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Results of RACP member survey: “Are you COVID-19 safe?” – a full report

November 2021

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Executive Summary

In September and October 2021, the College conducted a survey of members in Australia on the impact of COVID-19 and the Delta variant on physicians and their work. RACP members, along with other health care workers, have continued to provide vital health care throughout this pandemic. Members have also been an important source of medical advice to all governments and have provided valuable non-clinical time to health care organisations to rapidly develop internal protocols and procedures.

The "Are you COVID-19 safe?" survey was open between 17 September 2021 and 4 October 2021. It comprised 27 questions, not all of which required responses. There were 812 individual responses with the completion rate of 95%[1]. The results of the survey provide direct insight into physicians' access to vaccinations, views on booster shots for health care workers, the provision of and access to Personal Protective Equipment (PPE), and the impact of COVID-19 and the Delta variant on their work and well-being.

The respondents across Australia report:

- A very high vaccination rate for member physicians and paediatricans (98%).
- High support for health care workers to be prioritised for a booster vaccination (87%).
- Significant impacts of COVID-19 and the Delta variant on work role and workload (such as increased use of telehealth, increased patient cases and hours, and increased administrative time).
- Significant impacts of COVID-19 and the Delta variant on physician well-being (such as the experience of fatigue and burnout).
- Significant impacts on trainee physicians working in the public hospital system.
- The need for greater health service organisation support to employed physicians.
- A range of ongoing stressors on the health care system that need urgent address, along with the imperative to provide care that has been delayed due to COVID-19.
- Scope for improved access to suitable PPE both for private physicians and for employed physicians and paediatricians.
- Scope for improved processes, communications and pathways for physicians, including private physicians, as prioritised health care workers to receive vaccinations and boosters.
- Support for continued access to MBS telehealth items.
- The opportunity for the College as clinical leaders to be a source of clear evidence-based information to members, the public, and the decision-makers.

[1] There are over 23000 physicians practicing in Australia. As such, while the findings of the survey are informative and broadly aligned with the results of similar research conducted by other organisations, they cannot be confirmed as representative of the membership of the RACP.

Introduction

The “Are you COVID-19 safe?” survey was designed to monitor members’ status as key health care workers in all health care sectors. This survey is the third in a College series since the start of the pandemic. The first was on the introduction by the Australian Government of MBS telehealth items for specialists and consultant physicians. The second tracked member access to PPE.

All members practising in Australia received an electronic link to the voluntary survey. The questions covered perceived member well-being, access to vaccines and PPE, the experience of health service employer support, the impact on private physicians, and stressors on the health care system. The survey was open from 17 September until 4 October 2021.

Respondents were informed that only deidentified data would be used in the analysis and reporting. Question types varied and included multiple choice, Likert scales, checkboxes (some allowing more than one check), and free text.

The survey results are presented in the following sections:

1. COVID-19 vaccinations
2. Incidence of COVID-19 infection among members
3. Impact of COVID-19 and Delta variant on work and work role
4. Employer support
5. Perceived stress on the health care system
6. Respondents’ concerns relating to COVID-19 and work
7. Access to PPE

Respondent profile

- The majority of the 812 respondents were Fellows (81%), although an important proportion were trainees (19%).
- Most respondents practiced in metropolitan areas (83%)
- 20% were private physicians.
- 67% worked in public hospitals.
- Victoria (34%) and New South Wales (33%) had the highest proportions of respondents of all states and territories. There were no observed differences in responses between the jurisdictions, for example on vaccination status, proportions of those experiencing major difficulties in accessing vaccinations, and other questions where the number of respondents warrants comparisons. There was a higher proportion of Victorian and NSW respondents reporting increases in workdays and hours and patient numbers (69% and 57% respectively) compared to the next highest proportion in ACT (42%); however, the numbers of respondents in states other than Victoria and NSW are significantly lower (for instance, the ACT accounts for only 3% of respondents).
- Among the specialties represented within the College, the highest proportions of respondents were paediatricians (21% across various subspecialties), 15% general and acute medicine physicians and 9% geriatricians. Respondent demographics are shown in Table 1.

Table 1: Respondent demographics

Descriptor	% Respondents
Member type	
Basic trainee	9%
Advanced trainee	10%
Fellow	81%
Predominant state of practice	
Victoria	34%
NSW	33%
Queensland	11%
Western Australia	9%
South Australia	6%
ACT	3%
Tasmania	3%
Practice location (main)	
Metropolitan	83%
Inner regional	12%
Outer regional	8%
Remote	2%
Specialties (those with over 4% representation)	
General paediatrics, child community health, adolescent and young adult medicine, paediatric emergency medicine, paediatric rehabilitation	21%
General and acute care medicine	15%
Geriatric medicine	9%
Basic trainee	8%
Respiratory medicine and/or sleep medicine	6%
Cardiology	6%
Medical oncology	6%
Endocrinology	5%
Nephrology	5%
Palliative medicine	5%
Primary place of employment	
Public hospital	67%
Private hospital	6%
Employed by other health care service provider	4%
Self-employed in private practice	20%
Non-clinical	4%
Aboriginal Community Controlled Health Service or other Aboriginal Health Service	0.4%

Survey results

1. COVID-19 Vaccinations

- 92% supported mandating vaccinations for health care workers (HCW)
- 87% supported the prioritising of HCWs for booster shots
- 98% of respondents are fully vaccinated

Respondent access to vaccinations as prioritised health care workers:

- 75% reported no difficulties accessing their vaccination(s)
- 6% reported major difficulties.

Reported access difficulties related to poor internal communications, not including some specialties and trainees on the prioritisation lists, and overloaded bookings. For private practitioners, the access difficulties related to not being prioritised as a HCW if they also worked in a public hospital, poor access to vaccinations in private hospitals, failures in booking systems and notifications facilities, and a lack of facilitated vaccination pathways for private practitioners. Table 2 provides the complete results on these key findings.

Table 2: Respondents and COVID-19 vaccinations

Question	Yes	No	Undecided
Should COVID-19 vaccinations be mandatory for health care workers?	92%	5%	3%
Should health care workers be prioritised for booster shots?	87%	4%	9%
Fully vaccinated	98%	2%	
• With Comirnaty (Pfizer)	64%	-	
• With Vaxzevria (Astra Zeneca)	36%	-	
Any difficulties accessing vaccinations as a prioritised health care worker?	19% Minor difficulties 6% Major difficulties	75%	
Where vaccinated: • Workplace - Public hospital • Workplace - Private hospital • State vaccination hub • GP • Chemist	 68% 3% 20% 11% < 1%		

2. Impact of health care worker COVID-19 infections on members

The survey asked for the incidence of COVID-19 infection among members for the period between 31 March 2020 and 31 August 2021 and about the impact of health care worker infections on member working arrangements (Table 3).

- Only 1% of respondents reported any periods of not working due to being infected.
- 13% were furloughed as close or casual contacts
- 7% were asked to work (as close or casual contacts), but with precautions (such as in a different area, work with no patient contact such as through telehealth). Where furloughing was not required because the respondent was a close or casual contact, appropriate PPE and regular testing practices were in place.

Table 3: Impact of COVID-19 infections on respondents between 31 March 2020 and 31 August 2021

Question	Yes	No	N/A
Any periods of not working due to being infected by COVID-19	1%	99%	
Incidence of having been a close or casual contact & furloughed*	5% as close contact 7% as casual contact	7% as close contact 8% as casual contact	73%
Incidence of having been a close or casual contact & asked to work but with precautions	2% as close contact 5% as a casual contact	6% as a close contact 7% as a casual contact	80%

*Temporarily suspended by your employer

3. Impact of COVID-19 Delta variant outbreak on work and work role

This set of questions explored any changes to members' workload in 2021 due specifically to the COVID-19 Delta outbreak (Table 4).

- Over half of the respondents (53%) reported increases in either their patient caseload or time working (number of days or hours).
- A range of other changes were reported by respondents.

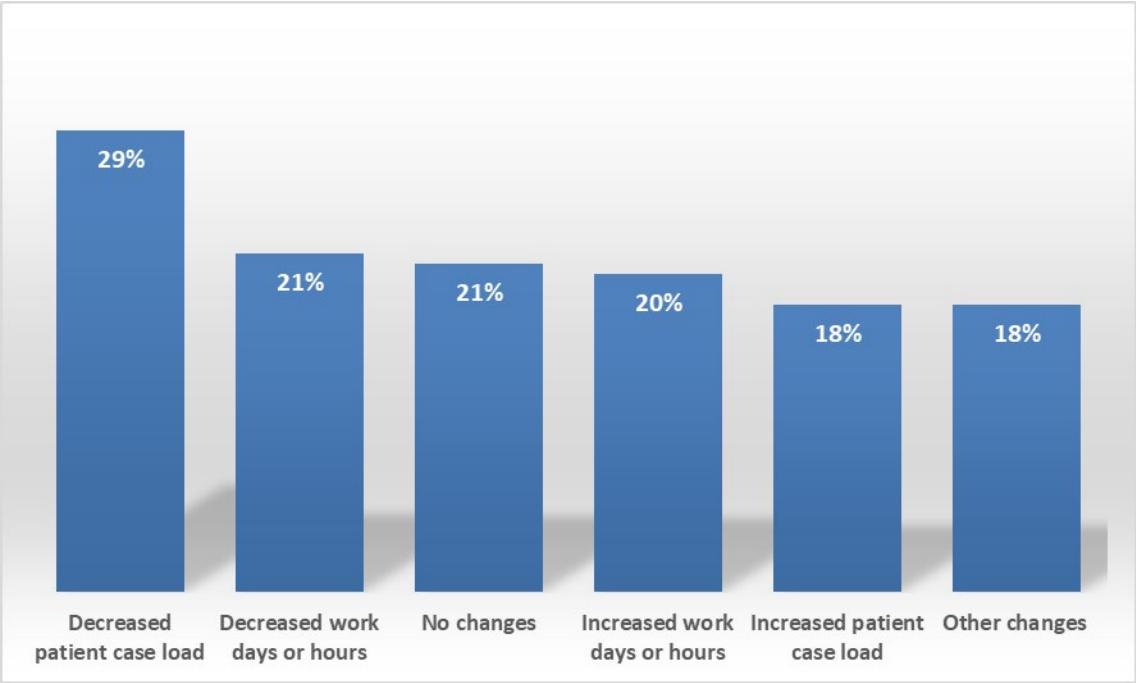
Table 4: Respondent experience of the impact of COVID-19 Delta outbreak on their workload (multiple options could be selected)

Question choices	All members	Private physician responses only
Increased workdays or hours	28%	20%
Increased patient case load	25%	18%
No changes	26%	21%
Decreased patient case load	14%	29%
Decreased workdays or hours	7%	21%
Other changes	29%	18%

Other changes predominantly related to the greater use of telehealth (24% of "other changes" specified); dealing with staff shortages (13%); increased non-clinical work such as response committee and procedure development work, meetings (12%); patient demand which included COVID-19 related demand but also dealing with patient concerns and mental health issues (8%); and redeployment to another health service area (7%).

Since respondents could choose multiple options to describe their experience in this context, it is important to recognise that physicians may be working under conditions impacted by several factors, such as increased workdays, increased patient case load and other changes. Respondents reported that they have not been able to take annual leave or study leave, have been required to cover furloughed staff, have spent time reassuring other staff, have worked with fewer junior staff and attended to more administrative work.

For private physician respondents (20% of the sample), the impact of the COVID-19 Delta variant has been different. For 50% of private physician respondents, COVID-19 Delta variant has led to a decreased patient case load and/or decreased work hours or days (Figure 1).



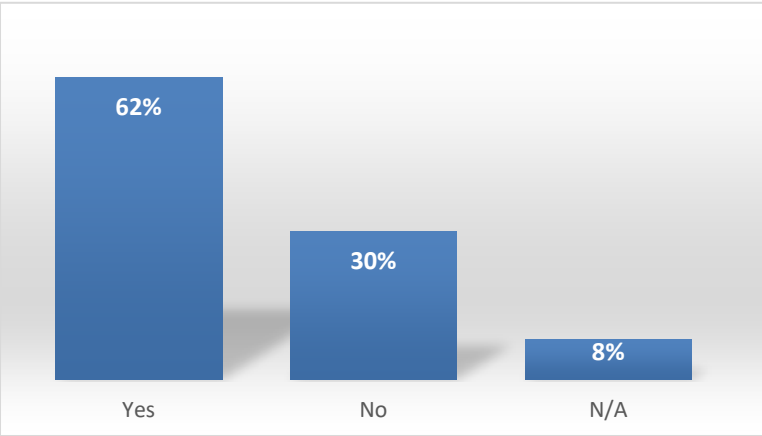
Among “other changes” for private practitioners, the greater use of telehealth and seeing patients that others were unable to see were noted.

4. Employer support

Respondents were asked if their employer had provided them with sufficient support during this pandemic to manage the increased risk of COVID-19 infection and increased workload and stress. Employers include public hospitals, private hospitals, Aboriginal Community Controlled Health Organisations (ACCHOs), and other health service organisations.

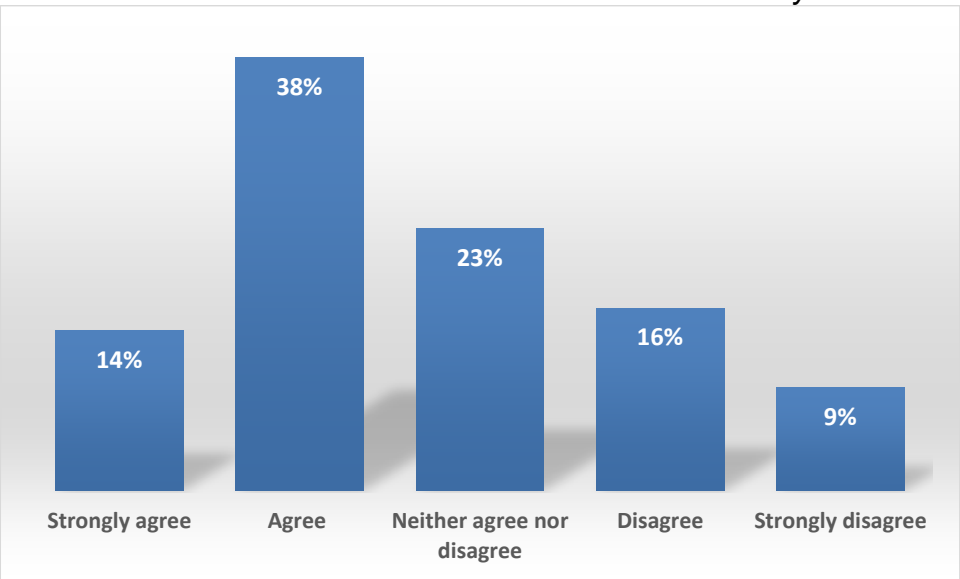
Although 62% of the respondents reported that their employer had provided them with sufficient support, 30% said they did not (Figure 2).

Figure 2: Did employers provide sufficient support to manage the increased risk of COVID-19 infection and increased workload and stress?



Members were also asked to respond to the statement *I feel supported by my employing organisation for the new "COVID normal world” to deliver health care safely*. (Figure 3)

Figure 3: Respondent agreement with the statement *I feel supported by my employing organisation for the new "COVID normal world" to deliver health care safely*.



Key points from Figure 3:

- 52% agreed or strongly agreed that they felt supported by their employing organisation to deliver health care safely as we proceed in the future.
- 23% had a neutral view.
- 25% of respondents did not feel supported by their employing organisation to deliver health care safely in a COVID normal world (i.e., strongly disagreed or disagreed with the statement)

There is scope to improve confidence in health system management. Where respondents added comments to their rating of employer support, two strong themes could be identified:

1) The perceived need for health service organisations to address:
    - Patient care services that have been delayed or where resources were diverted or facilities repurposed.
    - Insufficient staff support in a health system already burdened by HCW shortages, low staff morale, staff stress and exhaustion.

2) The perceived need for all governments to bolster the hospital and health care system to address:
    - Building inadequacies (e.g., improve ventilation, meet isolation room requirements).
    - Staff shortages.
    - Unpaid additional hours (such as for COVID-19 related administration).
    - The need to balance the recent use of telehealth with the demand for more comprehensive health care services (recognising that telehealth has not met all the needs during COVID-19).
    - Patient care demand, some of which will be due to postponed care and diagnosis and exacerbation of conditions.

Select comments

No planning, no indication of a strategy except a reactive response to minor issues right now.

I feel I have been asked to personally ameliorate a staffing crisis that could have been prevented by decisions suggested by senior clinical staff, that, if followed would have averted staffing shortages. Resources and facilities and support are inadequate for delivering safe, comprehensive non-COVID clinical care.

There have been no provisions made for how we are to function in a COVID normal world at all.

Health service wants to continue to be "revenue neutral", and also wants change (e.g., telehealth) while not assisting clinicians and clinician managers to change.

So many chronic illness patients denied health care service to manage COVID surge as priority.

5. Perceived stress on the health care system

Respondents reported significant concerns with stressors on the health care system due to COVID-19. Any or all of the four options could be checked and a free-text box was provided to add other concerns and comments.

Table 5 shows that respondents were concerned about all four stressors on the system:

- Staff burnout (87%)
- Reduced capacity to address non-COVID-19 related health service needs including hospital admissions (82%)
- Delays in health screenings and medical check-ups (81%)
- The increase in COVID-19 hospital admissions (76%).

Table 5: Respondent concerns about any of the following stressors on the health care system due to the COVID-19 (multiple options could be selected)

Question choices	**%**
Staff burnout	87%
Reduced capacity to address non-COVID-19 hospital admissions	82%
Delays in screening and routine medical check-ups potentially leading to exacerbations of other medical conditions	81%
Increase in COVID-19 hospital admissions	76%
Other	23%

"Other" concerns about the stressors on the health care system (23%) were as follows:

- The mental and physical stress on staff (17% of comments in this section).
  These factors also help to explain staff burnout. Contributing factors to mental and physical stress were reported as quick changing rosters, loss of morale, insufficient staff, fears for personal safety, working under conditions of fatigue, post-traumatic stress, demoralisation, the inability to take leave, organisational pressure to meet pre-COVID-19 key performance indicators, and for trainees, continuing to work with significant disruptions to training.

- Staff shortages (16% of comments in this section).
  Comments indicated that registrars have been deployed which left some areas short-staffed, staff have been furloughed, redeployed, or may be absent due to staff illness or infection, and health services are unable to recruit from other states.

- The need for improved health service organisation management responses (13%)
  Respondents raised the need for better communications and policies that have standard operating procedures (which should not be crisis driven), as well as managing resources in ways that assume COVID-19 cases will continue. The adequacy of physical facilities, such as the level of ventilation and levels of outpatient capacity, need to be reviewed and rectified.

- Drains on system capacity: current and anticipated (12%).
  Respondents described the impact of using PPE and other protective protocols (which decreases the capacity of the system to provide health care services), the reduced capacity

of intensive care units and emergency departments, the lack of hospital beds, reduced elective health service provision and an overuse of telehealth in hospitals (acknowledged as not allowing for complete care).

- The need to resource health care that is not COVID-19 related (9%).
  Respondents recognised that the COVID-19 response has diverted resources away from health services. In addition to delayed diagnoses, there have been limited rehabilitation and therapy health care services, especially for people with disability, and a reduced access to tertiary care services. There is a need for mental health care services, including for children. These needs must be planned for in view of an already strained system capacity.

- Stressors placed on private practice.
  Private practice is an integral part of the Australian health care system. Several respondents noted that there a lack of recognition of private practitioners who have been faced with financial stress placed on their practices because of COVID-19 and the Delta variant.

Select comments

There are no concrete policies in place which are to be considered standard operating procedures till the pandemic is cleared irrespective of break out of cases or not. This makes the hospital environment subjected to risks where a large number of staff will have to go out of work when there are cases.

So much non-Covid related illness is probably pent-up demand and I feel there will be a post Covid catchup that could also cause significant burnout.

This seems very reactive when we have seen the international response. I also think the health system should be preparing more vigorously for coming out of COVID.

No acknowledgement on the impact in the private system - who is supporting me and my colleagues who do not have a staff specialist income to fall back on?

6. Concerns relating to COVID-19 and work

Respondents, like many health care workers, are under duress. These results are for the question: *Are you seriously concerned about any of the following related to COVID-19 in relation to your work*?

Respondents' two most serious concerns relating to COVID-19 and work were fatigue (64%) and risk of infection and/or illness (62%) (reported in Figure 4). Moral distress (47%) and risk to mental health (46%) were also highly ranked. Of concern, 22% of respondents reported being worried about risk of death.

Private practitioners are also concerned about their livelihood (22% concerned about the financial viability of their practice out of the 20% sample).

Considering that respondents could choose several concerns, the compound effect of risks on any one individual could be high.

Figure 4: Personal concerns relating to COVID-19 and work

Among the comments made for "Other", many reiterated concerns about the stressors on the health care system due to COVID-19 as described in the previous section.

Select comments

Physician mental health is suffering and the lack of innovation and advocacy by hospitals will result in clinician error and ill health. This puts patients and colleagues at risk.

The cancelling of annual leave will lead to burn out and moral distress and needs to be worked through to ensure staff can take their allocated leave.

Potential for the entire facility to be shut down from a single exposure (in a small regional hospital with staffing difficulties at the best of times).

Taking COVID home and infecting vulnerable family members is the top concern.

Shortage of ICU beds/ not being able to get access to services to for all patients due to overload.

I am burnt out from not seeing my family, from not being able to enjoy my annual leave… people are dying every day from cancer, stroke, heart attacks, MVAs all day every day.

Effects on training with changes in staffing and rotations due to COVID.

One concern that I see is the erosion of the medical practitioner/physician as a credible source of information.

7. Access to PPE

Because of the June 2021 introduction of new guidelines by the Infection Control Expert Group on PPE for healthcare workers, the survey also explored physician access to appropriate P2/N95 respirators and eye protection. While most respondents reported they did have access (80%), inconsistent access is of concern, especially considering the previously reported fear of infection among many responders.

Table 6: Access to PPE in employing health service organisations

Access to appropriate P2/N95 respirators	**Yes**	**No**	**Sometimes**	
	80%	8%	12%	
Access to eye protection	**Yes**	**No**	**Not consistently**	**Don't know**
	80%	3%	11%	6%

Select Comments

Not all sizes are available at all times. Staff are too overworked to set things up properly - they bring their own mask size, do their job and move on. Staff who follow (doctors) who don't know where the PPE is stored - or don't have security access to it - are left with ill-fitting masks or none.

N95 masks had to be worn longer that surgical masks. We were nonstop told how expensive PPE was.

Lack of access to appropriate masks - I was fit tested to a particular mask then told these were too expensive and rarely provided.

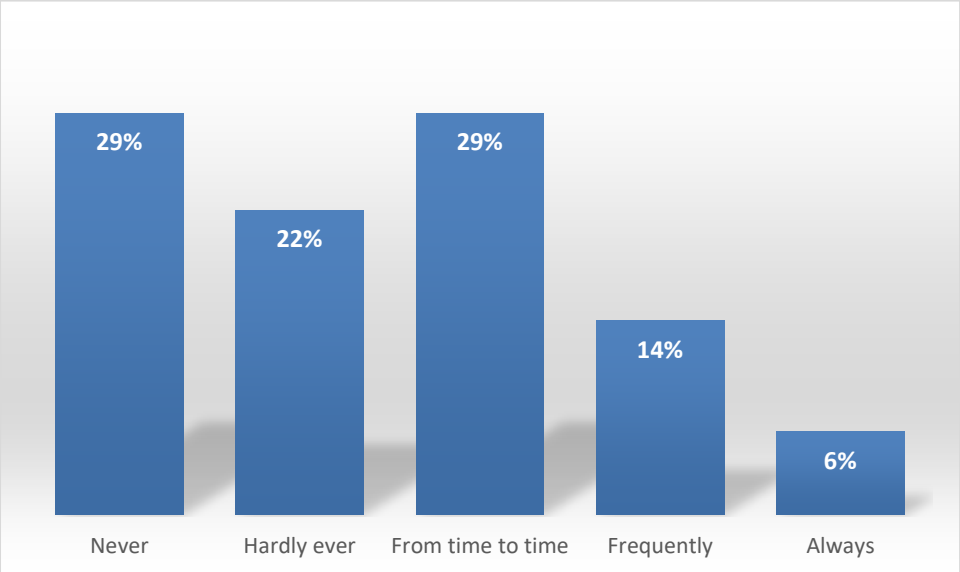
The eye protection provided is not fit for purpose as it falls off your face. The alternate brand that works but is a little more expensive is not provided.

We are asked to clean our eyewear and reuse it multiple days in a row, as such it is usually difficult to see through the face shields and they are often not worn for personal safety (e.g., tripping).

- **Private practitioners**

For private practitioners, the incidence of difficulties accessing supplies of PPE was higher, with 20% of respondents stating they always or frequently had difficulties compared to 8% of physicians employed in health services. 29% of private practitioners stated they had difficulties from time to time (which was again higher than those employed in health service organisations where 12% reported some difficulties). Only half of these respondents (51%) never or hardly ever experienced difficulties.

Figure 5: Private practitioner difficulties accessing supplies of appropriate PPE



For those private practitioners that reported difficulties accessing sufficient supplies of PPE, their highest need was for P2/N95 respirators (77%), but there was also significant need for surgical masks (40%) and protective eyewear (34%).