THE QUARTERLY

A Better Culture

Q2 2023

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The College was founded in 1967 as the Australian College of Medical Administrators and attained its Royal prefix in 1979. In August 1998, when links with New Zealand were formally established, the College changed its name to The Royal Australasian College of Medical Administrators.

RACMA is a specialist medical college that provides education, training, knowledge, and advice in medical management. Recognised by the Australian and New Zealand Medical Councils, it delivers programs to medical managers and other medical practitioners who are training for or occupying specialist leadership or administration positions. It is the only recognised way you can become a Fellow in the speciality of Medical Administration.

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From the President

In late 2022, the Commonwealth approached RACMA to undertake a project to start addressing the Culture of medicine. By 2023, the project had commenced, and has now become known as "A Better Culture".

All of us who have proceeded through medical training have been aware to varying degrees, for generations, of issues of bullying, racism, discrimination, harassment and sexual harassment in medicine. For generations, we have held the belief that the next generation would do better, would be better, but decades have passed without the issues improving very much at all.

Then came graduate medical education, and the hope was that people who had life experience, who had worked in other industries, with other norms, would be more able to call out and protect themselves from harmful workplace behaviours. This materialised to some small degree but has not produced the seismic shift that is needed- the annual medical training survey continues to report unacceptable levels of harmful workplace behaviours.

RACMA Fellows and Associate Fellows have a particular responsibility and opportunity in this journey. IF we are indeed the leaders that we position ourselves to be, we must be willing to examine our own practices, to identify levers that we have failed to pull, and to honestly reflect when courage was needed, but lacking. There are system issues that have prevented us from definitively solving every issue, but there are also things that are within our individual and collective remit that we have not done.

I am very pleased to have received the first report to come out of A Better Culture – qualitative analysis conducted by the Nous Group, based on interviews with 20 Fellows and Associate Fellows with senior and extensive health leadership experience. The report is the project's first window into the experiences, challenges, wisdom and beliefs of senior medical leaders, and I encourage you to read it in full by clicking here. It gives some actionable items that could be implemented in workplaces in very short order, and others that will require long term, strategic thinking to fully embed.

In counterpoint to that report, which gives voice to those who are or have been the conventional leaders of healthcare, this edition of the Quarterly gives voice to a range of the members of the newly formed Reference Groups of A Better Culture. Reference group members were invited to write a short piece of their experiences, their hopes, their reasons for becoming involved (testimonials start on page 11). They are a diverse group, who have shared with us their experiences – and we should listen.

These short pieces, in varying style and approach, paint a picture that needs to be changed. Some of the stories are confronting to read, some will make you uncomfortable. The material is published uncensored and unedited, except for changes to protect anonymity were requested. Many of the authors have chosen to be anonymous, some have consented to be identified. They are a diverse and energetic group.

The perspectives presented in the Nous Group report vary in some parts from the perspectives of the authors of the articles in this edition of the Quarterly. That is to be expected. Rarely does any one group hold the totality of truth. I would encourage you to read them as partner volumes – a perspective from leadership, and perspectives from every stage on the career ladder – even from a medical student. IF a piece elicits a strong emotional response from you (positive or negative) – it is an opportunity to reflect and better understand our own biases – and we all have biases.

I am enormously proud that the Commonwealth has entrusted RACMA to establish, support and Host A Better Culture, and I encourage all Fellows and Candidates to become active agents for change as the project evolves. To promote the ongoing work of the project a website has been developed abetterculture.org.au and I encourage you all to visit the website to stay up to date.

I thank the RACMA Fellows and Associate Fellows who volunteered their time to participate in the Nous Group study and those who have already volunteered to participate in Reference Groups. I particularly thank the authors of the 23 short pieces contained in the pages of this Edition of the Quarterly. Working together, with focus and resolve, A Better Culture really is within reach.

And given A Better Culture was developed in response to the annual Australian Medical Training Survey (MTS) results showing disturbingly high rates of bullying, harassment, racism and discrimination across the healthcare sector, it is pertinent to remind our Candidates the 2023 MTS has opened. I encourage all our Candidates to participate in this year's MTS to share their views on the workplace environment in terms of culture and wellbeing, as well as education and training experiences. It is imperative you complete the survey to ensure data can be generated and used to drive change we need and support positive culture in our sector. The survey link is at the end of the medical registration renewal process.

It is also timely to remind Members of our partnership with the Royal Australasian College of Surgeons (RACS) to make the Operating with Respect (OWR) online learning module available to College members. Fellows, Associate Fellows and Affiliate Members can access the material through the Members Hub – Online Learning Materials on the RACMA website, while Candidates can access the module through Canvas in the 2023 Fellowship Training Program.

The module was developed by RACS to improve our knowledge and understanding of unacceptable behaviours, enabling us to recognise when they occur and the adverse impact they have on individuals, team performance and patient safety. The OWR module is a valuable educational activity, which contains video scenarios and reflective questions. Fellows and Associate Fellows who complete this module can claim 1 CPD hour for this activity under the Educational Activities Standard.

Finally, I would like to take this opportunity to remind Members RACMA 2023 in Auckland is fast approaching. Under the theme Leadership in Action, the Conference Committee have organised many high calibre speakers, including Lord Nigel Crisp, Member of the House of Lords of the United Kingdom, New Zealand Health and Disability Commissioner Morag McDowell and New Zealand Ministry of Health Director-General and Chief Executive Dr Diana Sarfati. There are also some great workshops before the Conference to take advantage of which will cover Restorative Health Systems, A Better Culture, Advancing Women in Leadership and RACMA and the Rural Medical Workforce Crisis. Register now at racmaconference.com.au/2023-registration.

As always, if you have any ideas or feedback about the future direction of the College and its work, please email me president@racma.edu.au

Dr Helen Parsons CSC
President

CPD Update

The changes to the College's CPD requirements have now been in place for more than a year in Aotearoa New Zealand and more than six months in Australia. Feedback from Members has been encouraging with many having already met their yearly requirements.

The Medical Board of Australia and Medical Council of New Zealand have enhanced the requirements for registration as a medical specialist, so that CPD activities will now be more closely related to a doctor's real-life work experience and require a reflection on their medical practice and its outcomes.

A reminder for Fellows the specific requirements for registration are 50 hours of CPD activities including:

1. A Professional Development Plan
2. An Annual Conversation with a peer, colleague or employer
3. A mixture of activities in the following three categories:
   - Category 1: Reviewing Performance
   - Category 2: Measuring Outcomes
   - Category 3: Educational Activities

A reminder for Associate Fellows that while they do not need to meet the CPD requirements for specialist registration, the College constitution requires them to undertake a modified CPD program to maintain their membership of the College. This has been slightly modified from previous years and requires 20 hours of CPD activities relevant to the College competencies including a Professional Development Plan (with a maximum credit of five hours).

Support is available through the CPD landing page on the RACMA website. You can also email the friendly team in the College office at cpd@racma.edu.au or contact your jurisdictional CPD coordinator:

- Aotearoa New Zealand — Dr Dilky Rasiah
- Australian Capital Territory — Dr Kate Tindall
- New South Wales — Associate Professor Peter Thomas
- Queensland/Northern Territory — Dr Thuy Pham
- South Australia — Dr Krish Sundararajan
- Tasmania — Dr Allison Turnock
- Victoria — Dr Ian Graham
- Western Australia — Dr Ranjit Paul

2022 Certificates

Members are reminded CPD compliance certificates for 2022 are now available for download from the MyRACMA platform. For instructions on how to download your certificate please click here.

Those Members who are not yet compliant may still finalise their 2022 CPD activities by contacting the College office at cpd@racma.edu.au. The College would like to remind Members who do not finalise their 2022 CPD program within the next few weeks, their membership may be cancelled.

Upcoming College CPD Activities

2023 Monthly Webinar Program

Members are reminded to keep an eye out for email reminders with Zoom details and information for the remaining webinars for 2023.

Wednesday 27 September 12:30 - 1:30pm AEST
Dr Anne Duggan, CEO Australian Commission on Safety and Quality in Health Care
Topic: Complaints Management

Wednesday 25 October 12:30 - 1:30pm AEDT
Dr Paul W. Long, Founding Director Centre for Health Leadership
Topic: Disseminating research into medical engagement in hospitals in Australia

Wednesday 29 November 12:30 - 1:30pm AEDT
Dr Jennifer Alexander MCom MB BS MHP FRACMA FAFPHM (RACP) FAICD
Topic: Disability Royal Commission

2023 Short Course Program

This year's program is coming to an end in September. The remaining courses, which are being offered online, focus on coaching skills and will be delivered by Mark Bramwell. For more information visit www.racma.edu.au/members-hub/cpd/2023-cpd-short-courses/

RACMA 2023

Members who attend the College Conference will be credited for 12 hours educational activity. There are also a number of workshops before the conference which will also help fulfill CPD requirements. The workshops are:

- An Introduction to Restorative Health Systems — Wednesday 11 October, 10:30am - 3:30pm Cost: $375 per person (5 CPD hours)
- RACMA and the Rural Medical Workforce Crisis — Wednesday 11 October, 12:30pm – 2:00pm. No charge.
- Advancing Women in Leadership —Wednesday 11 October, 2:30pm – 4:00pm. No charge.

If you haven't yet registered, visit www.racmaconference.com.au

Professional Development Plan (PDP) — The Key to Your CPD

Your annual PDP is the cornerstone of your continuing professional development. It is a mandatory requirement for RACMA CPD compliance, MCNZ recertification, and MBA registration.

Creating a PDP at the beginning of the CPD cycle serves as a guide to stimulate targeted learning and professional development over the next 12 months. The process requires some reflection, and the college expects that it may take up to 5 hours to complete the document. The PDP should be a 'road map' guiding the selection of relevant activities. Having a PDP ensures that your CPD is focused on the activities that will provide the most benefit to you, based on your identified development needs. The PDP is most effective when it incorporates specific goals that are achievable, of high benefit and appropriate to your work setting.

Developing a PDP begins with a reflection on all the facets of your practice as a medical administrator, including your strengths, weaknesses, and particular interests. From this reflection, you can construct a plan of proposed activities which is targeted at enhancing your abilities, addressing issues, and taking advantage of opportunities for practice improvement. The plan includes your expected outcomes from each activity and how these achievements will be measured. It is not mandatory for PDPs to be discussed or reviewed within a peer group; however, many Members find input from colleagues helpful in refining their plans. A structured conversation with a peer, colleague, or employer is also a mandatory component of your CPD program and reflections on this conversation may help inform the formation and ongoing maintenance of your PDP.

The PDP is a dynamic document which should be reviewed throughout the year, to reappraise your progress and record successes and disappointments. These reviews may result in the PDP being revised to accommodate your changing learning requirements and outcomes. The PDP is not finalised until the end of the CPD cycle when a final review allows you to reflect on your progress and help develop your PDP for the next year.

Evidence that you have created a PDP must be documented in your MyRACMA portfolio. You may use the RACMA template, which is also downloadable within MyRACMA and on the College website.

The 2023 Continuing Professional Development Short Course Program Finishing Soon!

Build more robust coaching skills with the remaining two online short courses for 2023, delivered by Mark Bramwell.

For more information visit the RACMA website.

If you have any questions or for more information, please email us at cpd@racma.edu.au

REGISTER NOW

A Better Culture

CEO Update

Dr Jillann Farmer
Chief Executive Officer

In December 2022 I accepted a role to lead a project being initiated by RACMA that has been branded as "A Better Culture". The project was launched as a response to the medical training survey which showed that reported rates of bullying, harassment, racism and discrimination (BHRD) were disturbingly high, with a disproportionately worse experience of first nations trainees.

The Survey is conducted each year at the time of registration renewal.

The headline results that prompted the setting up of this project are below (previously published in The Quarterly's last edition).

- 30% of prevocational or specialist trainee doctors witnessed bullying, harassment, racism, or discrimination in the workplace in the 12 months preceding the survey. For RACMA Candidates this percentage was 36%.
- 22% of the general population and 24% of RACMA Candidates reported experiencing it themselves.
- The combined overall total of those who experienced or witnessed these adverse behaviours was 34% in the overall survey group.

The rates were lower for Trainees in General Practice, with 19% witnessing bad behaviour and 16% experiencing it.

For non-GP specialties, 34% had experienced these behaviours and 23% had witnessed it.

Breakdown by category

Bullying – 12% experienced, 21% witnessed (RACMA 16%, 24%)

Harassment – 8% experienced, 13% witnessed (RACMA 13%, 17%)

Discrimination – 9% experienced, 13% witnessed (RACMA 8%, 15%)

Racism – 6% experienced, 13% witnessed (RACMA 3%, 14%)

Racism

If we look at the data from the 191 respondents who identified as Aboriginal or Torres Strait Islanders, there are some confronting differences.

20% of Aboriginal and Torres Strait Islander colleagues have directly experienced racism in the workplace. 30% of them have witnessed it.

That compares with 6% experiencing racism and 13% witnessing racism for non-Aboriginal and Torres Strait Islander respondents.

Why does this matter?

At its most basic, of course it matters that doctors are experiencing personal harm in the workplace. Even more compelling is evidence that this in turn harms patients.

"Disrespect is a threat to patient safety because it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practice". Leape L et al Academic Medicine, Vol. 87, No. 7 / July 2012.

Poor workplace culture is a **patient safety risk** –

- Reduced likelihood of speaking up about concerns
- Reduced likelihood of asking for help
- Reduced likelihood of openly discussing errors
- Increased cognitive load
- Reduced problem-solving capacity.

How are we going to fix this? With a funded duration of just 2 years from January 2023, it would be naive to believe we could fix it in that time frame. In fact, the project has 2 deliverables in this first phase. They are:

1. An engagement approach
2. A tangible and achievable plan for change.

This comes with considerable risk that it becomes just another glossy plan that gets put in the drawer and forgotten. We need to generate a compelling case for change and a groundswell of support so that the complex and gargantuan task of system wide reform can happen.

What do I hope for from A Better Culture?

I have some of my own ideas, but it isn't mine to define. I will be retired within the decade, and the future of healthcare will lie in the hands of those who are right now at the beginning of their careers.

I hope for generational change. I hope for intersectional equity to permeate the way we work, how we interact with one another and how we shape the future of healthcare. This is going to require a paradigm shift, willing to relinquish those parts of the old culture of healthcare that are no longer serving us well, but careful to retain those things that have a value proposition moving forward.

My hope is that we can create a clear and compelling vision of a possible future, and a roadmap for how we can collectively get there. It won't be easy. We can expect pushback from those who benefit from the current culture, or who struggle to share the vision of what could be better. Change is hard, even if you want the change.

A Better Culture is setting up a place where those who are the future can be supported by those of us who are willing to relinquish the past, and move together and purposefully forward to the healthcare system we aspire to.

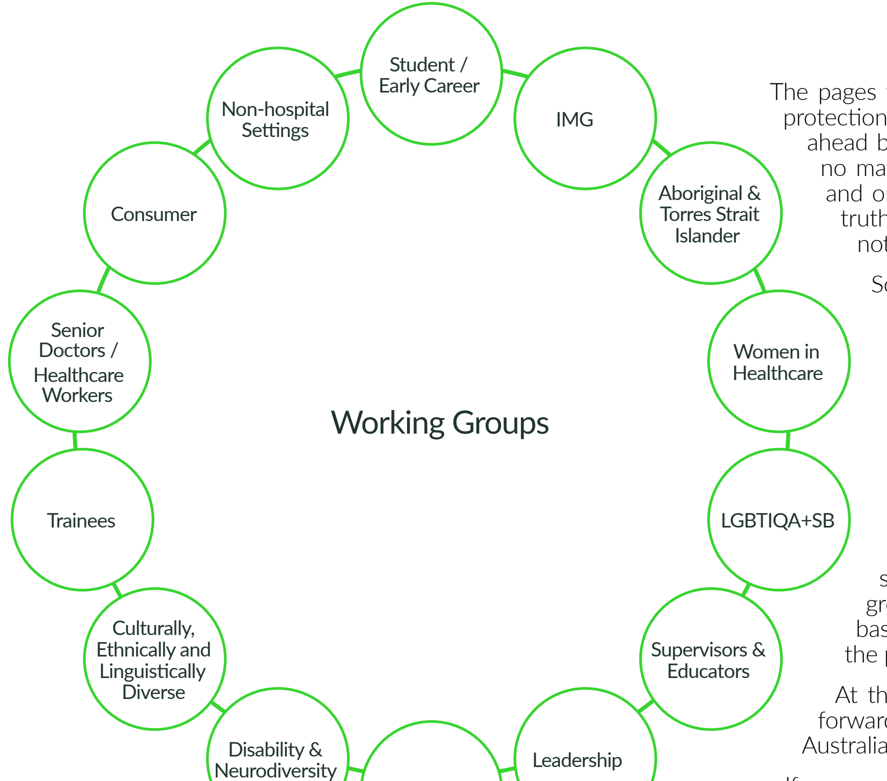
We have just 18 months to create this vision with sufficient clarity that it will attract resourcing for ongoing implementation.

How will we get there?

The project's structure is designed to give voice to those who are not the usual leaders and power brokers in the system. It is designed to leverage communications technology, informal and formal channels of communication, and flexible ways of working together.

Reference groups have been established and will evolve over the course of the project. We expect that the reference groups will have moving membership and we have structured things to facilitate flexibility and maximise participation. The reference groups will be the "brains trust" of lived experience and practical allyship to keep the project grounded in what is real, what actually matters, and what can help move us to A Better Culture. We have had requests for other reference groups, and these are being considered at present.

The first task we gave the reference group members was to pen a short piece on their experiences or their hopes for a better culture.



The pages that follow contain these contributions, some with the protection of anonymity, and reading them defines the challenge ahead better than I ever could, and inspires me to keep at this no matter how hard it gets. My thanks to the contributors – and one day, may we have a culture where we can all speak truth to power and know it will lead to better outcomes and not fear that we will pay a personal price.

So far we have more than 310 participants in the reference groups. Their next task will be to review the proposed project approach, give frank and fearless feedback on how it could be better, and this will then shape the appointment of the Working groups. Every reference group will have a member who also sits on the Working group to keep communication between the two mechanisms efficient and consistent.

At present, we have proposed 4 working groups reflecting the 4 pillars of the project (Competencies, Training, Framework and Measurement), but this is not set in stone and awaits the input from the reference groups. The working groups will generate the content, based on input from all of the reference groups, to map out the path to a better culture.

At the end of 18 months, we aim to have a clear pathway forward that is adopted by healthcare systems and workers Australia wide.

If you would like to be part of this journey, EOIs for the reference groups remain open. I hope you will join us to build A Better Culture.

From the Chair

Ms Helen Szoke AO
Advisory Board Chair

I was honoured and keen to take on the role of A Better Culture Advisory Board Chair. Our health system is such a critical and necessary part of our lives in Australia, and this means to get the best results, we need to ensure that as a workplace, it is safe, effective and productive. For all of us who have worked within the sector or with the sector, we know this is a work in progress. Professor Jillann Farmer has outlined what A Better Culture hopes to achieve. There are many people who have worked on addressing bullying, harassment, discrimination – either within the hospital sector, with the medical colleges and also through the peak bodies for nursing and allied health. We all know this is a continuous improvement project which is critical to the future of our health sector.

A Better Culture will outline a pathway, and hopefully one that will be informed by the input of clinical practitioners along the way. We need to ensure at the end of this funded project that there is a compelling case to continue the work of engagement and action. We hope to build on the work that has already been undertaken by Medical colleges to further extend an understanding, not only of the harm of discrimination, bullying and harassment, but also the improvements that can achieved in a health sector where it is safe to report, where interventions are made to prevent and all people can participate productively

Improve Efficiencies and Reduce Wastage

Male Consultant, 10 Years Post-Fellowship, International Medical Graduate

Working in the Australian medical system as an IMG, both at a registrar level and consultant level gives a good insight to the workings of a medical service which works well but seems to be getting more and more stretched.

I have worked in a few systems around the world and appreciate the quality of medical service that is available in Australia for people, without incurring a financial burden. In fact, one of the best parts of the Australian medical system is that the public system is doing an excellent job with best quality care for everyone.

On the other hand, having worked in resource limited settings the amount of "wastage" that occurs in our system is disappointing to see. I believe that even though we should treat people without worrying about costs, there needs to be thinking about inefficiencies and wastage, in terms of disposables, resources, time and manpower. Knowing that there is definitely a better way to do things, I am keen to see it improve in our system in Australia. This will help our environment and hopefully give more efficient and appropriate services to our community and save money too.

The advantage in our current system is that we have a willing group of skilled individuals who are also concerned with inefficiencies and wastage. There are many people with varied experiences from Australia and around the world who have ideas to improve services.

The problem, as it is everywhere, is that change is difficult and slow in a big system.

Utilising ideas from people with varied experiences from all around the world would be helpful to achieve this aim. I would think the focus for the coming years would be to improve efficiencies and reduce wastage without affecting outcomes.

Systems that Care

Female Emergency Medicine Specialist >20years

Being ill or injured and having to go to hospital is a terrifying experience for most people. Sometimes, this is the worst day of a person's life. Patient-centered and family-centered care is when we, as practitioners, contemplate more than medical problems and standard treatment guidelines. It is when we consider the unique context for each person we treat and allow space for everything they bring into the healthcare relationship.

I like to imagine working in a hospital and health system where this patient-centered focus impacts on more than just the treatment regimes we craft for each person, but rather translates through to every process we follow and into every conversation we have. Hospitals are big bureaucracies governed by inflexible and system-centric documents that do not always speak to the practitioner-patient interface. What would policies look like if their primary purpose was to support staff to consider:

- *What does the patient need most from me now?*
- *How do I make this easier for the patient?*
- *How can I best support my colleague to provide the care each patient deserves?*

I am sorry to say that from where I sit, the whole system is very broken right now. As healthcare providers, we all have more going on than we have capacity to deal with. I get that. However, every time we limit down, just do our required bit and keep our very necessary blinkers on to the screaming need around us, we are adding to the problem. We continue to perpetuate the complex, fractured system that patients need to negotiate, and we erode the reasons we became health professionals — because we care and because we want to help.

Patients and health workers need systems that care, and systems that care always put patients first.

My Ideal Workplace

JK ~ Lesbian of South Asian Origin, Female PGY6

I remember a workplace where I felt included. It was a place where I was seen as a diverse collection of identities rather than monolithic.

I am a woman of south Asian origin, an immigrant, a lesbian, a survivor of burns and survivor of emotional abuse in a same sex relationship.

In my ideal workplace it is not assumed that I am heterosexual because I do not fit what is assumed to be the 'typical look' of a lesbian. It is realized that diversity exists in many forms and that lesbians and queer women belong to all races, ethnic backgrounds, cultural and religious identities. The staff around me celebrate LGBT pride as much as they do Harmony Day. There is no assumption that I have a male partner because I am of an ethnic minority. The staff in my workplace have received LGBT sensitivity training and are aware of basic differences between sexual orientation and gender identity. They have a balanced view of LGBT health, knowing what health issues are common but also realizing the strength and resilience of LGBT people.

They respect my sexual orientation and assume my life is no different from theirs. Like cultural festivals are celebrated in the workplace, days important to me like "international day against homophobia" and "wear it purple day" are recognized. No one blinks at displays of rainbow emblems and flags as it is seen as part and parcel of being in an inclusive environment. My colleagues ask me about my personal life in the same way they would for a straight colleague. They show an interest in my life and are not hesitant to ask questions for clarification.

In my ideal world, this would be the environment that would help me transition to **thrive** from survive.

Three Brief Insights

Natalie Burch ~ Female Consultant, Rural Generalist and Medical Educator

1. **Community of Practice of Learners**

I sold my failing rural medical practice to a corporate 4 years ago, hoping that with their greater resources and branding, they would solve our workforce crisis.

This failed to eventuate for many reasons.

I was left as the only fully qualified VR doctor in what should be a 7-doctor practice.

We did, however, have an excellent reputation as a teaching practice. So, we left the corporates to continue their focus on recruitment and locums while we built a practice based on learners. I managed a cohort of learners including students, interns, RMOs, registrars and IMGs. To do this, I had no patient load of my own but still plenty of patient contact as most require me to see every patient with them. Having lived and worked in that town for 20 years, I knew most of the patients and so they got the best of both worlds. They had a thorough and diligent doctor with a large amount of time and an experienced consultant GP who knew them and their community well.

We developed a community of practice for education, work culture and personal connections, all thriving within the group. Learners selected and delivered much of the formal education with my role mainly providing structure, experience, and support. Naturally, they also supported and taught each other.

Individual meetings were scheduled to ensure that each person had an opportunity to speak about issues important to them. I also orchestrated workflow to make sure anyone flagging received help and issues were dealt with promptly. All of this was made possible because I did not have my own patient load and had the time and mental space to oversee this group of learners.

2. **GP as a Consultant**

On setting up a novel GP supervision model I had an epiphany.

In most medical careers, you start life as a junior doctor who carries out the coal face jobs taking histories, writing notes, organising tests, etc. Then, as a registrar, you take on more responsibility, decision making, team management and you are the powerhouse of the team. Once Fellowed, the consultant is more about bigger picture work - leadership, research, implementing policy, best practice and teaching. They do much less of the coal face work.

However, a GP does exactly the same job from the day they set foot in a practice - which may even be as an intern - to the day they retire. Obviously, they do this with more efficiency and skill than the intern. Don't get me wrong, these tasks are critical but after 20 years they become tiresome.

Many GPs will spice up their work with skin clinics, work at the local Uni, etc. However, such decisions are self-directed and are not inherent in the GP career progression as it is for other specialties. Much of our work could not only be done by interns, but done better, which, as with all other disciplines, would leave the consultant to provide experience, expertise, knowledge and wisdom. Everyone benefits from this. Patients get a diligent and thorough junior doctor for a good amount of time. Junior doctors get good experience and expert support. Consultant GPs get to move forward with their careers and are rewarded for their years of experience, no longer having to do the coal face jobs.

General Practice is becoming more and more complex with less reward (financially and otherwise). We need to rethink the way our career as consultant GPs are structured before we die out altogether.

3. **Meetings are Brutal Places**

They are driven, fast paced, agenda-ed within an inch of their lives.

They don't achieve their ends or at least the ends of the majority of attendees. The only blessing is that the majority are on virtual platforms now which leaves participants who are being ignored, talked at, or belittled, to continue on with their actual work - that which actually produces something - or at the very least, to soothe their distress with a computer game while looking very attentive.

I am an introvert. I think slowly but deeply. It takes time to form my ideas. If I have the space to do so, my comments and ideas are generally useful. But in most of the meetings the only thing achieved is a good score in my phone sudoku.

I am not alone. There are many people for whom meetings are not only a waste of time but are brutal, damaging and demoralising. And you will never know it because even if you ask, you don't give me time to think, or speak, or feel safe to answer.

Please change the way you meet.

Don't assume you know what will work for people. Ask them. Then, shut up and listen to their answers.

Why ask or demand people attend a meeting then proceed to ignore them, their ideas and their work? It makes no sense.

Next meeting, send out the invite to only those who want to come, who enjoy the meetings in the current format, and feel that they are productive and enjoyable. If everyone turns up, either they are too scared to refuse, or you have an excellent meeting.

What is a Better Culture in the Workplace?

Kim Hansen ~ Female Consultant, 15 Years Post Fellowship, PGY 24

Picture this: You're working hard, putting in long hours to serve your patients and improve their care, both at the bedside and behind the scenes. But instead of getting the support and encouragement you deserve, your bosses are giving you the cold shoulder, undermining your efforts, and making you doubt your aspirations. A bad culture is like a bad dream - leaders who don't want you to spread your wings and soar high. They may even discourage you from applying for leadership roles, telling you to focus on other things, like 'the children'. Family is important, but we can be great parents and ambitious professionals too.

Now, let's envision a good culture, one that fosters growth and empowers clinicians. Here, leaders are like our biggest cheerleaders, genuinely interested in our aspirations. They actively seek out conversations with us, wanting to know where we see ourselves in the future. "Hey, tell me what you're passionate about and let's figure out how to make it happen," they say.

In a good culture, opportunities are not scarce commodities guarded by a select few; they are a buffet spread waiting for us to dig in. Our leaders don't just hoard the best roles for themselves or their favourites; they actively create chances for everyone. "Come on, let's grab a coffee and discuss the upcoming opportunities," they'd say. "You'd be great for that role. Go for it!"

In such an environment, we feel valued, appreciated, and motivated to be our best selves. It's like being part of a winning team where everyone's strengths are celebrated, and the whole organisation thrives as a result. Patients get better care and doctors feel motivated by the better culture. We deserve leaders who lift us up, not tear us down. Let's create cultures where success is celebrated and opportunities are for all. Together, we can build a workplace that nurtures dreams and empowers each and every one of us to be the best doctors we can be.

Once Upon a Time...

Female Consultant > 20 Years' Mental Health Experience

In a small town, there lived a doctor named Dr Emily Thompson. She was known for her compassion and dedication to her patients, always going above and beyond to provide the best care possible. However, one fateful day, her world came crashing down.

Dr Thompson received a call that would forever change her life. Her father had been involved in a tragic accident and had passed away under the most traumatic and awful circumstances. The shock and devastation were overwhelming, leaving her without any closure. It felt as if her entire world had collapsed around her.

Despite her own immense grief, Dr Thompson knew she had an obligation to her patients. She returned to work, but her heart felt fragile and afraid. Symptoms of trauma and post-traumatic stress disorder haunted her every day. Depression and scattered thoughts made it difficult for her to focus on her patients, whom she desperately wanted to help.

To her surprise, Dr Thompson found solace in the most unexpected places. Her clients, sensing her pain, showed incredible empathy and understanding. They offered kind words and gestures, reminding her that she was not alone in her suffering. It was through their shared experiences of loss and grief that she began to heal.

Not only were her clients supportive, but her colleagues also stepped up to offer help and support wherever they could. They recognized her vulnerability and provided a safe space for her to express her emotions. Even her bosses, understanding the magnitude of her loss, allowed her to take an extended leave to grieve properly.

The additional help and support Dr Thompson received became a lifeline for her recovery. It allowed her to acknowledge her own pain and be more open with others. She realized that vulnerability and connection were powerful tools in healing not just herself, but also her patients.

As Dr Thompson's journey of healing unfolded, she couldn't help but marvel at the goodness and compassion of people. She discovered that given the chance, individuals were eager to offer help and support, even in the most challenging times. This newfound understanding transformed her perspective, not just as a doctor, but also as a human being.

Dr Thompson's story touched the hearts of many healthcare leaders and health ministers across the country. It reminded them of the importance of empathy and support within the medical profession. Her story became a driving force for change, inspiring leaders to prioritize the mental well-being of healthcare professionals and foster a culture of compassion and understanding.

In the end, Dr Thompson's personal tragedy transformed her into a beacon of hope for others. Through her own healing journey, she found strength and resilience, spreading a message of empathy and support that resonated far beyond the walls of her small town.

My Australian Nursing Career

Letitia Lewandowski, Registered Nurse, RIPRN, RAN

Il am an American trained nurse and have been working primarily in rural emergency departments for the past 12 years. I have had a few days with good staff to know what works well. A brilliant day for me borders on chaos in the Emergency Department with staff who work in harmony, completing each other's tasks without verbal communication, all the while giving good patient care (with smiles on their face). No matter how challenging a day is, if you have staff who work in union with positive attitudes, it is a good day.

Unfortunately, my Australian nursing career started with me sporting my favourite stethoscope and within the first minute of my first day of work, I was asked "what do you think you are, a doctor?!". Sadly, I turned around and put my stethoscope in the locker.

The first four years were filled with hardcore bullying from my co-workers and management. More recently, I was working in an environment where bullying was not only known but accepted by management. One staff member going as far as saying, through tears, "this place has broken me."

It seems like we go to great lengths to make policies and procedures to combat bullying, but their efficacy doesn't reach beyond the computer screen. While I have had a good manager and good days, I have found the norm in my Australian nursing career to be filled with oppressive and belittling behaviour from many of my colleagues and mangers. I feel like this needs to change.

Create Better Workforce Transition for OTDs

Leonard Goh ~ Male PGY5, Malaysian OTD

I am an overseas trained doctor (OTD) who hails from Sarawak, Malaysia. Having recently arrived in Perth in March 2023, I am happy (and frankly relieved) that the working culture in my current workplace is a major improvement from the work environment I have left behind. The adjectives of "overworked", "understaffed", and "underpaid" have now been mostly replaced by "adequate work-life balance" and "fair remuneration" when updating family and friends back home about my work.

Nevertheless, the Hospital Health Check 2023 report by the Australian Medical Association (Western Australia)'s Doctors in Training (DiT) Practice Group remains concerning[1]. Staffing shortages persist, with knock-on impacts on rostering, access to leave, and ultimately levels of burnout. Notably, 1 in 2 respondents from the Child and Adolescent Health Service report feeling burnt out. A whopping 31% of Western Australian DiTs also reported experiencing bullying and harassment.

This is where I feel OTDs such as myself have a lot to offer and contribute. More can and should be done to facilitate OTDs' entry into the Australian (especially Western Australian) healthcare system to bolster the workforce numbers. With sufficient manpower, incidence of work-related stress and burnout can be minimised, and we may potentially see a reduction in bullying and harassment too[2].

Structural bottlenecks that constrain an OTD's ability to contribute to the ecosystem should also be resolved. For example, between the limited availability of Australian Medical Council Clinical Examination dates and scarcity of Workplace-Based Assessment positions, OTDs on the Standard Pathway towards general registration have a difficult time progressing in their careers. This translates to delayed attainment of general registration and consequently an involuntary delayed entry into specialist training programmes, representing a loss in capacity building.

I look forward to further discussions to seamlessly transition OTDs into the workforce, to support A Better Culture for all.

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Moral Injury

Female Consultant Psychiatrist, Three Years Post-Fellowship

For some time now, I have been trying to understand the impact that nearly two years of bullying by my line manager has had on me. Burnout doesn't quite explain my experience; besides, it is neither a lack of resilience nor incompetence that is the cause for it. Although it feels like Post-Traumatic Stress Disorder, the most appropriate name for my experience is Moral Injury, which has resulted from workplace bullying in the form of gaslighting, manipulation, intimidation, threats (verbal and written), sabotage and exclusion.

I joined this organisation because I genuinely believed them when the person who hired me told me that they were looking for culture change! Interestingly, this person left within weeks of me joining. I quickly realised that this was an organisation that flaunts its values publicly, but where shadow values drive the business of healthcare. A toxic work culture, where bullying is normalised and, unfortunately, when the matter is escalated, no one cares to check in on you — not HR and not the line manager's line manager.

I am a quiet, petite, coloured female who is competent, confident, and well aware of how good I am at my job. I build relationships and command respect. I am not afraid to call out bad behaviours, poor patient management, lack of integrity and bullies – and I will continue to do so no matter where I am! I don't care for or crave fame, positions of power or friends in the workplace. I care about patient-centred care. Unfortunately, these qualities make me an easy target for bullies who feel threatened that their lack of integrity and incompetence will be found out.Fortunately, my spiritual practices have kept me grounded. I am slowly working through my troubles and am in a better place than I was some time ago.

- Not about individual "Resilience and "Wellbeing"
- Not a Doctors Health Program (but if successful will have profound effects on health, resilience and wellbeing)
- Challenge traditional perceived locus of control

- More emphasis on occupational health and safety, especially psychological safety
- More emphasis on drivers, enablers and perpetuators of adverse workplace cultures
- More emphasis on organisational responsibilities
- More emphasis on hard levers
- More collaboration with non-health partners eg Race Discrimination Commissioner, SafeWork Australia, Respect@Work

Surviving a Rotten Culture

Female consultant, 12 years post-fellowship

This is my story, one I at times was unsure I would survive to tell. It is one of bullying and the worst of medical culture, but also of hope, of hidden strength and the power of people to help a friend and colleague facing their lowest point.

My career had been relatively immune from bullying, my sub-specialty one where most people are friendly and decent — we give our time freely and look after each other. I felt safe and happy and had been in my consultant role for a decade. But by the end of pandemic restrictions, my young family needed more of me, and the intense shift-work roster (intended to be temporary years earlier) was becoming unsustainable for them, and for me.

I looked to make changes within my role and workplace, too lacking in confidence to make a move elsewhere. Although seemingly supportive, something then changed in my workplace– decreased flexibility, historical allegations of malpractice and threats turned my request into something much, much more. Something that threatened to derail, and possibly end my career, and in the darkest moments, my life. Having sought changes for the benefit of my children, instead I found myself looking at them as they slept, wondering what their lives would be like without me in it.

I fought hard – to be heard and to be treated fairly, for policies to be adhered to, and for the bullies to be recognized for what they were. I don't think I won in that regard.

Instead, I found the strength to reach out to colleagues elsewhere and a core group of friends, all within the profession (for those outside the hospital system can never really understand) who helped me win in leaving and finding another career within my small subspecialty and city. From a situation that I wouldn't have believed I could survive, I won confidence and self-belief I didn't realize I possessed. Those who helped me through the darkness will forever have my gratitude. My story isn't over yet – I don't know where my changed direction will take me. But the darkness that threatened to engulf it all has ended and my faith in people, although very shaken, has been restored.

Desperate for Change

Female Senior Consultant, 6 Years Post-Fellowship

The word *culture* in the workplace setting can be difficult to define but is often loaded with meaning for the whole team. Our workplace recently underwent an external review and one of the top priorities agreed by all was designated as 'improve workplace culture'. Culture is often seen as 'someone's fault' but, in fact, culture is owned by all of us and the actions, attitudes and behaviours of all of us influence the *feel* of a workplace.

So, what is the problem with our culture? 'A' felt that staff being passive aggressive was the problem. He felt it much better that people just told each other exactly what they thought. 'B' described the problem as being when people like 'A' were so overtly aggressive and couldn't communicate without being offensive. Different craft groups often hold their own quite fixed internal cultures and norms of behaviour that are unacceptable to others (and deeply unpleasant for others within the tribe who have learnt not to complain). A small informal coffee table session on the importance of culture led to discontent as those involved felt they were being directly targeted and labelled as a problem rather than trying to bring them along for the journey.

Unfortunately, it seemed that things were so far beyond a healthy culture that any attempt at change made things worse. Not trying to make change was also seen as a reflection of the poor culture "because clearly no one is interested in this or cares about it". When asked, it was not possible for even small numbers of people to agree on what 'good culture' might look like.

One solution presented was to get a management consultant to help us. Given the massive cost and failure to implement the above-mentioned external review this seemed fairly unpalatable so on we go, all desperate for change and yet stuck in our spiral downwards!

Change Implementation

Simon Tucker BSc MB ChB MRCS FRCEM FACEM AFRACMA ~ Clinical Director Emergency Medicine

During a recent College workshop — the question posed was:

"Which is more important for change implementation – policy development or the culture within an organisation?"

Some of those attending spoke about development of robust and rigid policies to drive change and hold teams accountable for non-compliance. Others spoke about the importance of healthy culture within healthcare.

In truth – both have a role – however, my experience is that effective policies are better developed and adopted in organisations with healthy cultures.

NSW Health promotes the CORE values of Collaboration, Openness, Respect and Empowerment. Hospitals with healthy cultures truly embrace these CORE values. Properly applied, these CORE values:

- Provide the foundations for implementing effective change
- Nurture and promote staff development
- Improve staff satisfaction in the workplace
- Improve retention and recruitment
- Impact positively of staff welfare and wellbeing

Collaboration, Openness and Respect promote harmonious relationships key to developing a healthy workplace culture. Where this exists, effective clinical polices can be agreed to assist with decisions relating to patient care. Where there is a need for change, effective engagement and empowerment of staff to implement change is effective leadership.

A Much-Awaited Better Culture Shift

Female, Advanced Trainee in General Adult Psychiatry

I can't fathom my gratitude for the masterminds of this project, which I am sure will bring a significant shift in our healthcare work culture.

I am an International Medical Graduate who arrived in Australia in 2016 and started working as a Resident Medical Officer in the Australian healthcare system in 2017. I am currently in the Psychiatry Training program. Throughout my years in the system, as a woman in medicine, I have experienced terrible work culture in some units and a few fantastic well-supported teams.

As one supervisor told me after a racist, sexist encounter on my after-hours shift as a Psychiatry Registrar from one of the Emergency department consultants, "We Australians are very parochial". I must agree with him sometimes, but other times I see extreme kindness, compassion, and an inner need to change in the people around me. In my opinion, the parochial dimension of Australians comes from a place of geographical isolation for centuries and possibly peoples' fears or insecurities around acknowledging the mistakes of our older generations, which have caused much grief and trauma in the collective consciousness of Australians. We are terrified of talking about racism, but it happens as racial microaggressions everywhere you go, even in the workplace. Sometimes, the most unexpected person, even a person of colour, will inflict such microaggressions. The hardest part is determining if it is a racial microaggression. Only the person who makes a racial slur or discriminates against others would know the answer. In some ways, we don't need to see the perpetrator's inner world; we must tune into our own emotions to see how the microaggression has affected us, to respond mindfully and possibly shed some light for that person into their own unconscious or partly or fully conscious behavior.

Our Values

1+

Inclusive: We welcome all healthcare workers.

2+

Collective: Multidisciplinary input is required, always.

3+

Positive: We believe change will happen.

4+

Respectful: Only equals can share respect. We are all equals.

A Better Culture Within Reach

Haseeb Riaz, 3rd year medical student (he/him)

In early August, WA held a Healthcare Workforce Summit to address some of the issues around the pipeline for allied health and medical staff. As a student, hearing the conversation about better wellbeing and environments for juniors to train was a true delight.

The archaic perspective that ripples through many medical hierarchies at times of '*this was how things were and that's how it should be for you*' seems to be getting slowly addressed. From commitments to better workplace conditions for juniors around leave and overtime, to a better level of support and wellbeing considerations for junior staff.

I, for one, am starting to become more and more optimistic about A Better Culture within reach in the next generation.

Safe to be Our Imperfect Selves

Dr Emily Harrison, FACRRM ~ Rural Generalist

The culture of medicine revolves around perfectionism, shame, and blame. Despite efforts towards inclusivity, outdated attitudes persist.

We idealize doctors as superhuman, infallible beings devoid of emotions or weakness. This perception begins in medical school and persists throughout training, reinforcing the expectation of perfection. When we encounter traumatic experiences in our careers such as heart-breaking clinical cases and mistreatment from colleagues, the expectation is that we will be tough and suppress our emotions. When mistakes or failure occur, they are met with blame and shame, creating a culture that neglects the emotions, values, and experiences of doctors as humans.

We must acknowledge the profound impact that this culture of perfectionism, shame and blame has on doctors at all levels. Where perfectionism, competition, criticism, and fear of failure are prevalent, imposter syndrome, burnout, depression, and anxiety are common.

We all play a role in the creation of, and maintenance of this culture. Not just as victims but also perpetrators. At times, we will all unintentionally act in ways that contradict our personal values and perpetuate the cycle of shame and perfectionism. We must pause and reflect on our behaviour and consider how we have contributed. In these moments we must resist the temptation to choose comfort over courage. Instead, we can come to terms with our impact and take the essential steps to dismantling and rebuilding for positive change.

Transformation in culture requires us to flatten the hierarchy, embrace complexity, learn from mistakes, and encourage clinical courage. We need to change from a culture that values perfection and imposes high expectations to one that acknowledges doctors are humans too, with a need for connection and support. Understanding that emotions are a natural part of the human experience fostering resilience, thriving and true authentic happiness among clinicians.

Creating a culture of comfort! Where we have a soft place to land when we fall, and we feel safe to be our imperfect selves.

'he tāngata he tāngata he tāngata'

Female Consultant Psychiatrist, Mid-career

My employment with indigenous mental health service is a great privilege but also one that is Taumaha, which in te reo māori translates to work that carries a heavy emotional toll. As such, my experience working within this specialist indigenous mental health space has similarities to being part of a close knit family that operates on a set of cultural values that governs how we treat each other and our patients (whaiora) and that of their whānau (family).

The team was, at times, under-resourced but never short of aroha (love) for other mental health teams, whaiora, and whānau and anyone within the organisation that needed support. Cultural values and the way of being that acknowledge diversity defined how this team welcomes trainees, students and newcomers to the health organisation. It was a welcome to the land and country and a show of support as the host of the land and exercising responsibility of caring for newcomers.

Food was abundant and cups of tea and cakes in the large whare kai (kitchen) was the norm, showing manākitanga. It was a way to fill the near empty emotional tanks of exhausted clinicians. The kitchen was also where clinical work happened, in short a therapeutic space for clinicians' whaiora and their whānau.

The work is heavy and challenging and as clinicians strive to close the health inequity gap, often wearing multiple hats, the desire and motivation to support whaiora and whānau becomes an unwavering commitment. Ultimately, the key principle of this workplace, given the enormity of its responsibility towards its people, is best expressed by the well-known whakataukī, 'he tāngata he tāngata he tāngata (it's the people, it's the people, it's the people). That includes everyone involved in the health care system, creating a unique and very special environment to be in.

Respect

Thomas Drake-Brockman

Let's talk about junior doctors and respect. Medicine is a team endeavour and without respect it cannot function.

Respect cuts many ways in the lives of junior doctors. Respect means that we are offered a reasonable working environment, where we are able to do our jobs safely, work within our abilities, and with appropriate levels of supervision and support. Respect means that we are listened to when we raise issues in the hospitals where we work, and the health services that run them.

Respect for us as real people who have lives outside of the hospital means that we should have timely access to leave, that we should not be expected to work unreasonable hours, or to stay back unrostered on the spur of the moment, and that we should not be contacted out of our working hours.

We are a passionate workforce. We want to care for our patients across Australia in hospitals and the community. But if the culture of our workplaces does not improve, healthcare will continue to hemorrhage junior doctors. Medicine is not, and must not be, the rodeo that it was decades ago. Traditional hierarchies, perverse incentives, well-founded fears of retribution, and the pressure of shortages hold us back, but can't be permitted to continue.

We need healthcare to come into the 21st century with us and realise that we are here to care for our patients, but we cannot do that without respect.

Unveiling Covert Structural Racism: A Moment of Reflection

Dr Soumitra Das, MBBS, MD, FRANZCP ~ Consultant Psychiatrist , EMH/Western Health, Harvester Pvt, Essendon Pvt, Sunshine Pvt

International medical graduates (IMG) arrive with boundless dreams, embarking on a journey that brings significant changes to their lives. Often leaving behind familiar societies with their inherent discontents, they seek an ideal destination where their aspirations can flourish. Their diverse cultural backgrounds have endowed them with the strength to weather life's adversities, fostering resilience in the face of challenges. Despite encountering demeaning behaviour, they possess an admirable level of tolerance. However, they also grapple with fears, questioning the consequences of unfavourable assessments by organizations like AHPRA and the looming uncertainty of visa status.

Criticism, whether logical or not, often strikes deep, as they internalize it, questioning their worth and abilities. A prevailing cultural norm that "the boss is always correct" contributes to this response; a deeply ingrained mindset not easily shed within the first months of their arrival. One may witness an International Medical Graduate (IMG) instinctively rising when a professor enters the classroom, as if on autopilot. But amidst such behaviour, we must ponder, whose responsibility is it to embrace these respectful attitudes and prevent their exploitation within the system? The answer lies with the leaders, managers, and the organizations themselves.

The question arises: do these organizations sufficiently empower their immigrant staff? While sections like "people and culture" in orientation programs aim to familiarize newcomers, they can be rendered ineffective when those tasked with safeguarding their interests instead perpetrate aggression. Ensuring a secure environment hinge on the sensitivity of those in positions of power to recognize and appreciate diverse cultural nuances.

Challenging stereotypes is paramount, including the notion that certain IMG trainees lack the ability to manage certain cases like BPD. It is crucial to understand that individuals from all backgrounds possess unique strengths and knowledge that can contribute positively to the medical field. Engaging in mandatory cultural training for senior medical officers should be embraced not as an affront to one's identity but as an opportunity to foster a more inclusive and empathetic healthcare landscape.

In conclusion, shedding light on covert structural racism necessitates profound reflection and introspection. By acknowledging these challenges and taking proactive steps to address them, we pave the way for a more equitable and supportive environment, fostering the success of international medical graduates and strengthening our collective commitment to a fair and just world.

A Better Culture

Improving Culture in General Practice

Adjunct Professor Karen Price ~ Immediate Past President, RACGP

Improving culture is a critical task of any leadership. My research into General Practice culture and relationships illustrates many levels at which to act. The structural macro, the local practice and the personal. Structurally, medicine is a high stakes profession with increasing intolerance of uncertainty, ambiguity, paradox, or time needed. Indeed, some intolerance of the messiness and complexity of humanity. We know the quadruple aim is important, yet a loss of clinical leadership has resulted in a technocratic prizing of only a quarter of the quadruple aim, being healthcare efficiency. The metrification of healthcare. Relationships take time and yet drive efficiency in teams, in health care worker patient dyads and in culture. Policy is blind to their enabling effect, and it takes good leadership to role model them. Constant measurement has eroded the human and goodwill in the mistaken fetish of performative work.

At a local level, spending social time together with personally selected GP peers fosters relationships of learning. GPs in this case must have a trusted peer to enact this fully. Much can be supported within practices, but there is a need for a practice level investment in facilities to bring back collegial teamwork.

At a personal level, GPs mostly need time away from clinical work to do the reflective cognitive and affective work which is quality improvement.

Only recently I have spoken with a PHN in my region on this. When I was President of the RACGP I put the 'GP clusters' on the strategic plan of the RACGP and I am told they are still there. This is a vision that Scotland have enacted that Denmark do with small groups and is similar to the QI that formed around the divisions of general practice. This is a vision to bring back these local groups of GPs together, much like the previous divisions, to enable collaborative practice, interprofessional co-operation, learning and reflective practices. It enables ground up local innovation depending upon community needs. Led effectively (a critical need) this can assist with QI practices. These days a data hub could form around the cluster much like is done in Sweden. Our technology notably well behind this clinician led need to interrogate and benchmark personal practice with regional data.

This also assists with burnout and emotional exhaustion of an isolated profession which needs to sustain its workforce. Clusters could support QI work, academic work distributive organizational capacity, data collection and supports humanity by enabling the physician experience of healthcare delivery to be a positive and meaningful one.

On a practical implementation level, they would need to take some time to be enabled and could sit under the PHN but MUST be GP led if there is to be uptake. Culturally there is a lot of trust that needs to be restored in government and institutions, and a move away from a toxic competitive environment without losing sound economic principles. This requires excellent leadership not bureaucratic management.

Clusters are one part of the whole but allowing informal environments will support the profession of General Practice and likely spread to and involve other primary care professions. I cannot emphasise enough they need to start with GP led clinical groups to begin the trust required. I have a whole thesis on this, so I'd better stop now.

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The Brutality of Modern Medicine

54 Year Old Female Consultant, 22 Years Post Fellowship

I am 54. A rural generalist, former GP obstetrician, medical educator. I have had almost no contact with the other side of the health industry, being much too busy to get sick.

A recent diagnosis of cancer changed all of that.

In the lead up to diagnosis, I saw my GP and several other doctors. They were good doctors, knowledgeable and kind.

But the system is set up to actively preclude treating patients as fully realised people. One GP visit my doctor was running late. This didn't bother me at all. I think it's not sensible to book a doctor's appointment when you don't have time to wait. But she cared. She was hurried and flustered and unfocussed. I was actually okay, so didn't mind the lack of time and attention she had available for me. But I did reflect that if I wasn't fine, if I had depression, or had a problem I was embarrassed to talk about, there was no way in hell I would have spoken up about it. I know full well that my GP would be upset to hear that.

So, I thought about how brutal this system is on both doctor and patient. No one benefits, no one gets what they need. Burnout is almost normal now and starts in medical school. The damage that is done to us as human beings from the day we walk into medical school is immeasurable. That damage is compounded and paid forward throughout our careers to our colleagues and our patients.

The cancer in my body is gone thanks to the good care of these excellent doctors, but it continues to metastasize in my medical community. I don't believe the treatment is surgery, chemo, or radio but a radical change in approach to the whole notion of illness, wellness, and healthcare.

A Better Culture in our healthcare system starts now

But You Were Born Here, Right?

Male Surgical Fellow

A question asked so innocently yet phrased to suggest only one acceptable answer.

"Um, yea." I hesitantly reply, feeling disappointed in myself for not owning my truth. But the reality is, I am one of the lucky ones: a perfect Australian accent, a love of footy and a relaxed 'no worries' attitude makes it seem impossible that I migrated here from a third-world country at the age of 3. And this situation is not unique: one-third of Australian's population are born overseas, yet it seems many prefer to hide that part of themself.

Diversity is a broad term that extends beyond gender and also encompasses the vital domain of multiculturalism. Celebration and empowerment of our ethnicity and multicultural society seems to have sadly missed the opportunity to be at the forefront of positive change. Fostering an inclusive environment that values and celebrates different cultural backgrounds, languages, and perspectives enables individuals to bring their authentic selves to the workplace which unlocks a wealth of creativity, innovation, and problem-solving capabilities. By recognizing and continuing to nurture multiculturalism, the healthcare industry can effectively harness the power of diversity of its workers and also patients, propelling us toward improved health outcomes and societal harmony.

Insights from a Junior Medical Officer Forum

Dr Elise Witter ~ Psychiatry Registrar, Chair JMOFQ and AMAQ Committee of Doctors-in-Training

In 2022, the Junior Medical Officer Forum of Queensland explored the current experience of team culture among junior medical officers (JMOs), aiming to characterise the impact of the COVID-19 pandemic on team dynamics and the junior medical workforce. Several key findings can inform the objective and direction of a better culture. While a majority identified that COVID had a very negative or negative impact on workplace culture, almost 40% identified no or a positive impact, highlighting a collegiate culture of doctors and their colleagues banding together on the frontline.

The greatest contributors to poor culture were identified as staff shortages and workload, rather than other changes such as restrictions of social events, limited educational and networking events and use of PPE and social distancing impeding communication with colleagues. This demonstrates the importance of targeting systems factors such as excess workload, fatigue and poor staffing in order to mitigate psychosocial hazards that negatively impact staff wellbeing, morale and workplace culture.

Where culture was identified as negative, there were disproportionately higher levels of bullying and harassment, with 58% of JMOs reporting experiencing or witnessing bullying overall. Bullying and harassment was highly detrimental to the learning environment, morale and productivity, with several JMOs reporting that bullying contributed to consideration of a career outside of medicine.

When asked how team culture could be improved, there was an overwhelming response from JMOs that they simply wanted to be recognised and feel valued as a member of the team. This is a small yet meaningful change that will significantly impact the culture of hospitals. This survey therefore illustrated an aspiration for a better culture – one in a work environment free from bullying and harassment, adequately staffed with a manageable workload, with a team that appreciates the value of all employees and works collaboratively during times of adversity.

Change the Narrative

Dr Nisha Khot ~ Obstetrician/Gynecologist, Australian Doctor who Trained Overseas, RANZCOG Board Director, RDAV Board Director, Clinical Director of O&G

"Doctors who come to Australia from UK, Ireland, USA are absolutely fine. But IMGs (international medical graduates) who come from elsewhere…they are a problem. Their training just isn't good enough." This is not a view from a different era. It is a current view.

I am an Australian doctor who trained overseas (India and UK). I hate the term IMG. Let's be honest and acknowledge that we very rarely use the term IMG to mean white, Caucasian doctors. We use it almost exclusively to refer to non-Caucasian doctors. We, who come from 'elsewhere', are IMGs in perpetuity even after living and working in Australia for decades. The term IMG marks us out as different, dare I say, inferior to local graduates. A dog whistle is a subtly aimed message which is intended for and can only be understood by a particular group. Conversations like the one above are dog whistles, heard loud and clear by their intended target.

Approximately one third of Australian doctors trained overseas. This proportion rises to 50% or higher in rural and regional areas. Increasingly, overseas trained doctors come from countries other than the UK, USA or similar. Bullying and discrimination surveys consistently show higher rates experienced by IMGs, especially those who migrate from non-English speaking countries. Australia is fortunate that doctors from overseas want to work here. Yet, we are constantly reminded of how we did not 'have to make the choice to come to Australia.' We are reminded of how we should show gratitude and accept that we will be forced to work in professional purgatory with inadequate mentoring and lack of career progression, while being subjected to unacceptable behavior and messaging that we are not good enough.

If we are to change the culture of our workplace, we must change this narrative of the 'grateful IMG' to one of a *respected, supported and valued Australian doctor who trained overseas.*

Improving Workplace Culture: A Plea for Change

Anantha Ramanathan, MBBS MS FRCS FRACS FACS RPVI ~ Clinical Associate Professor and Director of Vascular Surgery

Having worked as a surgeon in four continents including four Western jurisdictions, I should know something about workplace culture. Without batting an eyelid and with my hand on heart, I can say Australia's is the worst. Thankfully, I am in a good place now.

Rather than dwell on the negative experiences I have had, especially in Australia, I will concentrate on the positives that I see in my current environment.

The patients and staff are very diverse, yet everyone is treated with absolutely no difference irrespective of race or country of origin. Complaints against surgeons are rare and if they do arise, are addressed objectively, expeditiously, and comprehensively, without being weaponized. Patient safety mechanisms are vigorous and transparent. There is no room for whispering campaigns. The heads of departments wouldn't dream of bringing their offspring into their own departments.

The American College of Surgeons and specialty societies are stand-alone institutions that contribute to education but are not responsible for examining or certifying surgeons. They do not lend their names to sham reviews and other dubious instruments of bullying.

Public hospitals and private hospitals are separate and there are no VMO positions where one can monopolize referrals to public hospitals while enjoying the perks of private operating. There is a very strict Stark Law in operation which prevents manipulation of health services by families.

I am happy to share my experiences further with a view to improving the system.

What's Countering in Countertransference?

Mahesh Rajasuriya MD (Psychiatry), FRANZCP Psychiatrist

We all have emotions. Humans are emotional animals. Health care workers are humans. Consumers are humans. We all have emotions.

Sigmund Freud coined the term transference to denote the set of emotions a consumer develops towards her therapist. If she has developed emotions such as anger towards you, she would respond to you with anger mostly. Even when there are not enough grounds to be angry at you. Conversely, the health care worker will develop a set of emotions towards the consumer. This is called countertransference.

The most damning thing about countertransference is that 99% of the time we are not aware of it. This is what's really countering about countertransference. We might say or do something that we shouldn't, and wouldn't, because of the countertransference. We might go out of the way, sometimes beyond professional boundaries, to be patronizing or to be too accommodating or to be intimate with our patient.

Let's try a simple practical step to see our countertransference. Is my behavior today affected by my countertransference or not? Of course not! Well think again - can there be any possibility? Hmm... Maybe. Think. Ask. Check. Think again. Reflect. Recognize. This simple step of asking this question from yourself every day, every hour, might gradually make you incrementally more capable of recognizing the countertransference in you. Incrementally preventing disastrous consequences. Not only towards consumers and their families, but towards your colleagues, too.

Let's build a culture where we acknowledge that we have strong emotions towards the consumers that we care for. And for our colleagues. Let's build a culture where countertransference is accepted and managed. Not denied, shamed, and ignored. Let's build a culture where it is easier to be professional.

A Better Culture for LGBTIQA+SB People

Dr James Allen

To me, a better culture in Medicine for LGBTIQA+SB People has these key features.

An understanding that this area of health is profoundly impacted by the prolonged period of a child's life where neither the parent nor the child is aware of that child's eventual identity, and that a public health campaign can highlight to parents the preventable harm that can occur when a child assimilates homophobic values from their parents.

Clinicians must also become empathetic in understanding that LGBTIQA+SB children in homophobic families who have a sense of their diverse identity live with profound levels of anxiety and genuine apprehension of abandonment that generates stress equivalent to a chronic pervasive threat to their life. This childhood trauma changes epigenetics, behaviour, and cognition.

This is why every doctor must be educated and competent in this area and medical education on the topic should not be limited to the clinicians who are motivated to educate themselves voluntarily.

True equality for LGBTIQA+SB People in relation to the medical profession means this:

1. An apology from every medical institution in Australia to the LGBTIQA+SB People for historic and current suffering caused by:
   a. defining homosexuality as a mental illness,
   b. placing it in the same category as paedophilia,
   c. conducting research of unethically poor quality,
   d. harmful interventions.
2. Representation on the NHMRC and the Australian Health Ethics Committee.
3. Representation in the Australian Medical Council to reform curriculum in a manner that ought to have been undertaken in 1974 when homosexuality was removed from the DSM.
4. Voting representation for LGBTIQA+SB People at the board level of every specialist medical college.
5. A comprehensive and authentic pathway towards rectifying the persisting false health beliefs that continue in our society as a result of the medical profession's past mistakes.
6. Meaningful engagement with good-faith on current issues for the intersex and gender diverse communities.
7. Health economics that match funding to demonstrable needs for the LGBTIQA+SB community including Medicare funding models that account for the peak in healthcare demand in early adulthood when LGBTIQA+SB youth gain independence often with loss of family support, housing vulnerability and hardships that block advancement in a critical time creating lifelong disadvantage.

Only then can we say that we have discharged our moral and ethical duty to current the harm caused by the medical profession to LGBTIQA+SB People.

Still a Way to Go

Female Consultant, >30 Years of Practice

This is a story about changing societal expectations and norms over time.

Many years ago, I was accepted into a specialist training program- I was so excited, determined that I could have it all- a dream career, an academic path, a family. I didn't question why I was the solo 'token' female taken into training that year. I didn't question why it was so difficult to prove myself worthy of that token spot when I had male colleagues who had performed poorly but assumed acceptance based on family connections, their school, their perceived 'place' in society.

During training, I laughed off the constant rumors regarding alleged affairs with consultants and alleged trysts in hidden places. I laughed off advice about how to get places with sexual favours. I joked away unwanted sexual advances. I loved my job but I learned that, unlike my male colleagues, while I could possibly *have it all* it would come at a considerable cost.

Not surprisingly, my career has pivoted since that time. I subsequently changed specialties and as a 'mature aged' trainee, experienced none of the overt gender discrimination of preceding decades. I have thrived and succeeded professionally beyond my earlier expectations. I have a wonderful family. I imagine I am seen as being successful.

But while it is not as overt, subtle discrimination remains pervasive; specialty training often coincides with childbearing years and it remains difficult for women to access part-time training, support for breast feeding, flexible training, and assessment opportunities. Women are overlooked for professional positions based on biases in relation to their family roles. Women often have to work harder and prove themselves more to achieve parity with their male counterparts in professional roles. Women are under-represented on professional committees and in leadership roles.

While I may be seen as successful, it has often been a struggle and it has definitely been a juggle. There is always a niggle of *but what if* —what if I hadn't had to and didn't have to deal with all that.

We have come a long way, but there is still a way to go.

Who's With Me?

Consultant Anatomical Pathologist of 6 years (her/she)

My most recent experience would make excellent content for a Miles Franklin worthy book. I wish there was a safe place to tell my story of surviving medical workplace bullying but if I wish to climb my way to leadership and be the change, that time is not now.

I yearn for workplaces for myself and the next generation of pathologists in which psychological safety is a given. One where trainees have a safe space to learn, where each member of the team feels valued and appreciated, where no one is destroyed by errors made, where work life balance is encouraged, and where strong visible leadership sets the standard for acceptable behavior. These are the workplaces which produce quality pathology. Our patients deserve no less.

So, how do we get there? Who do we promote to leadership positions? What tools, training, and mentors do we give them?

Do we continue to perpetuate the status quo and promote those who won't rock the culture boat?

Do we continue to promote those who seek status and power?

What measures of positive workplace progress are we assessing?

Are our executives held to account for workplace culture or just the bottom line? Are they not interlinked anyway?

Are we prepared to hold colleagues to account for their behavior no matter their seniority, clinical skill, or potential earnings for a company?

I don't have the answers but I'm not the only one asking these questions. I hold out hope that this cultural shift is not only possible but necessary

Who's with me?

A Better Culture for Women

Female Consultant, 15 Years Post-Fellowship

I yearn for a better, safer culture for women in the medical workplace. Despite the advances of feminism within the broader community, we remain a haven of rampant sexism, born of concreted hierarchies, of averted gazes and of bleak acceptance.

My own experience is not isolated or remarkable. As an intern, I was inappropriately touched by a senior cardiologist in a medical supplies' cupboard. As a specialist trainee, I was subjected to a constant stream of "banter" of an explicit sexual nature, peddled by a consultant and direct supervisor. As a specialist, I was groped by my head of department during a meeting about departmental restructuring.

Every time I spoke up, I was told that it was part of the job, best to play along, not to make waves. These were powerful men that had a hand in my career. It wasn't worth the drama. Human Resources suggested that no one would believe me, that it would be my word against his. Had I considered the rumors that would circulate? People would think that I was a lover spurned (yes, I was really told this). Maybe I had it in for him, this man that was "such a friendly guy." I learnt the hard way that Human Resources is not on the side of the complainant; their priority is the organization and the status quo.

In my own specialist medical workplace, the most egregious of the abusers was brought low and eventually dismissed because he made the error of straying from his usual prey, which was the pool of young female specialist trainees under his supervision. Instead, a member of the ancillary staff was targeted, someone who was just outside his sphere of influence, whose career was not held within his outstretched and groping hands.

I yearn for a time when these issues are seen through the lens of occupational health and safety, where hospitals and medical organizations are held accountable for the harm perpetuated when women are not believed.

Primum non nocere

Dr Edward Wims MRCPsych, FRANZCP ~ Male Consultant, 13 Years Post Fellowship

"Heads will roll." These were the first words from the general manager's mouth upon hearing of a critical incident on one of the wards. These three little words exemplify what can go wrong with the culture of organisations where blame, and ascribing blame becomes the norm.

It is exceptionally rare for clinicians to deliberately enter the workplace to cause harm to patients. Indeed, the vast majority of us entered our chosen fields with noble ambitions of alleviating suffering and ideally reversing harm caused by disease and illness.

Regardless of professional background, the majority of clinicians are familiar with the concept of 'primum non nocere' (*first, do no harm*), yet as organisations have developed over time, this is a concept that has not moved to managerial and administrative levels. A blame culture causes harm to clinicians, the organisation, and eventually to the patients we are looking after.

Sadly, culture is not something that is talked about when we talk about clinical governance, but I would argue it is the foundation of good clinical governance and patient safety and hand and hand with this is psychological safety within the workplace. Psychological safety allows clinicians to acknowledge mistakes without fear of punishment or retribution and allows the organisation to grow and learn.

Blame culture has resulted in countless Root Cause Analyses and lessons have allegedly 'been learnt' yet the evidence would say this is not the case. The same mistakes occur over and over again, with clinicians burdened by increasingly large policy documents and more time away from direct patient care to demonstrate they are adhering to these policy directives.

Psychological safety allows for innovation and puts the patient back at the centre of care, rather than the focus being protecting the organisation from litigation and blame.

The Better Culture project is a once in a generation opportunity to create a safe workplace within health care in Australia. It will take courage and vulnerability to make the changes necessary, but the rewards will be amazing.

We Are All People

Female Emergency Advanced Trainee, PGY11

I have had the privilege of working at more than 15 hospitals across 2 states, often coming into contact with bad cultural undertones but fortunately discovering hidden gems!

I have yet to find the elusive "unicorn" workplace; however, I believe I have come pretty close. From rostering requests being considered, overtime being optional (and paid!), to the genuine smiles and teamwork approach in a department. Where leadership is not only that; followership is encouraged! Ego is not at the forefront, learning/teaching/community are the focus. Where people bother to remember your name and care to know a little about you, have a little chat/laugh whilst being efficient - not just being the work horse.

This is a stark contrast to when you are made to feel an inconvenience for taking sick or bereavement leave, or (forbid!) study leave for exams. To have to 'prove yourself' before you feel welcome. The times when you become the submissive female doctor in order to keep the peace. The times you know your place is not to make a suggestion that may be valid but different to your colleague/s. These places are often less efficient, feel sterile and lose the focus of our patients being humans.

In order to provide the best care for our community, we need to remember we are all people, not just doctors.

Creating Change

A/Prof Rhea Liang ~ Past Chair, Operating With Respect Education Committee, RACS

I'm not going to talk about my experiences as a woman in surgery, because even though it has involved bullying, discrimination, sexual harassment and even a sexual assault, the high prevalence of my experiences has been well documented already. And not just documented, but documented repeatedly over years, without any change... until recently. So, I'll talk about what made change instead.

It took a sentinel event in 2015 to prompt action within RACS. While the event was shocking to the general public, we surgical women knew it was common. We whispered in change rooms about who to be careful of, who to make sure not to be alone with. It was part of our unofficial handover. The nurses helped too, taking us aside in a sisterhood of safekeeping.

What made the difference in 2015 was that societal expectations had changed. Surgeons were no longer on a pedestal tall enough to excuse such behavior.

The public scrutiny of RACS in the days after the disclosure of this event made it impossible not to take action. We were also fortunate to have leaders who listened, but more importantly, to invest the necessary resources. And this is how the Building Respect program was born.

It is rare to have evidence of actual behavior change (https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/BR-Eval-Report-FINAL-2021-11-03.pdf). Most of the literature in culture change describes program actions in detail, and surrogate markers such as 'increased awareness' or 'more reporting'. These are not enough. Behaviors must change 'on the ground' because that is where culture is established.

I look forward to working with A Better Culture, bringing the lessons learned from the ongoing RACS Building Respect project.

I Want a Better Culture...

Female Consultant Physician, 40s

...for those of us that are told *"There's no point in making a complaint about bullying as it never ends well for anyone."*

...for those of us that have heard time and time again *"Oh that is just how he is…."* as an excuse for poor behavior amongst senior doctors.

...for our trainees, so they don't get pressured into training full-time after parental leave by a male supervisor as they *"won't get enough clinical exposure otherwise"*.

...for our trainees, so they don't get told *"You aren't cut out for this."*

...for me, so I never have to hear again *"Why don't you come back to work when you are ready to work properly"* in response to my request to work part-time after parental leave.

...for our patients, so they don't get referred to as *"The abdo pain in room 2."*

...for our trainees, so they will choose when and if they have children, and not feel pressure to limit their family size.

...for other women leaders, so we have a seat at the table where the decisions are made.

...for other new women consultants, so they can start from a place of assumed competency and leadership, not having to prove themselves time and time again.

...for me, so I never have to hear again *"Oh but he's done his time"* when questioning why when I asked for split on-call it was a *"No"* but for my older, male colleague it was a *"Yes"*.

Most of all I want a better culture for the people we care for as healthcare professionals — our patients, their families and our colleagues across all disciplines and stages of training.

You'd Never Have Guessed I'm Disabled!

Dr Sarah Bernard ~ She/Her, Consultant Geriatrician, 7 Years Post-Fellowship, Autistic, ADHDer, Disabled

Looking up from the Emergency Department flight deck, I see a colleague heading my way. They have the stride of a referrer. I prepare my referral-acceptance script. Their gaze shifts as they notice my badges: "Autistic" "ADHD" "Disabled, Happy, Proud".

Their response: they would never have guessed I have autism and ADHD.

It's not surprising. Disability representation in media is based on stereotypes I don't match. As to disability representation in the medical profession? It's rare. Doctors usually don't disclose due to fear of discrimination.[1] The first time I wore my badges to work, I posted a selfie on an ADHD doctor's Facebook group. "You're brave!" they exclaimed.

It's not that I'm brave. I'm mostly safe. I'm a consultant with an established career. I'm white. With those advantages, my risk of disability disclosure is much lower.

It's not that I'm brave. In fact, I'm afraid. Autism and ADHD are largely genetic. My kids are disabled. My fear is: my kids don't learn to camouflage their autism, and one day they're killed by police.[2] Or, they do learn to camouflage, and one day they suicide. Autistic camouflage is associated with suicide.[3]

It's not that I'm brave. I'm just tired. Constantly arranging my face, speaking and moving like I'm neurotypical. Camouflage is exhausting. Wearing my neurodivergence on my sleeve, there's a little more permission to be myself.

Disability discrimination is often unintentional.[4] My challenge to you? Tune into your workplace. Here's a snapshot of conversations overheard in the last 6 months that are branded onto my soul:

"If we make adjustments for doctors with disability, it will be unfair to the others."

"Cute little fella, he was 10 and came in with constipation. He had adhd and autism. I think his mother had it as well to be honest. She was useless."

"Have you met the (specialty) registrar? I have never met someone so 'spectrum-y'. Zero personality."

The next time you say something about us, try these:

Faced with a choice between moral integrity or personal gain, Autistics are *64 times* more likely than neurotypicals to pick the moral option. Even if they know their choice will stay secret. Your organisation could DREAM of that reputation.[5]

ADHDers are magnificent problem solvers thanks to immense cognitive drive and creativity.[6]

A diverse health workforce is more than just good PR, it saves lives.[7,8,9]

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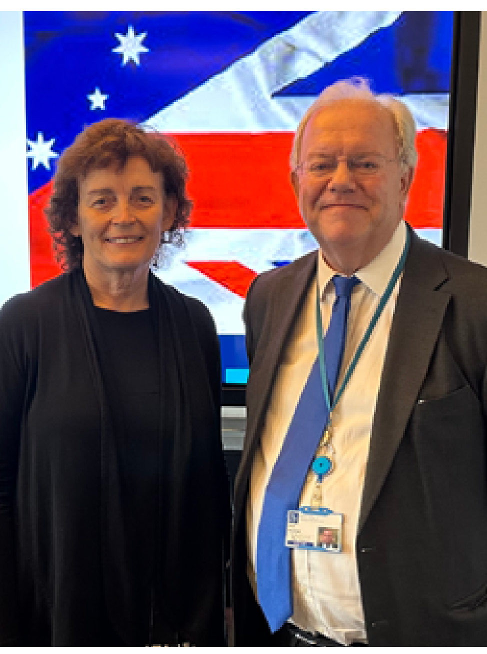
"Head shot of Dr Sarah Bernard, a white woman doctor with a white stethoscope around her neck and three disabled pride badges that read from top to bottom 'Autistic', 'Disabled, happy, proud' and 'ADHD'. She is facing the camera and smiling slightly"

2023 UK Study Tour

RACMA's much anticipated first overseas study tour came to fruition in July this year with a group of 16 Members who travelled to the UK. For one week, Members engaged with a wide range of senior leaders and managers on health systems structures, planning, funding, integration, clinical governance, innovations and challenges. The group heard from executives from the National Health Service (NHS), the General Medical Council and the Faculty of Medical Leaders and Managers, as well as senior and front-line leaders in the public and private sectors, including acute hospitals, primary care, mental health, and leadership and management.

The initiative was born from a suggestion at the 2022 Board Strategic Planning Day as a way for College Members to learn from other health systems and help RACMA deliver on its strategic priorities of delivering high-quality Member services and support and expanding the College's influence.

Some of the tour participants share their learnings for all RACMA Members in the following articles.



Cromwell Private Hospital

Dr David Rankin FRACMA

The RACMA study tour was privileged to meet with Dr Sarah Frankton, the medical director of Cromwell Private Hospital in Earls Court, London.

Cromwell hospital opened in 1981 to provide healthcare to the Abu Dhabi royal family. It was purchased by Bupa in 2008 and is rated as one of the best private hospitals in London.

It offers 118 individual ensuite rooms, 5 operating theatres, 7 chemotherapy infusion chairs, 9 dialysis units, an ICU and an advanced radiotherapy service. The radiotherapy service is operated by Genesis Care – an Australian based company. The hospital specialises in cancer treatment, orthopaedic and general surgery. Admissions are evenly distributed between medical and surgical patients. They do not offer maternity services and the ICU does not provide ECMO.

Thirty percent of patients come from overseas, predominantly UAE, Kuwait and Pakistan.

There are 762 consultants (VMOs) who all have revenue targets. BUPA pre-approves each insured patient admission and sets the fees that the specialists may charge.

Afterhours coverage is provided by registrars from the local public hospitals, most of whom are completing their PhD studies. The hospital does not operate a formal Emergency Department, though acute admissions are accepted 24/7, but require a referral. They have recently opened a walk-in urgent care centre that operates from 8:00am to 8:00pm and is staffed by emergency physicians. Patients are guaranteed to be seen by the emergency specialist within 30 minutes of arrival.

The hospital does not have an EMR, as it is seen as prohibitively expensive. Though the medical director is keen for the Board to reconsider its position.

Demand for private hospital services in London appears high with the deteriorating access in the NHS trust hospitals. 22% of UK adults now hold private health insurance, a number that has nearly doubled in the past four years. Some patients report that they believe they are assisting the NHS by accessing private hospital care. Cromwell hospital has recently purchased the adjoining hotel and is in the process of converting it into additional theatre and ward space.

Although the hospital projected an overall modern, clean and airy feel, perhaps the highlight of the tour was looking through one of the suites designed to service the UAE royal family. The suite we were able to view was effectively a serviced apartment that included an immense bathroom, lounge room, waiting area and patient room. The patient room alone was around 30 square meters. The suite was furnished and finished to a very high standard. Patients pay between 10 and 15,000 pound per night for these suites and patients are not in a hurry to leave.

As medical director, Dr Sarah Frankton reported very similar challenges to those faced in Australian private hospitals with clinical governance, medical staff management and managing quality services within financial constraints.

See it, say it, sort it…

Dr Krishnaswamy Sundararajan FRACMA

The primary organisation in charge of overseeing physicians who work for the NHS in the UK is the General Medical Council (GMC)[1]. Their primary responsibility has been to control the medical industry by regulating doctors while also assisting patients. There is a growing belief among doctors working for the NHS that the GMC has been overly strict in regulating medical practise and that doctors who identify as BAME[2] (Black, Asian, Minority, and Ethnic) have been subjected to unfavourable treatment, even though this group constitutes close to 42% of the NHS workforce.

To the GMC's credit, they've taken on this problem head-on and released a report titled *Tackling Disadvantage in Medical Education*3. The GMC data reveal ongoing disparities, particularly in terms of the worse outcomes for UK graduates of African or African-British descent, who, on average, have poorer success rates on speciality exams and are less likely to receive an offer when applying for speciality training than other UK-qualified groups[4,5].

UK black graduates had lower pass percentages in specialised exams (62%), compared to UK white graduates (79%), Asian graduates (68%), Asian-British graduates (68%) and trainees of mixed heritage (74%). The GMC has disclosed compartmentalised data on postgraduate medical school accomplishments by specific ethnic group for the first time ever and they need to be applauded for their transparency and earnestness in addressing this burning issue.

According to reports[6], the GMC was working with organisations including Health Education England and the Royal College of Psychiatrists to assess a variety of attractive programmes aimed at enhancing trainees' access to educational and supportive resources. In saying that, recent reviews which were in the public limelight, for instance, the Bawa-Garba case[7] and the Manjula Arora[8] case, have also highlighted significant lapses in what in an Australian context, would consider miscarriage of natural justice and breach of procedural fairness. The lessons learnt from these two cases reverberate across the medical fraternity in the developed world and it behoves us as a specialty of medical administrators to be vigilant and ensure that similar errors are not committed knowingly or inadvertently.

In contrast, in our system, with AHPRA[9] leading the way, in collaboration with the medical boards, we have a much more balanced system that ensures that due diligence is undertaken in matters related to dealing with complaints against doctors and that substance prevails over rhetoric and objective evidence trumps subjective feelings. It is also reassuring to note that this report from the GMC has resonated with the specialist colleges and faculties[10,11], for instance, the FICM (Faculty of Intensive Care Medicine) in the UK, has acknowledged that there are areas of deep concern and more needs to be done to close the attainment gap[12].

While we haven't commissioned a similar review in BAME populations in an Australian medical context, it will be intriguing to know what such a review might show, also, in a general sense, the lack of improvement in closing the achievement gap between doctors of diverse racial and gender backgrounds is particularly alarming.

It is obvious that each of us involved in medical education and administration needs to think about what further steps we might take to make a difference. The RACMA study tour to the GMC and NHS was an eye opener and for me as with dual qualification (RACMA and CICM) it was an experience of introspection and soul searching to question myself if I had an unconscious bias towards any member, based on their race, ethnicity, or preferences.

As a college, it would be pertinent for us to reflect on the following aspects, firstly, to better understand the reasons influencing differential achievement in medical administration, if that exists, research will need to be done into the effects of gender, ethnicity, and educational background on exam success. Secondly, gathering information on equality, diversity, and inclusion from our members so that we may better understand the disparities in our field's leadership and management roles.

Finally, I would like to acknowledge that I have lifted and shifted the title, see it, say it, sort it from the rail network in the UK as it is pertinent to the issues we face in the medical domain, and as the title would suggest, it's important that we handle this uncomfortable issue, with all honesty and sincerity and for the GMC to perhaps reflect on their motto and move towards supporting doctors and protecting patients!

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Medical Regulation — England v Australia

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During the recent RACMA UK study tour, we heard an interesting talk by Dr Roy Donnelly, a registered Australian medical practitioner and FRACMA who now practices as a barrister in London. He has a particular interest in medical negligence, professional conduct and disciplinary matters involving health practitioners. The study tour group enjoyed learning about the differences between medical regulators while enjoying wine provided by our host at London's Middle Temple Hall.

The presentation compared and contrasted the respective disciplinary regimes in Australia and England. The regulator for the medical profession in the UK is the General Medical Council (GMC). Dr Donnelly explained that the GMC investigates and 'prosecutes' matters. There is a Medical Practitioner Tribunal Service (MPTS) which is independent of the GMC. A general observation Dr Donnelly made was that the GMC tends to impose harsher penalties on practitioners than do the authorities in Australia.

Pursuant to section 35C(2) of the *Medical Act 1983* (UK), a "person's fitness to practise shall be regarded as "impaired" for the purposes of this Act by reason only of:

(a) misconduct;

(b) deficient professional performance;

(c) a conviction or caution in the British Islands for a criminal offence,or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;

(d) adverse physical or mental health; or

(d) not having the necessary knowledge of English;

(e) a determination by a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession to the effect that his fitness to practise as a member of that profession is impaired, or a determination by a regulatory body elsewhere to the same effect".

We were advised that the *Medical Act 1983* (UK) does not include a definition of "misconduct". The common law is used to provide guidance. Of note, there is no formal "unprofessional conduct" option: an individual is either fit or unfit to practise. However, Dr Donnelly advised a warning may be possible for minor breaches if the practitioner is not found unfit to practise.

The GMC's "Good Medical Practice" is similar to the Medical Board of Australia's "Good Medical Practice Code of Conduct". The GMC's obligation to self-refer includes where the individual has accepted a caution from the police or been criticized by an official inquiry (e.g., in a coronial inquest); or charged with or found guilty of a criminal offence. We were informed that there is a strong culture of self-referral in the UK. This particular requirement to self-refer if criticized in a coronial investigation is different to that in Australia.

Of particular interest was a discussion regarding how far wrongdoing, seemingly unrelated to medical practice itself, should affect a practitioner's right to practice medicine. Dr Donnelly stated that allegations of dishonesty are a major issue in the UK and a finding of dishonesty is serious. "Erasure" is often considered an appropriate sanction although this may be changing.

In both jurisdictions, it is accepted that dishonesty in a transaction unrelated to medical practice can in some circumstances lead to a sanction on the reasoning that such conduct undermines public confidence in the medical profession. In one recent case, a UK Paediatric Cardiac Anaesthetist had dishonestly used his wife's free rail travel pass to avoid paying rail fares. Although this conduct was unconnected to medical practice, it was fraudulent although not on a large scale. The GMC suspended the doctor from practice for six months. There was some criticism of this decision on the basis that the conduct was relatively minor and in the criminal court the conduct would rank very low in the scale of offences dealt with by magistrates daily, yet the professional penalty was substantial. In fact, the doctor received a mere £500 fine. The regulatory sanction imposed was widely argued to be unreasonable.

Regarding the inter-relation between criminal proceedings and regulatory action, the law in England is the same in Australia: namely that a practitioner acquitted of a criminal offence can nonetheless be prosecuted by the regulator as there is no double jeopardy. It is somewhat anomalous that a non-professional offender in a criminal court may walk out after sentencing knowing the full extent of the ramifications of their offence whereas a professional person, having been sentenced by a criminal court, may face the prospect of a severe occupational penalty imposed by a regulator.

In a regulatory proceeding in Australia, the standard of proof is lower than in a criminal case where the standard is proof beyond reasonable doubt. The standard of proof is the balance of probabilities but having regard to the seriousness of allegation: this is known as the *Briginshaw* standard. Conversely, if the practitioner was convicted of a criminal offence then a certificate of conviction would be sufficient proof of the offence in the regulatory proceedings. In the UK, there is also a distinction between the criminal standard and civil standard of proof.

Dr Donnelly noted there is a heavy reliance by the GMC on insight, reflection and remediation. We discussed how this may create a dilemma for the practitioner who does not consider they have done anything wrong since their defence will be perceived as a lack of insight. Sometimes a matter is contested up to a certain point and then when the practitioner cannot persuade the regulator of their view, the practitioner may change tack, admit fault and rely on that admission as evidence of remorse and insight. There could be unfairness if a practitioner genuinely believes what they did was appropriate because they will be under considerable pressure to capitulate in order to demonstrate remorse and insight to receive a reduced penalty.

The landscape of medical regulation may be changing in the UK. Dr Donnelly suggested that the UK approach may become somewhat more lenient after recent outcries against harsh disciplinary outcomes in relatively minor matters, particularly relating to sanctions imposed for dishonesty. It will be interesting to watch the evolution of the GMC from afar.

Overview of Medical Leadership in the NHS — is there a plan?

Dr Suhan Baskaranathan FRACMA

Understanding the NHS medical leadership model

A group of RACMA members had the privilege of participating in the UK study tour of the National Health Service (NHS). The opportunity allowed us to meet and hear how the NHS has addressed medical leadership, specifically in response to the Francis report into the Mid Staffordshire NHS Foundation Trust in 2010 and more recently after the pandemic.

Since the release of the Francis report, the NHS has commissioned two further pieces of work, firstly by the Hayes group (2013) and secondly, the King's Fund (2014), both of which echoed that the front-line staff and managers felt that the leadership style needed to change from the "top-down" performance-driven culture to a patient-centric and team-centric culture. It was interesting to witness how the new approach of an inclusive, compassionate leadership culture was implemented. The NHS has developed its nine-phase self-directed modules to enable all clinical staff to be better leaders irrespective of their roles or positions.

The Challenges Ahead for NHS England

The NHS recently celebrated 75 years, and as the provider of public health, it is in crisis.

The system has struggled over the last decade, with cracks more visible, since the pandemic. The challenges the NHS faces are not dissimilar to other countries. The same issues prevail of access blocks issues, the challenge of the aging population and increasing patient complexity. The systemic problem is the shortage of its medical workforce and the inability to retain its staff. An interesting fact is that 42% of the NHS medical workforce is represented by international medical graduates who currently hold very few senior roles and are subject to greater scrutiny from the General Medical Council (GMC), making career progression and equity of opportunities a disparity. Raising questions around discrimination, equity and inclusion.

20-30 years ago, Australian and New Zealand graduates would travel to work or pursue specialist training opportunities in the NHS. The paradigm shift now sees UK and international graduates migrating out of the UK for better pay and work-life balance. The exodus of experienced senior clinicians significantly strains timely and safer care delivery.

Meeting the Senior Medical Leaders

Our tour began with a meeting with the National Medical Director of NHS England. This is the most senior doctor in England's National Health Service, taking policy advice from the Department of Health's Chief Medical Officer and setting the national priorities for the 42 Trusts. The role is strategic, setting the clinical direction for the NHS by working closely with the 42 Integrated Health Care Boards, hospital Chief Executives, and professional college bodies to align the NHS England's strategic vision.

Our next visit was to the GMC, the peak medical watchdog and licensure. Here we learnt that the GMC is incorporating a framework for generic professional capabilities into the medical school curriculum. One of its prerequisite domains is to include leadership and teamwork to foster a compassionate culture early in the undergraduate curriculum. Particularly developing the concept that every clinical doctor is a leader.

Our final visit was to the Faculty of Medical Leadership and Management (FMLM), the third major player in promoting medical leadership (soon to be a College in its own right). The FMLM is crucial in providing leadership training and development, offering educational programs and an opportunity to network among other medical professionals.

Unfortunately, we could not meet with middle management medical leaders due to the current junior and senior medical strikes that were taking place. With current workforce shortages and retention, most medical directors hold a dual role.

Whilst with the GMC and FMLM, we understood that five clinical leadership opportunities are available across the NHS. Four of these positions comprise the national FMLM Clinical Fellows Programmes, and the fifth is the chief registrar position at the Royal College of Physicians. These positions offer speciality or non-accredited trainees 12 months to work in national organisations, contributing to and leading projects. We heard from one of the fellows working within the GMC looking to run a targeted leadership program for ethnic minority and female doctors throughout the NHS. The purpose of this role is to support leadership talent development. Again, it was noted that the senior leader of the GMC, also a trainee supervisor, held a part-time clinical role in their Trust. NHS England has five dedicated 12-month training positions to serve the NHS compared to approximately 120 three-year specialist training positions based in Australia. It relies on its clinical leadership roles to improve and support patient care.

What is being done to Improve Medical Leadership in the NHS?

Since the Francis report, there has been much debate and an emphasis on ensuring clinical leadership is addressed through the medical school curriculum, postgraduate colleges and self-directed modules available to medical staff. The GMC and FMLM also play a role in medical leadership. The various approaches aim to increase clinical leadership at all levels within the system.

The approach to senior medical leadership and management at face value is based on clinicians that have shown natural leadership and management skills and, over time, perfected skills in management roles. This idea is rapidly challenged by the struggles to retain NHS consultants beyond the retirement age 59 in clinical and management leadership roles losing expertise and experience.

The presumed intent is to phase- out the "top-down old system approach" and introduce a "bottom-up new system approach" to engage and empower doctors through the clinical leader model. It is unclear how this is being coordinated, delivered and achieved by the GMC and FMLM and the role each is playing.

The NHS has taken a multi-prong approach to encouraging leadership. Like clinical medicine, leadership training is best learned through practical experiences. For most, leadership's critical aspect is putting theoretical knowledge into action through the skills and behaviours required to work collaboratively and effectively with others. RACMA is committed to providing training programmes to support its trainees and clinicians in medical administration through its various programs. The need for a dedicated medical administration training model would be a game changer in the NHS. The current challenge the NHS faces is to provide well-trained senior clinical leaders to help implement the changes required within the NHS and address the need for greater involvement and engagement from the followers.

The overview of the medical leadership journey in the NHS reinforced how fortunate we were that our college forebears had insight into developing the College and the ongoing role RACMA needs to play in shaping the future of medical leadership.

Innovation in the NHS — Is it making a difference?

Nuala Foley — Associate Director Commercial and Enterprise
Dr MaryAnn Ferreux — Executive Medical Director
Kent Surrey Sussex AHSN, UK

This year the UK marked 75 years of the birth of the NHS. Despite the challenges that the NHS faces as it recovers from the COVID backlog, ageing population, and economic crisis, it is a timely reminder of the innovative concept that was brought to fruition all of those years ago.

This was the starting point for innovation – which is in essence a new method or idea. It is more than improving the status quo — it is about being novel, and 75 years ago that's exactly what the NHS was.

Move forward to 2023 and we have much more complexity and demand. The NHS is more than treatment for the sick, it is also about prevention, education, and caring for a diverse population which is rapidly growing. There is a heightened lens on addressing health inequalities and improving the health outcomes for the entire population equitably, whilst ensuring that innovative solutions address and support this goal.

There is now greater awareness of the interconnection between health and wealth, and the importance of living life well – not just longer. There is a driving focus on sustainability, meeting net zero aspirations and adapting the health system to cope with the impact of climate change. To do all this, innovation must be front and centre of system thinking in the UK – we can't and won't achieve what we want to do with more of the same thinking.

The Accelerated Access Collaborative (AAC) hosted by NHS England, manages the NHS Innovation Service, which acts as matchmaker for industry and healthcare innovators, as well as providing up to date information and advice on how to get innovations adopted by the NHS. Within this service, there are 15 Academic Health Science Networks (soon to be called Health Innovation Networks) who help to identify and deliver effective evidence-based innovations and interventions to healthcare challenges at pace and scale. Some of these are delivered through centrally funded programmes and others more localised tailored programmes, reflecting that local needs may differ due to geography, population, and socio-demographic profiles.

Innovation has a crucial role in alleviating the burden of ill health in the UK, but it must also deliver economic growth and wealth creation in order to successfully demonstrate social value and impact. This has been reinforced within the governance of the newly created Integrated Care Systems (ICS) who have been tasked with improving the outcomes in population health and healthcare; addressing inequalities in outcomes, experience, and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development. The challenge for AHSN's will be delivering on our remit to improve quality, productivity, and efficiency for the NHS and ICSs within the wider context of global financial uncertainties and rising patient demand for health and care services.

One advantage that AHSNs do have is the ability to collaborate across institutional boundaries and sectors to accelerate solution generation and streamline adoption and spread. Fundamental to our success is the ability to form strong partnerships with clinicians, academia, and industry to develop solutions that best meet heath care needs whilst enabling the spread of best practice through knowledge exchange. But the reality is that the innovation sector can be noisy, competitive, and at times fickle, jumping from one flashy technological advancement to another. It is therefore vital to understand the value proposition for innovation being introduced to a health care setting and know the relevant legislative and governance regulation requirements that ensure safety and quality.

The innovation landscape in the UK is fluid and constantly changing. It is influenced by policy, politics, media, social media, and industry lobbying amongst others. Therefore, it has become vital that AHSNs do not stand still. We are exploring opportunities to use the rapid adoption of technology post-COVID to change the culture and environment within the NHS to support our workforce. We are supporting the development of integrated data sets to analyse population data within the system to allow ICSs to make more informed decisions for patients and better understand the burden of disease and unmet need. We are also working to ensure that we stay connected to research and evidence creation, using data to support value-based decision making and evaluation of outcomes and impact. We have prioritised partnering with clinicians and co-designing innovation with the communities that we serve, to ensure that we develop new innovative treatments that deliver equitable healthcare services, increase access, mitigate digital exclusion, and support diversity and inclusion.

Our goal is to enable and support change and transformation in the NHS, breaking down siloed ways of working and reducing barriers to the spread and adoption of new technologies and solutions. Ultimately our success as an innovation leader, is our ability to work with others towards a common goal. We must all work together to continue to adapt to the world in which we live and ensure the success of healthcare delivery for all.

> “The only way to thrive is to innovate. It's that simple.
>
> *~Alex Tabarrook*

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Dr Diana Sarfati
Director-General of Health & Chief Executive, Ministry of Health, New Zealand

Dr Rawiri McKree Jansen
CMO Te Aka Whai Ora

Dr Myra Ruka
Clinical Equity Lead Te Whatu Ora Waikato, Te Manawa Taki Region and Te Aho O Te Kahu

Dr David Tipene-Leach
Te Pūkenga's Te Kura i Awarua Rangahau Māori Research Centre

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