

# Prevalence of bullying, discrimination and sexual harassment among trainees and Fellows of the College of Intensive Care Medicine of Australia and New Zealand

The Board of the College of Intensive Care Medicine of Australia and New Zealand

The College of Intensive Care Medicine (CICM) of Australia and New Zealand is responsible for specialist training education and setting of standards in intensive care medicine in these countries. The CICM mandates the minimum standards for intensive care units seeking accreditation for training in intensive care medicine.<sup>1</sup> Trainee welfare is considered to be paramount and is specifically documented: "trainees will work and learn in an environment that is supportive and respectful and free of harassment, bullying and undue conflict."<sup>1</sup>

During the course of hospital inspections for accreditation for intensive care training, the CICM received reports of behaviour consistent with bullying and discrimination. These reports led to temporary suspension of accreditation or imposition of conditions on accreditation of some units, pending workplace reform. There were also ongoing anecdotal reports of bullying behaviour identified in the anonymous annual trainee feedback survey. Similar reports of unprofessional behaviour among surgeons emerged and made national news in early 2015.<sup>2</sup> These prompted calls for a Senate inquiry into such behaviour among the medical profession in general.<sup>3</sup>

Against this background, and because of a lack of information on bullying, discrimination and sexual harassment (BDSH) in intensive care practice in Australia and New Zealand, the CICM commissioned a survey of all its trainees and Fellows to identify the prevalence of BDSH.

Our aims were to:

- quantify the prevalence of BDSH behaviours in the intensive care environment
- identify demographic features associated with these behaviours
- determine whether people experiencing these behaviours are likely to report it
- explore specific demographic factors that place an individual at risk of experiencing these behaviours.

## Methods

Over a 4-week period between 8 February and 8 March 2016, we invited all Fellows and trainees registered with the CICM to participate in an online survey about their

## ABSTRACT

**Background:** Anecdotal reports about bullying behaviour in intensive care emerged during College of Intensive Care Medicine (CICM) hospital accreditation visits. Bullying, discrimination and sexual harassment (BDSH) in the medical profession, particularly in surgery, were widely reported in the media recently. This prompted the College to formally survey its Fellows and trainees to identify the prevalence of these behaviours in the intensive care workplace.

**Methods:** An online survey of all trainees ( $n = 951$ ) and Fellows ( $n = 970$ ) of the CICM.

**Results:** The survey response rate was 51% (Fellows, 60%; trainees, 41%). The overall prevalences of bullying, discrimination and sexual harassment were 32%, 12% and 3%, respectively. The proportions of Fellows and trainees who reported being bullied and discriminated against were similar across all age groups. Women reported a greater prevalence of sexual harassment (odds ratio [OR], 2.97 [95% CI, 1.35–6.51];  $P = 0.006$ ) and discrimination (OR, 2.10 [95% CI, 1.39–3.17];  $P = 0.0004$ ) than men. Respondents who obtained their primary medical qualification in Asia or Africa appeared to have been at increased risk of discrimination (OR, 1.88 [95% CI, 1.15–3.05];  $P = 0.03$ ). Respondents who obtained their degree in Australia, New Zealand or Hong Kong may have been at increased risk of being bullied. In all three domains of unprofessional behaviour, the perpetrators were predominantly consultants (70% overall), and the highest proportion of these was ICU consultants.

**Conclusions:** The occurrence of BDSH appears to be common in the intensive care environment in Australia and New Zealand.

Crit Care Resusc 2016; 18: 230-234

experience of BDSH in the preceding 12-month period, using the SurveyMonkey tool (see online Appendix at [cicm.org.au/Resources/Publications/Journal](http://cicm.org.au/Resources/Publications/Journal)). To obtain maximal participation, we notified all Fellows and trainees of the forthcoming survey in early January. After the survey was commissioned, weekly reminders were sent to all Fellows and trainees during the survey period.

## Definitions

We used the following definitions:

- bullying: the use of force, threat or coercion to abuse, intimidate or aggressively dominate others; systematic and/or continued unwanted and annoying actions of one party or a group, including threats and demands
- discrimination: unjust or prejudicial treatment, especially on the grounds of race, age or sex
- sexual harassment: involving the making of unwanted sexual advances or obscene remarks
- trainee: a doctor who is registered with the CICM training program to become an intensive care specialist
- Fellow: a doctor who has completed all the requirements of the training program with the CICM and is an intensive care specialist and a Fellow of the CICM (FCICM)
- new Fellow: a FCICM of < 3 years' experience
- younger Fellow: a FCICM with 3–10 years' experience
- experienced Fellow: a FCICM with > 10 years' experience.

## Statistical analysis

An independent statistician at the University of Queensland performed our statistical analysis using SAS, version 9.4 for Windows (SAS Institute). We performed a descriptive analysis of the demographic data of respondents and compared it with known variables from the target population. Responses to the questions on whether participants had experienced BDSH were broken down by CICM status, age, sex, region where they obtained their degree, and state or country of practice. We conducted logistic regression to estimate odds ratios, 95% confidence intervals and *P* values, and performed sensitivity analysis with two assumptions on data for non-respondents.

## Results

### Demographic data

We sent the link to the survey to all trainees ( $n = 951$ ) and Fellows ( $n = 970$ ) of the CICM. Of the 1921 Fellows and trainees surveyed, responses were received from 979 (51%).

A comparison of the demographics of respondents with the target population showed that more Fellows than trainees responded (60% v 41%), and a slightly lower proportion of men than women responded (49% v 54%). The distributions of the survey participants in age groups and regions of medical degree were similar to the target population.

The overall prevalences of having experienced bullying, discrimination and sexual harassment were 32%, 12% and 3%, respectively. In Table 1, we report the demographic profile of respondents who reported any of the three

behaviours. Experience of bullying appeared to be prevalent in similar proportions across all age groups, both sexes, all geographic regions and all categories of CICM status. The experience of sexual harassment was more prevalent among female respondents and younger trainees and Fellows. The experience of discrimination was reported by a higher proportion of women than men. Bullying and discrimination were more likely to be reported than sexual harassment. Level 3 ICUs were the most frequent location for all three types of behaviour. Consultants (from within and outside the ICU) were the most frequent perpetrators of all three behaviours.

### Multivariate analysis

The results of our logistic regression analysis are shown in Table 2. Because there were only two respondents in the > 70-years age group, we did not include these participants in the age analyses. We collapsed the state or country of practice into a smaller number of groups, due to small numbers in many of the original groups, and consolidated the region where the basic medical degree was obtained into three groups. We conducted additional analysis with just two groups (Australia, New Zealand and Hong Kong [ANZ–HK] v the other regions).

Women and younger age groups had higher odds ratios of having experienced sexual harassment. Respondents who obtained their degree in Asia or Africa appeared to have been at increased risk of discrimination, but respondents who obtained their degree from ANZ–HK may have been at increased risk of being bullied. Practising in other countries or some states or territories of Australia (Australian Capital Territory, Western Australia, South Australia, Tasmania and the Northern Territory) appeared to be associated with a lower risk of sexual harassment, although the number of reported events was very low. Additional analysis of collapsed regions of ANZ–HK v the other regions showed no evidence of a difference for bullying ( $P = 0.48$ ), discrimination ( $P = 0.11$ ) or sexual harassment ( $P = 0.36$ ).

### Sensitivity analysis including non-responders

We undertook a sensitivity analysis based on the assumption that people who had experienced occurrences of BDSH were more likely to respond to a survey about it. We based this analysis on two scenarios:

- scenario 1, assuming that proportions of people who had experienced BDSH were the same for respondents and non-respondents
- scenario 2, assuming that none of the non-respondents would have reported BDSH in the previous 12 months.

Table 3 shows the proportions reporting positive responses based on the two scenarios, as well as the actual survey results.

**Table 1. Demographic profile of respondents reporting any of the three behaviours**

Variable	Behaviour		
	Bullying, % (n = 969)	Sexual harassment, % (n = 924)	Discrimination, % (n = 921)
Participants reporting behaviour in previous 12 months	32%	3%	12%
Of participants reporting behaviour			
Experienced this behaviour on > 3 occasions	49%	21%	42%
Reported the behaviour	40%	13%	18%
Predominant location behaviour was experienced	(n = 263)*	(n = 26)*	(n = 101)*
Level 3 ICU	50%	42%	52%
Level 2 ICU	11%	19%	13%
Level 1 ICU	19%	15%	18%
Private	6%	4%	5%
Other	14%	20%	12%
Predominant perpetrator			
ICU consultant	44%	60%	57%
Other consultant	26%	16%	13%
ICU nurse	–	20%	–
Other	14%	–	22%
Age of participants reporting behaviour (years)	(n = 309)*	(n = 28)*	(n = 112)*
< 30	20%	11%	7%
30–39	31%	3%	13%
40–49	34%	2%	13%
50–59	36%	3%	12%
60–69	30%	2%	6%
Sex of participants reporting behaviour			
Women	35%	6%	19%
Men	31%	2%	10%
CICM status of participants reporting behaviour	(n = 311)*	(n = 28)*	(n = 112)*
Experienced Fellow (> 10 years)	36%	2%	9%
Young Fellow (3–10 years)	35%	2%	12%
New Fellow (0–3 years)	26%	6%	17%
Trainee (after first-part exam)	32%	3%	14%
Trainee (before first-part exam)	25%	4%	9%

ICU = intensive care unit. CICM = College of Intensive Care Medicine. \* Number of respondents (experiencing the behaviour) who answered that question.

## Discussion

### Key findings

Our cardinal findings are that experiences of BDSH were reported by both trainees and Fellows. Of these, bullying was the most prevalent, followed by discrimination and sexual harassment.

This represents the most comprehensive survey on BDSH behaviours occurring among intensive care doctors. Previous studies of bullying in the intensive care environment have focused mainly on nurses.<sup>4,5</sup> BDSH behaviours have been reported in all levels of the medical profession. Previous

surveys have identified bullying and harassment prevalences ranging from 30% to 89% among residents and junior medical officers.<sup>6</sup> A recent survey of specialist obstetricians and gynaecologists in the United Kingdom identified a 44% prevalence rate of bullying among the respondents.<sup>7</sup> The finding of a higher prevalence of sexual harassment among women is consistent with previous publications.<sup>2,8</sup>

The finding that most of these behaviours took place in Level 3 ICUs needs to be interpreted with caution. Most CICM trainees and Fellows work in Level 3 ICUs, and therefore response rates are likely to be skewed towards Level 3 ICUs. Of concern are the low reporting rates for

**Table 2. Multivariate analysis of survey results**

Factor	Behaviour		
	Bullying, odds ratio (95% CI)	Sexual harassment, odds ratio (95% CI)	Discrimination, odds ratio (95% CI)
CICM status			
Experienced Fellow (> 10 years)	1.77 (1.07–2.93)	0.29 (0.07–1.27)	1.26 (0.53–2.98)
Young Fellow (3–10 years)	1.77 (1.07–2.94)	0.39 (0.10–1.49)	1.74 (0.76–3.98)
New Fellow (0–3 years)	1.15 (0.63–2.09)	1.47 (0.45–4.78)	2.66 (1.10–6.42)
Trainee (after first-part exam)	1.49 (0.90–2.45)	0.61 (0.18–1.96)	2.19 (0.98–4.89)
Trainee (before first-part exam)	1.00 (reference)	1.00 (reference)	1.00 (reference)
<i>P</i>	0.096	0.10	0.08
Sex (women)	1.14 (0.84–1.53)	2.97 (1.35–6.51)	2.10 (1.39–3.17)
<i>P</i>	0.39	0.006	0.0004
Age group (years)			
60–69	0.97 (0.50–1.89)	0.66 (0.08–5.24)	0.46 (0.14–1.57)
50–59	1.22 (0.81–1.82)	0.67 (0.18–2.41)	0.95 (0.52–1.72)
40–49	1.12 (0.81–1.54)	0.51 (0.17–1.47)	0.93 (0.58–1.48)
30–39	1.00 (reference)	1.00 (reference)	1.00 (reference)
< 30	0.54 (0.25–1.15)	3.75 (1.3–11.19)	0.48 (0.14–1.61)
<i>P</i>	0.34	0.03	0.6
Region degree obtained			
Australia, New Zealand, Hong Kong	1.00 (reference)	1.00 (reference)	1.00 (reference)
European Union, United States	0.66 (0.46–0.95)	0.63 (0.23–1.74)	1.05 (0.60–1.84)
Asia, Africa	0.71 (0.49–1.01)	0.25 (0.05–1.09)	1.88 (1.15–3.05)
<i>P</i>	0.04	0.15	0.03
State or country of practice			
New South Wales	0.91 (0.60–1.38)	0.49 (0.19–1.26)	1.14 (0.63–2.04)
Other Australia	0.87 (0.56–1.37)	0.08 (0.01–0.66)	0.66 (0.33–1.34)
Other country	0.59 (0.37–0.96)	0.18 (0.04–0.85)	0.57 (0.27–1.21)
Queensland	0.89 (0.58–1.38)	0.32 (0.10–1.02)	1.08 (0.58–2.02)
Victoria	1.00 (reference)	1.00 (reference)	1.00 (reference)
<i>P</i>	0.27	0.03	0.21

CICM = College of Intensive Care Medicine.

**Table 3. Sensitivity analysis (taking survey non-responders into account)**

Experienced in previous 12 months	Scenario 1	Scenario 2	Survey
Bullying	32%	16%	32%
Sexual harassment	3%	1.5%	3%
Discrimination	12%	6%	12%

these behaviours identified in our survey. The reasons for not reporting were not explored in this survey, but previous surveys have identified some factors that affect reporting rates, including that such challenges in the workplace can adversely interfere with professional progress, as can the stigma associated with being seen as a “victim”.<sup>8</sup>

### Strengths and limitations

The strengths of our survey include a response rate (51%) that was comparable to or higher than that of other colleges undertaking similar surveys (the Royal Australasian College of Surgeons [RACS] [48%]<sup>2</sup> and the Royal College of Obstetricians and Gynaecologists, UK [28%]<sup>7</sup>). All the trainees and Fellows we surveyed were part of a registered database, which ensured that the entire cohort was contactable and had the opportunity to participate. Other strengths of our survey are that it was anonymous and had high content validity. A notable difference between our study and that of the RACS is that the RACS study comprised two surveys — a survey of the members of the College of Surgeons administered by an independent body, and a survey of employers and educators. The RACS did not

have access to the individual survey responses. There were also differences in the RACS definitions of BDSH compared with our definitions.

Limitations of our study include a limited overall response rate, which may have inflated our estimates of prevalence if non-responders were likely to be those who did not experience these behaviours. We attempted to account for non-responders in our sensitivity analysis, which suggested that the true prevalence lies somewhere between scenarios 1 and 2, and meant that bullying may have been experienced by between 16% and 32% of the College Fellows and trainees in the previous 12 months. Similarly, between 6% and 12% of the College Fellows and trainees may have been discriminated against, and between 1.5% and 3% may have been sexually harassed in the previous 12 months.

The lack of research-validated definitions for BDSH in the medical workplace is another potential limitation. Gathering data simultaneously from hospital human resources departments would likely have provided additional information on the prevalence and individual and hospital responses to such behaviours.

### Conclusion

BDSH are common in intensive care practice and training in Australasia. Such behaviour is inconsistent with CICM standards and is unacceptable.<sup>9</sup> The expectation of the College is that all Fellows and trainees will take action to eliminate such behaviour from both their own practice and that of their peers. The College will work with other professional bodies but is also committed to undertaking independent action to eliminate such behaviours from the intensive care workplace.

### Competing interests

None declared.

### Author details

Bala Venkatesh  
 Charlie Corke  
 Raymond Raper  
 Mary Pinder  
 Dianne Stephens  
 Gavin Joynt  
 Peter Morley  
 Rinaldo Bellomo  
 Rob Bevan  
 Ross Freebairn  
 Benoj Varghese  
 Michael Ashbolt

Felicity Hawker

Stephen Jacobe

Sarah Yong

The Board of the College of Intensive Care Medicine of Australia and New Zealand, Melbourne, VIC, Australia.

**Correspondence:** [bmvenkat@bigpond.net.au](mailto:bmvenkat@bigpond.net.au)

### References

- 1 College of Intensive Care Medicine of Australia and New Zealand. Minimum standards for intensive care units seeking accreditation for training in intensive care medicine [policy document]. Melbourne: CICM, 2015. [http://www.cicm.org.au/CICM\\_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-3-Minimum-Standards-for-Intensive-Care-Units-Seeking-Accreditation\\_2.pdf](http://www.cicm.org.au/CICM_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-3-Minimum-Standards-for-Intensive-Care-Units-Seeking-Accreditation_2.pdf) (accessed Oct 2015).
- 2 Crebbin W, Campbell G, Hillis DA, Watters DA. Prevalence of bullying, discrimination and sexual harassment in surgery in Australasia. *ANZ J Surg* 2015; 85: 905-9.
- 3 Parliament of Australia. Medical complaints process in Australia. Canberra: Parliament of Australia, 2016. [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Medical\\_Complaints](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Medical_Complaints) (accessed Oct 2015).
- 4 Ganz FD, Levy H, Khalaila R, et al. Bullying and its prevention among intensive care nurses. *J Nurs Scholarsh* 2015; 47: 505-11.
- 5 Fang L, Huang SH, Fang SH. Workplace bullying among nurses in South Taiwan. *J Clin Nurs* 2016; 25: 2450-6.
- 6 Leisy HB, Ahmad M. Altering workplace attitudes for resident education (A.W.A.R.E.): discovering solutions for medical resident bullying through literature review. *BMC Med Educ* 2016; 16: 127.
- 7 Shabazz T, Parry-Smith W, Oates S, et al. Consultants as victims of bullying and undermining: a survey of Royal College of Obstetricians and Gynaecologists consultant experiences. *BMJ Open* 2016; 6: e011462. doi: 10.1136/bmjopen-2016-011462.
- 8 Jagsi R, Griffith KA, Jones R, et al. Sexual harassment and discrimination experiences of academic medical faculty. *JAMA* 2016; 315: 2120-1.
- 9 College of Intensive Care Medicine of Australia and New Zealand. Prevention of bullying, discrimination and harassment in the workplace [policy document]. Melbourne: CICM, 2016. [https://www.cicm.org.au/CICM\\_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-20-Prevention-of-Bullying,-Discrimination-and-Harassment-in-the-Workplace.pdf](https://www.cicm.org.au/CICM_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-20-Prevention-of-Bullying,-Discrimination-and-Harassment-in-the-Workplace.pdf) (accessed Oct 2015). □