Professional Behaviour in the Workplace: The behaviour we walk by...
1. Introduction
Acknowledgement of country

I would like to acknowledge the Custodians of the Land on which we meet today here in Melbourne - the Wurundjeri, Boonerwrung, Taungurong, Djajawurrung and the Wathaurung groups.

I would like to pay respect to the Elders, both past and present, and extend that respect to other Aboriginal and Torres Strait Islander people who are present.
# Outline of session

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**BREAK**
Session objectives

1. Provide an opportunity for participants to reflect on their own experiences
2. Clarify the role and impacts of bystanders on workplace and training environment cultures
3. Uncover different perspectives on behaviour within a hypothetical scenario
4. Explore individual approaches to responding to unprofessional behaviour
5. Provide an overview of one organisation’s approach to engaging bystanders
6. Discuss organisational strategies for responding to unprofessional behaviour
7. Provide an overview of the relevant work undertaken by the College (as well as identifying further areas of work)
2. Bystanders
Group Activity 1 - Reflection

In your table groups, introduce yourself and answer the following questions:

1. Think of a time when you walked past something and later wished you hadn’t
2. What was going through your mind?
3. What would you have liked to have done differently?
Workplace behaviour and bystanders

High prevalence of disrespectful behaviour

Ignoring disrespectful behaviour creates an unsupportive culture

Negative impacts on doctor wellbeing and patient outcomes

Hierarchical relationships can discourage speaking up out of fear of reprisal
Individual approaches – a hypothetical scenario
Creating a safe workplace: Responding to bullying and harassment

Part 1 - The Interaction

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Group Activity 2a – Measuring behaviour

Scale the behaviour in the video using the guide below

Positive workplace interaction

Completely inappropriate workplace behaviour
Background

**Dr Gerard Tobin** is a 56-year-old respiratory physician. He has a VMO appointment to the hospital as well as a busy private practice with rooms located across the road.

Dr Tobin graduated from university three decades ago. He is married with 3 adult children – two of whom are still at university, one in his final year of medicine.

Dr Tobin is a supervisor of training and holds a number of committee positions with both the College and Thoracic Society.

Dr Tobin is a committed doctor who works very long hours. He firmly believes that medicine is a vocation and sets high standards for both himself and his team.

Dr Tobin’s team comprises a basic physician trainee and an intern.

**Dr Rebecca Smart** is a PGY3 in her first rotation as a basic physician trainee. She is bright, collegiate and gets along well with the nursing staff but is sometimes a bit disorganized and lacks time management skills. She is still very junior but clearly keen to learn.
It is around 12.30 on a Monday in the first few weeks of the clinical year.

Dr Tobin’s team has been on take over the weekend and it has been busy. There are a large number of new admissions to sort through and several of them are quite unwell.

Whilst Dr Smart is trying her best, she feels completely overwhelmed with the number of new admissions and keeps confusing patient’s details. The intern is also not much help having only started a couple of weeks ago.

One of the new patients is a 60-year-old male who was admitted several hours earlier with a community-acquired pneumonia. When Dr Smart reviewed him in the Emergency Department immediately following the morning handover, he was quite unwell, hypotensive, hypoxic and confused.

Even though Dr Smart had written him up for antibiotics, Dr Tobin has just found out that the patient was transferred to the ward without being given antibiotics and there were several hours of delay in the commencing the antibiotics.
Group Activity 2b – Exploring different perspectives

Each table group will be given a set of questions to answer to explore a different perspective in the hypothetical scenario.
Panel discussion 1 – Individual approaches

Dr Helen Rhodes – Fellow/Board perspective
Prof Michael Ackland – Fellow perspective
Dr Daryl Cheng – Trainee perspective
Dr Nick Arvantitis – Wellbeing perspective
Dr Owen Bradfield – Medico-legal perspective
Creating a safe workplace: Responding to bullying and harassment

Part 3 - Bystander intervention

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BREAK
3.40pm-4.00pm
4. Organisational approaches
Towards Zero: Anti Bullying Action in Conversation

Amanda Cattermole
Deputy Secretary
Community Services Programs and Design
Department of Health and Human Services
8 May 2017
## WHAT WILL BE COVERED

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THE JOURNEY SO FAR

- Bullying: what’s an acceptable number?
- Lived experience at DHHS
- What does it mean?
  - Bystander culture
  - Morale issues/loss of productivity

Most importantly this has a significant negative impact on the lives of our people and the culture of the place in which we work.
AN ACTION PLAN TO TRANSFORM CULTURE

Principles for action
1. Not too much diagnosis
2. A line in the sand
3. Experiment and take risks
4. Tackle on many fronts
5. Visibility of action is critical
DRAWING A LINE IN THE SAND
EXAMPLE ANTI-BULLYING ACTION PLAN

**Short term goal**
Reduce the organisation’s People Matter Survey bullying results over the next 12 months in line with the average results of VPS Departments

- Hold an Executive Officer forum and invite a guest speaker to share information on potential precursors and actions
- Develop guidance material with staff about how to action incidents of bullying – HR to identify what behaviours have occurred and what the outcomes are, and make it readily available e.g. fact sheets on this intranet
- Identify and better support bullying ‘hot spots’ within the Division including data collection and anonymous feedback mechanisms
- Include metrics in exit surveys, employment exercises, performance development plans (PDP)
- Work with HR to get better assistance, accountability loops and promote a better work culture
- Introduce Peer Support Network and bully focus induction in each branch
- Workshops to be rolled out to strengthen leadership to ensure leaders have clarity on their expected role in dealing with bullying
- Develop communications and hold forums to support people address bullying. Communications will include messaging that there will be no negative consequences for reporting bullying and case studies and concrete examples of what is and isn’t bullying
- Investigate other organisations who have successfully tackled bullying or taken action on workplace bullying and use key learnings
- 360 degree feedback on managers to support staff to call it out and build a sense of responsibility

**Support staff to tackle bullying**
To help prevent and reduce symptoms of victims, perpetrators and by-standers to help rehabilitation for those who have been subject to bullying by holding regular wellbeing initiatives e.g. Mindfulness, conflict coaching, meditation, yoga, Myers Briggs testing and other supportive services

- Regular values awards for people who have excelled at meeting the DHHS values and SOE

**Long term goal**
To build a workplace that is respectful, caring and free from bullying or inappropriate behaviour

- Develop a communication campaign that incorporates clear messages that taking action is everyone’s responsibility
- Gather information through HR interaction with managers on issues regarding a bystander culture & empowering staff including understanding cultural differences

**Build a sense of responsibility in all staff to reduce bullying**

- Investigate how information about action taken against bullies can be known
- Encourage availability of different supportive services to help rehabilitation

- Support people to re-engage by encouraging availability to access supportive services. For e.g. Employee Assistance Program (EAP), Critical Incident Response Management (CIRM)

- Help people tell their story by making available different techniques like healing groups

**Encourage individual and collective healing**

We all continue to commit to our personal pledges and adhere to the Statement of Expectations
Panel discussion 2 – Organisational approaches

Dr Helen Rhodes - Fellow/Board perspective
Ms Linda Smith – College perspective
Ms Amanda Cattermole – Organisational perspective
Dr Owen Bradfield – Medico legal perspective
Dr Hong Wu – Trainee perspective
Vanderbilt model

No change

Level 3 “Disciplinary” Intervention

Pattern persists

Level 2 “Guided” Intervention by Authority

Apparent pattern

Level 1 “Awareness” Intervention

Single “unprofessional” incidents (merit?)

“Informal” Cup of Coffee Intervention

Vast majority of professionals—no issues—provide feedback on progress

Adapted from reference 1.
5. The College’s role and closing remarks
Professional behaviour in context

Physician/Trainee
- Wellbeing and self-care
- Self awareness
- Social network/support
- Professional development

Workplace
- Service delivery
- Site of training
- Performance management

College
- Professional standards
- Site accreditation
- Supporting quality training and supervision

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What are my obligations?

- **Legal obligation** not to bully, harass or discriminate in the workplace
- **Contractual obligation** to comply with law and employer’s policies
- Meet **professional standards** and abide by the **College Code of Conduct**
College update

Standards, policies and guidelines

Culture, training and support

Partnerships

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