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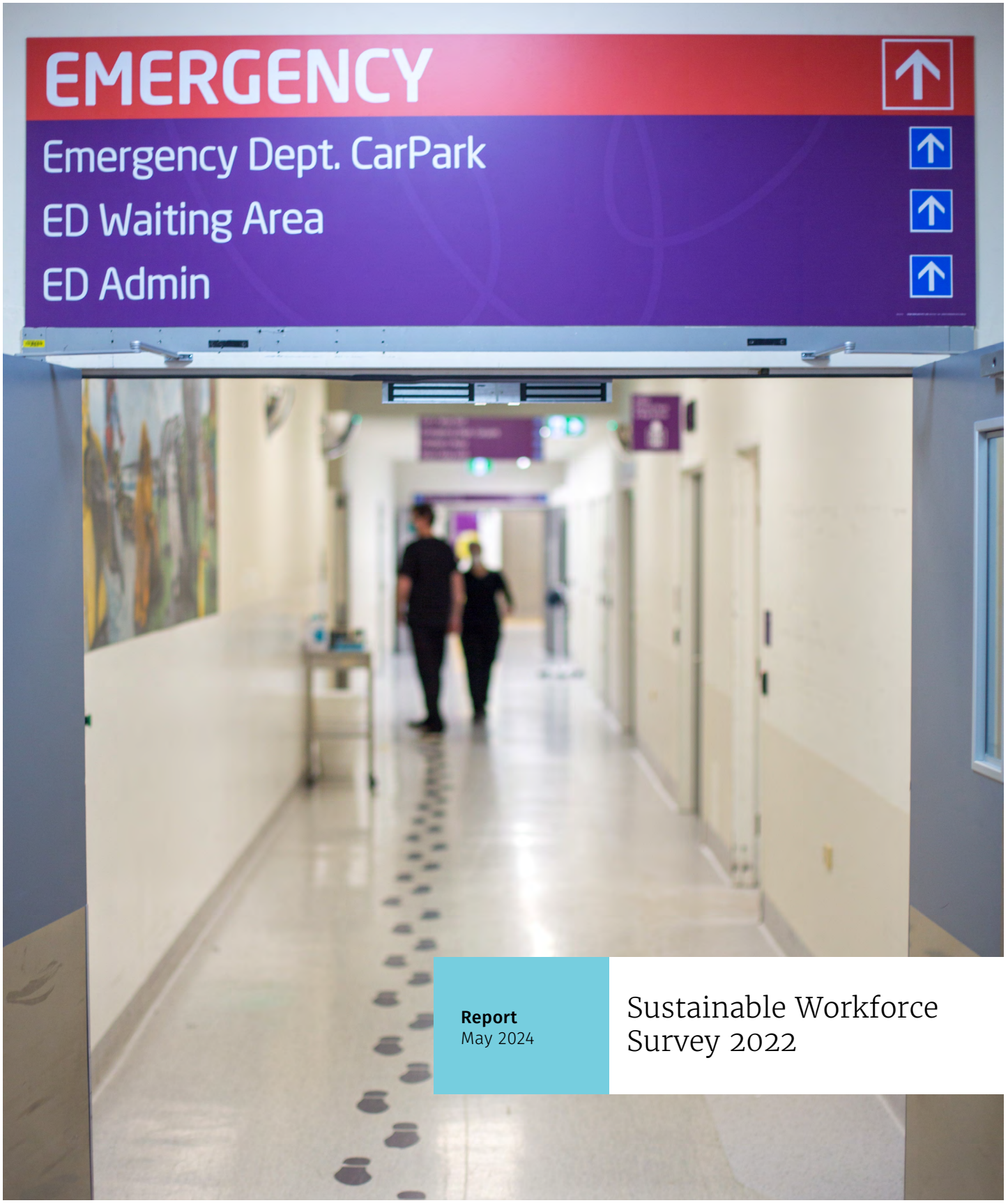


Report
May 2024

Sustainable Workforce Survey 2022

Australasian College
for Emergency Medicine

Sustainable Workforce Survey 2022

The Australasian College for Emergency Medicine's (ACEM) Sustainable Workforce Survey is a triennial survey to understand the work conditions, health, and wellbeing of ACEM members and trainees. This is fundamental for the College's commitment to fostering a safe and sustainable emergency medicine workforce. A 'sustainable' workforce is one in which the emergency medicine workforce is able to maximise its health, professional satisfaction, and career longevity, thereby optimising its ability to meet the emergency medicine care needs of the population.

The 2022 survey was the third iteration of the survey (previously conducted in 2016 and 2019) and was distributed to all active members and trainees in November and closed in December 2022. The survey asked respondents a range of questions about their demographics, workplace conditions, work-life balance, job satisfaction, stress, burnout, future career plans, and experiences of discrimination, bullying, sexual harassment, and harassment (DBSH).

Emergency departments sit at the intersection of primary and hospital-based care and are the safety net within the healthcare system when other services cannot cope. The timing of the 2022 survey fell during the third year of the COVID-19 pandemic, which exacerbated existing strains of access block, overcrowding, and the increasing complexity of patients presenting to emergency departments. Within this context, many survey respondents reported heightened levels of workplace stress and burnout, coupled with deteriorating trends in numerous health and wellbeing measures. Notably, the survey highlights an alarming increase in those who indicated an intention to leave the emergency medicine workforce in the next decade, primarily due to unsustainable workplace pressures.

ACEM is grateful to all members and trainees who participated in the survey and shared their invaluable perspectives and experiences. Everyone has the right to feel safe in their workplace and have sustainable and meaningful careers, but the survey findings indicate that this is not the case for many of ACEM's members and trainees and validates what our members have been telling us. The College recognises the increasing pressures and threats to the emergency workforce and held a summit at the end of 2023 to discuss the issues and the future of our specialty. The College is and will continue to advocate strongly to governments to improve workforce planning and workplace safety and will continue to investigate the push and pull factors for why people choose emergency medicine or choose to leave emergency medicine.

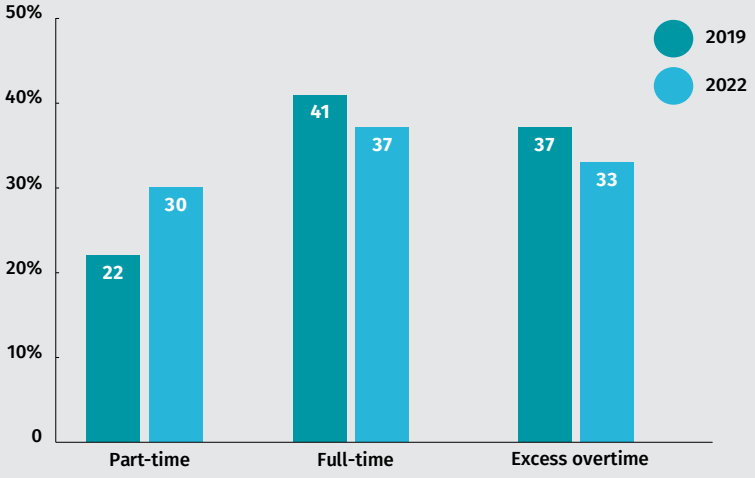
> *"Personal and organisational wellbeing are only possible in a healthy system. My experience is a system constantly under significant pressure, with minimal funding or resources for flexibility.*
>
> *I personally get little relief from stop-gap solutions and tokenistic offers (I love the wellbeing week cupcakes, but…). I hope that the results of this survey can contribute to structural reform for a healthier and more sustainable and resilient public hospital and healthcare system."*
>
> ***30–35-year-old FACEM trainee***

Survey responses and employment

728 **survey responses** were received

53% of respondents were **employed on a full-time contract** (down from 60% in 2019)

Total hours worked (in most recent usual week)



The past 12 months

Top stressors

77% **Overcrowding in ED** (up from 63% in 2019)

66% **Access block** (up from 56% in 2019)

Burnout

55% reported moderate to severe **work-related burnout** (up from 50% in 2019)

34% reported moderate to severe **patient-related burnout** (up from 12% in 2019)

Discrimination, bullying, sexual harassment, and harassment

40% experienced DBSH by a **patient or carer** (comparable to 41% in 2019)

25% experienced DBSH by a **colleague** (down from 47% in 2019)

Work-life balance

69% reported the demands of work interfered with **home and family life** (up from 65% in 2019)

37% reported the balance between **personal and professional commitments** was about right (down from 43% in 2019)

How the COVID-19 pandemic impacted respondents

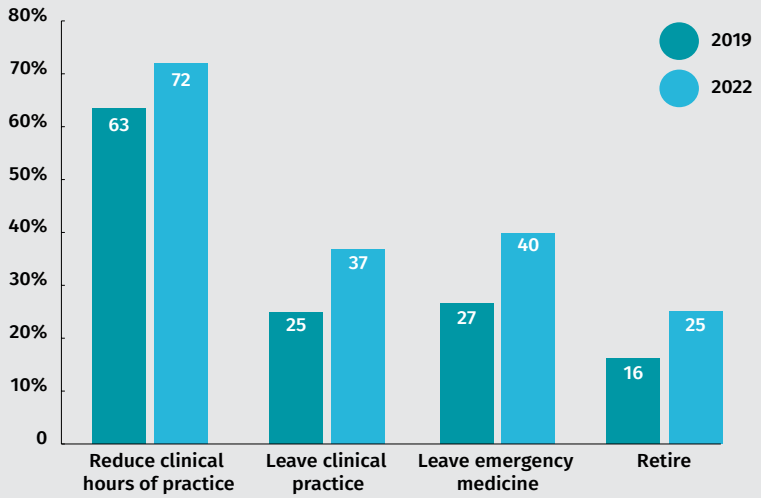
54% reported worsened **understaffing issues**

34% reported increased **stress/burnout**

21% reported worsened **ED overcrowding/ access block**

> *Understaffing [is the] main and severe issue – recruitment, understaffed as a whole, increased sickness leave, complicates patient assessment, increases time to see patients, carer/PPE fatigue, some staff suffering fear of infection and passing on to loved ones.*
>
> *46-50-year-old FACEM*

Future career plans (next 10 years) of respondents



Reasons for leaving clinical practice or emergency medicine

"I do not think working one FTE in emergency medicine is a sustainable career path in the current climate."
36-40-year-old FACEM

"Unsure if I can continue with emergency medicine if things continue to get worse re: access block, bed demands, poor funding GP system to prevent ED presentations"
30-35-year-old FACEM trainee

1. Background

The Australasian College for Emergency Medicine (ACEM) launched the third iteration of the Sustainable Workforce Survey on 1 November 2022. The two previous surveys (in 2016 and 2019) played a crucial role in the College's commitment to building a positive culture in the emergency medicine workforce. The triennial survey to measure key areas of the health and wellbeing of ACEM members and trainees will be essential to enable ACEM to prioritise support and undertake advocacy activities that contribute to creating a sustainable emergency medicine workforce that benefits healthcare professionals and the communities they care for. The 2022 Sustainable Workforce Survey captured updated information and enables comparison of trends compared to the 2016 and 2019 surveys.

2. Summary of survey findings

The survey garnered 728 responses from FACEMs, FACEM trainees and other ACEM members.

Employment profile

- 52.6% (a decrease of 8% from the 2019 survey) of respondents were employed on a full-time contract.
- Respondents reported an average of 42.3 hours of work per week (a decrease from 44.2 hours in the 2019 survey), 37.6 paid hours and 4.7 unpaid hours.

Work-life balance

- 37.0% (a decrease of 6% from 2019) agreed that the balance between their personal and professional commitments was about right.
- 68.7% (an increase of 4% from 2019) agreed that the demands of their work interfered with their home and family life.

Satisfaction with primary workplace

- 64.6% (a decrease of 10% from 2019) were satisfied with the overall work at their primary workplace.
- The most satisfying aspects of work at respondents primary workplace were interactions with colleagues (77.8%), career progression (69.3%), and remuneration/pay (66.9%).

Workplace conditions

- 65.4% had worked more than 12 consecutive hours at their workplace.
- 96.7% FACEMs trainees vs. 16.7% FACEMs had worked rostered night shifts in the past 12 months.
- 34.4% never received at least one 24-hour period off work for every night shift.
- 93.6% FACEMs vs. 30.0% FACEM trainees had been rostered on-call in the last 12 months.

Workplace stress, fatigue, burnout and general health

- The top three workplace stressors reported by respondents were overcrowding in the ED (77.3%, an increase of 14% from 2019), access block (66.3%, an increase of 10% from 2019), and conflicts with other clinical teams (27.3%, a decrease of 7% from 2019).
- 36.2% (an increase of 7% from 2019) of respondents had felt professionally isolated.
- 87.3% of respondents reported that they had felt anxious at work.
- 83.6% of respondents reported that fatigue had impacted their performance at work in the past 12 months.
- 55.2% (an increase of 10% from 2019) of respondents reported moderate to severe personal burnout.
- 54.9% (an increase of 5% from 2019) of respondents reported moderate to severe work-related burnout.
- 34.3% (an increase of 22% from 2019) of respondents reported moderate to severe client/patient-related burnout.
- 53.8% (a decrease of 9% from 2019) of respondents rated their general health as very good or excellent.

Future career plans

- 71.7% (an increase of 9% from 2019) of respondents reported that they were likely to reduce their hours of clinical practice in the next 10 years.
- 36.6% (an increase of 12% from 2019) of respondents reported that they were likely to leave clinical practice in the next 10 years.
- 40.0% (an increase of 13% from 2019) of respondents reported that they were likely to leave emergency medicine in the next 10 years.
- 24.8% (an increase of 9% from 2019) of respondents reported that they were likely to retire in the next 10 years.

Experiences of discrimination, bullying, sexual harassment or harassment (DBSH)

- 39.5% (comparable to 41% in 2019) of respondents reported that they had experienced DBSH by a patient or carer in the past 12 months.
- 24.9% (a decrease of 22% from 2019) of respondents reported that they had experienced DBSH by a professional colleague in the past 12 months.
    - 14.3% (a decrease of 6% from 2019) experienced discrimination.
    - 20.3% (a decrease of 10% from 2019) experienced bullying.
    - 10.8% (a decrease of 6% from 2019) experienced harassment.
    - 3.8% (an increase of 2% from 2019) experienced sexual harassment.

Impact of COVID-19

- The primary impacts of COVID-19 on workplaces and individuals included deteriorated understaffing issues (53.7%), increased stress/burnout (34.1%), and worsening of ED overcrowding/access block (21.3%).

3. Purpose and scope

This report provides the findings from ACEM's 2022 Sustainable Workforce Survey. A 'sustainable' workforce refers to 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 care needs of the population in Australia and Aotearoa New Zealand. Broadly, the survey focuses on work conditions, job satisfaction, work-life balance, work stressors, personal support mechanisms, and experience with discrimination, bullying and harassment within emergency medicine. The sustainable workforce survey is administered triennially and has been conducted twice previously, in 2016 (Australasian College for Emergency Medicine, 2016) and 2019 (Australasian College for Emergency Medicine, 2019).

The 2022 Sustainable Workforce Survey went live on 1 November and closed on 9 December 2022.

4. Survey aims

The survey aims to capture updated perceptions from ACEM's members and trainees about their work conditions and wellbeing, and monitor trends from previous iterations of the survey.

The survey is also part of ACEM's commitment to monitoring the emergency medicine workplace culture and experiences of discrimination, bullying, sexual harassment and harassment (DBSH) among its members and trainees on a regular basis. Overall, the findings from this survey will help to determine the success of ACEM's efforts to instigate changes to ED culture and to expand upon its important work focused on wellbeing, diversity, and inclusion.

Considering the potential impacts the COVID-19 pandemic may have had on the emergency medicine workforce and ED work environment, the 2022 survey will be essential to capture updated information, such as workplace stressors, changes in workplace conditions and job satisfaction, to inform the ACEM's ongoing initiatives and advocacy on promoting a sustainable emergency medicine workforce.

5. Method

5.1 Setting and participants

Participation in the survey was voluntary, and completion of the survey was considered implied consent.

A standalone email invitation addressed by the ACEM president was sent to all active members and trainees on ACEM's mailing list. Eligible participants included all active FACEMs, FACEM trainees, emergency medicine Certificate/Diploma/Advanced Diploma trainees and graduates, DipPHRM trainees and graduates, and SIMG applicants. Following the email invitation, the survey was promoted on social media (ACEM's Facebook, LinkedIn and Twitter accounts) and ACEM's electronic digital media (*Trainee News, Faculty Updates* and *Bulletin*).

5.2 Survey

The anonymous survey was hosted on the QuestionPro online platform and respondents were asked not to provide identifying information (such as names of people and workplaces). Respondents were initially directed to a screening questionnaire asking whether they were currently undertaking paid work in Australia or Aotearoa New Zealand. Paid work refers to any type of employment (including casual, sessional and/or locum contracts). If they responded yes to the screening question, they were directed to complete the full survey. If the respondents were not undertaking paid work in Australia or Aotearoa at the time of the survey, they were ineligible for the survey.

The survey asked respondents a range of demographic, workplace, job satisfaction and work-life balance questions; their plans for the future; questions about their general health; and their experiences of DBSH in the workplace. Wellbeing questions asked about available support services, experiences of anxiety, fatigue, and professional isolation. Respondents were asked to respond to questions on burnout sourced from 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 are aggregated 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).

The survey mirrors the 2019 survey questions, which were developed following internal discussions with relevant committee members and stakeholders. 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). Additional questions on the implication(s) of the COVID-19 pandemic were also added, and respondents were provided opportunities to provide feedback on how the COVID-19 pandemic has impacted aspects of their workplace or their wellbeing at work.

5.3 Data cleaning and analysis

Prior to data analysis and reporting, the survey submissions were checked to remove incomplete or duplicate 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 these questions were removed from the dataset.

Unless otherwise reported, responses to five-point Likert and Likert-type questions were collapsed into three categories for analysis and reporting, for example satisfied (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). Thematic coding of responses to open-ended questions was undertaken, with major themes identified and reported.

5.4 Limitations

The survey only included respondents who were employed at the time of the survey, for them to reflect on various aspects related to their workplace conditions, job satisfaction, and work stressors. Response bias may be an issue, with respondents who were 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 might impact the generalisability of the findings. An additional limitation is the low number of respondents from the 'other' category of members (emergency medicine certificate/diploma/advanced diploma trainees and graduates, DipPHRM trainees and graduates and SIMG applicants), as such when the member categories are analysed separately, the results for this group should be interpreted with caution.

6. Results

6.1 Respondent characteristics

A total of 728 survey responses (compared to n = 806 in the 2019 survey and n = 1,187 in the 2016 survey) were included in the analysis and reporting after removing the duplicates and incomplete responses. Demographics (gender, age groups), ACEM membership category, and country of primary medical degree of respondents are shown in **Table 1**.

The majority of respondents were FACEMs (80.6% vs. 77.8% in 2019, 59.0% in 2016), followed by FACEM trainees (16.8% vs. 19.9% in 2019, 40.8% in 2016), with 2.6% comprising other member categories (2.4% in 2019, 0.3% in 2016). Of the respondents in 2022, 0.3% (n = 2) self-identified as Aboriginal and/or Torres Strait Islander, 0.4% (n = 3) as Māori and 0.3% (n = 2) as Pacific Islander.

Table 1 Demographic and membership profiles of respondents.

	2022 survey respondents (n = 728)		ACEM membership (n = 7,016)	
	n	%	n	%
Gender				
Female	377	51.8%	3,153	44.9%
Male	336	46.2%	3,842	54.8%
Prefer not to say	15	2.0%	21	0.3%
ACEM membership				
FACEM	587[a]	80.6%	3,582	51.1%
Advanced FACEM trainee	104	14.3%	1,907	27.2%
Provisional/TS1 FACEM trainee	18	2.5%	442	6.3%
Other member	19	2.6%	1,085	15.5%
Age group (years)				
Less than 30	6	0.8%	601	8.6%
30-35	99	13.6%	1,946	27.7%
36-40	135	18.5%	1,442	20.6%
41-45	119	16.3%	1,119	15.9%
46-50	139	19.1%	774	11.0%
51-55	102	14.0%	590	8.4%
56-60	67	9.2%	299	4.3%
More than 60	49	6.7%	219	3.1%
Prefer not to say	12	1.6%	26	0.4%
Primary medical degree				
Australia	390	53.6%	3,083	43.9%
Aotearoa New Zealand	80	11.0%	400	5.7%
Other countries	239	32.8%	2,574	36.7%
Prefer not to say	19	2.6%	959	13.7%

Notes: [a]includes three Paediatric emergency medicine Specialist (FRACP); ACEM membership demographics as of 1 January 2023; Other members included: emergency medicine Certificate/Diploma/Advanced Diploma trainees and graduates, DipPHRM trainees and graduates, and SIMG applicants.

6.2 Employment and workplace profiles

This section provides information on the geographical distribution of respondents' primary workplace, employment status, number of paid and unpaid hours, number of workplaces and type of primary workplace.

6.2.1 Primary workplace locations

The geographical distribution of respondents' primary workplace, comparing the 2022 and 2019 surveys, is shown in **Table 2**. There were 616 (84.6%) respondents whose primary workplace is in Australia (n = 696, 86.4% in 2019) and 112 (15.4%) in Aotearoa New Zealand (n = 110, 13.6% in 2019).

Table 2 Geographical distribution of respondents' primary workplace.

Location	2022 FACEMs (n = 587)	2022 FACEM trainees (n = 122)	2022 Total (n = 728)	2019 Total (n = 806)
Australia	**84.5%**	**85.2%**	**84.6%**	86.4%
Jurisdiction				
ACT	2.2%	0.8%	1.9%	2.2%
NSW	22.0%	18.9%	21.2%	23.9%
NT	3.6%	4.1%	3.6%	2.4%
QLD	15.8%	25.4%	17.4%	21.5%
SA	5.8%	4.1%	5.4%	3.3%
TAS	2.9%	2.5%	2.7%	3.1%
VIC	18.6%	22.1%	19.4%	22.1%
WA	13.6%	7.4%	13.0%	8.2%
Remoteness				
Major city	55.5%	60.7%	56.2%	55.5%
Regional	26.9%	23.0%	26.2%	29.2%
Remote	2.0%	1.6%	2.2%	2.1%
Aotearoa New Zealand	**15.5%**	**14.8%**	**15.4%**	13.6%
Remoteness				
Metropolitan	8.2%	11.5%	8.8%	8.3%
Regional/Rural	7.3%	3.3%	6.6%	5.3%

6.2.2 Current employment status

Overall, around half (52.6% vs 60.4% in 2019) of the respondents were employed on a full-time contract, with FACEM trainees (68.0% vs. 67.7% in 2019) more likely than FACEMs (49.4% vs. 58.0% in 2019). There was a decrease in FACEMs reporting only full-time employment compared with the 2019 survey, while this remained consistent among FACEM trainees (**Figure 1**).

52.6% (a decrease of 8% from 2019) were employed on a full-time contract.

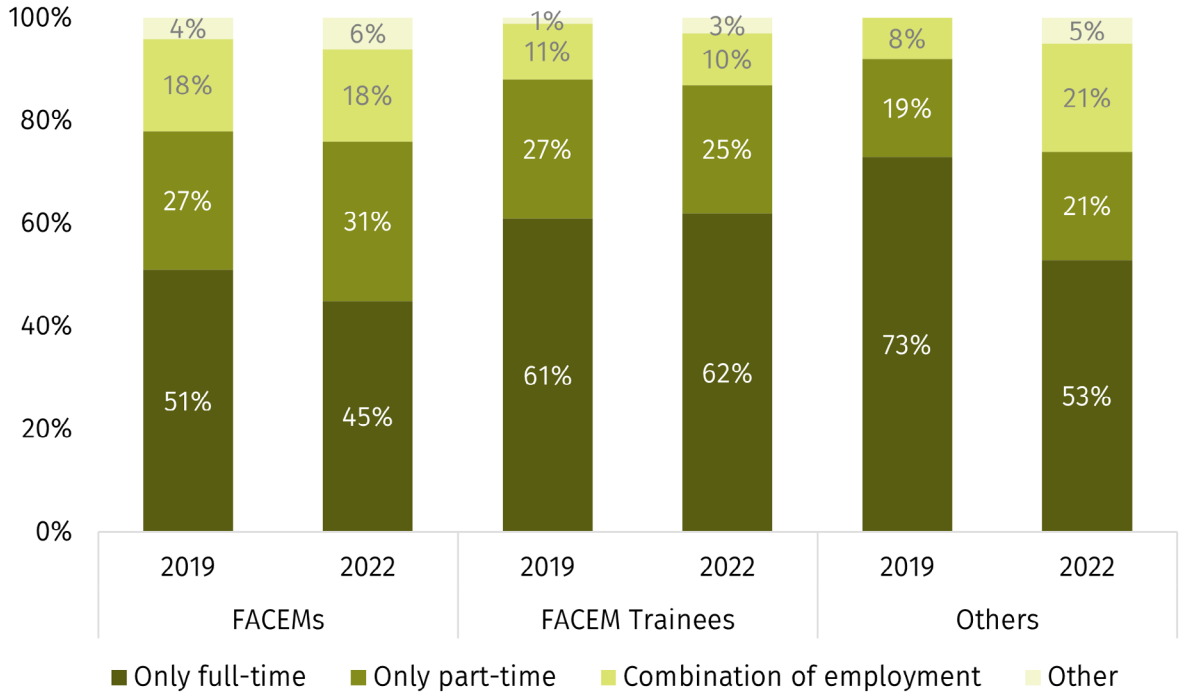


Figure 1. Employment status of respondents, by ACEM membership (n = 795 in 2019, n = 728 in 2022). Other types of employment included visiting medical officer contract, casual/locum/sessional, self-employed, and telehealth contractor.

6.2.3 Number of paid and unpaid hours

Respondents were asked to provide the number of paid and unpaid hours they worked in their most recent usual week across different settings. A summary of the hours worked across the settings, and a comparison to the 2019 survey is shown in **Table 3**.

An average of 11.1% of total hours worked were unpaid hours.

Table 3 Number of paid and unpaid hours per week that respondents reported working.

Type of work	2022			2019
	Min	Max	Mean	Mean
Clinical paid hours			33.9	36.0
Public hospital ED clinical work	5	80	23.3	25.5
Private hospital ED clinical work	2	60	1.4	1.6
Clinical support/ED office time (FACEMs)	1	40	6.2	6.0
Pre-Hospital/retrieval	4	60	0.8	1.4
Other clinical work	1	55	2.2	1.5
Non-clinical paid hours			3.7	3.7
Tertiary education institution/research	1	35	0.8	0.7
Protected teaching time (trainees)	1	10	0.5	0.6
Medical education (including EMET)	1	20	0.5	0.8
Other non-clinical work	1	40	1.9	1.6
Total paid hours	**3**	**100**	**37.6**	39.7
Total unpaid hours	**0**	**50**	**4.7**	4.5
Total paid and unpaid hours	**4**	**110**	**42.3**	44.2

Note: min = minimum response; max = maximum response; mean = average response; ED = emergency department, EMET = emergency medicine education and training.

Total hours worked was combined and classified into three categories: part-time (<37.5 hours per week), full-time (37.5-45 hours per week) and excess overtime (>45 hours per week). The proportion of respondents who reported working part-time hours increased significantly in 2022 from previous surveys, which was seen across all member categories (**Figure 2**).

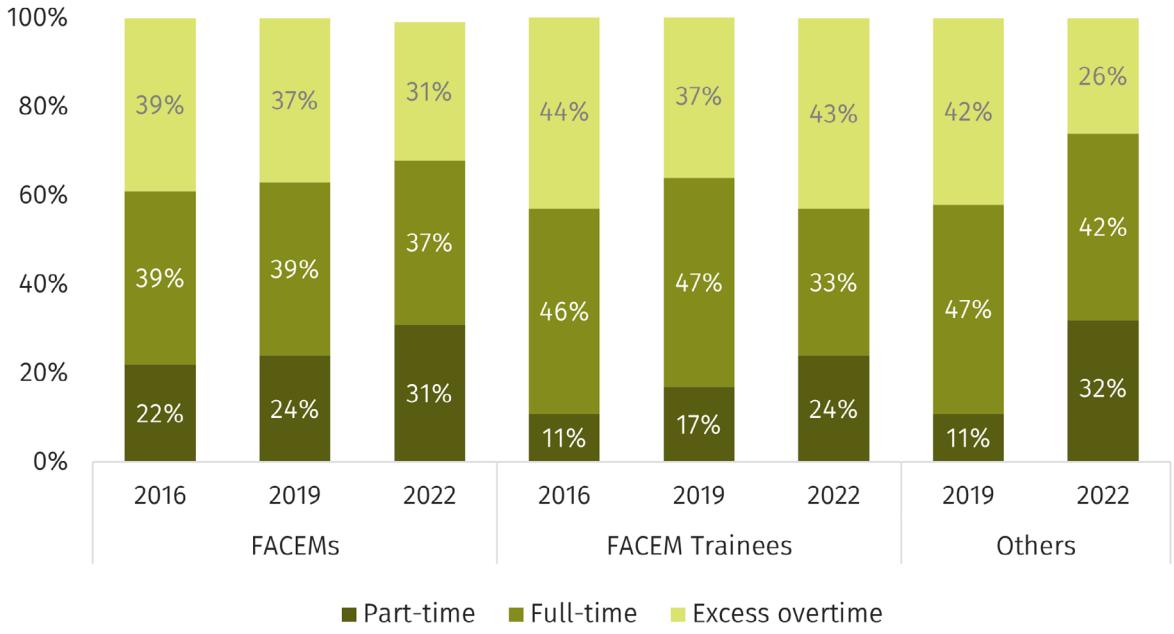


Figure 2. Respondent's total hours worked per week (part-time, full-time, excess overtime), by ACEM membership (n = 1,185 in 2016, n = 805 in 2019, n = 727 in 2022). No data was available for the 'Others' category from the 2016 survey.

There were differences in hours worked by gender, with females more likely than males to report working part-time hours (36.9% vs. 21.4%). While males were more likely to work full-time (41.7% vs. 33.4%) and excess overtime (36.6% vs. 30.0%) compared with females. The same trends occurred in the 2019 and 2016 surveys (**Figure 3**).

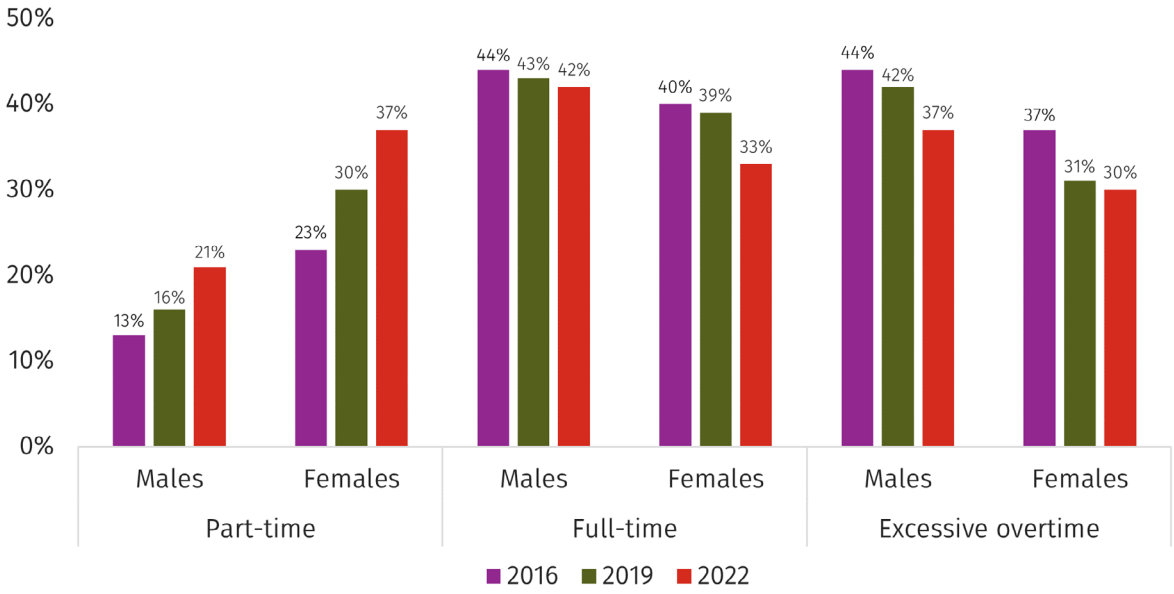


Figure 3. Respondent's hours worked per week, by gender (n = 1,185 in 2016, n = 805 in 2019, n = 727 in 2022).

6.2.4 Number of workplaces

Respondents were asked about the number of workplaces they were employed at. Overall, just over half (56.0% vs 55.8% in 2019) were employed at a single workplace, one-third at two workplaces (32.9% vs. 31.7% in 2019), and 11.1% (12.5% in 2019) at three or more workplaces. FACEMs (48.7%) were more likely than FACEM trainees (22.3%) to work at multiple workplaces, consistent with the 2019 survey findings (Figure 4).

56% worked at a single workplace.

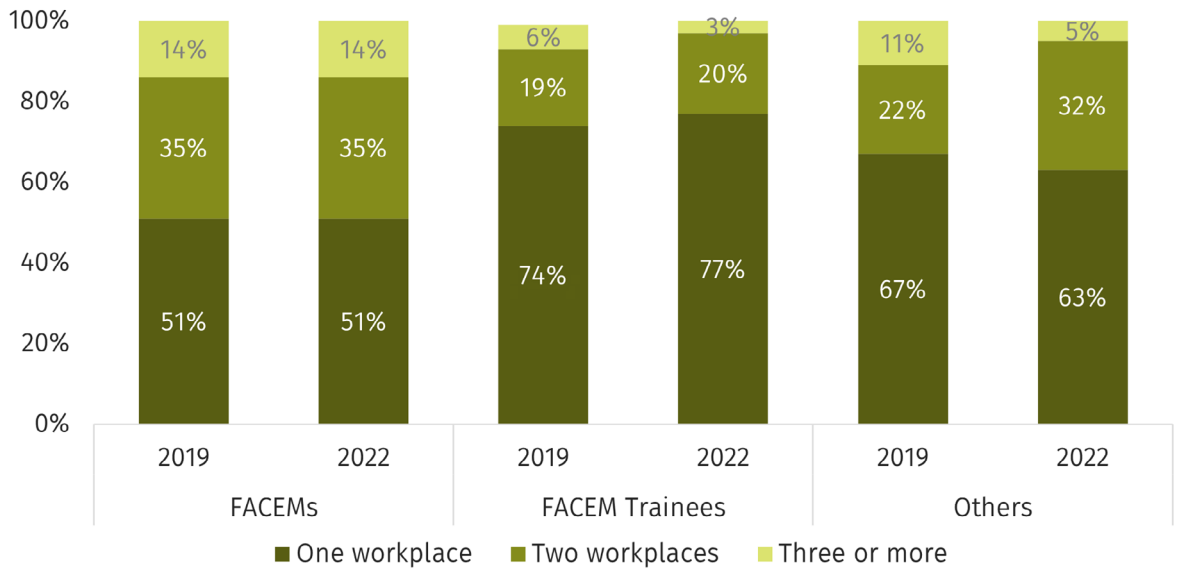


Figure 4. Number of current workplaces respondents reported working at, by ACEM membership (n = 795 in 2019, n = 721 in 2022).

6.2.5 Type of primary workplace

Most respondents reported working in a public hospital ED as their primary workplace (88.9% vs. 89.6% in 2019), whilst 3.8% (2.5% in 2019) reported working in a public hospital non-ED, 3.0% (3.8% in 2019) in a private hospital ED and 4.3% (4.2% in 2019) in other workplaces (private non-ED, pre-hospital/retrieval and tertiary educational institution). There were no major differences between ACEM membership categories and no significant changes since 2019.

92.7% (88.9% in emergency department versus 3.8% in non-emergency department) worked in the public hospital setting.

6.3 Job satisfaction and work-life balance

This section provides information on respondents' perception of their work-life balance and satisfaction with various aspects of their primary workplace.

6.3.1 Overall work-life balance

Respondents were asked to indicate their level of agreement with two statements related to their work-life balance. Firstly, *the balance between my personal and professional commitments is about right*; then *the demands of my work interfere with my home and family life*.

Overall, 37.0% agreed (43.2% in 2019, 42.7% in 2016), 19.1% were neutral (19.7% in 2019, 18.3% in 2016), and 44.0% disagreed (37.1% in 2019, 39.0% in 2016) that the balance between their personal and professional commitments was about right. There was a significant increase in the proportion of FACEM trainees who reported disagreement with this statement (61.5%) compared to previous surveys (48.8% in 2019, 45.7% in 2016) (Figure 5).

37.0% (a decrease of 6% from 2019) agreed that the balance between their personal and professional commitments was about right.

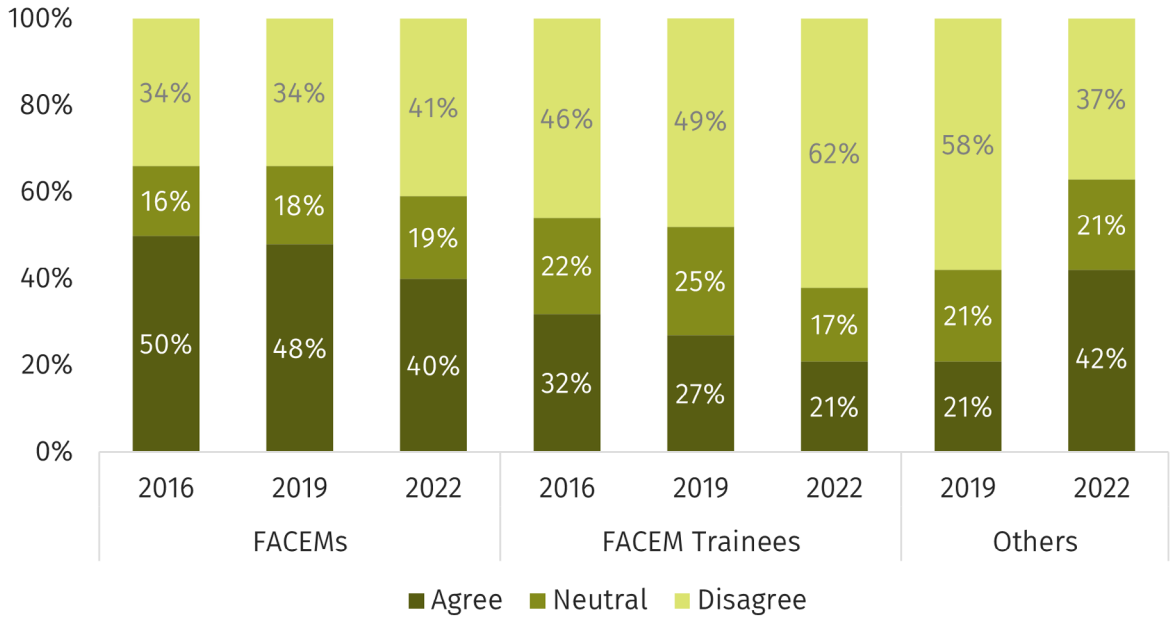


Figure 5. Respondents level of agreement with the statement, 'The balance between my personal and professional commitments is about right', by ACEM membership (n = 1,166 in 2016, n = 806 in 2019, n = 728 in 2022). No data was available for the 'Others' category from the 2016 survey.

For the statement regarding the demands of my work interfere/interfered with my home and family life, 68.7% agreed (65.4% in 2019, 65.9% in 2016), 17.2% were neutral (16.5% in 2019, 17.5% in 2016), and 14.1% disagreed (18.1% in 2019, 16.6% in 2016). FACEM trainees (81.1%) were more likely than FACEMs (66.3%) to agree with this statement (**Figure 6**).

68.7% agreed that the demands of their work interfered with their home and family life.

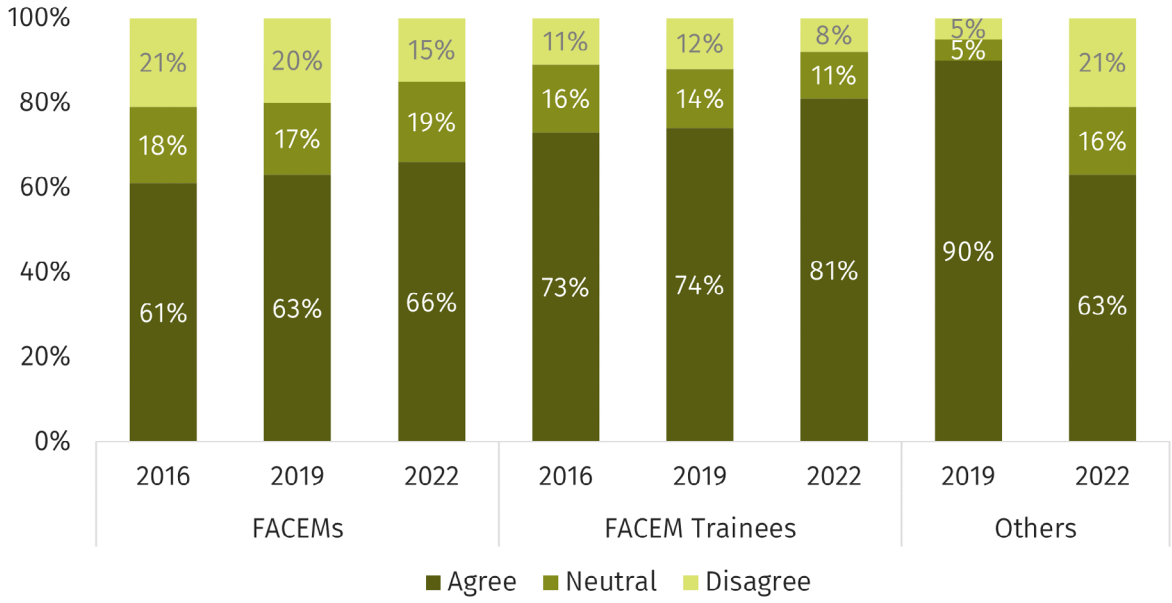


Figure 6. Respondents' level of agreement with the statement, 'The demands of work interfere with my home and family life', by ACEM membership (n = 1,163 in 2016, n = 806 in 2019, n = 728 in 2022). No data was available for the 'Others' category from the 2016 survey.

6.3.2 Primary workplace satisfaction

Respondents were asked to indicate their overall level of satisfaction with various aspects of their work at their primary workplace. The most satisfying aspects were interactions with colleagues (77.8%), followed by career progression (69.3%) and remuneration/pay (66.9%). Respondents were least satisfied with the staffing levels, with two-thirds reporting dissatisfaction. The trends were comparable with the findings of previous survey iterations (**Table 4**).

Table 4 Respondents' level of satisfaction with various aspects of work at their primary workplace.

Satisfying aspects of workplace	2022			2019	2016
	Dissatisfied	Neutral	Satisfied	Satisfied	Satisfied
Interactions with colleagues	10.2%	12.0%	77.8%	80.0%	82.2%
Your career progression so far	12.6%	18.1%	69.3%	72.3%	71.2%
Your remuneration/pay	19.8%	13.4%	66.9%	75.1%	65.4%
Overall work	22.5%	13.0%	64.6%	74.5%	69%
Rostering	24.5%	13.3%	62.2%	66.0%	60.9%
Ease of arranging leave	23.5%	16.8%	60.0%	67.2%	N/A
Ability to focus on chosen projects in clinical support time	23.7%	22.6%	53.7%	54.6%	44.4%
Opportunities to network with professional colleagues	20.3%	29.5%	50.2%	51.2%	N/A
Recognition you get for your work	28.7%	21.8%	49.6%	55.2%	46.4%
Time allocated to learning or maintaining core skills	29.5%	24.0%	46.3%	53.5%	43.5%
Staffing levels	66.3%	7.7%	25.9%	36.5%	39.1%

Note: The options regarding ability to focus on chosen projects in clinical support time and opportunities to network with professional colleagues were only applicable to FACEMs. Respondents could select all aspects relevant to them, so the total percentage adds up to more than 100%.

Of note, 93.8% of respondents working in remote locations reported that they were satisfied by the interactions with colleagues compared to 78.7% from regional areas and 76.8% from metropolitan areas. Further, 81.3% of respondents in remote locations reported that they were satisfied with their remuneration/pay, whereas only 65.1% of regional and 67.2% of metropolitan respondents reported that they were satisfied. Also, 72.9% of female respondents reported being satisfied with their remuneration/pay compared to 60.7% of males. FACEMs were more likely to indicate being satisfied with staffing levels (27.6%) compared to FACEM trainees (16.4%) as well as those in remote locations (37.5%) compared to regional (21.0%) and metropolitan (28.0%) respondents.

6.3.3 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. The top three responses were *team environment* (71.8% vs. 67.1% in 2019), the *variety of the work* (60.2% vs. 64.8% in 2019), and the *clinical work* (58.1% vs. 68.9% in 2019). A word cloud showing aspects of workplaces that respondents reported enjoying most is shown in **Figure 7**.

Figure 7. Respondents' most enjoyable aspects of their primary workplace (n = 728). The larger font in the word cloud indicates more common responses.

6.4 Workplace Conditions

The following questions focus on paid and unpaid professional work.

6.4.1 Working more than 12 hours consecutively

Respondents were asked to report on how often they worked more than 12 consecutive hours at their primary workplace. Overall, most of the respondents reported *never* (34.6% vs. 33.0% in 2019) or *occasionally* and *some of the time* (60.8% vs. 62.9% in 2019) working more than 12 consecutive hours, with smaller proportions reporting working 12 hours consecutively *most* or *all of the time* (4.6% vs. 4.0% in 2019). The frequency that respondents worked more than 12 consecutive hours by ACEM membership category and the changes since 2019 is shown in **Figure 8**.

Those working in regional (70.6%) and remote (75.0%) areas were more likely to work more than 12 hours consecutively than those working in metropolitan areas (62.4%)

65.4% had worked >12 consecutive hours, with (4.6%) doing so all or most of the time.

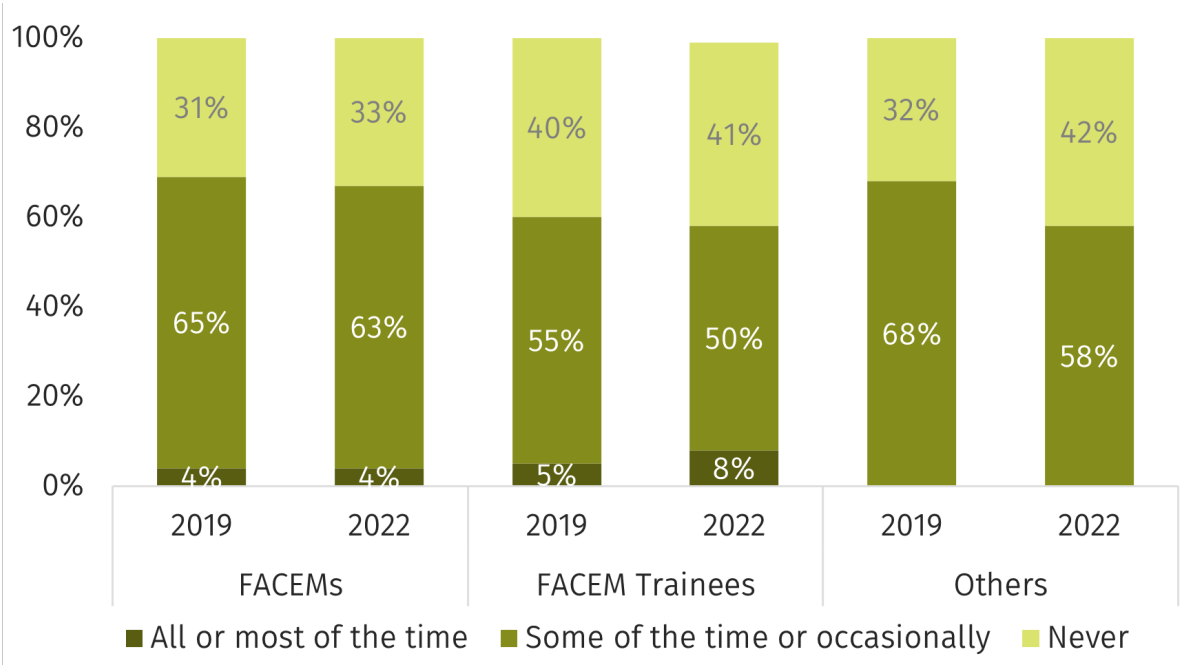


Figure 8. Frequency respondents reported working more than 12 consecutive hours, by ACEM membership category (n = 796 in 2019, n = 720 in 2022).

6.4.2 Worked rostered night shifts

Overall, a third (31.3% vs. 36.7% in 2019) of respondents reported having worked rostered night shifts in the past 12 months. FACEM trainees were significantly more likely than FACEMs (96.7% vs. 16.7%) to work rostered night shifts (**Figure 9**).

31.3% had worked night shifts in the past 12 months (96.7% FACEM trainees vs. 16.7% FACEMs).

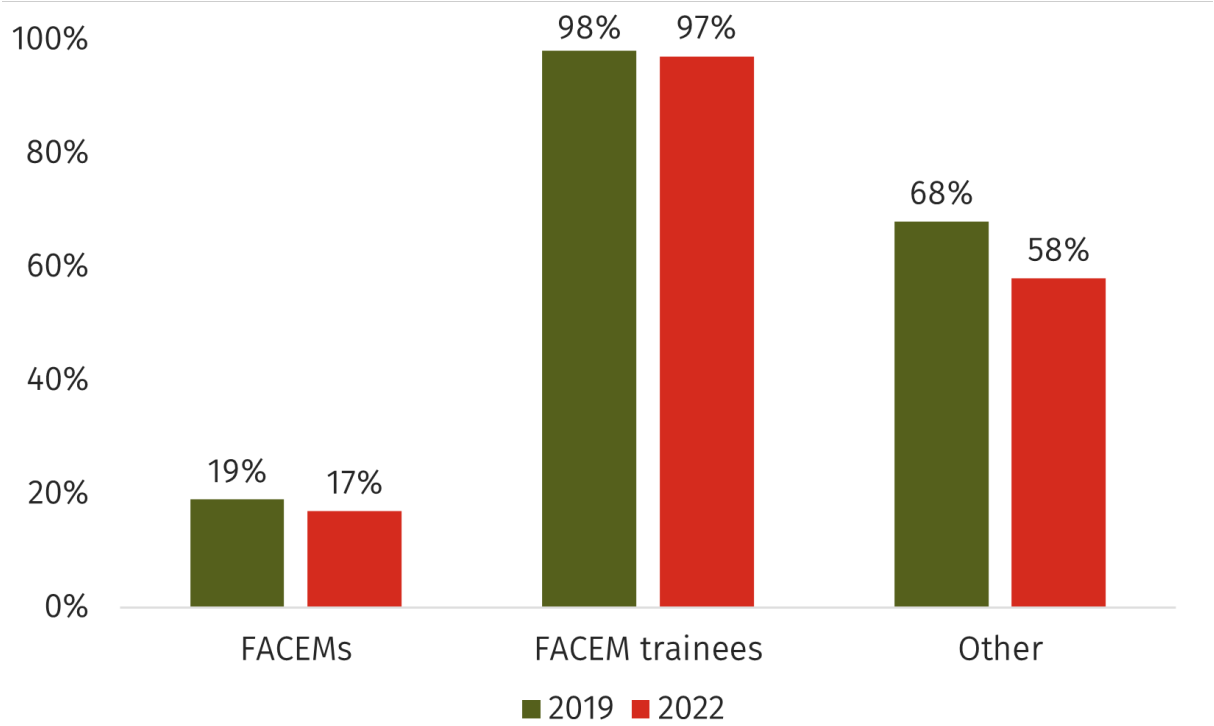


Figure 9. Respondents who reported working rostered night shifts in the past 12 months, by ACEM membership category (n = 783 in 2019, n = 720 in 2022).

The percentage of respondents who reported working night shifts in the past 12 months reduced with age, from 100% (96.0% in 2019) of those aged <30 years to 6.1% (3.8% in 2019) of those aged >60 years.

Respondents who reported being rostered night shifts 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, 24.1% (23.9% in 2019) of respondents reported that they *always* or *often* received at least one 24-hour period rostered off work for every night shift, 41.5% (39.4% in 2019) *sometimes* or *rarely* received the time off, and 34.4% (36.6% in 2019) *never received* the time off. A comparable proportion of FACEMs (36.1%) and FACEM trainees (34.5%) reported *never* receiving at least one 24-hour period off work for every night shift in the past 12 months (**Figure 10**).

Respondents working in metropolitan (69.0%) areas were more likely to receive the recommended time off after night shifts compared to those working in regional (58.8%) and remote (62.5%) areas.

34.4% never received at least one 24-hour period off work for every night shift in the past 12 months.

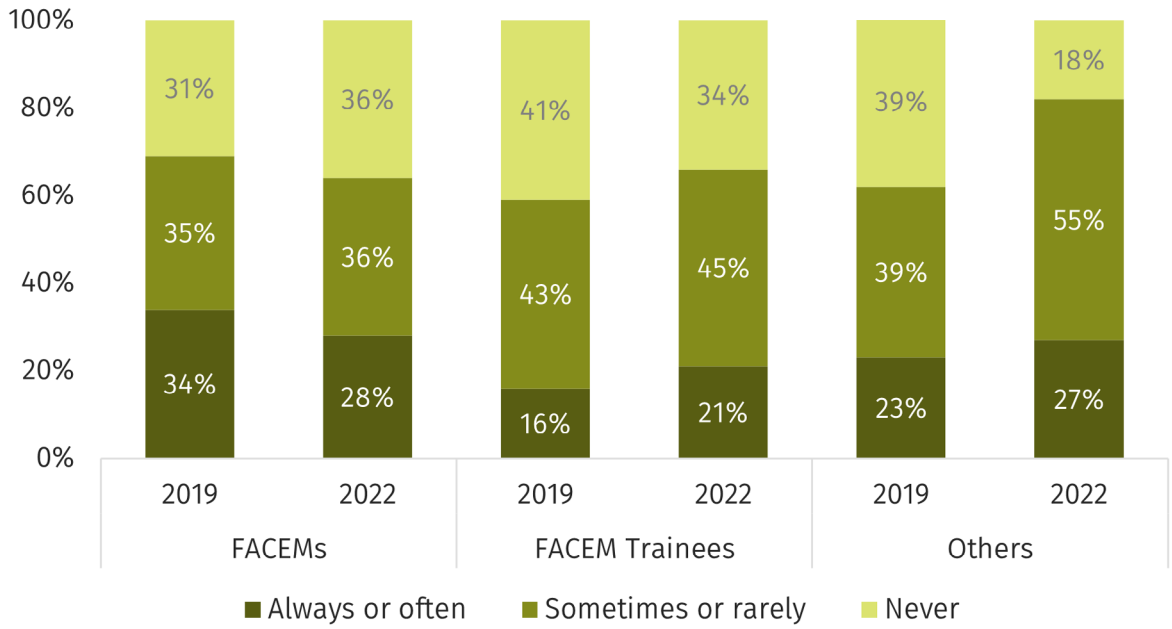


Figure 10. Frequency that respondents reported receiving at least one 24-hour period off work for every rostered night shift in the past 12 months, by ACEM membership (n = 284 in 2019, n = 224 in 2022).

Of note, females were more likely to report *always* or *often* receiving at least one 24-hour period off work for every rostered night shift (28.2%) than males (18.1%). Those working in metropolitan areas were more likely to report *always* or *often* receiving at least one 24-hour period off work for every rostered night shift (29.1%) than those working in regional (14.7%) and remote (12.5%) areas.

6.4.3 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 seven-day period, how often they were contacted, and how often they had to attend the workplace.

Overall, 81.8% (83.1% in 2019) of respondents reported being rostered on-call in the past 12 months. Males were more likely to report being rostered on-call (86.1% vs. 85.8% in 2019) than females (78.0% vs. 78.1% in 2019). The percentage of respondents who reported being rostered on-call in the past 12 months by ACEM membership category and the changes since 2019 is shown in **Figure 11**.

81.8% had been rostered on-call in the past 12 months (93.6% FACEMs vs. 30.0% FACEM trainees).

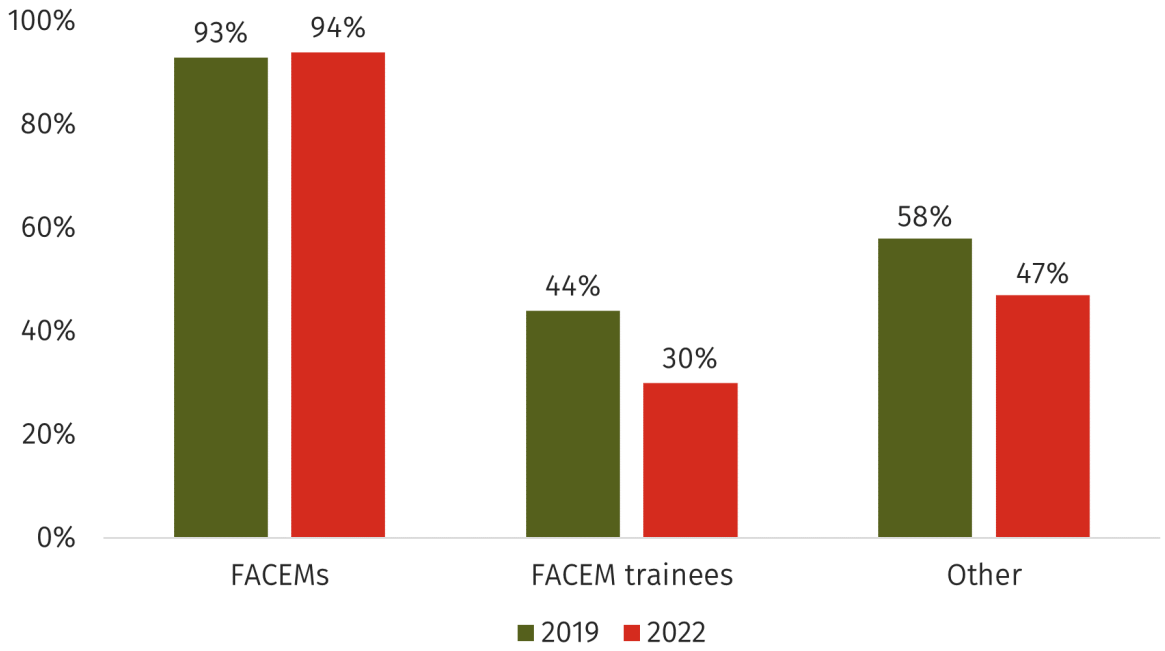


Figure 11. Respondents that reported being on-call in the past 12 months, by ACEM membership (n = 783 in 2019, n = 718 in 2022).

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

Of those who reported being rostered on-call, 7.5% (10.0% in 2019) reported being on-call for more than two nights in a seven-day period all or most of the time, 41.4% (46.9% in 2019) reported being rostered on-call for more than two nights *occasionally* or *some of the time* and 51.1% (43.1% in 2019) that they were *never* on-call more than two nights. The frequency that respondents reported being rostered on-call more than two nights in a seven-day period by ACEM membership category and the changes since 2019 is shown in **Figure 12**.

Those working in metropolitan (57.6%) areas were more likely to report *never* being on-call for more than two nights in a seven-day period than those working in regional (40.9%) and remote (21.4%) areas.

48.9% (an 8% decrease from 2019) were on-call more than two nights in a seven-day period in the past 12 months.

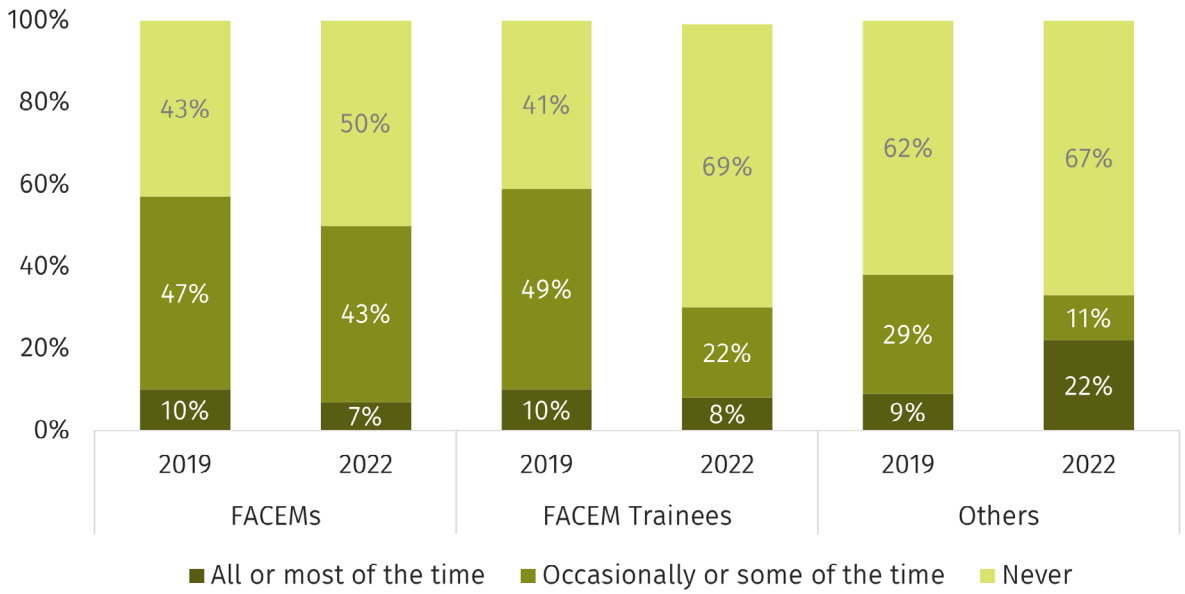


Figure 12. Frequency respondents reported being rostered on-call for more than two nights in a seven-day period, by ACEM membership category (n = 648 in 2019, n = 587 in 2022).

6.5 Workplace Stress

Respondents were asked questions about their experiences of workplace stress. These questions included the most stressful aspects of their primary workplace, methods offered by their employer to help deal with workplace stress, and respondents' personal responses to stress.

6.5.1 Top stressors

Respondents were asked to identify the top three stressors of their primary workplace from a list of 14 stressors with the option to select another stressor(s). The stressors that were nominated by the largest percentage of respondents included overcrowding in the ED (14% increase from 2019) and access block (10% increase from 2019). The top five stressors were consistent with the findings from the 2019 survey (**Table 5**).

Table 5 Respondents' most stressful aspects of their primary workplace, by ACEM membership (n = 781 in 2019, n = 713 in 2022).

Stressful aspects of work	2022 FACEM (n = 575)	2022 FACEM trainee (n = 119)	2022 Total (n = 713)	2019 Total (n = 781)
Overcrowding in the ED	77.6%	78.2%	77.3%	62.5%
Access block	68.2%	59.7%	66.3%	56.2%
Conflicts with other clinical teams in the workplace	29.0%	18.5%	27.3%	34.4%
Unrealistic patient or community expectations	24.2%	36.1%	26.8%	22.5%
IT Issues	22.8%	14.3%	21.2%	22.7%
Pressures from workplace administration and executives	18.1%	10.1%	16.5%	21.5%
Aggressive or violent patients (or carers)	12.3%	12.6%	12.3%	16.0%
Expectation to meet ED performance KPIs	9.2%	9.2%	9.4%	16.6%
Conflicts within my work team	5.4%	6.7%	5.6%	7.0%
Negative implications due to COVID-19 pandemic	5.2%	5.0%	5.6%	N/A
Meeting ACEM training requirements	1.0%	24.4%	5.3%	6.0%
Meeting my Continuing Professional Development (CPD) requirements	5.9%	2.5%	5.2%	N/A
Threat of litigation	2.1%	0.8%	1.8%	2.2%
Negative media comments	1.2%	1.7%	1.5%	N/A
Other	10.1%	8.4%	9.8%	8.1%

Note: Respondents selected up to three responses. 'Other' stressors mentioned focused predominantly on staffing issues.

6.5.2 Primary employer assistance in managing stress

Respondents were asked to select the methods their primary employer offered to help them manage stress at work. Compared with the 2019 survey, the methods that were selected more frequently included an *Employee Assistance Program (EAP)* and *counselling* (10% increase from 2019), *resources for wellbeing* (6% increase from 2019), and *free food or drinks* (8% increase from 2019). On the contrary, the methods that were less frequently selected were *professional development* (7% decrease from 2019) and *easy access to leave* (5% decrease from 2019). It is noteworthy that more than one in ten respondents reported that no methods were offered by their primary employer to help them manage stress at work (**Table 6**).

Table 6 Methods primary employer offered to help respondents manage stress at work (n = 773 in 2019, n = 708 in 2022).

Methods offered by employers to manage stress	2022 (n = 708)	2019 (n = 773)
Employee Assistance Program and counselling	62.4%	51.6%
Supportive leadership	41.5%	39.6%
Fostering a collaborative and supportive team culture	36.2%	35.8%
Staff social events	36.2%	33.6%
Adverse event debriefing	25.6%	25.5%
Mentoring program	24.4%	26.4%
Debriefing activities (excluding adverse event debriefing)	24.0%	21.6%
Resources for wellbeing	21.3%	14.9%
Wellbeing activities (e.g., meditation, exercise activities)	20.9%	19.4%
Professional development	20.6%	27.7%
Easy access to leave	20.6%	25.5%
Free food or drinks	15.9%	8.3%
Improving working conditions (e.g., providing medical scribes or new equipment)	9.9%	4.9%
Other	2.8%	1.7%
None	13.0%	13.7%

Note: Respondents could select all the methods that applied to them, so the table adds up to more than 100%.

6.5.3 Personal response to stress

Respondents were asked to indicate how they typically managed stress. Compared with the 2019 survey, the strategies that were selected more frequently included spending time with family (8% increase from 2019), physical exercise (7% increase from 2019), spending time with friends (13% increase from 2019) and taking time off work (8% increase from 2019). In contrast, the strategies that were less frequently selected compared to the 2019 survey include taking a holiday (6% decrease from 2019) and eating more than usual (5% decrease from 2019) (Table 7).

Table 7 Respondents typical response to manage their stress (n = 763 in 2019, n = 707 in 2022).

Response to managing stress	2022 (n = 707)	2019 (n = 763)
Spend time with family	64.1%	56.1%
Do something I enjoy	57.4%	58.3%
Increase physical exercise	50.1%	42.6%
Spend time with friends	42.6%	30.0%
Take a holiday	30.0%	35.5%
Avoid being with people	27.0%	25.7%
Discuss concerns with a mentor	25.3%	22.7%
Eat more than usual	24.9%	30.0%
Take time off work	23.5%	15.7%
Drink more alcohol	22.5%	25.4%
Practice mindfulness or other relaxation techniques	19.4%	22.8%
Pray	7.8%	9.2%
Formal debriefing	5.8%	3.8%
Use prescription drugs	1.1%	2.0%
Use recreational drugs	1.0%	0.4%
Smoke more cigarettes than usual	0.8%	2.1%
Other	5.7%	5.2%

Note: Respondents could select all options that applied to them, so the table adds up to more than 100%. Other typical responses to managing stress included talking with colleagues and friends and reducing their FTE at work.

6.5.4 Support services

Respondents were asked if they were aware of eight specific support services available to doctors, with the option to nominate other support services that they were aware of. The majority (85.6% vs. 79.9% in 2019) of respondents were aware of their *workplace EAP* and 43.7% (27.6% in 2019) were aware of *ACEM's member and trainee EAP service*. However, 9.0% (11.6% in 2019) of respondents reported not being aware of any available support services (Table 8).

Table 8 Percentage of respondents who reported being aware of support services available to doctors (n = 689).

Support services available to doctors	Total (n = 689)
Your workplace's EAP	85.6%
ACEM's member and trainee EAP service (Converge International)	43.7%
Australasian Doctors' Health Network Services (e.g. Doctors' Health Advisory Service Victoria; Doctor's Health Advisory Service NZ)	25.4%
DRS4DRS	19.7%
AMA Peer Support Service	17.9%
The Australian Indigenous Doctors' Association	4.6%
Te ORA Māori Medical Practitioners Association	2.2%
Other	3.5%
I am not aware of any available support services	9.0%

Note: Respondents could select all services that they were aware of, so the table adds up to more than 100%. Other common responses included MPS and insurance companies. EAP = employee assistance programs.

6.5.5 Professional isolation

Respondents were asked if they had 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.

Of the 693 respondents in 2022, 36.2% (29.3% in 2019) reported *feeling professionally isolated* in their primary workplace in the past 12 months, 56.9% (65.8% in 2019) reported *not feeling professionally isolated*, and 6.9% (4.9% in 2019) were *unsure*. The proportion of respondents who felt professionally isolated by ACEM membership category and the changes since 2019 are shown in **Figure 13**, with a noticeable increase in the proportion of respondents reporting feeling professionally isolated across all member categories, compared with the 2019 survey.

Professional isolation was more likely to be reported by respondents working in remote (50.0%) and regional (39.6%) locations compared to those in metropolitan locations (34.0%).

36.2% (an increase of 7% from 2019) of respondents had felt professionally isolated in their primary workplace in the past 12 months.

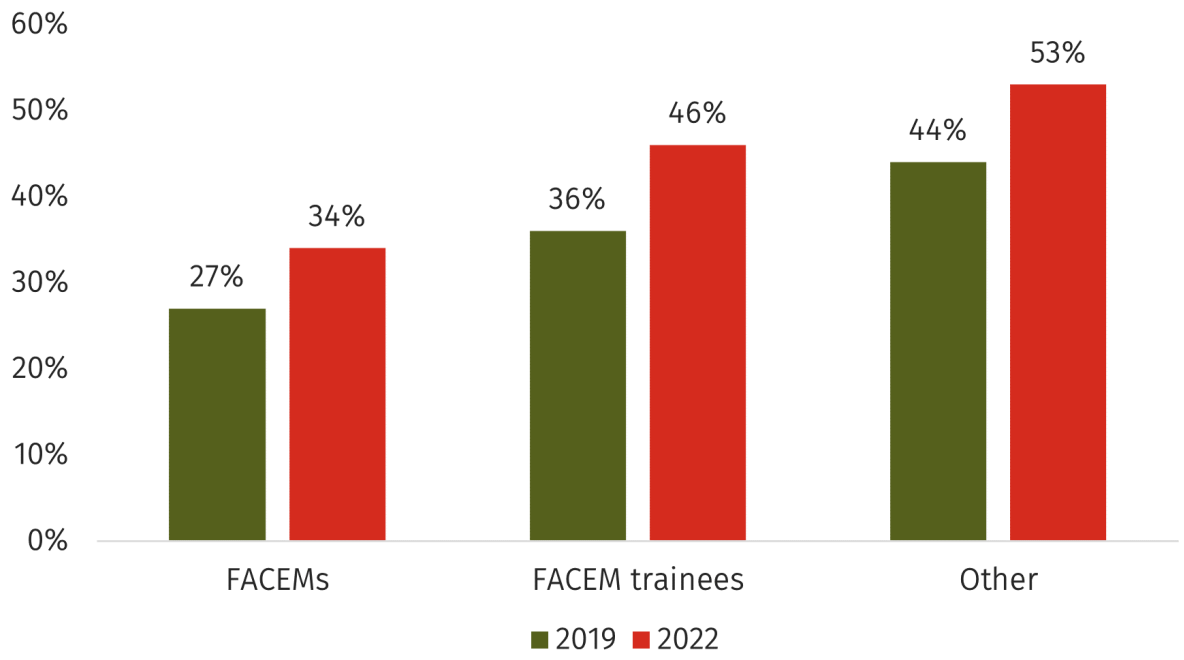


Figure 13. Proportion of respondents that felt professionally isolated at their primary workplace in the previous 12 months, by ACEM membership category (n = 755 in 2019, n = 693 in 2022).

6.5.6 Incivility and rudeness

Respondents were asked about their experiences of workplace incivility and rudeness and whether these behaviours were displayed by their supervisor, co-workers (e.g. other ED staff or hospital staff) and clients/patients. **Table 9** shows the respondents who experienced uncivil and rude behaviour from supervisors, co-workers and clients/patients by ACEM membership category and the changes since 2019.

More females (76.8%) than males (68.7%) reported that their co-workers were hostile, uncivil, or rude to them.

23.8% (a decrease of 5% from 2019) of respondents reported that their supervisor was hostile, rude, or uncivil.

73.0% (a decrease of 3% from 2019) of respondents reported that their co-workers were hostile, rude, or uncivil.

98.7% (an increase of 2% from 2019) of respondents reported that clients/patients were hostile, rude, or uncivil.

Table 9 Percentage of respondents who experienced hostility, rudeness and incivility from their supervisor, co-workers and clients/patients, by ACEM membership category.

Hostile, uncivil and rude behaviour	2022	2019
My supervisor is hostile, uncivil or rude to me (n = 710 in 2019, n = 661 in 2022)	23.8%	28.8%
FACEM	23.4%	28.2%
Trainee	26.3%	33.8%
Other	18.8%	11.1%
My co-workers (other ED staff or other hospital staff) are hostile, uncivil or rude to me (n = 750 in 2019, n = 688 in 2022)	73.0%	75.7%
FACEM	72.4%	75.3%
Trainee	78.1%	79.8%
Other	58.8%	79.4%
My clients/patients are hostile, uncivil or rude to me (n = 751 in 2019, n = 690 in 2022)	98.7%	96.4%
FACEM	98.4%	96.6%
Trainee	100%	96.6%
Other	100%	88.9%

6.6 Anxiety

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

6.6.1 Anxiety at work

Of the 691 responses to this question in 2022, 12.7% (13.0% in 2019, 7.3% in 2016) reported that they never felt anxious at work, 72.5% (76.4% in 2019, 73.8% in 2016) reported that they felt anxious at work *occasionally* or *some of the time*, and 14.8% (10.9% in 2019, 18.9% in 2016) reported feeling anxious *most* or *all the time*. FACEM trainees were two times more likely than FACEMs (26.1% vs. 12.5%) to report feeling anxious at work *most* or *all of the time* (**Figure 14**).

Females were more likely to report that they had felt anxious at work (90.7% vs. 94.6% in 2019, 96.2% in 2016) compared with males (83.6% vs. 80.9% in 2019, 90.0% in 2016).

87.3% of respondents reported feeling anxious at work.

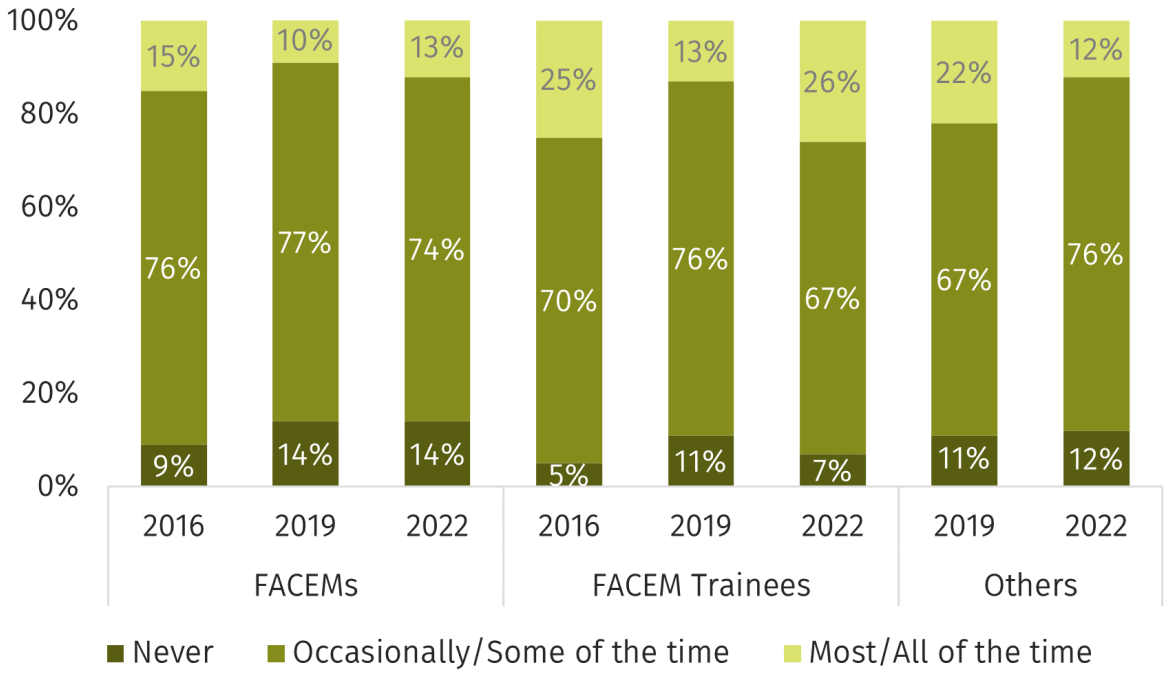


Figure 14. Proportion of respondents who reported feeling anxious at work, by ACEM membership category (n = 1,183 in 2016, n = 749 in 2019, n = 691 in 2022). No data was available for the 'Others' category from the 2016 survey.

99% of those feeling anxious at work reported that their workplace contributed to this anxiety.

6.6.2 Anxiety outside of work

Of the 691 responses in 2022, 24.6% (25.2% in 2019, 20.2% in 2016) reported that they have *never* felt anxious outside of work, 70.3% (69.6% in 2019, 75.0% in 2016) reported that they felt anxious outside of work *rarely* or *occasionally*, and 5.1% (5.3% in 2019, 4.8% in 2016) reported feeling anxious outside of work *most* or *all the time*. Comparable proportions of FACEMs and FACEM trainees (75.1% vs. 78.3%) reported feeling anxious outside of work, with this remaining relatively consistent across three survey iterations (**Figure 15**).

Females were more likely to report that they felt anxious outside of work (80.5% vs. 84.5% in 2019, 83.4% in 2016) compared with males (71.0% vs. 66.6% in 2019, 76.9% in 2016).

75.4% of respondents reported feeling anxious outside of work.

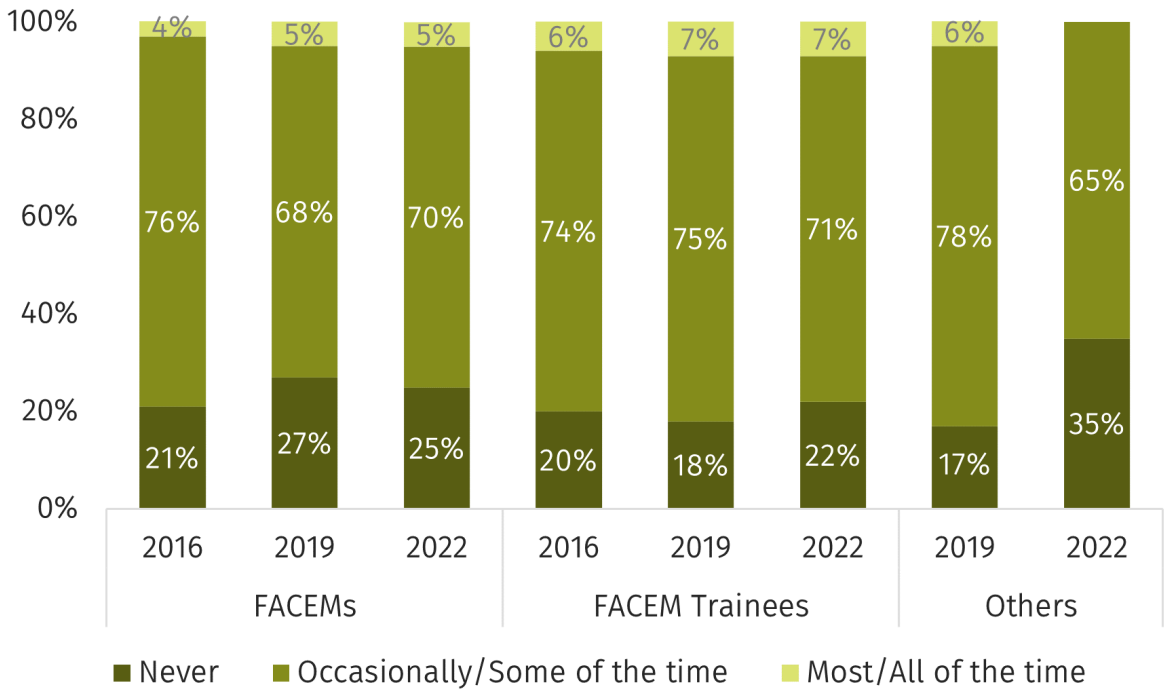


Figure 15. Proportion of respondents who reported feeling anxious outside of work, by ACEM membership category (n = 1,181 in 2016, n = 750 in 2019, n= 691 in 2022). No data was available for the 'Others' category from the 2016 survey.

96% of those feeling anxious outside of work reported that their workplace contributed to this anxiety.

6.7 Fatigue

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.

83.6% of respondents reported that fatigue had affected their performance at work in the past 12 months.

Many respondents reported that fatigue had affected their performance at work in the last 12 months (83.6% vs. 80.7% in 2019). Females were more likely to report that fatigue had affected their performance at work (86.5% vs. 84.4% in 2019), compared to males (80.8% vs. 77.1% in 2019). FACEM trainees (94.7%) were more likely than FACEMs (81.8%) to report that fatigue had affected their work performance in the last 12 months (**Figure 16**).

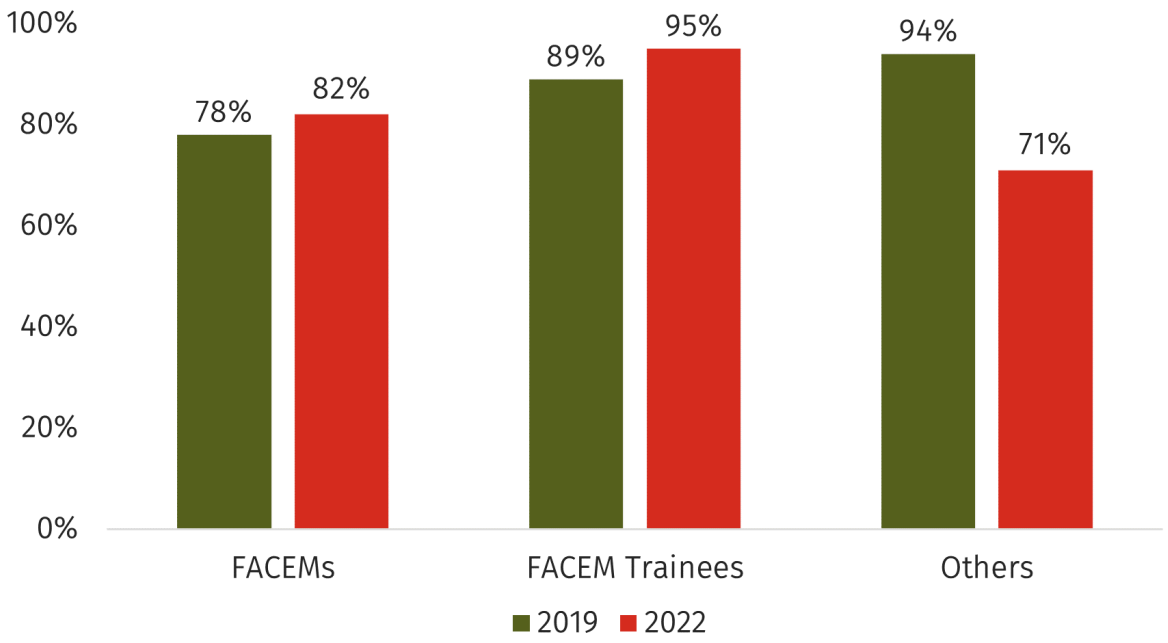


Figure 16. Percentage of respondents who reported that fatigue had affected their performance at work in the previous 12 months, by ACEM membership category (n= 742 in 2019, n = 685 in 2022).

6.8 Burnout

Burnout is a state of physical or emotional exhaustion that also involves a sense of reduced accomplishment and loss of personal identity. To measure burnout, respondents were asked to respond to a set of questions from a validated tool to measure burnout, called the Copenhagen Burnout Inventory (CBI). For this report, the scores categorised as high and severe were combined into one group.

6.8.1 Personal burnout

Personal burnout is a state of prolonged physical and psychological exhaustion. Overall, 44.9% (55.0% in 2019) of respondents were classified as having no or low personal burnout, 43.6% (36.1% in 2019) had *moderate* personal burnout, and 11.6% (8.9% in 2019) had *high* or *severe* personal burnout. Noticeable decreases were seen in the proportion of FACEM trainees (20% decrease from 2019) and FACEMs (10% decrease from 2019) who reported *no* or *low personal burnout* (**Figure 17**).

Personal burnout reduced with age, with 64.1% of respondents aged 30 – 35 years reporting *moderate to severe* personal burnout while 39.6% of respondents aged over 60 reported this. Females (58.0% vs. 53.2% in 2019) were also more likely to report *moderate to severe* personal burnout than males (51.7% vs. 37.5% in 2019). In 2022, fewer respondents working in remote (31.3%) areas reported *moderate to severe* burnout, compared to those working in metropolitan (56.4%) and regional (54.2%) areas.

55.2% (an increase of 10% from 2019) of respondents reported moderate to severe personal burnout.

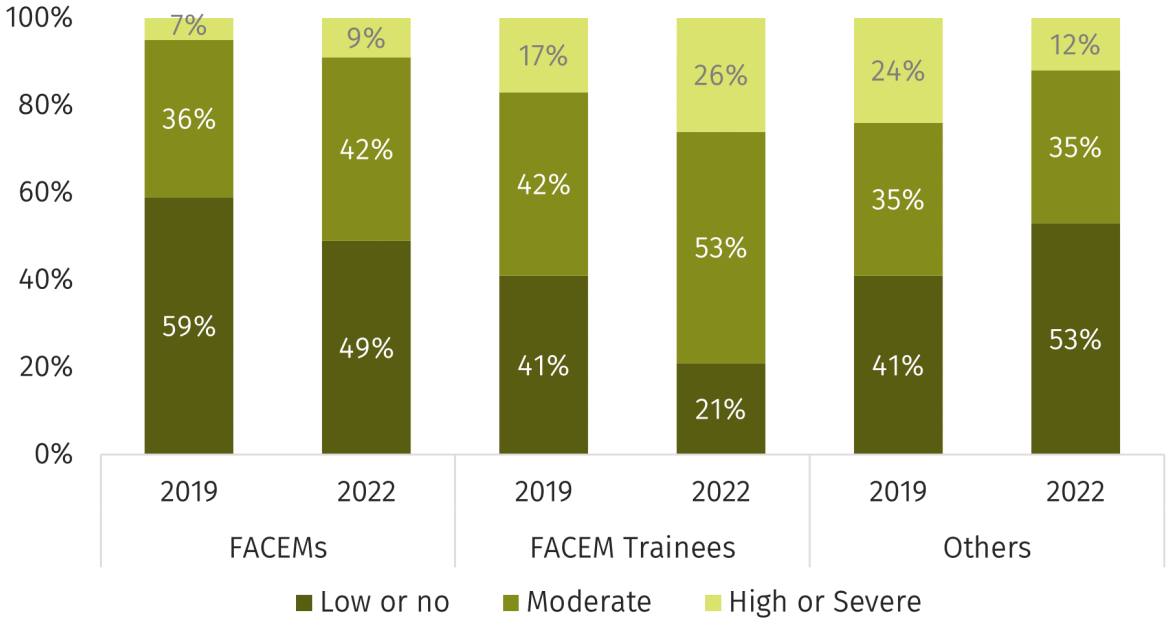


Figure 17. Proportion of respondents experiencing personal burnout, by ACEM membership category (n = 729 in 2019, n = 682 in 2022).

6.8.2 Work-related burnout

Work-related burnout is a state of prolonged physical or psychological exhaustion, which is perceived as related to a person's work. In the 2022 survey, 45.2% (49.8% in 2019) of respondents were classified as having *no* or *low* work-related burnout, 39.2% (43.1% in 2019) had *moderate* work-related burnout, and 15.7% (7.1% in 2019) had *high* or *severe* work-related burnout. The proportion of respondents who have work-related burnout by ACEM membership category and the changes since 2019 are shown in **Figure 18**.

Similar to personal burnout, work-related burnout reduced with age, with 55% of respondents aged 30 – 35 years but only 43.8% of respondents aged over 60 reporting *moderate* to *severe* burnout. Females (56.3% vs. 55.0% in 2019) were more likely to report *moderate* to *severe* work-related burnout than males (52.3% vs. 45.6% in 2019). Those working in remote (31.3%) areas were less likely to be classified as having *moderate* to *severe* work-related burnout compared to those working in regional (53.0%) and metropolitan (56.7%) areas.

54.9% (an increase of 5% from 2019) of respondents reported moderate to severe work-related burnout.

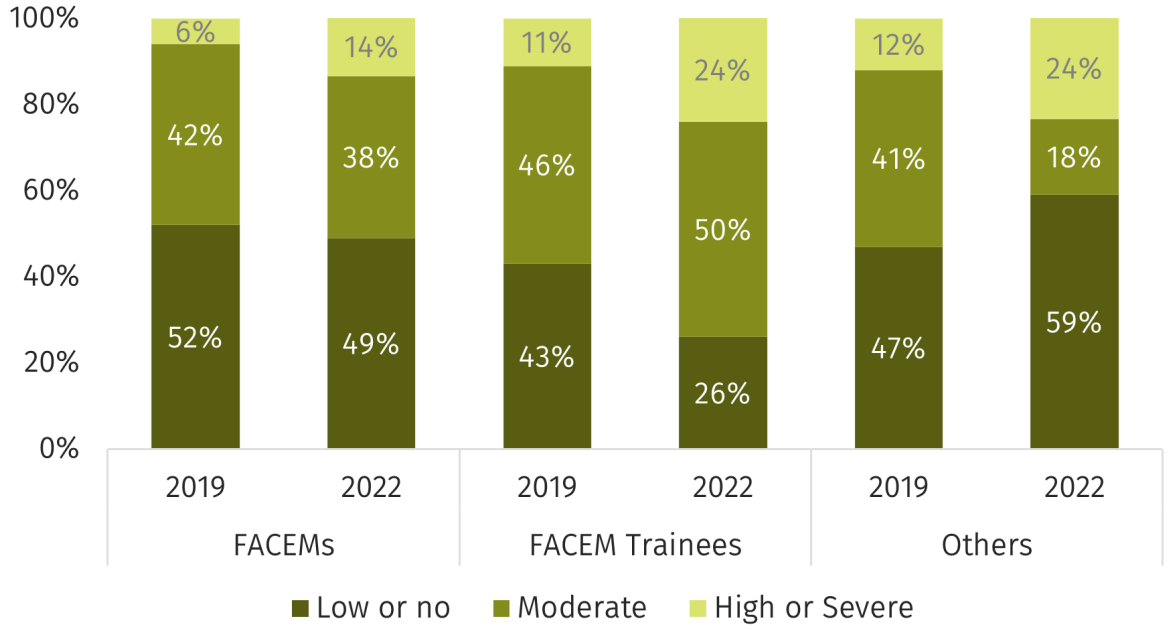


Figure 18. Proportion of respondents experiencing work-related burnout, by ACEM membership category (n = 729 in 2019, n = 682 in 2022).

6.8.3 Client or patient-related burnout

Client/patient-related burnout is defined as a state of prolonged physical and psychological exhaustion, which is perceived as related to a person's work with clients/patients. Overall 65.7% (87.4% in 2019) of respondents were classified with *no* or *low* client/patient-related burnout, 26.8% (11.0% in 2019) had *moderate* client/patient-related burnout, and 7.5% (1.6% in 2019) had high or severe client/patient-related burnout. Significant increases in those reporting *moderate* to *high/severe* client or patient-related burnout were seen across all member categories, compared to the previous survey (**Figure 19**).

Client or patient-related burnout was not impacted by age with the percentage of respondents who reported *moderate* to *severe* burnout ranging between 28% and 40% for the different age groups. Males (36.1% vs. 15.3% in 2019) were more likely to report *moderate* to *severe* client or patient-related burnout than females (32.5% vs. 9.7% in 2019). While those working in remote (31.3%) and regional (31.4%) areas reported lower *moderate* to *severe* client or patient-related burnout compared to those working in metropolitan (35.9%) areas.

34.3% (an increase of 22% from 2019) of respondents reported moderate to severe client/patient-related burnout.

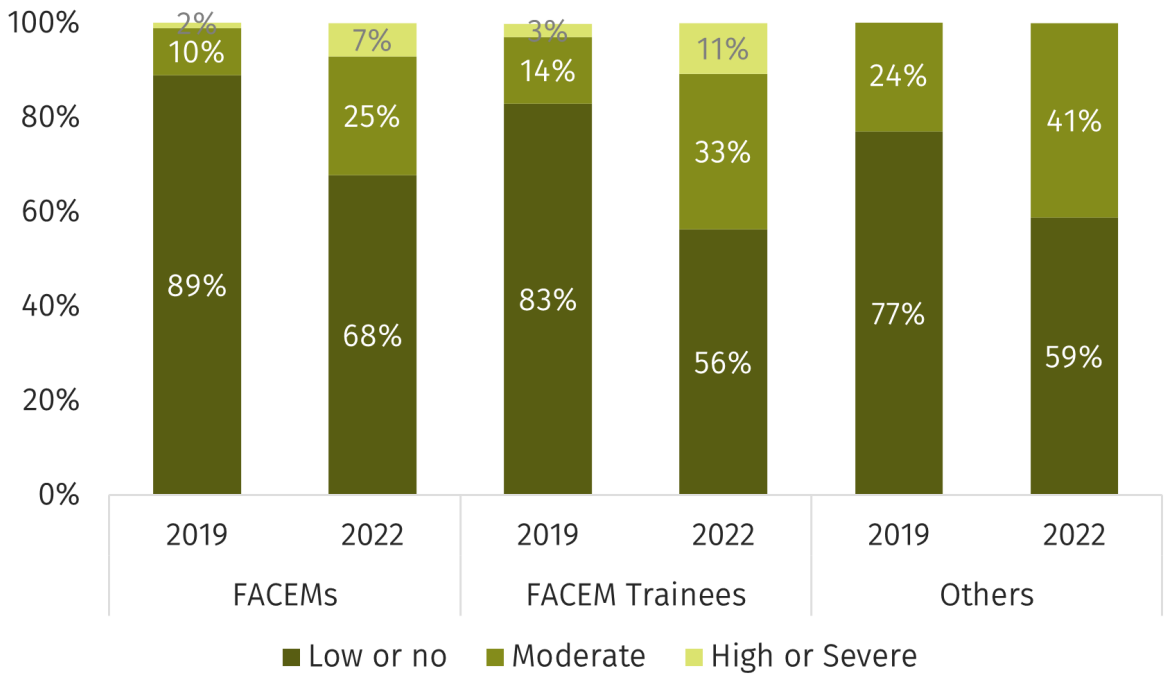


Figure 19. Proportion of respondents experiencing client-related burnout, by ACEM membership category (n = 729 in 2019, n = 682 in 2022).

6.9 General Health

Respondents were asked to rate their personal health on a 5-point Likert scale from *poor* to *excellent*. Of the 679 respondents, 21.5% (22.8% in 2019, 19.8% in 2016) rated their health as *excellent*, 32.3% (39.8% in 2019, 38.6% in 2016) and 31.4% (24.1% in 2019, 28.2% in 2016) reported their health as *very good* and *good*, respectively, while 11.3% (11.3% in 2019, 10.8% in 2016) and 3.5% (1.9% in 2019, 2.4% in 2016) reported their health as *fair* or *poor*, respectively. There was a decrease in the proportion of FACEMs (56.2% vs. 65.5% in 2019, 62.6% in 2016) and FACEM trainees (37.5% vs. 54.2% in 2019, 52.7% in 2016) who self-perceived their general health as *very good* or *excellent* (**Figure 20**).

53.8% (a decrease of 9% from 2019) of respondents rated their general health as very good or excellent.

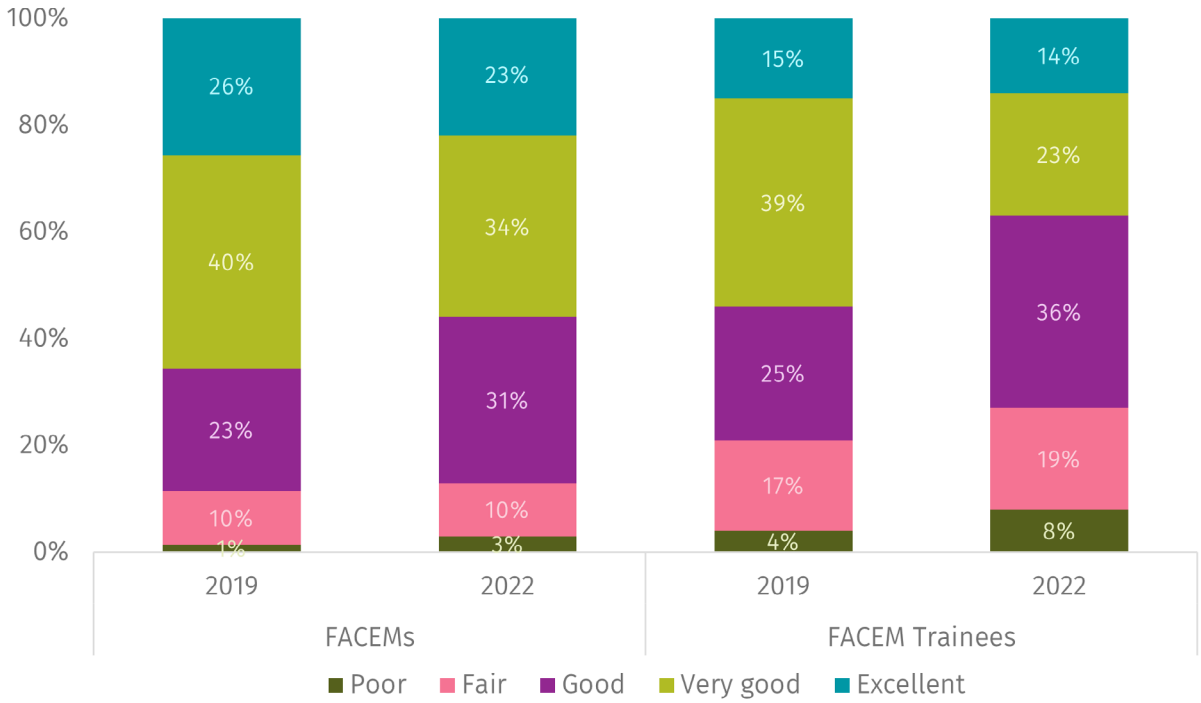


Figure 20. Self-reported general health of respondents, by ACEM membership category (n = 1,149 in 2016, n = 723 in 2019, n = 679 in 2022).

6.10 Future Career Plans

Respondents were asked a series of questions on their future career plans, specifically whether they were likely to reduce their hours of clinical practice, leave clinical practice, leave emergency medicine, or retire in the next 10 years.

6.10.1 Reduce hours of clinical practice in the next 10 years

Of the 679 respondents, 71.7% (62.8% in 2019, 64.6% in 2016) were likely, 9.9% (9.3% in 2019, 10.7% in 2016) were *neutral*, and 18.4% (27.9% in 2019, 24.7% in 2016) reported that they were *unlikely* to reduce their hours of clinical practice. There was a significant increase in FACEMs reporting that they were *likely* to reduce their hours of clinical practice in the next 10 years (71.4% vs. 61.1% in 2019) (**Figure 21**).

The percentage of respondents reporting that they were *likely* to reduce their hours of clinical practice in the next 10 years was relatively consistent across the age groups (between 61% and 83% for all groups except those aged over 60 with 95.7%). A higher percentage of respondents working in remote (81.3%) areas said that they were *likely* to reduce hours of clinical practice in the next 10 years compared to those in metropolitan (72.7%) and regional (69.1%) areas.

71.7% (an increase of 9% from 2019) of respondents were likely to reduce their hours of clinical practice in the next 10 years.

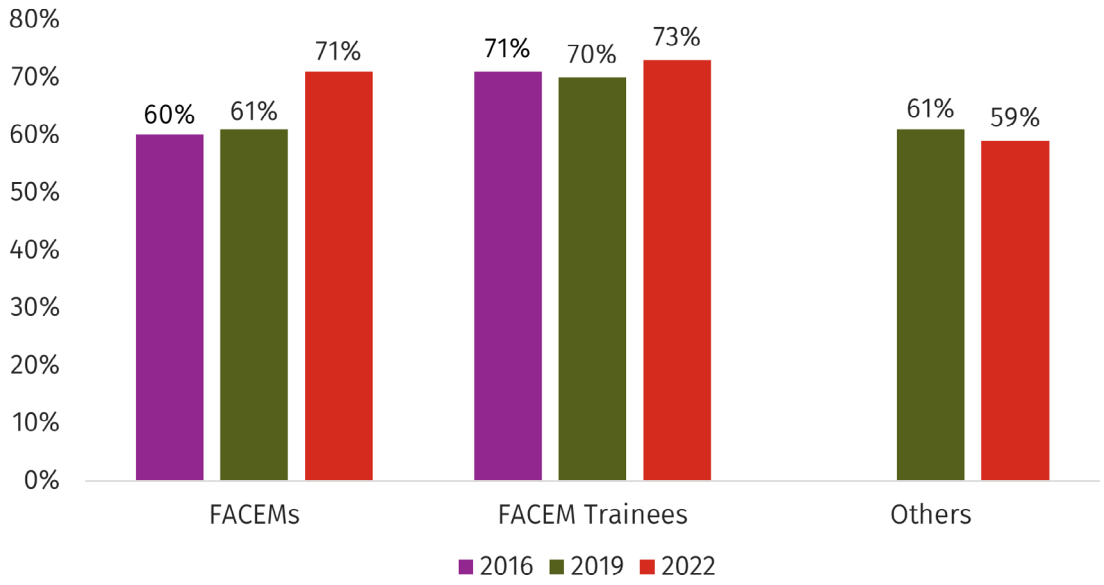


Figure 21. Percentage of respondents who were likely to reduce their hours of clinical practice in the next 10 years, by ACEM membership category (n = 1,172 in 2016, n = 731 in 2019, n = 679 in 2022). No data was available for the 'Others' category from the 2016 survey.

6.10.2 Reasons for wanting to reduce hours of clinical practice in the next 10 years

Of the 484 who indicated that they were likely to reduce their hours of clinical practice in the next 10 years, 477 provided a reason why they were likely to do so. The most common themes and their frequencies are presented in Table 10.

Table 10 Respondents' reasons for wanting to reduce their hours of clinical practice in the next 10 years (n = 477).

Reasons to reduce hours of clinical practice	% of respondents
Unsustainable workplace conditions/stress	53.7%
To improve work-life balance	28.7%
Older age/transitioning to retirement	16.8%
Intend to increase non-clinical work/other work	7.1%
To improve health/wellbeing	6.7%
Can afford it financially	2.3%
Other	5.7%

Note: Respondents could provide multiple reasons. 'Other' reasons included so they could complete training/exams, to have a change, or that they just wanted to work less hours.

Some examples of comments reflecting these themes are presented below:

> *'I do not think working 1 FTE in emergency medicine is a sustainable career path in the current climate.'*

> *'To facilitate work life balance, minimise burnout, exam preparation and gaining other qualifications to allow me to reduce clinical FTE to gain nonclinical times.'*

'Achieve better work-life balance. Spend more time with family and participating in my hobbies. The amount of tax paid on the extra income (from increased hours) is not worth it – I would rather spend that time with my children, husband and riding my horse. Nonclinical time is less stressful and exhausting than clinical practice. I would prefer to increase my nonclinical time at the expense of clinical time.'

'My balance of family and work are not quite right – very young family miss me on evenings/on calls.'

'I have already done this in an effort to decrease burnout, stress, anxiety. I do not believe that working full time in ED is in any way sustainable in its current form.'

'Because medicine is a disaster and is destroying my life. I am not paid enough to do this job. I don't remember the last time I had an enjoyable day at work.'

6.10.3 Leave clinical practice in the next 10 years

Of the 679 respondents, 36.6% (24.7% in 2019, 22.0% in 2016) were likely, 17.3% (13.5% in 2019, 15.5% in 2016) were neutral, and 46.1% (61.7% in 2019, 62.5% in 2016) reported being *unlikely* to leave clinical practice in the next 10 years. There was a considerable increase in the proportion of FACEMs who reported they were *likely* to leave clinical practice in the next 10 years (40.2% vs. 27.4% in 2019) (**Figure 22**).

The percentage of respondents reporting that they were *likely* to leave clinical practice in the next 10 years increased with age, starting from none among those aged <30 years, to 15.0% of those aged 30-35, and peaking at 95.7% for those aged over 60 years.

36.6% (an increase of 12% from 2019) of respondents were likely to leave clinical practice in the next 10 years.

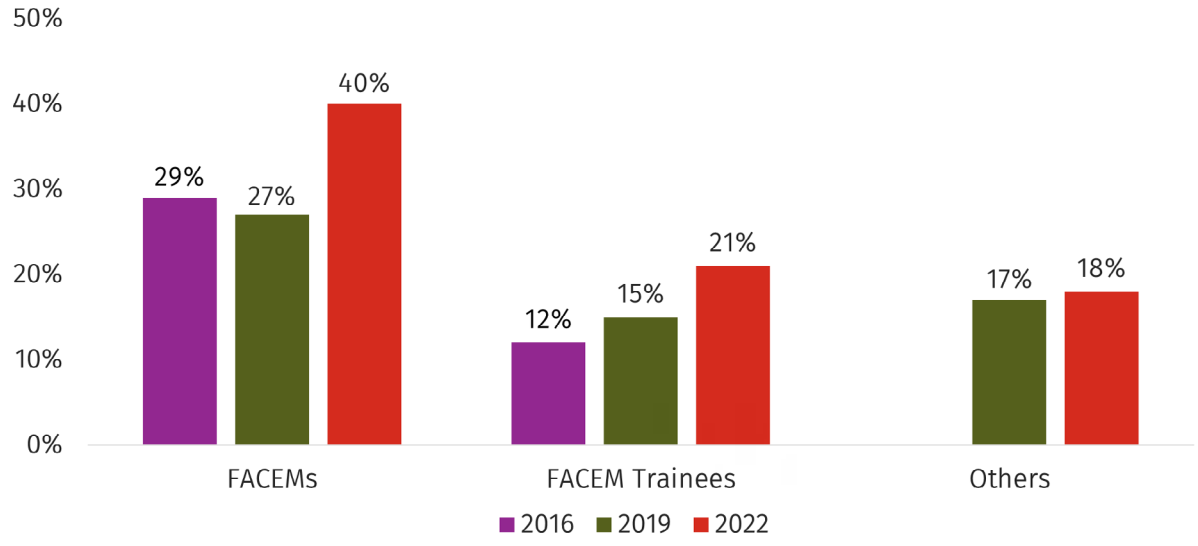


Figure 22. Percentage of respondents who were likely to leave clinical practice, in the next 10 years, by ACEM membership category (n = 1,172 in 2016, n = 732 in 2019, n = 675 in 2022). No data was available for the 'Others' category from the 2016 survey.

6.10.4 Leave emergency medicine in the next 10 years

Of the 679 respondents, 40.0% (26.8% in 2019, 25.2% in 2016) were *likely*, 15.3% (14.1% in 2019, 17.6% in 2016) were *neutral*, and 44.7% (59.3% in 2019, 57.3% in 2016) reported that they were *unlikely* to leave emergency medicine in the next 10 years. Notably, there were significant increases in the proportion of FACEMs (42.4% vs. 28.2% in 2019, 30.1% in 2016) and FACEM trainees (31.3% vs. 20.1% in 2019, 17.7% in 2016) reporting that they were *likely* to leave emergency medicine in the next 10 years compared to the 2019 survey (**Figure 23**).

The percentage of respondents reporting that they were *likely* to leave emergency medicine in the next 10 years generally increased with age from less than 20% for those in their 30s to 95.7% for those aged more than 60 years. Respondents working in remote (56.3%) areas were more *likely* to report that they were likely to leave emergency medicine in the next 10 years compared to those working in metropolitan (39.5%) and regional (39.6%) areas.

40% (an increase of 13% from 2019) of respondents were likely to leave emergency medicine in the next 10 years.

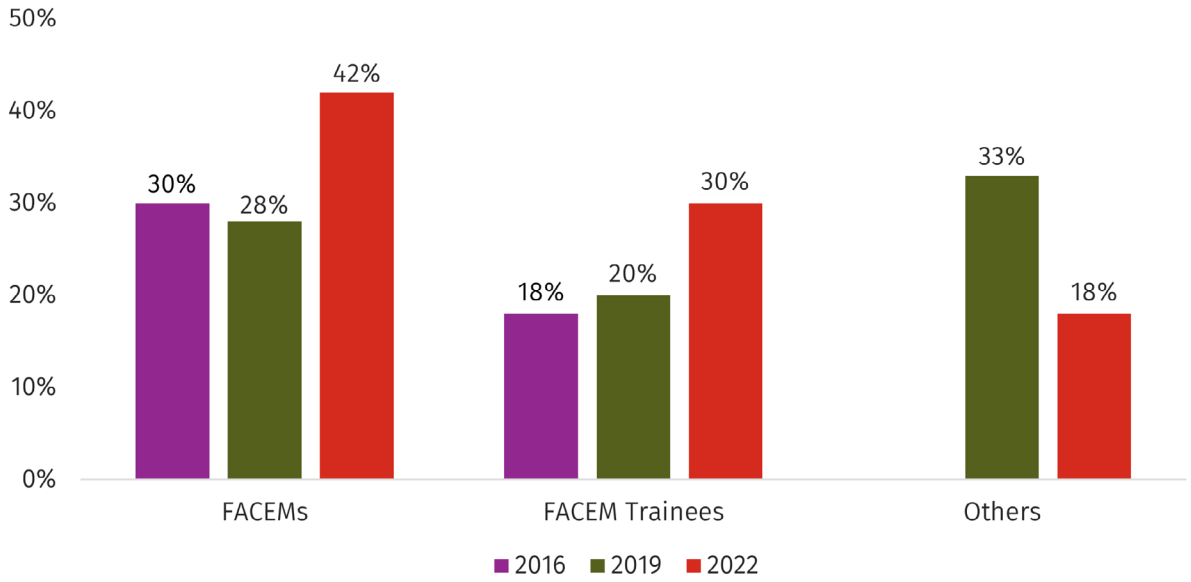


Figure 23. Percentage of respondents who were likely to leave emergency medicine in the next 10 years, by ACEM membership category (n = 1,168 in 2016, n = 732 in 2019, n = 678 in 2022). No data was available for the 'Others' category from the 2016 survey.

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

Of those likely to leave clinical practice or the emergency medicine workforce in the next 10 years, 283 provided reason(s) why they were likely to do so. The most common themes and their frequencies are shown in **Table 11**.

Table 11 Respondents' reasons for wanting to leave clinical practice and/or the emergency medicine workforce in the next 10 years (n = 283).

Reasons to leave clinical practice or emergency medicine workforce	% of respondents
Unsustainable workplace conditions/ requirements/pressure	61.1%
Older age/transitioning to retirement	30.4%
To improve personal life	8.8%
Wanting a change in career	6.7%
To improve health/wellbeing	3.5%
Other	2.8%

Note: Respondents could provide multiple reasons. Other reasons included to pursue other professional interests and not wanting to become a Fellow.

Some examples of comments reflecting these themes are presented below:

'Because I am 57 and I think that the intensity of clinical emergency medicine has an expiry age.'

'Find that current levels of work are unsustainable.'

'Hospital administration still has the mindset that access block is an ED problem, without any solutions on how to solve a hospital wide issue.'

'Age…plan to cut down hours in my 50s. It's not a speciality for older doctors. The late nights, recalls, physical nature of the job, limited access to holidays at peak times.'

'The hours and on call are gradually debilitating. I do get frustrated with inefficient management, defensive management, including over investigating and treating and clinical waste. It can all be harmful.'

6.10.6 Retire in the next 10 years

Of the 679 respondents, 24.8% (15.8% in 2019) reported that they were *likely*, 9.3% (7.2% in 2019) were *neutral*, and 65.9% (77.0% in 2019) reported being *unlikely* to retire in the next 10 years. The proportion of respondents who are likely to leave emergency medicine by ACEM membership category and the changes since 2019 are shown in **Figure 24**.

The percentage of respondents reporting that they were *likely* to retire in the next 10 years increased with age from 2% of those in their 30s to 95.7% of those aged more than 60 years. Males (28.3% vs. 20.7% in 2019) were more likely than females (21.3% vs. 10.7% in 2019), to report that they were planning to retire in the next 10 years. A higher percentage of respondents working in remote (31.3%) locations reported that they were *likely* to retire in the next 10 years compared to those working in metropolitan (24.5%) and regional (25.0%) locations.

24.8% (an increase of 9% from 2019) of respondents are likely to retire in the next 10 years.

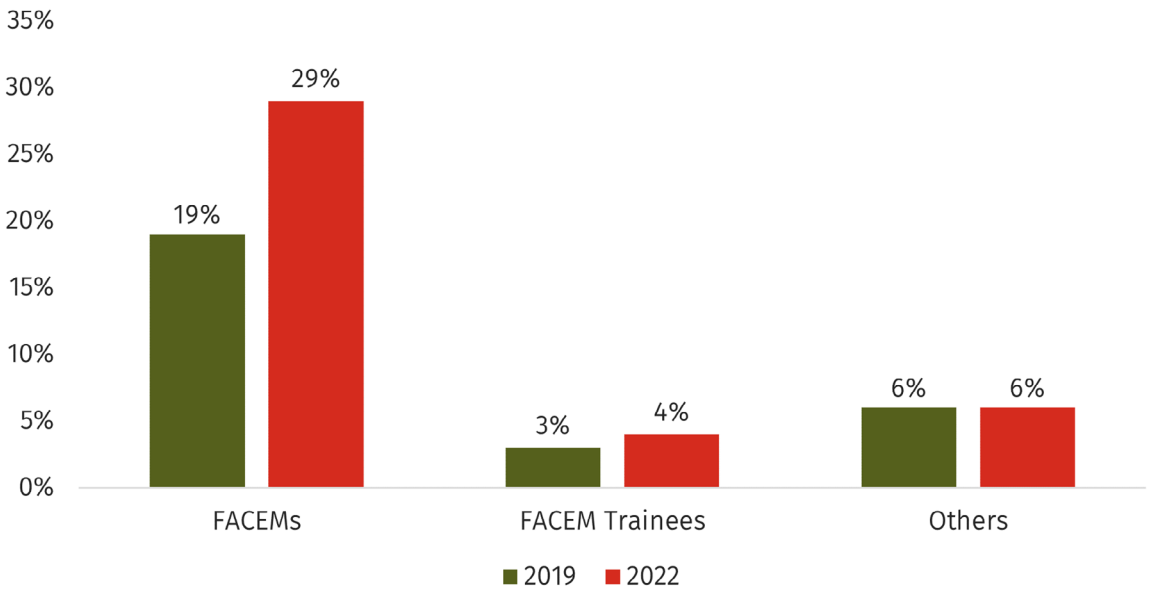


Figure 24. Percentage of respondents who were likely to retire in the next 10 years, by ACEM membership category (n = 726 in 2019, n = 669 in 2022).

6.11 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) in the past 12 months, by patients or carers and by professional colleagues.

6.11.1 DBSH by a patient or carer in the past 12 months

Of the 676 respondents, 39.5% (40.6% in 2019) reported that they had experienced DBSH by a patient or carer in the past 12 months. The percentage of respondents who reported experiencing DBSH by a patient or carer in the past 12 months by ACEM membership category and the changes since 2019 are shown in **Figure 25**.

Females were much more likely to report experiencing DBSH by a patient or carer in the past 12 months (45.8% vs. 49.0% in 2019) than males (32.1% vs. 32.0% in 2019). The proportion of female respondents who reported experiencing DBSH from patients or carers reduced with age from 62.5% in those aged 30-35 years to 10.0% in those >60 years of age, whereas the pattern was not observed among male respondents (ranged from 25%-40%). The proportion of respondents who reported experiencing DBSH by a patient or carer was higher among those working in metropolitan (43.6%) areas compared to those working in regional (32.0%) and remote (31.3%) areas.

39.5% of respondents had experienced DBSH by a patient or carer in the past 12 months.

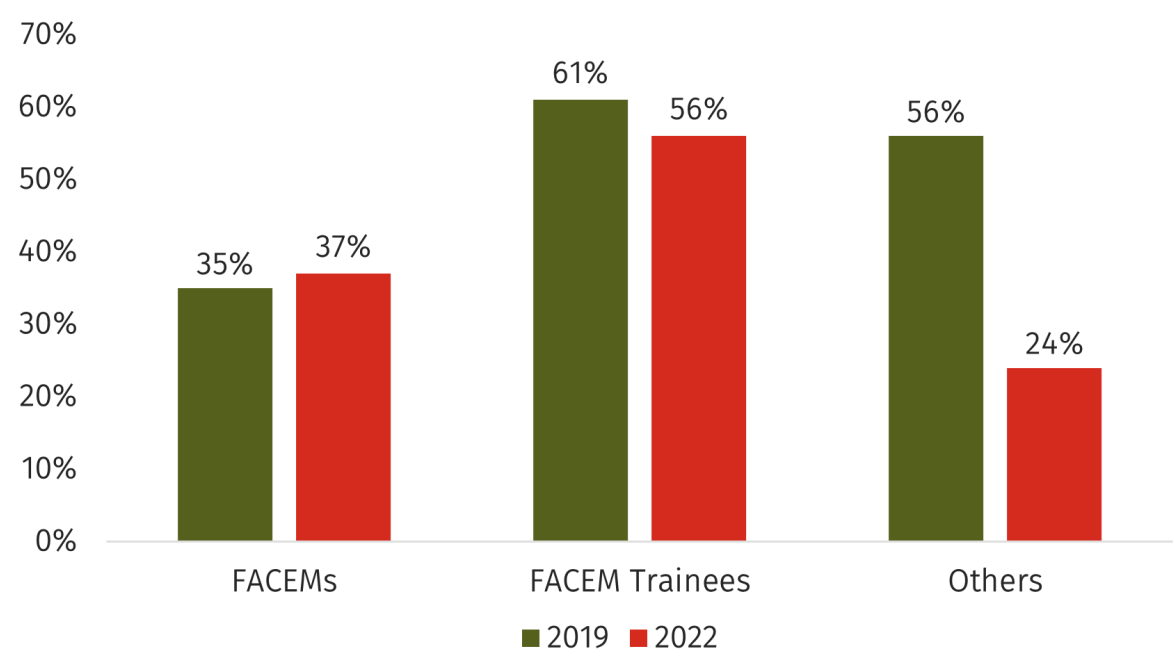


Figure 25. Percentage of respondents who experienced DBSH by a patient or carer, by ACEM membership category (n = 710 in 2019, n = 676 in 2022).

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

Of the 676 respondents, 24.9% (47.4% in 2019) reported that they had experienced DBSH at work by a professional colleague in the past 12 months. A reduction in the proportion of respondents reporting having experienced DBSH by a professional colleague was seen across all membership categories, compared to the 2019 survey (**Figure 26**).

Females (27.2% vs 53.7% in 2019) were more likely than males (21.4% vs 41.0% in 2019) to report having experienced DBSH by a professional colleague in the previous 12 months. Those working in remote (12.5%) areas were less likely to report experiencing DBSH from professional colleagues than those in metropolitan (24.2%) and regional (27.0%) areas.

24.9% (a decrease of 22% since 2019) of respondents had experienced DBSH by a professional colleague in the past 12 months.

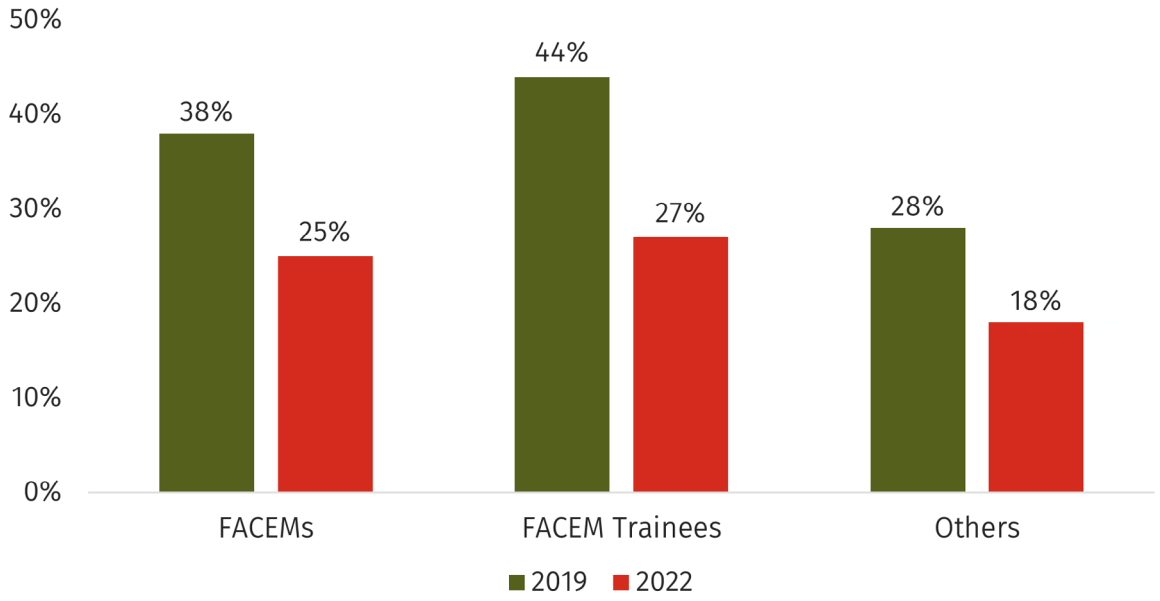


Figure 26. Percentage of respondents who experienced DBSH by a professional colleague in the past 12 months, by ACEM membership category (n = 713 in 2019, n = 676 in 2022).

Of those who responded to whether they experienced DBSH from a professional colleague in the last 12 months, 14.3% (20.3% in 2019) reported that they had experienced discrimination, 20.3% (30.0% in 2019) experienced bullying, 10.8% (17.3% in 2019) experienced harassment, and 3.8% (2.4% in 2019) experienced sexual harassment. FACEM trainees were generally more likely than FACEMs to report experiencing all aspects of DBSH (**Figure 27**).

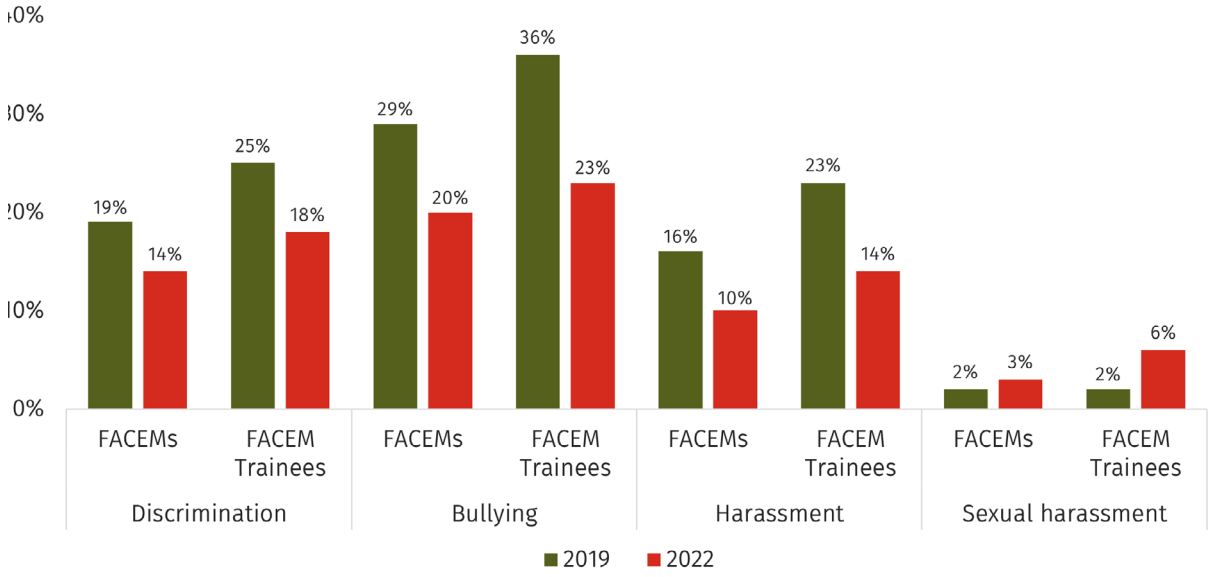


Figure 27. Percentage of respondents who experienced each DBSH behaviour by a professional colleague in the past 12 months, by ACEM membership category (n = 713 in 2019, n = 676 in 2022).

6.11.3 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 other role(s) or not disclose the role(s) of the perpetrator(s). Overall, FACEMs and other speciality consultants were most frequently nominated as the perpetrators of displaying DBSH behaviours (**Table 12**).

Table 12 Role of the perpetrator(s) of DBSH experienced by respondents in the workplace, by a professional colleague.

Perpetrator	Discrimination		Bullying		Harassment		Sexual Harassment	
	2019 (n = 138)	2022 (n = 97)	2019 (n = 200)	2022 (n = 137)	2019 (n = 113)	2022 (n = 73)	2019 (n = 14)	2022 (n = 26)
FACEM	55.1%	53.6%	48.0%	56.2%	34.5%	49.3%	28.6%	38.5%
ACEM trainee	9.4%	11.3%	4.0%	5.1%	5.3%	8.2%	7.1%	0%
ACEM college examiner	7.2%	5.1%	3.0%	2.9%	5.3%	2.7%	0%	3.8%
ACEM SIMG	0%	0%	0.5%	0.7%	0.9%	1.4%	0%	0%
ACEM college staff member	6.5%	4.1%	3.5%	1.5%	0.9%	0%	0%	0%
Admin staff	8.0%	8.2%	4.5%	5.8%	3.4%	9.6%	0%	3.8%
Allied health worker	1.4%	5.2%	0%	0.7%	0%	2.7%	0%	0%
Director of EM	21.7%	9.3%	16.5%	11.7%	11.5%	8.2%	0%	0%
Director of EM training	8.7%	3.1%	6.0%	2.2%	7.1%	2.7%	0%	3.8%
Intern	0.7%	4.1%	0%	1.5%	0%	0%	7.1%	0%
Medical administrator	22.5%	22.7%	16.5%	20.4%	8.8%	21.9%	7.1%	7.7%
Nursing staff	18.8%	30.9%	14.5%	15.3%	11.5%	15.1%	7.1%	7.7%
Nurse unit manager	13.0%	13.4%	8.5%	10.2%	6.2%	11.0%	0%	0%
Operational staff (e.g. Ward person)	0.7%	3.1%	0.5%	1.5%	0%	1.4%	0%	0%
Other medical officer (CMO/ SMO)	8.0%	16.5%	4.5%	18.2%	3.5%	12.3%	0%	3.8%
Other speciality consultant	31.9%	33.0%	26.5%	27.7%	22.1%	26.0%	28.6%	7.7%
Other speciality trainee	23.2%	27.8%	23.5%	19.0%	24.8%	16.4%	14.3%	15.4%
Paramedic	2.9%	7.2%	1.0%	4.4%	0.9%	2.7%	7.1%	7.7%
Registrar	14.5%	14.4%	7.5%	8.8%	8.0%	8.2	7.1%	7.7%
Other	4.3%	8.2%	2.5%	7.3%	3.5%	4.1%	0%	7.7%
Prefer not to say	5.1%	8.2%	4.5%	2.2%	11.5%	6.8%	28.6%	11.5%

Note: Respondents could select more than one perpetrator of DBSH behaviour, so responses may add up to more than 100%. SIMG = specialist international medical graduate, EM = emergency medicine, CMO = career medical officer, SMO = senior medical officer.

6.11.4 Characteristic respondents were discriminated against

Respondents who indicated that they experienced discrimination at work in the past 12 months by a professional colleague were further asked which characteristics, protected under National/State/Territory law, they were discriminated against. Responses are summarised by ACEM membership category in **Table 13**. Consistent with the 2019 survey, the two most nominated characteristics respondents were discriminated against were gender and race.

Females accounted for 85.2% of respondents who experienced discrimination by gender. After the age of 50, there was a considerable reduction in those who experienced discrimination by gender compared to those under 50.

Table 13 Characteristic protected under National or State/Territory law, respondents believed being discriminated against (n = 138 in 2019, n = 97 in 2022).

Characteristic	FACEM		FACEM trainee		Total	
	2019 (n=101)	2022 (n=76)	2019 (n=34)	2022 (n=19)	2019 (n=138)	2022 (n=97)
Gender	54.5%	52.6%	48.5%	73.7%	52.9%	55.7%
Race	18.8%	28.9%	51.5%	42.1%	26.8%	33.0%
Colour	8.9%	19.7%	33.3%	31.6%	14.5%	23.7%
Age	16.8%	23.7%	12.1%	15.8%	16.7%	21.6%
Nationality	18.8%	18.4%	30.3%	21.1%	21.7%	19.6%
Family or carer responsibilities	21.8%	22.4%	12.1%	10.5%	18.8%	19.6%
Marital/relationship status	5.9%	9.2%	6.1%	5.3%	5.8%	8.2%
Sexual orientation	3.0%	3.9%	3.0%	26.3%	2.9%	8.2%
Religion	8.9%	6.6%	3.0%	10.5%	7.2%	7.2%
Pregnancy	10.6%	5.3%	7.7%	10.5%	5.8%	6.2%
Breastfeeding	1.5%	2.6%	7.7%	5.3%	1.4%	3.1%
Disability	N/A	1.3%	N/A	5.3%	N/A	2.1%
Other (prefer not to say)	19.8%	7.9%	21.2%	5.3%	19.6%	7.2%

Note: Respondents could select more than one characteristic, so responses may add up to more than 100%.

6.11.5 Type of sexual harassment behaviour

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 type(s) of behaviour were exhibited by the perpetrator(s). The percentage of respondents who experienced each type of sexual harassment behaviour is shown in **Table 14**.

Table 14 Types of sexual harassment behaviour respondents experienced in the workplace by a professional colleague (n = 14 in 2019, n = 26 in 2022).

Type of sexual harassment	2019 (n=101)	2022 (n=76)
Sexually explicit or offensive comments, jokes, or other forms of inappropriate language	57.1%	53.8%
Inappropriate physical contact	21.4%	38.5%
Questions or insinuations about my sexual or private life	21.4%	34.6%
Unwelcome sexual flirtations	64.3%	30.8%
Leering or graphic comments about my body and/or how my clothing looks on me	14.3%	26.9%
Displays of sexually explicit behaviour including sexual gestures, indecent exposure, or inappropriate display of the body	28.6%	11.5%
Demands for sexual favours	7.1%	7.7%
Display of sexually suggestive images, videos, emails, electronic messages, or notes	7.1%	3.8%
Persistent requests for dates	0%	3.8%
Sexual assault	0%	0%
Rape	0%	0%

Note: Respondents could select more than one type of sexual harassment experience, so responses may add up to more than 100%.

6.12 Experiences of DBSH

Respondents who reported experiencing discrimination, bullying, harassment and/or sexual harassment in the workplace by a professional colleague were asked if they would like to describe the behaviour(s) they experienced.

6.12.1 Experiences of discrimination

Twenty-five respondents provided a description of their experiences of discrimination in the workplace. The most common themes of discrimination focused on race/ethnicity, gender, salary and employment, and family/childcare commitment.

Some examples of comments reflecting these themes are presented below:

> *'A common occurrence is being ignored by other speciality consultants (mainly Caucasians and some Indian ethnic backgrounds) in the ED. They prefer to speak with my Caucasian FACEMs despite the need for that discussion to be had with me when in charge of the ED floor. My often exchange of pleasantries with these individuals is usually ignored.'*

> *'Being made to feel that I do not deserve to be an ACEM trainee, or that I cannot possibly be worthy of being an ACEM trainee because I am a person who is not Caucasian or male.'*

> *'Constant discrimination regarding pregnancy and insinuation around time off for being pregnant and breastfeeding upon trying to return to work.'*

6.12.2 Experiences of bullying

A total of 40 respondents provided a description of an experience of bullying. The descriptions of bullying experiences were often perpetrated by senior medical staff (FACEMs and other specialists). The bullying often involved belittling, degrading clinical work, unfair rostering, exclusion, and threats.

Some examples of comments reflecting these themes of bullying are:

> *'I experienced bullying by another speciality team registrar whilst working as a registrar in charge of a tertiary hospital – I was advocating for the safety of my patient.... In front of the patient, the registrar proceeded to berate me and said he would get anaesthetics to "do my job for me".....'*

> *'I had to intervene when a fellow FACEM was bullying a trainee in my department. The FACEM then turned on me and tried to attack my character in front of other witnesses.'*

> *'Being threatened that I should leave if I do not agree with various issues and people..... Told I would lose my job by my boss (non-ED). Yelled at. Vexatious complaints. Silent treatment and exclusion from meetings and projects.'*

6.12.3 Experiences of harassment

A total of 13 respondents who experienced harassment in the workplace described their experience. Common themes identified from the comments included, perpetrators undermining the clinical practice of respondents, humiliating behaviour in front of others, and perpetrators forcing their agendas onto respondents.

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

> *'A FACEM in my department was continually contacting me outside of work despite repeated requests not to contact me about work issues on my days off and while on annual leave. I was also subject to accusatory emails and false accusations to my director related to my work role.'*

> *'Long emails and texts making me feel guilty and also questioning my commitment to the department for not picking up extra clinical shifts.'*

> *'Professional degradation. Attempted to ridicule my medical practice against other non FACEM doctors. Her attempts failed and thus I was punished even further. Continuous emotional blackmail.'*

6.12.4 Experiences of sexual harassment

One respondent who reported experiencing sexual harassment provided an example of their experience; this involved inappropriate sexual comments being laughed off by peers.

6.13 Impact of COVID-19

Respondents were asked to comment on the impact of COVID-19 on their primary workplace or their wellbeing at work. A total of 536 responses were received, and the responses were categorised into key themes by frequency distribution (Table 15). Overall, nearly all comments focused on the negative implications of COVID, except for a small number of positive responses (6%), which highlighted improvements in staff wellbeing and support initiatives as well as team culture.

The most commonly raised issue associated with COVID-19 was understaffing, with many responses noting an increase in sick leave, COVID-19 furloughing, and colleagues leaving the ED workforce. In particular, many respondents noted a considerable decrease in senior experienced ED nursing staff, which led to the worsening of understaffing or issues with a more junior, inexperienced nursing and medical workforce. It was commonly noted that the reduction in staffing and increased levels of inexperienced staff caused increased levels of stress and burnout.

Another common theme involved a worsening of ED overcrowding and access block, which was caused by reductions in available staff, reduced space and resources, an increase in the complexity of patient presentations, and the rise in patient numbers associated with the lack of availability and/or accessibility to primary care services.

The impact of COVID-19 on respondents' workplace and wellbeing was a complex interaction of factors which often contributed to stress/burnout amongst respondents. Several overarching impacts on wellbeing which were frequently mentioned included a lack of capacity in the health system that was magnified by COVID-19 and that EDs were often being made responsible for having to deal with the overflow of patients across the whole hospital system.

Table 15 The impact of COVID-19 pandemic on respondents' primary workplace and wellbeing at work (n = 536).

Impact of COVID-19	% of respondents
Worsened understaffing	53.7%
Increased stress/burnout	34.1%
Worsened ED overcrowding/access block	21.3%
Frequent changes to processes/patient flow were challenging	16.0%
PPE impacting comfort/ability to communicate	14.6%
Staff retention and recruitment negatively impacted	15.3%
Increased workload/demands	10.8%
Lack of hospital executive/management support or understanding	8.2%
Increase in patient acuity or demands	7.8%
Morale/culture of workplace deteriorated	8.0%
Increase in presentations with lower acuity/primary care patients	7.5%
Fear about the impact of COVID-19 virus on self and family	6.2%
Increased wellbeing support/management support/team culture	5.8%
Negative impact on patient care	4.9%
Reduced resources/space	4.9%
Interactions with colleagues deteriorated	4.7%
Reduced patient interactions	4.3%
Negative impact on training/teaching	3.4%
Other (e.g. increased mental health presentations, concerns over the amount of waste generated, and reduced patient health literacy)	9.0%

Note: Respondents could provide multiple reasons and contribute more than one theme. PPE = Personal protective equipment

Some examples of comments reflecting respondents' experiences of COVID-19 on their workplace or wellbeing are:

'Main issue is lack of staff – huge amount of sick leave, always short staffed. Everyone is burnt out from being overworked and trying to work in a more stressful environment with PPE, lack of space, lack of staff and more patients. All the stress is in the ED and the rest of the hospital takes none of this one. Our culture has suffered, people have resigned – loss of most of our experienced nurses to other less stressful areas of the hospital. Trainees are leaving for GP training and it is hard to encourage junior doctors to become an ED registrar. So huge impact. It is no longer enjoyable and the feeling of being left to cope is very demoralising.'

'Understaffing [is the] main and severe issue – recruitment, understaffed as a whole, increased sickness leave, complicates patient assessment, increases time to see patients, carer/PPE fatigue, some staff suffering fear of infection and passing on to loved ones.'

'Workplace stress has been at extreme level, all including medical, nursing, allied health, ancillary staff from not just ED but all in the hospital have been affected which is soul crushing. No support for anyone just tokenistic, lip service offered by the powers that be. As everyone is under pressure, there is always a sense of discontentment with each other/amongst teams, sadly instead of us building a fraternity we are engaging more and more in tribalism. Mainly because there is no leadership from the organisational side for guidance. All staff in the hospital want to perform well and often better but are so hand tied, tongue tied, stifled….'

'Significant stress due to physical layout changes along with constantly changing PPE and cohorting requirements.'

'All the same ways that it's affected urban centres but effects are magnified in rural areas: e.g. losing 1-2 senior medical officers (SMOs) is 1/4 of our workforce, same with nurses and it is harder to recruit to rural areas…..At one point this year we had 7.5FTE recruited to cover a roster that required 16FTE – so huge amounts of overtime, and leaving department staffed by inappropriate persons, such as urgent care fellows or GPs (even a renal physician at one point).'

'Initial increased anxiety re severity of pandemic, increased wellbeing support (meals for ED staff, massages), better hospital awareness of ED challenges, but worse access block/overcrowding.'

6.14 Additional Comments by Respondents

Respondents were given the opportunity to provide additional comments on the survey or the contents of the survey, with 117 comments received. The key themes from the comments varied from training and exams, ACEM support, general health system deficiencies, issues with later career and workforce, and DBSH experiences.

7. Conclusion

The findings of the 2022 ACEM Sustainable Workforce Survey suggest that many ACEM members/trainees continued to experience high levels of stress and personal/work/patient-related burnout. Worryingly, the survey findings reveal that respondent wellbeing has deteriorated in almost every measure of health and wellbeing, compared with the previous survey iterations. Significant proportions of respondents reported deteriorating levels of workplace stress, burnout, and general health along with continuing high levels of fatigue and anxiety.

In addition, there was a decline in FACEMs who reported being employed on a full-time contract. There were also considerable increases in FACEMs who reported their intention to leave clinical practice or the emergency medicine workforce in the next 10 years. The reason was primarily due to unsustainable workplace conditions and pressure, with more than half indicating they were likely to leave the emergency medicine workforce due to this reason.

The major stressors identified in the survey (ED overcrowding, access block, and conflicts with other clinical teams) remain the same primary stressors identified in the 2016 and 2019 surveys. The additional strain of the COVID-19 pandemic, particularly on staffing levels, suggests that the pressure on EDs and ED staff is worsening and causing increased stress and burnout.

One positive shift from the 2019 survey was the declining number of respondents who reported experiencing DBSH by a professional colleague. In those that reported experiencing DBSH by a professional colleague, FACEMs and other speciality consultants remained the most nominated perpetrators, while gender, race, colour and age were the characteristics respondents were most frequently discriminated against.

FACEM trainees generally reported worse outcomes than FACEMs, particularly for work-life balance, satisfaction with various workplace conditions, fatigue/burnout, and even the experiences of DBSH behaviour. Subgroup analysis by gender also showed distinct differences in various aspects. For instance, females were more likely to report experiencing more hostile and uncivil behaviour, having anxiety, and experiencing DBSH from patients/carers or colleagues. In contrast, males were more likely to work excess overtime and never receive at least one 24-hour period off following night shifts. Similarly, there were differences by workplace remoteness, with those working in regional and remote areas more likely to feel professional isolation, to be on-call more frequently but less likely experience DBSH behaviour from patients compared to those working in metropolitan areas.

These findings highlight the increasing pressure on by EDs, staff, and their workloads, particularly with the added strain of the COVID-19 pandemic. Despite all this, the survey demonstrated that many 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, ACEM is committed to continuing and expanding upon its important work to advocate for improving wellbeing and workplace culture towards a sustainable emergency medicine workforce.

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Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au