Many respondents, however, indicated that information regarding legislation and regulations was readily accessible giving the reason "because it was available on the internet". A few others commented that, whilst they had never accessed the information, they just "believed it could be found on the internet".

There was a general sense that if there was a reason or specific purpose to locate any of the legislation or regulations, a person would make it their business to find it and understand. This was generally within a time of stress, hence the importance of ease of accessibility.

Understanding

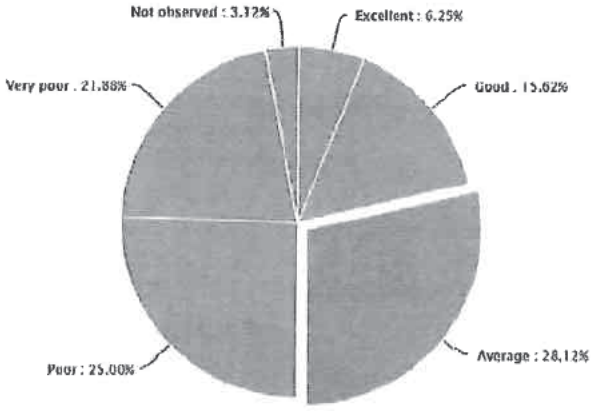


Figure 3: Legislative and regulatory requirements: Understanding

In terms of understanding within TCH & HS of those legislative and regulatory requirements governing workplace practices, nearly half (47 per cent) of the written respondents rated this as poor or very poor, about one-third (28 per cent) as average and 22 per cent of respondents considered understanding to be good or excellent.

Written comments supporting respondents' views that there was a general lack of understanding included: advice they had received after raising an issue contradicted information prescribed by legislation and regulations; when seeking early intervention, the advice they were provided was incorrect; and when doctors were defending their behaviour, it appeared they had no idea their behaviour breached various workplace laws.

In articulating the level of understanding, written respondents described it as patchy; virtually no understanding; an understanding of the "overall jist but no greater understanding", and a clear lack of understanding.

There were a few comments that although some of the legislation and regulations were described at orientation, it was not regularly reiterated beyond that. A few respondents indicated they felt there was a better understanding of the workplace health and safety

regulations which was "quite well covered" by the hospital in comparison to other policies.

Compliance

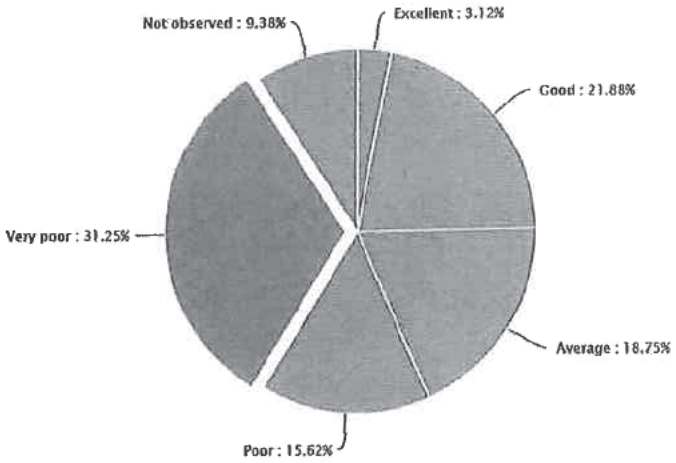


Figure 4: Legislative and Regulatory requirements: Compliance

In terms of compliance with legislative and regulatory workplace requirements, about half (47 per cent) of written respondents rated compliance as poor or very poor, about one-fifth (19 per cent) as average and one-quarter (25 per cent) as good or excellent. Generally, respondents made a connection between understanding and compliance in that if people did not understand the policies then it was highly unlikely they would comply with them.

A few respondents indicated that the level of compliance varies across the hospital.

A common observation made in the focus groups and in written submissions was that, whilst many people may understand the general nuances of the legislation, many struggle with its application. A number of people also stated that, whilst people understand they have rights as outlined in various legislation, they have little idea as to what to do in practical terms if they or their colleagues were to be on the receiving end of inappropriate behaviour.

On a few occasions, respondents suggested "seniors and executive don't seem to think these regulations and legislation apply to the health care system".

Locally based and developed policies, protocols and framework

Accessibility

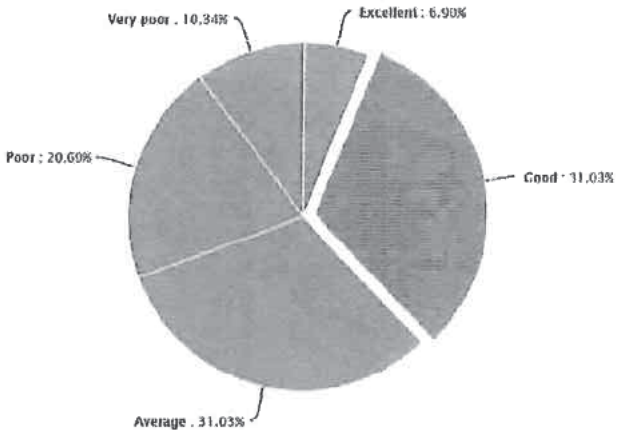


Figure 5: ACT Health and Canberra Hospital policies, protocols and frameworks: Accessibility

In terms of accessibility of information regarding ACT Health and Canberra Hospital policies, protocols and frameworks to guide and support workplace practices, conduct and behaviour about one-third (31 per cent) of written respondents rated this as poor or very poor, one-third (31 per cent) average and 38 per cent respondents indicated the accessibility was good or excellent.

An identified barrier to accessibility for Registrars was that there was no mechanism to access the intranet outside the workplace. Staff are required to use public computers in the open work spaces and, due to the nature of the reason as to why they were seeking information, they did not feel confident to do so for fear of ridicule, retribution, negative consequences, or targeting. This made accessing information confronting and a challenge.

Recurring themes were:

- Policies were not often accessed due to lack of time to do so as priority was given to caring for a patients and administrative tasks; and
- The large number of policies on the intranet and that "unless you knew the exact name of the policy it was extremely time consuming to locate the information you were after".

Understanding

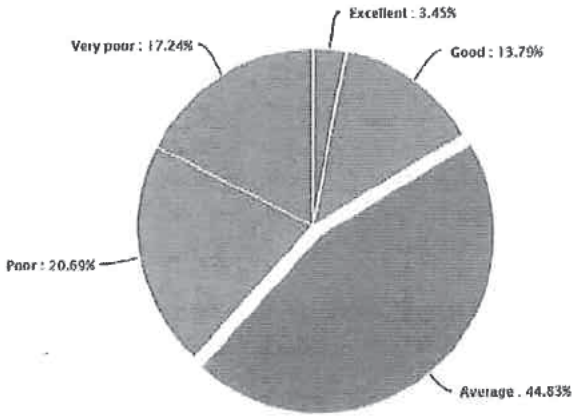


Figure 6: ACT Health and Canberra Hospital policies, protocols and frameworks: Understanding

In terms of understanding information regarding ACT Health and Canberra Hospital policies, protocols and frameworks, 38 per cent of written respondents rated this as poor or very poor, 45 per cent as average and 17 per cent as excellent or good.

Many of the comments indicated that there was limited training or professional development about these policies and protocols and that there was no or limited consultation with staff regarding development of them.

Compliance

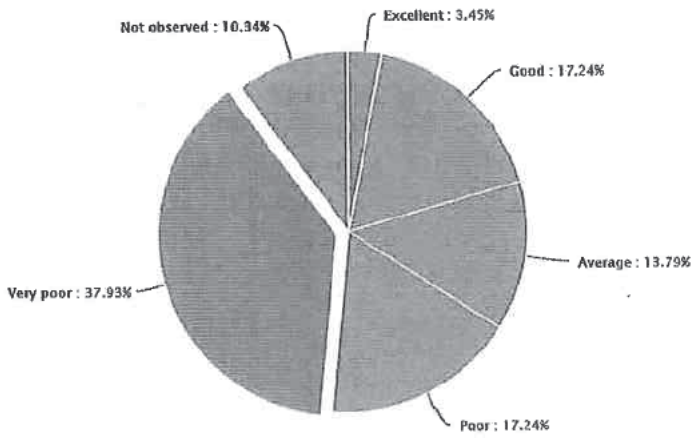


Figure 7: ACT Health and Canberra Hospital policies, protocols and frameworks: Compliance

In terms of compliance with ACT Health and Canberra Hospital policies, protocols and frameworks, over half (55 per cent) of written respondents rated this as poor or very poor, 14 per cent as average and 21 per cent indicated compliance was either good or excellent.

Comments provided supporting the poor and very poor rating assigned to compliance with internal policies included leadership not actioning the strategy to resolve bullying; the misconduct and discipline policy not being enforced; and minimal commitment to complying with EBA categories (particularly overtime, rostering and meal breaks).

A few respondents expressed views that suggested policies were developed more as "tick and flick" exercises to meet administrative expectations or as an insurance/protection mechanism to "cover themselves". There was a feeling of "here is the policy that promotes safe and healthy work environments" but then leaders giving no or limited attention to implementing, deploying or enforcing the policy.

4.1.2 ACT Health Policy: "Respect at Work – preventing and managing work bullying, discrimination and harassment"

The ACT Government Health has developed a policy "*Respect at Work – preventing and managing work bullying, discrimination and harassment*" which outlines principles and strategies for a positive and safe workplace environment. The policy provides detail on an escalating hierarchy of actions and strategies to resolve workplace bullying encompassing individual action, informal action, and formal complaint. The Review canvassed views regarding the effectiveness of each stage.

The question was:

- From your observation, how would you describe the effectiveness of each stage of the strategy to resolve workplace bullying?

SUMMARY

- TCH & HS's strategy to resolve bullying does not appear to be effective in any of its three stages: individual action, informal report, or formal complaint. The vast majority (over half) rated the internal strategy to resolve bullying as not very effective or not effective at all: individual action (62 per cent); informal report (58 per cent); and formal complaint (50 per cent).
- No contributor to the Review deemed any of the three stages to be extremely effective. About one-third (31 per cent) rated individual action very effective or somewhat effective, 38 percent rated the informal report as very effective or somewhat effective, and 46 per cent rated the formal complaint as very effective or somewhat effective.

4.1.2.1 Observations and Findings

A number of respondents indicated that the strategy to resolve bullying was not effective given the following justifications: people "did not bother with actioning any of the stages for reasons of fear of retribution, victimisation, being marginalised"; they didn't want to "rock the boat"; and for reasons of perceived likelihood of the consequence of being given a poor performance rating.

This above point was made several times. The Review Team was told trainees relied on performance ratings to progress through the highly competitive training program and furthermore, as trainees sign 12 month employment contracts, trainees were not prepared to take "the gamble" of raising a bullying complaint for fear of not having their employment contract renewed. Securing employment in Canberra was a particular concern due to the few number of hospitals in the ACT.

The Review Team noted that the privacy restrictions on providing information to staff concerning the extent of investigations undertaken and the outcome of processes may not be well understood by staff.

Individual action

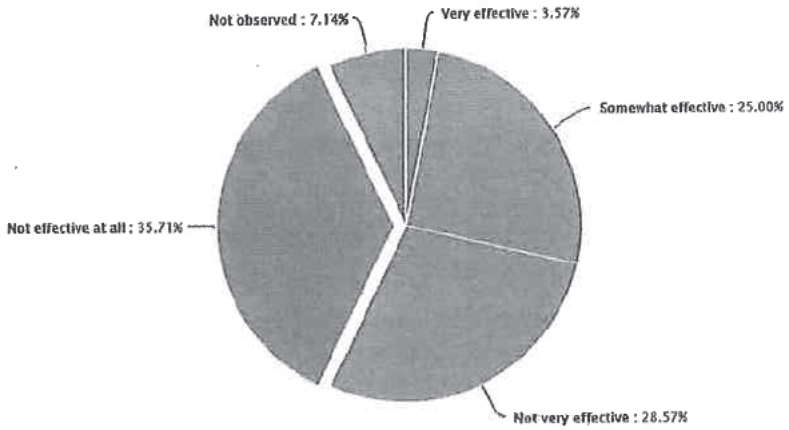


Figure 8: TCH & HS reesolving bullying strategy: Inividual action

64 per cent of written respondents indicated that the individual action strategy was either not effective at all of not very effective. Reasons respondents gave for these ratings included that it was difficult to address at an individual level as the alleged perpetrator was often in a senior position and had significant influence on reinstating employment contracts. The responses suggested evidence that the power differential was influencing outcomes.

Whilst nearly one-third of respondents (29 per cent) indicated the individual action strategy was either somewhat or very effective, there were no responses to indicate why respondents may have rated this way.

Informal Report

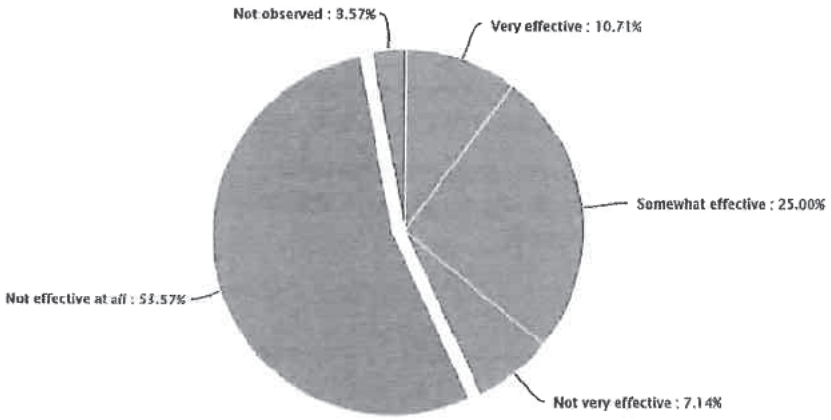


Figure 9: TCH & HS resolving bullying strategy: Informal report

61 per cent of written respondents indicated that the informal report strategy was either not effective at all or not very effective. Reasons respondents gave included:

- No onus on managers and/or little sense of responsibility by some managers to help resolve the issue. People commented they were requested to "stop complaining about it", counselled against further action and asked to consider the implication for their career.
- Managers involved in helping resolve the issue did not have the requisite skills, knowledge or mechanisms and lacked a good understanding of what bullying was. This was reflected in comments such as "but he didn't physical hurt you did he?' so "therefore it isn't really bullying".
- When support was sought, confidentiality was not maintained leading to further bullying and victimisation.
- Limited feedback to the person raising the issue and few or no apologies, with a sense that the inappropriate behaviour was condoned.
- Participants in focus groups commented that when the informal report stage was managed and implemented "the way it was supposed to" then it worked well.

Over one-third of respondents (36 per cent) indicated the informal report strategy was either somewhat or very effective. Some respondents indicated that when the strategy was implemented the way it was intended, it worked very well.

Formal Complaint

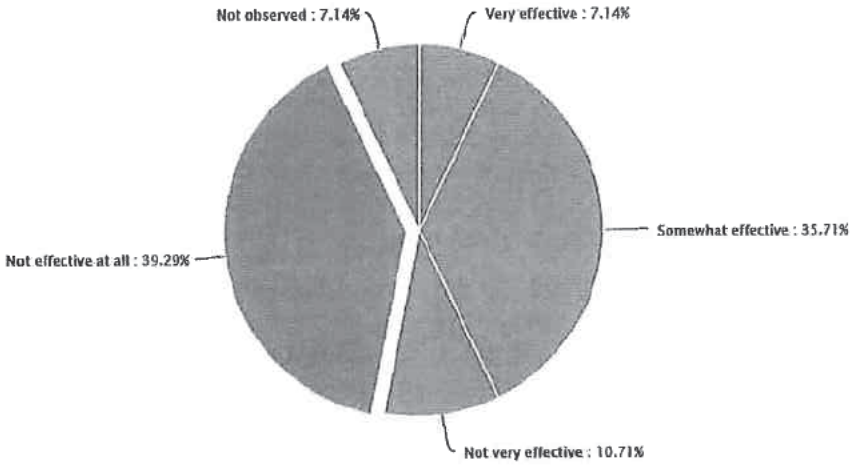


Figure 10: TCH & HS resolving bullying strategy: Formal Complaint

Half of the respondents indicated that the formal report strategy was either not effective at all or not very effective. There was indication that few have witnessed a formal complaint being made and, of those who said they had witnessed it, they said it very stressful, time consuming and with little reward.

Many expressed a sentiment that the process was highly "complicated, protracted, and adversarial" with very few instances of a successful outcome whereby the alleged perpetrator was "disciplined". Some said "why would you bother?" once again for reasons provided earlier (fear of retribution, victimisation, poor performance reviews, and employment impacts).

There were a few respondents who claimed the formal complaint process was not managed appropriately citing reasons of lack of confidentiality; being told to withdraw the complaint; the alleged perpetrator being involved in the decision making process; being threatened privately and publically; being misinformed; an evidence gathering process lasting months (with no resolution); and not being kept informed of progress.

Whilst 43 per cent of written respondents rated the formal complaints strategy as either somewhat or very effective, there were no responses to indicate why respondents may have rated this way.

4.1.3 Observed culture that enables bullying, discrimination and/or harassment behaviours

The questions asked in this section were:

- To what extent have you observed/witnessed or know of behaviours that indicate a culture that accepts or condones discrimination, bullying and/or harassment?
- What behaviour/s can be observed?

SUMMARY

- Nearly two-thirds (66 per cent) of respondents who provided written submissions indicated they had observed behaviours that were indicative of a culture that condoned or accepted bullying, discrimination and/or harassment. Nine per cent claimed they had not witnessed behaviours that indicated acceptance of bullying, discrimination and/or harassment behaviours and three per cent stated that they had rarely seen these behaviours displayed. Nearly one-fifth of respondents (19 per cent) had not provided a response.
- There was general recognition that, whilst there were some cultural issues around bullying, discrimination and/or harassment behaviours that required addressing, people wanted to make it clear that inappropriate behaviour was not widespread in every area of training specialty.

4.1.3.1 Observations and Findings

The recurring behaviour themes were a lack of (or untimely) action given to resolving inappropriate behaviour; no (or limited) consequences for wrongdoers; lack of effective communication (e.g. feedback methods); inappropriate personal interaction; and lack of compliance with legislation and policies.

There appears to be a "normalising" of inappropriate behaviour with subtle behaviours creeping into day to day practice. For example, sarcastic comments about performance or appearance being made and then when confronted saying "I was only joking". Also during ward rounds, it was felt it was becoming acceptable for Consultants to criticise decisions Registrars made regarding patient treatment in front of the Registrar, patient and other Consultants. A few respondents provided rationale for those Consultants and specialists who directed inappropriate behaviour such as yelling, screaming, swearing and throwing items at Registrars.

Some key behavioural themes that presented were:

Employment conditions and work practices

For example, rosters not complying with safe work standards; lack of support for overtime claims; being requested consistently to stay at work late despite not being on call; and always assigning less than desirable tasks to trainees in non-accredited speciality areas. Regarding employment and recruitment, several respondents identified discriminatory practice of females, when re-applying for positions, being asked about whether they were intending to become pregnant. Respondents said they were forced to lie for fear of losing their jobs.

Lack of, ineffective and untimely action

Many respondents indicated there was a lack of action in addressing inappropriate behaviour as evidenced by the little change in behaviour of the alleged wrongdoers. When issues were raised, the resolution process was badly managed giving rise to "positive reinforcement for aspiring bullies".

Some respondents commented that the process of "gathering evidence" was prolonged and dragged out to coincide with when the Registrar or junior doctor was due to leave (with many on temporary contracts) and so the issue was never resolved. There were also comments from Consultants who indicated they had made complaints which "didn't eventuate in anything".

Interpersonal skills

Some respondents indicated there were examples of overt inappropriate behaviour (public threats of physical violence) to more subtle examples (repetitive demoralizing remarks). This included Consultants using intimidating language; yelling and swearing at Registrars; sending text messages with crude language to deliver messages and intimidating emails; verbal threats to withdraw complaints; abusive phone calls (Consultant to Consultant and Consultant to Registrar); public humiliation and insulting remarks regarding competence; and spreading rumours. Incidents of sexual harassment and propositioning were mentioned in written submissions and focus groups.

Consultants not willing to assist

Numerous written submissions and focus groups mentioned Consultants not being willing to assist (particularly over the telephone at night). Consequently, these Consultants were not sought out to provide specialist advice, and junior doctors would make unilateral decisions without their input in order to avoid unpleasant conversations. Many Registrars contributing to the Review commented that despite not being fully trained specialists, they did not want to call Consultants or specialists due to the "abuse they knew they would get on the phone." Some Consultants and specialists made similar comments about others in their cohort.

Performance Feedback

Whilst there was general consensus that performance feedback was a critical component of an effective training program, concerns were raised that the way feedback was provided was inappropriate and constituted bullying / harassment. There was a sense that, in some work areas, feedback was sarcastic, publicly delivered, not backed up with evidence, and delivered using inappropriate language. However, some respondents expressed the view that there were situations when some Registrars received negative feedback they defaulted to naming the feedback "bullying" rather than considering it could be constructive feedback.

Noncompliance with legislation and policies

Many respondents indicated that compliance with legislation and policies by managers and supervisors was poor. A few expressed a view that managers and leaders thought they were beyond regulations and subsequently inappropriate behaviours manifested in the workplace.

Consequences and limited support

Respondents indicated that the highly competitive selection and progress pathways increased the risk of inappropriate behaviour. Registrars were fearful of the consequences (such as an employment contract not being reinstated, failing an assessment and training terminated) and so did not raise issues. Consequently, inappropriate behaviours were not called to account and therefore continued. Respondents stated that they had observed their colleagues raise complaints and then be told to 'shut up and put up' or were questioned as to whether they were 'cut out for this'. The process of voicing a complaint was often met with little or no support, and some respondents indicated there was a culture that made the person raising the concern feel they were the ones with the problem.

Leadership

Respondents commented that attracting specialists to Canberra was recognised as a challenge, and so every attempt was made to retain senior Consultants; consequently, any inappropriate behaviours they may display were not challenged as senior Consultants had threatened to quit. Observations were made that some leaders used their position to ask people to withdraw complaints, refused to escalate complaints, and told people to "stop whinging and to stop being troublemakers". Sentiments were also expressed that the fewer the number of supervisors, the greater likelihood of inappropriate conduct and behaviour.

4.2 Existing TCH & HS Culture Contributors

What is contributing to the existing TCH & HS Culture?

In order to answer this, the following questions were posed:

- In training specialist areas where the culture does not accept or condone bullying, discrimination and/or harassment, what characteristics do you see in the workplace that create this culture?
- In training specialist areas where the culture appears to accept or condone bullying, discrimination and/or harassment, what characteristics do you see in the workplace that create this culture?

SUMMARY

- Characteristics of those areas where bullying, discrimination and/or harassment is not accepted include: zero tolerance for inappropriate behaviour; competent and supportive leadership; clear processes; clearly defined values; and engaged and supportive staff.
- Characteristics of those areas that do accept bullying, discrimination and/or harassment include: lack of interpersonal skills and engagement; poor leadership; imbalance of power; little or no support for those wanting to raise issues; the nature of the work (i.e. stressful workplaces); ineffective work practices, systems and processes; and personal relationships between the manager dealing with the issue and the alleged wrongdoer.

4.2.1 Where the workplace does not accept or condone bullying, discrimination and/or harassment

The following factors were reported where a culture did not accept bullying, discrimination and/or harassment:

Zero tolerance for inappropriate behaviour

This included dealing with inappropriate behaviour with appropriate consequences and also having other staff members intervene, raise or report the incident when they see it happen.

Highly committed, competent and supportive leadership

This included senior staff who accepted ownership, set the direction and progress of their team or department, and were able to successfully engage their team. Attributes and qualities used to describe "good" leaders were: approachable; collaborative; provided timely feedback; genuinely cared about their colleagues and their patients; were competent at their profession; had a right mix of management and leadership skills; did not publicly humiliate anyone; were supportive, unbiased and ethical; acknowledged good performance and contributions to the care of patients; and were prepared to take action when rules were broken.

Clear processes that ensured a safe working environment

This included having processes and protocols in place that enabled sensible, appropriately staffed rosters and timely resolution of issues and concerns (particularly minor complaints) that had been raised. Having clear rules and guidelines meant people had a good understanding of what they were responsible for which helped them "do a good job".

Cleary defined values and an "open for business" approach

Many respondents provided comments that certain values were prevalent in healthy work cultures. This included an open-door policy balanced with maintaining confidentiality; being encouraging and supportive, respectful of decisions made (and not talking badly of another colleague or their decisions especially in front of junior staff or trainees); having a patient focussed approach; trust, not "gossiping" in public places or with junior staff; being respectful of each other's workloads; no yelling, mocking or screaming; and embracing diversity (especially in relation to race, religious beliefs, and gender).

Engaged and supported staff

Some respondents noted that where staff were engaged and committed, there was little likelihood of inappropriate behaviour. Mechanisms to support staff included mentoring; effective role modelling; processes/tools that can be readily accessed by those wishing to raise an issue; having a range of available supervisors; and advocacy to represent any staff raising concerns. A common theme centred around the organisation valuing and placing importance on the training element as critical to supporting staff.

4.2.2 Where a culture did accept bullying, discrimination and/or harassment

The following factors were reported where a culture appeared to accept or condone bullying, discrimination and/or harassment:

Engagement, interaction and relationships was lacking

There was a sense that there was an overall lack of engagement of staff in "whole of hospital processes" including consultation with staff in the development of policies. Lack of engagement was described as insular; absent; behind closed doors; and secretive. Some respondents commented that the connection and relationships between Consultants was poor with high levels of interpersonal conflict between Consultants. A lack of team spirit and team relationships was mentioned on several occasions.

Poor leadership and imbalance of power

A large proportion of respondents identified that there was a lack of clear leadership and those in leadership roles were either unwilling or unable to lead. In terms of describing leadership behaviours that were not conducive to health environments, this included public humiliation; shaming of others; lack of respect towards other staff; yelling and swearing. The notion of "power imbalance" between Consultants and Registrars was often raised with a description of "master servant mentality". This power imbalance resulted in those wishing to raise a concern about inappropriate behaviour being too fearful to complain due to perceived repercussions.

Little or no support for those wanting to raise an issue

Review contributors commented that there was little in the way of support should they wish to deal with bullying. Some commented that they had little confidence that the hospital was serious about eradicating the unacceptable culture.

Stress and burnout among Consultants and senior specialist

Comments were made that the stress Consultants were experiencing may be manifesting in inappropriate behaviours towards Registrars and specialist trainees. Some reasons cited for stress and burnout included the high pressure nature of the environment within which they work; lack of medical leadership; lack of specialist staffing; excessive administrative workloads; and poor clinical and teaching facilities.

Personal relationship between manager dealing with the issue and alleged wrongdoer

Where the alleged perpetrator and supervisor were closely connected, there was a feeling of lack of impartiality.

Ineffective work practices, systems, and processes

Several sub themes presented:

- Strategic planning – departmental priorities were not necessarily aligned to staff and patient safety.
- Staffing and rostering – under resourced departments which lead to high workloads and overworked staff (and therefore contradicting safe work practices); gender imbalance in staffing mix; rostering practices needing to be impartial and not favour people.
- Lack of processes - to ensure accountability, transparency and consequences for bullying, discrimination, and/or harassment behaviour.

4.3 Culture Shift

What can be done to shift the culture away from one which accepts bullying, discrimination and/or harassment?

Whilst the Review formulated recommendations based on findings from internal and external stakeholder engagement and from the desktop reviews, it was considered important to ask contributors:

- If you are aware of any training specialist areas where there has been a shift away from a culture of accepting or condoning bullying, discrimination and/or harassment to one that does not condone or accept it, what characteristics have you seen change?

- Where a culture that accepts or condones bullying, discrimination and/or harassment exists, what changes could or should be implemented to improve culture?

SUMMARY

- In those environments that had shifted away from a culture that accepted or condoned inappropriate behaviours to one that did not, this was mainly attributed to effective leadership and improved working conditions.
- With regard to leadership, personnel changes, clearer pathways and better access to leaders were observed as contributing to a positive shift in culture.
- Changes in the recruitment and retention structure and the provision of better support and work-life balance were also observed as contributing to a positive shift.
- Suggestions to create positive and safe cultures included: appropriately addressing inappropriate behaviour; more training; more support; improved bullying, discrimination and/or resolution pathways; improved performance development processes; encouraging staff to speak out; better leadership; and more interaction and communication.

4.3.1 What can be done to shift the culture?

Where staff had seen a movement or shift towards an environment that did not condone bullying, discrimination and/or harassment, three recurrent themes presented: leadership; work conditions; and better processes as described below:

Leadership

- A change in personnel; and clear pathways and access to leaders; better discussion between leaders of specialty areas; building and nurturing effective teams; placing importance on values.

Work conditions

- Registrars receiving two year contracts once they had satisfactorily completed their first year; pregnant doctors re-employed even if on maternity leave at the time and granted up to 12 months maternity leave; better work/life balance that offered family-friendly rotations and more reasonable workloads.

Better processes

- That facilitated resolutions and the notion of holding each other to account had been observed. For example, peers offering their colleagues constructive incidental feedback when their behaviour may not be deemed appropriate: pulling their

colleague aside gently and telling them "perhaps you were a little harsh" or when warranted "perhaps I can take over for a while".

Comprehensive feedback was provided by focus groups and written submissions as to what changes could or should be implemented to improve TCH & HS's specialist training culture. They are categorised below:

Address inappropriate behaviour

- This included having clearly defined consequences for instances of bullying, discrimination and/or harassment and then enforcing the consequences.

Training

- This included training for all parties (on relevant legislation, regulations and policies and also on what is appropriate and inappropriate behaviour); training for clinical leaders in management (conflict resolution, bullying, discrimination and/or harassment prevention and managing complaints); and training for Registrars (allowing adequate time to undertake training and implementing mentoring).

Support

- This included provision of support by way of advocacy for Registrars; nominating "safe" person/people in the department that Registrars can approach to raise concerns without the fear of retributions and counselling.

Improved bullying resolution process

- This included the development a clear pathway/s for reporting bullying. The pathway should eliminate potential for conflict of interest whereby the junior doctor who needs to raise an issue does so to a staff member who is separate to the department at which the bullying, discrimination and/or harassment is occurring and separate to those they may need to ask for job references. There also needs to be consideration to develop an effective process where unfounded accusations can be dismissed easily and early with minimal disruption, and those that are genuine can be progressed.

Communication

- This included communicating the expectation of zero tolerance of bullying, discrimination and/or harassment behaviour and other forms of inappropriate behaviour; raising awareness of what bullying behaviour is/is not; and informing staff of resources that are available to support them when dealing with incidents of bullying, discrimination and/or harassment.

Work practices

- This included developing rosters that complied with safe work practices; having appropriate staffing levels; recruiting programs that were free of discriminatory

practices; and offering 2-3 year employment contracts for high performing Registrars.

Performance development

- This included developing and implementing a process that will allow for providing performance feedback to Registrars who may not be doing well.

Speaking out

- This included encouraging staff who may be experiencing bullying, discrimination and/or harassment to speak out and also encouraging other staff who have witnessed bullying, discrimination and/or harassment to also speak out.

Leadership

- This included those in positions of power and influence to lead by example through early and timely intervention and tackling inappropriate behaviour as they see it occurring.

Interaction

- This included scheduling regular meetings between Consultants and Registrars to discuss progress and problem areas, and increased social interaction such as regular journal clubs which can be off site, and brainstorming with junior doctors.

5 Findings – Data from external parties regarding the clinical training culture at TCH & HS

A number of themes emerged from external parties who have observed the culture at TCH & HS. These are outlined below.

5.1 Supporting Culture

To what extent is there a culture that supports bullying, discrimination and/or harassment?

External perspectives indicate that, in parts of TCH & HS, a culture of allowing bullying, discrimination and/or harassment to occur exists. It is consistently noted that this is not a universal issue, but that some areas are 'toxic'.

The Royal Australasian College of Surgeons (RACS) and the Urological Society of Australia and New Zealand's report into the accreditation of surgical education and training post urology (SET3-SET6) focused particularly on the quality of the Urology training at TCH & HS. The Report considered both technical and non-technical issues such as trainee welfare, professionalism, teamwork and communication. A report presented on 4 June 2015 was the culmination of three inspections which occurred in August 2012, October 2014 and June 2015[12].

According to the Report, the inspectors found too many fundamental deficiencies in the delivery and manner of training to outweigh the advantages and concluded that trainee welfare is at jeopardy which is unacceptable. The inspectors stated that the unit had multiple opportunities to address the issues raised over previous inspections but had failed to do so; and therefore recommended the dis-accreditation of the SET Urology Training Posts at TCH & HS.

Some of the issues raised by the Report relating to culture included:

- There appeared to be a lack of respect and mistrust between Consultants as evidenced by body language and disrespectful exchanges. It also appeared to the inspectors that there were some attempts made to shield trainees and junior medical staff; however, the repercussions on trainees and the quality of training were still considerable.
- There was a culture of non-reporting at particular meetings for fear of intimidation and victimisation which was shared by trainees, junior medical staff and some Consultants.
- There is a general culture of "shaming", with particular examples as when trainees have presented complications within a meeting, being made to feel at fault when the real responsibility lies elsewhere. The inspectors noted that this culture of

[12] The Royal Australasian College of Surgeons (RACS) and the Urological Society of Australia and New Zealand (USANZ) – *Accreditation of Surgical Education and Training Post Urology (SET3-SET6) – Final Inspection Report*

shaming is enormously destructive for trainees and has the potential of encouraging avoidance behaviours.

- There is a perception of the trainees that they are "tainted" by association with a particular Consultant and their views and have been made to justify decisions that are not their own as if to punish them.
- Non-technical competencies such as collaboration, communication, management and leadership have been observed to be unsatisfactory. Conduct has shown to be antagonistic, secretive and undermining.
- Trainee welfare was a major concern for the inspectors, and they felt that the working environment was leaving a significant impact on the wellbeing of trainees. A general perception of unfair pressure and bullying, compounded by an environment where trainees feel neglected in mentor support and concerns, are dismissed surmounted to the inspectors' concern.

5.2 Existing Culture Contributors

What is contributing to the culture that exists?

External parties have identified a number of contributing factors where bullying, discrimination and/or harassment is occurring, including:

- The high patient numbers in clinics, in addition to a current shortage of senior staff and Registrars, is reducing time for training and education sessions, hence increasing pressure on the Registrars.
- A general lack of administrative support at times for the clinics, which sometimes resulted in Registrars being double booked for clinics.
- Rosters are subject to frequent change, often at extremely short notice, which is stressful for Registrars and inhibitive to their training.
- Registrars, interns and junior medical staff are often rostered without a Consultant or senior Registrar on-site after hours. This is a difficult position to be placed in for junior staff as they often lack certain competencies which limits the support they can provide.
- Conflicting management plans and protocols were not being adhered to by Consultants and placed considerable stress on the Registrars.
- There is a fear among Registrars of the consequences for their future career if they are seen to make a complaint.
- Poor leadership and management behaviours displayed by senior doctors, in particular when Registrars are made to feel at fault for something when the responsibility lies elsewhere.
- Apparent disharmony amongst the Consultant staff which has at times impacted trainees and the quality of training. Interpersonal conflict or "in-fighting" in the

workplace and between Consultants causes confusion for trainees about correct medical management and creates a stressful environment for Registrars.

Other characteristics are observed in organisational units where bullying, discrimination and/or harassment does not occur (often the converse of the elements listed above). These include:

- Good working relationships with ward nurses;
- Training Supervisors provide ongoing support and feedback to Registrars;
- Time reports have processes implemented to improve feedback discussions with trainees;
- Commitment to quality control and audit processes;
- Weekly teaching session co-ordinated by Consultants; and
- Culture Shift.

What can be done to shift the culture?

A range of ideas have been canvassed in relation to improving the culture to prevent bullying, discrimination and/or harassment. These are set out below.

Recruitment of Additional Staff

- The recruitment of additional staff will assist with the increasing number of patients, assist in the organisation and running of the training program, and ensure clinics are covered. This includes staff specialists, Visiting Medical Officers, Senior Registrars and Registrars. This will also ensure allocated time for training and research for Registrars is respected.

More involvement and engagement in training by senior staff

- Consultants should attend education sessions and present at them in order to contribute to the discussion and act as a source of information and guidance.

An audit of the rostering structure

- Trainees could be required to keep a daily record of their roster allocations over a particular period, which would be signed off by appropriate staff, and then compared with the official roster.

Consultants or Senior Registrars on duty after hours

- Ensures that a more experienced resident, Consultant or senior Registrar is on-site with the junior Registrars or residents after hours.

Management plans and protocols are followed

- Ensures adherence by all staff to management plans and protocols, including ward rounds and ward handover activities.

Protected space for Registrars

- Designating a protected space for Registrars in each speciality is important from a training and psychological perspective.

Open communication

- Transparent discussion of clinical problems and complications and not encouraging a culture of "shaming" other staff.

6 Findings – Evidence from external sources regarding bullying, discrimination and/or harassment cultures in other organisations

The following section provides an overview of information and observations provided by external sources.

6.1 External Observations

To what extent are cultures of bullying, discrimination and/or harassment evidenced?

It is widely acknowledged and reported that workplace bullying, discrimination and/or harassment occur in medical settings. 'Discrimination, bullying and sexual harassment are significant and persistent problems in medical work environments'[13]. This is despite the fact that bullying, discrimination and/or harassment have been prohibited forms of conduct within the workplace for more than 30 years.

The cultures that support bullying, discrimination and/or harassment include[14]:

- Cultural values and practices which 'permit' or encourage acts of bullying, prevent reporting (because it is seen as a weakness) or expect they will endure it.
- A culture where workers are fearful of speaking up because of fears of victimisation and a 'code of silence' exists.
- Where leaders are not obviously modelling the behaviours identified in the policies or they "walk past behaviours" that happen in or near their presence.
- Where there is a lack of reinforcement of the messages within various legislation and policies that bullying, discrimination and /or harassment is not accepted.
- Where leaders are focused on their technical role, and do not take on the management and leadership role, including building team behaviours and acting quickly to address inappropriate behaviours.
- Where leaders lack an understanding of the scale or impacts and consequences of inappropriate behaviour.
- Where there is a failure to address emerging issues and concerns around bullying, discrimination and/or harassment systemically, quickly, confidentially and consistently.
- Performance development and management is inappropriately implemented through behaviours that are of a bullying, discriminating and/or harassing nature.

[13] Background Briefing, Expert Advisory Group to Royal Australasian College of Surgeons (2015)
[14] House of Representatives Inquiry into Workplace Bullying (2012)

- Leaders and managers who are not skilled in conflict management, bullying resolution strategies and constructively providing performance feedback.
- Where there is a lack of provision of support mechanisms and strategies to assist those who wish to raise an issue or complaint.

6.2 Existing Contributors

What is contributing to the culture that exists?

The review recently conducted by the RACS noted that the work environments in which there is a culture of abuse have a complex inter-related set of characteristics, including:

- The hierarchical structure of the workforce and the seniority of the perpetrator
- Lack of support for victims and/or whistleblowers. Similarly, the House of Representatives Inquiry into Workplace Bullying[15] identified that, in most workplaces, there are very few consequences for inappropriate work behaviour and breaches of the organisation's anti-bullying policies.
- Individuals who have become so accustomed to bullying that they frame this behaviour as normal or acceptable, thus ensuring ongoing acceptance of, and conformity with, the bullying, discrimination and/or harassment.
- Bullying, discrimination and/or harassment in the workplace being under-reported
- Systemic barriers to reporting, for example not wanting to be seen as a troublemaker; fear of retaliation, belief that nothing would change, and/or that the situation might deteriorate further.
- The stressful healthcare environment, particularly the pressures to meet administrative deadlines and targets.
- Lack of leadership engagement in addressing issues.

The Queensland Fire and Emergency Services (QFES) "*Independent review of an incident involving Queensland Fire and Emergency Services employees* noted the following as likely to contribute to the culture of bullying, discrimination and/or harassment[16]:

- Lack of accessibility for staff to policies and procedures governing workplace conduct and behaviour "created an environment of complexity and uncertainty about the correct procedures to follow, especially in the handling of sensitive complaints".[17]

[15] Ibid
[16] Queensland Fire and Emergency Services Independent review of an incident involving Queensland Fire and Emergency Services employees, December 2014
[17] Queensland Fire and Emergency Services Independent review of an incident involving Queensland Fire and Emergency Services employees, December 2014, pg 10

- The low level of awareness of the impact of unwelcome humour and "joking on" people. This 'mucking about' can be taken as offensive or threatening and repels the desire to raise an issue.
- Lack of accessibility to information and support. For example when information cannot be accessed directly by the individual but rather is facilitated by the HR department, this presents issues of lack of confidentiality.
- Rostering. A lack of protocols as to how staff are assigned their roster, combined with discretionary decision making powers in roster assignment, can give rise to harassment and intimidation through the allocation of less than desirable 'shifts'.

6.3 Shifting the Culture

What can be done to shift the culture?

The RACS Report notes the following mechanisms for addressing a bullying, discrimination and/or harassment culture:[18]

- Engage with gender discrimination and overcome the 'old boys' mentality. The report notes that these are broader societal issues and gender stereotyping is associated with bullying, discrimination and/or harassment.
- Positive communication. The Report notes the opportunity to 'change the discourse from one of comply with discrimination policy and legislation, to one about attracting and retaining the very best people, maximising teamwork, creating positive learning environments, valuing diversity and inclusion, maintaining the professionalism and reputation of the profession and ultimately, achieving better patient outcomes'.
- Articulate the roles and responsibilities of training supervisors. This includes ensuring that they are given clear induction on expectations around preventing and dealing with bullying, discrimination and/or harassment.
- The importance of leadership. The Report highlights the role of leaders in setting the tone for no tolerance for bullying, discrimination and/or harassment. 'Without a doubt, the commitment of senior leadership to creating a culture of respect within institutions is critical to minimising disruptive behaviour in healthcare".[19]
- Data collection and reporting. The Report notes that this allows for organisations to locate precisely any issues that may present in the 'cultural blind spot'. Effective data collection and reporting can also provide the vehicle to identify systemic issues, highlight best practice (high performing organisations), encourage accountability of supervisors, and help drive constructive performance feedback.

[18] Expert Advisory Group on discrimination, bullying and sexual harassment *Advising the Royal Australasian College of Surgeons Background Briefing*
[19] Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia quoted in RACS report*

- Allocating resources to address issues of bullying, discrimination and/or harassment. This would send a clear signal that inappropriate behaviour will not be tolerated. Resources could be directed towards an independent front line for inquiries (to receive and resolve complaints) and a helpline (to provide confidential advice, including on whistle blowing).
- Target the three levels (individual, team and organisational) that research identifies as contributing to ongoing inappropriate behaviour. The Report suggests that each level be involved in playing a part in the solution and that action occurs simultaneously at all levels.

The QFES *"Independent review of an incident involving Queensland Fire and Emergency Services employees"* had a particular focus on effectively managing complaints of inappropriate behaviour and conduct. It highlighted that a good practice resolution strategy would include:

- Mechanisms for immediate escalation of the issue;
- Clear accountability for actions to be taken by individuals and for overall coordination; and
- Regular review mechanisms to ensure the matter does not "fall off the radar".[20]

Furthermore, the QFES Report noted the following as important factors to consider in the development of processes and protocols to resolve work bullying:

- Demonstrating genuine intent to address the issues raised. This extends to keeping the person who raised the issue informed of progress (with regular updates). This has the added benefit of, in those circumstances where the outcome is unlikely to be that which is expected by the complainant, it can serve to "assist the person in coming to terms with what has occurred".
- Taking action at the time the issue is raised, otherwise there is possibility of an unsatisfactory resolution for the person raising the issue along with potential risk to long term organisational outcomes.
- Appropriateness and impact of the person raising the issue and the alleged perpetrator remaining in a close environment where they need to work together (particularly when the complainant feels unsafe or there is continued unacceptable behaviour).
- An effective complaints management system should ensure that employees are provided sufficient support throughout the process. However, the steps outlined in the relevant procedure for management of complaints did not include the provision of support to the complainant.

[20] Queensland Fire and Emergency Services *Independent review of an incident involving Queensland Fire and Emergency Services employees*, December 2014

7 Detailed summary of findings

In this section, we consider the evidence outlined in Sections 5 – 6 above to draw key conclusions about the extent to which a culture of bullying, harassment and/or discrimination exist, and the factors contributing to this culture.

7.1 Supporting Evidence

To what extent is there a culture that supports bullying, discrimination and/or harassment?

It is evident from the focus groups and written submissions that, while frameworks and policies have been put in place, they are not well understood and there remain instances where behaviour is inconsistent with the frameworks and policies. There are cultural factors evidenced at TCH &HS which have many similarities with evidence of cultures in other medical work environments and which are associated with a culture that accepts or condones bullying and harassment behaviours.

It is important to note that, while there is evidence of issues relating to bullying, discrimination and/or harassment that need to be addressed by the hospital, participants in the Review wanted to make it clear that this inappropriate behaviour was not widespread in every area of training specialty. Additionally, it has been acknowledged that a policy response has been put in place and some management action has already been taken.

However, despite this, 76 per cent of written submission contributors who responded to this question indicated they have observed behaviours that would indicate a culture condoning/accepting bullying, discrimination and/or harassment. Of those who responded to this question, 19 per cent claimed they had not witnessed behaviours that indicated acceptance of bullying, discrimination and/or harassment and four per cent indicated they had rarely seen these behaviours displayed[21].

It has been noted in other contexts that it is possible for people to voice that their organisation is a great place to work, yet also 'be experiencing or exposed to unacceptable behaviours".[22] This Review supports that notion.

Key elements that have been identified to contribute to the current situation are:

- *Lack of compliance with legislation and policies.* Employment conditions and work practices in some areas do not reflect what is contained in the legislation and policies governing workplace practices, behaviour and conduct. This suggests a lack of compliance with legislation, regulatory frameworks and local policies and protocols.

[21] There were 26 responses to the question 'To what extent is there a culture that supports bullying, discrimination and/or harassment at TCH & HS?'
[22] Queensland Fire and Emergency Services *Independent review of an incident involving Queensland Fire and Emergency Services employees,* December 2014

- *Lack of, ineffective and untimely action.* TCH & HS's strategy to resolve bullying does not appear to be effective and implementation of the Informal Report action of the strategy was particularly lacking due to the lengthy resolution processes. Where issues were well known, there appeared to be a reluctance or inability to resolve them. This is indicative of a failure to address emerging issues and concerns around bullying, discrimination and/or harassment systemically, in a timely manner, confidentially and consistently.
- *Less than desirable interpersonal skills displayed.* There appears to be a normalising and minimisation of unacceptable behaviours. Examples provided were of Consultants using intimidating language; yelling and swearing at Registrars; sending text messages that contain crude language, verbal threats to trainees to withdraw complaints; abusive telephone calls from Consultant to Consultant and Consultant to Registrar, public humiliation; and insulting remarks regarding competence.
- *Performance feedback delivered inappropriately.* Whist there was recognition that feedback was an important component of specialist training, review input suggested that there was a culture of "shaming" in some work areas. Comments indicated that where negative performance feedback was experienced, it could be sarcastic; publicly announced; not backed up with evidence; and/or delivered using inappropriate language.
- *Consequences and repercussions.* There is a perception amongst some review contributors that staff can be fearful of speaking up because of fears of victimisation.
- *Limited support.* Evidence suggests that support mechanisms and strategies are not sufficiently effective to assist those who wish to raise an issue or complaint. Views were expressed that voiced complaints were often met with little or no support, and some respondents indicated there was a culture that made the person raising the concern feel they were the one with the problem.

Evidence from various reports and literature indicate a culture in the medical profession that accepts and condones bullying, discrimination and/or harassment. RANZCOG noted low morale and distress of Registrars affecting the culture of training at TCH & HS. The RACS and Urological Society of Australia and New Zealand's report raised concerns that resulted in the withdrawal of the accreditation status of TCH & HS for training. Behaviours observed and named by respondents were similar to those outlined in the desktop and external reviews that depicted a culture of bullying, discrimination and/or harassment.

7.2 What is contributing to the culture?

For TCH & HS to ensure it provides a safe, positive culture, it will need to take into account the factors that have been identified as contributing to a culture of bullying, discrimination and/or harassment. An analysis of similarities and key factors across stakeholder views and desktop reviews suggest the following as having the greatest impact on culture:

Leadership: A number of Review contributors conveyed perceptions that there was a lack of demonstrable leadership and management behaviours displayed by some senior doctors. Feedback suggests that Review contributors considered that, whilst most doctors are very good at their speciality, they may not have displayed sufficient people management and leadership skills.

Leaders and managers were reported as lacking skills in conflict management, bullying resolution strategies, and provision of constructive performance feedback. Team building behaviours are lacking and not enough attention is given to prompt action in order to address inappropriate behaviours.

An apparent disharmony amongst the Consultant staff was also noted on several occasions and that ,at times, this has had a negative impact on trainees as they felt they were caught in the middle and the quality of training was compromised.

Some said the interpersonal conflict or "in-fighting" between Consultants caused confusion about correct medical management and created a stressful environment for Registrars.

Review contributors suggested that, in some parts of the organisation, there was an 'old guard' who was perceived as self-focused, lacking in empathy and regard for others' welfare. Further suggestions were made that, where there was a large power differential, bullying was more likely to occur and that with a lot of power in the hands of the supervisors a "master/servant mentality" was sometimes evident. As competition was fierce for training places, one poor performance report is seen to fundamentally impact a junior doctor's chance of success.

Some Consultants and Registrars contributing to the Review commented that where Consultants were experiencing stress, this may be manifested in inappropriate behaviour towards Registrars and specialist trainees, however further analysis is required to assess the extent of this.

A culture of acceptance established over time: There is a view that the culture has emerged over time as a result of behaviours that were perceived to be acceptable in the past. In other words, there is a perception that some doctors have an attitude of 'we survived... you should be able to do the same.' Views were expressed that trainees were in a difficult position, with perceptions that, if they did speak up and challenge the behaviours, their training career would 'go up in smoke'.

Furthermore, an expressed view of some junior doctors was that over time there were indications that it had become normal to think 'you just put up with it' - the very high workloads and stress and a sense that 'you do not need to be treated well'.

Some Review contributors indicated that TCH & HS has operated in silos of specialisation, which has the effect of building up cultures within each speciality which are not as easily impacted by corporate intent as they might otherwise be.

Awareness and understanding: There was a reported low level understanding of the bullying, discrimination and/or harassment policies and associated staff obligations. Some Review contributors suggested that on occasions individuals may not have been

aware that their behaviour may have been perceived as bullying and that they may been behaving that way for years. Sentiments were expressed that the majority of these individuals may be conceptually against any type of bullying behaviour, however, they may be unaware that the behaviours they are exhibiting constitute bullying.

Process to resolve inappropriate behaviour. Review contributors indicated that the current strategy to resolve bullying, discrimination and/or harassment was not effective, citing two main reasons based on their observations: (i) they had seen few changes in those people who had displayed inappropriate behaviours and had been through the process; and (ii) a lack of willingness to adopt the strategy because it was lengthy; stressful; had few support mechanisms and did not always maintain confidentiality.

Some Review contributors mentioned that where issues are well known, there appears to be a reluctance or inability to resolve the issue. Little or no support for those wanting to raise an issue instils little confidence that TCH & HS is serious about eradicating the unacceptable culture.

8 Recommendations

High level recommendations to shift the culture at TCH & HS are outlined below.

8.1 Key considerations in changing culture

In identifying recommendations, the data and analysis summarised above has been supplemented with key principles for changing organisational culture as briefly outlined below:

- **Complexity of Culture**: Culture is created by the people in the organisation over time. The current culture is powerful: it is a highly complex, inter-related set of socially constructed meaning that has been created through history by people with their own complex values and assumptions[23]. Changing the culture therefore requires a recognition that:
  - An inter-related set of system wide interventions are required operating at the individual, group and whole of organisational levels.
  - Cultural change takes time and sustained effort.
- **Tone comes from the top**: Those with power in the organisation will have the most impact on the existing culture and efforts to shift that culture. As a result, clarity of the vision for the culture, associated role modelling and accountability of senior people 'to set the tone' will be critical for success.
- ***Clarity of purpose & vision:*** Clarity of purpose and vision is a powerful element in aligning people towards a new future. In the case of TCH & HS, this is about (re) connecting the ultimate goal of the medical profession, patient care and safety, with a positive, supportive culture.
- **Build from the positive**: As outlined, the Review has found evidence that the culture across TCH & HS is varied, meaning that there are parts of the organisation with a positive organisational culture which does not accept bullying or harassment. Further, policies have been developed and management action has been taken to shift the culture. It is important to build from these positive attributes.
- **Changing culture is an adaptive challenge:** Adaptive challenges[24] are those which are difficult because their solution requires people to fundamentally change their way of behaving and operating. Therefore, the solution lies within the very people who create the situation. This means that it will be important to engage people in changing this culture towards one where bullying and harassment is no longer acceptable across TCH & HS.

[23] Schein (1998), Organisational Culture and Leadership
[24] Heifetz, R, Grashow, A and Linsky, M (2009) *The Practice of Adaptive Leadership.*

8.2 Recommendations

The following recommendations are made to further improve the culture of TCH & HS towards one where bullying, discrimination and/or harassment does not occur and is not tolerated.

It is noted that prior to execution of these recommendations:

- Further detailed planning for execution of these recommendations is required; and
- Consultation with the leadership and support staff to fully develop these recommendations in light of other change initiatives is required.

The high level recommendations are:

1) Work with the Executive and Clinical Directors to conduct further detailed analysis of those areas noted in this Review as having a culture that accepts or condones bullying, discrimination and/or harassment.
2) Engage senior leaders and staff across TCH & HS in developing a statement of the desired culture for success. Key points about this approach are:
   a) Evidence[25] supports that teamwork, communication and collaboration between professionals are essential to patient safety. Messaging needs to connect positive leadership and collaborative behaviour with the ultimate role of the medical profession, patient care and safety.
   b) Incorporate subconscious bias/bullying, discrimination and/or harassment and impact awareness training within education sessions.
3) Using the statement of desired culture as the basis, develop, implement and embed a 'saturation' communications campaign:
   a) Positive focus; build a collaborative, respectful culture focused on patient and colleague care.
   b) Incorporate social media communication as well as conventional mechanisms.
   c) Clarify what is and what is not bullying, discrimination and/or harassment.
4) Adjust reward and performance measures for leaders to reflect desired leadership behaviours and capabilities.
5) Develop and institute mandatory leadership and management training for all clinicians who hold a leadership or management position:
   a) Management skills: managing team, preventing bullying, discrimination and/or harassment, dealing with bullying, discrimination and/or harassment.

[25] United Kingdom's General Medical Council (GMC), Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia quoted in RACS report*

b) Leadership capability: including team leadership capabilities, building commitment to leadership behaviour to enable patient care, giving and receiving feedback constructively.

c) Clarity on what is and what is not bullying, discrimination and/or harassment.

6) Review governance structures in relation to the accountabilities and reporting requirements associated with bullying and harassment, in particular the specialist training leadership team (the Chief Executive, Director General, Executive Directors and Clinical Directors).

7) Strengthen policy statements to clarify and commit to consequences for unacceptable behaviour. Evidence gathered in the Review suggests that areas warranting particular attention are:

a) Support for individuals wanting to resolve a situation (for example, role of HR / MOSCETU in support provision).

b) Clarity of consequences for engaging in unacceptable behaviour.

c) Management action where unacceptable behaviour is witnessed.

d) The processes for managing and resolving bullying and harassment issues.

Appendix A – Terms of Reference

Review of the clinical training culture at The Canberra Hospital

Terms of Reference

Following a range of issues in relation to structure, governance, leadership and interpersonal relationships and behaviours of doctors at Canberra Hospital and Health Services, ACT Health wishes to engage KPMG to examine and consider:

- The frameworks, policies and supports in place to guide the conduct and behaviour of doctors[26] participating in specialty training or responsible for training or supervising specialist trainees.
- The extent to which these frameworks, policies and supports are understood and applied by those doctors.
- The drivers for when the conduct and behaviour of those doctors is inconsistent with these frameworks and policies.
- What could be done to improve the conduct and behaviour of those doctors to improve the overall culture of the hospital. Whether there are cultural factors which exist in relation to doctors where there is a greater likelihood of displaying the behaviours inconsistent with the frameworks and policies.

As you have advised, there is a significant body of evidence already available for our consideration and that we can anticipate approximately one week of stakeholder engagement to validate and refine the findings already identified.

You have also advised that the following are out of scope:

- Consideration of conduct and behaviour by staff of Canberra Hospital and Health Services who are not doctors participating in speciality training or responsible for training or supervising specialist training.
- Findings or judgements regarding the conduct or behaviour of individual doctors.
- Resolution of allegations, complaints and issues identified as part of the evidence gathering exercise.
- Advocacy at the request of any contributor to the review.

Discussed at initial meeting with Nicole Feely, Ian Thompson & Kim Smith Friday 19th June

Agreed at Engagement commencement meeting with Ian Thompson, Kim Smith, Joel Madden and Gabrielle Sek, 24 June 2015

[26] Including employees of the Canberra Hospital and visiting medical officers to the Canberra Hospital

Appendix B – Review Method

Stage 1: Project initiation and planning

Stage 1 determined an agreed approach by both TCH & HS and KPMG regarding the identification of internal and external stakeholders to engage; the method by which to engage with these stakeholders; documents to be reviewed for the purposes of the desktop review; and timing of deliverable.

In terms of data gathering, TCH & HS assumed responsibility for:

- Identifying individual internal and external stakeholders to be engaged.
- Inviting individual internal participants to focus group sessions.
- Invites individual internal Review contributors to submit written submissions.
- Providing the Review with all relevant documents to undertake the desktop review.

In terms of data gathering, KPMG assumed responsibility for:

- Design of stakeholder engagement instruments.
- Facilitating focus groups.
- Organising external consults/interviews.

Stage 2: Data and information gathering

The data and information analysed was gathered from focus groups and written submissions facilitated by the Review Team where participation was voluntary (internal stakeholders); a number of consultations/interviews conducted by the Review Team with external stakeholders; as well as documentation provided by TCH & HS in relation to work bullying, discrimination and/or harassment; workplace practices, conduct and behaviour; and culture and relevant work unit accreditation); and other relevant information relating to organisational culture and inappropriate behaviour in the workplace.

As advised by TCH & HS:

- The following three categories of internal stakeholders were invited to attend focus groups:
  - TCH & HS Executive, including Clinical Directors
  - Staff specialists (including senior staff specialists) and Visiting Medical Officers (VMOs)
  - Registrars in accredited training positions
- The following external stakeholders were consulted / interviewed:
  - Australian Medical Association (AMA ACT); Industrial Officer

- Committee of Presidents of Medical Colleges; Chief Executive Officer
- Australian Salaried Medical Officers Federation (ASMOF), Mr Ian Cassie

- The following documents formed the basis of desktop review:
  - The Royal Australasian College of Surgeons (RACS) and The Urological Society of Australia and New Zealand (USANZ) – Accreditation of Surgical Education and Training Post Urology (SET3-SET6) – Final Inspection Report
  - The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) – Re-accreditation of The Canberra Hospital – Follow-Up Visit Report (September 2014)
  - ACT Health – 2012 Workplace Culture Survey – Medical Officer Reports
  - ACT Health – Health Directorate Code of Conduct
  - Corporate Governance Statement
  - Misconduct and Discipline Policy
  - Respect at Work – preventing and managing work bullying, discrimination and harassment Policy
  - ACT Public Services – Respect, Equity and Diversity Framework 2010
  - ACT Health – Values Fact Sheet
  - ACT Health – Values Poster
  - ACT Health Workforce Plan
  - PSS orientation presentation
  - Orientation welcome letter from the Director-General.

Further to the above documents the Review also reviewed reports from other jurisdictions:

- House of Representatives Standing Committee on Education and Employment – Workplace Bullying Report (October 2012)
- Queensland Fire and Emergency Services report on Workplace Bullying
- Royal Australasian College of Surgeons recent report.

Stage 3: Data analysis and development of high level recommendations

An analysis of the data collected was conducted against the following questions:

1. To what extent is there a culture that supports bullying, discrimination and/or harassment at TCH & HS?

a. To what extent are legislation, policies, and frameworks accessible, understood and complied with? (This includes legislative and regulatory frameworks and locally developed policies, protocols and processes.)

b. How effective is TCH & HS' policy for resolving work bullying?

c. To what extent does TCH & HS have a culture that accepts/condones bullying, discrimination and/or harassment? What behaviours describe that culture?

2. What is contributing to the culture that exists?

   a. What characteristics are present in those training specialist areas which do not accept/condone bullying, discrimination and/or harassment?

   b. What characteristics are present in those training specialist areas which do accept/condone bullying, discrimination and/or harassment?

   c. What characteristics/practices had changed in those areas which shifted from accepting/condoning bullying, discrimination and/or harassment to not accepting these behaviours?

3. What can be done to shift the behaviours in evidence and improve the overall culture of the hospital?

   a. What changes could or should be implemented to improve culture that accepts/condones bullying, discrimination and/or harassment?

Stage 4: Report preparation and finalisation

This Report provides:

- Review of the existing clinical training culture including identification of the degree to which the existing cultural policy frameworks are being followed;
- High level observations drawn from our analysis of the stakeholder data and desktop research, regarding the factors influencing the culture within the identified organisational units; and
- High level recommendations regarding next steps to address Review findings.

Assumptions

The Review Team's assumptions in undertaking this Review were that:

- ACT Health would provide, in a timely manner, all of the existing data regarding this cultural concerns which exist.
- ACT Health required a positive approach to this activity. The Review would not seek information for the purposes of ascribing blame to individuals or teams, but to identify, as far as possible, the factors which contribute to the existing culture and

identify high level recommendations as to how to shift this culture towards the desired culture.

- ACT Health would provide the Government's Respect, Equity and Diversity Framework and other ACT Public Service and local workplace policies which have been introduced to address what is expected of the behaviours to be demonstrated by staff in ACT Health and across the ACT Public Service.
- ACT Health would assist the Review Team to identify and make arrangements with the stakeholders who will provide data relevant to this Review.
- Stakeholders would be available to provide information as required within the timeframe of the Review.
- Communication with internal and external stakeholders regarding the Review would be managed by ACT Health. The Review Team was available to provide input to this communication.
- ACT Health would provide assistance in coordinating internal stakeholder focus groups.

Appendix C - Conduct of Review

Internal stakeholders as identified by TCH & HS could provide input to the Review via two mediums - participation in focus groups and the provision of written submissions. 19 focus group sessions were organised by TCH & HS and were conducted by the Review Team between Thursday 2 July and Friday 10 July 2015. TCH & HS organised the Registrars' focus group sessions by areas of speciality and issued invitations accordingly:

- TCH & HS Executive (including Clinical Directors) – one focus group session offered
- Staff specialists (including senior staff specialists) and VMOs – two focus group sessions offered
- Registrars in accredited training positions – 16 focus group sessions based on area of specialty.

Each focus group was assigned a duration of two hours with four scheduled every day: 7.30am, 12.00pm, 2.30pm and 5.30pm. Most focus groups were held for approximately 1 1/2 hours. The majority of participants attended either the 12.00pm or 2.30pm timeslots; with only one session attended by groups other that the executive cohort in a 7.30am timeslot and one conducted in the 5.30pm timeslot.

KPMG conducted all of the focus groups. At the beginning of each focus group session participants were advised of the standard approach being taken, the Review's terms of reference and relevant definitions and that participation was voluntary. Participants were encouraged to share their observations and to be open noting that input would be de-identified. They were also assured that privacy would be protected and that any comments, feedback, observations or insights provided would not identify the individual. Focus group participants were advised that the intent of the focus groups was not to delve into or resolve individual experiences but rather obtain a collective summary of recurrent themes.

Participants were asked to consider the Review questions from the perspective of their "work cohort" and asked to provide their observations and information relevant to experiences during the past 12 months. Details of each focus group (including number of invitees and date and time of each focus group) is provided in in the table on the following page. A total of 62 participants attended the focus groups conducted.

The guidance information provided for the focus groups was also explained in the instructions distributed to support the written submissions process. A total of 54 written submissions were completed using the template at Appendix D of this Report.

Three external stakeholders (AMA, ASMOF and the CPMC) were approached to provide observations regarding the training culture at the hospital. ASMOF was not able to respond within the Review timeframe. The AMA provided high level observations regarding the training culture while the CPMC provided suggestions regarding other contacts who could provide input to the review and did not comment specifically on the culture of TCH and HS.

The desktop review helped identify similarities and differences together with consistencies and inconsistencies with findings from other jurisdictions examining similar cultural aspects.

Focus Group Consultations – July 2015

Specialisation	Date and Time	No. of Invitees	No. of Attendees
Executive Directors and Clinical Directors	Thursday, 2nd July, 5:30pm	50	22
Unit Directors and Training Supervisors	Friday, 3rd July, 7:30am	60	15
Clinical Director and Training Supervisor for Obstetrics	Friday, 10th July, 9:30am	2	0
RACP – Neurology, Renal, Respiratory, Rheumatology, Infectious Disease, Cardiology, Endocrinology, Medicine, Gastroenterology, Neonatology	Monday, 6th July, 7:30am	30	1
RACP – Public Health, Rehabilitation RCPA – Pathology	Monday, 6th July, 12:00pm	19	3
RACR/RANZCR – Radiation and Medical Oncology	Monday, 6th July, 2:30pm	9	3
RACP – Generalist training	Monday, 6th July, 5:30pm	28	0
RACP – Generalist training	Tuesday, 7th July, 12:00pm	30	0
RACP – Generalist training	Tuesday, 7th July, 2:30pm	28	0
RACS – General surgery, vascular surgery, neurosurgery, ENT	Tuesday, 7th July, 5:30pm	13	0
RACS – Orthopaedics, Paediatric surgery, medical imaging	Wednesday, 8th July, 12:00pm	24	13
RANZCP – Mental Health, Child and Adolescent Psychiatry	Wednesday, 8th July, 2:30pm	28	0
ACEM – Emergency Medicine	Wednesday, 8th July, 5:30pm	30	0
RANZCOG – Obstetrics and Gynaecology	Thursday, 9th July, 12:00pm	6	4
ANZCA/ RACDS – Oral and Maxillofacial	Thursday, 9th July, 2:30pm	6 (4 ANZCA	0
			56

Specialisation	Date and Time	No. of Invitees	No. of Attendees
		and 2 RACDS)	
CICM – Intensive Care and Emergency Department	Thursday, 9th July, 5:30pm	28	0
RANZCOG – Obstetrics Gynaecology	Friday, 10th July, 9:30am	1	1
RACP – Urology	Friday, 10th July, 12:00pm	2	0
RANZCO – Ophthalmology	Friday, 10th July, 2:30pm	13	0

Appendix D – Focus groups' introduction script

Introduction/Scene setting

Thank you for agreeing to take part today.

[INTRODUCE KPMG PERSONNEL]

Purpose of Review

POWER POINT SLIDE: As you are aware, a range of issues have been identified in relation to structure, governance, leadership and interpersonal relationships and behaviours of doctors at Canberra Hospital and Health Services. Consequently, ACT Health has outlined the scope of this Review to examine and consider:

- The frameworks, policies and supports in place to guide the conduct and behaviour of doctors participating in specialty training or responsible for training or supervising specialist trainees
- The extent to which these frameworks, policies and supports are understood and applied by those doctors
- The drivers for when the conduct and behaviour of those doctors is inconsistent with these frameworks and policies
- What could be done to improve the conduct and behaviour of those doctors to improve the overall culture of the hospital; and
- Whether there are cultural factors which exist in relation to doctors where there is a greater likelihood of displaying the behaviours inconsistent with the frameworks and policies.

POWER POINT SLIDE: It is also important to highlight that this Review will not examine or consider:

- conduct and behaviour by staff of Canberra Hospital and Health Services who are not doctors participating in speciality training or responsible for training or supervising specialist training
- findings or judgements regarding the conduct or behaviour of individual doctors
- resolution of allegations, complaints and issues identified as part of the evidence gathering exercise; and
- advocacy at the request of any contributor to the review.

Use of the term culture

[NOTE THERE IS NO SLIDE FOR THIS - READ OUT]

We will use the term culture throughout this focus group. As you would be aware, culture is a widely used term often without specific meaning attached. Our definition of

culture for the purposes of this Review is 'the way we do things around here'. As you are also aware, culture itself is difficult to see; therefore we use evidence of behaviours, structures & processes as indicators of culture. In other words, these are the artefacts of culture which reflect both espoused values of the organisation and basic underlying assumptions.

Conduct of this focus group

The findings of the Review will help inform high level recommendations to improve the overall clinical training culture at Canberra Hospital. The purpose of today's focus group is to seek your input into the review, the scope of which we have just outlined.

We encourage you to share your observations and be open as this will help us better understand the situation from your perspective. We respect the sensitivities associated with cultural reviews so wish to assure you that all steps have been undertaken to ensure your privacy is protected and any comments you make and any feedback, observations or insights you provide during this focus group will not identify you.

Furthermore all written submissions will also be confidential.

Before we commence we would like to highlight that the intent of the focus groups is not to delve into individual experiences but rather to obtain a collective summary identifying recurrent themes. Taking this into account and recognising that there may be situations requiring individual resolution or case management we take this opportunity to remind you that the process to do so is outlined in the Canberra Hospital *Respect at Work* Policy. We have some copies with us here today.

Participation in this focus group is voluntary. This means you do not have to answer any of the questions if you do not want to. If at any time you would like to stop participating that is accepted and respected. The Review is being conducted by KPMG on behalf of ACT Health and is confidential; you will not be named in any reports we write.

Definitions

We are using the definitions identified in the Canberra Hospital *Respect at Work* policy.

- **Reasonable Management Action** – may include but not limited to:
  - setting performance goals and deadlines;
  - equitable allocation of work in accordance with staff capability and level;
  - informing staff of unsatisfactory work performance in a professional and constructive manner; and
  - addressing unacceptable workplace behaviour
- **Work Bullying** – repeated unreasonable behaviour directed towards one or more staff members by one or more staff members. Work bullying does not include reasonable management action taken in a reasonable way

- **Discrimination** – unfair treatment of an individual or group of people because they belong to a particular group of people of because they are associated with a particular characteristic or attribute as defined in discrimination legislation
- **Harassment** - a form of discrimination that is offensive, abusive, belittling or threatening behaviour directed at a person or persons because of a particular characteristic of that person. It can include sexual, disability or racial harassment

In terms of today's focus group we ask you to consider the questions from the perspective of your "home, work cohort". We also ask that when sharing your thoughts you consider what is currently happening and what has occurred in the last 12 months.

Today's focus group will last approximately 1 ½ to 2 hours and will be conducted in 5 parts:

Overview & timing

Welcome & read script	Questions	10 mins
1 **Awareness of and compliance with legislation & policies**	**1, 2, 3**	**15 mins**
2 **Observations of a culture that allows or condones discrimination/ harassment / bullying behaviours**	**4**	**15 mins**
3 **Factors / drivers of a culture which allows discrimination/ harassment / bullying behaviours to occur**	**5-7**	**30mins**
4 **What can be done to shift the culture?**	**8**	**30 mins**
5 **Other feedback**	**9**	**15 mins**

Now we are clear on the purpose and format; we can make a start.

Appendix E - Definitions

Defining work bullying, discrimination and harassment

These definitions are as outlined in the ACT Government Health *Respect at Work – preventing and managing work bullying, discrimination and harassment* Policy:

Work Bullying – repeated unreasonable behaviour directed towards one or more staff members by one or more staff members. Work bullying does not include reasonable management action taken in a reasonable way.

Discrimination – unfair treatment of an individual or group of people because they belong to a particular group of people of because they are associated with a particular characteristic or attribute as defined in discrimination legislation.

Harassment – a form of discrimination that is offensive, abusive, belittling or threatening behaviour directed at a person or persons because of a particular characteristic of that person. It can include sexual, disability or racial harassment.

Defining Reasonable Management Action

This is also as outlined in the ACT Government Health *Respect at Work – preventing and managing work bullying, discrimination and harassment* Policy.

- *Reasonable Management Action* may include but is not limited to:
- Setting performance goals and deadlines
- Equitable allocation of work in accordance with staff capability and level
- Informing staff of unsatisfactory work performance in a professional and constructive manner
- Addressing unacceptable workplace behaviour.

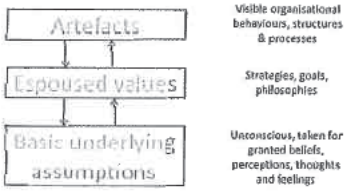
Defining Culture

Focusing on culture as a means to understand and improve workplace harassment and bullying incidents is consistent with findings from the House of Representatives Inquiry into Workplace Bullying which noted that '*It became clear from early on in the inquiry that workplace culture was a key determinant of whether bullying would occur and for how long it would be sustained*'[27]

Therefore it is important to define the term 'culture' as used in this report. The Review has adopted Edgar Schein's[28] well established definition of culture as a '*pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and*

[27] House of Representatives Inquiry into Workplace Bullying (2012) as referred to in Background Briefing, Expert Advisory Group to Royal Australasian College of Surgeons (2015)
[28] Edgar Schein (1992) Organisational Culture and Leadership

feel in relation to those problems'. In simple terms, culture is 'the way we do things around here' which has built up over time and is reinforced by people operating in that culture. Schein also articulates the three inter-related elements of culture which are shown in the figure below.



Three inter-related elements of organisational culture

Focus group participants and written submission respondents were informed of this definition.

Defined internal stakeholders

TCH & HS identified the following categories of the internal stakeholders:

- TCH & HS Executive, including Clinical Directors;
- Staff specialists (including senior staff specialists) and Visiting Medical Officers (VMOs); and
- Registrars in accredited training positions.

Appendix F - Written submission template

Survey: Canberra Hospital Training Culture Review

The Canberra Hospital
External Review of Specialist Training Culture Written Submission

Thank you for taking the time to contribute a written submission for the Review of the Clinical Training Culture at The Canberra Hospital (the Review). ACT Health has commissioned KPMG to conduct the Review.

Scope of the Review

A range of issues have been identified in relation to structure, governance, leadership, the interpersonal relationships and behaviours of doctors at Canberra Hospital and Health Services. Consequently, ACT Health has outlined the scope of the Review to examine and consider:

- The frameworks, policies and supports in place to guide the conduct and behaviour of doctors participating in specialty training or responsible for training or supervising specialist trainees
- The extent to which these frameworks, policies and supports are understood and applied by those doctors
- The drivers for when the conduct and behaviour of those doctors is inconsistent with these frameworks and policies
- What could be done to improve the conduct and behaviour of those doctors to improve the overall culture of the hospital; and
- Whether there are cultural factors which exist in relation to doctors where there is a greater likelihood of displaying the behaviours inconsistent with the frameworks and policies.

The Review will not examine or consider:

- Conduct and behaviour by staff of Canberra Hospital and Health Services who are not doctors participating in specialty training or responsible for training or supervising specialist training
- Findings or judgements regarding the conduct or behaviour of individual doctors
- Acting to resolve allegations, complaints and issues identified as part of the evidence gathering exercise; and
- Advocacy at the request of any contributor to the review

This form has been provided to enable you to provide a written submission for consideration in the Review, should you wish to do so. All submissions are confidential and will be reported in aggregate . We have provided a structured format for your submission in order to achieve consistency in the types of information received from all respondents and to ensure that the scope of the review is clear to those making a submission. We encourage you to complete all elements of the submission however this is not a requirement. You can make a submission using any or all of the fields provided including the free text field at the end of the submission form.

We request that when formulating your responses you consider the questions from the perspective of your home cohort (refer to you response to Question A). We also ask that your responses reflect what is currently happening and what has occurred in the last 12 months.

Please provide your submissions by **6pm Tuesday 14 July 2015.**

If you have any queries regarding this submission, please contact Suzanne Badalich at KPMG on mobile 0429193545 or email sbadalich@kpmg.com.au

By clicking on the Next button below you acknowledge that you have read and understood all of the information detailed in this notification, and agree to provide the submission.