Project Impact Report

A Better Culture

Message from the CEO

This report summarises the achievements of almost 30 months of work on A Better Culture - a small project, with limited lifespan and a very challenging task. The team I have been privileged to lead (staff, consultants and volunteers) embraced that challenge with enthusiasm and determination.

As a result, we have had significant impact, from commissioning research to reviewing existing practice, published gap analyses and consultation reports – we have turned our minds to every lever we could think of that would help to reduce bullying, harassment, racism and discrimination.

The work we have done far exceeds the original remit – and this has been achieved through the tireless work of the volunteers who supported us in reference groups and working groups, and also by the hard work of the in-house team. Our Advisory Board, Chaired by Dr Helen Szoke AO were stalwarts who provided wisdom and encouragement along the way. The RACMA Board who secured the funding for the project, and generously permitted the armlength approach we took, so that all colleges would feel ownership. That was an act of leadership. All have been so invested in this work, because we genuinely want better for the healthcare workers of this country.

In the pages that follow we attempt to catalogue the journey and the tangible outputs. We know that there is more impact than this – because we have seen conversations start or change as a result of the work we have undertaken.

It has been a privilege to lead this work, and I thank everyone who contributed.

Dr Jillann Farmer
CEO, A Better Culture

Introduction

"A Better Culture" is a project commissioned by the Australian Government Department of Health, Disability and Ageing in December 2022 using unspent Specialist Training Program funds held by RACMA. It is a response to the medical training survey, which has shown year on year that reported rates of bullying, harassment, discrimination and racism (BHDR) were disturbingly high, with a disproportionately worse experience among First Nations trainees.

For many years, the Medical Board of Australia has collected data about work and career plans to support workforce planning. In 2019, for the first time, a comprehensive medical training survey was offered and completed by almost 10,000 doctors-in-training.

That first survey demonstrated high levels of bullying, harassment, and discrimination, with 22% of trainees reporting that they had experienced these behaviours directed at them during the previous 12 months. Unfortunately, in the 2024 survey, with over 24,000 respondents, that number is still 22%, with racism included as a separate item in the 2022 and 2023 surveys, and sexual harassment added in 2024.

Across an entire generation of doctors-in-training, and despite significant efforts at addressing the issues, the results remain stubborn. The 2024 data is different in breakdown from 2019, with improvement in the reported proportion of cases that involve other healthcare staff, but an increase across that period of those experiencing behaviours at the hands of patients/family members or carer. Senior doctors, peers, nursing and allied health staff are, to varying degrees, also identified as sources of adverse behaviours.

Recognising the unacceptable nature of these persistent findings, in October 2022, the Commonwealth Department of Health and Aged Care reached an agreement with the Royal Australasian College of Medical Administrators to repurpose some unspent funds from RACMA's Specialist Training Program to establish A Better Culture.

The repurposing was to address the year-on-year findings of bullying, harassment, racism and discrimination that were reported through the Medical Board of Australia's Medical Training Survey. The original badging of the project was The Culture of Medicine. Funding was allocated *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 including specialist medical colleges, the Australian Medical Council (AMC), the Medical Board of Australia (MBA), the Australian Indigenous Doctors Association (AIDA) and the Council of Presidents of Medical Colleges (CPMC). The intended outcome for the project was to confirm a tangible and achievable approach that will be adopted by all key stakeholders to enact genuine and sustained behavioural change across the whole of specialist medical training.*

A Better Culture was established with independent governance over content, with its own advisory board, reference groups, and working groups. RACMA relinquished this function to deliver a program where all Colleges could participate as equal partners and share ownership of these important reforms.

Advocating for a cohesive approach

The project worked across three themes and with the help of five working groups and several commissioned bodies of works. Recognising the extent of reform needed to address the root issues, the advisory Board, proposed an approach to development of a national strategy for the health leaders to consider. The project proposes that the Australian Government Department of Health, Ageing and Disability considers establishing a national strategy to reform workplace culture in Australian Healthcare settings.

'The Pathway to Better' is a consolidated report with key recommendations from four out of five working groups. The recommendations are a call for action for employers, specialist colleges, state and federal governments to take meaningful steps in improving the culture of healthcare. The recommendations have been compiled by working group members, including individuals with lived experience, administrative professionals, active advocates, industry experts, research enthusiasts, academics, and frontline healthcare workers.

'Cultural Safety: From Compliance to Commitment' is a report from the Healthcare Worker Cultural Safety Working Group. Highlighting the large disparity in reported experiences between Aboriginal and Torres Strait Islander trainees and other cohort, this standalone report advocates for and offers actionable solutions to improve the cultural safety of healthcare workers—an area often overlooked or under-prioritized. With 29% of First Nations trainees considering leaving the profession, urgent efforts must be made to retain this valuable workforce.

Providing practical solutions

Culture of Healthcare Assessment Tool (CHAT)

The Culture of Healthcare Assessment Tool was developed to address a critical gap: the lack of a comprehensive, healthcare sector-specific tool to assess workplace culture and its underlying drivers. The tool is designed to be relevant for all healthcare workers, regardless of their role or career stage. It recognises that culture cannot be changed in isolation—healthcare is a team sport. For meaningful insights, a culture assessment must be implemented organisation-wide, not in silos.

Our gap analysis confirmed that no existing tool captures the full picture of workplace culture in healthcare. Most tools focus on the outcomes of culture or employee experience, rather than the root causes. Developed in partnership with Steople, this new tool provides a practical framework to identify key levers for change and supports organisations in their culture change journey, shifting from their current culture to one that reflects their values and aspirations.

The tool takes less than 15 mins to complete and is a key contribution of the project to assist with evidence-based decision making.

The tool is now owned by RACMA, which is in the process of seeking funding to undertake a third validation round further refinement and potential national implementation and scale-up.

Curriculum framework

A recursive consultation process has been undertaken over 16 months to develop the unified A Better Culture Curriculum.

Consultation has included all levels of education from medical school to retirement, a wide array of clinical and non-clinical medical practice (patient care, education, administration, consultation, legal etc), all specialist medical college members of the CPMC, and all states and territories. Consultation has been additionally supported by subject matter experts and the project's reference groups. The curriculum defines 10 outcome areas across the four AMC domains. Separate curricula apply to organisational leadership, trainers and learners.

Each curriculum is further developed into levels one to three, reflecting novice, intermediate and expert performance. A resource list and possible assessment modes are also suggested.

Contributing to the body of knowledge

During the first year of the project, (Phase 1) the team undertook extensive stakeholder engagement to aid in understanding the landscape. Phase 1 saw many activities that contributed to the knowledge base of the sector. From qualitative research to evaluation tool reviews and then a compilation of all the resources; all helped shaped the Phase 2 work program. These activities contributed to the detailed design of the Phase 2 work program.

The Environmental Scan

The Environmental Scan is a repository of initiatives and materials from across the sector and beyond, categorised by the five focus areas of the project. The array of work demonstrates the substantial financial and human resources invested to date in improving workplace conditions in healthcare. However, it also underscores a critical challenge - the fragmentation of efforts and the absence of a unified strategic direction.

Through its various activities, the project has highlighted the duplication of efforts and initiatives which despite good intentions, have not meaningfully shifted the dial on the workplace culture in healthcare settings.

Qualitative research for culture change

This qualitative study, conducted in partnership with the Nous Group, examined bullying, harassment, discrimination and racism affecting healthcare professionals and assessed the effectiveness of current responses. Through interviews with senior medical administrators, it identified seven key levers for cultural change. The findings inform recommendations for both the specialist medical colleges and the A Better Culture project.

MTS review

The review commissioned by the project and conducted by the PSC Global Observatory at the University of South Australia provides an analysis of the current Medical Training Survey (MTS) and its limitations. This report formed the basis for the project's recommendation to the Medical Board of Australia (MBA) to include a separate question on sexual harassment in the MTS — a recommendation that was positively adopted. It also formed the basis for the decision to develop a de novo tool for the measurement of culture.

Working Group Consultation Draft Reports

Phase 2 of the project commenced with the establishment of 5 working groups: Healthcare Worker Cultural Safety, Leadership Diversity, Workplace Behaviour Expectations, Individual-Level Interventions & Reporting Pathways and Curriculum Design.

Consultation drafts of working group reports were produced by 3 of the 5 working groups (The Curriculum Design Working Group and Healthcare Worker Cultural Safety Working Group reports were recursively consulted during development and did not produce a definitive, published consultation draft, but their final reports can be viewed here.

The consultation drafts provide an in-depth analysis of each topic, reviewing current efforts and recommending potential solutions. Extensively consulted with participants representing the profession's diverse career stages, ethnicities, genders and specialties, the reports offer valuable insights and comprehensive studies on these critical areas.

Creating change through collaboration

A central aspiration of the *A Better Culture* project has been to go beyond delivering a strategic approach, its aim has also been to cultivate a community of champions for change. This community, comprised of practitioners, healthcare leaders and safety experts, is committed to normalising conversations about healthcare worker safety. The emphasis is not on the resilience workers must build or the measures to improve their well-being but rather on affirming that healthcare worker safety is paramount and a core responsibility of those in leadership roles.

A Better Culture has demonstrated a strong commitment to fostering meaningful relationships by actively involving a diverse range of individuals from grassroots practitioners and trainees to leaders and administrators, in the design and delivery of the project. The project has also been a vocal advocate on the issue, presenting at various national and international forums.

- 211 healthcare professionals in 12 Reference Groups
- 40 additional healthcare professionals in 5 Working Groups
- 12 industry experts on an Advisory Board
- 38 organisations/individuals who participated in consultation of the working group reports.

The project's governance structure has been instrumental in engaging a significant number of participants while extending its reach through strategic stakeholder engagements, conferences, and events. Over the past two years, *A Better Culture* has actively collaborated with 16 specialist medical colleges, the Council of Presidents of Medical Colleges (CPMC), Unions, other education providers and several like-minded organisations and initiatives.

Although the project's influence is challenging to measure due to its short duration and the inherent complexities of workplace culture in healthcare, participant feedback has been overwhelmingly positive. Members have consistently noted substantial increases in their knowledge and the value of networks developed through their involvement in the project.

The project has presented at several conferences and sessions, continuing to share its learnings and strengthen its impact across the sector.

All materials produced by the project have undergone extensive consultation reflecting our commitment to collaboration and inclusivity. No single body holds all the answers; meaningful solutions must be collaborative to work for everyone.

Redefining the conversation

"While well-meaning, calling healthcare workers angels and heroes when we endlessly sacrifice our own health for the sake of patients — it is not helpful. It just reinforces the legitimacy of chronic underfunding. Nor should we as nurses and doctors — as we too often do — assume that self-sacrifice is part of being a healthcare professional."

Greg Rickard, FACN. (Workplace Behaviour Expectations Working Group, 2025)

Healthcare professions have long glorified the concept of healthcare workers sacrificing or risking their lives to perform their duty. The project has advocated for this narrative to change and emphasise to prioritise the healthcare worker safety;physical, psychological and cultural safety.

The project has highlighted how the wellbeing narrative is often overused, allowing responsible bodies to deflect from their legal and ethical obligation to provide safe working environments. We have consistently emphasised the need to reframe this narrative to focus on the safety of healthcare workers. The project has also advocated for greater accountability, ensuring that duty holders understand their responsibilities and that mechanisms are in place to ensure those in positions of power comply with safety obligations.

The project has also advocated for the better provision of data and to improve conditions for the ones most at risk. Two of our initiatives were positively adopted.

- Submission to the MBA – the project wrote to the Medical Board of Australia and, among other recommendations, requested the MBA include a question on sexual harassment and provide gender disaggregated reports of the medical training survey. Both recommendations were positively adopted.
- Submission to NSW Parliament – the project was also invited to make a submission to the NSW Parliament Select Committee on Remote, Rural and Regional Health. Our submission highlighted issues of racism, gender inequity, geographic narcissism and reputational risk associated with moving from a big metropolitan service to a regional one. Our CEO was then invited to appear and give evidence at the hearings, when she presented data that further explored the issues facing rural and regional healthcare professionals.

Lessons learned

Lack of discussion around racism across various policies

We found through our work that many Australian policies and strategies shy away from talking about racism directly, instead they discuss the issue peripherally. The workplace behaviour expectations working group conducted a code of conduct review revealing a clear need for greater honesty and transparency in how we understand and confront racism. As a nation, we must be more explicit and courageous in naming the issue if we are to create truly respectful and inclusive workplaces.

Missing data on ethnicity, neurodiversity and disability

Our analyses found that the Medical Training Survey and other similar instruments do not collect sufficient data on ethnicity of respondents to allow interrogation of results regarding impacts of race and language. Without these analyses, it is unlikely that the full picture can emerge, and we continue to have a collective "blind spot" about the impacts of race on career development.

There is also almost no data on the status of disability and neurodiversity in the healthcare worker population;a factor that contributes to stigma and masking. More open inquiry about the prevalence and needs of this population would be valuable and could form the basis of future research.

Learnings about governance of cultural consultation

In spite of efforts to establish appropriate cultural consultation, the project struggled with engagement. Some peak bodies refused to engage at all, with the valid criticism that the work regarding Indigenous trainees should be led and governed by Indigenous entities.

There were also errors in cultural governance, with a failure to establish clear expectations for our activities about how cultural input would be sourced and credited.

These learnings strengthened our resolve to publish the Cultural Safety report as a standalone report, in addition to the representation of cultural safety in the consolidated report, "The Pathway to Better". In particular, we have noted that our Curriculum is not (and should not be seen as representing) a cultural safety curriculum, and the Culture of Healthcare Assessment Tool does not measure cultural safety of Aboriginal and Torres Strait Islander staff. These are both bodies of work that bear further consideration for development under appropriate leadership and governance.

Lack of assessment tools to assess culture

As part of our gap analysis, we reviewed several existing tools and found that while many effectively report on cultural outcomes, they often fall short in identifying how to drive meaningful improvement.

A unified understanding of the elements that shape workplace culture is essential. This project has contributed to addressing that gap by developing a tool that focuses on measuring the key levers that influence culture.

The tool requires further investment and refinement to evolve into a fully viable and impactful intervention.

Occupational Health and Safety should be a tool, not a burden

Many organisations and individuals are delivering programs aimed and limiting the harm of healthcare work – without recognising that this is core occupational health and safety. If an occupation group (e.g. doctors) has a statistically higher risk of an adverse health outcome (e.g. suicide) then that must be tackled as an occupational health issue, not as individual failings to manage personal risk. This narrative must change.

We need a broker of culture change

We have had numerous conversations with specialist medical colleges, unions, funded initiatives, and other key stakeholders, many of whom have expressed that their ability to drive meaningful change is limited. Often, they are constrained to only use the levers within their direct control to address specific issues.

Communication is central to these efforts, yet it is frequently hindered by competing priorities and vested interests. A recurring message we have heard is the need for an independent broker;someone who can facilitate dialogue, channel communication, and help align perspectives to reach a shared path forward.

Given the complexity of the healthcare system, the role of an independent reviewer or facilitator is not just valuable it is often essential.

As a project with independent advisory board, we have been able to bring many different stakeholders together to discuss the important issues and propose solutions.

Governance structure is pivotal

A major factor in the success of the *A Better Culture* project was its strong and thoughtful governance structure. From the outset, considerable time and effort were invested in establishing a framework that aligned with the project's ethos and objectives and that investment paid off over the two-year course of the project.

Given the focus of the project on the least powerful players in the healthcare system specific effort was invested in bringing representation from those groups to the table and avoid engaging only with stakeholders who already have role, status and voice.

Stakeholders clearly understood their roles and responsibilities within the governance framework, which enabled consistent engagement, accountability, and shared ownership of outcomes.

Volunteers cannot shoulder this alone

Throughout this work we have been overwhelmed by the generosity of hundreds of volunteers who have helped us. Doctors, nurses and allied health professionals as well as patient advocates joined the effort to generate recommendations that would be impactful.

Whilst acknowledging the value of this volunteer workforce, whose support allowed us to deliver outputs far in excess of what our funding would have predicted, the question remains why, given that there are core occupational safety issues, is the predominance of work being conducted by volunteers?

The Australian healthcare system benefits from many thousands of hours of voluntary work done by members of all professions, but particularly the specialist medical colleges – which are membership organisations. Much of the national training effort to produce the next generations of specialists_comes through the unpaid work of colleagues across all specialities. This culture was of direct benefit to the project, but it is not at all taken for granted, and we are profoundly grateful for the many hours of unpaid work that supported us.

Mindful design of real engagement

Our engagement approach was successful, perhaps because it was intentionally unconventional. We did not engage solely through recognised bodies – because to do so limits the pool of people whose voices are elevated. We went direct to the professions, offering inclusive participation from the beginning, and the response was profound. Trainees, seniors, IMGs, doctors, allied health and nurses joined our work and broadened the base of collective intelligence that informed us. This was one of our key strengths.

A systems thinking approach is essential

Historically, issues of bullying, harassment, racism and discrimination have been examined through an individualist lens – find the perpetrator and remediate them. This approach has had limited success, because it fails to apply the lessons we have learned from patient safety to the domain of staff safety – namely, that addressing root causes is more effective than multiple interventions to try and prevent end-point harm.

Whilst there are some acts for which individuals must be held accountable (e.g. illegal, intentional or wilful), a whole of system approach to understand drivers, enablers and perpetuators of adverse behaviours will yield better results in the long term.

For far too long, issues with workplace culture have been addressed through reactive measures. We have focused on the outcomes, bullying, harassment, racism and discrimination, without adequately examining the systemic factors that allow these behaviours to persist. Ironically, in a profession grounded in diagnosing root causes, we have often failed to do just that when it comes to our own workplaces.

What is needed is a systems-thinking approach, one that takes a bird's-eye view to understand the broader structures, behaviours, and cultural norms that enable harm. Only by identifying and addressing these underlying causes can we shift from reactive interventions to proactive, sustainable change.

Conclusion

The *A Better Culture* project concludes on June 30, 2025. As we bring this chapter to a close, we recognise that the project has laid essential groundwork for lasting cultural change. It has created fertile ground for ongoing conversations and actions to improve healthcare worker safety.

We call on system leaders to unite their efforts and support initiatives like *A Better Culture*, which serve as vital intermediaries, connecting the key stakeholders needed to drive meaningful change. To transform the work into lasting impact, further investment and resources will be essential to turn insights into practical, sustainable solutions.

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

A Better Culture