![Australasian College for Emergency Medicine logo] Australasian College for Emergency Medicine
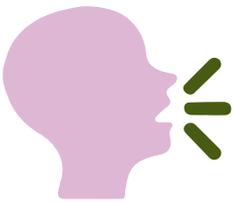
Sustainable Workforce Survey 2019 Factsheet
Findings 2020

Hostile, rude and uncivil behaviour

76% from co-workers

96% from clients/patients

Reasons given for reducing hours of clinical practice in the next 10 years

"The current stresses of overcrowding, inadequate staffing and access block make the job difficult and I cannot sustain this for much longer"

"'Feeling unsupported despite working harder every year with increasing numbers of patients and increasing access block."

"ED extreme workloads, stress, violent/difficult psychiatric and/or drug affected people endangering our staff..."

"I do not get enough time between shifts to recover both emotionally and physically"

Burnout and fatigue

45% reported moderate to severe **personal burnout**

50% reported moderate to severe **work-related burnout**

81% reported that **fatigue** had impacted their performance
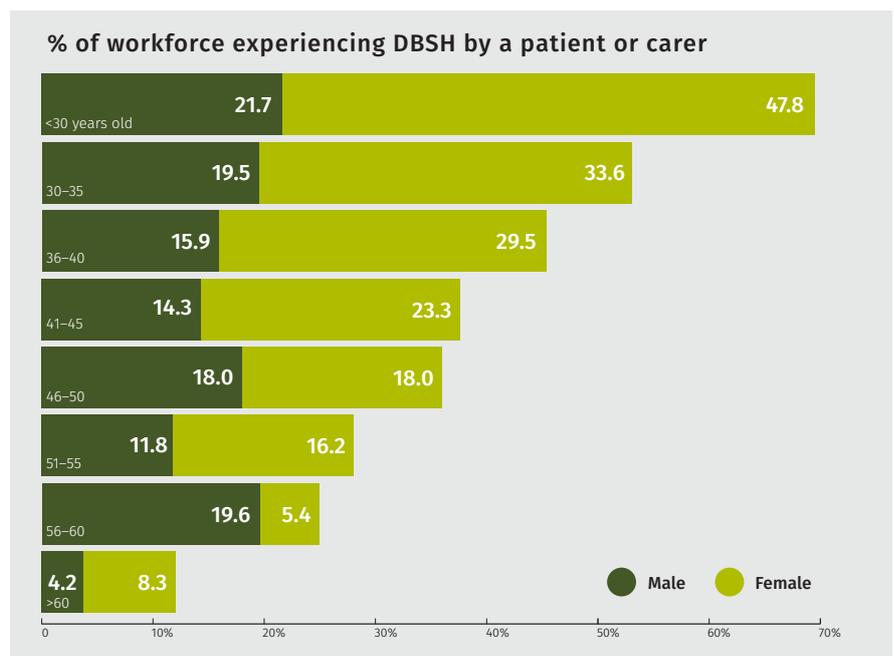
10% of the total hours worked were **unpaid hours**

Discrimination, bullying and sexual harrassment

47% of respondents had an experience of DBSH by a professional colleague

39% of respondents had experienced DBSH at work, by a professional colleague in the past 12 months

Experiences of DBSH by a patient or carer in the past 12 months decreased steadily with age for female respondents, but for males it remained relatively constant.

% of workforce experiencing DBSH by a patient or carer

Age	Male	Female
<30 years old	21.7	47.8
30–35	19.5	33.6
36–40	15.9	29.5
41–45	14.3	23.3
46–50	18.0	18.0
51–55	11.8	16.2
56–60	19.6	5.4
>60	4.2	8.3

■ Male ■ Female

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Australasian College
for Emergency Medicine

Findings
April 2020

2019 Sustainable Workforce Survey

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1. Background

Following on from ACEM's Workforce Sustainability Survey (November 2016) and the Discrimination, Bullying, Sexual Harassment and Harassment (DBSH) Survey (June 2017), it was decided to monitor emergency medicine workplace culture and experiences of DBSH among the membership and trainees on a regular basis. The Sustainable Workforce Survey was developed to focus on both of these issues and included questions from the Workforce Sustainability and DBSH Surveys. The survey was distributed to members and trainees on 30th May 2019 and closed on the 14th July 2019.

The survey garnered 806 responses from FACEMs, FACEM Trainees, and other ACEM members and trainees of varying training levels (including Specialist International Medical Graduates; Emergency Medicine Certificants and Diplomates; and Emergency Medicine Certificate and Diploma Trainees). A larger percentage of FACEMs responded to the survey, accounting for 78% of the survey respondents.

2. Summary of findings

2.1 Work Profile

+ Respondents averaged a total of 44.2 hours of work per week, 39.7 paid hours and 4.5 unpaid hours.

+ The majority (90%) of respondents were working in a public hospital emergency department (ED).

+ 49% of FACEMs, 24% of trainees and 33% of other respondents were working across more than one workplace.

2.2 Work-life balance

+ 37% of respondents disagreed that the balance between their personal and professional commitments was about right.

   — Trainees (48%) were more likely than FACEMs (33.7%) to disagree with this statement.

+ 65% agreed that the demands of their work interfere/interfered with their home and family life.

   — Trainees (74%) were more likely than FACEMs (63%) to agree with this statement.

2.3 Satisfaction with Primary Workplace

+ 74% were satisfied overall with their primary workplace.

+ 80% were satisfied with their interactions with colleagues.

+ 75% were satisfied with their remuneration.

+ 66% were satisfied with rostering.

   — Only 53% of trainees were satisfied with rostering.

+ 36% were satisfied with staffing levels.

+ Clinical work and team work were the most enjoyed aspects of working at their primary workplace.

2.4 Working Conditions

+ 58% of all respondents never or occasionally took a meal break at work.

+ 20% worked more than 12 consecutive hours at their workplace most or some of the time.

+ 36% have worked rostered night shifts in the past 12 months, including 98% of trainees and 19% of FACEMs.

   — Of those who reported working rostered night shifts in the past 12 months, 37% reported never having the recommended rostered time off following night shift.

2.5 Workplace Stress, Fatigue and Burnout

+ The top 3 workplace stressors reported by respondents were overcrowding in the ED (63%), access block (56%), and conflicts with other clinical teams in the workplace (34%).

+ 81% of respondents reported that fatigue had impacted their performance at work in the past 12 months.
  — Trainees (89%) were more likely than FACEMs (78%) to report this.

+ 45% of respondents were experiencing moderate to severe levels of personal burnout, including 59% of trainees and 41% of FACEMs.

+ 50% of respondents were experiencing moderate to severe levels of work-related burnout, including:
  — 57% of trainees and 48% of FACEMs.
  — 55% of females and 46% of males.

+ Only 13% of respondents were experiencing moderate to severe levels of client/ patient related burnout.

2.6 Future Career Plans

+ 63% reported that they were likely to reduce their hours of clinical practice in the next 10 years.
  — Trainees (70%) were more likely to do this than FACEMs (61%).

+ 25% reported that they were likely to leave clinical practice in the next 10 years.

+ 27% reported that they were likely to leave emergency medicine in the next 10 years.

+ 16% reported that they were likely to retire in the next 10 years, including 19% of FACEMs.

2.7 Experiences of DBSH

+ 41% reported experiencing DBSH from a patient in the previous 12 months.

+ 39% reported experiencing DBSH from a professional colleague in the previous 12 months. Of those:
  — 78% experienced bullying.
  — 53% experienced discrimination.
  — 45% experienced harassment.
  — 6% experienced sexual harassment.

+ Females (58%) were more likely than males (42%) to report having experienced DBSH by a professional colleague in the previous 12 months.

+ Overall, FACEMs were commonly reported as the perpetrator of DBSH behaviour, followed by other specialists and other specialist trainees.

+ Males were much more likely to be reported as the perpetrator of DBSH behaviour.

3.   Purpose and scope

The purpose of this report is to provide the findings from the Australasian College for Emergency Medicine's (ACEM's) 2019 Sustainable Workforce Survey. For the purpose of this report, a 'sustainable' workforce is one in which emergency doctors are able to maximise their health, professional satisfaction and career longevity, thereby optimising their ability to meet the emergency medicine (EM) care needs of the Australian and New Zealand populations.

4.   Survey aims

Following on from ACEM's Workforce Sustainability Survey (November 2016) and the Discrimination, Bullying, Sexual Harassment and Harassment (DBSH) Survey (June 2017), this survey aimed to assess if there had been any change in workplace behaviour, culture and practices following on from a number of ACEM initiatives, including support and advocacy activities.

The survey is also part of ACEM's commitment to monitoring the emergency medicine workplace culture and experiences of DBSH among its members and trainees on a regular basis.

5.   Method

5.1   Setting and participants

An invitation to complete the survey was sent via email, using MailChimp, to all 5,776 members and trainees on ACEM's mailing list, on May 30, 2019 asking them to complete the online Sustainable Workforce Survey before the survey closed on 14 July 2016. Eligible participants included all active FACEMs, FACEM Trainees (Provisional and Advanced), EM Certificate/Diploma trainees, EM Certificants, EM Diplomates, and SIMG applicants.

Following the email invitation, the survey was promoted on social media (ACEM's Facebook and Twitter accounts) and ACEM's electronic digital media (Trainee News, Faculty Updates and Bulletin). Participation in the survey was voluntary, and completion of the survey was considered implied consent.

5.2   Survey

The anonymous survey was hosted on the QuestionPro online survey platform and respondents were asked not to provide identifying information (such as names of people and/or locations). Respondents were initially directed to a screening questionnaire asking whether the respondent was currently undertaking paid work in Australia or New Zealand, or if not, whether they had undertaken any work in Australia or New Zealand in the past 12 months. If they responded yes to either of these questions, they were directed to one of two versions of the survey (Currently working or Worked in the past 12 months). If the respondent had not undertaken any paid work in the past 12 months, they were ineligible to complete the rest of the survey.

Both versions of the survey asked respondents a range of demographic, workplace, job satisfaction and work-life balance questions; a series of wellbeing questions; their plans for the future; questions about their general health; and their experiences of DBSH in the workplace. Wellbeing questions included questions about their colleague's wellbeing, available support services, experiences of anxiety, fatigue and professional isolation. Those who were working at the time of completing the survey were asked some additional workplace questions and asked to respond to items on burnout.

The survey was developed with questions sourced from the 2016 Workforce Sustainability Survey, the 2017 DBSH Survey, with questions on burnout sourced from the *Copenhagen Burnout Inventory* (CBI) (The National Research Centre for Work Environment, n.d.). Some of the survey questions were informed by ACEM's *Guidelines on constructing and retaining a senior emergency medicine workforce* (Australasian College for Emergency Medicine, 2015); *Ambulance Paramedics and the Effects of Shift Work* (Sarah Sofianopoulos, 2011), *The Nursing Incivility Scale: Development and Validation of an Occupation-Specific Measure* (Ashley M. Guidroz, 2010), as well as through internal discussion with the Diversity and Inclusion Steering Group (DISG).

The survey was piloted among three FACEMs and one FACEM Trainee, with minor edits to question wording and response options made following this.

5.3 Data cleaning and analysis

Prior to analysis, the data was cleaned to remove incomplete responses. Respondents were required to complete the sections on Job Satisfaction and Work-Life Balance to be included in the analysis. Those who did not complete this section were removed from the dataset.

With the exception of Table 1, responses from EM Certificate/Diploma trainees, EM Certificants, EM Diplomates and SIMG applicants were combined to form an 'Other' group when presenting data by level of ACEM training. Likewise, aside from Table 1, when reporting data by country of Primary Medical Degree (PMD) an 'Other' group has been used to report on all respondents with a PMD obtained in a country other than Australia, New Zealand or the United Kingdom.

Responses to five-point Likert and Likert-type questions were collapsed into three categories for analysis and reporting, for example satisfied (a combination of moderately satisfied and very satisfied), neutral, and dissatisfied (very dissatisfied and moderately dissatisfied); or agree (strongly agree and agree), neutral, and disagree (strongly disagree and disagree).

Quantitative analysis was carried out in STATA and qualitative analysis in NVivo. Quantitative analysis included calculation of frequencies and means; Chi Square tests; and calculation of Cronbach's alpha (a measure of internal consistency) for the CBI. Thematic coding of responses to seven open ended questions was undertaken, with major themes and sub-themes identified. These seven questions included why respondents were likely to reduce their hours of clinical practice; why respondents were likely to leave clinical practice and/or the EM workforce; and description of an experience of discrimination, bullying, sexual harassment and/or harassment. Comments were deidentified before inclusion in the report, a process that included removing specific staff roles and scenarios that could potentially identify the individual who made the comment, and correction of grammar and punctuation.

5.4 Limitations

A number of limitations exist with the data obtained from the survey, including the small response rate, with fewer responses received compared to the 2016 Workforce Sustainability Survey (1157) and the 2017 DBSH survey (2121). This limits the generalisability of the findings to the broader membership, as well as limiting some analysis that could not be conducted due to potential for identification of individual respondents. Also, FACEMs were over represented in the survey sample and FACEM Trainees and other respondents were under represented.

Response bias may also be an issue, with respondents who are more invested in work-life balance, wellbeing, workplace culture, and/ or having direct experiences of DBSH in the workplace potentially being more likely to respond, which will also impact on the generalisability of the findings.

6. Results

6.1 Respondent characteristics

A total of 806 responses to the survey were received. Respondents were asked to provide demographic information including age, gender, First Nations status, the country they obtained their primary medical degree (PMD) in, level of ACEM training, and the state/territory/country that their primary workplace is located. A comparison of respondents and ACEM membership data against the key demographic questions is shown in Table 1. As can be seen from the data, there is an over representation of FACEMs, those aged 41-60 years of age, and those who obtained their PMD in Australia or New Zealand.

Table 1 Demographic comparison of respondents with ACEM membership (n=806)

	ACEM membership (n=6055)		SW respondents (n=806)	
	n	%	n	%
Gender				
Female	2629	43.4%	373	46.3%
Level of ACEM training				
FACEM	2849	47.1%	627	77.8%
Advanced EM trainee	1804	29.8%	134	16.6%
Provisional EM trainee	587	9.7%	26	3.2%
SIMG	75	1.2%	3	0.4%
EM Diplomate	41	0.7%	5	0.6%
EM Diploma trainee	117	1.9%	4	0.5%
EM Certificant	135	2.2%	2	0.2%
EM Certificate trainee	447	7.4%	5	0.6%
Age group in years				
Less than 30	654	10.8%	26	3.2%
30 - 35	1662	27.4%	144	17.9%
36 - 40	1202	19.9%	153	19.0%
41 - 45	903	14.9%	152	18.9%
46 - 50	767	12.7%	151	18.7%
51 - 55	444	7.3%	80	9.9%
56 - 60	231	3.8%	63	7.8%
More than 60	188	3.1%	26	3.2%

NB: Percentages may not add up to 100% for some groups due to missing data.

Table 1 (continued) Demographic comparison of respondents with ACEM membership (n=806)

	ACEM membership (n=6055)		SW respondents (n=806)	
	n	%	n	%
Primary medical degree				
Australia	2821	46.6%	459	56.9%
New Zealand	391	6.5%	87	10.8%
United Kingdom	1187	19.6%	131	16.3%
South Africa	81	1.3%	19	2.4%
United States	79	1.3%	18	2.2%
India	165	2.7%	17	2.1%
Sri Lanka	74	1.2%	6	0.7%
Other	961	15.9%	37[1]	4.6%
Region				
ACT	102	1.7%	18	2.2%
NSW	1431	23.6%	192	23.8%
NT	140	2.3%	19	2.4%
QLD	1347	22.2%	173	21.5%
SA	309	5.1%	27	3.3%
TAS	129	2.1%	25	3.1%
VIC	1243	20.5%	176	21.8%
WA	602	9.9%	66	8.2%
New Zealand	597	9.9%	110	13.6%
Overseas	155	2.6%	NA	

NB: Percentages may not add up to 100% for some groups due to missing data.
[1] Other includes all remaining countries not listed where respondents obtained their primary medical degree.

Of the respondents 0.5% self-identified as Aboriginal and/or Torres Strait Islander, 0.7% as Māori and 0.1% as Pacific Islander.

6.2 Employment

This section provides information on the respondents current or most recent workplace. There were eleven respondents who were not working at the time of completing the survey and are excluded from analysis where applicable.

60% of respondents were employed on a full-time contract

Current employment status

Those who were working at the time of completing the survey were asked to indicate all the types of employment they were undertaking (Table 2). Almost two-thirds (60.4%) were working full-time.

Table 2 Type(s) of employment respondents reported working, by level of ACEM training (N=795)

	FACEM		Trainee		Other		Total	
	n	%	n	%	n	%	n	%
Full-time	359	58.0%	107	67.7%	14	77.8%	480	60.4%
Part-time	245	39.6%	50	31.6%	4	22.2%	299	37.6%
VMO contract	68	11.0%					68	8.6%
Casual contract or locum	65	10.5%	18	11.4%	2	11.1%	85	10.7%
Sessional	14	2.3%	1	0.6%			15	1.9%
Other	3	0.5%					3	0.4%

NB: VMO = Visiting Medical Officer. Responses for each group add up to greater than 100%, as respondents could be working across multiple types of employment.

Further analysis was carried out on this question, focusing on those who selected only one type of employment and those who selected a combination of the types of employment. Results are shown in Figure 1, with FACEMs (51%) and Trainees (61%) less likely to report only working full-time, compared to those classified in the Other training level group, although these differences were not significant.

Figure 1 Current employmezt status of respondents, by level of ACEM training (n=795)
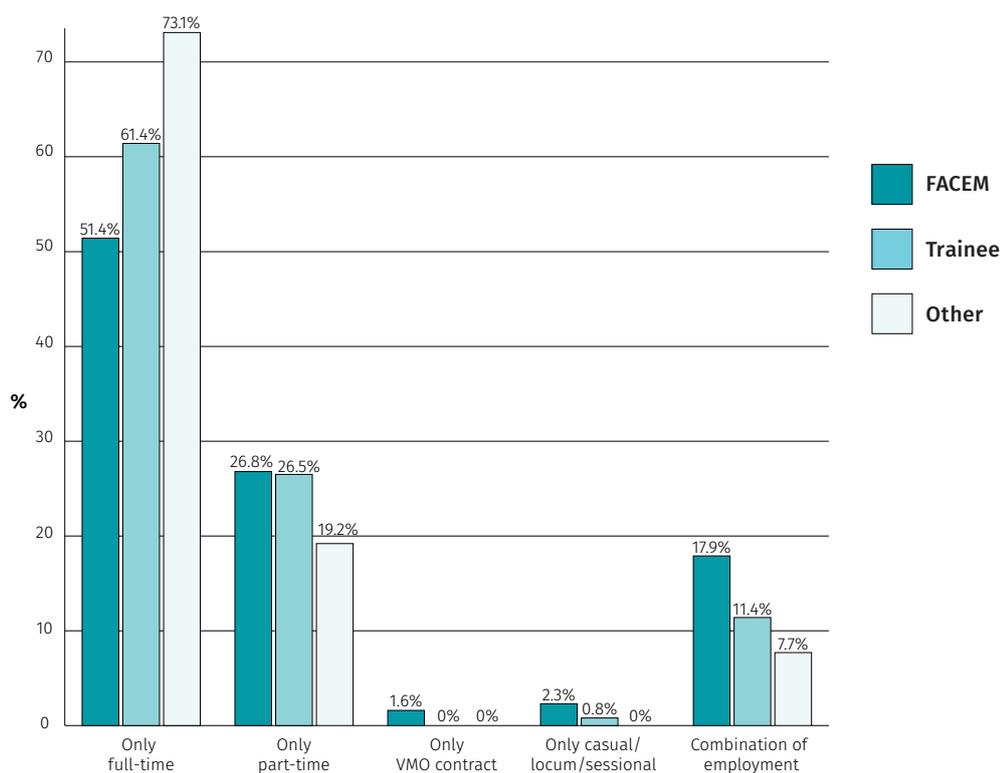
Of those who had a combination of employment status types, 82% had a combination of two status types, 18% had a combination of three status types and one was employed under four different types. Part-time and casual was the most common combination (34%); followed by part-time and Visiting Medical Officer (VMO) (28%); and full-time and casual (19%).

Number of paid and unpaid hours

To gain an understanding of the number of hours our members and trainees are working across all their workplaces, respondents were asked to provide the number of paid and unpaid hours they worked in their most recent usual week at work across different settings. One respondent preferred not to answer this question and is excluded from this analysis. A summary of the hours worked across the settings is shown in Table 3.

Table 3 Number of paid and unpaid hours per week that respondents reported working (n=805)

	Mean	sd	Min.	Max.
Clinical paid hours	**36.0**	**11.4**	**0**	**96**
Public hospital ED clinical work	25.5	13.0	0	80
Private hospital ED clinical work	1.6	5.8	0	50
Clinical support/ ED office time (FACEMs)	6.0	7.4	0	60
Pre-Hospital/ retrieval	1.4	6.5	0	96
Other clinical work	1.5	6.6	0	52
Non-clinical paid hours	**3.7**	**7.0**	**0**	**52**
Tertiary education institution/ research	0.7	3.1	0	30
Protected teaching time (Trainees)	0.6	1.6	0	10
Medical education (including EMET)	0.8	2.6	0	20
Other non-clinical work	1.6	5.4	0	40
Total paid hours	**39.7**	**10.8**	**8**	**100**
Total unpaid hours	**4.5**	**5.2**	**0**	**37**
Total	**44.2**	**12.3**	**8**	**110**

NB: sd = standard deviation; Min. = minimum hours; Max. = maximum hours.

On average, 10% of the total hours worked are unpaid hours

Hours worked across settings were combined and the total was classified into three categories: part-time (less than 37.5 hours per week), full-time (37.5-45 hours per week) and excess overtime (more than 45 hours per week). A summary of the classified hours is available by level of ACEM training in Figure 2 and by gender in Figure 3, with the difference in hours worked by gender statistically significant ($\chi^2(6$, $N = 795) = 32.5571$, $p < 0.001$).

Figure 2 Hours worked per week by training level (N=805)

Legend: FACEM, Trainee, Other
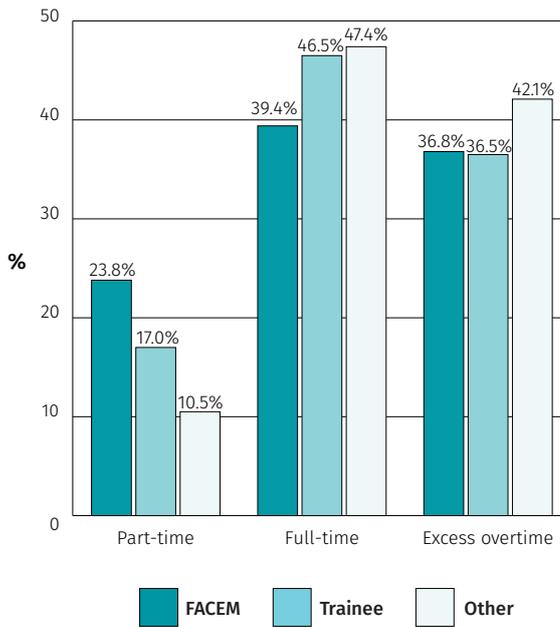
Figure 3 Hours per week, by gender (N=795)

Legend: Male, Female
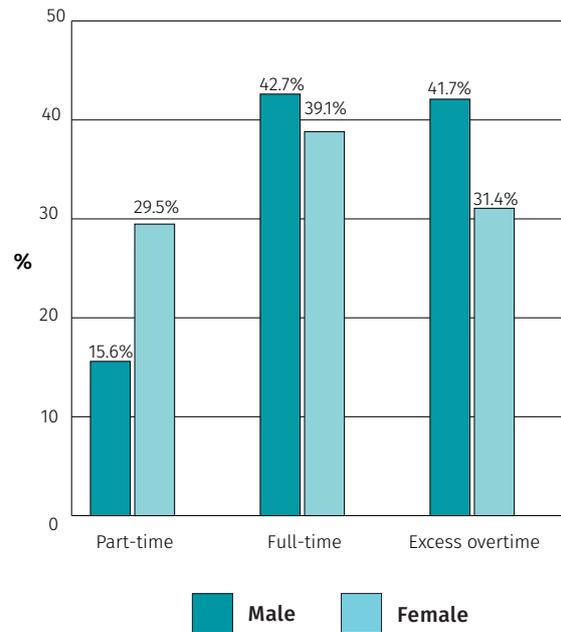
Number of workplaces

Those who were working at the time of completing the survey were asked to provide the number of workplaces they were employed at. Overall most (87.5%) were employed at one or two workplaces with almost three quarters (74.7%) of FACEM trainees working at one workplace, with significant differences between groups, $\chi^2(10, N=795) = 33.6667$, $p < 0.001$. A summary is available in Figure 4.

Figure 4 Number of current workplaces respondents reported working at, by level of ACEM training (N=795)

Legend: FACEM, Trainee, Other
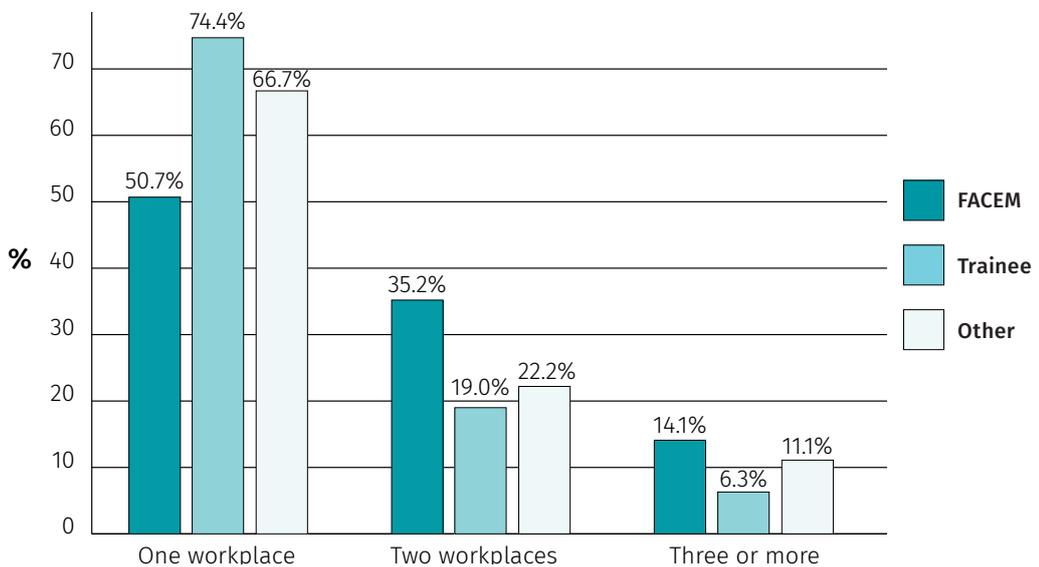
Type of primary workplace

Those who were working at the time of completing the survey were asked about their current primary workplace, with those not working at the time of completing the survey asked about their most recent primary workplace. Almost all the respondents were or had been working in a public hospital ED as their primary workplace (90%), 4% reported working in a private hospital ED, 3% in a public hospital non-ED, 2% in pre-hospital/ retrieval, 1% in tertiary education, and 2% in a private hospital non-ED or another workplace. A breakdown by level of ACEM training is available in Figure 5, over page.

90% were working in a public hospital ED

Figure 5 Respondents' primary workplace by type, by level of ACEM training (N=806)
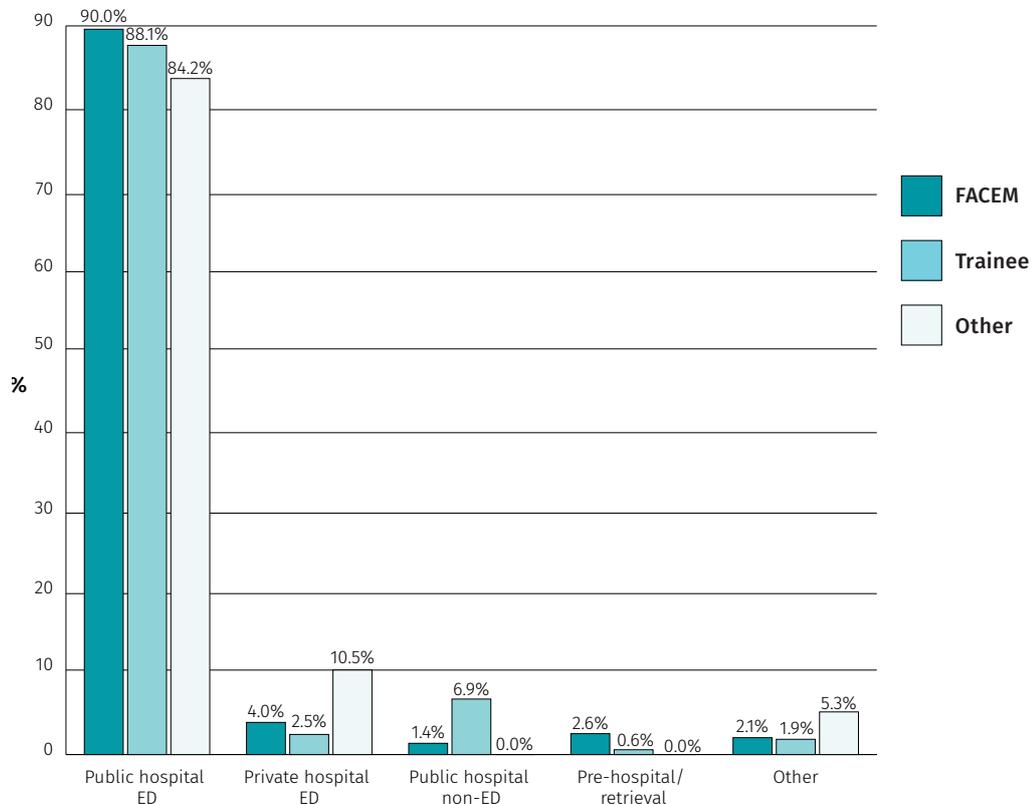
6.3 Work–life balance

This section provides information on the perceptions of respondents regarding their work-life balance. Respondents who were not working at the time of completing the survey were asked to respond based on their most recent workplace. Twenty-five respondents did not complete the Work-life balance section, which is reflected in the decrease in sample size for the relevant questions.

Overall work–life balance

To gauge the overall work-life balance of respondents, they were asked to indicate their level of agreement with two statements. Firstly, *the balance between my personal and professional commitments is/was about right*; then *the demands of my work interfere/interfered with my home and family life.*

43% agreed that the balance between their personal and professional commitments was about right

Overall 43% agreed; 20% were neutral; and 37% disagreed that the balance between their personal and professional commitments was about right. However, Trainees and Other survey respondents reported a higher level of disagreement with this statement and the differences were significant $\chi^2(4, N = 806) = 27.7378$, $p < 0.001$ (Figure 6). This is consistent with the findings from the *ACEM Workforce Sustainability Report* (2016) where trainees also reported a higher level of disagreement with this statement than FACEMs.

Figure 6 Respondents' level of agreement with the statement 'The balance between my personal and professional commitments is about right', by level of ACEM training (N=806)
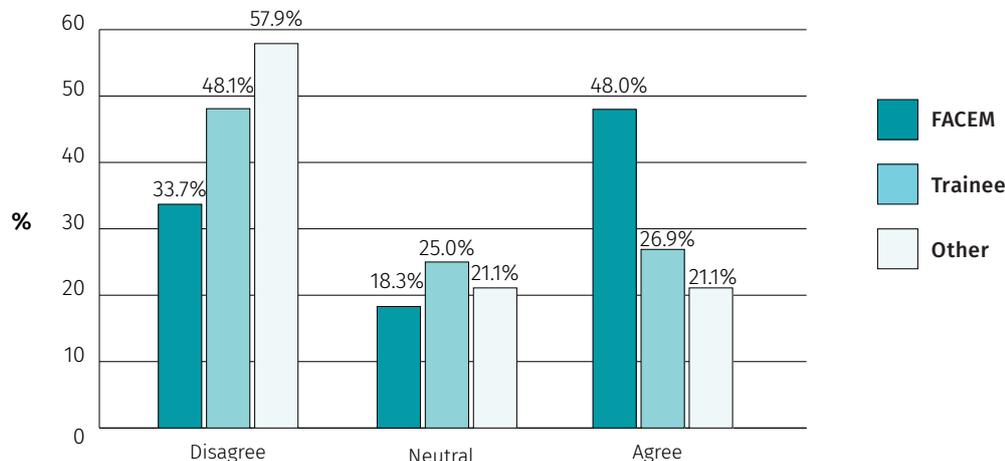
Overall 65% agreed, 17% were neutral and 18% disagreed with the second statement *the demands of my work interfere/interfered with my home and family life*. Trainees and Other survey respondents had a higher level of agreement with this statement than FACEMs and the differences were significant $\chi^2(4, N = 806) = 12.9043$, $p < 0.05$ (Figure 7). Again, this is consistent with the findings from the *ACEM Workforce Sustainability Survey Report* (2016) where 78% of Trainees reported agreement with this statement compared with FACEMs (61%).

65% agreed that the demands of their work life interfere(d) with their home and family life

Figure 7 Respondents' level of agreement with the statement, 'The demands of work interfere with my home and family life', by level of ACEM training (N = 806)
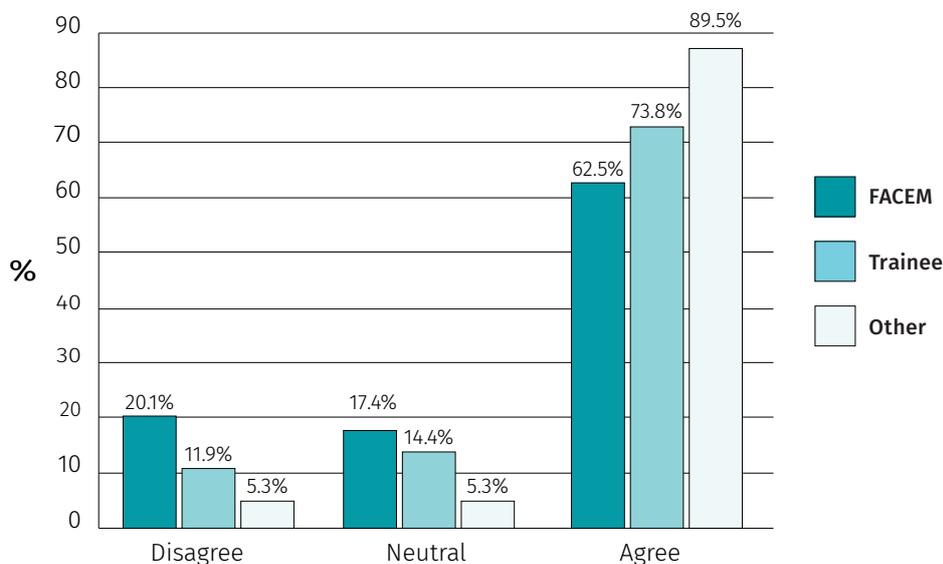
Primary workplace satisfaction

Respondents were asked to indicate their overall level of satisfaction with their work at their primary workplace, as well as with other aspects of their daily work, with responses summarised in Table 4.

Table 4 Respondents level of satisfaction with aspects of their primary workplace

		Dissatisfied	Neutral	Satisfied
	n	%	%	%
Interactions with colleagues	806	10.7%	9.3%	80.0%
Your remuneration/ pay	804	13.4%	11.4%	75.1%
Overall work	805	15.5%	9.9%	74.5%
Your career progression so far	801	14.4%	13.4%	72.3%
Ease of arranging leave	803	19.6%	13.2%	67.2%
Rostering	800	20.4%	13.6%	66.0%
Recognition you get for your work	804	27.6%	17.2%	55.2%
Ability to focus on chosen projects in clinical support time	593	26.0%	19.4%	54.6%
Time allocated to learning or maintaining core skills	802	24.8%	21.7%	53.5%
Opportunities to network with professional colleagues	801	17.5%	31.3%	51.2%
Staffing levels	802	52.0%	11.5%	36.5%

NB: Ability to focus on chosen projects in clinical support time was only applicable for FACEMs.

Overall work

Almost three-quarters of respondents reported being satisfied with their overall work. Trainees (21%) reported a greater level of dissatisfaction than FACEMs (14%) and those classified in the Other training level group (11%) towards their overall work. This slightly differs from the findings from the *ACEM Workforce Sustainability Survey Report (2016)* where 18% of both FACEMs and Trainees reported dissatisfaction with their overall work. There were significant differences between satisfaction with overall work and:

+ gender, with females more satisfied (79%) than males (72%) (χ2(4, *N* = 796) = 10.7965, *p* < 0.05); and

+ the country in which respondents obtained PMD, with respondents who obtained their PMD in Australia more satisfied (78%) than those who obtained their PMD in New Zealand (75%), the United Kingdom (75%) and Other countries (67%) (χ2(6, *N* = 773) = 14.0051, *p* < 0.05).

Rostering

Significant differences were observed in satisfaction levels with rostering by level of ACEM training, with FACEMs more satisfied (70%) compared to Trainees (53%) and the Other (42%) group (χ^2(6, *N* = 800) = 23.0269, *p* < 0.001).

Staffing levels

There were significant differences between satisfaction with staffing levels and the country in which respondents had obtained their PMD, with those who obtained their PMD in New Zealand (27%) or Other countries less satisfied (26%) compared to those who obtained their PMD in the United Kingdom (36%) or Australia (41%) (χ^2(6, *N* = 770) = 15.5503, *p* < 0.05).

52% were dissatisfied with staffing levels

Recognition for work

Trainees reported less satisfaction with the recognition they receive for their work (48%) than FACEMs (57%) and those classified in the Other training level group (63%).

Remuneration/pay

There were significant differences between respondent's satisfaction with their pay and:

+ level of ACEM training, with FACEMs more satisfied (79%) than Trainees (62%) and the Other group (47%) (χ2(4, N = 804) = 35.3865, p < 0.001);

+ the country in which respondents obtained their PMD, with those who obtained their PMD in the United Kingdom (85%) and Australia (81%) having higher levels of satisfaction than those who obtained their PMD in New Zealand (59%) and Other countries (61%) (χ2(6, N = 773) = 50.8298, p < 0.001). Of note, those who obtained their PMD from Other countries reported greater dissatisfaction (28%) compared to those who obtained their PMD in New Zealand (17%), Australia (10%) and the United Kingdom (8%).

Career progression

There were significant differences in respondent's satisfaction with their career progression and:

+ level of ACEM training, with FACEMs reporting higher satisfaction (76%) than Trainees (63%) and the Other group (47%) (χ2(4, N = 801) = 18.4757, p < 0.01);

+ age, with similar levels of satisfaction observed across age groups (70%-73% satisfied) except for those aged 41-45 years (68%) and those aged 56-60 years (81%) and over 60 years (100%) (χ2(14, N = 790) = 24.3585, p < 0.05);

+ the country in which respondents obtained their PMD, with those who obtained their PMD in Other countries reporting a lower level of satisfaction (60%) compared to those who obtained their PMD in the United Kingdom (84%), Australia (75%) and New Zealand (70%) (χ2(6, N = 769) = 17.8932, p < 0.01).

Time allocated to learning and maintaining core skills

There were significant differences in respondent's satisfaction levels toward time allocated to learning and maintaining core skills and:

+ level of ACEM training, with Trainees (36%) and those classified in the Other training level group (32%) reporting greater dissatisfaction than FACEMs (22%) (χ2(4, N = 802) = 14.8701, p < 0.01).

+ gender, with males reporting greater satisfaction (60%) than females (47%) (χ2(4, N = 793) = 17.7882, p < 0.01).

Opportunities to network with professional colleagues

There were significant differences in respondent's satisfaction levels toward opportunities to network with professional colleagues and:

+ level of ACEM training, with Trainees reporting greater dissatisfaction (29%) than FACEMs (15%) and the Other group (16%) (χ2(4, N = 801) = 43.0526, p < 0.001);

+ age, with satisfaction increasing with age from 25% for those aged under 30 years to 72% for those aged over 60 years (χ2(14, N = 790) = 41.8152, p < 0.001) (Figure 8, over page).

Figure 8 Respondents' satisfaction with opportunities to network with professional colleagues, by age (N=790)
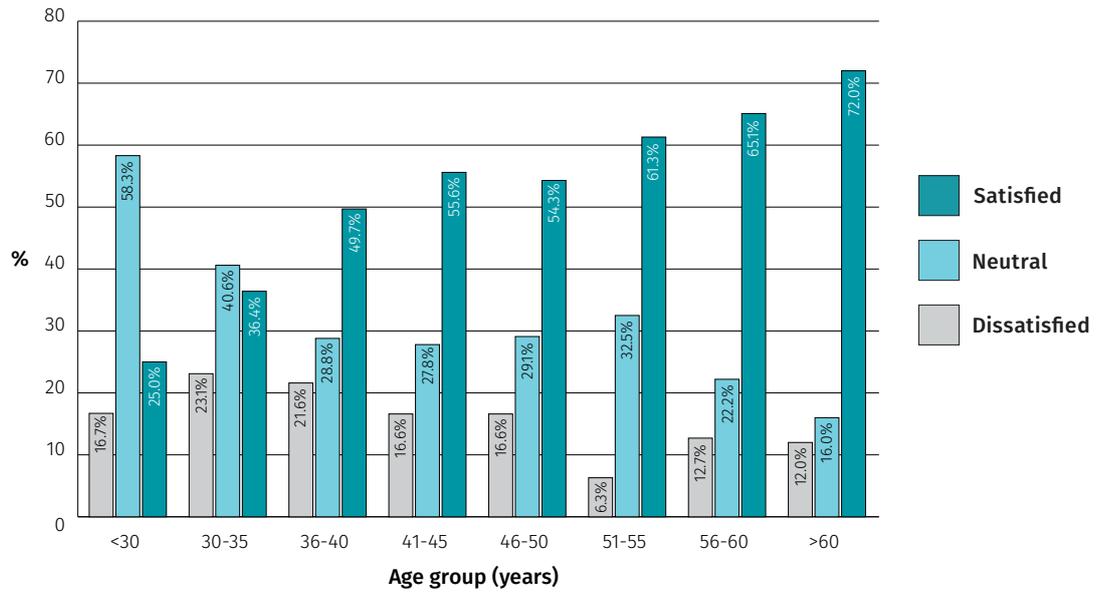
Enjoyable aspects of primary workplace

Respondents were asked what they enjoy(ed) most about working in their primary workplace, with the option to select multiple aspects of their work and/or describe the aspects they enjoyed the most (Figure 9). The top three responses were 'clinical work' (69%), 'team work' (68%) and the 'variety of the work' (65%). With 'patient care' (56%), 'teaching and mentoring' (54%), and 'making a difference' (46%) other aspects of work that respondents reported enjoying.

Figure 9 Aspects of respondent's primary workplace, which they reported enjoying the most (N = 806)

Number of annual leave days in the past 12 months

All respondents were asked to indicate the number of weeks of annual leave (excluding parental, conference and study leave) they had taken in the past 12 months. Twelve respondents indicated that this question was not applicable for them and are excluded from the analysis. Overall, 65% of respondents reported taking more than three weeks of annual leave in the past 12 months (Table 5). FACEMs were more likely to have taken more than three weeks of annual leave (69%) than Trainees (52%) and those classified in the Other training level group (53%).

Table 5 Number of weeks of annual leave taken in the past 12 months (N=799)

	n	%
None	28	3.6%
0-1 week	38	4.8%
1-2 weeks	89	11.3%
2-3 weeks	118	15.0%
3-4 weeks	168	21.3%
4-5 weeks	206	26.2%
More than 5 weeks	140	17.8%

Ease of arranging leave

Respondents were asked to indicate their level of satisfaction with the ease of which they can arrange leave from their primary workplace.

67% were satisfied with the ease of arranging leave

Overall, 67% of respondents were satisfied, 13% were neutral and 20% were dissatisfied with the ease of which they can arrange leave. FACEMs (71%) and those classified in the Other training level group (68%) reported greater satisfaction with the ease of arranging leave than Trainees (53%), with these differences significant (χ^2(4, N = 803) = 20.8373, p < 0.001) (Figure 10). There were also significant differences between the ease of arranging leave and age group (Figure 11, over page), with those aged 35 years or younger, 46-50 years, and more than 60 years reporting higher levels of dissatisfaction than other age groups (χ^2(14, N = 792) = 24.9762, p < 0.05).

Figure 10 Respondents reported satisfaction, by level of ACEM training (N=803)
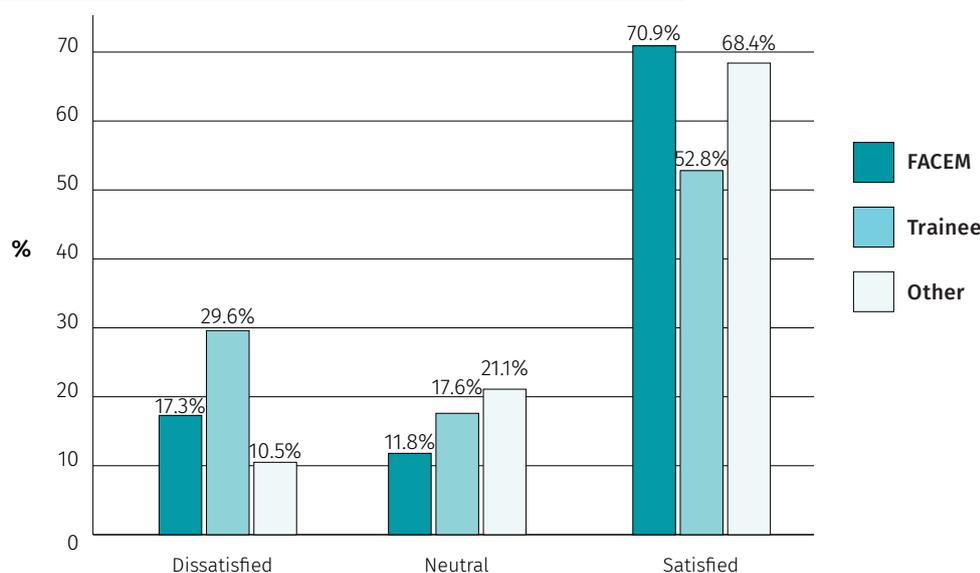
Figure 11 Respondents reported satisfaction with the ease of arranging leave, by age (N = 792)
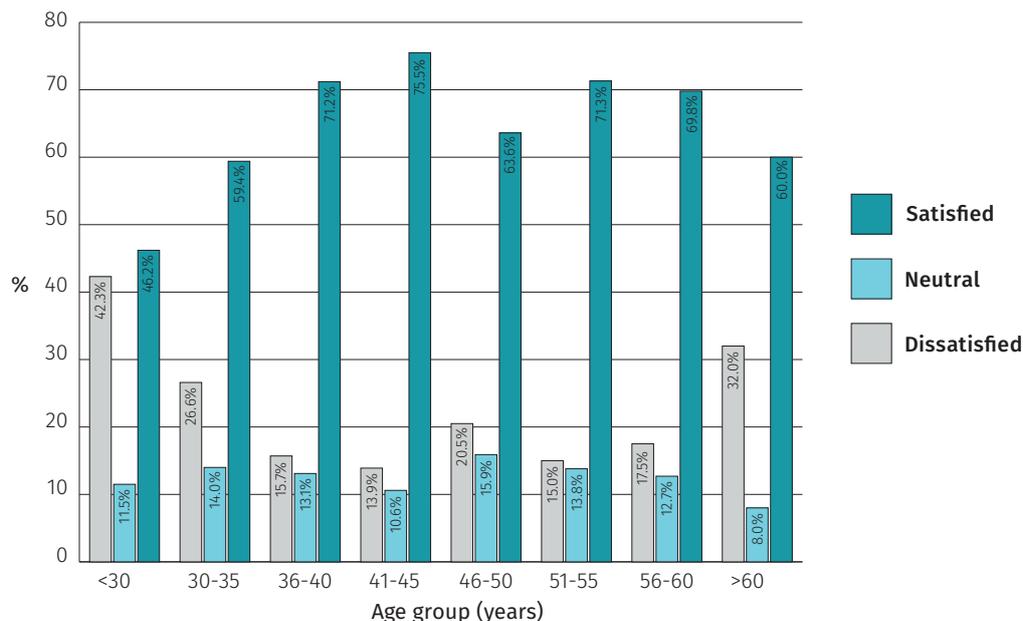
6.4   Workplace conditions

Frequency of meal breaks

Respondents were asked how often they take (took) 30 minute meal breaks at their (most recent) primary workplace, with responses summarised in Figure 12. Over half (58%) of the respondents reported occasionally or never taking a 30 minute meal break at their primary workplace, with less than one-third (27%) reporting taking a 30 minute meal break most or all of the time.

Figure 12 Frequency respondents reported taking a 30-minute meal break at their primary workplace (N = 799)
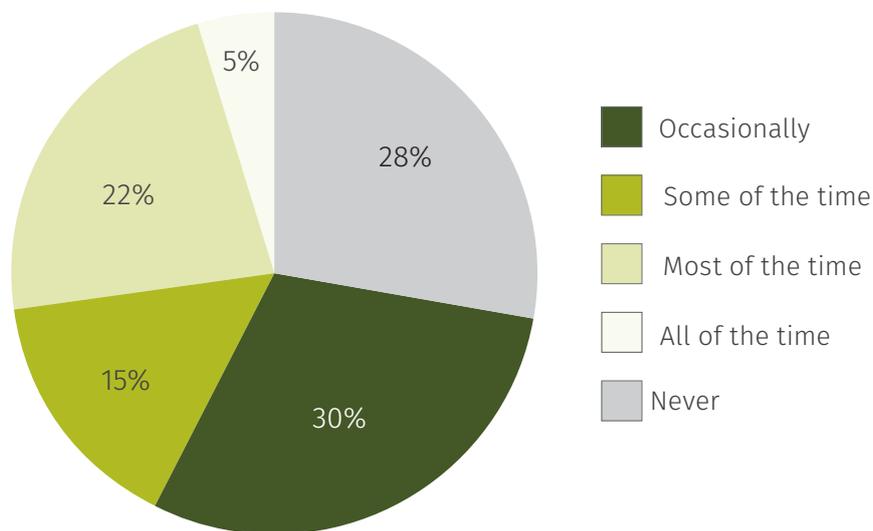
Compared to FACEMs and those classified in the Other training level group, trainees were more likely to report never taking a 30 minute meal break (33% compared to 27% and 21% respectively), although these differences were not statistically significantly (Figure 13, over page).

58% occasionally or never took a 30 minute meal break

Figure 13 Frequency respondents reported taking a 30-minute meal break at their primary workplace, by level of ACEM training (N = 799)
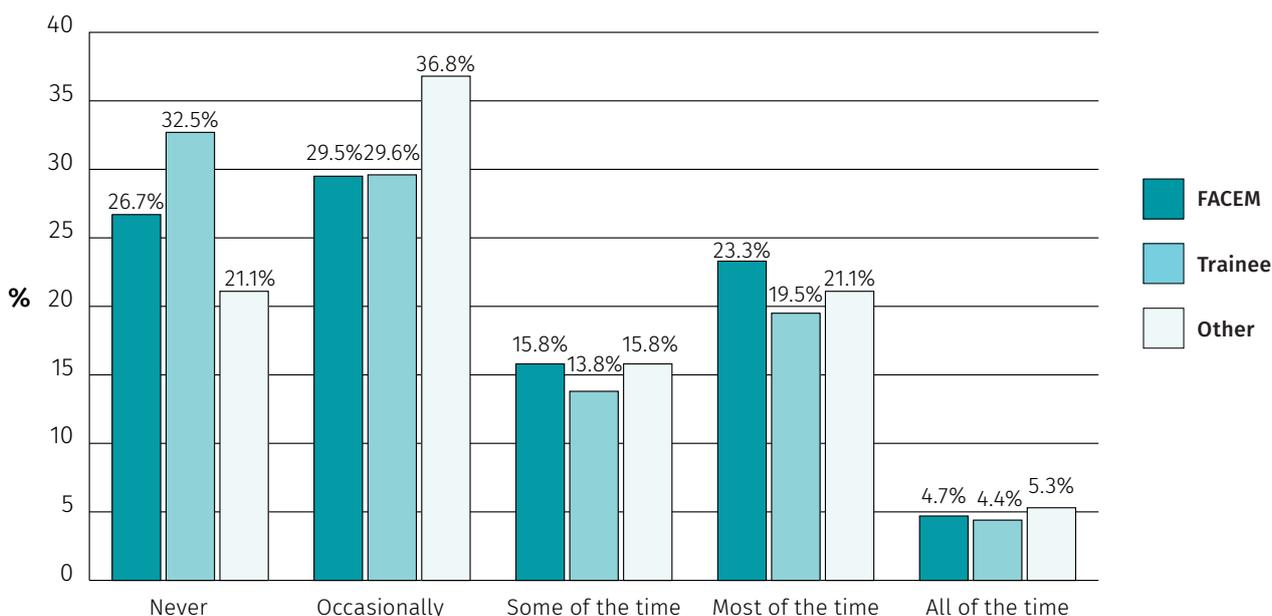
The following questions focused on paid and unpaid professional work.

Frequency of working more than 12 hours consecutively

Respondents were asked to report on how often they work(ed) more than 12 consecutive hours at their (most recent) primary workplace, with 796 people responding to this question. Overall most (80%) of the respondents reported never (33%) or occasionally (47%) working more than 12 consecutive hours. The remainder reported working more than 12 consecutive hours some of the time (16%), most of the time (4%) and all of the time (0.4%) (Figure 14).

Figure 14 Frequency respondents reported working more than 12 consecutive hours (N = 796)
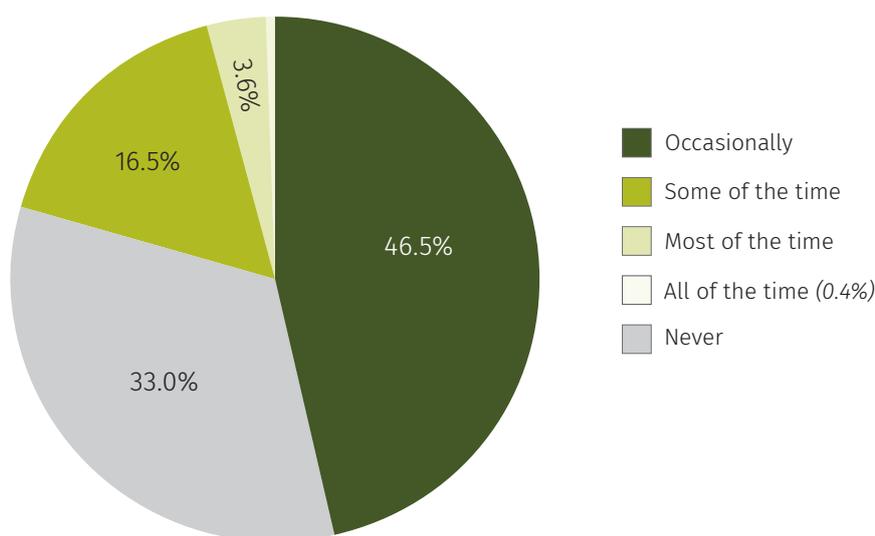
Figure 15 (over page) shows a breakdown of those who worked more than 12 consecutive hours by level of ACEM training. FACEMs (69%) and those classified in the Other training level group (68%) were more likely to report working more than 12 consecutive hours than Trainees (60%), although this difference was not statistically significant.

67% have worked more than 12 consecutive hours at their most recent primary workplace

Figure 15 Frequency respondents reported working more than 12 consecutive hours, by level of ACEM training (n=796)
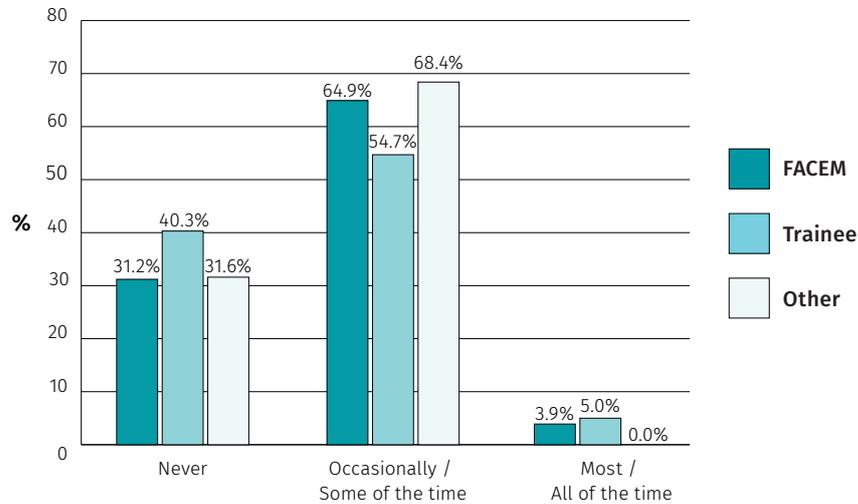
Working rostered night shifts

Over a third (36%, *N* = 796) of respondents reported having worked rostered night shifts in the past 12 months. Trainees (98%) and the Other training level group (68%) were more likely to report having worked rostered night shifts, compared to FACEMs (19%).

36% have worked rostered night shifts in the past 12 months

The percentage of respondents reporting working rostered night shifts decreased as age increased (Figure 16), with 96% of those aged less than 30 and 76% of those aged between 30 and 35 years of age having worked night shifts in the past 12 months, compared with 4% of those aged over 60 years. These differences were significant (χ^2(8, *N* = 783) = 197.9404, *p* < 0.001).

Figure 16 Percentage of respondents that reported working rostered night shifts in the past 12 months, by age (N = 783)
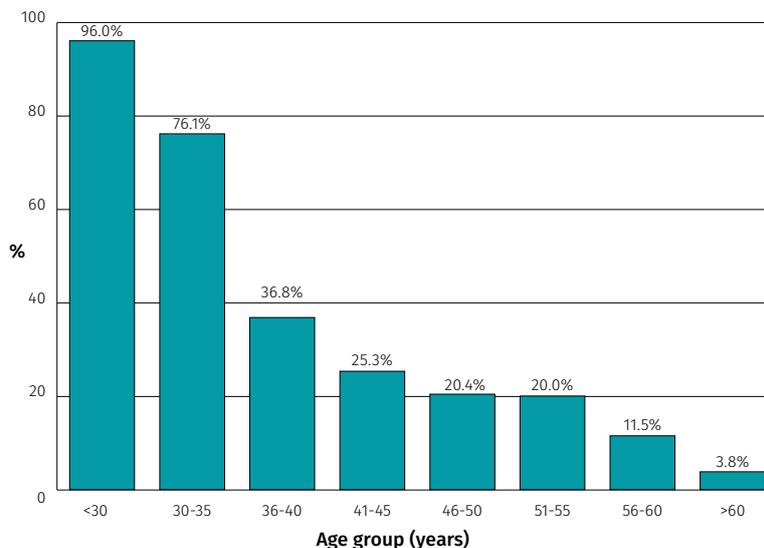
To investigate if employers were following the *Guidelines on constructing and retaining a senior emergency medicine workforce* (G23) (Australasian College for Emergency Medicine, 2015), respondents were asked how often they had at least one 24 hour period rostered off work for every night shift (excluding the first 24 hours following night shift). Overall, only 9% of respondents reported having met the recommended rostered time off after working rostered night shifts, with 37% reporting never having met the recommended rostered time off. For the rest of the respondents, 23% reported having the recommended time off occasionally, 16% some of the time and 15% most of the time. Trainees (41%) and the Other training level group (39%) were less likely to report having the recommended rostered time off compared to FACEMs (31%) (Figure 17), with this difference significant ($\chi^2(4$, *n* = 284) = 11.8677, *p* < 0.05).

Figure 17 Frequency that respondents reported having the recommended rostered time off following rostered night shifts in the past 12 months, by level of ACEM training (n = 284)
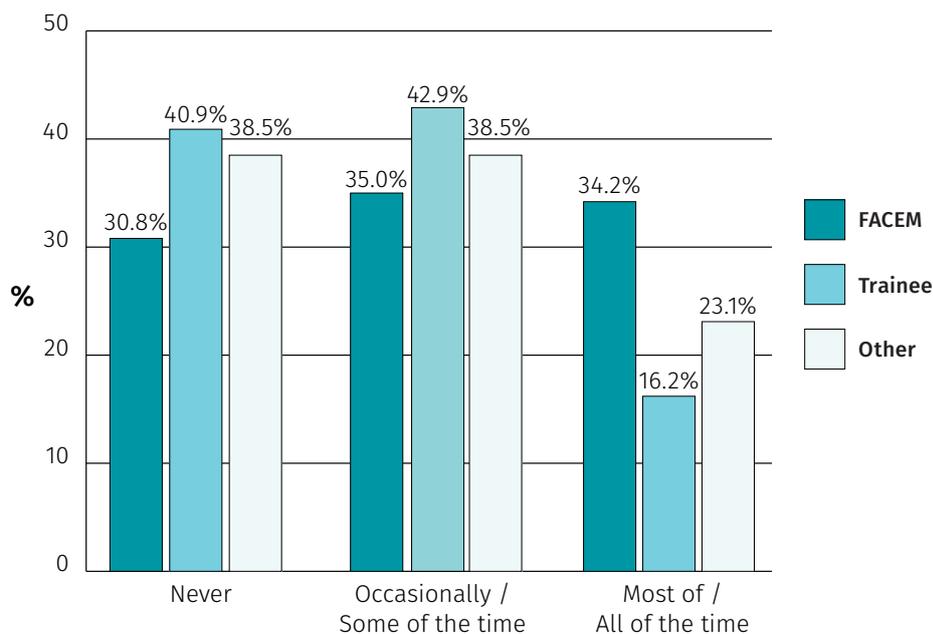
Rostered on-call

Respondents were asked to report if they had been rostered on-call in the past 12 months and, if so, how often they worked more than two nights on-call in a 7-day period, how often they were contacted, and how often they had to attend the workplace. Four did not respond to this question and were excluded from the analysis. Overall, 82% of respondents reported being rostered on-call in the past 12 months, with FACEMs (93%) more likely than trainees (44%) and the Other training level group (58%) to report this, with these differences significant ($\chi^2(2$, *n* = 792) = 215.5801, *p* < 0.001). Interestingly, males were more likely to be rostered on-call (86%) than females (78%), with this difference also significant ($\chi^2(2$, *n* = 783) = 8.0716, *p* < 0.05).

82% have been rostered on-call in the past 12 months

Worked more than two nights on-call in a 7-day period

Over half of those who reported being rostered on-call, were rostered on-call for more than two nights in a 7-day period (57%), with 5% reporting that they were rostered on-call for more than two nights all of the time.

Responses are summarised by level of ACEM training in Figure 18, with the Other training level group less likely to be rostered on-call for more than two nights in a 7-day period (38%), than FACEMs (57%) and Trainees (59%). The differences between being rostered on-call for more than two nights in a 7-day period and level of ACEM training were significant ($\chi^2(4$, n = 648) = 21.0999, p < 0.001).

Females were significantly less likely to be rostered on-call for more than two nights in a 7-day period (47%), than males (64%) ($\chi^2(4$, n = 641) = 28.8999, p < 0.001). Interestingly, those who worked in a metropolitan area were also less likely to be rostered on-call for more than two nights in a 7-day period (55%), compared to those who worked in a regional area (61%) ($\chi^2(2$, n = 648) = 6.6048, p < 0.05).

Figure 18 Frequency of respondents who reported being rostered on-call in the past 12 months and who reported being rostered on-call for more than two nights in a 7 day period, by level of ACEM training (n = 648)
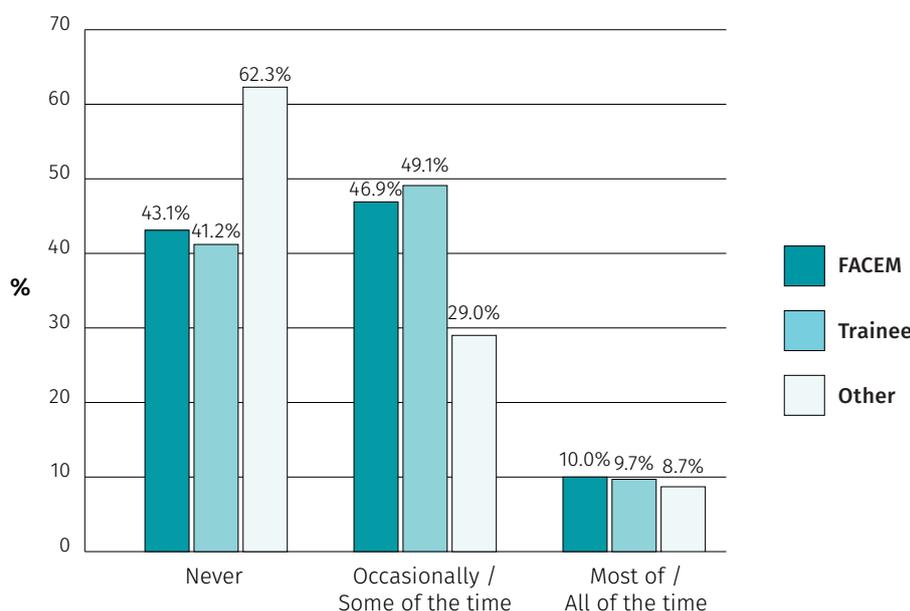
On-call and contacted by the workplace

Overall, the majority of those reporting being rostered on-call in the past 12 months were contacted while on-call (95%). Of the 618 who were contacted, 2% reported being contacted all the time, 14% most of the time, 35% some of the time, and 44% were contacted occasionally.

Responses are summarised by level of ACEM training in Figure 19 (over page), with FACEMs slightly more likely to be rostered on-call and contacted (96%) than Trainees (88%) and the Other training level group (91%), however this was not significant.

Figure 19 Frequency of respondents who reported being rostered on-call in the past 12 months and who reported being contacted while on-call, by level of ACEM training (n = 781)
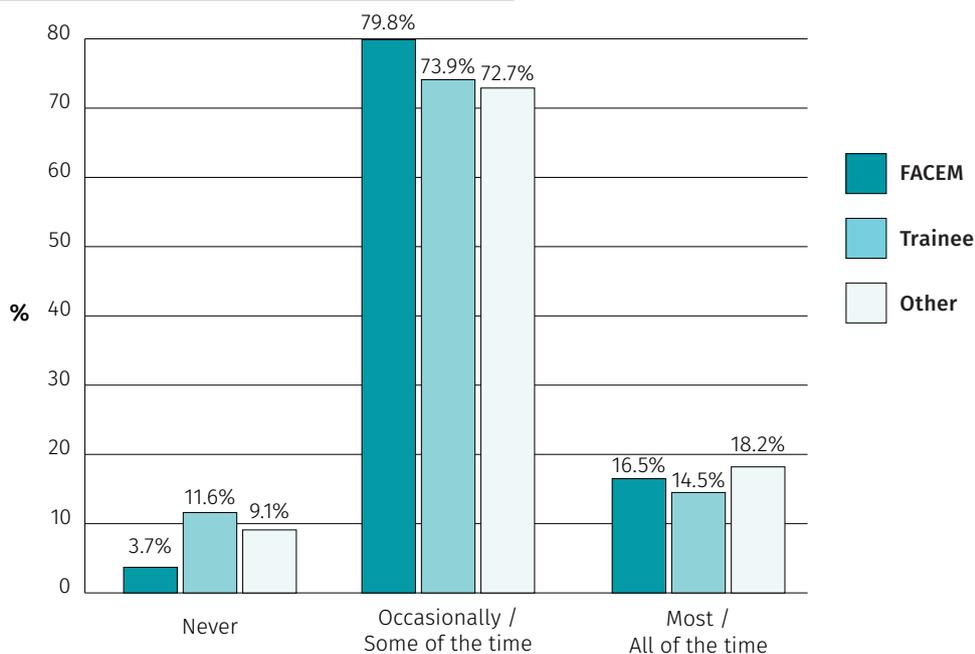
On-call and attend

Overall the majority of those who reported being on-call, reported having to attend the workplace (86%), with 4% reporting that they had to attend the workplace all the time. The remaining respondents reported attending the workplace occasionally (50%), some of the time (25%), or most of the time (8%).

Reponses are summarised by level of ACEM training in Figure 20. Those classified in the Other training level group were more likely to report having to attend the workplace (91%), than FACEMs (87%) and Trainees (81%), with these differences significant (χ^2(4, n = 648) = 19.7007, p < 0.001).

Figure 20 Frequency of respondents who reported being rostered on-call in the past 12 months and who reported having to attend the workplace, by level of ACEM training (n = 648)
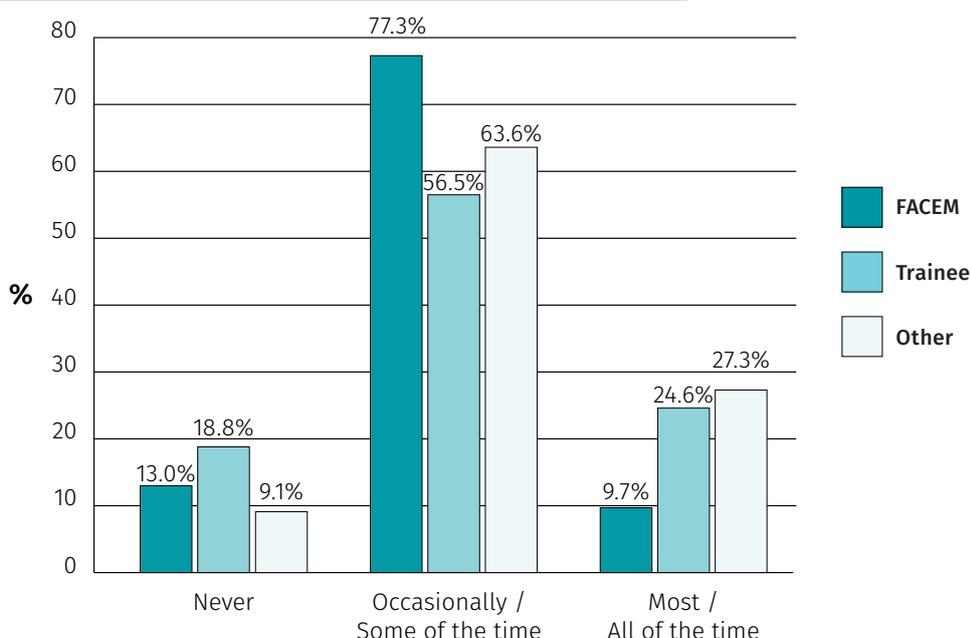
6.5 Workplace stress

Respondents were asked questions around their experiences of workplace stress. These questions included the top three workplace stressors for respondents, methods offered by respondents' primary employer to help them deal with workplace stress, and their personal response to stress. Responses to these questions are summarised below.

Top 3 stressors

Respondents were asked to identify the top three stressors of their primary (or most recent) workplace from a list of 17 stressors, with the option to specify other stressors. Eleven did not continue past the on-call questions and are excluded from further analysis as appropriate. Overall the top three stressors identified were overcrowding in the ED (63%), access block (56%), and conflicts with other clinical teams in the workplace (34%). The top three stressors are consistent to those identified by respondents to the *ACEM Workforce Sustainability Survey (2016)*. Responses are displayed in Figure 21 and are presented by level of ACEM training in Table 6 (over page).

Figure 21 Most stressful aspect of respondents' primary workplace (N = 781)

Workplace stressor – Overcrowding in the ED

Overcrowding in the ED was reported in the top three workplace stressors across level of ACEM training (62-68%), age group (50-70%), gender (62-63%), those working in metropolitan/ urban and regional/ rural areas (59-64%), and irrespective of where respondents gained their PMD (61-71%).

Workplace stressor – Access block

While access block was reported in the top three stressors across all sub-groups, more FACEMs were likely to report access block in their top three stressors (60%), compared with Trainees (44%) and the Other training level group (37%). The differences between these groups was significant (χ^2(2, *N* = 781) = 16.0148, *p* < 0.001).

Workplace stressor – Conflicts with other clinical teams

Conflicts with other clinical teams was reported in the top three workplace stressors across level of ACEM training (33-37%), age group (31-40%), gender (32-38%), and those working in metropolitan/ urban and regional/ rural areas (33–36%). Those who obtained their PMD in New Zealand were less likely to report conflict with other clinical teams as a top three stressor (27%) than those who obtained their PMD in Australia (34%), the United Kingdom (38%) or another country (36%).

Table 6 Respondents most stressful aspects of their primary workplace, by level of ACEM training (N = 781)

	FACEM		Trainee		Other		Total	
	n	%	n	%	n	%	n	%
Overcrowding in the ED	377	**62.3%**	98	**62.4%**	13	**68.4%**	488	**62.5%**
Access block	363	**60.0%**	69	**43.9%**	7	**36.8%**	439	**56.2%**
Conflicts with other clinical teams in the workplace	210	**34.7%**	52	**33.1%**	7	**36.8%**	269	**34.4%**
IT Issues	144	23.8%	28	17.8%	5	26.3%	177	22.7%
Unrealistic patient or community expectations	130	21.5%	39	24.8%	7	**36.8%**	176	22.5%
Pressures from workplace administration and executives	145	24.0%	22	14.0%	1	5.3%	168	21.5%
KPIs and/or the 4-hour (Australia) or 6-hour (New Zealand) target	87	14.4%	39	24.8%	4	21.1%	130	16.6%
Aggressive or violent patients (or carers)	92	15.2%	30	19.1%	3	15.8%	125	16.0%
Conflicts within my work team	44	7.3%	9	5.7%	2	10.5%	55	7.0%
Meeting ACEM training requirements	6	1.0%	40	25.5%	1	5.3%	47	6.0%
Inadequate staffing	30	5.0%	7	4.5%	0	0.0%	37	4.7%
Threat of litigation	13	2.1%	4	2.5%	0	0.0%	17	2.2%
Other	51	8.8%	11	7.2%	1	5.3%	63	8.1%

Workplace stressor – IT Issues

Those whose primary workplace was located in a regional-rural area were more likely to report IT issues (29%) as a workplace stressor, than those whose primary workplace was located in a metropolitan/ urban area (19%), with this difference significant (χ^2(1, N = 781) = 10.6834, p < 0.01).

Workplace stressor – KPIs and/or the 4 hour (Australia) or 6 hour (New Zealand) target

Those who obtained their PMD in New Zealand were less likely to report KPIs and/or the 4 hour (Australia)/ 6 hour (New Zealand) target (5%) as a workplace stressor, than those who obtained their PMD in Australia (20%), United Kingdom (15%), or another country (16%), with these differences significant(χ^2(3, N = 749) = 12.0611, p < 0.01).

Primary employer assistance in managing stress

Respondents were asked to select the methods their primary employer offers to help them manage stress at work. Responses are summarised in Figure 22 (over page) and Table 7 (over page). Of the 773 who responded to this question, 52% indicated that their primary employer offers an employee assistance program (EAP) and counselling; 39% reported that they had supportive leadership; 36% reported that their employer fosters a collaborative and supportive team culture; and 14% were not aware of any methods their primary employer offered to help them manage stress at work.

Figure 22 Methods primary employer offers to help you deal with stress at work (N = 773)

EAP and counselling

There were significant differences between those likely to report that their employer offers an EAP and level of ACEM training, gender, remoteness and where a respondent obtained their PMD. With:

+ FACEMs (55%) and Trainees (44%) much more likely to report that their employer offers an EAP and counselling to help them deal with workplace stress than the Other training level group (17%) (χ2(2, N = 772) = 15.3313, p < 0.001);

+ males (46%) less likely to report that their employer offers an EAP and counselling to help them deal with workplace stress, than females (59%) (χ2(2, N = 763) = 13.6432, p < 0.01);

+ those whose primary workplace was located in a regional/ rural area (47%) less likely to report that their employer offers an EAP and counselling to help them deal with workplace stress than those whose primary workplace was in a metropolitan/ urban area (54%) (χ2(1, N = 772) = 4.2291, p < 0.05); and

+ those who obtained their PMD in New Zealand (80%) more likely to report that their employer offers an EAP and counselling to help them deal with workplace stress than those who obtained their PMD in the United Kingdom (56%), Australia (48%), or another country (45%) (χ2(3, N = 741) = 31.3420, p < 0.001).

Table 7 Methods primary employer offers to help respondents manage stress at work (N = 773)

	n	%
Employee Assistance Program and counselling	399	51.6%
Supportive leadership	306	39.6%
Fostering a collaborative and supportive team culture	277	35.8%
Staff social events	260	33.6%
Professional development	214	27.7%
Mentoring program	204	26.4%
Adverse event debriefing	197	25.5%
Easy access to leave	197	25.5%
Debriefing activities (excluding adverse event debriefing)	167	21.6%
Wellbeing activities (e.g., meditation, exercise activities)	150	19.4%
Resources for wellbeing	115	14.9%
Free food or drinks	64	8.3%
Improving working conditions (e.g., providing medical scribes or new equipment)	38	4.9%
Other	13	1.7%
None	106	13.7%

Staff social events

Those whose primary workplace was located in a regional/ rural area (29%) were less likely to report that their primary employer offers staff social events, than those whose workplace was located in a metropolitan/ urban area (37%), with this difference significant (χ²(1, N = 772) = 4.8844, p < 0.05).

Professional development

FACEMs (32%) and those classified in the Other training level group (33%) were more likely than Trainees (11%), to report that their primary employer offered professional development to help them manage stress, which was significant (χ²(2, N = 772) = 27.6318, p < 0.001).

Mentoring program

Trainees (61%) were more likely than FACEMs (18%) and the Other training level group (6%), to report that a mentoring program was offered by their primary employer, with these differences significant (χ^2(2, *N* = 772) = 120.9044, *p* < 0.001).

There were also significant differences between those who reported that their primary employer offers a mentoring program and age (χ^2(7, *N* = 761) = 78.2111, *p* < 0.001), with older respondents less likely to report that their primary employer offers a mentoring program (Figure 23).

Figure 23 Percentage of respondents reporting that a mentoring program is offered by their employer, by age (N = 761)
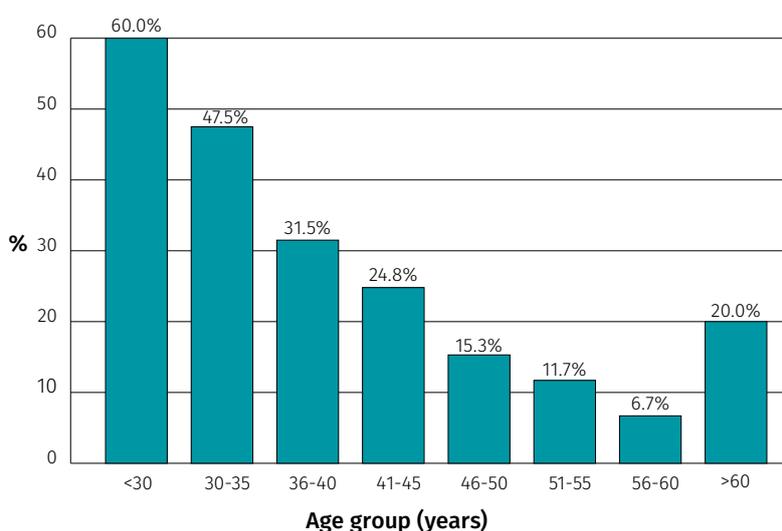
Easy access to leave

FACEMs (29%) were more likely to report easy access to leave being provided by their primary employer than Trainees (13%) and the Other group (17%), with the differences between these groups significant (χ^2(2, *N* = 772) = 16.3350, *p* < 0.001).

Debriefing activities (excluding adverse event debriefing)

Those whose primary employer was located in a regional/ rural area (17%) were significantly less likely to report that their employer offers debriefing activities (aside from adverse event debriefing), than those whose primary employer was located in a metropolitan/ urban area (24%) (χ^2(1, *N* = 772) = 6.4618, *p* < 0.05).

Wellbeing activities (e.g. meditation, exercise activities) and resources for wellbeing)

FACEMs were significantly more likely (21%) than Trainees (14%) and the Other group (0%), to report that wellbeing activities were offered by their primary employer (χ^2(2, *N* = 772) = 8.6586, *p* < 0.05).

Males (12%) were significantly less likely than females (18%), to report that resources for wellbeing were offered by their primary employer (χ^2(2, *N* = 763) = 11.7310, *p* < 0.01). Those whose primary workplace was located in a regional/ rural area were also significantly less likely to report that their employer offered wellbeing activities (14%) or wellbeing resources (11%) than those whose workplace was located in a metropolitan/ urban area (23% and 17% respectively) (χ^2(1, *N* = 772) = (8.9010 and 5.3400), (*p* < 0.01 and *p* < 0.05)).

There were also significant differences among respondents reporting whether wellbeing activities were offered by their employer based on their age (χ^2(7, *N* = 761) = 15.3647, *p* < 0.05), with the findings presented in Figure 24 (over page).

Figure 24 Percentage of respondents reporting that wellbeing activities are offered by their employer, by age (N = 761)
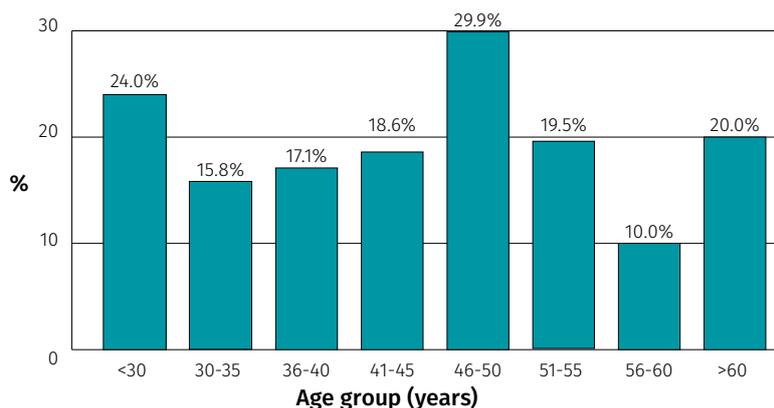
No methods offered by primary employer to help manage stress at work

Respondents whose primary workplace was located in a regional/ rural area (18%) were more likely to report that their employer offered no methods to help them manage stress at work, than those whose workplace was located in a metropolitan/ urban area (11%), with the difference between these groups significant ($\chi^2(1, N = 772) = 7.1123, p < 0.01$).

Personal response to stress

Respondents were asked to indicate what their typical response to stress was, with 763 responding to this question. Responses are summarised in Table 8 and Figure 25. Over half indicated that they do something they enjoy (58%) and/or spend time with their family (56%), to cope with stress. Other coping strategies included increasing physical exercise (43%), taking a holiday (36%), spending time with friends (30%) and eating more than usual (30%).

Table 8 Respondents typical response to manage their stress (N = 763)

	n	%
Do something I enjoy	445	58.3%
Spend time with family	428	56.1%
Increase physical exercise	325	42.6%
Take a holiday	271	35.5%
Eat more than usual	229	30.0%
Spend time with friends	229	30.0%
Avoid being with people	196	25.7%
Drink more alcohol	194	25.4%
Practice mindfulness or other relaxation techniques	174	22.8%
Discuss concerns with a mentor	173	22.7%
Take time off work	120	15.7%
Pray	70	9.2%
Formal debriefing	29	3.8%
Informal debriefing	16	2.1%
Smoke more cigarettes than usual	16	2.1%
Use prescription drugs	15	2.0%
Use recreational drugs	3	0.4%
Other	40	5.2%

Figure 25 Typical response of respondents to stress (N = 763)
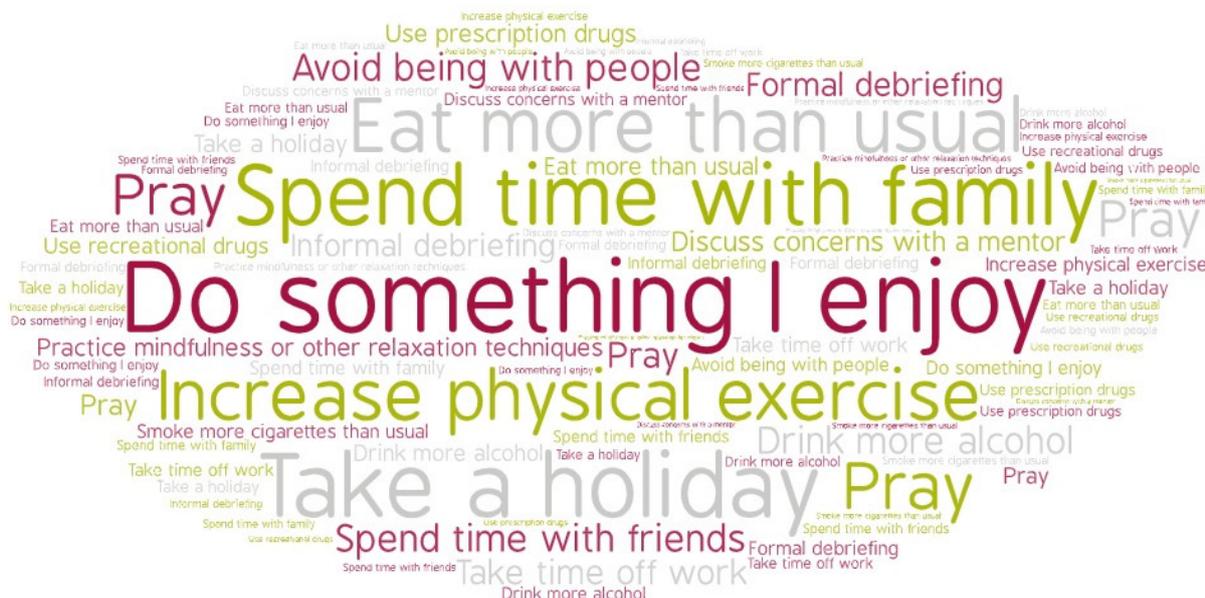
6.6   Concern about a colleague

Respondents were asked if they had been concerned about the health and/or welfare of a work colleague in the past 12 months. Seven of the 759 who responded to this question indicated that the question was not applicable and have been excluded from this analysis.

81% had been concerned about the health and/or welfare of a work colleague in the past 12 months

Overall, the majority (81%) of respondents reported being concerned about the health and/or welfare of a colleague in the past 12 months. There were significant differences between being concerned about a colleague and level of ACEM training, with 94% of those classified in the Other training level group, 82% of FACEMs and 74% of Trainees reporting that they had been concerned about a colleague in the past 12 months (χ^2(2, *N* = 752) = 7.6090, *p* < 0.05).

Ability to take action

Irrespective of whether respondents had been concerned about a work colleague in the past 12 months, they were asked if they felt able to take action within their primary workplace if they were concerned about a colleague. Five of the 759 who responded to this question indicated that this question was not applicable and have been excluded from analysis.

61% felt that they were able to take action in their primary workplace if they were concerned about a colleague

Overall, 61% of respondents felt that they were able to take action in their primary workplace if they were concerned about a colleague, with 25% reporting that they did not know if they were able to, and 14% reported that they felt unable to take action. There were significant differences between feeling able to take action if concerned about a colleague, by level of ACEM training (Figure 26); and by location of their PMD (Figure 27).

FACEMs (67%) were more likely to indicate that they felt able to take action if concerned about a colleague, compared to Trainees (43%) and Other levels of ACEM training (39%), with these differences significant (χ^2(4, $N = 754$) = 33.2330, $p < 0.001$).

Figure 26 Percentage of respondents reporting whether they were able to, unable to, or did not know whether they could take action at their primary workplace if concerned about a colleague, by level of ACEM training (N = 754)
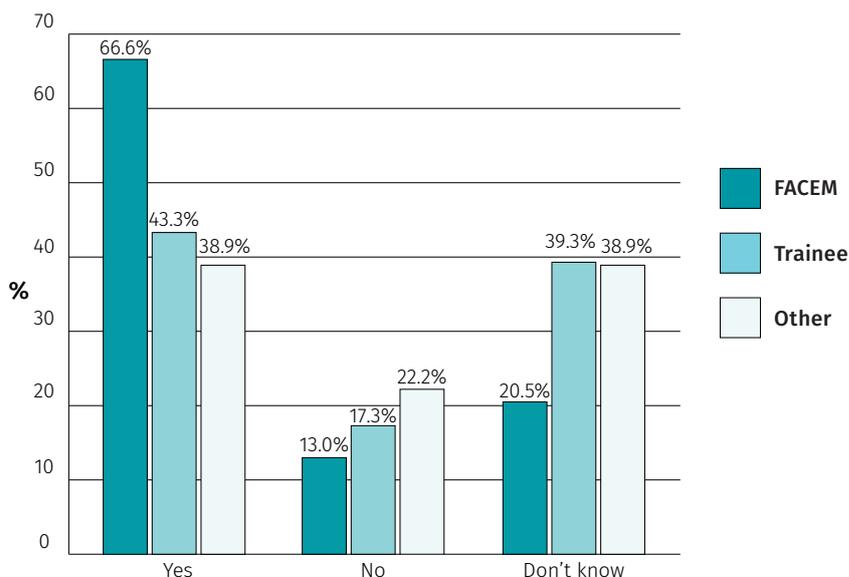
Those who obtained their PMD in the United Kingdom (69%) and Australia (64%) were more likely to report that they felt able to take action if concerned about a colleague, compared to those who obtained their PMD in New Zealand (58%) or another country (49%) (χ^2(6, $N = 725$) = 14.0215, $p < 0.05$).

Figure 27 Percentage of respondents reporting whether they were able to, unable to, or did not know whether they could take action at their primary workplace if concerned about a colleague, by country of PMD (N = 725)
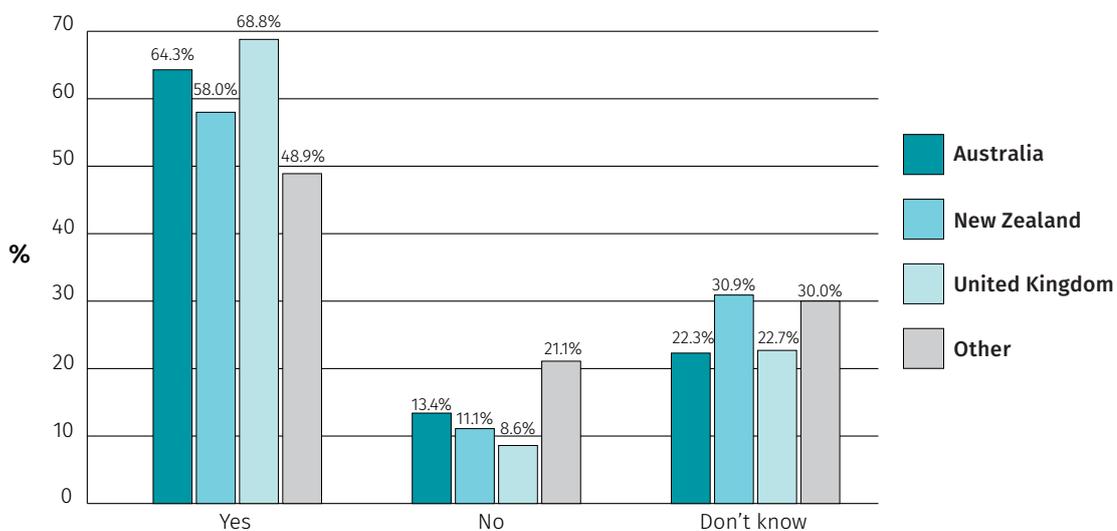
6.7 Support Services

Respondents were asked if they were aware of seven specific support services available to doctors, with the option to nominate other support services available to doctors, that they were aware of. The majority (80%) of the 756 who responded to this question were aware of their workplace EAP, however 12% of respondents reported not being aware any available support services (Table 9).

Table 9 Percentage of respondents who reported being aware of support services available to doctors

	FACEM		Trainee		Other		Total	
	n	%	n	%	n	%	n	%
Australia Only Support Services (*N* = 650)								
Australian Doctors' Health Advisory Services (e.g., Victorian Doctors' Health Program)	238	47.5%	51	37.8%	2	14.3%	291	44.8%
AMA Peer Support Service	102	20.4%	20	14.8%	2	14.3%	124	19.1%
Remote and rural services (e.g., Bush Support Services)	7	1.4%	0	0.0%	1	7.1%	8	1.2%
New Zealand Only Support Services (*N* = 106)								
New Zealand Doctors' Health Advisory Service	25	28.4%	1	7.1%	1	25.0%	27	25.5%
Support Services Available to all Respondents (*N* = 756)								
Your workplace's Employee Assistance Program (EAP)	493	83.7%	103	69.1%	8	44.4%	604	79.9%
ACEM's member and trainee EAP service (Converge International)	169	28.7%	40	26.8%	0	0.0%	209	27.6%
Other	17	2.9%	1	0.7%	0	0.0%	18	2.4%
I am not aware of any available support services	50	8.5%	30	20.1%	8	44.4%	88	11.6%

Eighteen respondents nominated other support services available to doctors, which included primary care provider(s) (0.9%), local medical support groups/services (0.7%), health care providers (0.4%) and insurance companies (0.4%).

6.8 Professional Isolation

Respondents were asked if they felt professionally isolated in their primary workplace in the past 12 months, where professional isolation was defined as a sense of isolation from professional peers, resulting in a sense of estrangement from professional identity and practice currency, or a feeling that they have 'no one to turn to' to discuss and share professional issues and ideas.

29% felt professionally isolated in their primary workplace in the past 12 months

Of the 755 who responded to this question, 29% reported feeling professionally isolated in their primary workplace in the past 12 months, 5% were unsure and 66% reported not feeling professionally isolated. Those classified in the Other training level group (44%) were more likely to report that they felt professionally isolated at their primary workplace in the past 12 months, than Trainees (36%) or FACEMs (27%), with these differences significant, $\chi^2(4, N = 755) = 22.3149$, $p < 0.001$ (Figure 28).

Figure 28 Response rates to whether respondents felt professionally isolated at their primary workplace in the past 12 months, by level of ACEM training (N = 755)
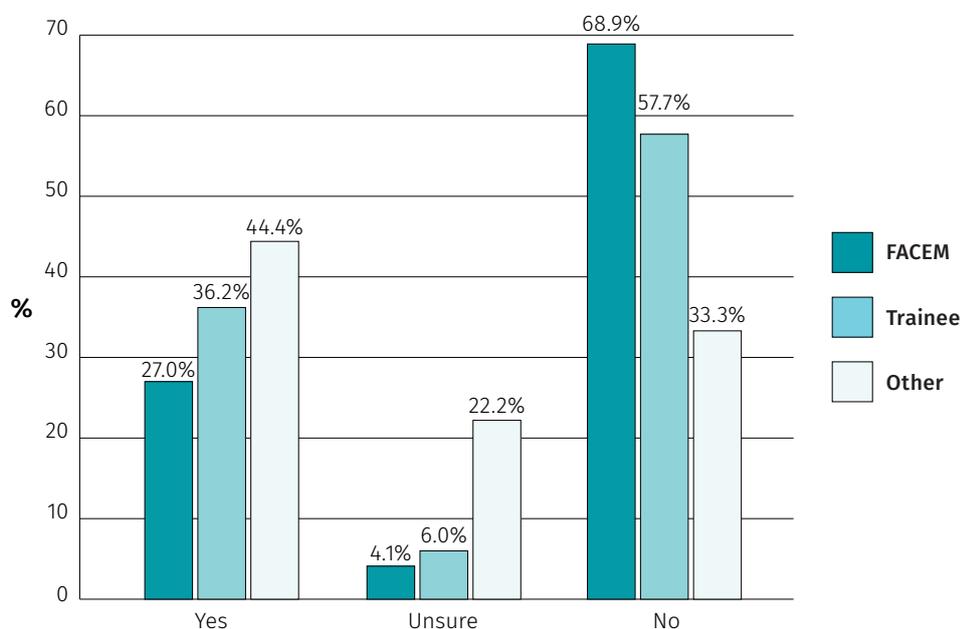
Those who obtained their PMD in a country other than Australia, New Zealand or the United Kingdom were slightly more likely to report that they had felt professionally isolated at their primary workplace (38% compared to 26-27%), although this was not significant.

Respondents whose primary workplace was located in a regional/ rural (32%) area were more likely to report that they had felt professionally isolated in the past 12 months, than those whose primary workplace was located in a metropolitan/ urban area (28%), although this difference was also not significant.

6.9 Incivility and rudeness

ACEM's Diversity and Inclusion Steering Group identified that incivility and rudeness have an impact on workplace culture and wellbeing, as they are potentially daily occurrences experienced by the emergency medicine workforce. Respondents were asked about their experiences of workplace incivility and rudeness and whether these behaviours were displayed by their supervisor, co-workers and/ or clients/patients. The overall results are summarised in Table 10 (over page), as well as presented by level of ACEM training.

29% reported that their supervisor is hostile, rude or uncivil

A total of 752 responded to these questions, with 42 indicating that the question about incivility and rudeness from their supervisor was not applicable, two reported that the question about incivility and rudeness from their co-workers was not applicable and one reported that the question about client/patient incivility and rudeness was not applicable. While 80% of respondents were satisfied with their interactions with their colleagues (see Table 4), 29% reported that their supervisor is hostile, rude or uncivil towards them, 76% reported that their co-workers are hostile, rude or uncivil and 96% reported that their clients/patients are hostile, rude or uncivil towards them.

Table 10 Frequency that respondents reported experiencing hostility, rudeness and incivility from their supervisor, co-workers and clients/patients, by level of ACEM training

	Never		Occasionally / Some of the time		Most / All of the time	
	n	%	n	%	n	%
My supervisor is hostile, uncivil or rude to me (N=710)	**505**	**71.1%**	**172**	**24.2%**	**33**	**4.6%**
FACEM	391	71.9%	126	23.2%	27	5.0%
Trainee	98	66.2%	44	29.7%	6	4.1%
Other	16	88.9%	2	11.1%		
My co-workers (e.g., other ED staff or other hospital staff) are hostile, uncivil or rude to me (N=750)	**182**	**24.3%**	**534**	**71.2%**	**34**	**4.5%**
FACEM	144	24.7%	416	71.2%	24	4.1%
Trainee	30	20.3%	108	73.0%	10	6.8%
Other	8	20.5%	10	25.6%	21	53.8%
My clients/patients are hostile, uncivil or rude to me (N=751)	**27**	**3.6%**	**689**	**91.7%**	**35**	**4.7%**
FACEM	20	3.4%	543	93.0%	21	3.6%
Trainee	5	3.4%	130	87.2%	14	9.4%
Other	2	11.1%	16	88.9%		

76% reported that their co-workers are hostile, rude or uncivil

Trainees were more likely (34%) than FACEMs (28%) or the Other training level group (11%) to report that their supervisor was hostile, rude or uncivil towards them, while FACEMs (75%) were slightly less likely than Trainees (80%) and the Other group (79%) to report that their co-workers are hostile, rude or uncivil towards them. The Other group were less likely to report that their clients/patients were hostile, rude or uncivil towards them (89%) than FACEMs and Trainees (97%), with these differences significant ($\chi^2(4, N = 751) = 12.7692, p < 0.05$) (Figure 29).

Figure 29 Frequency that respondents reported experiencing hostility, incivility or rudeness by clients/patients, by level of ACEM training (N = 751)
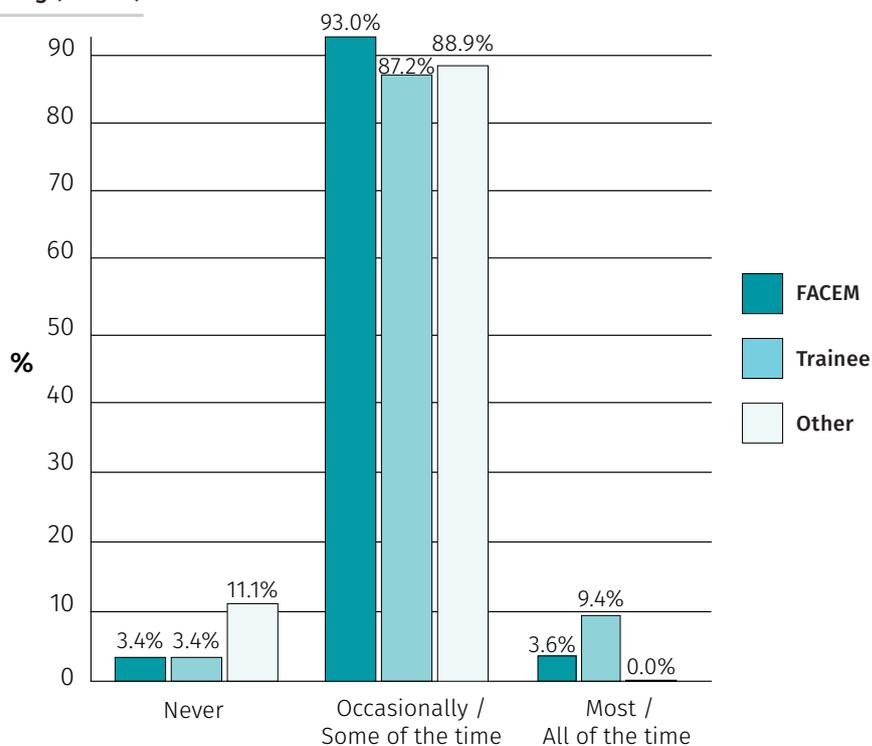
There were also significant differences between experiencing hostility, incivility or rudeness by a co-worker and age ($\chi^2(14, N = 739) = 35.9048, p < 0.01$) (Figure 30, over page); and by gender ($\chi^2(4, N = 741) = 29.5390, p < 0.001$) (Figure 31, over page).

Figure 30 Frequency that respondents reported experiencing hostility, incivility or rudeness by a co-worker, by age (N = 739)

	Never	Occasionally / Some of the time	Most / All of the time
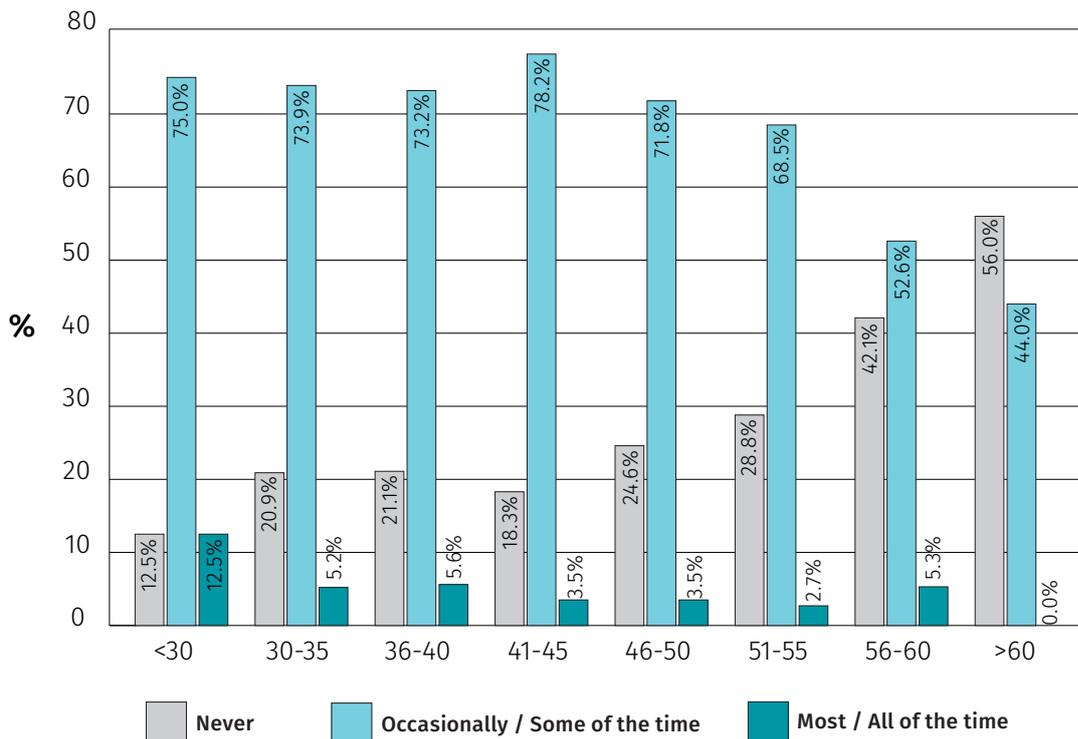
Figure 31 Frequency that respondents reported experiencing hostility, incivility or rudeness by a co-worker, by gender (N = 741)
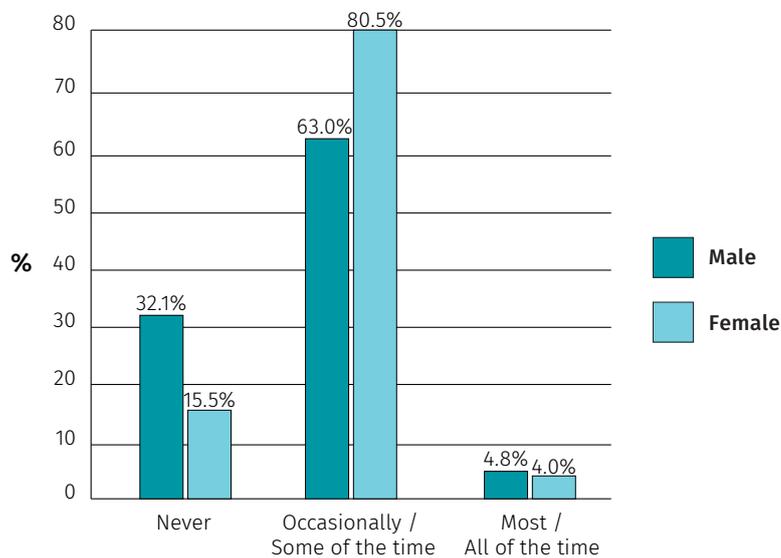
6.10 Anxiety

To measure workplace anxiety respondents were asked about how frequently they experience anxiety at work and outside of work. If respondents indicated that they experienced anxiety at work and/or anxiety outside of work, they were asked how much their workplace contributed to the anxiety they felt.

Of the responses, 87% (*N* = 749) reported that they felt anxious at work, with all of those who reported this, reporting that their workplace contributed to this anxiety. Three-quarters (75%, *N* = 750) reported that they have felt anxious outside of work, with 96% of those who reported this, reporting that their workplace contributed to their anxiety outside of work.

Anxiety at work

Of the 749 responses to this section, only 13% reported that they have never felt anxious at work, 76% reported that they felt anxious at work occasionally or some of the time, and 11% reported feeling anxious most or all of the time at work. FACEMs were slightly less likely to report feeling anxious at work (86%), than Trainees and the Other group (89%), with the Other group more likely to report that they felt anxious at work most or all of the time (22%), compared to Trainees (13%) and FACEMs (10%) (Figure 32), although, these differences were not significant.

87% reported that they have felt anxious at work

Figure 32 Frequency that respondents reported feeling anxious at work, by level of ACEM training (N = 749)
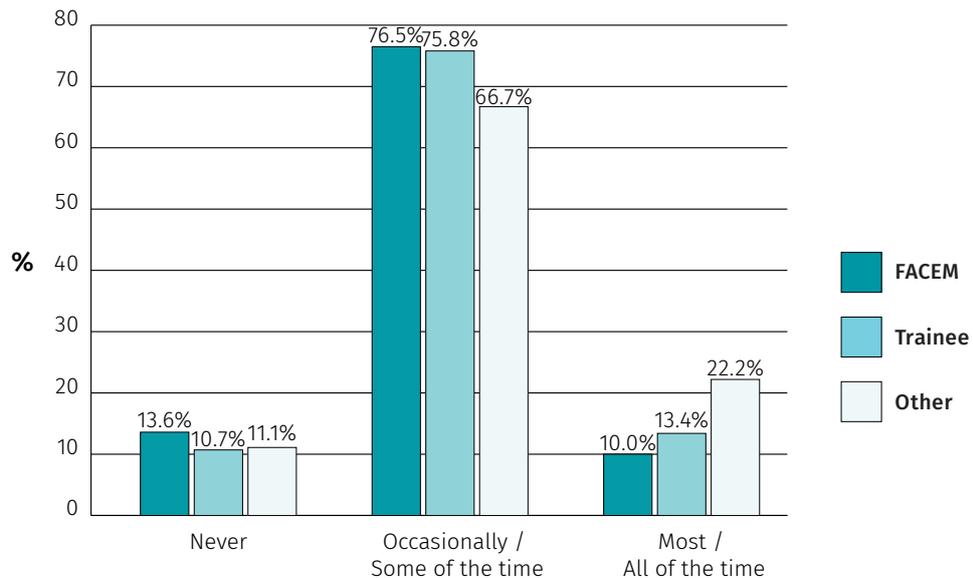
There were however significant differences between respondents reporting feeling anxious at work by gender (see Figure 33), with females more likely to report that they had felt anxious at work (95%) compared with males (81%) (χ^2(4, N = 740) = 42.2175, p < 0.001). Interestingly, while females were significantly more likely to report that they felt anxious at work, males were significantly more likely to report that they felt anxious at work most or all of the time.

Figure 33 Frequency that respondents reported feeling anxious at work, by gender (N = 740)
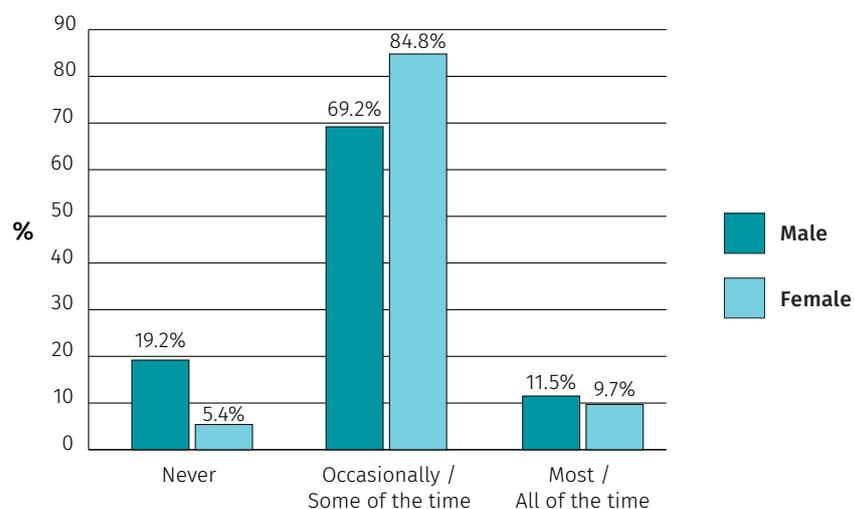
Those who obtained their PMD in another country were also significantly more likely to report that they felt anxious at work most or all of the time (20%), compared to those who obtained their PMD in Australia (10%), New Zealand (4%), or the United Kingdom (8%) (χ^2(6, N = 719) = 20.3019, p < 0.01) (Figure 34).

Figure 34 Frequency that respondents reported feeling anxious at work, by country in which they obtained their PMD (N = 719)
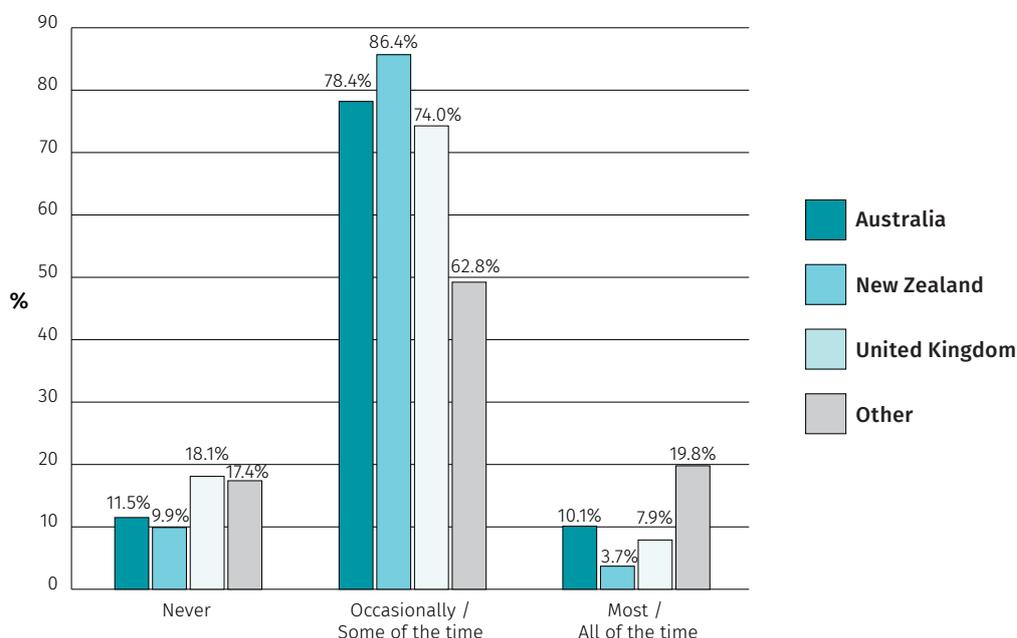
100% of those who reported feeling anxious at work reported that their workplace contributed to this anxiety

Of the 652 who reported that they felt anxious at work, only 0.1% reported that their workplace never contributes to the anxiety they feel at work, 32% reported that their workplace rarely or occasionally contributes to the anxiety they feel at work, and 55% reported that their workplace contributes to a moderate amount or a great deal of the anxiety they feel at work. Figure 35 (over page) shows a breakdown of the amount to which, respondents felt their work contributes to the anxiety they feel at work, by level of ACEM training.

Figure 35 Frequency that work contributes to the anxiety respondents feel at work, by level of ACEM training (N = 652)
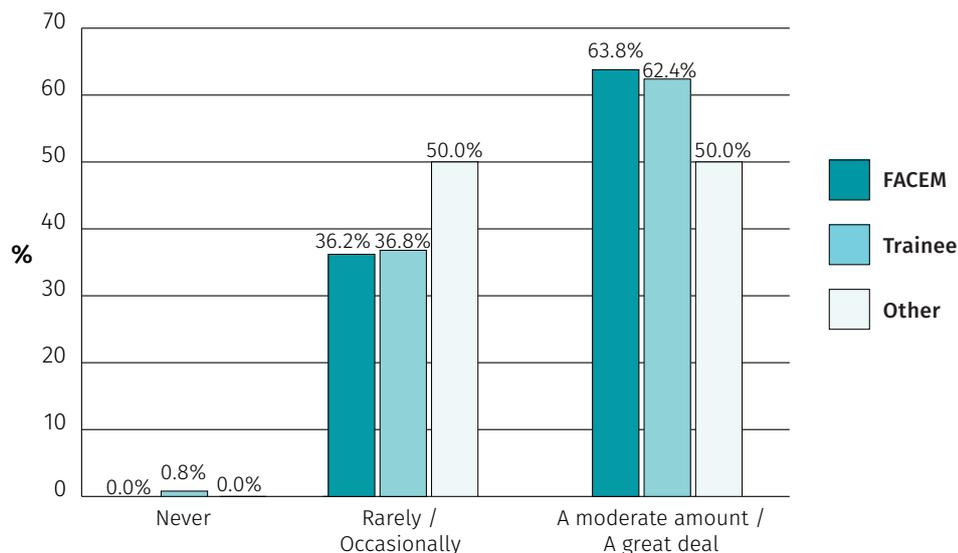
Anxiety outside of work

Of the 750 responses to this section, only 25% reported that they have never felt anxious outside of work, 69% reported that they felt anxious outside of work rarely or occasionally, and 5% reported feeling anxious outside of work most or all of the time. FACEMs were less likely (73%) than Trainees (82%) and those in the Other training level group (83%), to report that feeling anxious outside of work, although this difference was not significant (Figure 36).

75% reported that they have felt anxious outside of work

Figure 36 Frequency that respondents reported feeling anxious outside of work, by level of ACEM training (N = 750)
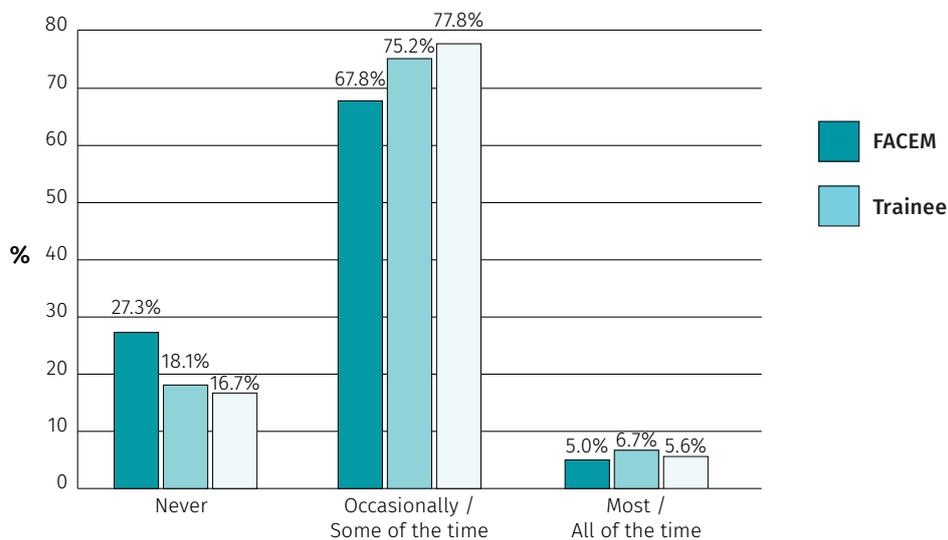
There were significant differences between respondents reporting feeling anxious outside of work and gender (see Figure 37, over page), with females more likely to report that had felt anxious outside of work (85%) compared with males (66%) ($\chi^2(4$, $N = 741) = 36.1630$, $p < 0.001$).

Figure 37 Frequency that respondents reported feeling anxious outside of work, by gender (N = 741)
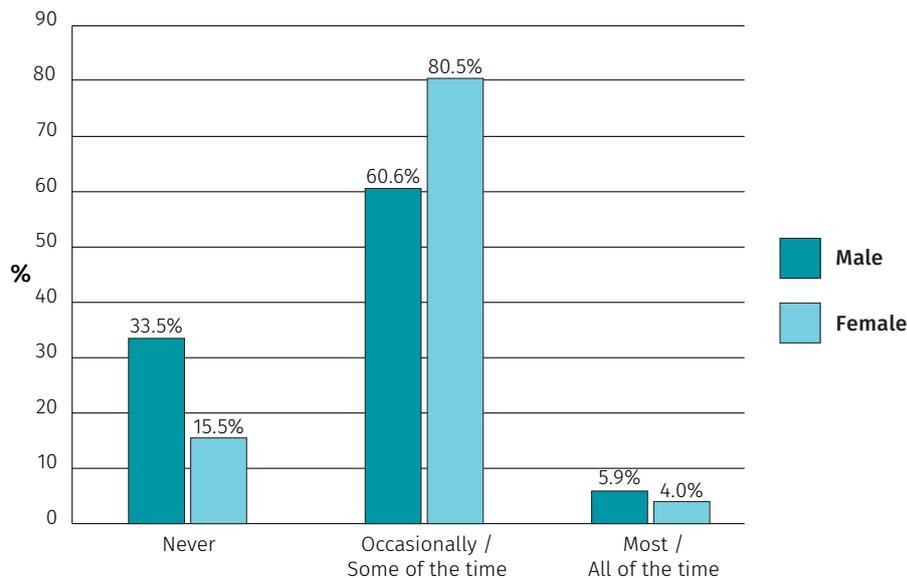
96% of those who reported that they felt anxious outside of work reported that their workplace contributed to this anxiety

Of the 561 who reported that they felt anxious outside of work, 4% reported that work never contributes to the anxiety they feel outside of work, 54% reported that their workplace rarely or occasionally contributes to the anxiety they feel outside of work, and 42% reported that their workplace contributes a moderate amount to a great deal of the anxiety they feel outside of work. FACEMs (97%) were slightly more likely to report that their workplace contributes to the anxiety they feel outside of work, than Trainees (94%) and those in the Other training level group (93%), although these differences were not significant (Figure 38).

Figure 38 Frequency that respondents reported feeling that work contributes to the anxiety they feel outside of work, by level of ACEM training (N = 561)
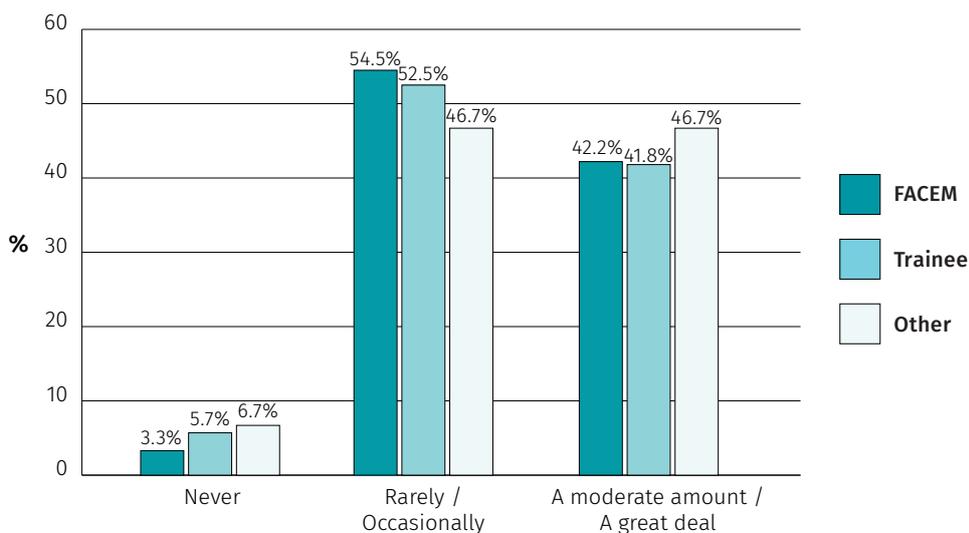
6.11 Fatigue

There are rising levels of concern amongst the College about the impact fatigue is having on the sustainability of the emergency medicine workforce. Fatigue is more than feeling tired and drowsy, and in a work context, fatigue is mental and/ or physical exhaustion that reduces the ability of individuals to perform their work safely and effectively.

81% of respondents believed fatigue had affected their performance at work.

Respondents were asked if they believed fatigue had affected their performance at work in the past 12 months. The majority of respondents reported that they did believe fatigue had affected their performance at work (81%), and 19% did not believe fatigue had affected their performance at work (N = 742). Those classified in the Other training level group (94%) and Trainees (89%) were more likely to report that fatigue had affected their performance at work, compared to FACEMs (78%), with these differences significant (χ^2(2, N = 742) = 11.4956, p < 0.01). Females were also significantly more likely to report that fatigue had affected their performance at work (84%), compared to males (77%) (χ^2(2, N = 733) = 6.4591, p < 0.05). Overall, the percentage of respondents reporting that fatigue had affected their performance at work decreased with age, with these differences also significant (χ^2(7, N = 731) = 23.3786, p < 0.01) (see Figure 39).

Figure 39 Percentage of respondents reporting that fatigue has affected their performance at work in the past 12 months, by age (N=731)
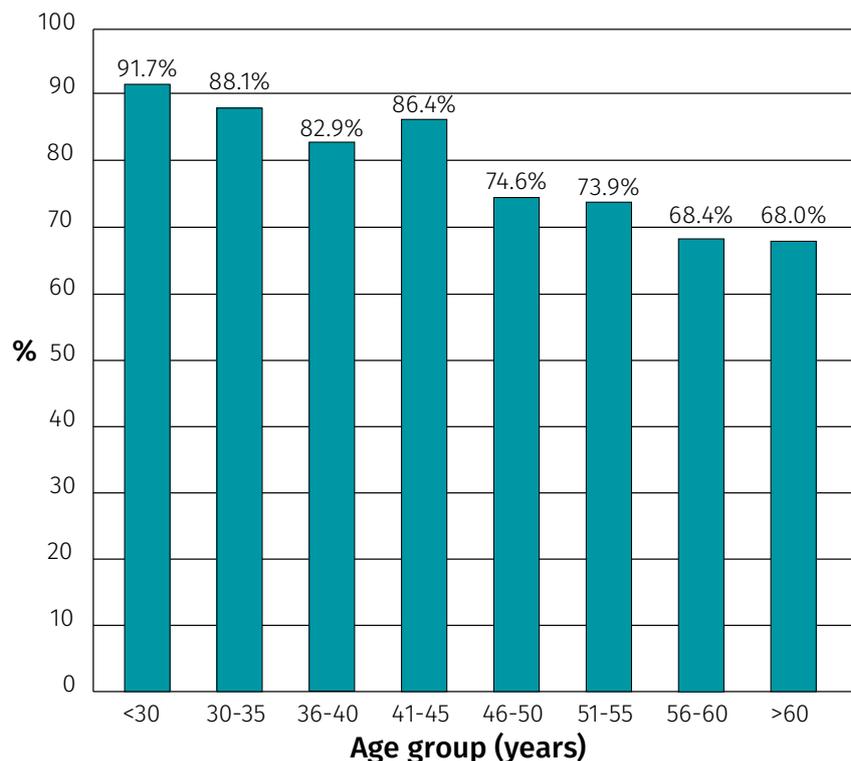
6.12 Burnout

Burnout is a special type of work-related stress, it is a state of physical or emotional exhaustion that also involves a sense of reduced accomplishment and loss of personal identity.

To measure burnout of the ACEM membership, respondents were asked to respond to a set of questions that form a validated tool to measure burnout, called the Copenhagen Burnout Inventory (CBI) (*The National Research Centre for Work Environment*, n.d.). The CBI is designed to measure personal, work-related and client-related burnout. Responses to measures for personal, work-related and client related burnout have been aggregated[2] and scored, with the scores categorised into four groups:

+ No - Low (mean score less than 50 for the measure),

+ Moderate (mean score 50-74 for the measure),

+ High (mean score 75-99 for the measure), and

+ Severe (mean score of 100 for the measure).

For the purpose of this report High and Severe have been collapsed into one group.

This question was not applicable for the ten respondents who were not working at the time of completing the survey, leaving 729 who responded to this section.

Personal burnout

Personal burnout is a state of prolonged physical and psychological exhaustion. Overall, 55% of respondents were classified as having no or low personal burnout, 36% were classified as having moderate personal burnout, and 9% as having high/severe personal burnout. Trainees (59%) and those in the Other training level group (59%) were more likely to be classified with moderate, high or severe personal burnout than FACEMs (41%), with these differences significant ($\chi^2(4, N = 729) = 26.4752, p < 0.001$) (Figure 40).

45% of respondents reported moderate to severe personal burnout

Figure 40 Percentage of respondents experiencing personal burnout, by level of ACEM training (N = 729)

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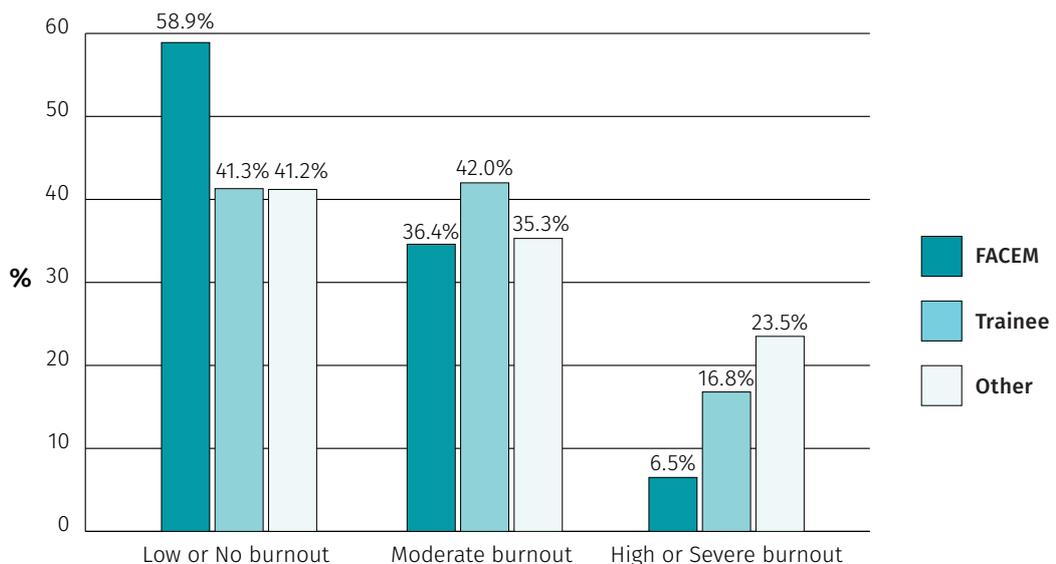
[2] Personal Burnout, *m* = 46 (range: 0-100) cronbachs alpha = 0.93. Work-related burnout, *m* = 48 (range: 0-100) cronbachs alpha = 0.91. Client-related burnout, *m* = 28 (range: 0-86) cronbachs alpha = 0.90.

There were also significant differences in personal burnout by age group (χ^2(14, N = 718) = 43.8639, p < 0.001), with personal burnout tending to decrease with age, as presented in Figure 41.

Figure 41 Percentage of respondents experiencing personal burnout, by age (N = 718)
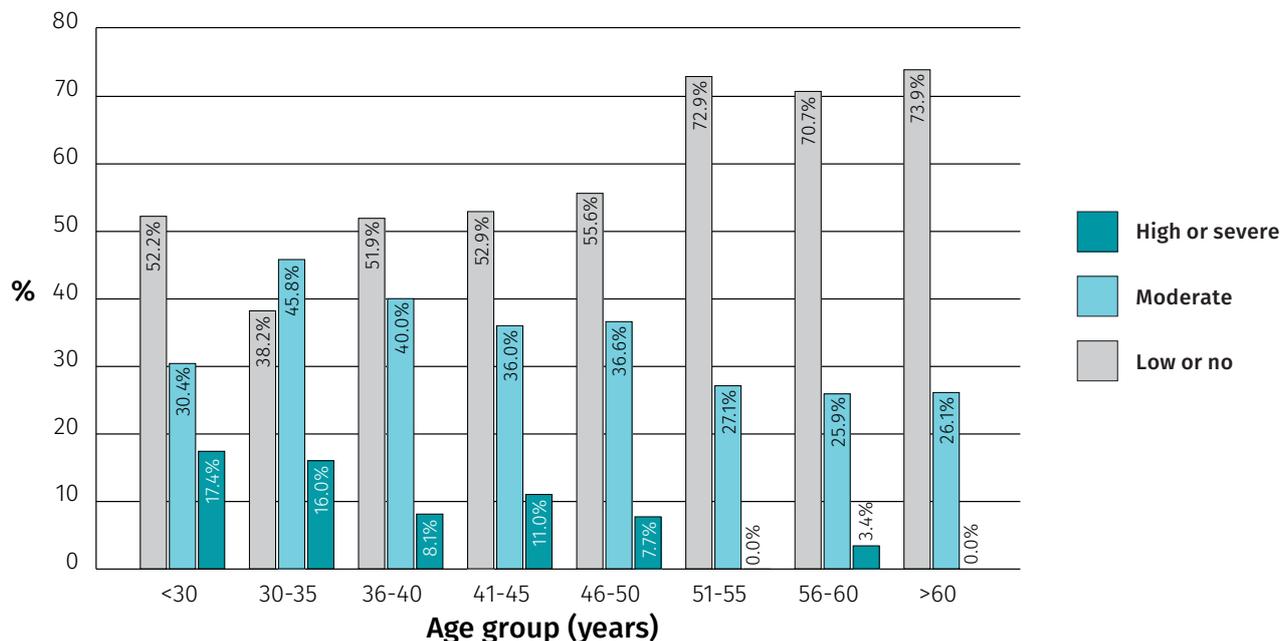
Gender was also a factor in whether personal burnout was experienced (Figure 42), with females experiencing higher levels of personal burnout than males (χ^2(4, N = 720) = 30.2818, p < 0.001).

Figure 42 Percentage of respondents experiencing personal burnout, by gender (N = 720)
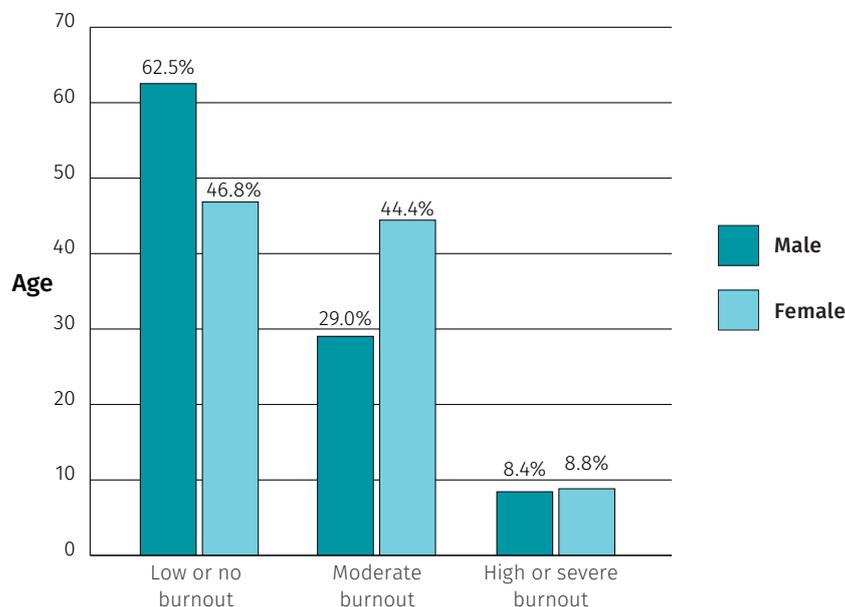
Significant differences were also observed based on respondents' country of PMD, with greater levels of high to severe personal burnout observed in respondents who gained their PMD in a country other than Australia, New Zealand or the United Kingdom (χ^2(6, N = 700) = 14.7410, p < 0.05), with this data presented in Figure 43 (over page).

Figure 43 Percentage of respondents experiencing personal burnout, by country of PMD (N = 700)
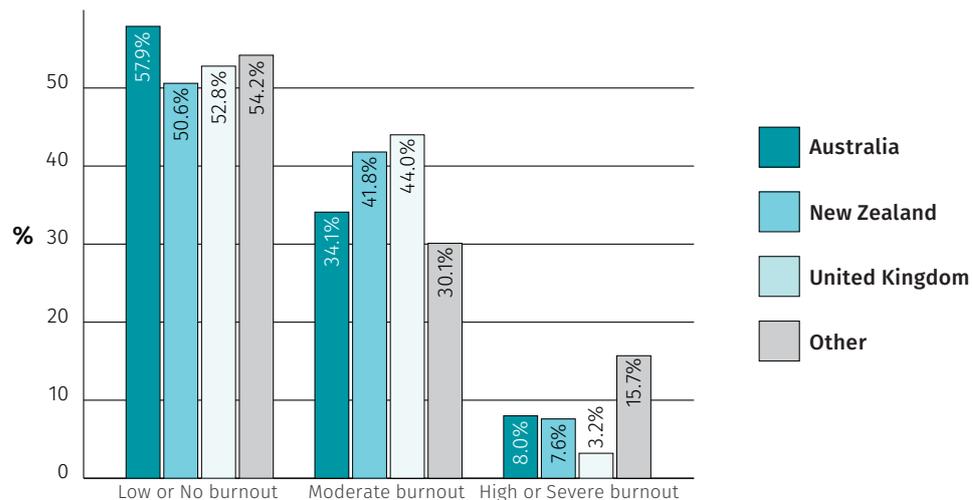
Lastly, respondents whose primary workplace was located in a regional/remote area, were more likely to be experiencing personal burnout than respondents whose primary workplace was in a metropolitan/ urban area (χ^2(2, N = 729) = 8.8656, p < 0.05) (Figure 44).

Figure 44 Percentage of respondents experiencing personal burnout, by workplace remoteness (N = 729)
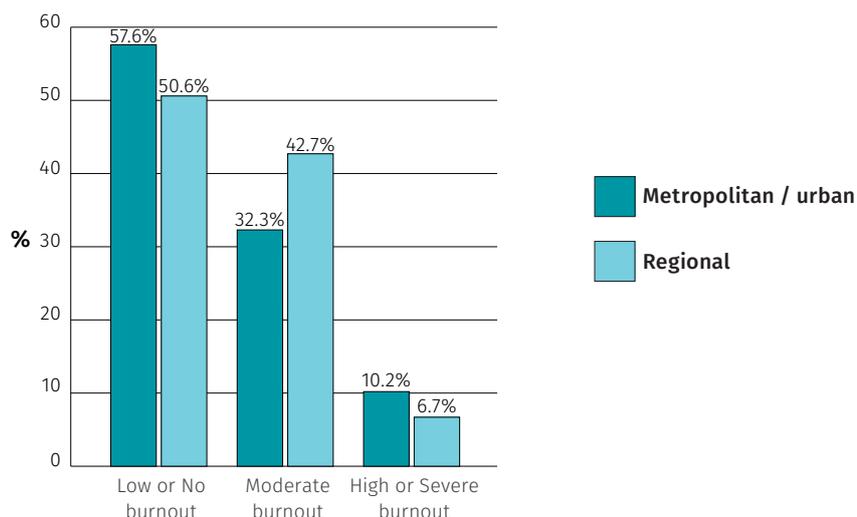
Work-related burnout

Overall, 50% of respondents were classified as having no or low work-related burnout, where work-related burnout is defined as a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work. Of the remaining respondents, 43% had moderate work-related burnout, and 7% were classified as having high/severe work-related burnout. FACEMs were less likely to report moderate, high or severe work-related burnout (48%), than Trainees (57%) and the Other training level group (53%), although these differences were not significant (see Figure 45, over page).

While females were more likely to be classified overall with moderate, high or severe work-related burnout (55%) than males (46%), males were more likely to be classified with high or severe levels of work-related burnout (9%) than females (5%), see Figure 46, over page. The differences between work-related burnout and gender were significant (χ^2(4, N = 720) = 26.8583, p < 0.001).

50% of respondents reported moderate to severe work-related burnout

Figure 45 Percentage of respondents experiencing work-related burnout, by level of ACEM training (N = 729)
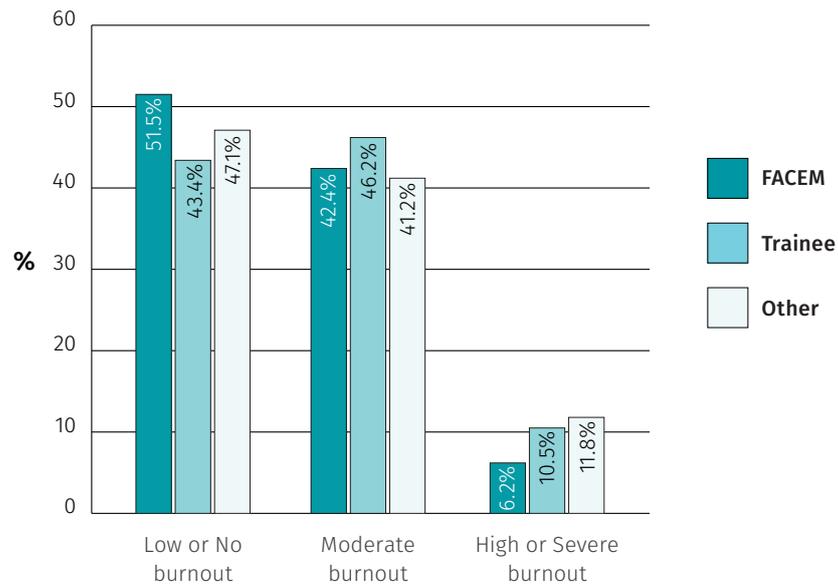
Figure 46 Percentage of respondents experiencing work-related burnout, by gender (N = 720)
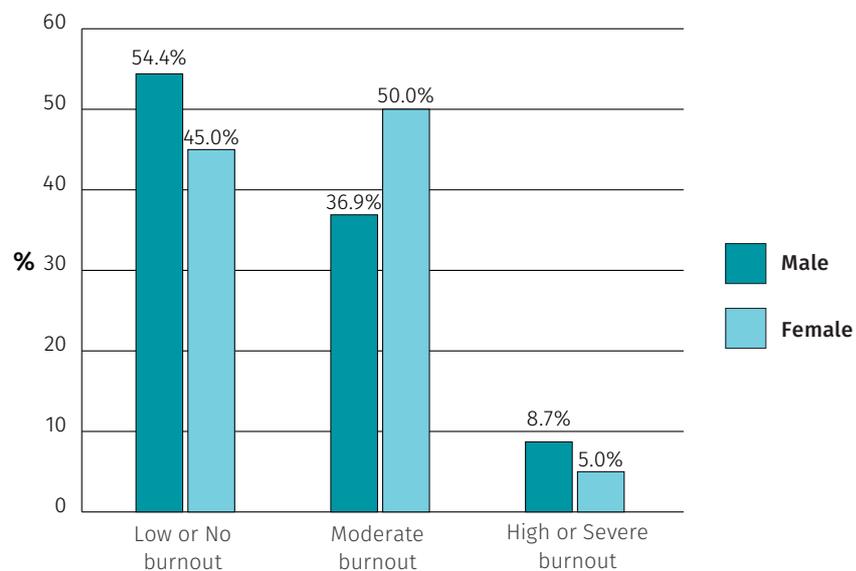
Client or patient-related burnout

Overall, 87% of respondents were classified with no or low client/patient-related burnout, 11% were classified with moderate client/patient-related burnout, and 2% as having high/severe client/patient-related burnout. Where client/ patient-related burnout is defined as a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work with clients/ patients. FACEMs were less likely to be classified with moderate, high or severe client/patient-related burnout (11%) than Trainees (17%) and the Other training level group (23%), although this difference was not significant (Figure 47, over page).

87% of respondents reported no or low client or patient-related burnout

Figure 47 Percentage of respondents experiencing client-related burnout, by level of ACEM training (N = 729)
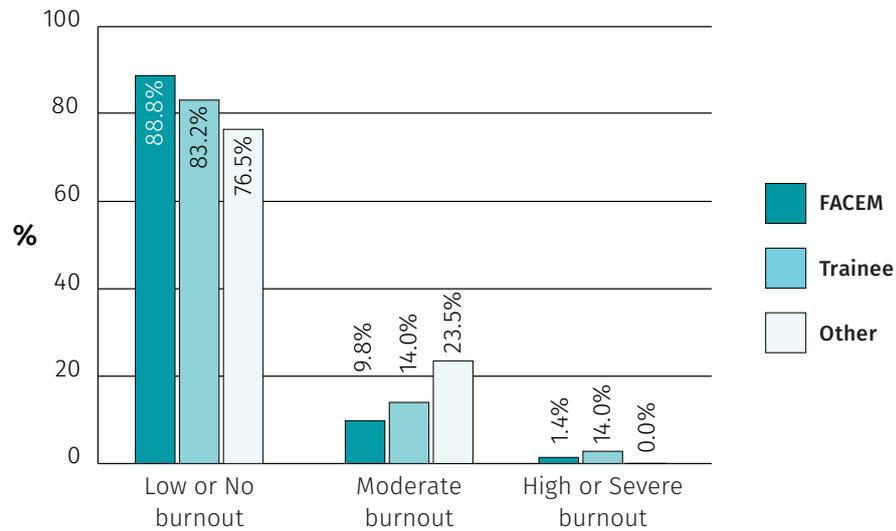
6.13 Plans for the future

Respondents were asked about their future plans with respect to whether they were likely to reduce their hours of clinical work, leave clinical practice, leave emergency medicine, or retire in the next 10 years. The percentage of respondents reporting that they're likely to alter their work practices is presented in Figure 48 (over page) by level of ACEM training. The differences between level of ACEM training and the percentage of respondents reporting that they are likely to:

+ Reduce hours of clinical practice was not significant;

+ Leave clinical practice, was significant ($\chi 2(4$, *n* = 732) = 12.4235, *p* < 0.05);

+ Leave emergency medicine was not significant; and

+ Retire, was significant ($\chi 2(4$, *n* = 726) = 28.6614, *p* < 0.001).

The findings will be discussed further under the relevant sub-headings.

63% of respondents reported that they were likely to reduce their hours of clinical practice in the next 10 years

Figure 48 Percentage of respondents reporting that they are likely to reduce their hours of clinical practice, leave clinical practice, leave emergency medicine or retire in the next 10 years, by level of ACEM training
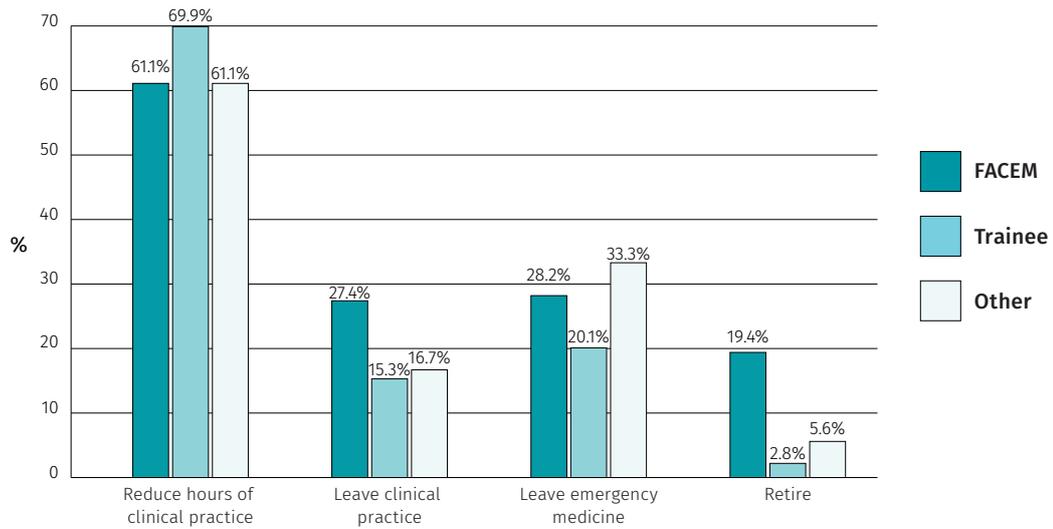
The percentage of respondents reporting that they are likely to alter their work practices in the next 10 years is presented in Figure 49 by age group. The differences between age group and the percentage of respondents reporting that they are likely to:

  +   Reduce hours of clinical practice was significant ($\chi 2(14, N = 721) = 43.6081, p < 0.001$);

  +   Leave clinical practice, was significant ($\chi 2(14, N = 722) = 216.6390, p < 0.001$);

  +   Leave emergency medicine was significant ($\chi 2(14, N = 722) = 195.0085, p < 0.001$); and

  +   Retire, was significant ($\chi 2(14, N = 716) = 380.0708, p < 0.001$).

Figure 49 Percentage of respondents reporting that they are likely to reduce their hours of clinical practice, leave clinical practice, leave emergency medicine, or retire in the next 10 years, by age
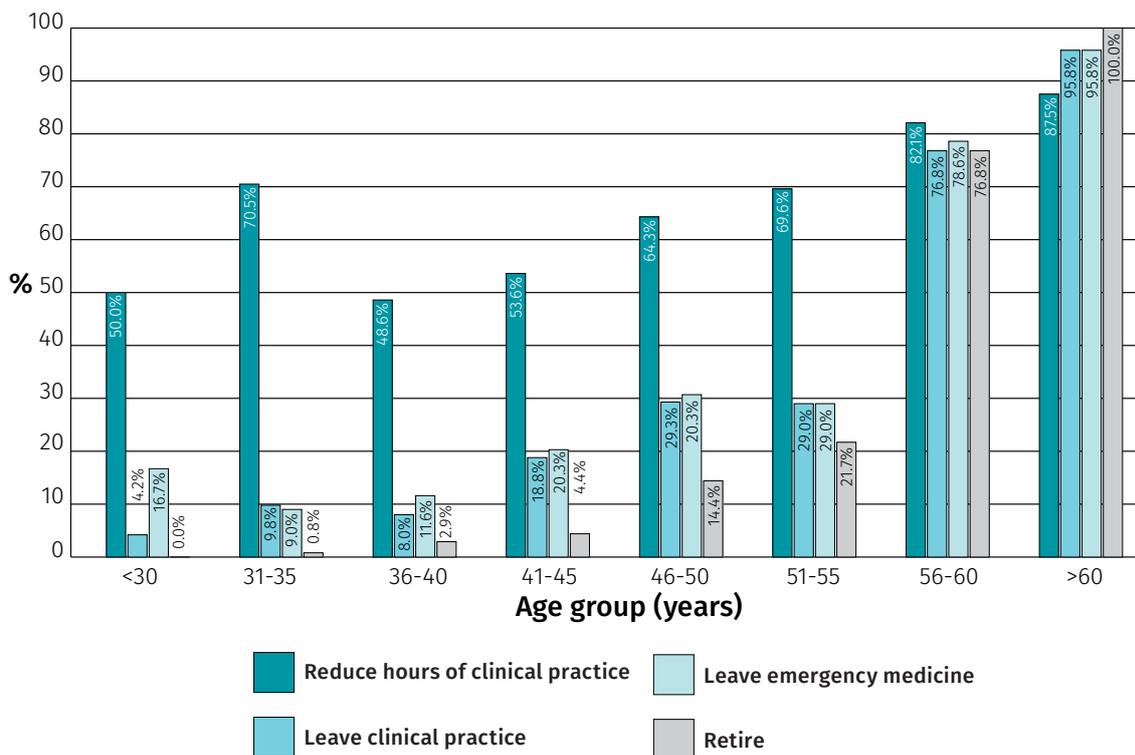
The percentage of respondents reporting that they are likely to alter their work practices is presented in Figure 50 by gender. The differences between gender and the percentage of respondents reporting that they are likely to:

  + Reduce hours of clinical practice was not significant;

  + Leave clinical practice, was significant (χ2(4, N = 723) = 16.5640, p < 0.01);

  + Leave emergency medicine was significant (χ2(4, N = 723) = 14.4562, p < 0.01); and

  + Retire, was significant (χ2(4, N = 717) = 14.5693, p < 0.01).

Figure 50 Percentage of respondents reporting that they were likely to reduce their hours of clinical practice, leave clinical practice, leave emergency medicine or retire in the next 10 years, by gender (N = 723)
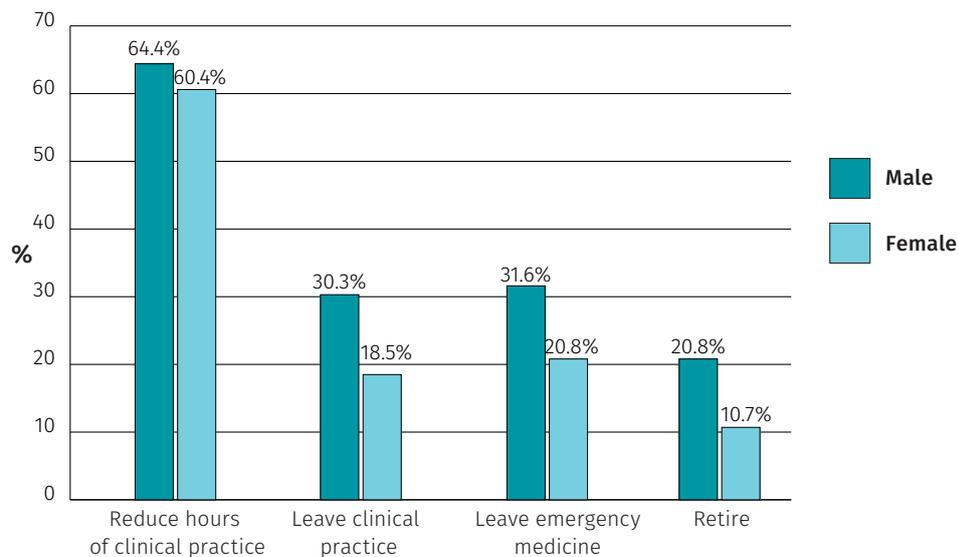
Reduce hours of clinical practice in the next 10 years

Two of the 733 respondents to the question asking how likely they were to reduce their hours of clinical practice in the next ten years indicated that the question was not applicable and have been excluded from analysis. Overall, 63% of respondents reported that they were likely to reduce their hours of clinical practice in the next ten years, 9% were neutral, and 28% reported that they were unlikely to reduce their hours of clinical practice in the next 10 years. A higher percentage of Trainees (70%) reported that they were likely to reduce their hours of clinical practice in the next 10 years, compared with FACEMs (61%) and the Other training level group (61%) Figure 48.

The percentage of respondents reporting that they are likely to reduce their hours of clinical practice in the next 10 years, was greatest in those aged over 55 years, with these differences significant (χ^2(14, N = 721) = 43.6081, p < 0.001) (Figure 49).

Respondents whose primary workplace was in a regional/ rural location (69%) were also more likely to report planning to reduce their hours of clinical practice in the next 10 years, compared with those whose primary workplace was in a metropolitan/ urban area (60%), with these differences significant (χ^2(2, N = 731) = 7.3028, p < 0.05) (Figure 51, over page).

Figure 51 Percentage of respondents reporting that they are likely to reduce their hours of clinical practice in the next 10 years, by remoteness (N = 731)
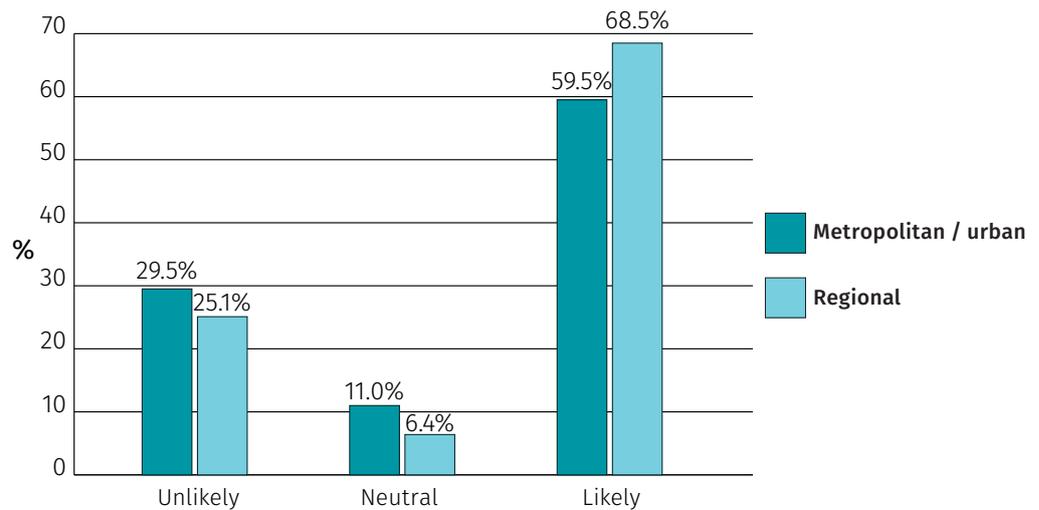
Reasons for wanting to reduce hours of clinical practice in the next 10 years

Those who reported that they were likely to reduce their hours of clinical practice in the next 10 years were asked why they were likely to do so. Of the 459 who indicated that they were likely to reduce their hours of clinical practice in the next 10 years, 444 provided a reason why. The main reasons reported, included to improve their work-life balance; because of the unsustainable workplace conditions, requirements and/or pressures; or to improve their health and/or wellbeing. Table 11 (over page) presents the themes and their frequencies, from respondent comments on the reasons for wanting to reduce their hours of clinical practice.

Table 11 Respondents reasons for wanting to reduce their hours of clinical practice in the next 10 years, themes and frequencies (n = 444)

	n	%
Improve work–life balance	**171**	**38.5%**
Family interests/ responsibilities	86	19.4%
Family or carer responsibilities (includes pregnant women)	37	8.3%
Spend more time with the family	35	7.9%
Start a family	10	2.3%
Pursue other interests	35	7.9%
Unsustainable workplace conditions/ requirements/ pressure	**150**	**33.8%**
Unsustainable workload	50	11.3%
Currently working too many (excessive) clinical hours	15	3.4%
Rostering	39	8.8%
Unsustainable workplace conditions for EM specialists	36	8.1%
Unsustainable requirements/ expectations	26	5.9%
by hospitals administration (includes KPIs)	13	2.9%
by staff, and patients	5	1.1%
by ACEM	4	0.9%
Under resourced (includes treating people in corridors)	21	4.7%
Inefficient workplace practices/ systems	18	4.1%
Poor Hospital/ ED leadership	17	3.8%
Access block (includes fighting for beds, bed block)	13	2.9%
DBSH/ rudeness/ incivility	13	2.9%
Inability to access leave	2	0.5%
Improve health/ wellbeing	**111**	**25.0%**
Reduce fatigue	47	10.6%
Reduce stress/ anxiety	30	6.8%
Burnout	17	3.8%
Age	**78**	**17.6%**
Transitioning to retirement	27	6.1%
Improve sustainability of EM specialist career	**52**	**11.7%**
Increase non-clinical work	**40**	**9.0%**
Can afford to financially	**20**	**4.5%**
Job dissatisfaction	**18**	**4.1%**
Explore another career/ higher education	**15**	**3.4%**
ACEM training requirements (for trainees)	**10**	**2.3%**
Lack of recognition/ respect (from colleagues and management)	**9**	**2.0%**
Reduce public ED hours	**6**	**1.4%**
Be available to increase private ED hours	**4**	**0.9%**

Some examples of comments reflecting the themes in Table 11 are presented below:

'Growing family... Likely to experience a degree of burnout and will want to prioritise my family, particularly if work is a grind.' – FACEM.

'... to enable time for outside work activities including friends and families.' – Trainee

'... inability to get holiday/ school leave with the kids... reached the breaking point. By going part-time, I hope to be able to get away with my family... and control my schedule more. The ED is very overwhelmed, at least I can try to get away from it more often.' – FACEM.

'More time to relax and enjoy my life and time with family' – Trainee.

'Over the 2 decades I have been working in ED, the state of EDs has changed dramatically. Each year there are more presentations, access block continues to worsen, staffing levels do not increase enough to deal with the increasing workload, administrative targets become more unrealistic, we deal with more violence, there is no time to eat/go to the toilet or take time to teach on a shift.' – FACEM.

'... clinical practice the most exhausting part of the job. Some of that is the patients themselves: unrealistic expectations, the worried well, demanding families. But the majority of it is the constant battle to get patients the care they need in a timely manner. The circular phone calls with admitting teams, the inpatient registrar/ consultant expectations of work-up, bed block, wait times for outpatient clinics. 40hrs of face-to-face patient contact in an ED that rarely slows down is just too exhausting to maintain indefinitely. It also leaves no time for admin, patient follow up, or the occasional collegiate cup of coffee with someone from another speciality. – Trainee.

'Shift work is becoming more challenging.... I am so exhausted at the end of every shift... I am unable to participate in other activities in my life to the level I would like to. I do not get enough time between shifts to recover both emotionally and physically. Rosters are inflexible and do not [consider] needs around fatigue, family commitments or circadian rhythm preferences. I would like to work full-time for financial reasons but feel my health will suffer if I do this for much longer.' – FACEM.

'ED extreme workloads, stress, violent/ difficult psychiatric and/ or drug affected people endangering our staff, grossly insufficient security staff levels, overcrowding, bed block, poor computers with frequent IT problems, equipment missing or not restocked, unrealistic GP referrals, unrealistic nursing home referrals, paramedics bringing inappropriate patients who live outside our catchment area due to other hospitals being on diversion or bringing patients with problems that they should know our hospital cannot admit, police bringing behaviour problems, e.g., violent angry people, to ED without good medical or real psychiatric reason. Difficulties contacting inpatient unit clinicians who don't answer pagers or phones. Silly obsession with time based KPIs such as the 4-hour target. Medical students, interns and junior HMOs needing enormous amounts of assistance and supervision on top of my own hectic workload. Being called in at night or early morning hours after a very tiring work shift and being expected to take over a critical patient despite lack of sleep. Having to transfer and escort complex ICU patients across the city to other hospitals due to lack of ICU beds ... The list goes on and on and getting worse every year.' – FACEM.

'Cannot maintain current workload without severely compromising my physical and emotional wellbeing. The current stresses of overcrowding, inadequate staffing and access block make the job difficult and I cannot sustain this for much longer.' – Trainee.

'Loss of satisfaction with my current work environment – leadership (lack of), inefficient workflows/ practices, loss of caring attitude in colleagues, inability to access leave, overcrowding/ access block.' – FACEM.

'Feeling unsupported despite working harder every year with increasing numbers of patients and increasing access block. Continual refusal from [hospital executive] to employ more staff to allow ongoing high-quality patient care.' – FACEM.

'the change in the locum industry particularly the widespread use of agencies at employer's insistence has created a system where MOST of the work offered demands unsafe hours. Requests to work 7 or more 10-hour shifts in a week, shifts with a scant 8 hours between that turns out to be less, on-call with call-ins and no fatigue leave or even possibility of taking time without pay to recover. I hated unsafe hours when I was young, age hasn't made me [fonder] of them.' – FACEM.

Leave clinical practice in the next 10 years

One of the 733 respondents to the question asking how likely they were to leave clinical practice in the next ten years indicated that the question was not applicable and have been excluded from the analysis. Overall, 25% of respondents reported that they were likely to leave clinical practice in the next ten years, 14% were neutral, and 62% reported being unlikely to leave clinical practice in the next 10 years.

25% of respondents reported that they were likely to leave clinical practice in the next 10 years

The percentage of respondents reporting that they were likely to leave clinical practice in the next 10 years increased with age, and peaked at 96% for those aged over 60 years, with these differences significant (χ^2(14, N = 722) = 216.6390, p < 0.001) (Figure 49). A higher percentage of males (30%) than females (19%), reported that they were likely to leave clinical practice in the next 10 years, which was also significant (χ^2(4, N = 723) = 16.5640, p < 0.01), as displayed in Figure 50.

Leave emergency medicine in the next 10 years

One of the 733 respondents to the question asking how likely they were to leave emergency medicine in the next ten years indicated that the question was not applicable and have been excluded from the analysis. A total of 27% of respondents reported that they were likely to leave emergency medicine in the next ten years, 14% were neutral, and 59% reported that they were unlikely to leave emergency medicine in the next 10 years.

27% of respondents reported that they were likely to leave emergency medicine in the next 10 years

The percentage of respondents reporting that they were likely to leave emergency medicine in the next 10 years also increased with age, with these differences significant (χ^2(14, N = 722) = 195.0085, p < 0.001) (Figure 49). The percentage of males (32%) reporting that they were likely to leave emergency medicine in the next 10 years, was again significantly higher than for females (21%) (χ^2(4, N = 723) = 14.4562, p < 0.01) (Figure 50).

Reasons for wanting to leave clinical practice and/or leave the emergency medicine workforce in the next 10 years

Those who reported that they were likely to leave clinical practice or leave the emergency medicine workforce in the next 10 years were given the opportunity to comment on why they were likely to do so, with 199 of the 207 providing a response.

The main reasons given by those reporting that they were likely to leave clinical practice and/or the emergency medicine workforce in the next 10 years, were because of the unsustainable workplace conditions, requirements and/or pressures; as a result of their age; and to improve their health and/or wellbeing.

Table 12 Respondents reasons for wanting to leave clinical practice and/or the emergency medicine workforce in the next 10 years, themes and frequencies (n=199)

	n	%
Unsustainable workplace conditions/ requirements/ pressure	**81**	**40.7%**
Unsustainable requirements/ expectations	23	11.6%
by hospitals administration (includes KPIs)	15	7.5%
by staff, and patients	6	3.0%
Unsustainable workload	6	3.0%
Misuse of the ED	3	1.5%
Inefficient workplace practices/ systems	21	10.6%
Rostering	20	10.1%
Professional Isolation	1	0.5%
Poor Hospital/ ED leadership	18	9.0%
DBSH/ rudeness/ incivility	16	8.0%
Under resourced	15	7.5%
Unable to provide acceptable clinical care	14	7.0%
Low morale and poor ED or workplace culture	13	6.5%
Conflict with other teams	9	4.5%
Lack of job security	8	4.0%
Fear of prosecution	2	1.0%
Access block	7	3.5%
Aggressive patients	5	2.5%
Age	**74**	**37.2%**
Retirement	39	19.6%
Improve health/ wellbeing	**57**	**28.6%**
Reduce stress/ anxiety	15	7.5%
Burnout	11	5.5%
Reduce fatigue	7	3.5%

Table continued over page

Table 12 continued

	n	%
Job dissatisfaction	45	22.6%
As a career, EM is not sustainable	33	16.6%
Changing scope and environment of EM	19	9.5%
Explore another career/ role	17	8.5%
Improve work–life balance	16	8.0%
Increase non-clinical work	11	5.5%
Lack of recognition/ respect (from colleagues and management)	9	4.5%
ACEM Training requirements (trainees and FACEMs)	8	4.0%

Some examples of comments reflecting the themes in Table 12 are presented below:

'... the overall burden of drug affected and [mental health patients] is wearing me down and my compassion is waning. Add to that a frustrating IT system and the overt hostility of inpatient teams... acuity is high, expectations of patients unrealistic, no regular breaks on shift, staying late every shift... the scales are tipping away from continuing in such a stressful workplace. I am also dismayed by the change of emergency medicine to a GP service for complex patients who they don't have time for but don't really have a true emergency.' – FACEM.

'ED is not sustainable with increasing demands on service delivery and increasing costs of a societal perception of 'infinite health care'. Problem solving by politicians is usually looking at reducing wages/ staffing numbers/infrastructure... which makes my work more difficult.' – FACEM.

'The work is overwhelming, and there appear to be few moments that feel fulfilling or perhaps it is more that I no longer have the time or energy to appreciate the better aspects of the job. The shift work can be exhausting, especially during winter months. The amount of paperwork removes the joy of clinical work. It feels like the system is broken, and there does not appear to be much concern for people's wellbeing from the executives and higher admin officers. And their approach to improving wellness feel more like a band aid than a permanent solution.' – Trainee.

'... the widespread abandonment within the emergency medicine community of the pursuit of clinical excellence, replaced by the prioritisation of arbitrary KPIs and the 'reduction of variability' otherwise known as mindless protocol-based cookbook medicine.' – FACEM.

'Ten hour clinical shifts are too long: decision making fatigue after ten hours (even in younger consultants, when they are candid), while the clinical work gets harder, the reason to leave practice is a culture that rewards only 'NEAT' compliance and never objecting to (an unsafe) inward looking culture that is highly inappropriate in a modern workplace.' – FACEM.

'Emotionally unsafe work conditions forecasted for future in ED. I can't see myself facing that amount of risk due to access block and overcrowding every day for more than 10 years. It would be very unhealthy for anyone.' – Trainee.

'Although working part time, I can still feel the frustrating, physically, mentally and emotionally draining environment. Every speciality dislikes ED since we are giving them more workload. People at social events/ conferences tend to turn away as soon as they hear we are Emergency Department workforce. It is also very hard to manage patients and family expectations, [which are] getting worse and worse. E.g., I've been waiting for 45 minutes, I want to get everything done right now, I want to be back to 100% now. Perhaps something to do with generation and upbringing. Some measures have been taken to cope with these issues over the course of time. Unfortunately, nothing seems to be working except cutting hours way back down. Not only medical colleagues, but also nursing colleagues seem to be affected by these issues and as a result, the teamwork/team culture and cohesiveness is falling apart. Because of all these factors, even though I'm at the start of my consultancy, I'm already planning my retirement from the workforce.' – FACEM.

'The work is physically and mentally taxing. It is taking longer to recover from each shift as I get older. More of my personal non work time is consumed I recovery without being productive in other interests or family pursuits.' – FACEM.

'It's always horrendously busy, short staffed, the dept is usually blocked and doing evening shifts screws up my sleep pattern and I'm always tired out. It's not sustainable for me to keep working like this.' – FACEM.

'... the four-hour rule has brought an anxiety to working in EM that wasn't there before... even on days that are overwhelmingly busy I feel like failure (despite pretty good care delivered) if the time targets don't add up.' – FACEM.

'I find the evening and night shifts harder on my body as I get older, and these shifts are where you need to be on your best mentally and physically.' – FACEM.

'... ten-hour shifts are exhausting for people over 50 (and younger actually). The last two hours it's hard to maintain concentration and compassion etc.' – FACEM.

'Dissatisfaction with where emergency medicine is heading, and the unrealistic expectations placed on emergency physicians.' – FACEM.

Retire in the next 10 years

Seven of the 733 respondents to the question asking how likely they were to retire in the next ten years indicated that the question was not applicable and have been excluded from the analysis. Overall, 16% of respondents reported that they were likely to retire in the next ten years, 7% were neutral, and 77% reported being unlikely to retire in the next 10 years.

16% of respondents reported that they were likely to retire in the next 10 years

Unsurprisingly, the percentage of respondents reporting that they were likely to retire in the next 10 years increased with age, with these differences significant (χ^2(14, N = 716) = 380.0708, p < 0.001) (Figure 49). Males (32%) were also significantly more likely than females (21%), to report planning to retire in the next 10 years (χ^2(4, N = 717) = 14.5693, p < 0.01) (Figure 50), which could in part be explained by the higher percentage of male respondents (18%) in the > 55 year age groups compared to females (4%).

6.14 General Health

Respondents were asked to rate their personal health on a five-point Likert scale from poor to excellent. Only 23% of the 723 respondents reported that their health was excellent, 40% and 24% reported their health as very good and good respectively, while 11% and 2% reported their health as fair or poor. FACEMs were more likely (66%) than Trainees (54%) and those in the Other training level group (39%), to rate their health as very good or excellent, with these differences significant ($\chi^2(6, N = 723) = 19.0549, p < 0.01$) (Figure 52).

Figure 52 Self-reported general health of respondents, by level of ACEM training (N = 723)
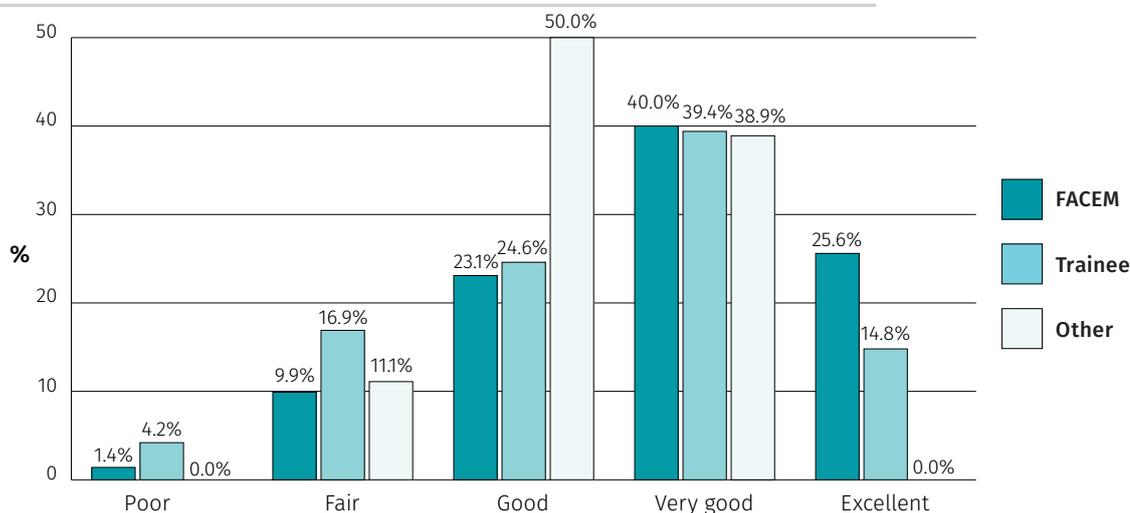
Days off work due to illness

Over one quarter (28%) of the 723 respondents reported that they had no days off in the last 12 months due to physical or mental illness, with 43% of respondents reporting that they had only 1-2 days off work. A further 17% of respondents reported having 3-5 days off, 5% had 6-8 days off, 2% had 9-10 days off, and 5% had more than 10 days off work due to physical or mental illness in the past 12 months. There were significant differences between the number of days taken off work due to physical or mental illness and gender, with females more likely to have taken time off work (79%), compared to males (65%) ($\chi^2(10, N = 714) = 22.0686, p < 0.05$).

72% of respondents had time off work due to physical or mental illness in the past 12 months

There were significant differences between level of ACEM training and the number of days off work reported by respondents due to physical or mental illness ($\chi^2(10, N = 723) = 41.4718, p < 0.001$), with FACEMs (31%) and those in the Other training level group (39%) much more likely than Trainees (13%) to have not taken any days off due to illness (Figure 53, over page).

Figure 53 Approximate number of days off work, reported by respondents, due to physical or mental illness in the past 12 months, by level of ACEM training (N = 723)
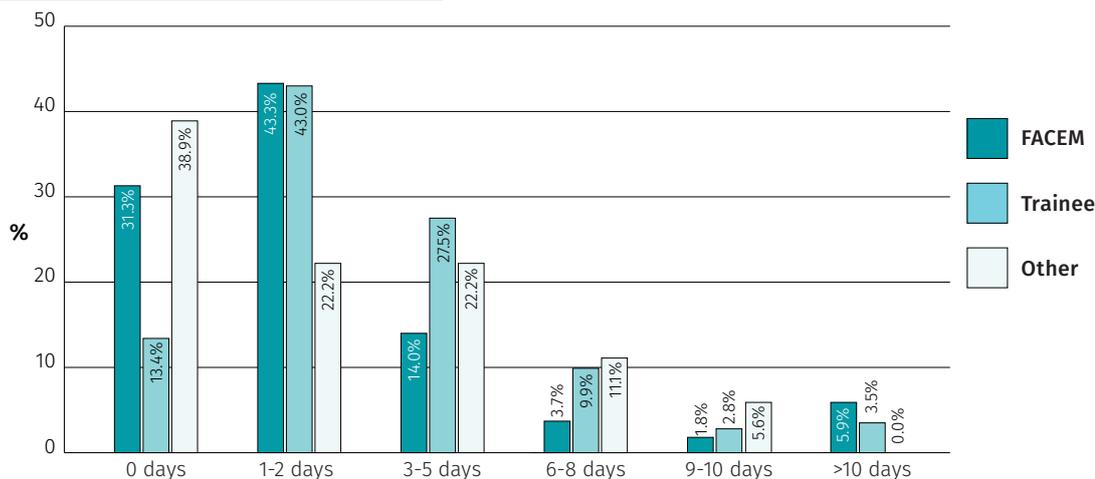
Went to work unwell

Of the 723 respondents who responded to the question on the number of days they went to work when they were either physically or mentally unwell in the past 12 months; 10% reported that they didn't go to work when they were physically or mentally unwell. However, 27% reported that they went to work 1-2 days, 24% went to work 3-5 days, 14% went to work 6-8 days, 6% went to work 9-10 days, and 17% reported that they went to work unwell more than ten days in the last 12 months.

90% of respondents reported that they went to work when they were physically or mentally ill in the past 12 months

Trainees (26%) and those in the Other training level group (28%) were more likely to report that they went to work when they were physically or mentally unwell than FACEMs (17%), although these differences were not significant (Figure 54). There were significant differences between the number of days respondents went to work when they were unwell and gender, with females less likely to go to work when they were unwell (95%) compared to males (86%) (χ^2(10, *N* = 714) = 27.0470, *p* < 0.01).

Figure 54 Approximate number of days respondents reported going to work when they were physically or mentally unwell in the past 12 months, by level of ACEM training (N = 723)
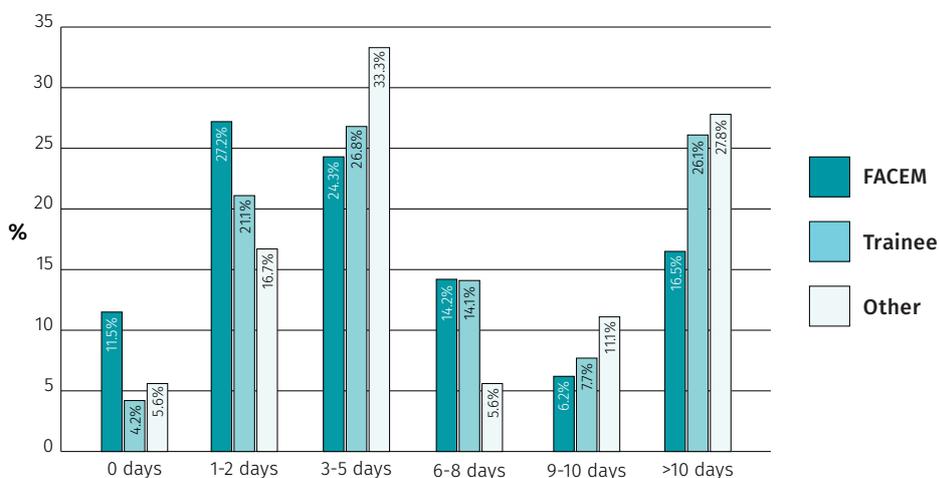
Have a GP or GP clinic

Overall, 80% of the 723 respondents reported having a GP or GP clinic that they could visit for their own personal health concerns. FACEMs were significantly more likely (82%) than Trainees (72%) and the Other training level group (67%), to report having a GP or GP clinic that they could visit for their own personal health concerns, $\chi^2(2, N = 723) = 9.2520$, $p < 0.05$.

80% of respondents had a GP or GP clinic that they could visit for their own personal health concerns

Females were significantly more likely to report having a GP or GP clinic that they could visit for their personal health concerns (89%) than males (71%) ($\chi^2(2, N = 714) = 35.7021$, $p < 0.001$). Those who obtained their PMD in New Zealand (95%) were also significantly more likely to report having a GP or GP clinic that they could visit for their personal health concerns than those who obtained their PMD in Australia (79%), the United Kingdom (75%) or another country (77%) ($\chi^2(3, N = 697) = 13.4525$, $p < 0.01$).

Ease of talking to a GP

Respondents were asked how easy it was for them to talk to a GP about their personal health concerns, with a total of 157 of the 722 respondents indicating that the question was not applicable for them. For the purpose of this report responses have been collapsed into two categories easy (combined responses from very easy and easy) and difficult (combined responses from difficult and very difficult).

75% of respondents reported that it was easy for them to talk to a GP about their personal health concerns

Overall, 75% of respondents reported that it was easy for them to talk to a GP about their own personal health concerns. Interestingly, Trainees were significantly more likely (41%) than FACEMs (21%) and the Other training level group (27%) to report that it was difficult for them to talk to a GP about their personal health concerns ($\chi^2(2, n = 565) = 17.8474$, $p < 0.001$). Generally, respondents were more likely to report that it was easy for them to talk to a GP about their own personal concerns as age increased, and these differences were significant ($\chi^2(7, n = 557) = 17.0366$, $p < 0.05$).

Sought help for stress, anxiety or depression

Respondents were asked if they had sought help for stress, anxiety or depression from a health professional in the past 12 months, with the option to indicate that the question was not applicable. Fourteen of the 721 respondents indicated that the question was not applicable and have been excluded from the following analysis.

21% of respondents reported that they had sought help for stress, anxiety or depression from a health professional in the past 12 months

Over a fifth of respondents (21%) reported having sought help for stress, anxiety or depression from a health professional in the past 12 months, with females significantly more likely to report that they had sought help in the past 12 months (26%), compared to males (16%) ($\chi^2(2, N = 698) = 13.7911$, $p < 0.01$).

6.15 Discrimination, Bullying, Sexual Harassment and Harassment (DBSH)

Respondents were asked a series of questions about their experiences of Discrimination, Bullying, Sexual Harassment and Harassment (DBSH), by a patient or carer in the past 12 months, by a professional colleague, and by a professional colleague in the past 12 months. DBSH can not only severely impact the person who experiences the behaviour but the workplace and the sustainability of the emergency medicine workforce.

DBSH by a patient or carer in the past 12 months

Overall, 287 (41%) respondents reported that they had experienced DBSH by a patient or carer in the past 12 months. FACEMs were significantly less likely to report that they experienced DBSH by a patient or carer in the past 12 months (35%) compared to Trainees (61%) and the Other training level group (56%) (χ^2(2, N = 710) = 32.3461, p < 0.001), as presented in Figure 55. Figure 55 also displays the percentages of respondents by level of ACEM training, who reported experiencing DBSH by a professional colleague ever and in the past 12 months, which will be discussed in the following sections.

Figure 55 Percentage of respondents reporting experiencing DBSH by a patient or carer or professional colleague, by level of ACEM training (N = 710)
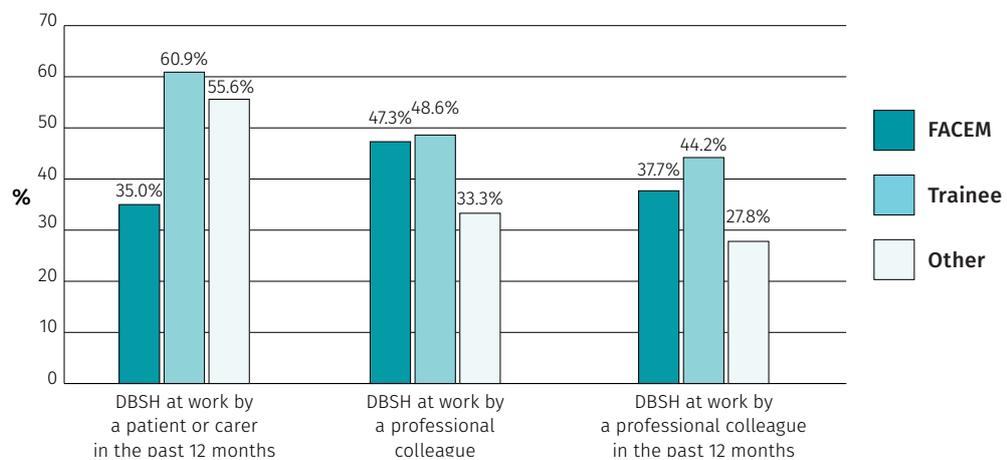
There were significant differences between those who reported that they had experienced DBSH by a patient or carer in the past 12 months and gender, with females (49%) much more likely to report DBSH by a patient or carer than males (32%) (χ^2(2, N = 701) = 22.8110, p < 0.001) (Figure 56). Also presented in Figure 56 is the percentage of male and female respondents who reported experiencing DBSH by a professional colleague ever and in the past 12 months, which will also be discussed in the following sections.

Figure 56 Percentage of respondents reporting experiencing DBSH by a patient or carer or professional colleague, by gender (N = 701)
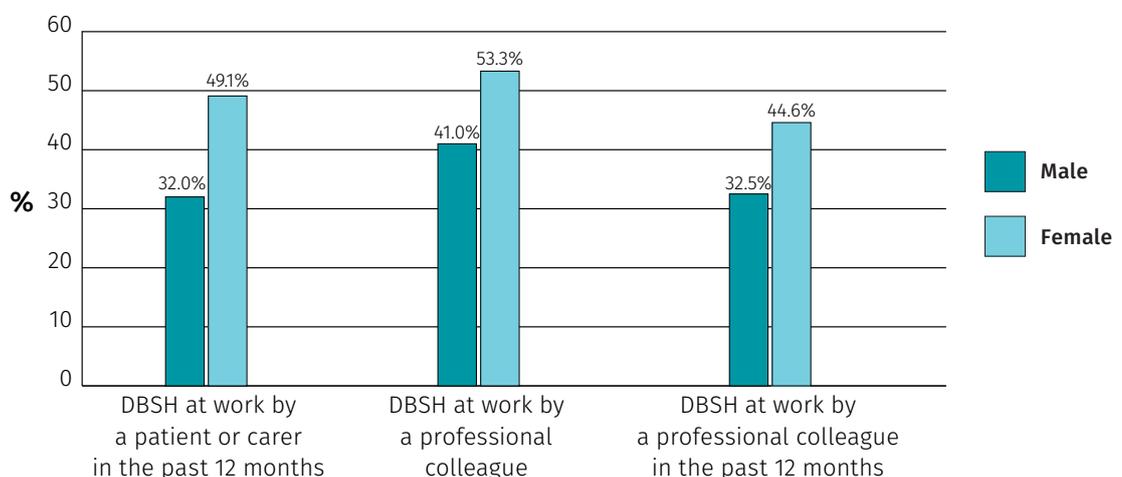
Interestingly, the percentage of female respondents who reported having experienced DBSH by a patient or carer in the past 12 months decreased steadily with age, but remained relatively constant for males across age groups as highlighted in Figure 57, with these differences significant (χ^2(7, N = 701) = 38.2900, p < 0.001).

Figure 57 Percentage of respondents reporting experiencing DBSH by a patient or carer in the past 12 months, by age and gender (N = 697)
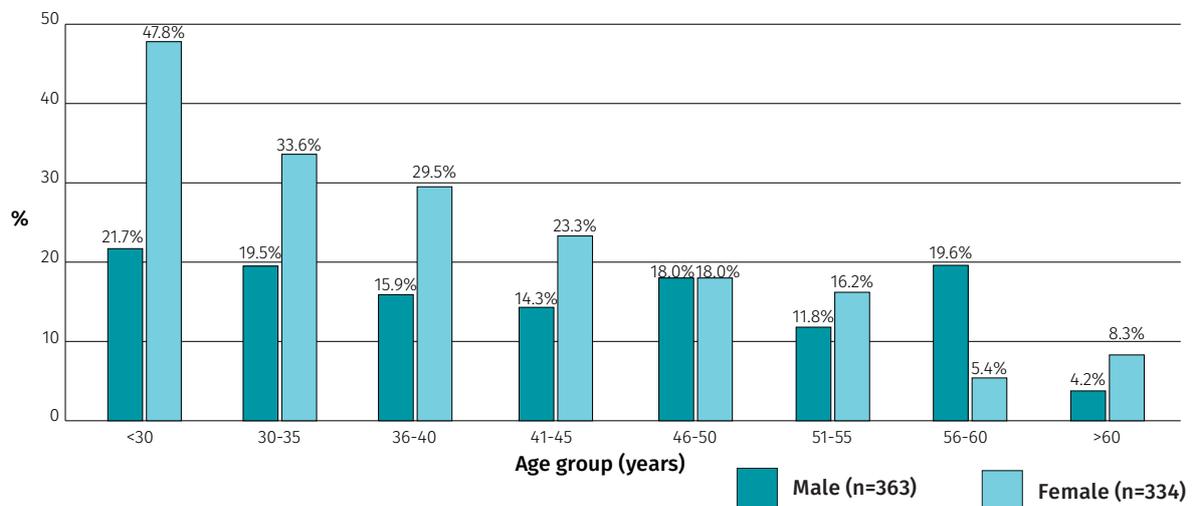
DBSH by a professional colleague

A total of 334 (47%) respondents reported that they had experienced DBSH by a professional colleague. FACEMs (47%) and Trainees (49%) were more likely to report that they had experienced DBSH by a professional colleague than those in the Other training level group (33%), however these differences were not significant (Figure 55).

There were significant differences between those who reported that they had experienced DBSH by a professional colleague and gender, with females (53%) more likely to report experiencing DBSH by a professional colleague, than males (41%) (χ^2(2, N = 701) = 11.7573, p < 0.01) (Figure 56). Respondents whose primary workplace was in a regional/ rural area were also significantly more likely to report having experienced DBSH by a professional colleague (53%), compared to those whose primary workplace was located in a metropolitan/ urban area (44%) (χ^2(1, N = 710) = 6.4653, p < 0.05).

DBSH at work by a professional colleague in the past 12 months

For the respondents reporting having experienced DBSH by a professional colleague, 275 (39%) reported that they had experienced DBSH at work, by a professional colleague in the past 12 months. Of these, 145 (53%) reported that they had experienced discrimination, 214 (78%) experienced bullying, 17 (6%) experienced sexual harassment and 123 (45%) experienced harassment in the past 12 months. With 124 reporting that they experienced one type of DBSH, 82 reported experiencing two types, 65 experienced three types, and four reported that they experienced discrimination, bullying, sexual harassment and harassment in the past 12 months by a professional colleague.

Trainees (44%) and FACEMs (38%) were more likely to report that they had experienced DBSH by a professional colleague in the past 12 months, than those classified in the Other training level group (28%), although these differences were also not significant (Figure 55). Of those who had experienced DBSH, Trainees were more likely to experience bullying (76%), while those in the Other training level group were more likely to experience discrimination and sexual harassment (Figure 58, over page). Again, females (58%) were more likely than males (42%) to report having experienced DBSH by a professional colleague in the previous 12 months.

Figure 58 Percentage of respondents who reported experiencing DBSH by a professional colleague in the past 12 months, by level of ACEM training (N = 701)
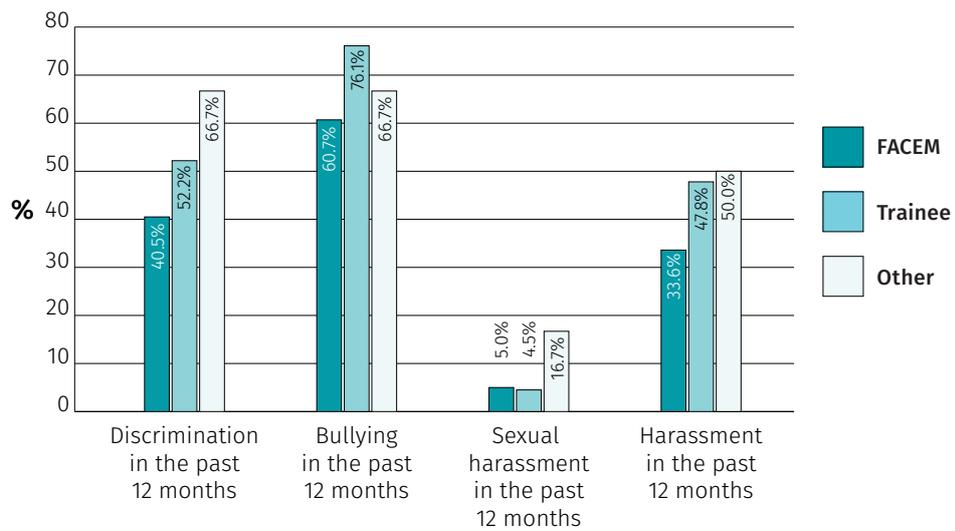
There were significant differences between those who reported that they had experienced DBSH by a professional colleague in the past 12 months and gender, with females (45%) again more likely than males (33%) to report DBSH by a professional colleague, χ²(2, *N* = 701) = 12.4149, *p* < 0.01 (Figure 56).

Discrimination

Of the 145 who reported that they had experienced discrimination in the past 12 months by a professional colleague, 22 (15.2%) reported experiencing it only once, 77 (53.1%) experienced it 2-5 times, 28 (19.3%) 6-20 times, and 18 (12.4%) reported experiencing discrimination more than 20 times. A total of 138 respondents who experienced discrimination by a colleague in the previous 12 months completed the follow-up questions on their experience.

Bullying

For the 214 who reported having experienced bullying in the past 12 months by a professional colleague, 43 (20.1%) experienced it only once, 111 (51.9%) experienced it 2-5 times, 36 (16.8%) experienced it 6-20 times, and 24 (11.2%) experienced it more than 20 times. Two-hundred respondents completed the follow-up questions on bullying.

Sexual Harassment

Of the 17 respondents who reported experiencing sexual harassment by a colleague in the past 12 months, 12 (4.4%) reported experiencing it only once, four (1.5%) experienced it 2-5 times, and 1 (0.4%) reported experiencing it over 20 times. Fourteen of these respondents completed the follow-up questions on their experiences of sexual harassment.

Harassment

For the 123 who reported experiencing harassment in the past 12 months by a professional colleague, 30 (24.4%) reported experiencing it only once, 62 (50.4%) experienced it 2-5 times, 15 (12.2%) 6-20 times, and 16 (13.0%) experienced it more than 20 times. One-hundred and thirteen respondents chose to complete the follow-up questions on their experience of harassment.

6.16 Who displayed the DBSH behaviour

Respondents were asked to select the role(s) of the perpetrator(s) who displayed the DBSH behaviour, from a list of 19 roles, with the options to describe another role or not disclose the role(s) of the perpetrator(s). Overall FACEMs, other speciality consultants and other specialty trainees were more frequently nominated as the perpetrators of DBSH (Table 13). Those who reported that they had experienced sexual harassment at work in the past 12 months by a professional colleague were more likely to not disclose the role(s) of the perpetrator(s). For those who nominated another role in response to who displayed the behaviour, hospital management, hospital administration and hospital executive were frequently mentioned.

Table 13 Role of the perpetrator(s) of DBSH experienced by respondents in the workplace, by a professional colleague

	Discrimination (n=138)	Bullying (n=200)	Sexual harassment (n=14)	Harassment (n=113)
	%	%	%	%
FACEM	**55.1%**	**48.0%**	**28.6%**	**34.5%**
ACEM trainee	9.4%	4.0%	7.1%	5.3%
ACEM college examiner	7.2%	3.0%	0.0%	5.3%
ACEM SIMG	0.0%	0.5%	0.0%	0.9%
ACEM college staff member	6.5%	3.5%	0.0%	0.9%
Admin staff	8.0%	4.5%	0.0%	3.5%
Allied health worker	1.4%	0.0%	0.0%	0.0%
Director of EM	21.7%	16.5%	0.0%	11.5%
Director of EM training	8.7%	6.0%	0.0%	7.1%
Intern	0.7%	0.0%	7.1%	0.0%
Medical administrator	22.5%	16.5%	7.1%	8.8%
Nursing staff	18.8%	14.5%	7.1%	11.5%
Nurse unit manager	13.0%	8.5%	0.0%	6.2%
Operational staff (e.g. wardperson)	0.7%	0.5%	0.0%	0.0%
Other medical officer (CMO/SMO)	8.0%	4.5%	0.0%	3.5%
Other speciality consultant	**31.9%**	**26.5%**	**28.6%**	**22.1%**
Other speciality trainee	**23.2%**	**23.5%**	**14.3%**	**24.8%**
Paramedic	2.9%	1.0%	7.1%	0.9%
Registrar	14.5%	7.5%	7.1%	8.0%
Other	4.3%	2.5%	0.0%	3.5%
Prefer not to say	5.1%	4.5%	28.6%	11.5%

NB: Respondents could select more than one perpetrator of DBSH behaviour, so responses may add up to more than 100%.

6.17 Gender of who displayed the DBSH behaviour

Respondents were asked to select the gender(s) of the perpetrator(s) of the DBSH behaviour, with males more frequently nominated as the perpetrators of DBSH (Table 14). Those who reported that they had experienced sexual harassment at work in the past 12 months by a professional colleague were more likely to not disclose the gender(s) of the perpetrator(s).

Table 14 Gender of the perpetrator(s) of DBSH experienced by respondents in the workplace, by a professional colleague

	Discrimination (n=138)	Bullying (n=200)	Sexual harassment (n=14)	Harassment (n=113)
	%	%	%	%
Female	52.2%	51.5%	14.3%	48.7%
Male	81.2%	76.5%	64.3%	73.5%
Prefer not to say	6.5%	4.5%	21.4%	9.7%

NB: Respondents could select more than one gender perpetrating DBSH behaviour, so responses may add up to more than 100%.

6.18 Geographic location of the person who displayed the behaviour

Respondents were asked to select the location(s) of the perpetrator(s) by selecting from the eight Australian States/Territories, New Zealand, or another overseas country, with the option to not disclose the location(s) of the perpetrator(s). Overall, a higher percentage of respondents reported that the perpetrator(s) of:

+ discrimination, bullying and harassment were located in New South Wales, Queensland and Victoria; and

+ sexual harassment were located in Queensland and New Zealand.

The geographic location(s) of the perpetrator(s) of DBSH in the workplace are presented in Table 15.

Table 15 The geographic location(s) of the perpetrator(s) of DBSH experienced by respondents in the workplace, by a professional colleague

	Discrimination (n=138)	Bullying (n=200)	Sexual harassment (n=14)	Harassment (n=113)
	%	%	%	%
Australian Capital Territory	2.2%	1.0%	0.0%	2.7%
New South Wales	**29.0%**	**24.0%**	**7.1%**	**25.7%**
Northern Territory	0.0%	0.5%	0.0%	0.9%
Queensland	**23.2%**	**23.0%**	**28.6%**	**20.4%**
South Australia	5.1%	5.0%	0.0%	4.4%
Tasmania	4.3%	2.5%	14.3%	1.8%
Victoria	**25.4%**	**21.0%**	7.1%	**21.2%**
Western Australia	5.8%	7.0%	7.1%	3.5%
New Zealand	8.0%	12.0%	**28.6%**	15.0%
Another overseas location	0.7%	0.5%	0.0%	0.0%
Prefer not to say	4.3%	5.0%	7.1%	5.3%

NB: Respondents could select more than one location of the perpetrators of DBSH behaviour, so responses may add up to more than 100%.

6.19 Characteristic respondents were discriminated against

Respondents who indicated that they experienced discrimination at work in the past 12 months by a professional colleague were asked what characteristics, protected under National/State/Territory law, were discriminated against. Two people did not respond to this question, with those who did respond, selecting up to seven characteristics. Responses are summarised by level of ACEM training in Table 16. Gender (53%) was the most commonly reported characteristic respondents reported being discriminated against, followed by race (27%) and nationality (22%).

Trainees were significantly more likely to report that they had been discriminated against due to race and colour (race, 52%; colour, 33%) compared to FACEMs (race, 19%; colour, 9%) and those in the Other training level group (race, 25%; colour, 0%) (race, $\chi^2(2, n = 138) = 13.5634, p < 0.01$; colour, $\chi^2(2, n = 138) = 12.6699, p < 0.01$).

Table 16 Characteristic protected under National or State/ Territory law, respondents reported being discriminated against

	FACEM		Trainee		Other		Total	
	n	%	n	%	n	%	n	%
Gender	55	54.5%	16	48.5%	2	50.0%	73	52.9%
Race	19	18.8%	17	51.5%	1	25.0%	37	26.8%
Nationality	19	18.8%	10	30.3%	1	25.0%	30	21.7%
Family or carer responsibilities	22	21.8%	4	12.1%	0	0.0%	26	18.8%
Age	17	16.8%	4	12.1%	2	50.0%	23	16.7%
Colour	9	8.9%	11	33.3%	0	0.0%	20	14.5%
Religion	9	8.9%	1	3.0%	0	0.0%	10	7.2%
Pregnancy	7	10.6%	1	7.7%	0	0.0%	8	5.8%
Marital/ relationship status	6	5.9%	2	6.1%	0	0.0%	8	5.8%
Sexual orientation	3	3.0%	1	3.0%	0	0.0%	4	2.9%
Breastfeeding	1	1.5%	1	7.7%	0	0.0%	2	1.4%
Other (prefer not to say)	20	19.8%	7	21.2%	0	0.0%	27	19.6%

Other characteristics respondents reported being discriminated against included, based on their skills and experience; their profession; other personal characteristics; and other employment, activity or personal reasons.

Gender

Overall, the percentage of those reporting that they had been discriminated against in the past 12 months by a professional colleague based on their gender, significantly decreased as age increased ($\chi^2(7, n = 134) = 16.3718, p < 0.05$) (Figure 59, over page). Females were significantly more likely to report being discriminated against because of their gender (74%), compared to males (17%) ($\chi^2(2, n = 135) = 42.4943, p < 0.001$) (Figure 60, over page).

Those who obtained their PMD in another country (57%), were less likely to report that they were discriminated against based on gender, compared to those who obtained their PMD in Australia (65%), the United Kingdom (65%) or New Zealand (62%), (Figure 61, over page) ($\chi^2(3, n = 121) = 9.3592, p < 0.05$).

Figure 59 Percentage of respondents who reported experiencing discrimination by a professional colleague in the past 12 months based on their gender, by age (n = 134)
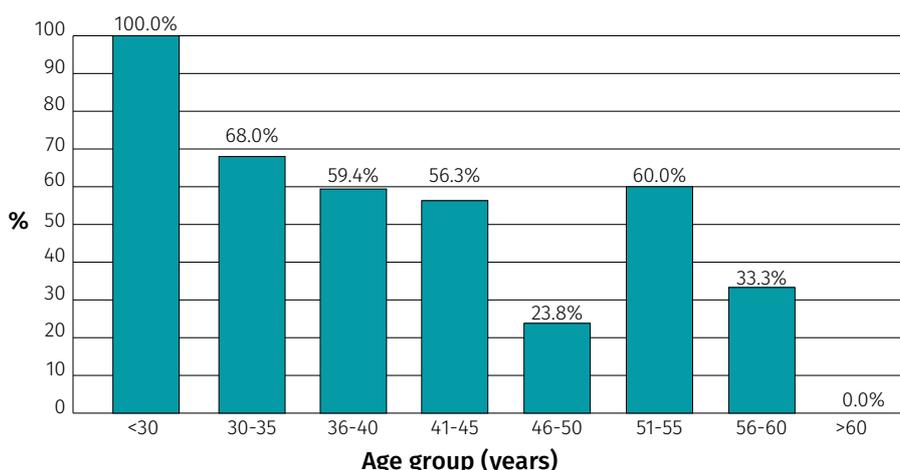
Respondents whose primary workplace was located in a metropolitan/ urban area were significantly more likely to report that they were discriminated against based on their gender, compared to those whose primary workplace was located in a regional area (χ^2(1, n = 138) = 5.2495, p < 0.05) (Figure 63).

Figure 60 Percentage of respondents who reported being discriminated against based on their race, nationality, colour, religion and gender; by gender (N = 135)
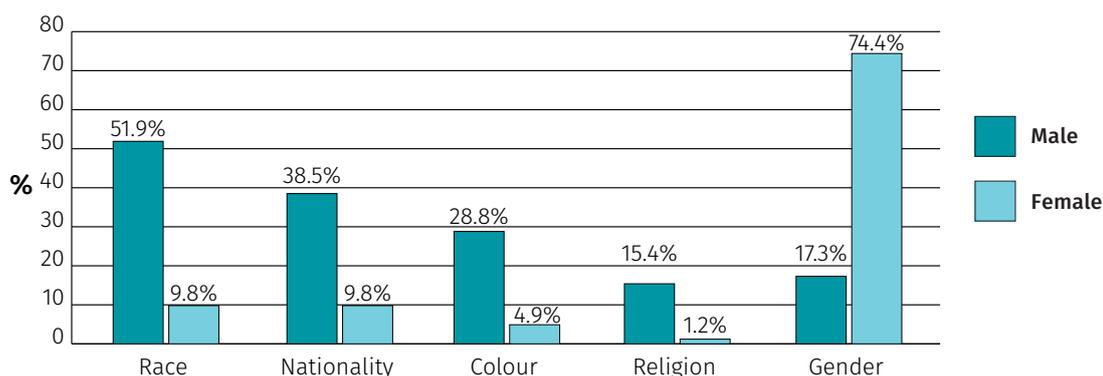
Race, Nationality, Colour and Religion

Males were significantly more likely to report discrimination based on their race (52%), nationality (39%), colour (29%), and religion (15%), than females (race and nationality, 10%; colour, 5%; religion, 1%)[3], see Figure 60. Males were also significantly more likely to report that they were discriminated against based on their sexual orientation (4%) than females (1%) (χ^2(2, n = 135) = 33.7580, p < 0.001).

Those who obtained their PMD from another country were also significantly more likely to report that they had been discriminated against based on their race (46%), nationality (46%) and colour (35%), compared to those who obtained their PMD in Australia (race 9%, nationality 6%, and colour 3%), the United Kingdom (race 12%, nationality 18%, and colour 0%), and New Zealand (race 23%, nationality 23%, and colour 8%)[4].

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[3] Race, χ^2(2, n = 135) = 31.7031, p < 0.001; Nationality, χ^2(2, n = 135) = 16.2139, p < 0.001; Colour, χ^2(2, n = 135) = 15.2810, p < 0.001; Religion, χ^2(2, n = 135) = 10.3334, p < 0.01.

[4] Race, χ^2(3, n = 121) = 17.2003, p < 0.01; Nationality, χ^2(3, n = 121) = 20.2093, p < 0.001; Colour, χ^2(3, n = 121) = 23.1006, p < 0.001.

Figure 61 Percentage of respondents who reported experiencing discrimination based on their race, colour and nationality; by country in which they obtained their PMD (n = 121)
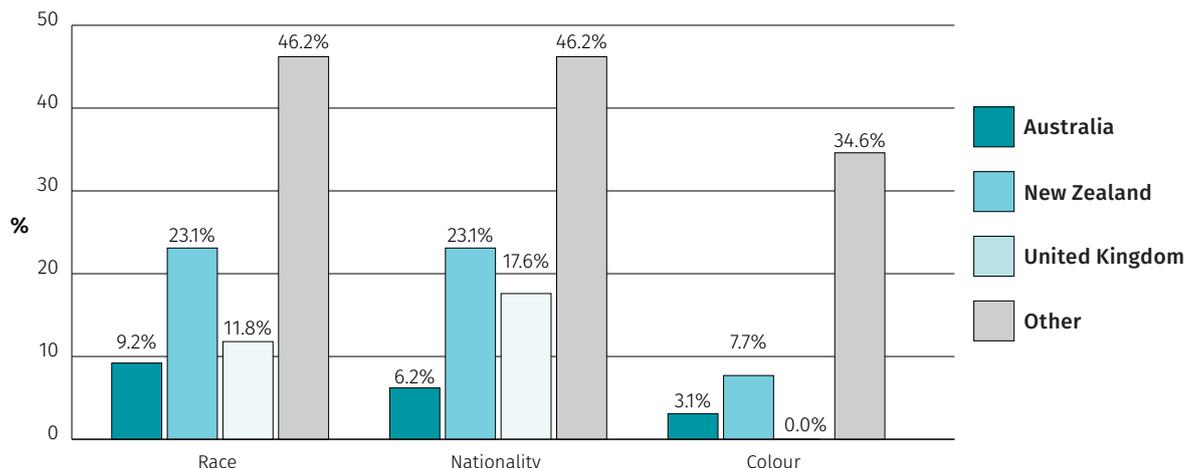
Marital/relationship status and family/carer responsibilities

Those whose primary workplace was located in a metropolitan/ urban area were significantly more likely to report that they were discriminated against based on their family/carer responsibilities (24%) and marital/ relationship status (9%), compared to those whose primary workplace was located in a regional area (9% and 0% respectively) (χ^2(1, *n* = 138) = (4.6442 and 4.2462 respectively), *p* < 0.05) (Figure 62).

Figure 62 Percentage of respondents who reported experiencing discrimination based on their gender, marital status and family/carer responsibilities; by remoteness (n = 138)
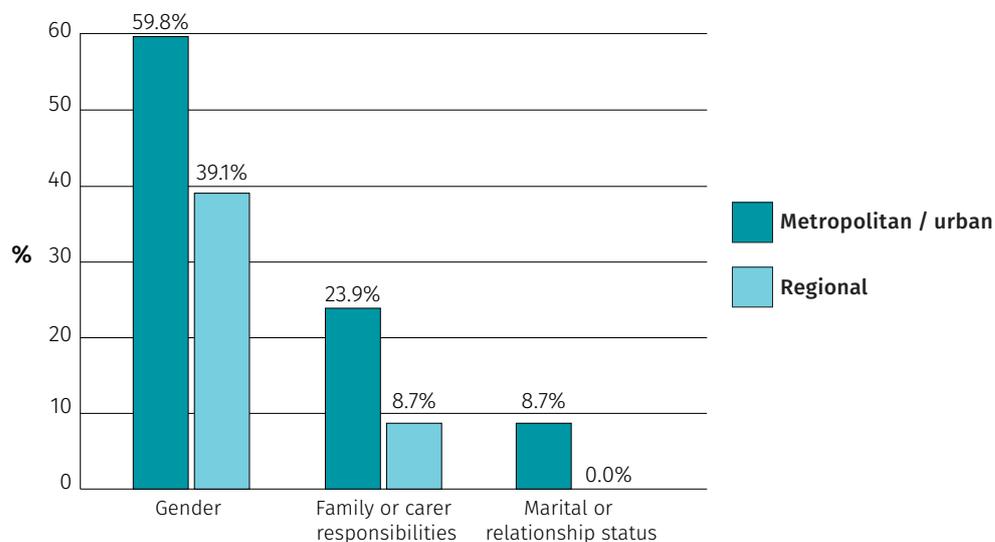
6.20 Sexual Harassment

Respondents who indicated that they had experienced sexual harassment at work in the past 12 months by a professional colleague were asked to indicate what types of behaviour were exhibited by the perpetrator(s). Respondents could select from a list of 11 behaviours and or describe another behaviour. Overall, unwelcome sexual flirtations and sexually explicit/offensive comments, jokes or other forms of inappropriate language were more likely to be selected (Table 17, over page).

Table 17 Types of sexual harassment behaviour respondents experienced in the workplace by a professional colleague (n = 14)

	n	%
Unwelcome sexual flirtations	**9**	**64.3%**
Sexually explicit or offensive comments, jokes or other forms of inappropriate language	8	57.1%
Displays of sexually explicit behaviour including sexual gestures, indecent exposure, or inappropriate display of the body	4	28.6%
Inappropriate physical contact	3	21.4%
Questions or insinuations about my sexual or private life	3	21.4%
Leering or graphic comments about my body and/or how my clothing looks on me	2	14.3%
Demands for sexual favours	1	7.1%
Display of sexually suggestive images, videos, emails, electronic messages, or notes	1	7.1%

6.21 Result of the DBSH behaviour experienced in the workplace

Respondents were asked if they experienced any detriments as a result of the DBSH behaviour they experienced in the workplace by a professional colleague. Respondents could indicate that they did not experience any detriments or select from a list of eight detriments, with the option to describe another detriment. Those who responded, were more likely to report that they experienced hurtful and humiliating comments made about them or towards them as a result of the DBSH in the workplace by a professional colleague. Those who reported that they experienced sexual harassment in the workplace by a professional colleague were more likely to report that they did not experience any detriment as a result of the sexual harassment. The detriments experienced by respondents as a result of the DBSH behaviour are presented in Table 18.

Other detriments reported by respondents included decline in mental health; impact to patient outcomes or patient safety; and a loss of professional reputation, income and/or job/employment (includes being forced to resign or demoted).

Table 18 The result of the DBSH respondents experienced in the workplace by a professional colleague

	Discrimination (n=138)	Bullying (n=200)	Sexual harassment (n=14)	Harassment (n=113)
	%	%	%	%
Hurtful and humiliating comments made about or towards you	**49.3%**	**54.0%**	**14.3%**	**46.9%**
Being denied a promotion/ job	**31.9%**	14.0%	0.0%	15.0%
Being denied opportunities at work (procedures, resuscitation)	**22.5%**	14.5%	7.1%	13.3%
Excluded from meetings directly related to your role	21.0%	**21.5%**	0.0%	12.4%
Being denied appropriate rostering	19.6%	12.5%	0.0%	12.4%
Being assigned meaningless tasks unrelated to your role	18.8%	14.0%	0.0%	8.0%
Being denied training opportunities	18.1%	10.5%	0.0%	7.1%
Excluded from social events where other colleagues have been invited	11.6%	6.5%	0.0%	7.1%
Other detriment	18.1%	15.0%	7.1%	12.4%
Did not experience any detriment	13.0%	**22.5%**	**71.4%**	**28.3%**

NB: Respondents could select more than one result of the DBSH behaviour, so responses may add up to more than 100%.

6.22 Sought to address the DBSH

Respondents were asked if they sought to address the DBSH they experienced in the workplace by a professional colleague, and could select as many of the 14 'yes' options or select one of the three options that described why they did not seek to address the DBSH. Overall, 66% sought to address discrimination, 69% bullying and 56% harassment. Over half (57%) of the people who reported that they had experienced sexual harassment did not seek to address the behaviour.

Those that did seek to address the DBSH perpetrated in the workplace did so through discussion with family, friends or personal network; with a peer; with a senior colleague or mentor; or they brought the behaviour to the attention of their supervisor or manager.

Table 19 presents the responses for those who did not take action to address the DBSH behaviour and Table 20 presents the responses for those who did take action to address the DBSH behaviour.

Table 19 Reasons respondents reported for not seeking to address the DBSH they experienced in the workplace by a professional colleague

	Discrimination (n=138)	Bullying (n=200)	Sexual harassment (n=14)	Harassment (n=113)
	%	%	%	%
No	34.1%	31.5%	57.1%	42.5%
I didn't want to	15.9%	16.5%	42.9%	25.7%
I wasn't able to at the time	15.2%	9.5%	7.1%	10.6%
I didn't feel I needed to	2.9%	5.5%	7.1%	6.2%

Table 20 Actions respondents took to address the DBSH they experienced in the workplace by a professional colleague

	Discrimination	Bullying	Sexual harassment	Harassment
	% (n=91)	% (n=200)	% (n=14)	% (n=113)
Yes	65.9%	68.5%	42.9%	57.5%
Discussed it with family, friends or personal network	**38.4%**	**30.0%**	**28.6%**	**23.0%**
Discussed it with a peer	**31.9%**	**34.5%**	14.3%	**23.0%**
Discussed it with a senior colleague or mentor	**26.8%**	**25.5%**	**21.4%**	17.7%
Brought to the attention of my supervisor or my manager	**24.6%**	**30.5%**	**42.9%**	**31.9%**
Discussed it with a union, medical association or representative	15.2%	10.5%	7.1%	8.0%
Addressed it directly with the person	14.5%	16.5%	7.1%	8.8%
Made a complaint to ACEM	7.2%	3.5%	0.0%	2.7%
Made an informal or formal complaint to HR or another office in the workplace	6.5%	11.0%	7.1%	4.4%
Discussed it with a lawyer or legal service	5.1%	7.5%	0.0%	2.7%
Made a formal complaint with an external agency	1.4%	1.5%	7.1%	0.0%
Spoke to my employer's counselling service	0.7%	2.0%	0.0%	1.8%
Reported it to a regulatory authority (e.g., AHPRA/ MCNZ)	0.7%	0.5%	0.0%	0.0%
Made a complaint to another relevant college	0.0%	0.5%	0.0%	0.9%

NB: Respondents could select more than one action taken, so responses may add up to more than 100%.

6.23 Result of the action taken to address the DBSH

Respondents who reported that they took action to address DBSH by a professional colleague in the past 12 months were asked to indicate what the result was of the action they took. Respondents could select from 15 possible results or describe another result, with responses summarised in Table 21.

Ninety-one (66%) respondents who reported that they had experienced discrimination by a professional colleague in the past 12 months sought to address this behaviour, 137 (69%) of those who experienced bullying sought to address the behaviour, six (43%) of those who experienced sexual harassment addressed the behaviour, and 65 (58%) sought to address the harassment behaviour they experienced. Of those who sought to address their experience of discrimination, bullying and harassment, over one third (45%, harassment; 40%, bullying; and 36%, discrimination) did not expect action to be taken. Of note, the behaviour continued for:

+ 50% of those who took action to address sexual harassment;

+ 35% of those who took action to address harassment;

+ 31% of those who took action to address bullying; and

+ 30% of those that took action to address discrimination.

Also, 17% of those who took action to address discrimination and 15% of those who took action to address bullying, reported that they were victimised for making a complaint.

Of those who took action to address discrimination and bullying, 18% and 14% respectively reported that the complaint was not progressed by the receiving body. Half of those who took action to address their experience of sexual harassment reported that their employer made changes to the workplace to prevent the behaviour in the future and the behaviour stopped. Other responses included no outcome/result and legal action being undertaken.

Table 21 Result of the actions respondents took to address the DBSH they experienced in the workplace by a professional colleague

	Discrimination (n=91)	Bullying (n=137)	Sexual harassment (n=6)	Harassment (n=65)
	%	%	%	%
I did not expect action to be taken	**38.5%**	**40.1%**	16.7%	**44.6%**
This behaviour continued	**29.7%**	**30.7%**	**50.0%**	**35.4%**
I was victimised for making a complaint	**16.5%**	14.6%	0.0%	9.2%
Complaint was not progressed by receiving body	14.3%	**17.5%**	0.0%	7.7%
This behaviour stopped	11.0%	10.9%	**50.0%**	12.3%
Complaint has not yet been finalised	8.8%	8.0%	0.0%	6.2%
I left my job	7.7%	7.3%	0.0%	10.8%
I moved to another location	8.8%	7.3%	0.0%	7.7%
I received an apology	7.7%	8.0%	0.0%	3.1%
The perpetrator moved to another location	4.4%	5.8%	16.7%	6.2%
I took extended leave	4.4%	5.1%	0.0%	7.7%
My employer made changes to the workplace to prevent this behaviour in the future	4.4%	5.1%	**50.0%**	4.6%
I withdrew my complaint	0.0%	0.7%	0.0%	0.0%
I received compensation	0.0%	0.0%	0.0%	0.0%
Police investigation conducted	0.0%	0.0%	0.0%	0.0%
Other	9.9%	5.1%	0.0%	1.5%

NB: Respondents could select more than one result of the action they took, so responses may add up to more than 100%.

6.24 Negative repercussions of taking action

Those who took action to address the behaviour they experienced by a professional colleague were asked to indicate if there were any repercussions of taking action.

+ Only three people who reported that they took action responded to this question, with all three reporting experiencing negative repercussions.

+ A total of 115 people who took action to address bullying responded to this question, with 28.7% and 27.8% respectively reporting that they either did experience negative repercussions or were unsure if they experienced negative repercussions as a result of taking action.

+ Of the six who took action to address sexual harassment, half did not experience any repercussions as a result of taking action and half were unsure if they experienced negative repercussions.

+ A total of 54 people who took action to address harassment, responded to this question, with 25.9% reporting that they experienced negative repercussions and 33.3% reporting that they were unsure if they experienced negative repercussions as a result of the action they took.

6.25 Potential barriers to taking action

Respondents were given the option to nominate any potential barriers to taking action to address the DBSH behaviour, with their responses presented in Table 22 (over page). The main barriers respondents reported to taking action, included uncertainty about whether the behaviour would be judged as serious enough, the effect on their future career options and the impact on their reputation.

Other potential barriers respondents reported to taking action to address the DBSH they experienced in the workplace, included their perception that there was no point in seeking to address the behaviour, as from their experience nothing would change; they did not think it was worth making a complaint; or were unable to make a complaint.

Table 22 Barriers respondents reported to taking action to address the DBSH they experienced in the workplace

	Discrimination (n=91)	Bullying (n=137)	Sexual harassment (n=6)	Harassment (n=65)
	%	%	%	%
Effect on future career options	**49.3%**	**35.0%**	21.4%	**30.1%**
Loss of reputation for self	**40.6%**	**33.0%**	14.3%	**28.3%**
Uncertainty about whether the behaviour would not be judged as serious enough	**36.2%**	32.5%	**42.9%**	**32.7%**
Potential for victimisation	**36.2%**	32.5%	14.3%	25.7%
The stress associated with filing a complaint and enduring an investigation	31.9%	**37.0%**	14.3%	**28.3%**
Fear of being blamed	25.4%	22.5%	14.3%	17.7%
Concern of not being believed or taken seriously by management	24.6%	24.0%	**28.6%**	22.1%
Impact on my daily practice	21.0%	25.5%	21.4%	18.6%
Uncertainty about whether the behaviour would be judged as normal	21.0%	21.5%	**28.6%**	19.5%
Effect on assessments	21.0%	13.5%	7.1%	8.8%
Loss of support from supervisors, colleagues, friends, partner, family	18.1%	16.0%	0.0%	14.2%
I was not aware of how to make a formal complaint	10.9%	11.0%	14.3%	8.0%
Only wanted to complain informally, but didn't know how to do this or who to go to	10.1%	11.0%	21.4%	8.8%
Impact on my family	8.0%	9.0%	7.1%	11.5%
Loss of reputation for perpetrator	5.8%	5.0%	14.3%	4.4%
Other	4.3%	5.5%	0.0%	5.3%
Did not experience any barriers	10.9%	12.0%	21.4%	15.0%

NB: Respondents could select more than one barrier to taking action, so responses may add up to more than 100%.

6.26 Experiences of DBSH

Those who reported that they experienced discrimination, bullying, sexual harassment or harassment in the workplace by a professional colleague, were asked if they would like to describe an example of the behaviour they experienced.

Experiences of discrimination

Thirty-four (25%) respondents provided a description of their experiences of discrimination in the workplace. The descriptions of discrimination frequently involved discrimination by senior staff, discrimination of women with respect to pregnancy and raising children, and discrimination relating to rostering, with the themes and frequencies available in Table 23 (over page).

Table 23 Respondents experiences of discrimination, themes and frequencies

	n	%
By senior staff	**13**	**38.2%**
Gender – being female	**12**	**35.3%**
Childcare responsibilities	5	14.7%
Pregnancy or breastfeeding	4	11.8%
Rostering	**10**	**29.4%**
Career progression	**8**	**23.5%**
By ACEM	**4**	**11.8%**
Union or advocacy efforts	**3**	**8.8%**
Other	**2**	**5.9%**

Some examples of comments reflecting these themes are presented below:

'Not having temp contract extended to cover maternity leave when others automatically had theirs extended.'

'[as a parent] comments were made regarding changes in roster in order to meet family demands. [Made to] feel that [I was] not part of the team or that [I was] working less than [my] colleagues. Eventually due to health and family reasons, I have reduced my FTE - I [would] rather earn less and be happy in both my work and home life.'

'Not having equal rostering, opportunities or consideration as on temp contract.'

'[accusations made about my presentation] despite [telling management] it was work that was causing me stress with understaffing (dangerous clinical level) and being rostered for too many shifts because of understaffing.'

'... saw [other] colleagues get long service leave and I was refused, saw [other colleagues] get offers of special arrangements with part time work enabling them to keep their leave and professional entitlements... excluded from meetings regarding my area of [work]. The hospital (and department) has done this repeatedly when anyone complains about the culture or their treatment...'

'[ACEM], assessments including exam and WBAs are biased and disadvantage to a group of trainees.'

Experiences of bullying

A total of 52 (26%) respondents provided a description of an experience of bullying. The descriptions of an experience of bullying were often complex and multifaceted, involving multiple people and teams, indicating a group culture of bullying. Also supporting this were reports of bullying by a single person, which respondents commonly reported as being witnessed (Table 24, over page).

Table 24 Respondents experiences of bullying, themes and frequencies

	n	%
Complex and multifaceted	**27**	**51.9%**
Involved nursing	8	15.4%
Involved Hospital Administration	6	11.5%
Involved other care teams	6	11.5%
Single person – face to face	**23**	**44.2%**
Witnessed	15	28.8%
Not witnessed	1	1.9%
Involved victim's performance in the workplace	**18**	**34.6%**
Involved patient care	**17**	**32.7%**
Affected EM Specialist Training	**8**	**15.4%**
Affected professional reputation	**8**	**15.4%**
Affected mental wellbeing	**7**	**13.5%**
Resulting in serious and or severe mental health issues	4	7.7%
Single person – not face to face (electronic)	**3**	**5.8%**
Indirect	**3**	**5.8%**
ACEM reported as perpetrator	**2**	**3.8%**

Some examples of comments reflecting these themes of bullying are presented below:

> '… repeatedly tried to undermine my current leadership role by questioning my appointment to the role… I have been the target of email abuse and undermining comments made in public forums, including in front of [staff].'
>
> '…made to feel inferior and harshly spoken to when handing over to another consultant.'
>
> '… would make snide comments during meetings [towards] me … criticize me to others, etc.'
>
> '… I understand that [other departments/ departmental staff are not] thrilled to get a phone call from ED (we're just giving them more work, and they're probably overloaded already), but being constantly met with disdain and nastiness is quite tiring.'
>
> '… bullying by nursing staff in the emergency department in trying to push patients to the ward when it was unsafe to do so because of potential for patient to 'breach'. Multiple [public] confrontations,… threats, questioning clinical judgement in front of patients.'
>
> '… spoken to rudely by [a colleague], [including] being shouted at, impacting on clinical care of a patient. This [colleague] is a known bully and has had repeated similar behaviour to other colleagues. A formal complaint was made to the hospital executive which had no outcome (as was expected).'
>
> 'Multiple episodes of derogatory marks, eye rolling, general rudeness etc… when making a referral. Always the same offenders… Usually minor behaviours that [I] don't feel [are] worthwhile of a complaint, and likely if a complaint is made the offender will deny/ gaslight you, but enough that avoidance behaviour is sought… Often will let a patient breach and refer to next specialist the following day, seek an alternative specialty to refer to etc. (enough that I believe patient care is… compromised).'
>
> '… [displayed] behaviours… designed to detract from my new role - i.e. 'forgetting' that I was a consultant and introducing me to patients and families and co-workers as a registrar. Not willingly accepting tasks that I had assigned…'
>
> 'Multiple inappropriate and personally attacking statements used during the meeting, which did not focus on our hospital as a whole, but on our department… as being [responsible for] the entire hospital's dysfunction.'

Experiences of sexual harassment

Three (20%) respondents who reported experiencing sexual harassment, provided an example of their experience, all reported experiencing repeated, inappropriate sexual behaviour such as comments and physical contact.

Experiences of harassment

Of those who experienced harassment in the workplace, 25 (22%) provided a description of their experience. Common themes identified from the comments included, perpetrators undermining the clinical practice of respondents (for example by ignoring direct instructions) or making inappropriate requests, with the themes and their frequencies available in Table 25.

Table 25 Respondents experiences of harassment, themes and frequencies

	n	%
Undermining clinical practice	**8**	**30.8%**
By other clinical teams or administration	5	19.2%
Inappropriate requests	**8**	**30.8%**
Personal attacks and incivility	**5**	**19.2%**
Denied shifts, activities or opportunities	**4**	**15.4%**
Other	**2**	**7.7%**

Some examples of comments reflecting respondents' experiences of harassment are:

'…required… to attend the ED after midnight to either send patients home or effect their transfer to another facility. My colleagues working in the ED at the time had the situation in hand and had not requested my presence. I… was effectively ordered to attend, which I did, and it made a small difference to the waiting time in the ED, and none whatsoever to the overcrowding issue.'

'… repeatedly asked to attend meetings in the middle of the workday without prior notice: I was told there would be no face to face meeting with the person involved… The following day I was then pressured into attending a face to face meeting…'

'Surgeon using intimidating language… insinuating that I didn't make the correct diagnosis or have an appropriate treatment pathway ([I did,] the patient was accepted for admission)

'The continuous belittling by inpatient teams when referring patients is dreadful and toxic. A senior surgeon hung the phone up on me as he disagreed with the ED admission policy.'

'When making referrals, the inpatient registrar speaks quickly, asks the next question just a fraction before I have finished speaking, uses a tone that suggests I am asking for a great favour when making a referral, interrupts to ask the MRN [to look at patient tests/ results online]… rather than listening, rejects the referral with an insincere offer to review at any time, and asks for many details with the implication that any sensible clinician would have done this test… Asks for investigations or processes that will delay the case to another person's shift. Makes requests without saying please and hangs up without saying thank you.'

7. Conclusion

Despite the smaller response rate compared with previous similar surveying activities, the findings from the 2019 Sustainable Workforce Survey suggest that a significant number of our members and trainees continue to experience stress and personal and work-related burnout. In addition, the survey also showed that large percentages of respondents had experienced DBSH from a patient and/ or and from a professional colleague in the previous 12 months.

The ED environment and the three dominant stressors identified by the respondents in this survey (ED overcrowding, access block and conflicts with other clinical teams) are no doubt major contributing factors to the stress and burnout experienced by respondents and may influence behaviour exhibited by colleagues. Indeed, the three dominant stressors identified are in line with results from the 2016 Workforce Sustainability Survey, and demonstrate that the health system continues to be strained, culminating in increased pressure on EDs, ED staff, and their workloads.

Despite all this, the report also showed that a large number of members and trainees continue to find personal satisfaction with emergency medicine as a profession, however in the current ED environment this may not be sustainable. Thus, the College is committed to continuing with and expanding upon its important work focused on diversity and inclusion, wellbeing and workplace culture begun in recent years.

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