Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF ERWIN CHUN KONG LOH

I, Professor Erwin Chun Kong Loh of Level 5, 340 Albert Street, East Melbourne, in the State of Victoria, Group Chief Medical Officer & Group General Manager of Clinical Governance at St Vincent's Health Australia (**SVHA**), do solemnly and sincerely declare that:

1. Insofar as this statement concerns the Ethos Program, I am authorised by SVHA to make this statement on its behalf. Where I make comments more generally about best practice for health organisations in responding to allegations and concerns, and bringing about cultural change within health organisations, I make those comments in my personal capacity.

2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Background and qualifications

3. I have the following qualifications:

   (a) Bachelor of Medicine and Bachelor of Surgery from University of Melbourne;

   (b) Bachelor of Laws from Monash University;

   (c) Master of Health Services Management from Monash University;

   (d) Master of Business Administration from Southern Cross University; and

   (e) PhD in Management from Australian Institute of Business.

4. I am also a Fellow of the Australian Institute of Company Directors and a Fellow of the Royal Australasian College of Medical Administrators.

5. Attached to this statement marked **EL-1** is a copy of my curriculum vitae.

6. I am currently the Group Chief Medical Officer & Group General Manager of Clinical Governance at SVHA. I have held this role since 2018.

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7. In this role, I am the Group Executive accountable for Clinical Governance (Patient Quality and Safety), Patient Experience, Clinical Improvement, Professional Governance of clinicians and Research.

8. I am currently also a Clinical Professor at Monash University, an Honorary Clinical Professor at the University of Melbourne and an Honorary Professor at Macquarie University.

9. Prior to taking up my current role, between 2012 and 2018, I was the Chief Medical Officer / Executive Director at Monash Health. Prior to that I was the Deputy Chief Medical Officer at the Peter MacCallum Cancer Centre for three years.

10. I have previously sat on a number of Boards, including the Law Institute of Victoria, Australian Medical Association (Victoria), Monash Health Research Precinct Pty Ltd, the Hudson Institute of Medical Research, and the Australasian College of Legal Medicine, and I am currently on the Board of the Royal Australasian College of Medical Administrators and I serve as its Vice President.

Workplace bullying and harassment in the health sector

11. Workplace bulling and harassment in the health sector has received significant attention in the past decade.

12. In 2016, the Victorian Auditor-General's Office published a report titled 'Bullying and Harassment in the Health Sector'[1] which found that across the health sector, there was:

    (a) generally poor accountability for inappropriate behaviour;

    (b) a 'double standard' where some (often senior) individuals are perceived as 'untouchable';

    (c) widespread under-reporting due to the belief that the reported behaviour will not be addressed, a distrust of human resources departments and a fear of repercussions; and

[1] Victorian Auditor-General, *Bullying and Harassment in the Health Sector* (Report, March 2016) <https://www.audit.vic.gov.au/sites/default/files/20160323-Bullying.pdf>.

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(d) normalisation and acceptance, particularly by junior doctors, of inappropriate behaviour.

13. In 2018, a number of colleagues and I conducted research into inappropriate behaviours experienced by doctors while undertaking speciality training. We sampled six speciality training programs across multiple Australian States. We found that:[2]

> *Almost all participants reported confronting (personally experienced or witnessed) inappropriate behaviours during their training, perpetrated most commonly by senior doctors. Key themes of inappropriate behaviours that emerged were belittling and humiliation, sexually inappropriate behaviour, inappropriate behaviour as part of the 'culture' of medicine, reluctance to raise concerns due to fear of recrimination, and impacts of inappropriate behaviour.*

14. The health sector has a very entrenched hierarchy and a very insular environment. In that kind of environment, unprofessional behaviours can create a culture that puts staff and patients at risk. For example, we know that the more complaints are made against a doctor, the more likely that doctor's patients are to experience adverse clinical events and outcomes.

The Ethos Program at SVHA

15. SVHA started the Ethos Program in 2017, in an attempt to tackle the issues described above. Generally-speaking, the Ethos Program has some themes in common with the Vanderbilt Promoting Professional Accountability model (**Vanderbilt model**) that is used widely in the United States of America and in some hospitals in Australia, under the "Speaking up for Safety" program run by the Cognitive Institute. Two key differences between the Ethos Model and the Vanderbilt model are discussed below.

16. As Group Chief Medical Officer & Group General Manager of Clinical Governance at SVHA, I am responsible for the SVHA's Ethos Program.

17. Attached to this statement and marked **EL-2** is a Frequently Asked Questions document about the Ethos Program. Also attached to this statement and

[2] Sotoodeh Abhary et al, 'Inappropriate Behaviours Experienced by Doctors while Undertaking Speciality Training' (2018) 2(4) *BMJ Leader* 140.

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marked **EL-3** is a copy of a PowerPoint presentation regarding the Ethos Program. While I explain what the Ethos Program is below, further information about the program can be found in these documents.

18. The Ethos Program is a peer-led early intervention program designed to:

(a) recognise staff who exhibit positive behaviour and/or are exceptional role models;

(b) remove barriers to speaking up about behaviour that undermines patient and staff safety; and

(c) respond quickly, fairly and transparently to all staff.

19. The Ethos program encourages a culture of speaking up and feedback. As part of the program, staff receive training about how to 'speak up', and there is an online messaging system for staff to submit feedback about observed positive or negative behaviour. Rather than using the words 'positive' and 'negative', we refer to 'feedback for recognition' and 'feedback for reflection'. This is important as the Ethos Program does not seek to be a punitive reporting system. Instead, it is intended to be a tool to improve people's behaviour in a constructive way.

20. When a feedback for reflection message about a staff member is made in the Ethos messaging system, unless the message suggests conduct that is sufficiently serious to warrant disciplinary action, the staff member will receive feedback about how their behaviour was perceived in the form of an Ethos "message". The feedback is delivered in a confidential and respectful manner by a trained Ethos Messenger, who is usually a peer of the staff member. This is often done over a coffee or another form of informal conversation.

21. Staff members can also enter feedback for recognition messages, which will be shared with the subject of the message and their line manager. This is the first way in which the Ethos Program differs from the Vanderbilt model – the Vanderbilt model only captures negative feedback. Feedback for recognition messages can also be directed towards the organisation's reward and recognition programs where they exist. Across SVHA's hospitals, approximately half of the messages entered into the Ethos messaging system are 'feedback for recognition' – that is, positive feedback.

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22. The Ethos Program applies to all staff, including volunteers and students. This is the second way in which the Ethos Program differs from the Vanderbilt model – the Vanderbilt model only applies to doctors.

23. The Ethos program is endorsed by the SVHA Board and Executive Leadership Team.

24. The aims of an Ethos feedback for reflection message are to inform an individual about how their behaviour has been perceived by another staff member and to offer an opportunity to reflect and think about ways they may behave differently next time.

25. An Ethos message is not in any way disciplinary or punitive in nature, it is not part of a formal process or investigation, and it is not coaching or counselling.

26. Ethos is not a standalone system. Employees are first encouraged to speak up about inappropriate behaviour at the time it occurs, without fear of negative repercussions. The Ethos Program does however provide an alternative where an employee feels uncomfortable raising a concern directly with a colleague.

27. An Ethos message can be entered anonymously, or the person can choose to be identified. We have found that most people are comfortable being identified, with only approximately one third of reports being made anonymously. However, the anonymous function can be useful where people want to flag a concern, but may be concerned about damaging a relationship with a person or where they are genuinely unsure whether their concerns are valid.

Assessment of level of inappropriate behaviour

28. Each Ethos message entered into the system is considered by a triage team that is trained to consider whether the feedback goes down the informal route for recognition or reflection, or through the formal route to the human resources department.

29. Each Ethos message is classified as either Level 1, Level 2, Level 3 or Level 4:

    (a) A Level 1 classification is for incidents of mild inappropriate behaviour which have minimal impact on a patient or staff member. For example, if someone has behaved rudely or ignored another staff member, that would be classified as Level 1.

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(b) A Level 2 classification is used where the subject's behaviour has had an impact on a patient or staff member but the impact is not severe enough to warrant formal disciplinary action. In these cases, you want to give the person feedback because, if the conduct continues to happen, it may become a formal matter. For example, if a staff member has been rude towards another staff member and that has led to significant emotional distress.

(c) A Level 3 classification is for any incident that needs to be formally reported to human resources, for example, if the behaviour is such that it should receive a formal warning or other formal disciplinary action.

(d) A Level 4 classification is for incidents that are very serious or illegal, for which the subject should be suspended or terminated, and which will require escalation and reporting via legal channels, including to the police in appropriate cases. In the history of the Ethos program at SVHA, this has not occurred.

30. Ethos is not used for patient errors or risks, which are generally managed through a health system's safety incident management systems.

31. Allegations of child sexual abuse by a staff member would constitute a Level 4 classification and be appropriately escalated. We would not expect people to rely on Ethos to report such matters, although if they did it would be triaged to human resources. However, there may be undesirable staff behaviours that don't meet this threshold (for example, inappropriate comments in front of children) which may sit within a lower level classification and could be addressed through a peer conversation. This provides an opportunity to signal appropriate standards of behaviour at an early stage. Conversely, it provides a platform for model behaviour to be recognised, reinforced and rewarded. It also is intended to contribute to a culture where people feel empowered to raise concerns more broadly.

Measuring the success of the Ethos Program

32. In 2017 and 2018, SVHA undertook an initial Longitudinal Investigation of Negative Behaviour (**LION**) survey.[3] This provided a baseline measure of the level of inappropriate behaviour at SVHA.

33. In 2021 and 2022, SVHA undertook another LION survey to see how the program had been tracking. While the study has not yet been published and the data is still being analysed, preliminary indications are that there has been significant reductions in bullying and harassment incidents.

34. Interestingly, we have found that over the past two years, especially over the period of the COVID-19 pandemic, that the number of messages entered in the Ethos system has declined. We have also found anecdotally that people have started speaking up a lot more to raise issues. That is a good thing. The ideal outcome we would like to see is that the Ethos Program (a retrospective messaging tool) is not used at all because people are speaking up at the time. Having a culture where people feel they can speak up about concerns not only keeps staff safe, but also keeps patients safe. A culture that encourages staff to raise workplace harassment issues has broader implications for the ability of staff to speak up on issues such as patient safety.

Effecting cultural change in an organisation

35. Culture change management is probably the hardest thing to do in any organisation, no matter what the profession or industry.

36. To effect cultural change in an organisation, it is not enough to just implement a system of anonymous reporting. The organisation has to have a whole program to allow staff to speak up to identify issues, to keep their eyes open and not be afraid to challenge the status quo.

37. It is about creating a culture where staff feel that they can safely speak up. The Ethos Program or a similar program of anonymous reporting can form part of that culture change, but it cannot stand alone.

38. It sounds basic, but cultural change starts at the top with the leadership. Change has to come from the Board, the executive team and senior

[3]Westbrook et al, 'The Prevalence and Impact of Unprofessional Behaviour among Hospital Workers: A Survey in Seven Australian Hospitals' (2021) 214(1) *Medical Journal of Australia* 31.

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management. They all need to encourage a culture of speaking up and being open to hearing criticism and concerns from staff and patients.

39. When people raise problems, the leadership cannot shut those concerns down. They first need to welcome the criticism or the bad news and thank the person for speaking up. They then need to act on the bad news to close the loop so that staff feel that they are being listened to and their concerns acted on.

40. Once an organisation has created that culture at the top level, it can be fostered within middle management.

41. While the senior management is important and the starting point for cultural change, middle management is key. Middle management includes nurse unit managers, and heads of medical units. If middle management is not properly engaged, they can create a "bunker mentality" and blame everyone at the top.

42. An organisation has to have the right people who are adequately equipped and who have the right training at that level. They have to be engaged and fundamentally support what senior management is trying to achieve. If they don't, any positive cultural change from the top will not be filtered down to the next level and the organisation's culture can actually get worse.

43. If senior management isn't aware of problems at the ward or unit level, this is generally because middle managers are only sharing the good news – "everything's fine, everything's fine" – or they're incompetent or ineffective. Either way, it's a problem for senior management. Senior management has to do its bit to ensure that middle managers have what they need to be effective (e.g. funding and workforce resources). Where that is the case and there are still problems, questions should be asked as to whether the right people are in the job.

44. It is important to create different pathways for people to raise concerns — which could include hotlines, programs such as Ethos and access to more senior management, where appropriate. Pathways for reporting concerns should not be limited only to a person's line manager, as they may be part of the problem.

Responding to allegations and concerns

45. An organisation's response to an allegation or concern is really important to encouraging people to speak up. When someone raises a concern, the organisation has to believe them and investigate properly.

46. I have been involved in cases where behaviours of concern have been picked up by nurses observing something that concerned them. When someone raises a concern, you've got to take it seriously and you've got to investigate properly.

47. In my experience at various health organisations, I have seen a number of examples of boundary breaches. These boundary breaches may be a warning sign of potentially more serious misconduct.

48. In my experience, most doctors understand boundaries – we are trained about appropriate boundaries from the beginning. Most health professionals therefore should have a good understanding of what constitutes appropriate boundaries with their patients. Ongoing professional training around these issues are usually not required except when a practitioner has had a breach, in which case, a reminder through appropriate training channels, organised by the employer or the regulator such as AHPRA, may be required.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

Declared at Level 5, 340 Albert St, East Melbourne
Victoria
on 24th of June 2022

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Erwin Chun Kong Loh

Before me

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CATHERINE HOOPER
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