Qualitative Research for Culture Change

A Better Culture

16 August 2023

nous

Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of country throughout Australia. We pay our respect to Elders past, present and emerging, who maintain their culture, country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

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1 Executive summary

This report presents the findings of a study conducted in collaboration with A Better Culture with the support of the Royal Australasian College of Medical Administrators (RACMA) to learn how leaders in Australian healthcare experience and organisational cultural challenges and foster a better professional environment for health practitioners. The study is one of the first activities of A Better Culture, an entity formed by RACMA and funded through repurposing of specialist training program funds. A Better Culture has the objective to cultivate systematic and sustained behavioural change across the healthcare sector to address the adverse findings relating to bullying, harassment, racism and discrimination identified in the 2021 and 2022 Medical Training Surveys[1]. We interviewed 20 experienced healthcare leaders who hold RACMA fellowship or associate fellowship to explore their experiences and views. The resultant transcripts were then subjected to thematic analysis. The study explored pervasive issues such as bullying, harassment, racism and discrimination that negatively affect the well-being of health professionals and explored the relative successes and limitations of approaches they have seen.

By exploring the firsthand accounts of healthcare leaders, this study aims to shed light on the effectiveness of current policies and initiatives, identify gaps in organisational responses, and highlight areas for improvement. Healthcare leaders play pivotal roles in shaping organisational culture and driving systemic change. By understanding insights and experiences of senior medical administrators, we identified seven levers influential in driving cultural change within healthcare institutions, and recommendations for both the college and A Better Culture.

Key findings:

1. **Leadership** is about the balance between a strong policy and a human touch. Both formal and informal leaders should recognise and cultivate leadership and management skills.

2. **Workplace Behaviours** stress the significance of training on communication across hierarchy and feedback mechanisms.

3. **Healthcare Workforce** psychosocial workplace health is paramount. Emphasis on addressing maladaptive stress responses and advocating for better working conditions was evident.

4. **Recognition and Consequences.** Collaboration, awareness of reporting barriers, and ensuring just, timely, and visible responses to issues are essential.

5. **Barriers to Change** highlighted the importance of collaboration with government and healthcare entities and the need for resourcing for culture change activities.

6. **Enabling Workplace Structures** underscored the potential of mentoring and innovative care models to promote team cohesion.

7. **Monitoring and Evaluation** can be enhanced by leveraging direct and indirect measures employed by experienced healthcare leaders.

Key recommendations for A Better Culture:

The college is positioned well to further advocate for a systemic change through A Better Culture. We have developed by five recommendations for this endeavour:

1. Ensure training measures reach all entrants into the system, and reinforce it throughout career progression

2. Prioritise buy-in from the professional colleges

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[1] [2021 Report](), [2022 Report]()

3. Align culture change initiatives to a uniting purpose

4. Shift towards a proactive approach

5. Effective culture change is best supported by a broader effort to improve the safety and sustainability of the healthcare workforce

2   Introduction

In this report we present the findings of a series of interviews with leaders in Australian healthcare conducted with A Better Culture through the Royal Australasian College of Medical Administrators (RACMA). The study sought to explore the challenges and experiences of healthcare leaders, particularly Chief Executive Officers (CEOs) and Chief Medical Officers (CMOs), in addressing cultural issues in healthcare and fostering a better professional environment for medical practitioners across Australia.

Healthcare is confronted with significant cultural challenges that adversely affect the psychological safety. These challenges include pervasive issues such as bullying, harassment of junior doctors by senior staff and conflict with patients and their families. The consequences of these challenges such as worker burnout are leading to an alarming proportion of doctors contemplating leaving the workforce altogether. The impact of these adverse experiences is particularly evident among doctors who identify as First Nations peoples, highlighting the need for targeted interventions to address systemic issues and improve the experiences of underrepresented groups in medicine.

The findings from the national Medical Training Survey have served as a consistent demonstration of the cultural issues affecting the healthcare workforce, and a call for change within the medical profession. The Medical Training Survey is sponsored by the Medical Board of Australia and the Australian Health Practitioner Regulatory Agency (AHPRA) to collate national, comparative, profession-wide data on the culture, environment and quality of medical training in Australia.

This project was catalysed in part by the findings of the 2022 Medical Training Survey. In this survey, 30 per cent of respondents (all doctors-in-training) reported having witnessed bullying, harassment, discrimination, or racism in their workplace in the preceding 12 months. Of those who experienced bullying themselves, the most common nominated perpetrators were senior medical staff, with 38 per cent of incidents related to bullying by someone within their own team and 39 per cent in their department but not their direct team. Alarmingly, 70 per cent of those who experienced bullying, harassment, discrimination, or racism did not report the behaviour. Of these, 55 per cent cited concern for possible repercussions as their reason for not reporting. Furthermore, only 47 per cent of those who reported adverse behaviour saw evidence of follow-up to their complaint. Overall, these findings suggest troubling patterns not only of adverse behaviours but also of disincentives for their correction. These are themes our team sought to explore in interviews. A more detailed breakdown of the relevant findings of the survey can be found in Appendix A   Detailed Summary of Medical Workforce Survey

We grouped the themes emerging from our interviews across seven conceptual "levers" for cultural change in healthcare. This grouping lends itself to translating insights into actions within A Better Culture's objective to cultivate systematic and sustained behavioural change across the healthcare sector. A more detailed description of this framework is outlined in Appendix B   The seven levers identified for culture change in healthcare

3   Study design

The methodology for this qualitative study was built around in-depth interviews with key healthcare leaders, predominantly Chief Executives and Directors of Medical Services. The focus of these interviews was to explore these leaders' professional experiences and insights regarding the shaping and influencing of organisational culture within their respective healthcare organisations. Particular emphasis was placed on efforts to prevent and address issues such as workplace bullying, harassment, racism, and discrimination.

The initial recruitment process of our 20 participants was primarily informed by a list of fellows from the Royal Australasian College of Medical Administrators with more than ten years in senior roles. We then recruited further from associates of the College who had expressed interest in A Better Culture, and an expression of interest survey sent to the broader RACMA mailing list. We approached respondents with a wide range of professional settings and demographic backgrounds, operating under the hypothesis that this breadth would provide a more comprehensive and representative sample of experiences across the Australian healthcare landscape, and thus yield a more varied set of ideas and themes.

Table 1 | Demographics of participants*

		Number of participants
Total		20
Gender	**Male**	10
	Female	10
	Other	-
Location of practice	**Metropolitan**	12
	Regional	8
Type of practice	**Private hospital**	3
	Public hospital	17
	Community health bodies (e.g., Broader State / Health District Roles)	11
	Australian Defence Force	3
	Academic appointment	4
International clinical experience		5

*Note – some participants' substantive experience spanned multiple settings, others had recently retired from practice.

Our research approach was guided by key lines of enquiry informed by A Better Culture's strategic objectives and hypothesised areas of strategic insight. These served to focus our interviews and shape the scope of our desktop research, allowing us to collate and synthesise relevant literature and information.

Table 2 | Key Lines of Enquiry

- What are participants' experiences as organisational leaders in addressing and preventing workplace bullying, harassment, racism and discrimination?
- How is prevalence of bullying, harassment etc. measured/monitored within their organisations? What processes and policies are in place, and how frequently are these reviewed?
- What do participants perceive as the drivers of workplace bullying, harassment, racism and discrimination?
- Who is perceived as responsible as the custodians of good culture? What role to formal/informal leaders and role models play in this?
- What are the barriers to and enablers of organisations addressing concerns about bullying, harassment, racism and discrimination when they are raised?
- How can we apply lessons from individual, leadership and organisational experiences to the next step of the Better Culture Initiative?

Data collected from the interviews were transcribed and subjected to thematic analysis. This qualitative method identifies, analyses and reports patterns within the data. Our aim was to pinpoint both recurring themes and outlier views to provide a comprehensive summary of the experiences, ideas, and recommendations of the participants. The systematic coding process enabled us to organise the data and extract insights.

Figure 1 | Study methodology
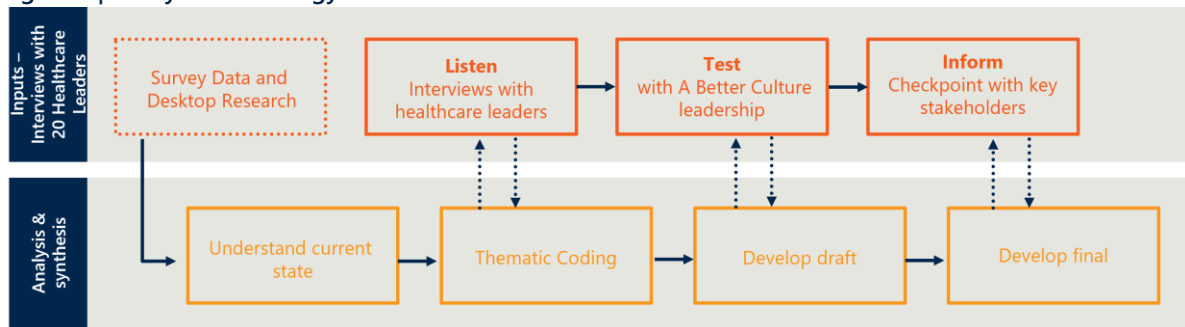
4 Findings

4.1 Leadership

Both formal and informal leadership within healthcare organisations shapes their culture

Leadership roles were not held to be exclusive to the executive level of hospitals and other healthcare organisations, but rather spanned across all tiers of the organisation. Some of these roles were formalised, forming clinical chains of hierarchy and responsibility and administrative overlays, while others were informal, such as peer relationships and interactions across disciplines and departments.

Participants held that those holding formal leadership roles had more explicit roles in articulating organisational values and policy. Informal leaders were held as significant in shaping culture both through role-modelling, and their influence on those working around them in their clinical environment. Both these formal and informal leadership roles were held to be important in shaping culture, but with informal leadership happening locally rather than being more visible at an organisational level.

Our participants emphasised that in both formal and informal instances, holding a leadership position did *not* equate to holding skills in "people management". Particularly, clinical leaders such as heads of unit or services were described as reaching their position through cultivation of an expert clinical skillset and seniority, rather than through recognition of their leadership capabilities. The result is that a position of expertise in managing health conditions merges with a position of managing people and teams, but with selection largely only contingent on competence in the former. Human Resources (HR) often faced constraints hiring for these positions due to limited applicant pools dictated by the limited number of clinicians with the requisite clinical skillset.

A small number of our participants also identified that intended independence of hiring practices in the public sector is often compromised by the influence of senior clinicians within the hiring organisation both through recommendations and departmental dynamics. Similarly, the specialist medical colleges were seen as able to influence hiring processes through the functions of an organisation's accreditation for taking doctors-in-training.

As a result, those in senior positions do not necessarily come equipped with skills in people-management and communication, and many unhelpful practices are tolerated by virtue of necessity.

Turn-over of leaders at the executive level impedes the effectiveness of culture change initiatives

Participants described executive levels as wanting to "make their mark" when they join an organisation, often working to overhaul processes and implement change in response to the issues evident to them in the organisation. The administrative and executive layer of organisations was held as having the potential to retain and reinforce cultural change across the more rapid turnover and movement of junior clinical staff.

It was acknowledged that meaningful change takes time and that turn-over at the executive role can impede this. Several participants identified that longevity in administrative leadership roles can foster the required consistency for effective change.

Mid-level managers are frequently overlooked in culture change initiatives

Mid-level managers such as Nurse Unit Managers were described as often overlooked in their potential value in culture change initiatives. Medical registrars and junior fellows were likewise seen as influential figures described as frequently being overlooked in change initiatives, in part due to competing interests in delivering their clinical duties. However, these parties were described as being the visible and influential determinants in many clinicians' day to day experiences, and as such central to the shaping and role-modelling of expectations.

Acknowledgement of the critical leadership roles of these managers is essential to foster buy-in for the effectiveness of culture change initiatives, particularly in recognition that the Medical Workforce Survey findings suggest significant numbers of perpetrators are staff like nurses.

Leaders must be invested in robust policies but also exhibit humanity

Our respondents described the vital importance of robust policies and procedures to guide their leadership functions. These structures allowed leaders to respond to issues in predictable, standardised fashions and be accountable to review and scrutiny. A well-implemented policy framework was described as a "bedrock" that guides actions, especially when dealing with complex matters like complaints and disputes. However, participants also highlighted the importance of exhibiting and acknowledging humanity when investigating and dealing with complaints. Demonstrating empathy and understanding was described as critically important in resolving many issues, and a means of maintaining trust and respect within the organisation.

A visible and in-touch executive layer can act on issues before they reach a point of provoking a formal complaint

Our participants described the importance of administrative and executive members of hospitals being visible to juniors and in touch with staff in order to identify cultural issues. Some highlighted that, when a healthcare leader's primary source of information is formalised complaints and notifications, they tend only to learn of issues when they are already more severe and difficult to address at the point of intervention.

While identifying greater contact with staff on the ground level would help awareness of issues before they become entrenched, this was acknowledged by some as an idealised model. Contact between the executive and junior staff is often constrained by organisational size and competing duties.

Early "course correction" in behaviour was seen as more effective that dealing with already entrenched behaviours, as such intervention during onboarding periods for new staff was identified as beneficial. This more proactive approach was described as allowing organisations to address and rectify emerging issues promptly, preventing these issues from becoming ingrained within the organisational culture.

4.2 Workplace behaviours

Subtle prejudice and privileged behaviours were held to be more common than overt racism

Participants stated that "overt" racism was relatively uncommon between medical staff. This was attributed by two participants in large part to doctors tending to train in diverse and multicultural cohorts and tending to come from socioeconomic backgrounds that facilitated travel and a breadth of experience outside of the workplace. We note that this description is not consistent with the findings of the Medical Training Survey and is likely not representative of the experiences of all medical staff.

In contrast, subtler forms of prejudice and racism were held to be commonplace relatively, particularly in the experiences of international medical graduates (IMGs) working in organisation. Racism was also held to be more common in patient interactions with clinicians who were people of colour.

Overt racial discrimination was also described as being more common in very senior health sector leaders, described as still bearing the hallmarks of a historical medical workforce composition of wealthy, Caucasian, male practitioners. It was observed that the effects of racial privilege become apparent when observing the racial background of members of the senior structures of healthcare organisations.

Descriptions of incidence of sexism and discrimination on the basis of gender was more varied between participants accounts. Sexism was described as common in very senior health sector leaders.

Discriminatory practices and prejudices towards LGBTQIA+ persons were not explored in depth in our interviews and represent an area for further dedicated study.

Experiences of bullying tend to arise from protracted mistreatment that often escapes external detection

Some instances of bullying arose from gross and visible mistreatment of individuals, but insidious forms of mistreatment were felt to be the more common form of bullying in healthcare workplaces. The predominance of more insidious mistreatment was attributed to the highly visible nature of many healthcare environments. Less overt mistreatment, such as incivility and microaggressions, was identified as able to erode morale and individuals' sense of belonging. These same behaviours were described as often dismissed as stress-induced behaviours. They were also described as being difficult to detect and to evidence, and resultingly being commonly overlooked at a Human Resources level.

Several participants expressed the view that longer term, "lower grade" mistreatment was underreported due to the same issues with evidencing and unsatisfactory HR responses. It was speculated that this pattern may account for the striking rates of bullying being reported in the medical workforce survey, at higher rates than a given organisation might see reported.

Instances of bullying often arise from the dynamics of power on communication, feedback and criticism

While acknowledging the gravity of issues with bullying in healthcare, participants reflected that perceptions and understanding of what constitutes "bullying" often arise from the power and communication between individuals. The unwelcomeness of criticism, particularly when delivered across hierarchical levels, was described as a common source of problems, with unskilled delivery of feedback often obscuring its intent. This highlights the delicate balance needed in providing effective supervision, which involves offering reasonable performance feedback without crossing the line into bullying.

Participants described three main factors contributing to the commonality of bullying complaints in the context of feedback in healthcare: first, the dynamic nature of patient care means that feedback is routinely required to ensure safe care; second the complex and interlocking hierarchies within clinical environments result in complex power dynamics; third the high-stress and time-sensitive nature of healthcare work often results in truncated, direct communication which can be perceived as aggressive or confrontational, regardless of intent.

More skilled communication between staff would improve the experience of many workers

Participants described that communication skills training does form a significant part of clinical training, particularly at the medical school level, but that this focussed exclusively on interactions with patients. Due to the public-facing nature of healthcare delivery this emphasis is understandable, but the approach was felt to understate the importance of cultivating skills for staff-to-staff interactions.

In the absence of formalised instruction, approach and habits for staff-staff interactions were felt to be learned during clinical placements, largely through role modelling and emulation of seen behaviour. This was identified as a key point underscoring the need for organisations to consciously foster positive workplace interactions.

The less robust administrative structures of private hospitals allowed for different workplace behaviours

Private hospitals exhibit unique characteristics, especially when compared to their public counterparts. Notably, care provision in private hospitals is predominantly led by consultants, with fewer junior staff involved in care delivery. This arrangement directly influences the dynamics and structure of the clinical teams.

In terms of administrative roles, private hospitals generally exhibit a less powerful administrative structure. This results in a greater reliance on peer-to-peer interactions and craft groups to regulate behaviour within the hospital. This setup places an emphasis on self-regulation and professional accountability among the staff.

However, the smaller scale of private hospitals also implies fewer layers of bureaucracy and fewer stakeholders to involve in culture change initiatives. While this streamlined structure could potentially speed up the decision-making process and implementation of initiatives, it also calls for a heightened level of responsibility and commitment from each individual involved. Given these distinct features, strategies for culture change in private hospitals would require a tailored approach that recognises and utilises the unique structure and dynamics of these institutions.

Non-urban healthcare organisations were described as vulnerable to poor workplace behaviour

Rural and remote healthcare organisations present their own unique set of characteristics. One such feature is the greater reliance on International Medical Graduates (IMGs) arising from the challenges these organisations face in attracting and retaining locally trained medical professionals. Our participants working in such settings described that, contrary to the stereotypical perception of the 'friendly countryside', racism is common in these settings.

Given their typically smaller size, rural and remote healthcare organisations were described as often having less administrative capacity. This can limit their ability to allocate resources to initiatives aimed at culture change, despite the critical importance of such efforts.

Recruitment for both clinical and administrative leadership roles was described as especially challenging in these settings due to the limited local pool of potential employees. As described in section 4.1, this was described as necessitating hiring of clinical staff on basis of clinical skillset alone and tolerance of poorer leadership skills. It was also described as leading to an increased reliance on early-career administrators, who were described as facing steep learning curves in managing complex organisational dynamics and addressing cultural issues. One participant described protecting their organisation's culture by using locum clinical staff and temp administrative staff "until the right candidate came along", but other proposed solutions for these particular challenges of non-urban healthcare were thin on the ground.

4.3 The health care workforce

Bad practices by individuals can be learnt at any stage of a healthcare career, and can be challenging to correct

Our participants explained the challenges faced at an organisational level to teach skills and correct bad behaviours that are often learned and embedded in a career leading up to employment at a given healthcare setting. They explained that many unhelpful traits and habits can be learnt at medical school and even earlier, and there are limits to the scope of transformation and re-education that an employer can provide over the course of employment.

While they were at pains to avoid the idea that cultural issues can be attributed to "a few bad apples", participants felt that the selection and training of healthcare workers needed to be examined across the whole of a professional lifespan, and that skills should be taught early, and reinforced throughout the person's career.

Prevalent stressors impact upon the mental health of members of the healthcare workforce, and compound interpersonal issues

The healthcare workforce faces persistent stressors that can exacerbate interpersonal issues. Our participants described overwork, burnout and fatigue to be significant contributors to workplace stress. These are intensified through staffing shortages and high workload demands, resulting in scheduling and leave constraints that impede recovery. This demanding and stressful environment was held to foster imperfect communication practices and contribute to conflict.

Addressing the drivers of workplace stress was seen as fundamental to creating the right environment for cultural change. Measures such as providing fairness in rostering, recovery post on-call shifts, adequate staffing ratios and suitable renumeration with award rates were all described as helpful in reducing the drivers of these mental health issues. Many participants described these challenges being a product of broader workforce challenges in healthcare, and not all able to be addressed at an organisational level.

The idea of the clinician a resilient "hero" distracts from the necessary skills, supports and structures needed to operate in healthcare roles

Participants described a problematic general perception that medical professionals inherently have high emotional and social intelligence and integrity. This was felt to bias training and curricula from focussing on cultivating these attributes. An example that was given is that clinical contracts and role descriptions tend to not emphasise these attributes at an individual level, and referred instead to overarching organisational values that staff are advised to align to. Some participants felt that psychological and relational duties should be a point of greater emphasis in clinical role descriptions and design.

The historical emphasis of workplace initiatives in fostering "resilience" was felt to be potentially harmful, implying that adverse experiences should be accepted and experienced passively rather than addressed. The concept of clinician as "hero" was felt to impede help-seeking behaviours. This can lead to de-valuing and lack of employee prioritisation, especially due to the pre-existing self-sacrificial culture of putting patients first. Several participants described how professional role and identity is core to many clinicians' sense of identity and worth. Conflation of personal and professional identity was highlighted a driver of conflict: criticism and feedback on performance of a clinical function can be experienced by healthcare workers as an attack on themselves and their value.

Rhetoric around self-sacrifice in delivering clinical care as "heroic" was seen as particularly damaging, as it was seen to reinforce unrealistic expectations, discouraging clinicians from seeking support when needed, for fear of appearing weak or incapable.

The dynamics of medical hierarchy select for and reward competitive individualism

Participants referred to some common characteristics and personality traits of medical staff that can be maladaptive in team environments. The notion that doctors are self-reliant, competitive and strong-willed is firmly held, with trainees often selected for, and being shaped by these stereotypes. These patterns of behaviour were described as leading to rigidity and tension, decreasing collegiality and collaboration. Participants described the marked functional difference between a "champion team" and a "team of champions".

Competition was described as build into every stage of medical training, from selection to medical schools and ranking in exams through to job selection and advancement in a specialty program.

An individualistic mindset was described as enabling a fear of failure and an expectation of perfectionism that was not conducive to an environment with dynamic team interactions and capability to respond collectively to sources of disruption and stress.

In a related theme, participants described a common pattern that if doctors' conduct is broached by HR, they will immediately engage their legal defence for fear of impact on their career prospects. The result is that when attempting to address an identified issue, things quickly escalate in an adversarial industrial or legal process. Challenges to a practitioner's conduct can be perceived not as an opportunity to take on feedback to improve practice, but instead a threat to career and livelihood.

Junior doctors' behaviour is strongly influenced by the competitive nature for roles and career progression

Junior doctors were described as subject to significant career anxiety resulting from short contracts and the challenging selection processes for their next role. The enmeshed nature of senior medical staff in selection processes for positions represents a perverse incentive to juniors reporting bullying behaviour or bad practice. Participants described that junior staff seek to avoid a reputation of being "difficult", and that those who conform to this pattern of behaviour tend to progress and reinforce this attitude as necessary for career progression. This cycle of role-modelling and reinforcement was described as a deeply entrenched culture that becomes challenging to disrupt.

Traditional factions and historical bastions of power endure in healthcare landscapes

Participants described the ongoing influence of historical male predominance in the medical workforce. Despite significant headway in achieving gender parity at junior levels, men were described as still predominating in executive and senior governing roles. In some cases these were described as hindering changes to working conditions and culture change initiatives. One such example was attitudes towards part-time working and training arrangements not being facilitated, with a resultant impact, for example, on those wishing to start a family but continue their professional role.

Other enclaves in clinical environments were described at clinical unit level, with factionalism and conflict between teams seen even in organisations that were held to have otherwise good cultural practices. These "factions" reportedly often hold considerable power and informal leadership, with administrative responses to issues impeded by the organisation's reliance on their clinical function.

4.4 Recognition and consequences

Underreporting of issues is attributed to hierarchical structures in healthcare

The factors contributing to underreporting of cultural issues in healthcare organisations are multifaceted, and tied closely to the hierarchical nature of healthcare systems.

As was touched upon in section 4.3, one of the key disincentives for doctors in training to report issues relates to the insecurity associated with their employment. These individuals are often on short-term contracts, creating a sense that they must endure problematic situations to progress in their careers. This lack of job security can discourage them from reporting issues, as doing so might jeopardise their employment or future opportunities.

Additionally, when the perpetrators of inappropriate behaviour are also the ones responsible for supervising their work and assessing their performance, trainee doctors often perceive that speaking up could harm their prospects of advancement. There is a significant concern that reporting such could tarnish their reputation within their professional college or the broader medical community.

Participants emphasised that accurate recognition of cultural issues is conditional on a safe and supportive environment where individuals feel empowered to report misconduct without fear of reprisal.

Recognition and response is biased towards discrete "incidents" which can miss more insidious cultural issues

Participants identified that a discrete incident is more likely to provoke a staff member to report an issue than a protracted period of lower intensity mistreatment. One participant referred to employees' perceptions of mistreatment as conditional on the "noise to signal ratio" in an organisation. That is, if an employee experiences consistent mistreatment and seems similar experiences for other staff they are less likely to report compared to someone experiencing gross mistreatment outside of an organisation's norm. Another participant referred to most organisations having "undercurrents" of cultural issues that escape notice, noting that as a senior medical administrator, their recognition of problems was often biased

towards critical incidents that were easier to detect. This concept has been described by sociologists as "normalization (sic) of deviance[2].

The impact of this recognition bias was felt to be twofold. Firstly, it results in under recognition of issues experienced in the day-to-day experience of healthcare workers. Secondly, it tends to shape responses to be reactive to incidents rather than being proactive in cultivating a better general culture. Multiple participants referred to the limitations of a response which relies on "weeding out the bad apples" for this reason.

It was also found that the rhetoric around "zero tolerance" of issues like bullying reinforces an absolute or binary idea of good and bad practices, shaping reporting behaviours to disclosure only when issues have passed a discrete threshold. Some participants argued that more nuanced messaging around reporting and proportional responses was more likely to foster a feedback and reporting culture.

Effective responses to issues are those that are timely, visible and fair

Participants reflected on the nature of effective responses to complaints. The importance of timely response was underscored. Prompt action following a complaint was described as instilling confidence in the system and reassures the complainant that their concerns are being taken seriously.

The visibility of an organisation's response to a complaint was also held to be important. Given that investigations and complaint processes for workplace issues are often be protracted, it is essential to keep complainants informed about the progress of their case. This visible response helps maintain trust in the system during what can be a challenging and lengthy process.

Participants described that misconduct should be acted upon decisively, regardless of the professional status of the individuals involved, avoiding exceptionalism for senior doctors and other healthcare professionals. Misconduct must be addressed in a consistent and reasonable manner to ensure fairness and maintain the integrity of the healthcare system.

Overall, it was felt that a clear link between the recognition of issues, the response to complaints, and the subsequent changes made to rectify the identified issues needed to be evident. Participants gave the example of issues raised in organisations surveys (discussed further in 4.7) which were often conducted without apparent response or change to reported issues, undermining the confidence of those who had completed the survey to take issues further.

An effective response will be consistent between employers, professional colleges and regulatory bodies

Participants described frustrations that responses at an organisational level are often not upheld by the other structures that regulate healthcare worker's behaviours. A recurring example was the perception that the professional colleges did not adequately collaborate with organisations in addressing misconduct in their trainees, with those responsible often progressing to their next position without penalty. In an extreme example, one participant described being pressured to rehire a problematic doctor or jeopardise the college's accreditation of their unit and hence ability to fill positions for that clinical service.

The Medical Board was described as holding a more removed but discrete function in response to incidents, described as being positioned to deal with misconduct that exceeded an organisations scope to address. We note that others have observed the Board's primary duties have related to patient safety, with less involvement in doctor-on-doctor conduct issues.

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[2] Vaughan, D., 1996. The Challenger launch decision: Risky technology, culture, and deviance at NASA. University of Chicago press.

4.5 Barriers to change

Broader health system and workforce issues are a significant barrier to meaningful culture change

Respondents described health system issues such as workforce shortages, workload pressures and occupational violence as examples of systemic barriers to cultural change. Overwork and fatigue (explored on an individual level in 4.3) impede meaningful implementation of cultural change practices. Multiple participants referred to risk of violent behaviour and psychological injury from interactions with patients being an ongoing source of distress and conflict in healthcare workplaces. This is reinforced by the data in the Medical Training Survey describing patients as the second most common perpetrators of bulling, harassment, discrimination and/or racism were patients and/or family/carers.

Service delivery pressures further generate sources of conflict. Two participants identified that the "four-hour rule" which refers to necessity to move patients from the emergency department to an admitted bed within four hours, commonly caused friction between the emergency department and admitting teams, as well as with hospital administrators that are tasked with bed management.

A lack of sustained and dedicated federal or state level government support and funding for culture change initiatives was also identified, impeding allocation of resources within organisations. Our participants identified that culture change initiatives tend to default to the executive level, but must be balanced with competing demands in the many facets of healthcare administration and clinical governance.

Culture change requires sustained investment of time and effort which is difficult to secure in healthcare settings

Change initiatives were described as requiring sustained investment from the organisation in terms of actionable initiatives for training and policy reform. However, the nature of organisational culture creates barriers to such initiatives. Participants described their respective organisations as slow to change. Organisations were described as not "defaulting" to encouraging good behaviour, often with an embattled mindset of maintenance of effort requiring the entirety of the organisation's resources.

The difficulty of sustaining cultural change is compounded by the turnover both of clinical staff, and lack of longevity in supporting structures and leadership.

4.6 Enabling workplace structures for better culture

Accountability and clarity of organisational roles and responsibilities supports workplace cohesion

Participants explained that in healthcare settings, the dynamics of patient care requires collaboration of diverse professionals, with differing chains of command and clinical decision making. This makes accountability and clarity in organisational roles indispensable for workplace cohesion. Clear organisational structures that delineate roles and responsibilities were described as important both to instil individual ownership of care but also ensure that every staff member knows exactly where they fit in the broader healthcare ecosystem.

A clearer understanding of each team member's specific duties and the expectations attached to their roles was described as helpful in reducing "turf wars", conflicts, and uncertainties. When issues arise, it also facilitates administrative evaluation and investigation. Furthermore, documented escalation pathways play a pivotal role by outlining how concerns or issues should be raised, and to whom, reinforcing the concept of accountability at all levels.

Colocation of staff can promote a sense of collaboration over hierarchy in clinical teams

The physical colocation of staff was described as a means of fostering collaboration across hierarchy. The examples of emergency department teams was explored as a clinical environment where staff of different levels and disciplines work alongside each other, and face stressors like patient aggression together. This was remarked on as one of the more stressful environments in hospitals, but where some of the greatest examples of teamwork had been seen. In ward and clinic environments, a lack of clear team space both at a medical team and multidisciplinary level was described, with some teams substituting functions like a weekly team coffee or pizza night in lieu of a dedicated space.

Aspects of this, described by one participant in terms of vertical team composition, was seen as enabling improved communication, as well as helping delineate roles within a team in a way that fostered a sense of peer collaboration.

Another participant gave the example of positive outcomes seen during geographic colocation of entire ward teams during the covid-19 pandemic, implemented as a means of reducing risk of staff-to-staff infection transmission, but similarly showed benefits of a sense of shared responsibility and camaraderie.

Mentorship programs have the potential to integrate social cohesion across hierarchical levels

Several participants pointed to the benefits of mentorship programs as a structure to improve communication and understanding across hierarchy. This largely was described as facilitating shared understanding and empathy for the challenges junior staff were facing

Mentorship programs, found in certain organisations and specialty college training programs, were viewed as a valuable tool to foster shared experiences and understanding between junior and senior members within medical institutions.

Initiatives to normalise "speaking up" during day-to-day practice improve feedback culture

Multiple participants described initiatives such as safety culture programs to embed and normalise provision of direct feedback into clinical and organisational processes.

It was acknowledged that when implementing these programs, it can be difficult to gain traction, and promotion can appear disingenuous to staff experiencing these issues. One participant described the success of an initiative that focussed initially on reinforcing hand hygiene in patient care, and normalising staff reminding each other when they had forgotten to practice it. This same concept was then extended to psychological safety, encouraging staff to speak up when witnessing harassment or other inappropriate behaviours.

In a similar vein, training programs to promote speaking up when positioned as a "bystander" during an incident were seen as beneficial in supporting the staff directly involved in incidents who may feel overwhelmed or unable to speak up themselves.

The provision of means of anonymous or aggregated feedback improves reporting rates

Participants described considerable benefit to providing avenues for anonymous feedback, particularly in hospital environments. This was seen as facilitating honest, unbiased reporting of issues while protecting whistleblowers who might otherwise not report out of concerns for their job security or reputation within an organisation.

Examples included online webforms, as well as routine practice reviews – for senior staff and medical administrators, several participants referred to the benefit of 360-degree reviews for providing aggregated feedback for an individual from multiple levels to gain more representative feedback.

The Vanderbilt model was seen as offering many promising features but presented some barriers to implementation

Many participants pointed to the Vanderbilt model as a useful tool for addressing cultural issues in hospitals. The model draws together administrative and clinical teams to address problems, and facilitates deidentified reporting of issues. It was also praised for allowing scalable responses and escalation, encouraging conversations with direct managers in the first instance.

Other participants described the model is expensive and resource intensive to implement, and requiring significant buy-in from senior leaders in hospitals due to the reputation of it commonly identifying performance issues at higher levels of organisations.

The creation of culture change policies by professional colleges can facilitate change for individual healthcare organisations

Participants emphasised the benefits of culture initiatives by the medical colleges in supporting organisational initiatives and structures.

The Royal Australian College of Surgeon's Operating with Respect course and integration into surgical training was described as a positive example of a culture change initiative in response to recognised issues of discrimination, bullying and sexual harassment. Several hospital-based participants attributed improvement in culture within local surgical units to this change, and one identified it as a useful resource in developing their own local training and policy documents.

Another example was the implementation of part-time work policies from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists which had flow on effects to rostering and staffing policies within hospitals which historically were less likely to facilitate these conditions. Further examples identified were the incorporation of reflective practices into the curricula for the Australasian College for Emergency Medicine and College of Intensive Care Medicine of Australia and New Zealand.

Integration of desirable non-clinical skills into hiring processes has the potential to improve cultural practices

Participants identified the potential capacity for hiring processes to select for attributes such as coachability, interpersonal and leadership skills, a willingness to listen and an ability to lead by example. While acknowledging the limitations imposed by often small pools of potential candidates, this stage of selection was seen as a largely missed opportunity to select for attributes felt likely to promote good organisational practices, and not just for clinical experience.

Some participants also identified that value in blinding of attributes like names and demographic data in early stages of selection for roles as a means to mitigate conscious and unconscious bias in the process on grounds of attributes like age and gender. It was not described how these forms of demographic bias can be addressed once participants reach the interview stage of an application.

Training in leadership skills, provision and receiving of feedback, teamwork and reflective practice were seen as means to improve workplace culture

Training in social and communication skills were seen as integral to improving the cultural practices of healthcare workers.

- Giving and receiving feedback: both giving and receiving feedback were described as vital skills that were often not formally taught to clinicians, but seen as high yield in reducing misunderstanding and experiences of bullying behaviour (described in Section 4.2).
- Leadership and management training: in clinical leadership roles were recognised as being awarded on the basis of clinical skillset rather than staff management skillset, this was seen as a high priority for supplementary training. It was recognised that healthcare workers of all levels adopt some leadership roles, and that the relevant skills were not native to everyone. It was also emphasised that "leadership" and "management" were often conflated, but that they can be considered distinct skillsets.

- Training teamwork: identifying the fundamental team basis of much of healthcare delivery and patient care, participants described the value in training staff in teamwork skills. One participant described this in terms of developing "champion teams" over an apparent default mindset of "teams of champions". Another described drawing on the work of Amy Edmondson around the concept of "teaming" which emphasises the importance of actively building and developing teams within organisations through affective and cognitive skillsets.

- Developing reflective practice: teaching reflective practice was described as a means of helping individuals develop insight into performance and cultural issues. It was also described as beneficial in training skills that assist individuals in overcoming some of the unhelpful aspects of personality styles and traits common in medical staff (outlined in Section 4.3).

Effective training in these skills should be both engaging and reinforced throughout a person's career in healthcare

Our participants related that effective training in communication and management skills for healthcare workers needs to be both engaging and embedded longitudinally throughout a healthcare career. Online modules and mandatory training initiatives were described as of limited value, contrasted with voluntary skill development initiatives and face to face or group training that encourages reflection and personalisation. The participants felt that when individuals chose to be part of training, they were more receptive, participatory, and inclined to apply the learned skills in their roles.

Many participants felt that introducing these skills early was crucial. They advocated for embedding such training throughout medical school, arguing that introducing these foundational skills during formative years not only sets the tone for professional behaviour but also provides students with tools to navigate their medical journey effectively. Within organisations, this training was generally only seen at onboarding or during protected teaching time like that delivered to medical interns. Participants acknowledged that competing demands in care delivery and resourcing meant these skills did not tend to be reinforced over the course of a clinician's time in their organisations as they would like.

Cultural safety training modules were seen to be of limited benefit, but face to face training and engagement with First Nations cultural safety educators were beneficial in fostering a shared understanding

Respondents described their experiences with cultural safety training modules, noting that online modules had limited benefit in promoting cultural safety within healthcare organisations. However, respondents highlighted positive experiences with examples of face-to-face training and direct engagement with First Nations cultural safety educators. This personal interaction allowed for a deeper exploration of cultural safety principles and the opportunity to learn from the lived experiences of First Nations individuals. Respondents found that this approach helped to foster a shared understanding among healthcare professionals, leading to improved cultural safety practices and better outcomes for First Nations patients and colleagues.

4.7 Monitoring and evaluation

Monitoring cultural issues in organisations was felt to be very difficult, and difficulty benchmarking for comparison over time can make it challenging to judge the effectiveness of a given intervention

Monitoring cultural issues within organisations was described as a challenging task. The intangible nature of organisational culture, combined with the myriad of factors influencing it, makes it a complex dimension to quantify and assess.

Moreover, when attempting to benchmark cultural health over time, the lack of consistent and objective metrics further complicates the process. Without a clear and consistent frame of reference, it becomes particularly challenging to determine the true impact and effectiveness of any implemented intervention. This ambiguity can lead to uncertainty in decision-making, and might even deter organisations from pursuing potentially beneficial cultural reforms. Thus, the difficulty in tracking and benchmarking cultural shifts underscores the importance of developing robust and reliable metrics for evaluating organisational culture.

Surveys are a commonly used tools to monitor organisational culture, but are limited by uptake rates, interpretation of questions and the types of incidents they capture

Surveys are commonly used tools to monitor organisational culture, but they have limitations in their effectiveness. One notable limitation is the often-low completion rate observed with surveys, which can impact the representativeness of the data collected. For example, the People Matters Survey, often used for benchmarking, may have limited effectiveness due to its complexity and lengthy nature.

Respondents also commented that the composition and questions contained in national surveys have been changing over time, making it difficult to use them as tools for trends.

Additionally, surveys may not accurately reflect the overall "temperature" of an organisation, as questions around instances of bullying or racism are biased to distinct events in respondents' memories and may miss instances of mistreatment that are accepted as normal or below a person's threshold to disclose. This reiterates the earlier description of normalisation of deviance.

Another common concern was with the interpretation of survey questions, as individuals may have different understandings of terms such as "bullying," leading to variations in responses.

Organisational data like sick leave can act as proxy markers to quantify and benchmark organisational cultural issues

Participants described needing to draw on multiple sources of information in order to gauge their organisations' culture. Complementary to direct feedback mechanisms such as surveys, and numbers of notifications, other organisational metrics were described as valuable proxy markers for assessing cultural issues within an organisation. Elevated rates of sick leave, for instance, might indicate underlying stressors in the workplace, which could be symptomatic of an unhealthy organisational culture, such as pervasive bullying, discrimination, or an excessive workload. By monitoring and analysing these indirect metrics alongside direct feedback tools, respondents described being able to get a more complete understanding of their cultural health, enabling them to identify, address, and benchmark organisational challenges more effectively.

5   Leadership Insights from the Royal Australasian College of Medical Administrators

Our participants' insights demonstrate that leadership training programs, including the College, can utilise all seven levers to influence culture change

Findings from this study salient to such programs were evident across seven thematic categories:

1. Leadership:

- Incorporate both leadership and management skills for formal leaders into the curricula, bust also foster development of these skills for informal leaders in healthcare settings
- The lived experience of our participants indicates that skilful execution of healthcare leadership draws on both robust policy and emotional intelligence

2. Workplace behaviours:

- Leadership training curricula should include training in communication across hierarchy, as well as how to give and receive feedback

3. The healthcare workforce

- All colleges and peak representative bodies should advocate for working conditions for healthcare works required for physically and psychologically safe workplaces
- Early career leaders will benefit from learning strategies to address prevalent maladaptive responses to stress, and promote help-seeking behaviours

4. Recognition and consequences

- When issues arise in the behaviour of a doctor in training or fellow of any College, the College should pursue collaborative responses with the healthcare organisations involved
- Curricula should cultivate awareness of the barriers to employees reporting issues
- Curricula should teach that lived experience from administrators indicates that responses to issues need to be visible, timely and fair

5. Barriers to change

- The colleges should pursue engagement with government, regulators and healthcare organisations to tackle systemic issues in healthcare
- Capacity and resourcing for culture change activities should be embedded into medical administration job positions and training

6. Enabling workplace structures for better culture

- The colleges should leverage the identified value of mentoring in supporting their doctors in training
- The colleges should explore innovation in models of care that promote cohesion in teams
- Culture change initiatives at the college level had the capacity for flow-on benefits to organisations employing their doctors in training

7. Monitoring and evaluation

- The techniques used by experienced healthcare leaders in monitoring organisational issues through both direct feedback tools (e.g., surveys) and indirect measures (e.g., employee sick days) can be taught to those earlier in their career

RACMA's curriculum is well-aligned to our recommendations, and well positioned to influence culture change through the practices of their fellows and associates

RACMA's curriculum is thematically aligned to incorporate many of the actions that our findings suggest can contribute to positive culture change.

The syllabus is divided into several sections, each addressing a distinct area of medical leadership, medical and health system expertise, learning and teaching, ethics and professionalism, communication, and cultural safety.

- Medical leadership: the learning objectives cover understanding leadership theories and frameworks, identifying personal leadership strengths and areas for development, leading others effectively, influencing the healthcare system, and leading for the future, with a focus on strategic planning and innovation.

- Learning, teaching and informed decision-making: this section emphasises the importance of lifelong learning, the use of evidence for decision-making, facilitating learning for others, and supporting research and innovation within the health system.

- Ethics and professionalism: this part of the curriculum emphasises understanding ethical frameworks, displaying and fostering professional conduct, promoting a culture of respect and inclusivity, and showing commitment to healthcare workforce health, safety and sustainable practice.

- Collaboration and teamwork: this section discusses fostering effective inter-professional teams, conflict management, and building effective stakeholder relationships.

- Medical management: this component covers understanding the principles of management, applying principles of risk management, understanding the role of digital health, managing financial resources, ensuring effective governance and managing health system change.

- Health advocacy and cultural safety: this section covers responding to the diverse health needs of Aboriginal, Torres Strait Islander, Māori, and other diverse populations, addressing the health needs of vulnerable populations, and influencing policy and practice to optimise health outcomes.

- Communication: this section focuses on understanding effective communication, communicating with positive influence and impact, and managing communication in challenging circumstances.

- Medical and health system expertise: this section focuses on recognising the factors that influence healthcare, leading patient-centred care, managing disasters and critical incidents, developing clinical governance systems, improving healthcare quality and safety, managing medicolegal matters, and managing the requirements for new technologies or practices.

The colleges are well positioned for positive influence through direct advocacy and collaboration across the healthcare sector

In order to influence culture change across all seven levers, the colleges should leverage not only their curricula but also their position for direct advocacy.

Our participants were clear in their understanding that the cultural issues in healthcare are wickedly complex and enmeshed in the influences and practices of multiple inter-related bodies. Addressing issues at an individual organisational level was described as insufficient, with a coordinated approach required across the sector and lifespan of a healthcare worker's career.

RACMA should seek avenues for collaboration with other professional colleges, with the Government and with organisations where their fellows and associates are employed.

6   Recommendations for A Better Culture

An enduring commitment is required at all levels of healthcare to drive cultural transformation. This involves establishing a framework for behavioural standards that sets clear expectations for professional conduct. To effectively address cultural challenges, the approach must be systemic, integrating initiatives across all aspects of healthcare, including training, policies, and work environments.

To foster cultural change, different layers of leadership must actively engage. This includes individuals taking responsibility for their own self-management, which involves self-awareness, coachability, and responsiveness to feedback. At the local unit level, leaders must create an environment that promotes respectful and inclusive practices. Administrative and organisational leaders are responsible for implementing policies, training programs, and systems that support a positive culture. Finally, at the health system level, efforts need to be made to support health workforce health and safety, and sustained provision of adequate resources for organisations to deliver change programs.

Meaningful and lasting change requires a sustained approach that prioritises culture change as an ongoing process. Building a positive culture will take time and effort, requiring continuous evaluation, adaptation, and improvement. It is crucial to avoid quick-fix solutions and instead prioritize long-term strategies that embed cultural change within the fabric of healthcare organisations.

1. Ensure training measures reach all entrants into the system, and reinforce it throughout career progression

To effectively drive culture change in healthcare, it is crucial that training efforts encompass all individuals entering the system. This should not only include medical students but also international medical graduates. To ensure the sustainability and longevity of this change, it is essential to reinforce and enhance the training received during professional college curricula. Furthermore, organisations should integrate culture change components into their induction processes, enabling new employees to immediately grasp the importance and expectations surrounding the desired cultural shift. By incorporating culture change principles into training programs and consistently reinforcing them, healthcare organisations can establish a lasting and transformative culture.

2. Prioritise buy-in from the professional colleges

The professional colleges play a crucial role in driving culture change for medical officers in healthcare. Doctors in training have a longer-standing relationship with their college compared to their specific employing organisation. This is significant because contracts with organisations are typically short and not the primary determining factor for securing further roles or advancing in training. As a result, doctors are more attuned to the rules, regulations, and culture fostered by their college than other bodies. Additionally, the accreditation processes conducted by colleges for healthcare organisations grant them a robust regulatory position in ensuring standards of practice across hospitals. Therefore, college buy-in and consensus are essential facilitators, noting that any opposition from colleges can hinder independent culture change efforts at an organisational level. Colleges are well place to serve as advocates for change rather than become bystanders in a complex system.

3. Align culture change initiatives to a uniting purpose

To effectively gain traction with healthcare workers, it is crucial to establish a united purpose for a culture change initiative. This involves tying the objectives of the initiative to vital outcomes such as patient safety and clinical excellence. For example, by emphasising how a positive culture promotes better patient outcomes and reduces medical errors, healthcare workers can understand the direct impact their actions have on patient safety. Healthcare organisations can garner support and engagement from their employees by clearly demonstrating how a positive culture directly contributes to enhancing patient safety and improving clinical outcomes.
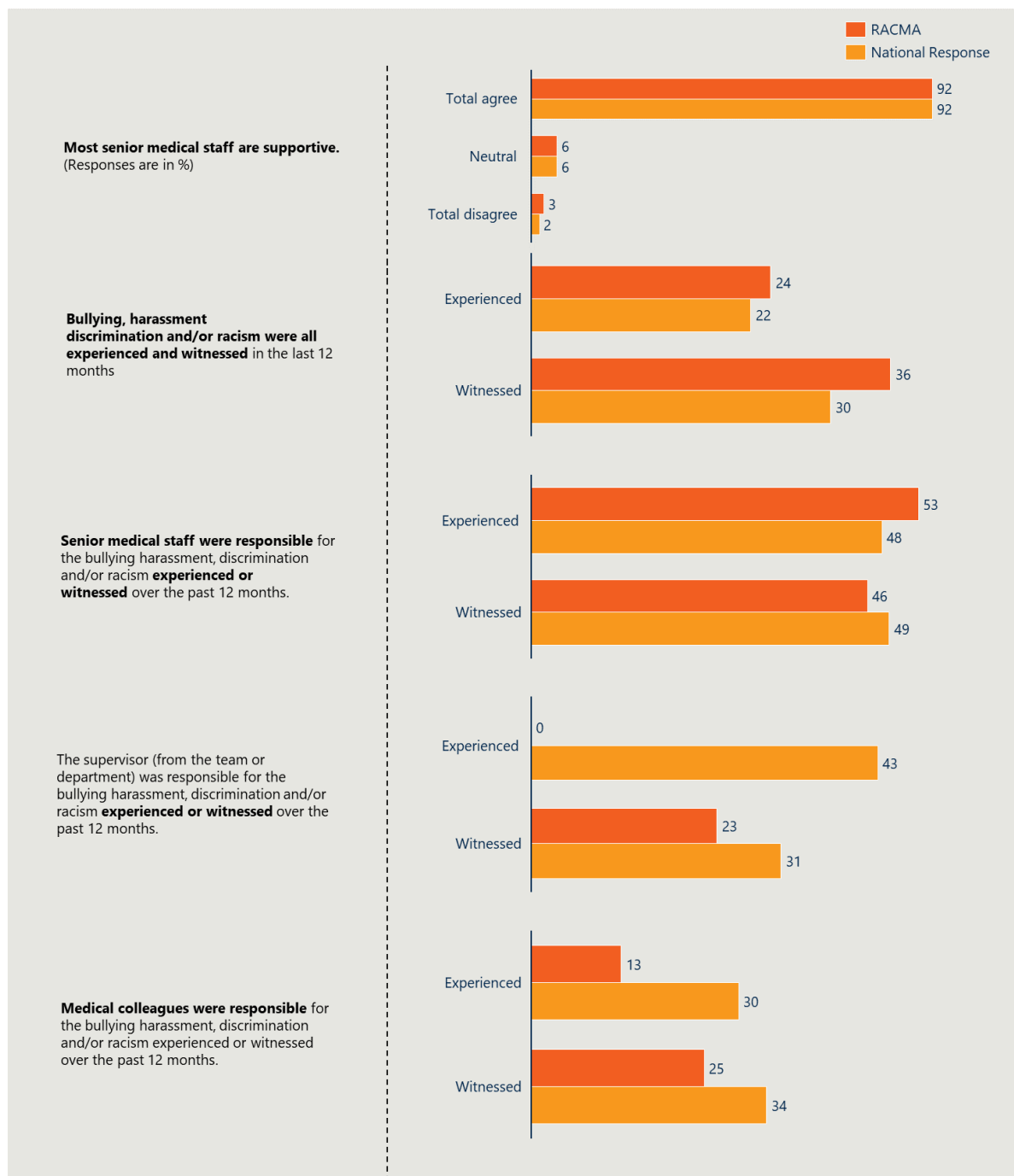
4. Shift towards a proactive approach

Approaches centred around "weeding out the bad apples" don't address underlying issues in healthcare culture. The current detection and response system is primarily biased towards tackling overt, highly visible issues, neglecting the subtler, underlying concerns. Instead of relying solely on punitive measures, adopting an early "course-correction" approach proves more valuable. Taking a proactive stance towards culture change involves prioritising training and skills cultivation, cultivating a workforce motivated to embrace positive change. While mandatory training modules may help set expectations and establish benchmarks, they often lack the capacity to genuinely transform motivations and catalyse culture change. Therefore, a shift towards a proactive approach, rather than a reactive response to critical incidents, is essential for long-lasting and impactful cultural transformation. A range of initiatives set the foundation for systemic cultural reform such as: mentorship programs, normalising 'speaking up', mechanisms for anonymous feedback, hiring for leadership as well as clinical expertise., and life-long training in essential leadership skills.
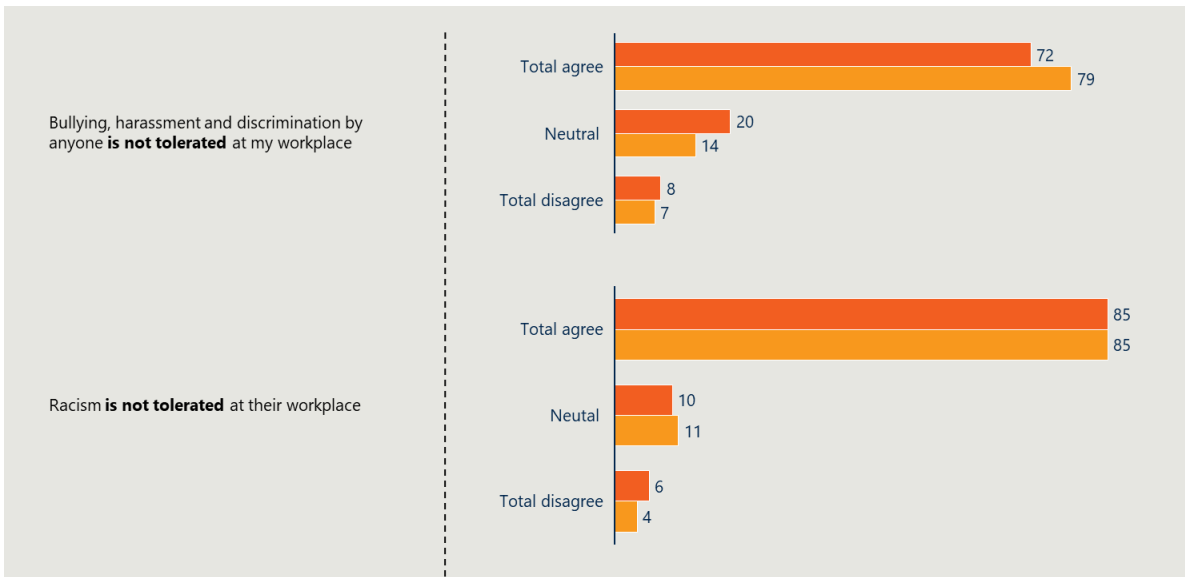
5. Effective culture change is best supported by a broader effort to improve the safety and sustainability of the healthcare workforce

To ensure the success of culture change initiatives in healthcare, they must be accompanied by broader measures that promote staff physical and psychological health and longevity. An essential aspect of this support is rooted in principles of fairness and equal opportunity. Merely focusing on culture change without addressing the underlying factors eroding safety in the healthcare workforce will render these initiatives ineffective. For instance, addressing fairness in rostering and remuneration is crucial, as inequities can contribute to a negative culture and dissatisfaction among staff. Effective approaches to fatigue management are also vital to safeguard the health and performance of healthcare workers, while a thoughtful national approach is needed to manage the diverse workforce comprising local and international medical graduates. By taking a holistic view and implementing these broader measures, healthcare organisations can establish a culture that not only inspires positive change but also nurtures their valued staff members.

Appendix A   Detailed Summary of Medical Workforce Survey

The 2022 Medical Workforce Survey indicates continuing prevalence of organisational issues. Below we present a subset of the findings relevant to our project, highlighting the results of RACMA respondents against the national total in order to contextualise the experiences of our study respondents in the national aggregate. Where RACMA respondent numbers were low, only the total responses are presented.

There is a positive culture at my workplace

- Total agree: 70 / 77
- Neutral: 20 / 15
- Total disagree: 10 / 8

I am confident that I would raise concerns/issues about bullying, harassment and discrimination

- Total agree: 90 / 76
- Neutral: 10 / 15
- Total disagree: 0 / 9

Bullying, harassment and discrimination by anyone is not tolerated at my workplace

- Total agree: 72 / 79
- Neutral: 20 / 14
- Total disagree: 8 / 7

Racism is not tolerated at their workplace

- Total agree: 85 / 85
- Neutal: 10 / 11
- Total disagree: 6 / 4

Experienced

Reason	Value
Concern about repercussions	55
Nothing will be done if I do report it	51
I feel it is not the accepted practice to report it	29
Lack of support	28
Lack of processes in place	15
Prefer not to say	15
Wasn't provided information on how or who to report to	12
Other	9

Witnessed

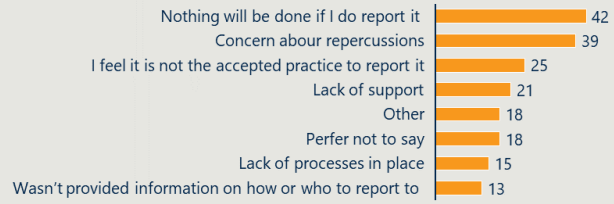| Reason	Value
Nothing will be done if I do report it	42
Concern abour repercussions	39
I feel it is not the accepted practice to report it	25
Lack of support	21
Other	18
Perfer not to say	18
Lack of processes in place	15
Wasn't provided information on how or who to report to	13

Concerns about repercussions and that nothing will be done if reported, **prevented reporting** bullying, harassment, discrimination and/or racism that **experienced** (national responses only)

Experienced
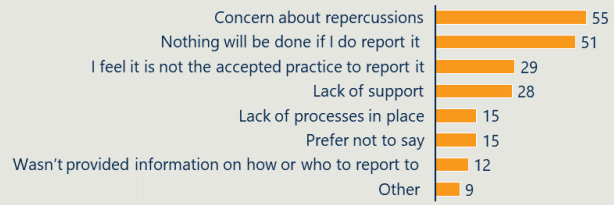
Effect	Value
No effect	21
Minor effect	34
Moderate effect	24
Major effect	13
Unsure	8

Witnessed

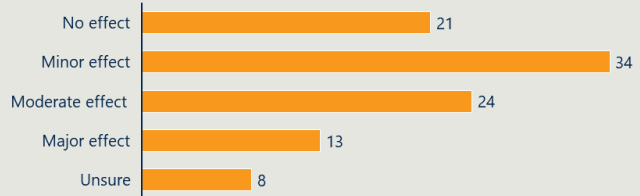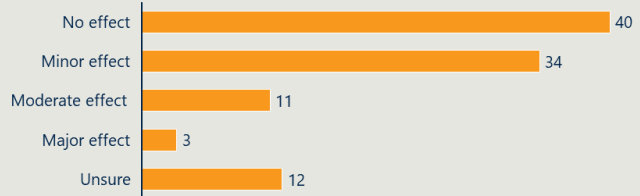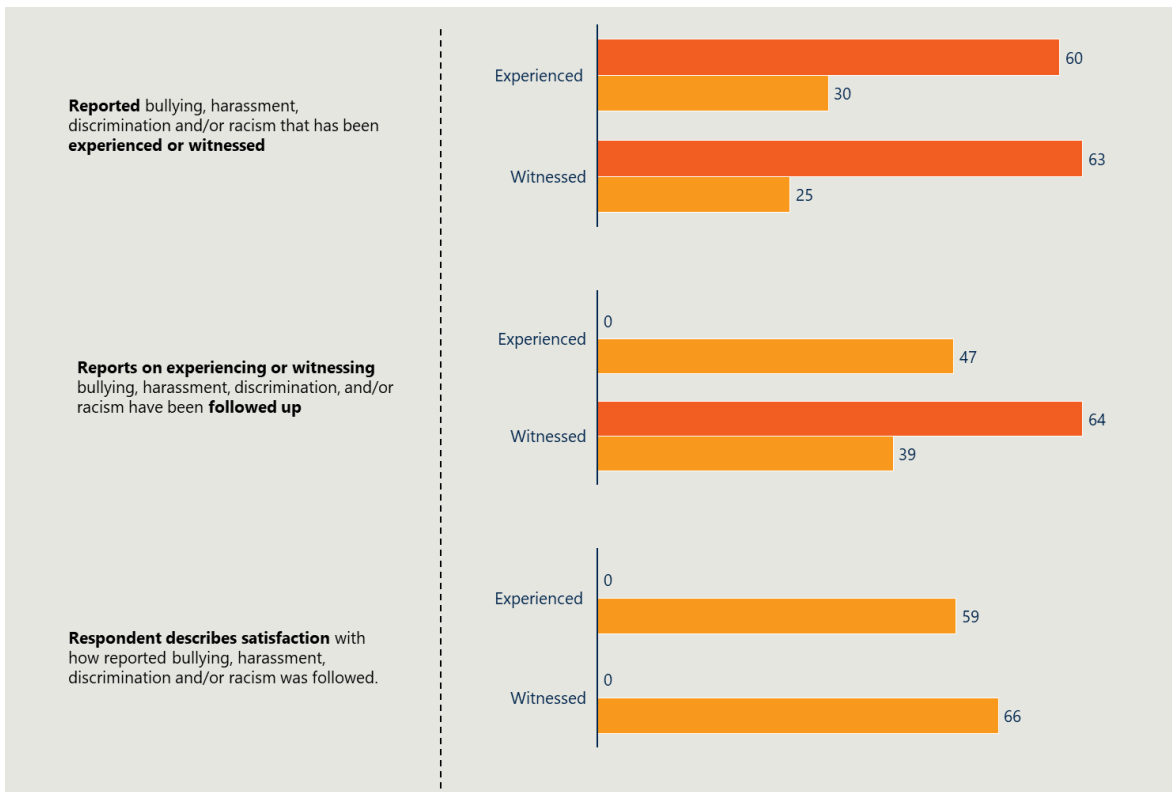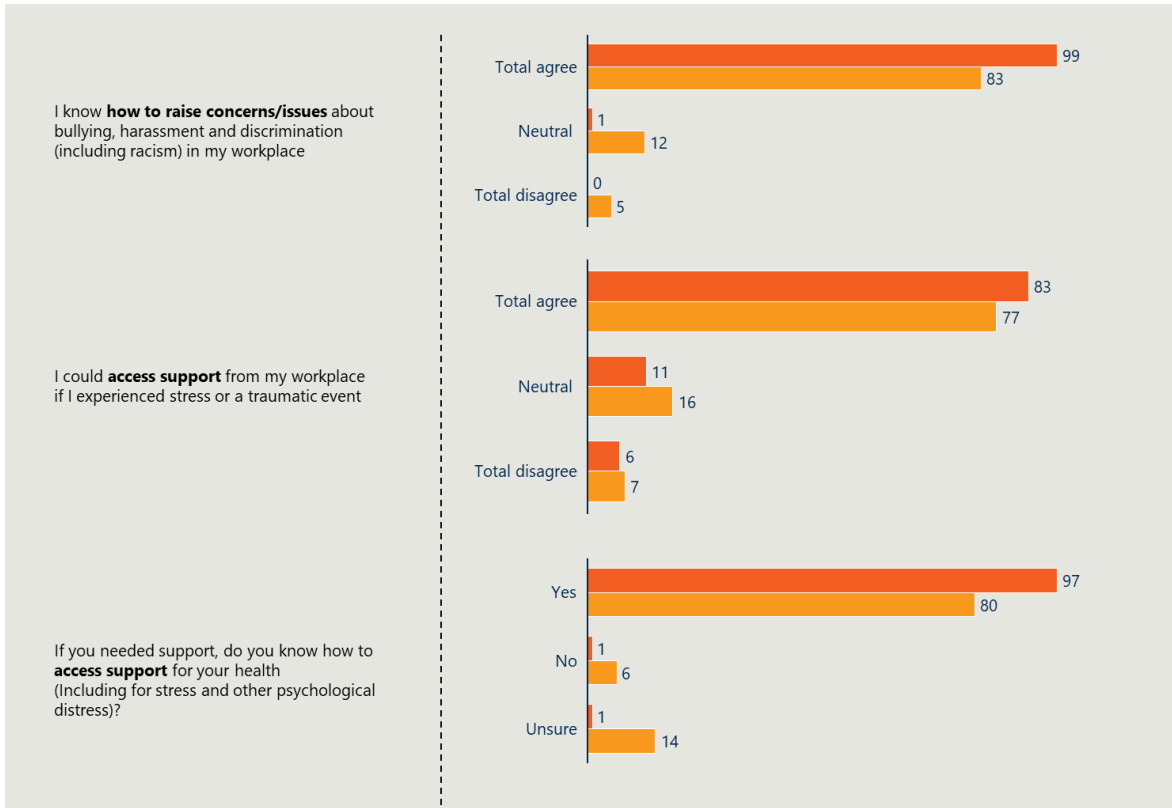| Effect	Value
No effect	40
Minor effect	34
Moderate effect	11
Major effect	3
Unsure	12

Experiencing or witnessing bullying, harassment, discrimination and/or racism **has adversely affected medical training**

I know how to raise concerns/issues about bullying, harassment and discrimination (including racism) in my workplace

- Total agree: 99 / 83
- Neutral: 1 / 12
- Total disagree: 0 / 5

I could access support from my workplace if I experienced stress or a traumatic event

- Total agree: 83 / 77
- Neutral: 11 / 16
- Total disagree: 6 / 7

If you needed support, do you know how to access support for your health (Including for stress and other psychological distress)?

- Yes: 97 / 80
- No: 1 / 6
- Unsure: 1 / 14

Reported bullying, harassment, discrimination and/or racism that has been experienced or witnessed

- Experienced: 60 / 30
- Witnessed: 63 / 25

Reports on experiencing or witnessing bullying, harassment, discrimination, and/or racism have been followed up

- Experienced: 0 / 47
- Witnessed: 64 / 39

Respondent describes satisfaction with how reported bullying, harassment, discrimination and/or racism was followed.
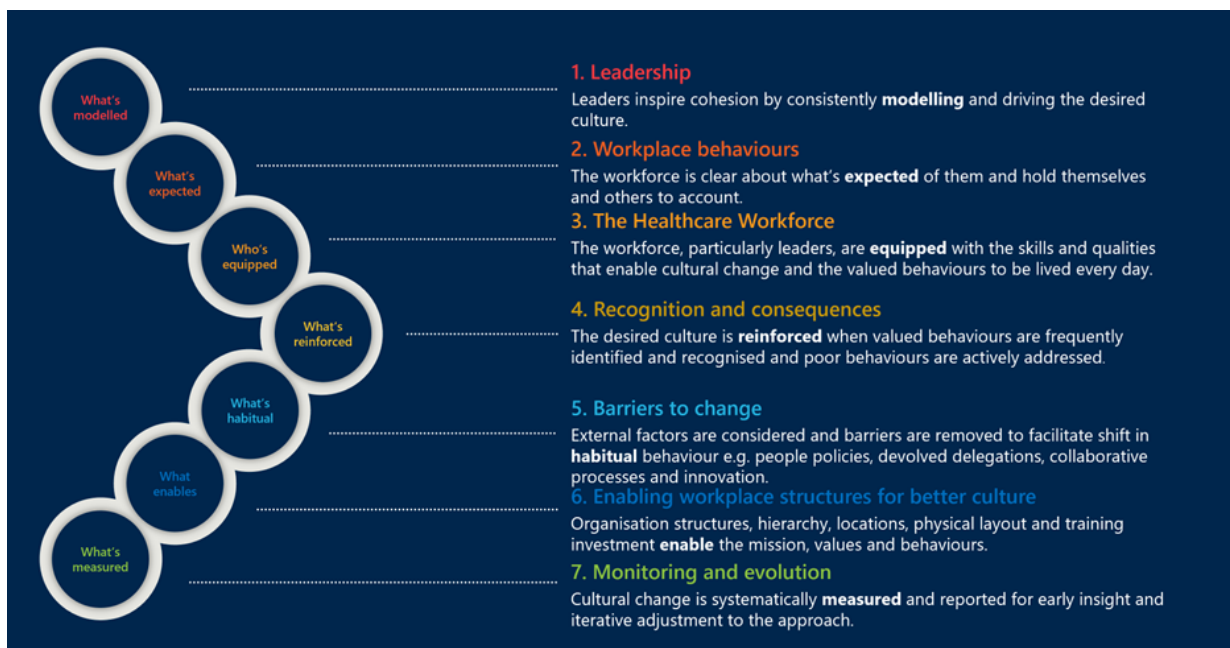
- Experienced: 0 / 59
- Witnessed: 0 / 66

Appendix B   The seven levers identified for culture change in healthcare

1. **Leadership:** Leaders must have an absolute commitment to focus on culture change and model this commitment to ensure success. Where leaders drive and model the requisite culture, this emphasises to staff the importance of the commitment. Initiatives for this lever clarify the leaders' role in the implementation of change and develop clear accountability mechanisms for effective implementation.

2. **Workplace behaviours:** The workforce must be clear about the culture – the values and behaviours expected of them – and hold themselves and others to account. Whilst the purpose and espoused values of an organisation rarely change, behaviours are refined over time as the culture evolves. This lever often includes initiatives that engage the workforce to translate the values into complete and clear expectations of not only what, but how, work is executed. This may be through, for example, sessions with staff to explore what the values and behaviours really mean when lived every day and agree to the mechanisms or tools they will use to hold themselves to account.

3. **The healthcare workforce:** The workforce, including leaders, must be equipped with the skills and qualities that enable cultural change and the valued behaviours to be lived every day. Initiatives for this lever can include targeted development of existing staff as well as for new recruits into the workforce.

4. **Recognition and consequences:** The desired culture is reinforced when positive behaviours are frequently recognised and rewarded, and poor behaviours are consistently addressed. This lever includes initiatives across formal and informal reward frameworks to ensure that behaviours aligned with the desired culture are promoted and violating behaviours are quickly and clearly discouraged. For example, ensuring that behaviours are an assessed criteria for hiring or promotion will demonstrate that positive behaviour is viewed as mandatory, not a 'nice to have'.

5. **Barriers to change:** Barriers are removed and practices and procedures are realigned to shift habitual behaviour. The determination of specific initiatives for this lever requires the organisation to review processes and systems to ensure they promote behaviour aligned with the desired culture. For example, if the culture shift includes the devolution of delegations, the organisation must assess all processes to ensure the requisite sign-offs match the new delegation framework.

6. **Enabling workplace structures for better culture:** Organisation structures, hierarchy, locations, physical layout and ICT investment enable the mission, values and behaviours. If these structures are misaligned, they will act as barriers to the desired behavioural shift. For example, if the desired culture is one of cross-team collaboration and teams are physically separated on different floors or in different buildings, then the physical layout will work against integration.

7. **Monitoring and evolution:** Cultural change is identified, measured and reported for early insight into the success of the culture change strategy. This allows for short-term, iterative adjustment to the strategy as well as longer-term review of whether the culture is being embedded. This lever serves to maintain both focus and accountability for the change process and ensure implementation initiatives across the other six levers remain contextually relevant and on track.

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