Australasian College for Emergency Medicine

Statement on Later Career FACEMs in Clinical Practice

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V1	Aug-2025	Approved by the Council of Advocacy, Practice and Partnerships

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1. Purpose and scope

This document is a statement of the Australasian College for Emergency Medicine (ACEM; the College) and relates to the changing expectations and needs of Later Career Emergency Physicians (LCEP) in clinical practice as they enter the later phase of their careers.

This document has been developed to support current and future LCEPs to reflect on their practice and to consider the multitude of career options that will enable them to have a sustainable career in emergency medicine (EM).

1.1 Disclaimer

ACEM recognises that each career journey is unique; therefore, the considerations presented in this document should be viewed as general guidance, ensuring that individual preferences and choices are protected.

This policy sits alongside all relevant national, state and territory regulatory, employment, industrial and discrimination legislation and should be interpreted in accordance with these (see Section 6). If College members require advice regarding these matters, they should contact their relevant medical association, medical indemnity organisation or their state or federal/national workplace ombudsman.

2. Definitions

ACEM/the College

The Australasian College for Emergency Medicine.

Emergency physician/FACEM

An emergency physician (EP) is a registered medical practitioner trained and qualified in the specialty of emergency medicine (EM). The recognised qualification of an emergency physician in Australia and Aotearoa New Zealand is the Fellowship of the Australasian College for Emergency Medicine (FACEM). Emergency physician is the preferred term to describe a registered medical practitioner trained and qualified in the specialty of EM. Other acceptable terms include staff specialist in EM, specialist in EM, specialist emergency physician and consultant in EM.

Later Career Emergency Physician

The age at which this transition begins is unique to each person, however the consensus among FACEMs is that an emergency physician over the age of 55 years who is still actively engaged in emergency medicine is classified as a Later Career Emergency Physician (LCEP).

Emergency medicine

Emergency medicine (EM) is a field of practice based on the knowledge and skills required for the prevention, diagnosis, and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.

Practice of medicine

The Australian Health Practitioner Regulation Agency (AHPRA) defines the practice of medicine as:

Any role in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services in the health profession.[1]

[1] Australian Health Practitioner Regulation Agency [internet]. Glossary. Melbourne Victoria: 2019.

The Medical Council of New Zealand defines the practice of medicine as:

Assessing, diagnosing, treating, reporting or giving advice in a medical capacity, using the knowledge, skills, attitudes and competence initially attained for the MB ChB degree (or equivalent). Prescribing medicines, the sale or supply of which is restricted by law to prescription by medical practitioners or designated prescribers. Signing any medical certificate required for statutory purposes, such as death and cremation certificates, holding out to the public, or representing in any manner that one is authorised to practise medicine in New Zealand.[2]

High acuity low occurrence medicine

Many EDs across Australia and Aotearoa New Zealand have developed models of care that allocate EPs to focus on one particular part of the spectrum of patient care for a particular shift. For the purpose of this statement, particular note is made of the high intensity, fast paced, complex resuscitation and emergent care (including decision making and procedures) that is required for higher acuity patients presenting to an ED. This type of clinical emergency medicine practice is increasingly being referred to in EM curricular as 'high acuity low occurrence' (HALO).

3. Introduction

A sustainable EM workforce allows emergency physicians to thrive – physically, professionally, and over the course of a lasting career. The demanding nature of high acuity low occurrence medicine in the emergency department (ED), characterised by a high cognitive load in a high intensity workplace, imposes unique challenges for emergency physicians as they age.

Sustaining the EM workforce requires structures that acknowledge the uniqueness of each physician's career and supports the individualised preferences of LCEPs. By fostering a culture of career flexibility and ensuring there are a range of career pathways, these systems can support far greater career longevity for current and future LCEPs and prevent the premature loss of valuable expertise from the healthcare system.

This document has four aims.

- To encourage emergency physicians to reflect on their practice and consider career pathways that align with their skills and interests and support longevity in EM.
- To remind emergency physicians of the physical and cognitive changes associated with ageing so they can plan and prepare for changes to work patterns and roles.
- To support Directors of Emergency Departments (DEMs) in workforce planning to accommodate changing work patterns and roles for LCEPs while ensuring equitable workload distribution.
- To highlight the strategic and organisational value of LCEPs by recognising their corporate knowledge, extended roles and ongoing contributions beyond the acute clinical environment of the ED.

4. ACEM position

ACEM affirms the importance of supporting LCEPs in identifying and pursuing fulfilling career pathways that align with their individual goals and practice needs. The College recognises the demands of EM practice and remains committed to supporting all emergency physicians to have sustainable careers.

ACEM considers LCEPs as invaluable with their corporate and clinical knowledge, their wealth of experience and the vital role they play as practitioners of high acuity low occurrence medicine, as well as the mentoring roles they assume and the irreplaceable expertise and wisdom they provide to ED teams and other settings where emergency care is provided.

ACEM recognises that LCEPs may wish to adapt their work patterns and roles to accommodate changing professional circumstances, thereby maximising their continued contributions to clinical care, medical education and research.

[2] Medical Council of New Zealand. Definition of the 'practice of medicine'. Wellington New Zealand: Medical Council of New Zealand; June 2018

ACEM is committed to actively promoting strategies and mechanisms to support the longevity of the LCEP's career – allowing them to continue to make multiple and varied contributions to their place of employment, the specialty of EM and the healthcare system in general.

5. Key themes and recommendations

This section is offered as general guidance. It outlines several key themes and provides a series of recommendations for LECPs, DEMs and workplaces.

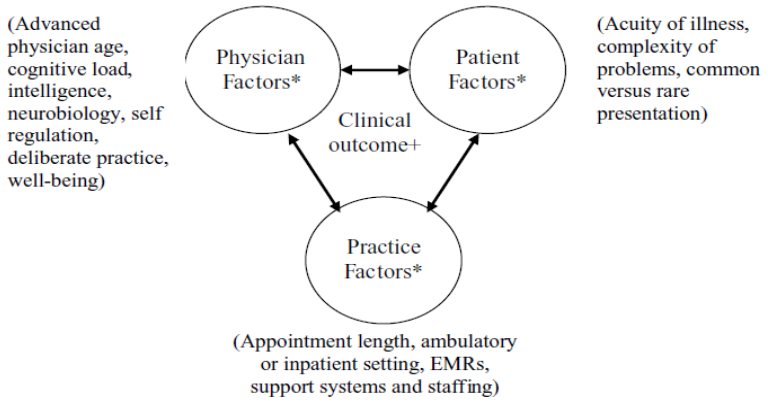
5.1 Implications of ageing for the clinician

Individuals experience age-related changes – some of which are listed below – in different ways and to varying extents. The intent of bringing these issues into focus is to encourage LCEPs to self-reflect and provides a framework that encourages adaptive strategies and the pursuit of ongoing professional fulfillment for all LCEPs as they enter and progress through this stage of their EM career.

As people age their physical and cognitive functions change.

- Physically, people need more light in order to see well, hearing may be impaired, and people may become fatigued more quickly.
- Crystallised cognitive function (wisdom/knowledge gained through experience) is likely to increase while fluid cognitive function (processing multiple bits of information to make real time decisions), which may be required in critical situations, is likely to decrease.
- Maintenance of fluid cognitive function is dependent in part on the amount of deliberate practice of this skill.

The performance of an individual clinician as they age will be dependent on the interplay between physician factors; patient factors; and situational factors; as illustrated in Figure 1 below.



Notes:
** = factors that interact as shown by arrows; par entheses next to each factor are examples. Situated cognition takes the approach of the individual and the environment and all of the above interactions can and do influence the outcome (patient care) in such a model.*
+ = clinical outcome is dependent upon these 3 factors, their interactions, and possibly other inputs.

Fig. 1 Interplay of factors on clinical outcomes [3]

Recommendations for FACEMs

a) Deliberate practice to maintain skills, especially on entering the sixth decade of life.

b) Tailoring CPD to the needs of the LCEP, including more opportunities to do simulations and address any skill gaps.

c) Using this statement as an opportunity to reflect on their practice and the spectrum of career options available as a LCEP.

[3] Durning S, Artino R, Holmboe E, Beckman T, van der Vleuten C, Schuwirth L. Aging and cognitive performance: Challenges for physicians practicing in the 21st century. Journal of Continuing Education in the Health Professions. 2010;30(3):153-160

5.2 Health and health maintenance

All emergency physicians will face health challenges (temporary or ongoing) during their career. They have a responsibility to consider how these may affect their work performance. Recognising the importance of safety for patients and clinicians, ACEM makes the following recommendations:

Recommendations for FACEMs

a) Be aware of the effects of ageing and reflect regularly on how this may affect them.

b) Manage fatigue and acute or chronic illness, recognising that recovery takes longer with age.

c) Disclose health issues to your DEM/manager so a management plan can be developed.

Recommendations for workplaces

a) Foster a culture that values, respects and supports EPs at all stages of their career and recognises that life circumstances may require changes to work patterns or roles.

b) Work with emergency physicians who have health issues to develop a joint management plan focused on safety for patients and the physician.

c) Encourage discussion on the impacts of changing life circumstances (including ageing) on work patterns/roles.

5.3 Rostering practices for later career emergency physicians

General principles

ACEM acknowledges that the LCEP work pattern and career path is unique to each individual. While there are universally applicable rostering principles, the transition will be most effective when led by the LCEP themselves and fully supported by the DEM and the workplace employer.

Departments should adopt rostering practices that prioritise the safety of patients, clinicians, and the team. Adjustments to standard rostering practices are most likely to achieve the desired outcomes when they are tailored to suit the individual and the department.

ACEM offers some age recommendations in rostering practices for LCEPs. These age recommendations may not be applicable or even desirable for all LCEPs. As a starting point, consider the following when rostering the LCEP:

a) Age 55. Discontinuation of late or evening shifts finishing later than midnight and of on call duties.

b) Age 57. Discontinuation of late or evening shifts.

c) Age 60. Discretion to choose clinical shifts that fit individual circumstances, including shift duration.

ACEM acknowledges that flexible rostering arrangements may result in some rostering challenges in smaller EDs due to small staffing numbers. The impact of flexible rostering arrangements can be mitigated through early planning and open discussion of career paths with DEMs and workplace employers in order for a long-term plan to be established.

Recommendations for FACEMs

a) Consider reducing hours

b) Actively manage later career planning through:

- An awareness of jurisdictional industrial agreements regarding transition to retirement.
- Familiarity with the local options for flexible work patterns.
- Regular discussions with the DEM/manager regarding current and evolving circumstances regarding ageing and the potential impacts on work practice and roles.
- Graduated adoption of changes over time.

c) Pursue opportunities throughout their career to develop skills that can add value to the organisation beyond clinical EM practice

Recommendations for workplaces

a) Encourage respectful conversations about potential changes to work practices or roles with ageing.

b) Be prepared to implement mutually beneficial rostering arrangements for LCEPs.

c) Increase the proportion of clinical support time.

d) Proactively consider how changes to work patterns could fit within broader operational needs of the organisation.

e) Review the rostering practices for LCEP engaged in active clinical emergency medicine with respect to:

- On call responsibilities
- Number of late or evening shifts
- Shift duration
- Shift finishing time
- Recovery time between shifts, particularly when moving from evening to day shifts
- Number of consecutive shifts
- Shift assignment to lower intensity clinical areas

f) Consider a tiered approach to on call arrangements when pre-fellowship senior trainees are available.

g) In regional and smaller urban district hospitals with less senior staff, consider sharing on call duties with critical care specialties.

h) Adhere to the provisions in national/jurisdictional employment law and embed the processes required to respond to requests for flexible work arrangements.

i) Provide opportunities for emergency physicians to develop and maintain extended skills, in addition to direct clinical EM practice.

j) Commit to retaining LCEPs by creating opportunities to contribute wisdom and expertise in achieving broader organisational objectives.

5.4 Transitioning

Supporting LCEPs in transition may involve adapting the structure and content of their work. Transition options can vary but must be appropriate to the experience and specific skillsets of the individual. Through this approach, the critical contributions of experience, corporate knowledge, local and external communication networks and relationships that are built over many decades may be retained by EDs and hospitals.

Recommendations for LCEPs

Possible roles can include, but are not restricted to, the following examples:

a) Modified or re-prioritised clinical work.

b) Teaching, including medical students, early career doctors, ACEM trainees (such as workplace-based assessments and on-the-floor observation and coaching).

c) Increased, or exclusive work in Short Stay Units/ Medical Observation Units and similar.

d) Increased, or exclusive work, in newer and evolving sub-specialty domains of EM.

e) Providing additional administrative support to the considerable burden of responsibilities of Departmental Directors and Leadership Groups.

f) Clinical support roles.

g) Increased participation in Quality Programs.

h) Electronic Medical Record and Information Technology related work.

i) Medico-legal related work.

j) Liaison roles.

Recommendations for workplaces

a) Provide opportunities for emergency physicians to develop and maintain extended skills, in addition to direct clinical EM practice.

b) Alternative practice roles and responsibilities such as administration, supervision, research and teaching should/could be increasingly viewed as viable options available to LCEPs who wish to seek a shift in clinical focus.

c) Reducing clinical hours, to be replaced by non-clinical portfolios, may not be viable for all LCEPs. ACEM advocates that support be provided to enable specialists over the age of 55 to continue working in clinical roles.

5.5 Preparing for later career and retirement planning

The decision to retire will have financial, health and social considerations which will be different for all. It is the responsibility the FACEM to discuss with the DEM/manager, how they manage clinically and what their plan is with regards retirement. Long-term planning should be incorporated into the annual performance review of all FACEMs.

Recommendations for FACEMs

a) Actively engage with career counselling and retirement planning, including financial planning, when approaching the later stages of careers.

b) Retirement planning should begin in early career as this makes the transition to later career easier.

Recommendations for workplaces

a) Negotiate with management for flexibility within the FACEM workforce, so as to accommodate later career FACEMs in ways that optimise the use of wisdom and experience.

b) Acknowledge the right of LCEPs to negotiate changed conditions appropriate to career stage.

6. Relevant legislation

Australian federal laws:

- Fair Work Act 2009 (Cth)
- Sex Discrimination Act 1984 (Cth)
- Disability Discrimination Act 1992 (Cth)

Australian state and territory laws:

- Discrimination Act 1991 (ACT)
- Anti-Discrimination Act 1977 (NSW)
- Anti-Discrimination Act 1992 (NT)
- Anti-Discrimination Act 1991 (Qld)
- Equal Opportunity Act 1984 (SA)
- Anti-Discrimination Act 1998 (TAS)
- Equal Opportunity Act 2010 (VIC)
- Equal Opportunity Act 1984 (WA)

Aotearoa New Zealand:

- Human Rights Act 2013
- New Zealand Bill of Rights Act 1990
- Employment Relations Act 2000

7. Other ACEM documents

- Regulation A
- Regulation B
- Regulation D
- Regulation G
- Regulation F
- Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services
- Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services – Toolkit

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