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ORIGINAL RESEARCH

What factors help and hinder efforts to address incivility in Australasian emergency departments? A modified Delphi study of FACEM perspectives

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Abstract

Objective: Workplace incivility is a global challenge for healthcare and a major leadership challenge facing emergency physicians. However, little is known about emergency physicians' understanding of the factors that help and hinder attempts to address incivility, or what emergency physicians believe are the priority factors to address. The present study makes a novel contribution to research in this area by examining the perceived enablers of, and barriers to, efforts to address incivility in Australian and Aotearoa New Zealand EDs.

Methods: An online modified Delphi study was conducted with 22 FACEMs. To structure the process, participants were sorted into four panels. Using a three-phase Delphi process, participants were guided through the process of brainstorming, narrowing down and ranking the factors that help and hinder attempts to address incivility in EDs.

Results: There was general agreement that FACEMs' cross-department relationships and networks were key helping factors, and that poor workplace culture and time pressure were major hindering factors. However, despite agreement about these three factors, a wide range of intrapersonal, interpersonal, intergroup, and organisational factors were identified as pertinent to attempts to address incivility in EDs.

Conclusion: The causes of incivility in Australian and Aotearoa New Zealand EDs are complex and highlight incivility in EDs as a key adaptive leadership challenge of emergency physicians. Fundamentally, the results underscore the need to foster a workplace culture of respect, inclusion and civility in Australasian hospitals.

Key words: *emergency department, incivlity, leadership.*

Key findings

- Emergency physicians have a rich and nuanced understanding of workplace incivility.
- Workplace culture was unanimously acknowledged as a major hindering factor to addressing incivility.
- Emergency physicians relationships and networks across departments and specialties identified as a vital helping factor for addressing incivility.

Introduction

Workplace incivility, defined as a violation of norms in social interactions, shown as disregard of co-workers, causing conflict and stress,[1] is a global challenge for healthcare. In the specific context of emergency medicine, incivility is experienced during interactions with colleagues within the ED as well as interactions with other health services, departments and specialities.[2,3] This underscores the need to foster a workplace culture of respect, inclusion, and civility within hospitals and healthcare more generally.

The challenges of incivility documented in the international medical literature are germane to the Australian and Aotearoa New Zealand context. For example, as shown by Rixon and colleagues[4] in their study of the leadership challenges of Australasian directors of emergency medicine, managing challenging, uncivil colleagues was a common problem facing directors, regardless of their leadership experience or the geographical location of their hospitals. However, establishing that workplace incivility is a leadership challenge facing emergency physicians is a necessary but insufficient prelude to actually addressing incivility in Australasian EDs.

Incivility is a complex, emergent phenomenon that has many distal

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and proximate causes and a host of subtle (e.g. forgetting to include others) and overt manifestations (e.g. behaving disrespectfully when disagreeing with colleagues, name calling and public criticism).[5] The complexity of incivility also means that it is a phenomenon that is best addressed not through the top-down imposition of policies from management but rather the local, everyday practices of the people involved.[5] Thus, in order to foster civility and create a thriving inclusive and respectful environment in EDs, it is first necessary to understand how emergency physicians think about factors that help and hinder attempts to address incivility. Moreover, given the need to foster local, contextualised efforts to address incivility – that is, leadership actions initiated by emergency physicians and trainees in the context of their own work experience, relationships, and environment – it is also necessary to understand the types of actions that emergency physicians would be prepared to enact.

Goals of this investigation

The aim of the present study was to explore FACEMs' beliefs about the factors that help and hinder efforts to address incivility in Australasian hospitals and EDs, with a view to identifying opportunities for FACEMs to initiate and lead efforts to foster civility in their hospitals.

Methods

Study design

The present study used an online modified Delphi method, situated within a broader action research framework. The use of action research within emergency medicine provides the opportunity to gain valuable insider insights and appreciate the beliefs and practices that animate institutions.[6] Such a research framework provides a strong alignment and congruence with the roles of the authors, who view study participants as having important knowledge and agency to contribute to research outcomes. While the Delphi approach is commonly known for its focus on striving for statistical consensus, the modified Delphi method used in the present study is geared to facilitate qualitative understanding among participants. Such an approach is particularly valuable in leadership development settings.[7] Furthermore, given that the purpose of the study was to identify FACEMs' beliefs about the factors that help and hinder attempts to address incivility in EDs, not to consolidate statistical agreement about these factors, we used the modified online Delphi method as an exploratory tool, which is an approach that provides leadership development opportunities for participants.[8] The study received ethics clearance from Swinburne University of Technology prior to commencement (SUHREC reference 20191353-1434).

Researcher reflexivity

AR and SW have a background in experiential approaches to leadership development, defined as techniques that are focussed on participant experience and sense-making.[9] CS brings a wealth of clinical and health systems leadership experience and has led civility-promotion initiatives. As leadership educators and coaches (AR and SW) and a clinician-manager (CS), this focus on experiential research positions the researchers in a way that encourages participants to reflect on and make sense of their lived experiences, with a view to learning from this experience and enacting these learnings in the workplace.

Selection of participants

Participants ($n = 22$; Table 1) were FACEMs who participated in the ACEM leadership development programme, 'Managing Challenging Colleagues'. These 22 participants were randomly selected from a much larger pool of FACEMs who had responded to a formal expression of interest from ACEM in this leadership development programme. Participants were invited to self-select into Delphi panels based on their self-described leadership experience; namely, new (<3 years), intermediate (3–5 years) and advanced (>5 years). Panel sizes were limited to a maximum of eight participants per panel to optimise participant engagement, which resulted in the formation of two 'new' panels.

Modified Delphi process

Panels were guided through a 4-week process of brainstorming the factors that help and hinder attempts to address incivility in EDs, narrowing down these factors, and then ranking them to identify the top three helping and hindering factors. Given the leadership development context, where high-quality dialogue and personal accountability are crucial, our modified Delphi was non-anonymous. Prior to embarking on the individual brainstorming, participants were instructed in the use of force-field analysis[10] as a leadership development tool. Forcefield analysis provides a framework to help people make sense of the forces that drive (helping forces) or block (hindering forces) movement towards a goal. In the context of incivility in EDs, this approach illuminates the factors variously facilitate and disrupt attempts to address incivility. Highlighting Delphi as a dialectical process allowed panellists to intentionally, and respectfully, explore disagreements and differences within their panels during the narrowing down and ranking processes, providing valuable leadership development learnings, while contributing to research fidelity. Finally, panels reviewed their final rankings to decide on which they would focus on as action items for creating change in their EDs.

Data analysis and rigour

Content analysis was used by the authors (AR and SW) to code and interpret participants' responses from the brainstorming phase. This enabled a common 'dictionary' to be created and used by and across the panels as they were guided through the steps of narrowing down and ranking. The team fostered rigour in several ways through the research process. First, the study and preparation of this manuscript have worked

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TABLE 1. *Demographics of panellists*

Sex	Age group (years)	State	Region	Country	FACEM period (years)
Advanced panel (>5 years of leadership experience)					
Male	40–49	NSW	Metropolitan	Australia	8
Female	40–49	QLD	Metropolitan	Australia	13
Male	40–49	WA	Metropolitan	Australia	3
Male	50–59	NSW	Metropolitan	Australia	6
Male	40–49	NSW	Regional/rural	Australia	2
Female	40–49	WA	Metropolitan	Australia	8
Intermediate panel (3–5 years of leadership experience)					
Female	30–39	NSW	Metropolitan	Australia	3
Female	50–59	SA	Metropolitan	Australia	8
Female	40–49	VIC	Metropolitan	Australia	6
Female	40–49	NSW	Regional	Australia	2
Male	30–39	WA	Metropolitan	Australia	4
Female	40–49	NSW	Regional	Australia	4
New 1 panel (<3 years of leadership experience)					
Female	40–49	VIC	Metropolitan	Australia	5
Male	30–39	NT	Regional	Australia	Trainee
Female	40–49	NZ	Regional	Aotearoa New Zealand	<1
Female	40–49	VIC	Metropolitan	Australia	2
Male	30–39	NSW	Regional	Australia	3
New 2 panel (<3 years of leadership experience)					
Female	40–49	NT	Regional	Australia	7
Female	30–39	NSW	Metropolitan	Australia	<1
Male	30–39	QLD	Metropolitan	Australia	Trainee
Male	30–39	VIC	Metropolitan	Australia	<1

in with recommendations for reporting qualitative research.[11] Second, the team provided a clear decision trail regarding the appropriateness of the modified Delphi and its relevance for a study on incivility, helping to address trustworthiness more generally.[12] Finally, we apply Forero and colleagues'[13] four-dimension criteria to assess the rigour of our qualitative research in Table 2.

Results

Helping and hindering factors

Participants identified a host of factors that help and hinder attempts to address incivility in EDs (Table 3). Content analysis revealed that these factors could be classified as either intrapersonal (i.e. within-person factors, such as personality or attitudes), interpersonal (e.g. history or quality of relationships between individuals), intragroup (e.g. quality of ED relationships, team climate, ED culture), intergroup (e.g. history or quality of relationships between ED and other specialties) and organisational or hospital-wide factors (e.g. the general workplace culture of a hospital). Overall, 26 helping factors and 33 hindering factors were identified. Notably, although the focus of the study was on incivility within EDs, a third of the factors identified related to intergroup and organisational factors.

In addition to identifying the range of factors that participants believe help and hinder attempts to address incivility in EDs, we wanted to understand what participants deemed the top three helping and hindering factors. The results of this ranking process are presented in Table 4. Notably, the key hindering factor identified by all panels was 'workplace culture', which is an organisational-level factor that describes general hospital culture rather than the culture of specific departments. The reasons provided for the identification of 'workplace culture' are exemplified the rationale provided by New 2 panel: 'There is a culture of acceptance of incivility to the point it becomes expected and to a degree accepted'. Moreover, most panels nominated another organisational-level factor, 'time pressure', as a significant hindering factor. The reasons provided for the identification of 'time pressure' are exemplified the rationale provided by New 1 panel: 'Lack of time reduces opportunities to develop strong relationships and a civil culture'. Notwithstanding cross-panel agreement about these two barriers,

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TABLE 2. *Auditing the research process*

Credibility To establish confidence that the results (from the perspective of the participants) are true, credible and believable	• Initial self-selection of participants into leadership programme vetted by ACEM • Cross section of experience levels of participants • Most research from outsider point of view – the present study within action research framework has participants as co-inquirers – generating ideas and making sense of them
Dependability To ensure the findings of this qualitative inquiry are repeatable if the inquiry occurred within the same cohort of participants, coders and context	• Process of formation of panels was based on explicit criteria of leadership experience • Study process was codified and explicit with clear instructions provided to panels through brainstorming, narrowing down and ranking • Encourage robust discussion through dialectic process focussing on disagreement and difference
Transferability To extend the degree to which the results can be generalised or transferred to other contexts or settings	• Diverse participants (age, sex, location, leadership experience) • Rich picture descriptions developed by the different leadership panel demographics of new, intermediate and advanced • Development of comprehensive descriptions of data findings relevant to emergency medicine context within Australia and New Zealand
Confirmability To extend the confidence that the results would be confirmed or corroborated by other researchers	• Research process was explicit and research outcomes documented at every step of the process • Common language created for panels through creation of the 'dictionary' • Enabled by an audit trail that tracked the research process step-by-step through decisions made by the research team

the panels were characterised by general disagreement about the barriers to addressing incivility. There was general disagreement between the panels about the helping factors. However, there was one factor on which most panels agreed: 'relationships and networks' – an intergroup factor. The rationale for this is exemplified by the Intermediate panel: 'Having an existing relationship and/or proximity with someone makes it harder to be uncivil. Long term relationships are particularly valuable'.

Key hindering factors to address

The Advanced and Intermediate panels nominated 'workplace culture' – an organisational factor – as the key hindering factor to address. For the Intermediate panel, this is because workplace culture represents 'a keystone barrier which underlies the impact of the other barriers and influences the way we respond to time pressure and stress; its impact can be sustained and is modifiable, while time and stress are unlikely to change much'. The rationale provided by the Advanced panel was similar: '[workplace culture is the] hardest to crack and… we…would be able to get the biggest gains if we crack it'. For New 1 panel, 'bias and discrimination' – an interpersonal factor – was selected because 'cultural, gender and other biases [and] discriminatory views actively impede formation of…beneficial practices' and because addressing bias and discrimination is 'crucial to developing a civil workplace culture and promoting relationships/networks'. Finally, New 2 panel nominated 'tribalism and silo-working' – an intergroup factor – because '[uncivil] behaviours within silos are…driven by the mentality and modelling of those behind them – their tribe – and therefore displaying these behaviours makes them part of that tribe'.

Preferred helping factors to foster

The New 1 panel nominated 'ED culture of building relationships and networks' – an intergroup factor – because it was the 'most significant enabler to addressing incivility' and because 'ED is well positioned to model standards of conduct to the health system at large because we are positioned at the intersection of many departments'. Similarly, the New 2 panel selected 'leadership' – an organisational factor – because of link between leadership and role modelling, and the proposition that 'leadership drives…culture'. The Intermediate panel nominated 'Professionalism' – an organisational factor – because it is 'the final backstop when other planks of positive behaviour fail; [it]…prevents outright rudeness and poor behaviour'. Finally, the Advanced panel chose 'reciprocity and "back scratching"' – an intergroup factor – because

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TABLE 3. *Factors that help and hinder attempts to address incivility in EDs*

	Hindering factors	Helping factors
Intrapersonal	General sense of ennui (listlessness/dissatisfaction)	Desire to address the problematic situation
	Inexperience	Confidence to address incivility
	Stress	Time management
	Imposter syndrome	
	Sense of worry about making situation worse	
	Personality characteristics (of self and other)	
	Familiarity with the other person	
	Dependence on uncivil others for assistance/ resources	
	Jealousy of other people	
Interpersonal	Different perspectives on problematic situation	Taking the time to get to know colleagues
	Bias and discrimination	Supportive colleagues
	History of incivility between people	Giving positive feedback to others
	Power differentials/dynamics	Initiating friendly conversations/interactions
	Cultural differences	Surprising the other party with warmth or competence
	Gender differences	
Intragroup	Culture (of conflict)	Shared/common goals
	Hierarchy (perceived or real)	Role modelling by senior staff
	Constant changing of team make-up	Empowerment
	Culture (of passive acceptance of incivility)	Team building
	Lack of support from senior staff when conflict arises	Open and calm environment
		Shared positive experiences
	Lack of acknowledgement of diversity	Clinical teamwork in ED (collaborative, multidisciplinary)
	Fears about speaking out about poor behaviour	
		Reciprocity and 'back-scratching'
Intergroup	Tribalism and silo working	Culture (ED culture of relationship building)
	Different goals of inpatient teams and ED physicians	Relationships and networks
	Competing priorities and perspectives	Feeling united against hospital executive
Organisational	Workplace culture	Workplace culture
	Complex management hierarchies and etiquette	Clear communication across teams
	Protocolisation	Patient-centred care
	Interruptions	Professionalism
	Time pressure	Professional development and training
	Lack of privacy	Teamwork
	The nature of shift work	Leadership
	Work complexity	

*Intra*personal refers to factors within the person, such as their personality, attitudes, beliefs and desires; *inter*personal refers to factors between people (e.g. their history with each other, perceptions of others, social actions); *intra*group refers to factors within a group, in this case the ED (e.g. quality of relationships among group members, group culture and climate); *inter*group refers to factors between groups, such as between ED and other specialties; and organisation refers to hospital-level factors (e.g. organisation culture, institutional leadership, policies, etc.).

'dovetailing agendas…satisfy differing agendas on both sides' and because reciprocity 'works on all levels on all relationships and interactions'.

Discussion

The present study of FACEMs' beliefs about factors that help and hinder attempts to address incivility in EDs suggests that emergency physicians have a rich and nuanced understanding of workplace incivility. Moreover, the identification of helping and hindering factors at the intrapersonal, interpersonal, intragroup, intergroup and organisation-level suggests that emergency physicians view workplace incivility as a complex phenomenon that has several underlying and interlocking causes, with no simple solutions. This perceived complexity is further suggested by the differences in opinion observed between the panels about the factors that help and hinder attempts to address incivility in EDs.

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TABLE 4. *Top three barriers to and enablers of efforts to address incivility in EDs across panels*

	New 1 panel		New 2 panel		Intermediate panel		Advanced panel	
	Barriers	Enablers	Barriers	Enablers	Barriers	Enablers	Barriers	Enablers
Rank 1	Workplace culture	Culture (ED culture of relationship building)†	Workplace culture	Patient-centred care	Time pressure	Relationships and networks	Time pressure	Relationships and networks
Rank 2	Bias and discrimination†	Relationships and networks	Competing priorities and perspectives	Leadership†	Stress	Role-modelling by senior staff	Stress	Time management
Rank 3	Time pressure	Clear communication across teams	Tribalism and silo working†	Clear communication across teams	Workplace culture†	Professionalism†	Workplace culture†	Reciprocity and back scratching†

†Denotes the barrier and enabler that this panel chose work on to address incivility in EDs.

Notwithstanding the differences of opinion about these factors, there were two notable areas of convergence. First, the general workplace culture of hospitals, which was broadly characterised as a culture of acceptance of incivility, was unanimously acknowledged as a major hindering factor. This underscores the vital importance of addressing workplace culture, which emerges from complex interactions between workplace practices, norms and conditions, in any initiative to address workplace incivility. Second, emergency physicians' relationships and networks across departments and specialties were acknowledged as a vital helping factor. The identification of 'relationships and networks' by the new, intermediate and advanced panels alike, reveals keen insight into the ways in which poor relationships between individuals and groups clears the way for the violation of norms in social interactions and the development of workplace cultures in which incivility is normalised. Thus, improving the quality of interactions and relationships with colleagues within the ED across the hospital is a practical, everyday way that emergency physicians can foster workplace civility.

Consistent with Klingberg and colleagues,[3] who found that most sources of incivility experienced by emergency physicians originated outside the ED, many of the problematic factors identified in the present study were intergroup and organisational factors (e.g. tribalism, competing priorities, workplace culture). Nevertheless, fully two-thirds of the hindering (e.g. culture and gender differences, ED culture, constant changing of team make-up) and helping factors (e.g. supportive colleagues, shared goals, clinical teamwork in EDs) identified were located within the ED, indicating that many of the roots of, and solutions to, are located in the ED.

The factors nominated by the panels as those they would address as a priority were illuminating, and broadly reflective of a host of recommendations made in ACEM's Discrimination, Bullying and Sexual Harassment Action Plan.[14] Notably, the pattern of results suggested that

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types of barriers and enablers chosen by panels were partly a function of their leadership experience. To illustrate, the preferred hindering (bias and discrimination, tribalism and silo-working) and helping factors (ED culture of building relationships and networks, leadership) of the New panels were weighted more to interpersonal and intergroup factors than organisational factors. By contrast, the preferred hindering (workplace culture) and helping factors (professionalism, reciprocity and 'back scratching') of the Advanced and Intermediate panels were weighted more to organisational and intergroup factors. Although the data does not permit strong inferences, this pattern of results is consistent with the notion that, as leadership experience and sphere of influence grows, so too does the organisational complexity of the interventions emergency physicians are prepared to initiate.

Finally, the success of the modified Delphi method used in this paper offers an example of a constructive approach that teams in healthcare settings can use to decide upon local, ground-up approaches to address incivility, and other similar complex problems. Emergency physicians may consider the use of such methods when initiating and designing interventions in their EDs and hospitals to foster participation and buy-in from colleagues.

Conclusion

Workplace incivility and the entrenchment of cultures of incivility are complex problems that are experienced acutely by FACEMs and ED staff. The findings of our study provide new insight into many options FACEMs have to address incivility in EDs, opening up new avenues of and opportunities for formal and informal leadership in the ED.

Limitations

There are several limitations to the present study creating possible bias. Our convenience sampling method, which targeted FACEMs who were enrolled in a leadership development programme, may have led to response bias in the factors identified. Moreover, our use of a free-response format encouraged answers that were salient to participants rather than comprehensive (e.g. identifying all possible helping and hindering factors). A final limitation relates to the fact that participant ethnicity was not measured in the present study. In the context of the topic of incivility, and the potential role of ethnic differences in perceptions and the experience of incivility, this is a factor that deserves consideration in future research.

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Competing interests

None declared.

Data availability statement

Data available on request from the authors.

References

1. Andersson LM, Pearson CM. Tit for tat? The spiraling effect of incivility in the workplace. *Acad. Manage. Rev.* 1999; **24**: 452–71.
2. Keller S, Yule S, Zagarese V *et al.* Predictors and triggers of incivility within healthcare teams: a systematic review of the literature. *BMJ Open* 2020; **10**: e035471.
3. Klingberg K, Gadelhak K, Jegerlehner SN *et al.* Bad manners in the emergency department: incivility among doctors. *PLoS One* 2018; **13**: e0194933.
4. Rixon A, Wilson S, Hussain S, Terziovski M, Judkins S, White P. Leadership challenges of directors of emergency medicine: an Australasian Delphi study. *Emerg. Med. Australas.* 2020; **32**: 258–66.
5. Porath C. *Mastering Civility*. New York: Hachette, 2016.
6. Eisenberg EM, Baglia J, Pynes JE. Transforming emergency medicine through narrative: qualitative action research at a community hospital. *Health Commun.* 2006; **19**: 197–208.
7. Fletcher AJ, Marchildon G. Using the Delphi method for qualitative, participatory action research in health leadership. *Int. J. Qual. Methods* 2014; **13**: 1–18.
8. Steinert M. A dissensus based online Delphi approach: an explorative research tool. *Technol. Forecast. Soc. Change* 2009; **76**: 291–300.
9. Braun V, Clarke V. Reflecting on reflexive thematic analysis. *Qual. Res. Sport Exerc. Health* 2019; **11**: 589–97.
10. Plack PT, Margaret M, Scott R. *Systems Thinking in the Healthcare Professions: A Guide for Educators and Clinicians*. Washington, DC: The George Washington University, 2019.
11. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook A. Standards for reporting qualitative research: a synthesis of recommendations. *Acad. Med.* 2014; **89**: 1245–51.
12. Forero R, Nahidi S, De Costa J *et al.* Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Serv. Res.* 2018; **18**: 1–11.
13. Powell C. The Delphi technique: myths and realities. *J. Adv. Nurs.* 2003; **41**: 376–82.
14. Australasian College for Emergency Medicine. Discrimination, Bullying and Sexual Harassment Action Plan. 2018. [Cited 26 Sep 2022.] Available from URL: https://acem.org.au/getmedia/533f9238-b12f-44ca-aa2a-38582002591c/ACEM_DBSH_Action_Plan.aspx

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