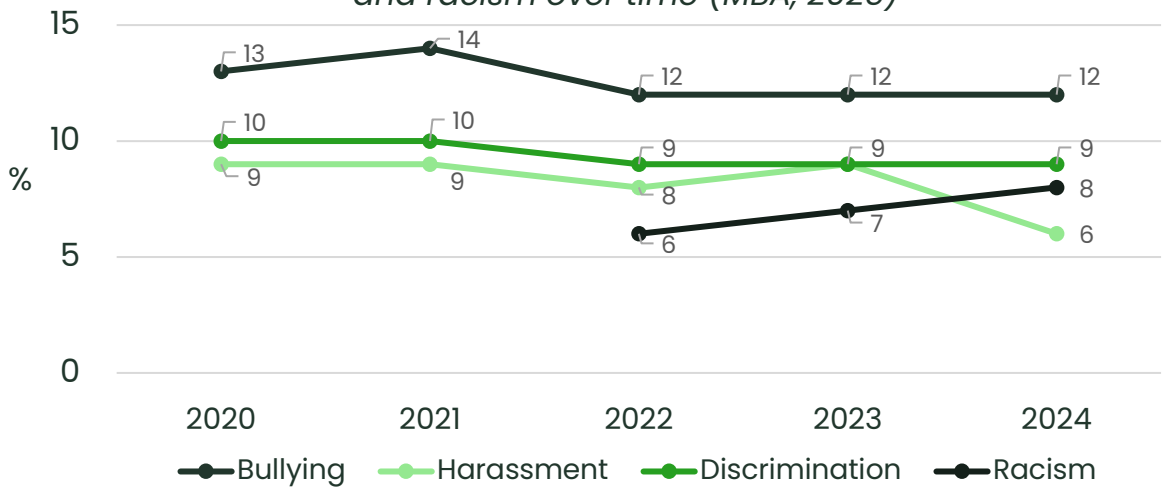
Background

The Medical Training Survey (MTS)

The MTS is a national, longitudinal, profession-wide survey of all doctors in training in Australia. First conducted in 2019, it is a confidential way to collect comparative data across jurisdictions, specialist medical colleges and training cohorts. Since 2020 it has been conducted concurrently with annual registration processes. The MTS is intended to track the quality of medical training in Australia.

The MTS is supported by doctors in training, jurisdictions, medical colleges, postgraduate medical councils, the Australian Medical Association, the Australian Medical Council, the Australian Indigenous Doctors' Association, doctors' health services, Medical Deans Australia and New Zealand, the Medical Council of NSW, the Australian Private Hospitals Association and the Australian Medical Students' Association, each contributing to the development and administration of the survey.

Experiences of bullying, harassment, discrimination and racism over time (MBA, 2025)



The first survey in 2019 found that of the 10,000 respondents, 22% of trainees reported an experience of bullying, harassment and discrimination during the previous 12 months (Medical Board of Australia, 2020). By 2024, the number of respondents had risen to 24,000 (just over 50% of the trainee cohort).

However, the prevalence of bullying, harassment and discrimination was largely unchanged, with racism included in the 2022 and 2023 surveys and sexual harassment included in 2024.

In 2024, reports of experiences of racism were 1 in 5 of Aboriginal and Torres Strait Islander trainees compared with 1 in 10 of the overall cohort (Medical Board of Australia, 2025).

With responsibility for these behaviours initially seen to lie at the feet of senior doctors, a deeper dive tells us that these behaviours are not the remit of any single professional group but rather are rife in healthcare. Whilst the behaviours are individual, the drivers, the enablers, exacerbators and failures to adequately address these behaviours are system issues.

Of additional concern is the observation that with an improvement in the reported proportion of cases that involve "other healthcare staff", there has been an increase in those reporting an experience of these behaviours by patients, family members or carers of patients.

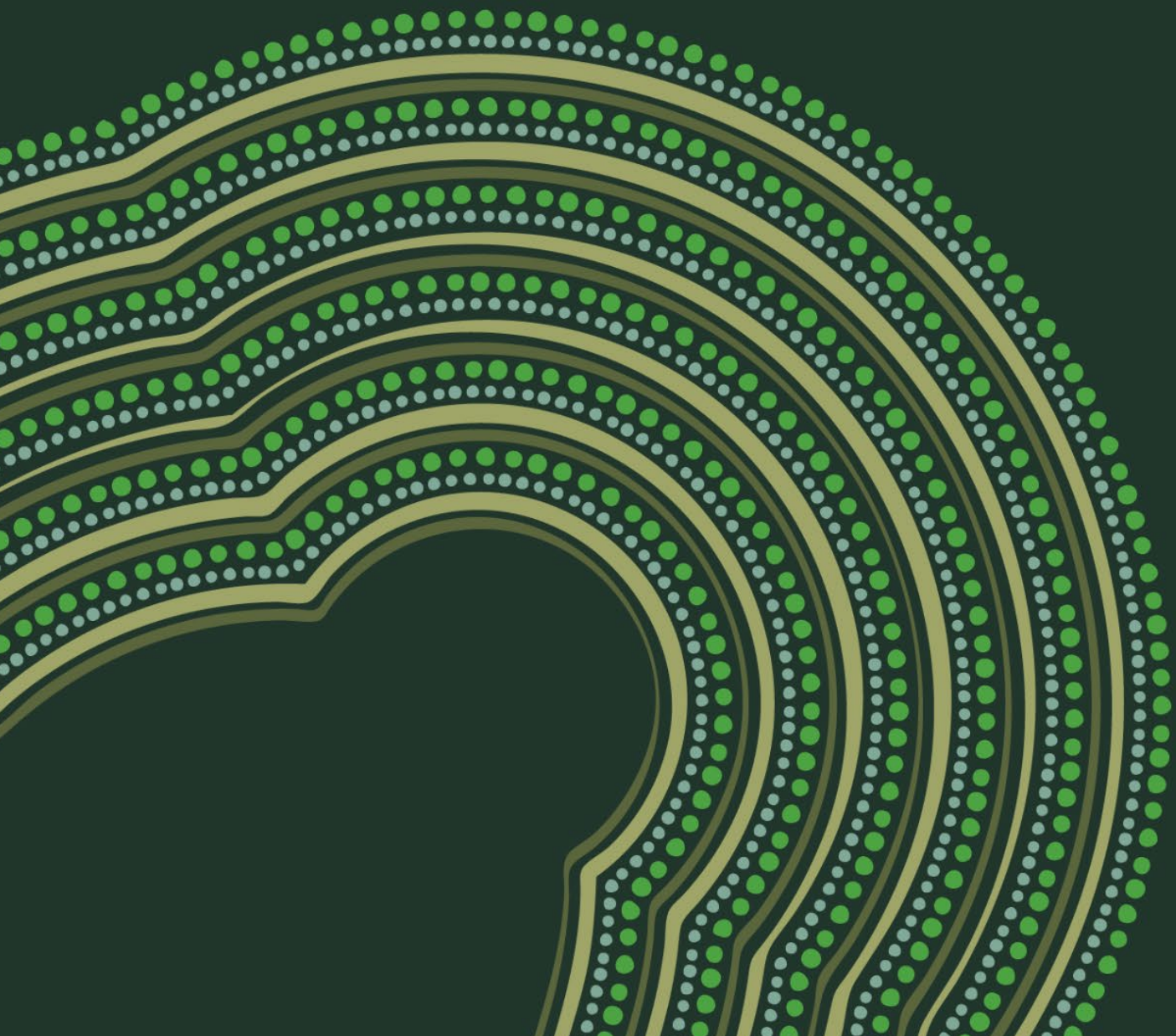
For example, in general practice in 2024, patients, family members or carers were responsible for 46% of experiences of bullying, harassment, discrimination and/or racism; 45% of witnessed experiences of these behaviours were attributed to this group (Medical Board of Australia, 2025).

Although noted, the behaviours of patients, family members or carers of patients were not the focus of A Better Culture working groups. Bullying, harassment, discrimination and/or racism perpetrated by these groups against health professionals in the course of their work warrants further consideration and response.

Previously seen as 'part of the job', these behaviours are in fact, psychosocial hazards that require proactive management by healthcare employers. It is no longer sufficient to say that the patients' needs must always come first – because sometimes, the patient (intentionally or not) harms the healthcare professional. An open discussion of what protections are appropriate and proportionate is long overdue. Racist slurs, sexualised or sexist commentary, sexual harassment and even sexual assault by patients have been 'part of the job' for too long.

When doctors in training were asked “are you considering a career outside medicine?”, 29% of Aboriginal and Torres Strait Islander trainees and 19% of all trainees agreed or strongly agreed. (Medical Board of Australia, 2025). This insight alone supports the rationale for A Better Culture.

3.0 Our Approach



Our Approach

Phase One

Environmental scan

The high prevalence of bullying, harassment, discrimination and racism in the Australian healthcare system attracted national scrutiny with a senate inquiry in 2016. Its findings regarding the impacts on patient safety and the psychosocial harm borne by the healthcare workforce received intense media scrutiny.

A snapshot of activity that ensued is captured in the environmental scan conducted by A Better Culture as it initiated its program of work

The activities included some or all the following:

- communications and awareness raising - awareness days, months, campaigns
- provision of information - fact sheets, website, promotional posters
- spokespersons, champions
- training and education - online, face to face
- policy
- codes of conduct - nine reviewed in detail
- reporting mechanisms
- escalating scales of interventions: informal, peer led to formal sanctions against individuals
- formal sanctions against health services conducting training - accreditation review, withdrawal of accreditation, withdrawal of specialist trainees from training posts

The apparent volume of effort underscores the perceived importance of addressing these issues across the system, while also revealing an uncoordinated and fragmented array of endeavours.

Commissioned works

During phase one, the project commissioned

- A qualitative study on leadership for culture improvement, commissioned under contract with the Nous Group
- An independent review of the Medical Training Survey's utility as a tool for cultural improvement (Crispin & Dollard, 2023), commissioned under contract with the University of South Australia.

Stakeholder engagement and detailed design

An iterative consultation and design process was conducted during Phase 1 of the project. It engaged over 200 participants in 12 reference groups, and a broader cohort through 20 interactive sessions conducted at workshops, conferences and online webinars, narrative submissions were received from reference group members and we engaged in direct consultation with leadership of key organisations.

The 12 reference groups were populated through an open expression of interest. Reference group Chairs were appointed from amongst the membership; Chairs were invited to engage their reference groups to generate responses to an initial series of focussed questions as 'starter' material. The reference groups had meetings with the Chief Executive to explore issues and priorities, and interactive sessions were conducted with specialist medical colleges through online forums and at conferences. A phase 2 work program was drafted based on the inputs received and then circulated through multiple cycles of reference group reviews and edits.

This led to the identification of the following three themes and 11 subthemes as the basis of A Better Culture's work program:

- Workplace behaviour expectations
  - Antidiscrimination
  - Cultural safety
  - Psychosocial risk management
- Career-long learning
  - Curriculum
  - Execution
  - Intervention
  - Diversity

- Measurement and action
    - Measurement
    - Transparency
    - Just culture
    - Safe reporting

Further consultation included additional meetings with the Chairs of the reference groups, with subsequent redrafting and repeat meetings. A revised draft was circulated for amendment, and once agreed, was presented to the Advisory Board and the Australian Government Department of Health, Disability and Ageing for endorsement.

Phase Two

Working groups

Five working groups were formed to advance work around these themes, comprising subject matter experts, health care stakeholders and representatives of the A Better Culture Advisory Board. Representation from the reference groups further ensured continuity in approach.

The focus of each of the five working group reports is shown:

- Workplace Behaviour Expectations Working Group (WBE)
- Curriculum Design Working Group (CD)
- Healthcare Worker Cultural Safety Working Group (HCS)
- Individual Level Interventions and Reporting Pathways Working Group (ILIRP)
- Leadership Diversity Working Group (LD)

The full consultation drafts and recommendations from the Workplace Behaviour Expectations, Individual Level Interventions & Reporting Pathways and Leadership Diversity working groups are available on our website. A decision was made to prioritise production of this report, rather than edit each individual report.

The Cultural Safety: From Compliance to Commitment Report and the A Better Culture Curriculum have been thoroughly revised and published as final reports – the superseded draft documents are not published.

Commissioned works

During Phase 2, the project commissioned and conducted two additional pieces of work:

- A report on currently available healthcare culture measurement tools, commissioned under a contract with Steople Australia and WhereTo Research.
- A workplace cultural measurement tool, also commissioned under a contract with Steople Australia and WhereTo Research[2].

Phase Three

The final consultation process

The resultant consultation draft reports of the working groups were the subject of widespread engagement. Over 90 organisations were invited to provide feedback including representatives of the Australian Government Department of Health, Disability and Ageing (DHDA), representatives of State and Territory health departments, 16 specialist medical colleges, the Council of Presidents of Medical Colleges, Medical Deans Australia and New Zealand, Aboriginal and Torres Strait Islander health and education sector representatives[3], The National Health Practitioner Ombudsman, Safe Work Australia, Work Health and Safety regulators in each jurisdiction, the Australian Medical Association, the Australian Council of Trade Unions, the Australian Salaried Medical Officers Federation, and select research institutions.

In total, 36 organisational and individual and stakeholders provided written feedback on the reports and their recommendations. These are listed with permission, in Appendix A. The full list of the original working group recommendations is shown at Appendix B.

[2] It should be noted that the workplace cultural measurement tool is not a cultural *safety* measurement tool – development of such a tool was not possible within the constraints of the project, but it is noted as a possible future body of work, which, if done, should be led by Aboriginal and Torres Strait Islander peoples

[3] The Lowitja Institute, the Australian Indigenous Doctors Association (AIDA), the National Aboriginal Community Controlled Health Organisation (NACCHO), the Institute of Urban Indigenous Health and the Coalition of Aboriginal and Torres Strait Islander Peak Bodies.

Further project outputs

A proposal for a national strategy to reform healthcare workplace culture, with support of a contract with Resilient Futures.

The themes that emerged

The consultation yielded evidence of significant interest and support for efforts to drive sustained change across the sector. There was some dissenting feedback about data or framing of language in the reports, but of note, there was no feedback of disagreement with any recommendations. Submissions were considered and detailed, with a high degree of commonality in the themes and insights which emerged. Respondents were asked to select the highest priority recommendations for each report, and those responses have informed this synthesis.

The following themes are discussed in the pages that follow:

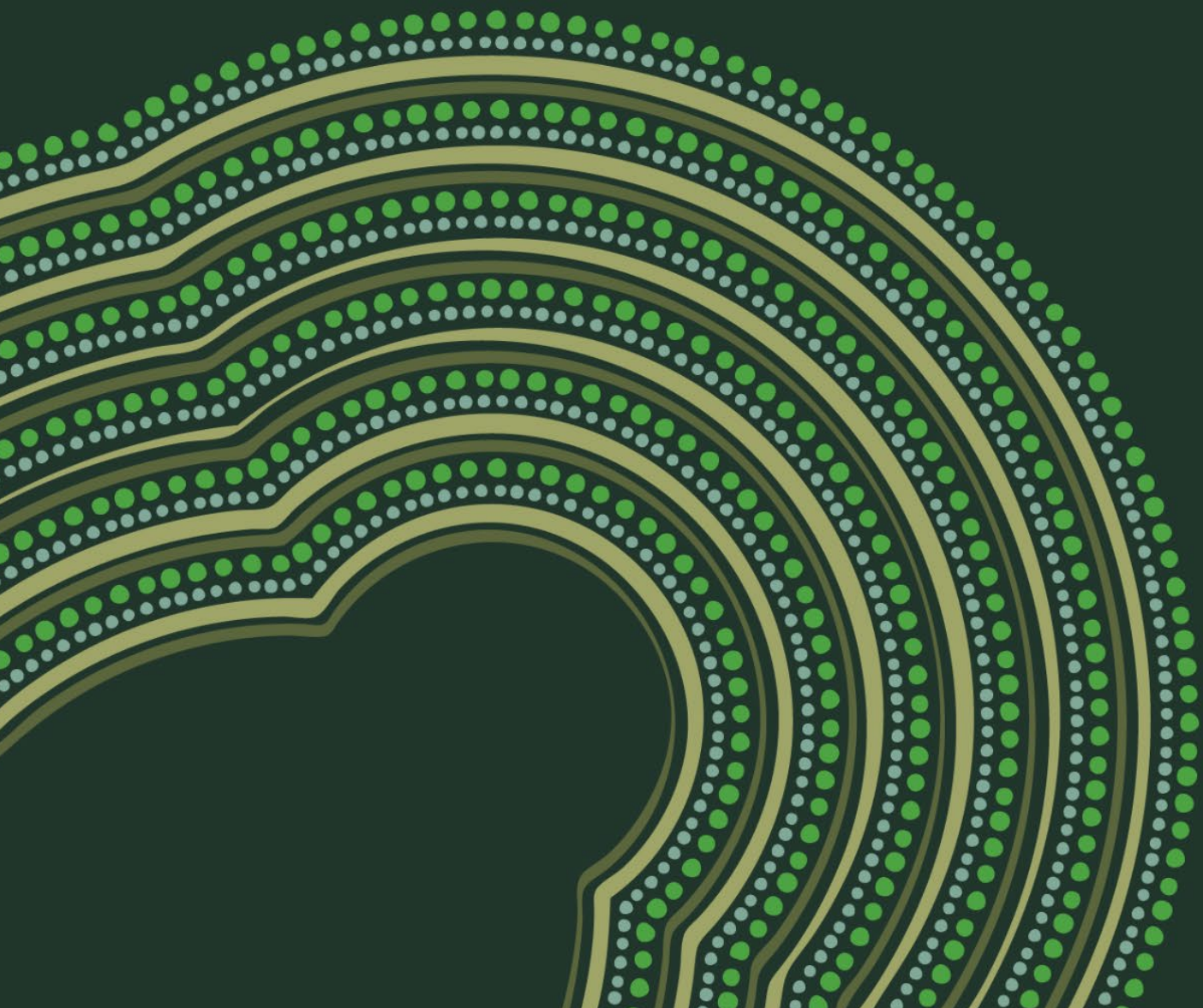
- Leadership and accountability
- Diversity and inclusivity
- Cultural safety
- Workplace health and safety
- Multiple levers
- Data-driven insights, monitoring and evaluation
- System reform and coordination

One recurrent aspect of feedback was a desire that there be a single, overarching report to integrate the final outputs of the project – resulting in the production of this report, rather than edited versions of separate consultation drafts.

The working groups were unanimous in their assessment that despite the implementation of actions intended to reduce bullying, harassment, discrimination and racism, they appear to have had limited impact with early career doctors/specialist medical trainees. No single action in isolation – nor in combination – could be shown to have 'moved the dial' for this cohort, at this time.

A scan of the published literature is similarly sobering. The limited body of research examining the impact of interventions reveals some green shoots, however closer interrogation is needed in order to assess the impacts on the experience of early career doctors in the Australian context. This is challenging in light of a paucity of comparable data and should be addressed as a priority as part of a national strategy.

4.0 The Pathway to Better



The Pathway to Better

A new way of approaching an old problem

Applying a systems lens to healthcare means viewing the health environment as a complex, interconnected system rather than a collection of isolated parts. It involves understanding how different components—such as social determinants, patients, healthcare professionals, healthcare services, regulators, policy makers, legislators, funders, data and technology—interact and influence one another.

The recommendations that follow arise from the undeniable conclusion that the sector is looking for national leadership, a collaborative approach and system-wide change.

This foundational work, supported by grassroots and institutional stakeholder consultation, informs A Better Culture's ultimate proposal for a coordinated national strategy, accompanied by action and resourcing to mitigate against system-level drivers, that is "a transformative approach to driving systemic change" (Resilient Futures, 2025, p. 6).

Address the vacuum at the top: Issues in governance, leadership and accountability

The imperative of overt leadership commitment to cultural change was amongst the most pervasive of all feedback arising during this consultation process. Leadership visibility, access to data, capability, diversity and cultural safety emerged as key focus areas.

Generate visible leadership commitment

Complex adaptive change requires leadership commitment. In healthcare, there is no 'leader' in the form of a visionary CEO as large companies might have – instead, leadership is distributed through federal and state governments, professional streams, district and local health governance structures and educational, advocacy and membership organisations.

Power to effect large-scale change, however, is concentrated in governments and fund holders, boards and senior executives.

Clinicians involved in the consultation process saw boards as having the right proximity to the work, and the power to lead and drive change - and their view was that boards have been relatively inactive in addressing workplace culture. Anecdotally, health professionals assessed that boards do not appear to be visibly engaged on the issues at the heart of this report; where engagement exists, governance oversight of these issues appears to be ineffective and risk management systems appear to be unfit for purpose.

Leadership commitment at board level would be evidenced by 'genuine attention to and appropriate governance and resource investment'. This was cited during consultation by regulators and WHS experts as central to good workplace health and safety.

A board's role in driving cultural change – as a critical underpinning to psychosocial safety at work – was described in many ways, including setting the vision and strategic direction, aligning cultural change with overall strategic goals, 'walking the talk' (showing commitment through action and behaviour), advancing a policy framework consistent with the change agenda and oversight of compliance with WHS regulations, guidelines and quality standards.

At the same time, the failure of boards and directors to engage with hard measures of performance against change metrics and WHS was a common observation, as well as a failure, in some cases, to view psychosocial safety through the same risk management lens as physical safety.

This could, in light of recent legislative and regulatory WHS changes, meet the criteria for an abrogation of a director's duties.

Whilst a focus on boards as the accountable entities in administration of health services is understandable, boards in the public sector are ministerially appointed, and their performance is accountable to health ministers.

So ultimately, and fully consistent with our Westminster system of government, the vacuum at the top can be traced to the desk of health ministers, who have rarely made public statements supporting the health, safety and protection of healthcare workers other than in response to horrendous episodes of physical occupational violence.

It would be surprising if a federal health minister could cite healthcare worker suicide data with the same fluency as a defence minister can discuss defence suicide – with this distributed model of accountability in the health sector allowing the issue to be invisible. Furthermore, it is probably not something that a health minister even considers within their remit.

Suicide in Healthcare

An Australian study by Petrie et al. (2024) examined the relative risk of suicide among healthcare professionals compared with other industry groups, finding that they are at significantly increased risk of suicide, with relative risk of different groups changing over time.

- Healthcare professionals were at increased risk of suicide compared to other occupations (rate ratio = 1.30, 95% confidence interval = [1.19, 1.42], $p < 0.001$),
- Nurses and midwives were identified as being at significantly increased risk of suicide (rate ratio = 1.95, 95% confidence interval = [1.73, 2.19], $p < 0.001$), with male nurse/midwives being at even higher risk.
- Suicide rates among female medical practitioners increased substantially over time ($p = 0.01$), with rates in this group more than doubling over the last decade.

Over this 17-year period, the age-standardised suicide rate of female medical practitioners increased from 3.1 per 100,000 in 2001–2006 to 15.0 per 100,000 persons in 2013–2017. This concerning finding is "yet to be fully understood or explained" (Petrie et al., 2024, p. 983).

Addressing the challenges of accountability requires the identification of quantifiable measures that can be tracked and viewed through a risk management lens at board and ministerial level.

The inability to articulate (and measure) KPIs and quantifiable deliverables in order to 'hold executive teams accountable' was described by each A Better Culture working group. For example, in the case of the Individual Level Interventions and Reporting Pathways Working Group, this was seen in the lack of board oversight of organisation-wide data on bullying, harassment, discrimination and racism - such as prevalence, incidence, nature of report, actions taken and time taken to resolution.

In the case of cultural safety, this must be framed as a core leadership competency, with accountability mechanisms that tie cultural safety to leadership evaluation and organisational KPIs.

In parallel, indicators that measure the cultural safety of healthcare staff that are developed under Aboriginal and Torres Strait Islander leadership should be incorporated into DHDA's and boards' reporting, and released to the public. These indicators should assess the internal culture affecting Aboriginal and Torres Strait Islander staff and trainees. Evaluation must be led by Aboriginal and Torres Strait Islander methodologies to ensure cultural integrity and accountability.

The requirement to publicly report on KPIs and quantifiable deliverables aligned with psychosocial and cultural safety is suggested as a means of dramatically improving transparency and accountability, and in turn, increase the priority given by boards to their governance responsibilities in these domains.

01

Recommendation 1

That health ministers require boards and directors general/secretaries for health to provide regular reporting on processes and outcomes for bullying, discrimination, harassment, sexual harassment and racism.

Generate data that can help leaders implement change

Qualitative research conducted as part of A Better Culture identified that monitoring cultural issues within organisations was considered challenging (Nous Group, 2023). This was seen to be particularly so in light of the complexity of healthcare environments, and the intangible nature of organisational culture.

Whilst A Better Culture has made extensive use of the MTS data, that survey's limitations were fully explored in an independent review conducted by the University of South Australia. In particular, it was noted that the MTS is not and was never intended to be a tool to measure workplace culture (Crispin & Dollard, 2023), something that the Medical Board has also reiterated.

For example, the survey does not collect data on race, other than identification of Aboriginal and Torres Strait Islander trainees, or data on disability or neurodiversity. The survey measures reported rates of certain behaviours, but does not capture culture or its drivers, and this leaves leaders uncertain on exactly how to address those results.

The environmental scan and literature review conducted by Steople Australia (2025) found that while existing surveys highlight some of the key challenges faced by health care staff (including doctors in in training, as shown via the MTS);

- most tools currently in use have multiple focus areas
- there is a lack of consistent and objective metrics
- there is limited consensus on the dimensions of culture specific to the healthcare workforce.

These challenges all serve to complicate benchmark cultural indicators and their comparability.

This finding was matched with agreement regarding the need to develop a robust survey and minimum data set that "represents best practice as a standardised approach that ensures data comparability and reliability across organisations" (Steople Australia, 2025, p. 5).

As an output of A Better Culture, a validated survey tool to generate meaningful insights into the current culture across healthcare environments has been developed.

Widespread uptake of this tool could address shortfalls in current culture measurement methods and deliver results which can be used to inform actionable improvement at the individual health service level.

Use of this tool would facilitate much improved data-driven decisions and interventions, in order to enhance the experience of those working in the Australian healthcare sector. It would allow evaluation of the myriad initiatives that are currently underway and which, based on the MTS data, are not improving things. It would also provide a frame for finding excellence and finally allowing employers to learn from evidence-based excellence, rather than emulating the things that have face validity, but no robust evidence of success.

Funding for the project was not sufficient to allow for the development of implementation tools for the survey – the tool, developed by A Better Culture, in its current form, has gone through quantitative testing. Further investment will be required for the development of scaffolds to support thorough analysis of the results and importing the tool on an online platform for implementation.

Nonetheless, the progress made thus far represents a robust approach to addressing healthcare workplace culture, and if fully developed and implemented could be a first and significant step.

Recommendation 2

02

That the DHDA, in discussion with the jurisdictions, fund the sufficient development of implementation resources to allow pilot sites to adopt the Culture in Healthcare Assessment Tool, and further invest in scale-up once efficacy of the tool is established.

Develop leaders who understand and can manage workplace culture

Leaders shape workplace culture by defining core values, setting expectations, and modelling behaviours that guide organisational norms. Through clear communication of the mission and vision, those holding explicit leadership positions are acknowledged as having the potential to establish a shared sense of purpose that can unite employees.

Workplace culture is significantly influenced - or 'driven' - by those in leadership positions, both formal and informal.

Leadership commitment, evidenced by genuine attention and appropriate governance and resource investment, was consistently cited by regulators and WHS experts as central to good WHS.

Key indicators of poor culture on the part of leaders and executive were described in working group consultation as:

- a tolerance of resistance to change by senior medical staff (on the part of leadership and executives)
- superficial application of policy, acceptance of ingrained unprofessional behaviour by long-time staff members and senior doctors
- a culture of covering up to protect some individuals (also highlighted in the Individual Level Interventions and Reporting Pathways Working Group report)

A further observation from the Curriculum Design Working Group (2025, p. 13) is that "becoming 'more senior' does not automatically [reflect] commensurate expertise in all relevant competencies, particularly competencies that are newly emerging". The example provided is that being a senior clinician does not always indicate a senior level of competence in creating culturally safe environments, yet it may be that they will assess the cultural competence of learners under their supervision.

This same report concludes that "in addition to learners and trainers, organisational leadership has a key role in establishing culture and should have equivalent curricular support" (Curriculum Design Working Group, 2025, p. 5).

Some offering feedback observed that appointment to leadership roles can arise as a correlate to displaying excellent clinical capabilities, and that in some scenarios, leadership traits were incidental or even accidental, rather than core to an appointment.

The need for ongoing professional development is widely accepted and incentivised in healthcare. Implicit in the observations of the authors of the Curriculum Design Working Group is the need for professional development at the senior clinician level to be targeted to developing a broader set of competencies – which will continue to emerge - beyond clinical competencies.

In large, complex organisational structures, leadership roles are not limited to the executive. These can range across all levels, often seen in those engaged in less formal, less explicit team leadership, influencing peers and coworkers across departments and clinical teams.

Middle management can be an important but sometimes overlooked group in leadership development planning. Efforts to drive change via policy can fail at the level of implementation at the coal face, with middle management resistance blocking its practical application (Nous Group, 2023).

An evidence-based framework outlining a curriculum to support a set of learning outcomes and a shared conceptual understanding of the competencies consistent with cultural capability for learners, trainers and organisational leadership has been developed as a key output of A Better Culture.

We invite all those involved in curriculum design and training product development to draw on this.

The need to foster a deep leadership pipeline is reflected in consensus around the need to specifically target middle managers in the development of capability to positively shape workplace culture.

03

Recommendation 3a

That the AMC, the CPMC, specialist medical colleges and employers incorporate the evidence-based curriculum framework developed by A Better Culture into the future development of training products.

Recommendation 3b

That the DHDA fund the development of a standardised set of learning modules and tools based on the aforementioned curriculum, to scale up implementation efficiently and minimise duplication and waste

Understand and address the lack of diversity in healthcare leadership

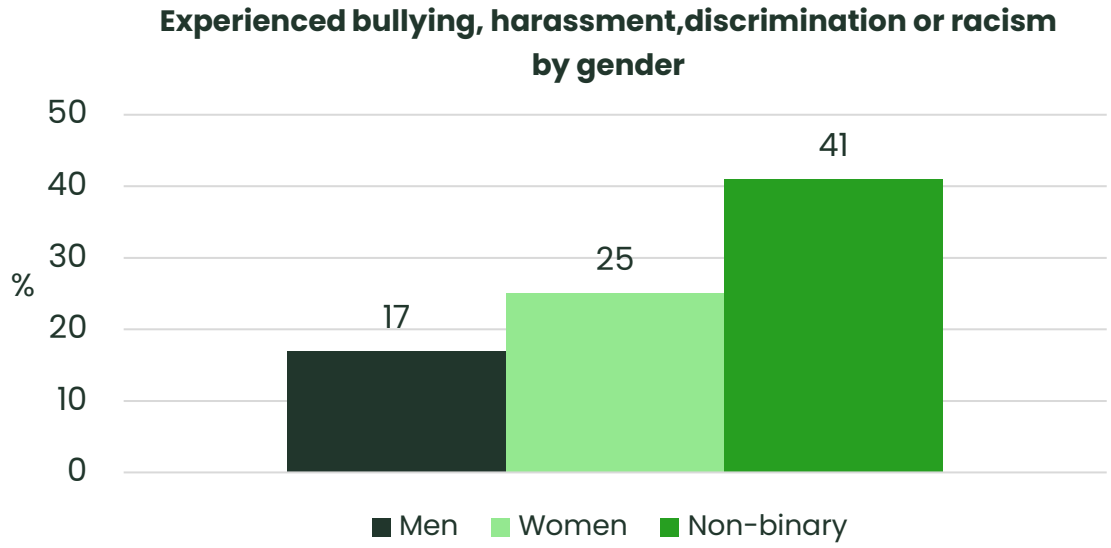
The link between diversity of leadership and the experience of diverse workforce members is a focus of recent research.

Conducted internationally and across a range of professions, this growing body of evidence shows that diverse leadership teams are associated with better organisational performance on a series of indicators - challenging the perception that diversity poses a risk to organisational success (Leadership Diversity Working Group, 2025).

The Leadership Diversity Working Group suggests that improving leadership diversity in health care is likely to have a positive impact on workforce experiences of bullying, harassment, discrimination and racism and in turn, a positive effect on healthcare systems. The group observed that "leadership in health care across the globe, with Australia being no exception, does not reflect the communities that healthcare entities serve, and does not even reflect the workforce that delivers services" (Leadership Diversity Working Group, 2025, p. 13).

However, improved national data is required to more fully understand workforce and leadership diversity in healthcare.

Whilst acknowledging that an intersectional approach is the optimal way of addressing diversity, the MTS does not provide sufficient data to allow a fully intersectional analysis. A Better Culture therefore prioritised consideration of two aspects of diversity (gender and race) in response to findings from the 2024 MTS.



Women (25%) and non-binary (41%) individuals were more likely to experience bullying, harassment, racism and discrimination than men (17%), with similarly high rates for Aboriginal and Torres Strait Islander trainees (40%) compared to the general cohort (MBA, 2025).

Additional observations were that while the proportion of women in medicine has grown (from 44.4% in 2021 to 45.37% in 2023), leadership diversity remains limited (Leadership Diversity Working Group, 2025). Despite making up 73% of the healthcare workforce, women remain underrepresented in senior leadership roles, holding only 30% of these positions.

The same can be said in relation to other diversity dimensions. As in the case of gender diversity, while Australia's healthcare workforce is ethnically diverse, this diversity does not extend into upper management and decision-making roles.

While it is incontestable that appointments to leadership roles should be based on 'merit', that term is often narrowly defined, and creates layers of bias that impact the ability of racial, gender and other minorities to compete.

Selection criteria can have veiled exclusionary language, opportunities to 'act up' might be done through informal processes (shoulder-taps) that give some candidates greater ability to demonstrate capacity.

Appointment on merit becomes an issue where merit is equated with a package of qualities demonstrated by those who have gone before. The concept of merit serves to disguise a variety of biases that prevent the progress of diverse candidates. Where 'merit' is defined as 'people like us', gender bias and racial bias has been shown to persist.

Alternative viewpoints recognise diversity as an asset, rather than something to be managed. Intersectional approaches to diversity are supported yet largely ignored in healthcare; it was posited that health care systems would benefit by viewing power structures and decision making through an intersectional lens.

Having regard to neurodivergence, remoteness, rurality, age, gender diversity or non-conformity and sexuality is "now considered the most powerful tool for driving reform, yet there is almost no examination of its application in healthcare" (Leadership Diversity Working Group, 2025, p. 6). Healthcare needs to challenge pervasive yet outdated stereotypical leadership models.

04

Recommendation 4a

That the DHDA develop a national program for measurement and reporting of workforce and leadership diversity in health care, with specific focus on re-examination and challenge of existing stereotypes of leadership.

Recommendation 4b

That workforce strategies and plans use this information to identify fall-off points in the career development pipeline and provide targeted interventions to diverse employees, enhancing their access to career opportunities.

Cultural safety for staff as a whole-of-business approach, not just a training course

Diverse and inclusive workplaces are shown to lead to better outcomes in all aspects of an organisation's work. In healthcare, this translates to improved patient care outcomes, particularly for Aboriginal and Torres Strait Islander communities.

The Healthcare Worker Cultural Safety Working Group identified that diverse leadership, inclusive of Aboriginal and Torres Strait Islander professionals, leads to better health outcomes and safer work environments (Healthcare Worker Cultural Safety Working Group, 2025). Yet the pathway to achieving greater leadership participation by Aboriginal and Torres Strait Islander professionals is not an easy one, with 29% of Aboriginal and Torres Strait Islander trainees (compared to 19% of all trainees) considering a career outside of medicine (Medical Board of Australia, 2025)

In order to support this, attention to the cultural safety of Aboriginal and Torres Strait Islander staff[4], not just patients, must be embedded within an organisation. It is not merely a question of training, but of embedding practices and accountability that make a difference.

[4] In 2020, Ahpra launched its Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 with a focus on cultural safety for patients. Its aim was to achieve nationally consistent standards, codes and guidelines across all registered health practitioners in Australia in relation to cultural safety. The stated vision was: "Patient safety for Aboriginal and Torres Strait Islander Peoples is the norm. We recognise that patient safety includes the inextricably linked elements of clinical and cultural safety, and that this link must be defined by Aboriginal and Torres Strait Islander Peoples (Ahpra, 2020, p.7).

Cultural safety must be framed as a leadership responsibility, not just a workforce initiative. Further, cultural safety must not only be endorsed at executive level but modelled by leadership across all tiers (Healthcare Worker Cultural Safety Working Group, 2025).

In a conference workshop hosted by A Better Culture, senior healthcare managers from all over Australia and Aotearoa New Zealand were asked if they had ever had cultural safety discussed as part of their performance agreement – and the answer was unanimously no. This is a strong signal that organisations have not taken the steps to move beyond training to meaningful changes in practice.

Embedding cultural safety of both patients and staff in strategic plans, linking it to executive KPIs, and fostering leadership behaviours aligned with cultural responsiveness are essential reforms. The Healthcare Worker Cultural Safety Working Group proposed cultural safety KPIs for leadership roles and national indicators that include Aboriginal and Torres Strait Islander workforce retention, promotion, and experience.

Cultural safety initiatives must distinguish Aboriginal and Torres Strait Islander cultural safety from broader multicultural frameworks which focus on cultural diversity. Cultural safety is concerned with individual and institutional health practice; cultural diversity combines Aboriginal and Torres Strait Islander people's diversity with culturally and linguistically diverse communities (Lowitja Institute, 2024).

The Healthcare Worker Cultural Safety Working Group acknowledged that Aboriginal and Torres Strait Islander staff experience compounded forms of discrimination that cannot be conflated with those of others.

Feedback to the consultation draft, and the internal operations of the project highlighted the critical gap of cultural governance. In recognition of the importance of this, and to give practice to the principle of privileging Aboriginal and Torres Strait Islander Voices, a full report *Cultural safety: From compliance to commitment* has been produced to focus on cultural safety and cultural governance. It is hoped that this will assist organisations to better and more fully engage with Aboriginal and Torres Strait Islander staff and communities to drive change.

It should also be noted that the Culture in Healthcare Assessment Tool discussed earlier is not intended to be a tool that measures cultural safety - it was not developed with appropriate Aboriginal and Torres Strait Islander leadership and co-design. However, the literature review undertaken in its development has revealed a very large gap affecting not just healthcare workers, but likely all Aboriginal and Torres Strait Islander workers in Australia – there is simply no measurement methodology to assess cultural safety. This deficit must be addressed but is beyond the scope and appropriate role of this project.

Recommendation 5

05 *That the Minister for Health consult with the Minister for Indigenous Affairs to develop approaches to evaluating and improving the cultural safety of the Indigenous workforce, noting that cultural safety focus to date has been on patients.*

New perspectives on workplace health and safety

There is a need to prioritise Workplace Health and Safety (WHS) in the face of a resource-constrained health system. The chasm between community expectation, ever-increasing system demand and finite health budgets has limited the capacity of health services to prioritise workplace safety. This needs to be turned on its head.

The psychosocial and behavioural impacts of an under-resourced and stressed system

The healthcare workforce in Australia faces significant daily pressures that impact their ability to provide quality care, including an unacceptably high prevalence and persistence of work-related harms - both physical and psychosocial. These include bullying, harassment, discrimination and racism, but can also include physical violence, although the latter is not measured in the Medical Training Survey. Aboriginal and Torres Strait Islander practitioners also carry colonial load[5], that compounds the stressors they experience.

Coupled with a relentless workload, these can lead to moral distress, emotional reactivity, exhaustion, hazardous behaviour, fatigue, burnout, serious error, safety violations and dissatisfaction.

[5] Colonial load refers to additional responsibilities (such as educating others or performing cultural roles in the workplace) carried by Aboriginal and Torres Strait Islander peoples. It is also sometimes referred to as 'cultural load', but this can have connotations that Aboriginal and Torres Strait Islander culture is the source of the load, rather than the colonial system.

These are exacerbated by staff shortages, scheduling and leave constraints; stressors in themselves (Workplace Behaviour Expectations Working Group, 2025).

Overwhelmingly, feedback respondents cited the need for a much-strengthened WHS focus in healthcare to drive improvement.

The language of healthcare angels and heroes legitimises chronic resource/demand mismatch

Self-sacrifice on the part of healthcare workers, and descriptions of healthcare workers as angels and heroes seems to be expected by society as part of being a health professional. It is described in our report as serving to reinforce "the legitimacy of chronic underfunding" of health care (Workplace Behaviour Expectations Working Group, 2025, p. 15).

The authors conclude that it is not reasonable to expect that healthcare workers should continue to place their own health or safety at risk in order to maintain service delivery. It is an expectation by many organisations and healthcare professionals that unfortunately persists and reinforces itself at every level of the system, from education, workforce planning, recruitment, to day-to-day practice.

Further, the report cites the disconnect between community expectations and the fiscal allocations by the government. These limit healthcare facilities' capacity to deliver high-quality care while also ensuring WHS and workplace behavioural standards are met.

It is a striking observation that efforts to prioritise work design and demand management in healthcare are applied to improve patient safety, but much less frequently to the protection of healthcare workers. This underpins arguably one of the most strongly supported sentiments across all working groups, reflected in the recommendation below.

06

Recommendation 6

That all healthcare leaders and stakeholders recognise that staff health and safety is as important as patient health and safety, and that the two are inextricably connected.

Practitioner wellbeing initiatives are not consistently addressing root causes of health worker harm

Over the past 5 years, there has been growth in the terminology of 'wellness' and 'wellbeing' applied to health workplace interventions. Some of these focus on individual practitioners, encouraging a perspective that distress is a personal failing for not managing to adequately do all of the things that can reduce harm. Some are attempting to address system and organisational factors, but without executive-level authority and budgetary support. The worst apply non-proven or tokenistic activities ('wellwashing') without committing to the hard changes that would make a real difference.

Wellbeing advocates in the medical space are, to varying degrees, practising occupational health (i.e. reducing harms caused by work) and struggling to get funding and recognition for sustained investment by employers They are sometimes doing this without the protections that would be afforded by a formal occupational health service, such as clear boundaries and confidentiality protections.

Some reputable and high-profile wellbeing programs have arisen in the USA, where there are two crucial differences:

- employers bear direct costs of employee ill-health far beyond workers' compensation claims, because health insurance is employer-sponsored. This makes the value proposition of investing in overall wellbeing stronger than it is in Australia.
- occupational health, especially psychosocial health, is not a protected and legislated requirement to the degree it is in Australia.

In Australia, the reluctance of healthcare leaders and workers to engage with Occupational Health and Safety, and the relative comfort of engaging with wellbeing programs, bears deeper reflection. Language is evolving, and some are now talking about 'health and wellbeing'. Very few explicitly engage around safety, and even fewer use the technical tools and expertise that abound in other industries.

07

Recommendation 7

That evidence-based workplace wellbeing programs that explicitly address occupational health, safety and system level issues in healthcare organisations be supported and funded accordingly.

Work design and demand management

It is well documented that poor work design leads to psychosocial and physical risks in the workplace and a similarly robust evidence base demonstrates that common, evidence-based approaches have been shown to reduce these risks.

Common work design solutions—borrowed from other settings and proven in healthcare—range from matching workers' job control to skills and experience, timely induction, training and supervision, workload management, safe work systems and procedures, provision of additional security and timely incident procedures in high risk areas, increased practical and emotional support during periods of high demand, to identification of the most common psychosocial risks and how these will be managed (Workplace Behaviour Expectations Working Group, 2025).

Similarly, demand management strategies play a crucial role by optimising resource use, streamlining care delivery, and ensuring patients receive appropriate care at the right time.

It is important to acknowledge that healthcare budgets are (and must be) finite. Health expenditure growth higher than GDP growth would result in a progressively more and more unsustainable situation. This was envisaged in 2005, when forward estimates that healthcare could cost almost 20% of GDP by 2045 were produced (Productivity Commission, 2005). It stands to reason then, that service delivery must eventually also be finite – there is only so much to be gained from efficiency, new models of care, new roles, technology improvements and other advances.

Demand, however, is elastic and apparently infinitely so. The system as resourced is simply unable to match the existing demand, and healthcare professionals on the front lines absorb the impact of that in their work every day. This results in moral injury, patient/carer aggression and staff-on-staff bullying and incivility. In the worst case, it contributes to poor mental health and even practitioner suicide.

Prioritisation of, and resourcing to support end to end demand-management and safeguarding of staff health must be the goal.

08

Recommendation 8

That healthcare employers recognise that without effective demand-management strategies, the healthcare workforce is exposed to increasing levels of psychosocial risk. Implementation of productivity and efficiency initiatives must include occupational health measures to protect staff.

Strengthened WHS mechanisms present a key opportunity

Our examination of the harms reported and past regulatory responses indicates that healthcare organisations have enjoyed relative impunity in failing to address WHS risks, and psychosocial risks in particular. Industries who have stepped boldly into health and safety reform generally enjoy higher levels of employee engagement, productivity and lower costs. Healthcare has ignored this, turning a blind eye to the very tools that could help.

This is not an empty assertion. Research by SafeWork Australia (2024) demonstrated that there was an almost complete vacuum of occupational health and safety codes and guidance for healthcare. This is all the more striking because National Disability Scheme claims data and ABS employment estimates by industry provided by SafeWork Australia (Figure 1) demonstrate clearly that the healthcare and social assistance industry is an outlier in terms of risk of injury, as indicated by frequency of serious injury claims, relative to other industries.

Figure 1 highlights the industries where a reduction in the serious claims frequency rate will have the greatest impact. The industries with the highest frequency rates in 2021-22 were agriculture, forestry and fishing (10.4), manufacturing (9.2), and health care and social assistance (9.1). These three industries accounted for 33.2% of serious claims in 2021-22, despite representing only 24.3% of workers. The frequency rate of 9.1 in healthcare and social assistance combined with the vast workforce combine to make this domain a marked outlier in overall risk.

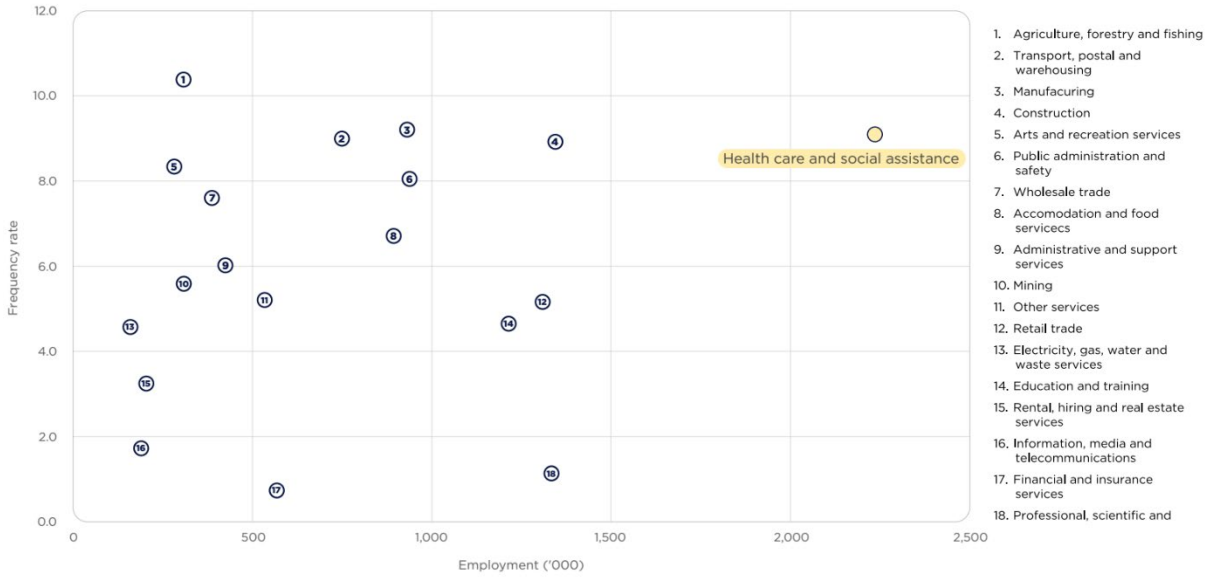


Figure 1 - Serious claims frequency rates, by size of industry (2021-22) (SafeWork Australia, 2024)

Further data regarding the cost of workplace injury in Australia (seen in Figure 2) demonstrate the significant costs due to loss of productivity as a result of absenteeism, presenteeism and premature death and labour withdrawal, borne by the healthcare and social assistance industry, with the highest rates in each category compared to other industry sectors (SafeWork Australia, 2022a). The report highlights the obvious point that sectors which experience the highest number of work-related injuries gain the most from their removal.

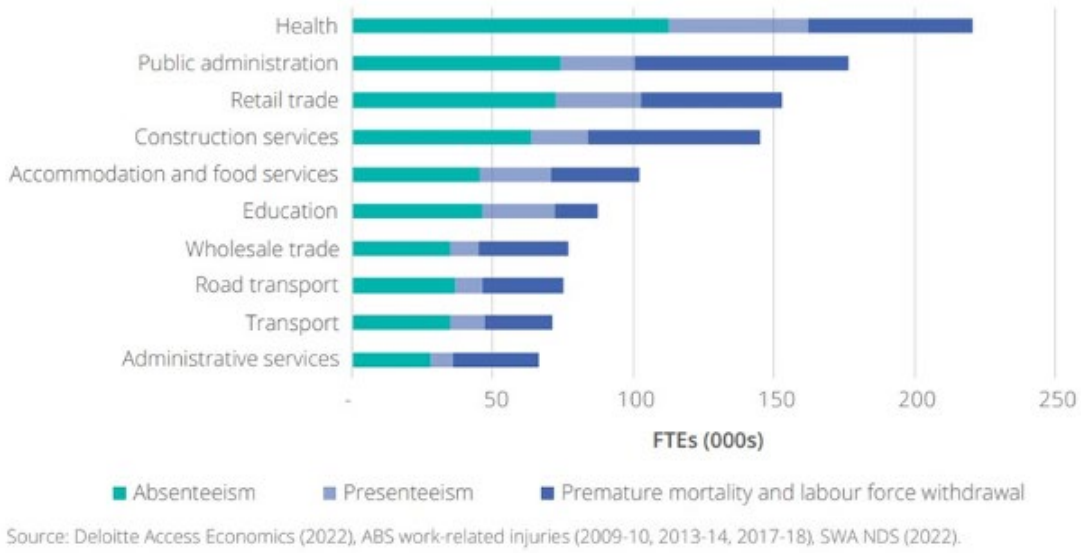


Figure 2 - Productivity loss by industry and component, 2008-18, Australia (SafeWork Australia, 2022a)

The benefits of strengthened regulatory approaches in other settings are widely acknowledged, with the potential of WHS legislative and regulatory mechanisms to improve the working conditions of all healthcare workers emerging as a key opportunity.

In the past, the legal obligation to manage WHS risk has been perceived by some to the sole responsibility of employers, with boards (governance, strategic priorities, policy, organisational structure) and leadership teams (staffing levels, workloads, resource allocation, maintenance of equipment, rostering) shaping culture and consequences for poor workplace behaviours. However, recent amendments to the *Work Health and Safety Act 201* (Cth), are now in force in all Australian jurisdictions. This makes it clear that specialist medical colleges share WHS obligations with healthcare employers for matters relating to medical college members' participation in training at these accredited sites.

There is a significant opportunity to improve both the perception and practice of workplace health and safety by including those aspects most relevant to medical practice in the training programs of respective specialties.

The SafeWork Australia Work Health and Safety (Managing Psychosocial Hazards at Work) Code of Practice (2022b), provides guidance to all jurisdictions on how to prevent harm from psychosocial hazards at work.

In addition, under changes to the *Sex Discrimination Act 1984* (Cth), employers and persons conducting a business or undertaking (PCBUs) - including specialist medical colleges as shared duty holders - have a positive duty to prevent sexual discrimination, sexual harassment and related forms of misconduct through the Respect@Work legislation. Supported by training and enforcement, these national legislative changes now provide a strengthened legal framework, with clear minimum standards related to acceptable workplace behaviours.

The practical application of these was overwhelmingly assessed as of vital importance, such that all duty holders discharge their duties to the healthcare workforce and to patients.

09

Recommendation 9

That governments, through their workplace health and safety regulators, give clear indications to duty holders of their obligation to protect healthcare worker safety by taking appropriate responsive regulatory actions.

Recommendation 10

10

That the AMC consider, in the current accreditation review of specialist medical colleges, a requirement that occupational health and safety relevant to the risks of each specialty form part of the assessable syllabus for specialist training programs, so that trainees can more effectively manage their own risks, and once qualified, are competent in supervision for safety.

Give a strong leadership voice to WHS

The potentially powerful application of WHS remedies is tempered when regulatory approaches are viewed as merely a tick box compliance exercise.

In fact, this is one reason that proponents of wellbeing programs argue as justification for avoiding incorporation into formal Occupational Health and Safety programs - the 'tick a box' reputation is repugnant to frontline workers.

Published guidance on the appropriate responses of employers to Respect@Work legislation makes it clear that employers must do more than simply have a policy in place to prevent sexual discrimination, sexual harassment and related forms of misconduct (*Sex Discrimination Act 1984* (Cth), s 47C) Duty holders are advised to take proactive and practical steps to identify potential systemic failures that put them at risk of non-compliance with their positive duty.

The potential to strengthen industrial instruments was the focus of feedback proposing that health employers should be required to incorporate positive obligations and enforceable mechanisms in industrial instruments, to eliminate psychosocial harms. Just as is the case in Respect@Work legislation, it is suggested that similar provisions be made in WHS legislative protections regarding bullying, discrimination and racism.

Concern was expressed of the risk of weaponisation of these – making clear the imperative to approach these challenges in a collaborative way. Other industries have managed to do this – without crippling productivity or financial viability.

Support was also expressed for the recruitment and elevation of WHS specialists to the executive teams of employing organisations. This reflects an acknowledgement of the challenge of engaging doctors and the need for seniority and expertise to do this effectively. It also reflects a recognition that healthcare settings are intrinsically hazardous environments.

Addressing physical and psychosocial risk in healthcare warrants a level of expertise commensurate with this level of risk (Workplace Behaviour Expectations Working Group, 2025).

Engaging senior health care professionals in positive workplace health and safety practices will be challenging. This is well beyond the reach of the most frequent models of WHS in healthcare, where a non-clinician WHS lead has a focus on standard workplace hazards (such as slips trips and falls, electrical hazards, and musculoskeletal injury). And yet, as highlighted in submissions, appropriate WHS practice requires consultation and meaningful engagement.

In some organisations now, clinicians are starting to undertake further training – these are usually nurses who can then step into a more clinically oriented role. Ironically, the very medical speciality with most expertise in this area, Occupational and Environmental Medicine, is virtually absent from healthcare organisations in Australia.

Senior doctors want to engage with people who have actual decision-making power or a direct reporting line to decision-making power. They are often impatient with compliance activities that seem to have little bearing on the true hazards of their day-to-day work. They are hesitant to embrace WHS because it is seen a meaningless compliance exercise, reputationally tainted with endless mandatory online learning modules. Having executive level presence of occupational health and safety in healthcare as happens in other high hazard industries, and as happens in healthcare for patient safety, would be a critical step.

Recommendation 11

11

That duty holders and WHS regulators seek and use competent WHS experts of seniority appropriate to the high level of risk, and with the capability to engage clinical staff and unions in meaningful analysis, collaboration and management of the risks of clinical work

Concurrent or shared duty holders

Both health services and specialist medical colleges owe duties to doctors under WHS law. That is, they are concurrent duty holders. Health services that employ trainees owe a duty to the trainees as "a worker" within the meaning of WHS laws, while specialist medical colleges - because of their role in conducting a business or undertaking (PCBU) which involves, in the case of trainees, facilitating the provision of specialist medical training, accepting applicants into the training program, designing curriculum and assessment, accrediting health services on an ongoing basis to provide workplace-based training and setting requirements for the supervisors of trainees -have a duty to consult, cooperate and coordinate with each other, and any others who have a duty in relation to the health and safety of specialty medical trainees (AMC, 2024).

Safe Work Australia has published a series of codes of practice:

- The Work Health and Safety (Managing Psychosocial Hazards of Work) Code of Practice, guiding legislation across all jurisdictions on the prevention of harm from psychosocial hazards at work
- The Model Code of Practice: Managing Psychosocial Hazards at Work, and
- The Model Code of Practice: Sexual and Gender-based Harassment

A new Model Code of Practice: Healthcare and Social Assistance Industry is in draft form at the time of writing.

A multifaceted response is essential

A caution on reliance on regulatory remedy is seen in the recognition that "regulatory requirements only motivate some leaders, with others being motivated by costs of staff turnover, patient safety concerns or complaints, or from tragedy such as the death of an employee as the result of occupational distress" (Western Australia Department of Health, correspondence, April, 2025). Levers in addition to (WHS) legislative frameworks are necessary to drive organisational change.

Individual level interventions (including 'Speaking Up' programs)

A selection of programs and individual level interventions, most oriented to promoting 'speaking up' - in various guises - were identified by the Individual Level Interventions and Reporting Pathways Working Group as having been implemented in Australia in recent years. Both industry experts and working group members provided extensive qualitative insight into their perceived efficacy. 'Speaking Up' programs have been shown internationally to play an important role in multifaceted approaches to driving professional accountability (Individual Interventions and Reporting Pathways Working Group, 2025).

The published literature identifies a plethora of definitions of 'speaking up' in healthcare. In this report and in the context of a professional accountability initiative, a 'Speaking Up' program refers to a structured conversation, where a discussion of a witnessed or experienced behaviour is consciously conducted with the person responsible for the behaviour, as a means of raising awareness of the occurrence and impact of a behaviour.

Formal 'Speaking Up' programs referred to in this report are not then, to be confused with 'in the moment' responses. 'Speaking Up' programs are intended to deliver constructive feedback. Different examples of 'Speaking Up' programs were presented to the working group. In some, feedback is delivered informally, by a colleague or peer who witnessed the behaviour. In others, the feedback is instigated by an online or written report of an incident, and feedback is then delivered by a trained colleague on behalf of a body who received the report. This is a practice that has been undertaken by at least one medical college.

Acknowledging the difficulties in comparability and evaluation, the working group concluded that with some exceptions, 'Speaking Up' programs appear to have had limited impact. One basis for this conclusion was the lack of difference in MTS results between sites which had implemented these programs and other site which had not.

Early career doctors in Australia described barriers to raising issues via the range of 'Speaking Up' programs in common with those identified for formal reporting, with industry experts emphasising the power imbalance between interns and senior doctors, professors. Principal house officers, unaccredited registrars or those working towards acceptance onto a specialist training program face similar barriers to engaging with 'Speaking Up' programs as a way of raising issues associated with bullying, harassment, discrimination and racism.

The internalisation of abuse, and sense of shame or an acceptance that 'this is just the way things are in medicine' underscores a sense of powerlessness perceived by early career doctors in the medical hierarchy.

Positive incidental effects of 'Speaking Up' programs were reported in the effect of raising behavioural awareness through training and the conversations which ensued. The failure of some individuals to moderate their behaviour following the enacting of low-level responses highlighted the need for these programs to be but one part of a hierarchy or graduated scale of interventions, culminating in effective reporting mechanisms and effective response (Individual Level Interventions and Reporting Pathways Working Group, 2025).

Where particular 'Speaking Up' programs appear to offer promise, these should be monitored and key success factors identified.

Recommendation 12

12

That employers and training bodies actively promote, support and monitor the provision and receipt of constructive feedback as a key indicator of positive workplace culture, where giving and receiving feedback is safe, normalised and expected as part of professional communication. 'Speaking Up' programs may be effective in delivering constructive feedback.

The role of specialist medical colleges in healthcare cultures of safety and respect

Specialist medical colleges impact on healthcare culture both directly and indirectly, playing an important role in supporting positive behavioural norms and expectations.

Specialist medical colleges select specialist medical trainees, develop and endorse training curricula, select and equip (in a professional sense) the doctors they appoint to supervise specialist trainees, and accredit and monitor training sites against their own accreditation guidelines. They specify Codes of Conduct - which set core behavioural expectations - and competencies; they advocate on behalf of and support their members. In some cases, they offer reporting pathways and psychological support for members involved in grievance processes.

Medical colleges can play a crucial role in setting behavioural standards in the medical training they govern. Office bearers and senior clinicians can serve as powerful role models, often demonstrating exemplary leadership, professionalism and ethical behaviour in clinical practice. Medical olleges are charged with ensuring that doctors engage in lifelong learning and continuous professional development.

Hospital training post accreditation guidelines have been regarded as one of the few levers within the control of medical colleges to influence and safeguard the working conditions in which their trainees work and learn. In recent years, accreditation guideline reviews have increasingly resulted in requirements - defined by specialist medical colleges - for employers to demonstrate conditions consistent with those supportive of positive workplace culture.

However, significant variation in the approach, commitment and attitude of medical colleges in regard to their role in workplace health and safety (WHS) became apparent through the consultation process.

It was of no surprise that early career doctors expressed confusion regarding medical college roles in dealing with bullying, harassment, discrimination and racism during training (Haskell et al., 2024). Feedback indicated that responsibility for managing WHS was perceived by some medical college representatives to rest with employers, relying on boards (governance, strategic priorities, policy, organisational structure) and leadership teams (staffing levels, workloads, resource allocation, maintenance of equipment, rostering) to shape culture and consequences for poor workplace behaviours.

As indicated above, under WHS laws, health services and medical colleges both owe duties to trainees, that is, they are concurrent duty holders. WHS duty holders in the case of medical colleges include those involved in accreditation, education and training of medical specialists.

Medical colleges are nevertheless limited in their capacity to act, as acknowledged by the NHPO, who agreed that medical colleges lack sufficient investigative powers (NHPO, 2023). Yet a failure or inability to address can be seen as entrenching the behaviours of concern.

Consultant/employee doctors and those in private practice who attend a given site all share a duty to manage the risk leading to and the consequences of poor workplace behaviours.

13

Recommendation 13

That all office bearers and officers of specialist medical colleges acknowledge and act on their responsibilities as concurrent duty holders in relation to the provision of training and associated activities. This extends to consultants and those in private practice.

Codes of conduct

Codes of conduct are more than policy artefacts — they shape behavioural expectations and send signals about what the system values and will tolerate. A code of conduct in healthcare can guide ethical practice, patient safety, and professionalism.

Additionally, it can protect healthcare institutions by ensuring compliance with legal and ethical standards. It can be an important tool to facilitate a shared understanding of the behavioural expectations of the auspicing body.

A Better Culture identified a plethora of codes of conduct, theoretically applicable to any early career doctor working in any given health service at any one time.

Codes of conduct analysis

Analysis of codes applicable to state health services, Ahpra codes of conduct for medical practitioners, allied health practitioners, midwives, nurses and psychologists, and the healthcare worker code of conduct for unregistered practitioners, against criteria developed by the working group, identified the following:

- at the time of writing, only three jurisdictions — New South Wales, South Australia, and Western Australia — have publicly available codes of conduct for public sector healthcare workers
- many are not comprehensive, lack updates to reflect recent legislative changes, and often fail to focus on system-level design and management issues
- four of the nine codes reviewed mention professionalism in relation to colleagues. The emphasis is typically on professionalism with patients and their families, often overlooking interactions with colleagues and overall workforce culture

- most codes address bullying and harassment, only two explicitly mention racism
- three codes provide guidance on what actions to take if the code is violated
- a few codes briefly reference the duties of supervisors and managers. Noting that supervisors and managers are also "workers", scant reference was made to additional responsibilities in leading and support their teams
- none of the codes reviewed addressed the responsibilities of leaders and hospital board members
- only South Australia's Respectful Behaviour Policy Directive mentions the responsibilities of executives in creating an environment that promotes positive behaviours among staff

The analysis concluded that in cases where codes exist, it remains unclear if they are consistently and robustly enforced (Workplace Behaviour Expectations Working Group, 2025).

A Better Culture supports the development of a consistent national or model code of conduct for all healthcare workers, applicable across the public and private sectors. This could potentially be adopted by the states in much the same way that the SafeWork Australia Model Code of Practice for Psychosocial Safety has been adopted and incorporated into legislation.

Cultural safety must be explicitly referenced in national codes of conduct and curricula as a core competency, supported by both induction and ongoing CPD - not an elective or standalone module. References to cultural safety in such codes must look beyond the patient experience and acknowledge that Aboriginal and Torres Strait Islander healthcare workers also have a right to cultural safety at work.

Six overlapping behavioural categories – each with a series of key elements – were identified for inclusion in a national healthcare code of conduct: healthy and safe work, workplace behaviours, person centred practices, effective communication, positive workplace relationships and a just and learning culture (Workplace Behaviour Expectations Working Group, 2025).

A Better Culture emphasises that cultural safety of both staff and patients should be a unifying theme underpinning each of these, ensuring that it is grounded in values-based professional expectations.

Recommendation 14

14

That Ahpra, in consultation with the national health practitioner boards, develop a consistent, evidence-informed national code of conduct for all healthcare workers, applicable across the public and private sectors, reflecting the following areas of focus: healthy and safe work, workplace behaviours, person centred practices, effective communication, positive workplace relationships and a just and learning culture.

A multifaceted response is essential

'Reporting' is an ambiguous term. It might be interpreted as 'letting someone know' all the way through to making a formal complaint to a regulator. Senior managers will be familiar with a 'report' scenario where a trainee is very clear that they want no action taken, but want someone to know what is happening.

Formal reporting and complaints management pathways have been simplistically seen as a decisive way to signal a 'zero tolerance' approach to bullying, harassment, discrimination and racism.

Consensus regarding their place at the top of a pyramid of responses, reflecting their role in supporting end-state issues resolution was clear, as was consensus that complaints handling processes need to be improved as these pathways were in the main, ineffective and potentially career-limiting.

Barriers to reporting

Underreporting is understandably rife. According to 2024 MTS results, 85% of early career doctors stated they knew how to report and 78% reported confidence that they would report, whilst only 33% of those who experienced and 28% of those who witnessed these behaviours actually did report. The MTS does not make clear what reporting took place.

Trainees who did not report attributed this to fears of repercussions (reputational harm, damage to career), the belief that nothing would be done and perceptions that it was not accepted practice to report. Several early career doctors interviewed outlined negative personal experiences of reporting.

Most assessed them as time consuming and slow with no feedback on outcomes. As one participant observed, "early career doctor mobility might also give employers a reason not to act if concerns are raised" (Individual Level Interventions and Reporting Pathways Working Group, 2025, p. 20).

Formal reporting mechanisms are configured as a 'one size fits all' pathway, failing to make provision for issues faced by vulnerable groups such as Aboriginal and Torres Strait Islander people and Specialist International Medical Graduates (SIMGs). The non-homogeneity of the SIMG cohort is important to acknowledge. Even the most 'privileged' SIMGs (white Anglophones) face disadvantage in the current system, characterised by established power dynamics, relationships and hierarchies. Those who are non-white and/or non-Anglophone face the additional challenges of racism, language and other cultural differences.

Specialist medical colleges were an alternative reporting option for specialist trainees. However, relationships amongst medical college Fellows can cause trainees to be uncertain if a report would be received by a person who was a close colleague or a commercial competitor, in turn undermining confidence amongst early career doctors regarding the objectivity of medical college reporting pathways.

A lack of awareness of and clarity around reporting pathways was also cited. Job mobility requirements, short term training rotations, short employment contracts, movement between hospitals, departments and jurisdictions compounded confusion regarding reporting pathways.

The desirability of routinely incorporating this information in induction and whenever a change of workplace occurred was highlighted by the working group. Inclusion as a brief part of clinical training sessions for PGY1 and 2 doctors was also seen as helpful with both awareness raising and normalising the idea of reporting and seeking support.

Trainee perceptions of the risk of reputational harm if they report is reinforced by the practice of informal information exchange about trainees (described as off-the-record comments about trainee performance/personality/suitability) between senior doctors, and the accompanying reputational biases that this can elicit.

Employers and medical colleges should assertively discredit and systematically dismantle this practice; it is this above all else that skews power towards those who have been justly challenged by a trainee.

It is simply not permissible to covertly communicate things about a trainee that are not suitable or defensible to put in writing, yet reports of this practice lead to the conclusion that this persists as a cultural norm in specialist training.

15

Recommendation 15

That employers and training bodies provide explicit confirmation that off-the-record conversations about individual early-career/trainee doctors are a breach of professional standards, may breach privacy legislation, are not supported, and may not be indemnified.

Effective and safe reporting processes

Reporting pathways and the associated response they trigger should be trauma-informed and structured with inclusivity and cultural safety in mind, in order to increase confidence and uptake. The ability to report anonymously – and the opportunity to access psychological support are further enablers of uptake (Individual Level Interventions and Reporting Pathways Working Group, 2025).

Depending on circumstance, specific adjustments or conditions may need to be met to accommodate vulnerable groups or those for whom formal structures cannot be accessed or that are simply not appropriate for a variety of reasons.

Some early career or trainee doctors will need time to consider whether to report or not, or may wish to report once a rotation is over. The short-term employment status of these doctors (in many jurisdictions) can create a situation where such a report ends up in limbo due to the reporting doctor no longer being an employee of the relevant entity.

It is widely acknowledged that the personal costs of engaging with a formal reporting mechanism can be high. One obvious solution that is frequently raised is for anonymous reporting to be more readily available. Total anonymity however provides challenges. There are limits to the extent of anonymity that can be guaranteed from both the perspective of procedural fairness and practicality (e.g. anonymity in a very small workplace).

However, a reporting pathway where the identity of the complainant is fully protected from any further dissemination without explicit consent may, in some circumstances, represent a suitable compromise. This might more appropriately be described as maintaining confidentiality regarding the identity of a complainant.

The ability to report anonymously is seen as a strength of a process that aligns with evidence-informed practice, and for which there are increasingly available options that leverage technology platforms. Concerns regarding anonymous reporting pathways as possible avenues which support vexatious complaints have not been evidenced.

Recommendations to reform reporting pathways to better align with evidence-informed practice are further outlined in the report of the Individual Level Interventions and Reporting Pathways Working Group.

16

Recommendation 16

That employers and educational institutions review reporting pathways for characteristics of best practice issues and complaints management, including trauma-informed and culturally safe lenses, with provision for anonymous complaints and access to psychological support.

The hallmarks of effective response processes

Procedural fairness, responsiveness to the specific circumstances and wishes of the reporting practitioner, timeliness of response and transparency in reporting of outcomes, to the extent possible, are seen as the hallmarks of effective response processes.

Formal pathways were a core focus of the Individual Level Interventions and Reporting Pathways Working Group. However, formal pathways are often unsuited to addressing behaviours of concern such as microaggressions, or other behaviours which fall short of the threshold definitions of bullying, harassment, discrimination and racism but which undoubtedly have the potential to undermine the psychological safety of workers.

An early career doctor who is experiencing bullying, harassment, discrimination or racism may intentionally eschew a formal reporting path and the expectation of subsequent formal investigational response – but still needs support. This support should be available without the need to commit to a formal and potentially difficult and protracted mechanism.

It was noted that models such as the Vanderbilt model were built on a graduated hierarchy of interventions.

The Vanderbilt accountability pyramid - seemingly widely taken up in various modified forms in Australia - reflects the need for a model with a range of responses, to match the spectrum of bullying, harassment, discrimination and racism witnessed and experienced (Baldwin et al., 2022).

It also reflects the reality that pathways responsive to the user's desired outcome may not be suitable for and may not even require formal processes.

Alternative, lower order (less formal) options for help seeking and issues resolution were identified by the working group in the range of interventions uncovered. Less onerous or less formal options for taking action offer the possibility of prompting earlier intervention and could contribute to the normalisation of early help seeking and support.

Widespread awareness and accessibility of a spectrum of less formal options is suggested as enabling earlier action to address behaviours of concern and to normalise help seeking (Individual Level Interventions and Reporting Pathways Working Working Group, 2025).

Examples of responses to behaviours of concern that would sit lower down in a hierarchy of help seeking interventions included:

- the seeking of support and advice through a confidential discussion with a trusted confidante
- the provision of informal, peer-to-peer feedback
- a cup of coffee conversation (based on the Vanderbilt model where a trained peer representative provides brief, non-judgemental feedback)
- restorative justice approaches (where the persons involved are bought together by a trained independent third party, to discuss the impact of the behaviour), and
- further independently facilitated mediation options.

The availability of multiple avenues to access less formal resolution options was highlighted as an enabler of action (online, via human resources, through line management, specialist medical college representatives, dedicated junior doctor welfare' officers), as was promulgation of the concept of a 'just culture' – taking a systems view rather than blaming individuals (except in examples of egregious misconduct, criminal acts or intentional abuse).

Important characteristics of less formal options went beyond accessibility and included visibility, confidentiality and user-centricity – that is, leading to actions or disclosures to which the user consents.

The immediate safety of the user and their wishes must be balanced against obligations of an employer for impartiality, procedural fairness and due process. An effective response must also be timely and transparent to the extent possible, in advising the user of progress and actions taken (Individual Level Interventions and Reporting Pathways Working Group, 2025).

17

Recommendation 17a

That accessible issue resolution options, which serve to normalise help seeking, be included in a graduated scale of interventions, ranging from confidential support and advice, progressing through to formal reporting as end-stage issue resolution.

Recommendation 17b

That education about these approaches to both formal and informal reporting and complaints handling should form part of intern induction content, with ongoing brief reinforcing interventions delivered throughout PGY 1-2 and incorporated as part of clinical teaching sessions.

The National Health Professional Ombudsman (NHPO) and its role in addressing concerns

The management of concerns about accredited specialist medical sites was the focus of the NHPO report (2023) *Processes for progress, part one: A roadmap for greater transparency and accountability in specialist medical training site accreditatio*n.

This review was commissioned by federal, state and territory health ministers to consider the fairness and transparency of accreditation processes, including complaint and appeal processes. Health ministers requested that the review give particular attention to the processes of specialist medical colleges.

The NHPO noted that many concerns and complaints regarding bullying, discrimination, harassment and racism at training sites relate to matters relevant to medical colleges and health service concurrent duties. As has been highlighted previously, recommendation 13 of the report states that health services and medical colleges must coordinate, cooperate and collaborate in order to manage these concerns and complaints - particularly in relation to bullying, harassment, discrimination and racism.

The development of a framework to manage concerns and complaints regarding accredited sites was also recommended by the NHPO. Work between the Australian Medical Council and the Health Workforce Taskforce to implement recommendation 13 is underway, but this work will not address the very large number of early career doctors who have no medical college membership or affiliation.

The difficulties faced by early career doctors not affiliated with a specialty training program and who report 'falling through the cracks' of the system should be addressed by an additional focus on those elements of reform that can have the broadest benefit. For example, the collaboration between medical colleges and jurisdictions may illuminate opportunities for better practice, and where those practices fall within the remit of employers, they should be extended to all early career doctors, not only those who are in a medical college training program.

18

Recommendation 18

That employers ensure that the work to implement recommendation 13 of the National Health Practitioner Ombudsman report Processes for progress, part one is enhanced to benefit doctors who are not affiliated with any specialty training program or medical college

An independent external assistance mechanism

Recognising the significant shortfalls of current approaches to reporting and complaints handling, there have been recent calls in the feedback received and in the published literature for an independent and external complaints handling mechanism. The persistent failure to hold senior clinicians to account for bullying, harassment, discrimination and racism fuels these calls.

Some have suggested that an independent external reporting function be part of an expanded remit of the NHPO. Whilst calling for the development of "a framework for managing concerns" about accredited specialist medical training sites, the NHPO confirmed its jurisdiction via email as follows:

"The NHPO accepts administrative complaints about Ahpra, the National Boards, accreditation authorities and specialist medical colleges.

The NHPO cannot consider complaints about healthcare employers, providers or health departments. The NHPO does not have jurisdiction related to considering healthcare employers' responsibilities.

The NHPO's role in relation to the implementation of recommendation 13 is limited to monitoring at this time" (NHPO, correspondence, April, 2025).

The Healthcare Worker Cultural Safety Working Group (2025) further recommended the establishment of an independent Aboriginal and Torres Strait Islander-led body to receive and act on cultural safety concerns. Anonymous, trauma-informed pathways that sit outside traditional employer-driven processes are essential to improve reporting, build trust, and drive organisational accountability.

Haskell et al. (2024) draw on analysis of current Australian processes and make a compelling case to "replace existing disparate mechanisms with a national framework supported by an independent investigation body". The authors note the recommendation of the NHPO for the development of a framework for managing concerns about accredited specialist medical training sites. The example of the National Integrity Framework (Sports Integrity Australia, 2023) is as cited as a model that could be applied in healthcare; the accountabilities of key stakeholders and suggested pathways for complaints handling by a proposed Australia-wide investigation body is provided.

These repeated and consistent requests for an independent, streamlined reporting and investigation body are the result of the myriad shortcomings analysed above.

There are many functional barriers to the establishment of an independent, centralised mechanism. Most relate to the response arm, attributable to the dispersed nature of governance of Australian healthcare: the hospital system operating under state or territory jurisdiction, private practices as independently operated businesses and specialist medical colleges as voluntary membership organisations.

Yet, the National Integrity Framework incudes some features, which if applied in health care, could address some of the barriers to taking action – whether via informal or formal pathways. For example, and most easily implemented, provision of a telephone triage service – or hotline – where a "trusted member of Sport Integrity Australia can provide guidance around the options [for taking action] available" (Sports Integrity Australia, 2023, p. 20), and which includes an anonymous reporting capability for people who feel they have been discriminated against in their sport.

The helpline service advises on the kinds of complaints it can receive, the most appropriate complaints handling pathway and what this is likely to entail, depending on factors such as what the conduct involves, the sport, and where the user is located. It provides guidance and support around indicative timelines for action, the likely range of outcomes that could result and identifies ways to access to psychological support. It also details the kind of issues Sports Integrity Australia can investigate and the kinds of issues that are most appropriately referred to individual sporting bodies, regulatory authorities or law enforcement.

In addition to providing valuable support and reducing the complexity of navigating issues resolution or formal complaints handling, such a service would provide a valuable source of de-identified data regarding the nature and frequency of issues across healthcare, the action taken/mode of resolution, and level of satisfaction achieved with the service and the outcome.

19

Recommendation 19a

That the DHDA establish an independent and nation-wide external assistance system, that can be accessed anonymously, and that directs healthcare workers to the most appropriate support and response mechanisms.

Recommendation 19b

That data from this system be made publicly available, including the volume of reports, the nature of issues and the advice given.

Some workplace settings pose unique challenges

Rural or remote settings, locations with low numbers of practitioners, specialties with very small numbers of trainees and private practice pose unique challenges.

Rural settings comprise a diversity of healthcare workplaces, including general practice, community health, Aboriginal and Torres Strait Islander health services and small isolated hospitals. Feedback told us that leadership diversity may be difficult to achieve in rural or remote settings, or in specialties and locations with low numbers of practitioners. Organisational structures are necessarily flat; there are few locally trained workers; recruitment and retention is extremely challenging; there is an increased reliance on SIMGs.

The intersecting impacts of geography, race and gender in rural or remote services combine to reduce the likelihood of achieving leadership diversity in these settings.

While formal reporting pathways are evident in hospitals and larger general practice, smaller general practice and rural or remote settings are typically lacking in reporting infrastructure and staff trained to deal with WHS issues.

Doctors in specialties and locations with low numbers of practitioners and trainees report a lack of trust in or absence of anonymous reporting pathways.

Anonymity in reporting (where it exists) is confounded by being 'the only trainee in town', thus, speaking up is complicated by the potential for a practice owner to be involved or party to an incident.

Challenges such as these are the case for all healthcare workers in these settings but are multiplied for SIMGs required to work in rural and remote services, who can carry the additional burden of the threat of deportation, inability to gain registration or reputational damage, in circumstances where their relationship with an immigration-sponsoring employer breaks down.

Recommendation 20

20

That the Rural Health Commissioner undertake a review of reporting pathways available to healthcare workers in rural and remote settings and make recommendations to achieve safe reporting for vulnerable groups, with anonymous reporting options included in those pathways.

Data, monitoring and evaluation – an ongoing need

A paucity of data regarding cultural indicators and drivers of poor workplace behaviour was agreed to exacerbate the challenges of reporting, monitoring and evaluating action at every level. Simultaneously, it was held that the data collection underpinning these processes was essential to provide a structured approach to measuring the progress of change, holding individual leaders and organisations to account and ensuring sustainable improvements.

The need for robust and relevant data

Issues associated with monitoring, measurement and comparability of data, both within and across organisations and over time were repeatedly highlighted by the working groups assembled to consider each area of A Better Culture's focus.

Examples include calls for the hard measures of performance against change metrics at board level, nationally consistent reporting and monitoring of complaints processes and outcomes, measurement and reporting of workforce and leadership diversity and cultural safety in health care.

The ability to use data driven insights as the basis for decision making is the holy grail. This means thinking about data and its quality. The MTS continues to provide valuable longitudinal data to inform insights regarding medical training in Australia. Its evolution over its first six years to include contemporary priorities such as sexual harassment and racism is a strength.

The need to continue to evolve was reflected in our recommendations around leadership diversity, with further expanded data collection called for in the dimensions of race, neurodiversity and disability allowing correlation of these factors with training experience.

Themes underpinning data quality and collection highlighted calls for objectivity, comparability, transparency, and where applicable, a national focus, as features of expanded data.

Monitoring and evaluation of progress towards cultural safety

Ongoing evaluation of cultural safety initiatives must be integrated into national data strategies. The Healthcare Worker Cultural Safety Working Group (2025) proposed using a longitudinal, culturally governed evaluation framework that includes indicators like Aboriginal and Torres Strait Islander retention, staff feedback, cultural safety training impact, and behavioural regression. Data must be disaggregated, comparative, and transparently shared. Without culturally governed, longitudinal evaluation, there is a risk of repeating short-term cycles of implementation without sustained change.

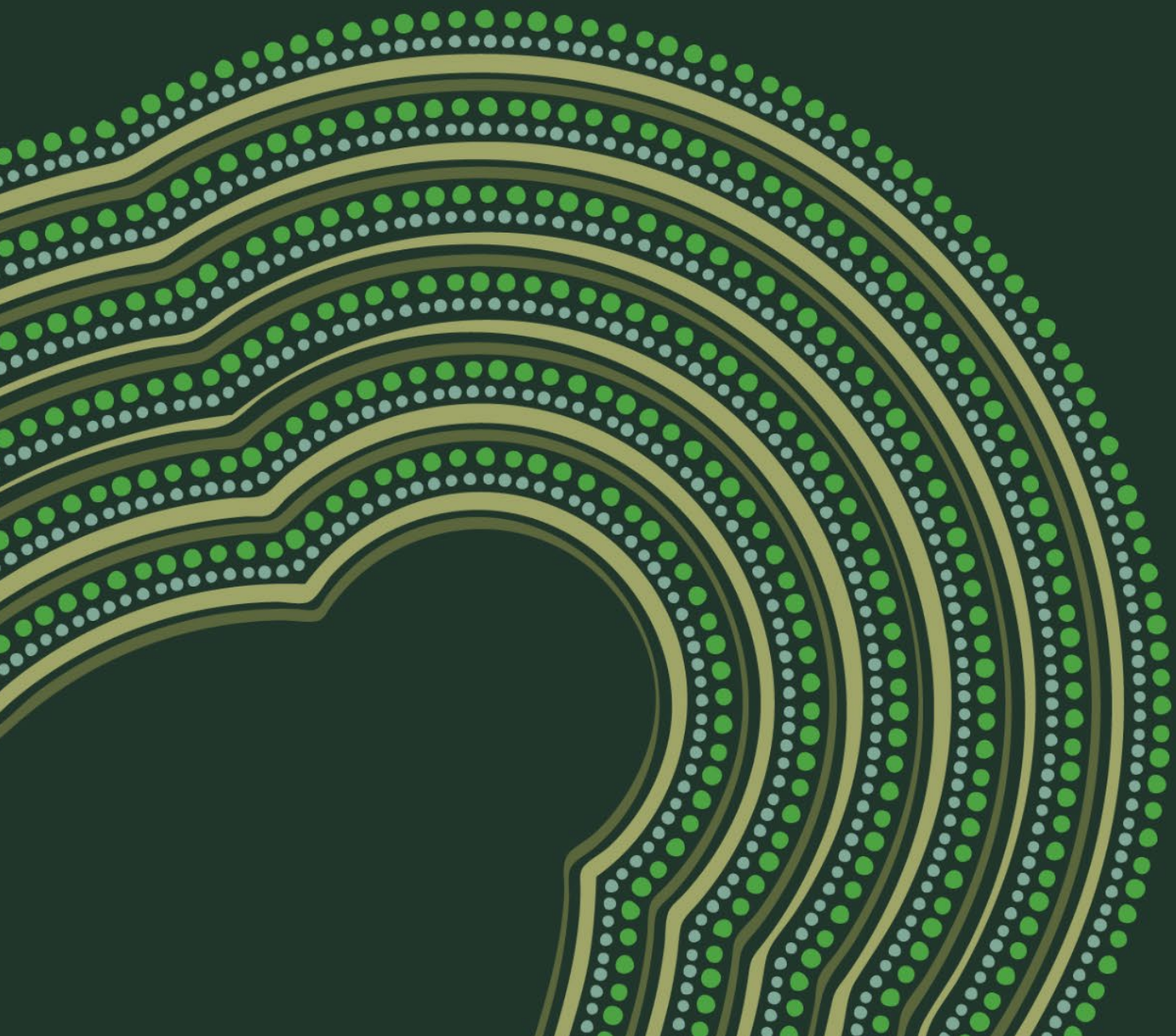
As noted above, we have identified gaps in both the focus on staff cultural safety and the measurement thereof. This gap likely affects workers across the nation, and accordingly, we recommend the initiation of discussions to develop, under appropriate governance, methods to measure and monitor healthcare (and other) worker cultural safety.

21

Recommendation 21

That nationally consistent data collection be prioritised in a strategic approach to driving culture change across healthcare, as the basis for ongoing monitoring, evaluation, comparability and data-driven decision making.

5.0 Conclusion



Conclusion

A Better Culture was commissioned in order to address the longstanding issues of bullying, harassment, discrimination and racism, revealed in year-on-year Medical Training Surveys.

The MTS data demonstrates that:

- these issues are seemingly intractable
- piecemeal efforts – however well intentioned – have not resulted in change, as reported by medical trainees
- compared to industry averages, alarmingly high numbers of medical trainees are considering careers outside medicine

This coincides with relentless and increasing pressure on healthcare, described as "...a mismatch between resourcing and demand, failing legacy systems, an ageing workforce, systemic inertia and the absence of a vision for change" (Resilient Futures, 2025, p. 6).

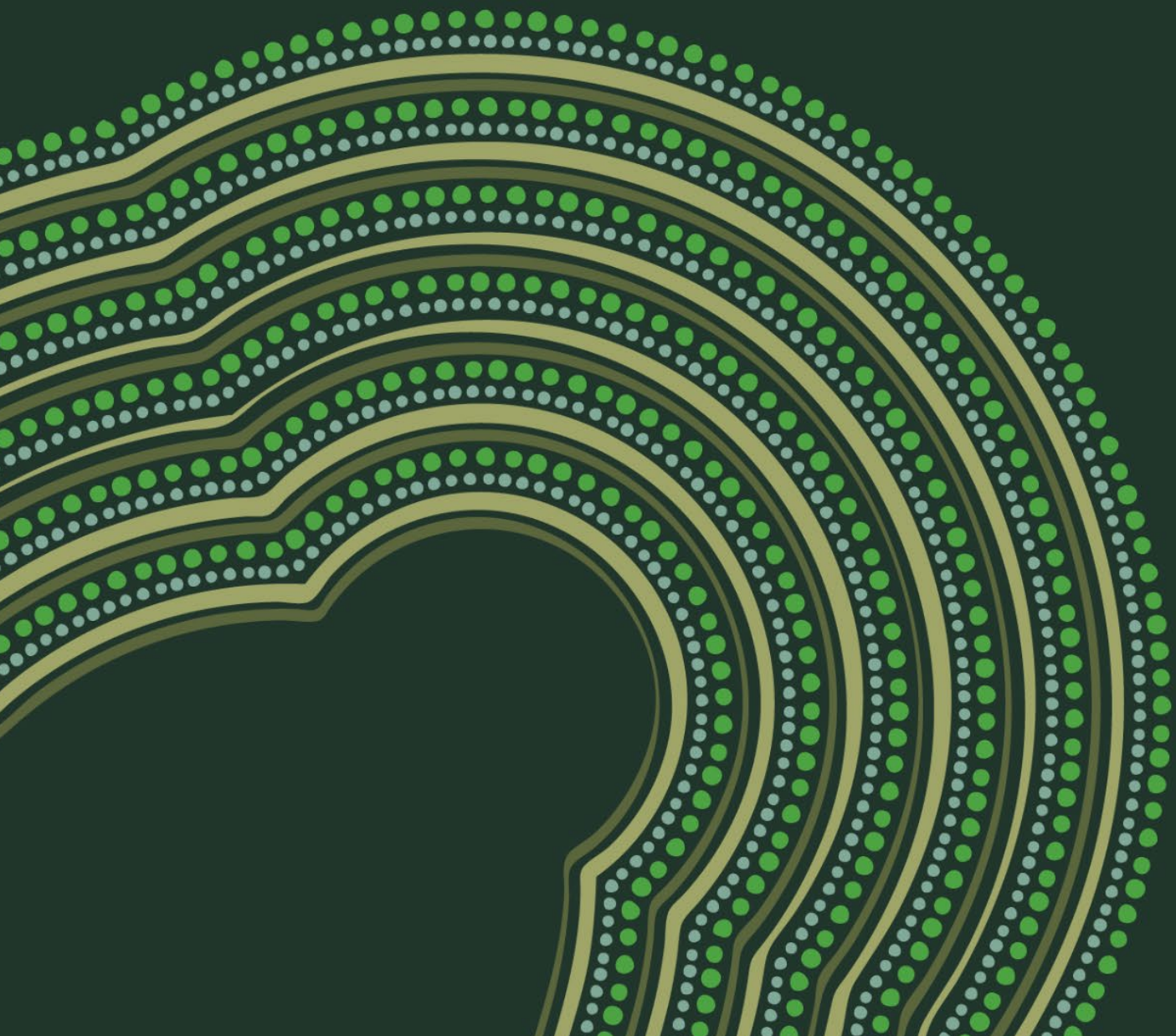
Over 2 years, A Better Culture has engaged, researched, advocated and convened across the healthcare system, to gauge the requirements for improvement. Our most salient finding is consensus regarding the need for coordinated sector-wide reform to address the drivers of workplace culture for all healthcare workers, not just those in medicine.

The proposal for a national strategy to reform healthcare workplace culture, to be read in conjunction with this report, arises from our analysis of these findings. It heralds the requirement for leadership of transformational change across the sector, with far-reaching implications for policy, practice and accountability.

Future implementation should necessarily be backed by ongoing resourcing and supported by unprecedented levels of cooperation and collaboration on the part of all stakeholders.

The sector has demonstrated its appetite for reform in the goodwill and effort donated to this consultation. Through development and, ultimately, implementation of a national strategy, the community at large can capitalise on this readiness for cultural change; to support patient care that meets community expectations, to enable our healthcare workforce to deliver care safely and to set a benchmark for exemplary healthcare service delivery outcomes.

6.0 Appendices



Appendix A: Consultation participants

Please note: While 36 organisations and individuals provided feedback, some elected not to be listed below. Additionally, this report reflects a modest revision of the working group consultation drafts and may not represent the individual views of those listed.

Organisations

1. Australasian College for Emergency Medicine (ACEM)
2. Australian Association of Psychologists Incorporated (AAPI)
3. Australian College of Rural and Remote Medicine (ACRRM)
4. Australian Council of Trade Unions (ACTU)
5. Australian Health Practitioner Regulation Authority (Ahpra) Aboriginal and Torres Strait Islander Health Strategy Unit
6. Central Adelaide Local Health Network
7. Fair Work Ombudsman
8. Medical Board of Australia (MBA)
9. Medical Deans Australia and New Zealand
10. Queensland Health
11. Royal Australasian College of Physicians (RACP)
12. Royal Australasian College of Medical Administrators (RACMA)
13. Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
14. Royal Australian and New Zealand College of Psychiatrists (RANZCP)
15. Royal Australian College of General Practitioners (RACGP)
16. SafeWork Australia
17. WorkSafe Commissioner WA

Individuals

1. John Biviano | Health Policy Strategist
2. Divya-Jyoti Sharma | Anaesthetist
3. Eric Wegener | Radiation Oncologist
4. Clare Skinner | Past President, Australasian College for Emergency Medicine
5. Simon Clarke | Professional Practice Manager
6. Tom Haskell | Emergency Physician
7. Nancy Merridew | General Medicine & Infectious Diseases Physician
8. Nicola Saggers | CPD Home Manager, Osler Technology
9. Kathy Doesburg | Diversity & Inclusion Specialist

Appendix B: Recommendations from working group consultation reports

Consultation draft reports can be found on our website.

Individual Level Interventions and Reporting Pathway Working Group Recommendations

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.

Leadership Diversity Working Group Recommendations

1. Develop a national program for measurement and reporting of workforce and leadership diversity in health care. This should:
   - Establish a baseline by transparently reporting current workforce composition and, at a minimum, examining gender and race (and preferably other aspects of diversity) to measure the diversity of different health profession cadres, along with how well that diversity is reflected across the range of seniority and pay scales.
   - Collect and report (as currently happens in other countries) data about the diversity of applicant pools for both jobs and training programs, and report on the related diversity of successful applicants.
   - Amend the Medical Training Survey so that data on race, neurodiversity, disability and more is collected, allowing correlation of these factors with training experience.

2. Using the data above (preferably, but if not available, using other methods), identify fall-off points in the career development pipeline and provide targeted interventions to diverse employees and enhance their access to career opportunities.

3. Address institutionalised drivers of inequality:
   - Collect and examine data on diversity for temporary promotions or special projects that are filled without a formal recruitment process.
   - Ensure that there is transparency of methods for funding allocation to leadership activities, so that unconscious bias against diverse leaders does not set them up for failure through inequitable resourcing.
   - Examine (for each professional grouping) gender and race pay gaps at each appointment level, and identify and address drivers of any gaps (e.g. overtime, inequitable or biased criteria for promotion)

4. Develop specific strategies to reach and motivate mid-level managers who are critical to creating a truly inclusive leadership pipeline. While top leadership commitment is key, the day-to-day experience of emerging leaders is shaped by their immediate supervisors.

5. Re-examine and challenge existing stereotypes of leadership
    - Implement strengths-based leadership development assessment and training. Current models of deficit-based assessments cause diverse groups to be under-valued by metrics that reinforce historical stereotypes of leadership.
    - Develop systems and structures to learn from First Nations ways of knowing and being for the benefit of all patient and staff populations.
    - Implement a variety of leadership models, learning from other cultures, including shared leadership

6. Implement programs that elevate the perception of diversity as an asset, rather than an issue to be managed.
    - Promote and celebrate multilingualism.
    - Leverage the global sourcing of healthcare staff — continuously invite and respect proposals for improvements and economies that are effective and proven in other countries, being sure to guard against unconscious preference for anglosphere or European initiatives.
    - Create systems and structures that allow employees of diverse perspectives to be valued and be seen to be valued. Encourage diversity of thought.

Workplace Behaviour Expectations Working Group Recommendations

1. All healthcare leaders and participants should recognise staff health and safety is as important as patient health and safety, and that the two are inextricably connected.

2. All stakeholders should recognise their shared responsibilities and collaborate to build capacity and appetite for reform to support positive healthcare workplace culture.

3. All stakeholders should optimise use of data and evidence to support reform efforts.

4. Governments should increase available resourcing or engage effective demand-management strategies so that healthcare professionals are not exposed to ever-increasing workload demands.

5. Governments should give clear indications to duty holders of their intent to protect healthcare worker safety by taking appropriate responsive regulatory actions.

6. Governments and industry partners should sponsor programs to support increased healthcare system duty holders' knowledge and capabilities around the legal frameworks and evidence-based risk management

7. Duty holders should mature their work health and safety (WHS) risk management approaches to improve the design and management of work, optimising workplace behaviours and cultures.

8. Duty holders should seek and use competent WHS experts of seniority appropriate to the degree of risk.

9. Educators, advocates, and leading employers should partner to reinforce consistent behavioural expectations and capabilities and develop evidence-based codes of conduct.

10. A Better Culture should develop a targeted communication campaign with content that demonstrates to key healthcare stakeholders the value of a better culture.

Healthcare Worker Cultural Safety Working Group

1. Streamline and Enhance Cultural Safety Training: Establish a unified foundation for CST with flexibility for locally tailored content, ensuring consistency and relevance while Reducing duplication. Expand training programs to include longer, immersive sessions that deepen engagement with local cultural, clinical, and community contexts.

2. Culturally Safe Supervision and Mentorship: Establish structured support systems to Empower First Nations trainees and staff.

3. Policy Integration: Embed cultural safety within governance frameworks and key organisational policies, aligning with measurable key performance indicators.

4. Sustainable Leadership: Equip leaders to model culturally safe behaviours and support them with robust accountability mechanisms.

5. Holistic Workforce Development: Promote flexible workplace policies, including cultural leave and tailored professional development opportunities.

6. Expand Cultural Safety Training Content: Include modules focused on fostering cultural safety among peers, trainees, and staff to create a more inclusive and supportive workplace culture.

Appendix C: References

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Our artwork is by Ngarrindjeri artist Jordan Lovegrove and represents the project's commitment to address long-standing issues in the culture of healthcare. The project is represented by the circular central meeting place and is surrounded by its key stakeholders (represented by the five people symbols).