Australasian College for Emergency Medicine

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Future of the Emergency Medicine Workforce

Issues Paper

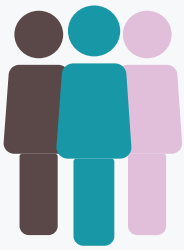
October 2020

Australasian College
for Emergency Medicine

Shape your future: ways to sustain the emergency medicine workforce

CONSULTATION – submissions close 16 December 2020

We are at a critical juncture. We need to ensure we are developing the emergency medicine workforce our communities require.



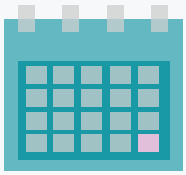
What are the problems we are trying to solve?

- Geographic maldistribution and impacts on health equity
- Extreme workloads, access block and inadequate staffing
- Meeting and balancing training and service provision needs

Where do we want to be?

We need to develop a plan that focuses on:

- equitable access to emergency care
- developing a sustainable FACEM workforce in which FACEMs are able to maximise their health, professional satisfaction and career longevity, and work in a safe healthcare system that enables them to deliver optimal care to patients
- a multidisciplinary workforce led by FACEMs
- training and educational support programs to ensure we maintain the highest possible standards across the workforce



What do you think the future looks like?

It is essential that ACEM members and trainees shape the future of emergency care and the emergency medicine workforce.

- Alternative accreditation models
- An increased middle-grade workforce
- More rural training pathways
- Other options?

Have your say

acem.org.au/workforce

Acronyms

ACEM (the College)	Australasian College for Emergency Medicine
CMO	Career Medical Officer
DEM	Director of Emergency Medicine
DEMT	Director of Emergency Medicine Training
EM	Emergency Medicine
EMC	Emergency Medicine Certificate
EMD	Emergency Medicine Diploma
EMAD	Emergency Medicine Advanced Diploma
FACEM	Fellow of the Australasian College for Emergency Medicine
FACRRM	Fellow of the Australian College of Rural and Remote Medicine.
FARGP	Fellowship in Advanced Rural General Practice (a Fellowship of the Royal Australian College of General Practitioners).
FRACGP	Fellow of the Royal Australian College of General Practitioners.
IMG	International Medical Graduate
SIMG	Specialist International Medical Graduate
VMO	Visiting Medical Officer
WPC (the Committee)	Workforce Planning Committee

Foreword

Thank you for taking the time to read this issues paper and thank you, in anticipation, for your valuable feedback. The paper we have put together for you is about our future, the future of our FACEM trainees (trainees) and the future of the care we all aim to give in Emergency Departments across Australia and Aotearoa New Zealand.

Our Emergency Medicine (EM) workforce is critical to improving emergency care delivered across Australia and New Zealand, and increasingly across the South Pacific and other parts of the world. The EM medical workforce is a complex web of FACEMs, trainees, Career Medical Officers, and ACEM Certificate/Diploma Graduates. In many parts of Australia and Aotearoa New Zealand we work alongside General Practitioners (GPs), Rural Generalists and other specialist physicians.

Across Australian Federal Government and State Health Departments, New Zealand Government and other health system leaders, we all realise that we are at a critical juncture and need to ensure we are developing the EM workforce our communities require. There needs to be a focus on the current maldistribution in regional and rural areas, a multidisciplinary workforce with FACEMs leading the way, and training and educational support programs to ensure we maintain the highest possible standards across the workforce.

Any solutions must confront the unique challenges that EM as a specialty faces – the interaction between the FACEM Training Program with jurisdictional workforce needs, in a resource-constrained health system. Whilst aspects of developing the solutions may be uncomfortable, the College recognises that it needs to take the lead and clearly define the distinction between the needs of trainees, the needs of the broader workforce and service provision, and develop solutions and models that can contribute to all.

We must also look to ACEM's Reconciliation Action Plan and Te Rautaki Manaaki Mana: Excellence in Emergency Care for Māori strategy to embed and support the College's existing work to support and grow the Māori and Aboriginal and Torres Strait Islander Peoples emergency physician workforce. Addressing the serious under-representation is essential to improving equity in health outcomes and making Emergency Departments culturally safe and competent environments for Māori and Aboriginal and Torres Strait Islander Peoples patients, family and staff.

This work will require vision, and importantly, conversation and collaboration with the membership and trainees, about what your Emergency Departments need to look like in the future. It will also see the College working with other specialist groups, particularly in regard to rural emergency care, and ways in which we can work together to ensure that all communities have access to the right care, at the right time, in the right place.

So, take your time. Think about your ED, but also take a system-level view of how EM workforce needs can be met across all communities and how ACEM and its members can lead this work. We need to ensure that we are forward thinking and can design solutions that health system leaders can implement, and which can successfully evolve over the next five to ten years. Solutions will be designed and implemented – it's up to us to make sure ACEM is a leading voice in that process.

Your input is vital to making this work.

Simon Judkins
Workforce Planning
Committee Chair

John Bonning
ACEM President

Introduction

The depth and breadth of the FACEM role is crucial to enhanced clinical decision-making and the delivery of safe, high-quality emergency care. A sustainable FACEM workforce is one in which FACEMs are also able to maximise their health, professional satisfaction and career longevity, working in a safe healthcare system, thereby delivering optimal care to patients across Australia and Aotearoa New Zealand. The benefits of a sustainable workforce also include retention of corporate knowledge, increased investment in hospital process development (the "safer system" both inside and outside the ED), reduced costs (through avoidance of repeated recruitment and reduced need for short-term/locum staffing), and most importantly, the establishment of a culture of clinical excellence and sound resource stewardship in both patient care, staff training and service operations.

The past two decades has seen significant growth in the emergency medicine specialist workforce and particularly in the number of FACEMs, such that the speciality now faces the serious issue of workforce oversupply in some areas, particularly in metropolitan regions. The drivers for this growth include an increasing supply of junior doctors wanting to undertake specialty training, uncapped specialty training capacity across Australia and Aotearoa New Zealand, and health system reliance on EM trainees to provide the bulk of the mid-level ED medical workforce. This has led to a 107% increase in the number of FACEMs between 2011 to 2019. (1)

However, there are simultaneously many EDs falling short of ACEM's staffing recommendations, ongoing reports from members and trainees of major shortfalls in staffing at their local hospitals, as well as significant concerns that the system cannot absorb the number of FACEMs coming through the specialist training pipeline.

The purported oversupply is exacerbated by a persistent maldistribution that impacts rural, regional and remote areas. Despite an ongoing trend of oversupply, the majority of FACEMs are still concentrated in metropolitan areas. Many rural, regional and remote EDs experience difficulty recruiting FACEMs and communities in these areas experience inequity in access to EM care. In short; we are facing a likely overall oversupply of FACEMs in total, yet a significant undersupply and maldistribution across many areas of Australia and Aotearoa New Zealand. While other specialists from General Practice in both Australia and New Zealand are working rurally providing emergency care, advanced emergency medicine expertise continues to remain less accessible in these areas. The College recognises the significance of these challenges to the specialty and to the community more broadly.

Across the health sector there is a wide range of work aimed at addressing workforce issues, including the development of the National Medical Workforce Strategy in Australia and the Health and Disability System Review in Aotearoa New Zealand. ACEM has had a significant role over recent decades in setting and advocating for workforce staffing standards across Australian and Aotearoa New Zealand EDs. The College also acknowledges, however, that the time has now come for ACEM to take a more direct and substantial role in determining what the future EM workforce will look like.

The ACEM Board approved the establishment of the Workforce Planning Committee (WPC; the Committee) at its August 2018 meeting.[1] The Committee reports directly to the ACEM Board and is chaired by Immediate-Past-President Dr Simon Judkins. It is the Committee's role to oversee the College's existing workforce-related policies and develop and deliver long-term solutions to address these significant issues.

Simon Judkins	Sally McCarthy	Suzanne Smallbane
John Bonning	Lynda Vine	Niall Small
Kimberly Humphrey	Didier Palmer	Gabriel Lau
Julia Peters	John Zorbas	Michael Gorton AM

Table 1 *Members of the Workforce Planning Committee*

[1] In 2017, the Trainee Selection and Workforce Planning Reference Group was established to advise the Board on policy matters relating to FACEM trainee selection and workforce planning. This group has now been revised to primarily focus on workforce planning matters.

Definitions

For the purposes of this paper, the following definitions will be used.

Emergency Medicine Certificate, Emergency Medicine Diploma, Emergency Medicine Advanced Diploma

ACEM's Emergency Medicine Certificate, Diploma and Advanced Diploma programs are qualifications providing doctors working in emergency departments or other emergency care settings, with adequate knowledge and sufficient clinical experience to be safe, efficient practitioners. These qualifications are aimed at non-FACEM doctors (e.g. Career Medical Officers, Junior Medical Officers) and those practising other specialties (e.g. FACRRM, FRACGP, Visiting Medical Officers).

Career Medical Officer

A Career Medical Officer (CMO) is a medical practitioner with general medical registration (in both Australia and Aotearoa New Zealand), whose principal focus is the provision of clinical care (either in hospital or community settings), and who (i) is beyond the traditional medical internship years AND (ii) is not and/or does not intend to be in a specialist training position/working towards Fellowship of a specialist medical college. Career Medical Officers are also known as Non-Vocational Doctors, Senior Medical Officers (SMOs), Hospital Medical Officers (HMOs) and/or Medical Officers, Special Scale (Aotearoa New Zealand). (2)

Emergency care

Provided at and by a wide range of facilities and providers from remote nurse run clinics, general practices, ambulance services, retrieval services, through to Emergency Departments. (3)

Emergency Department

A dedicated hospital-based facility specifically designed and staffed to provide 24-hour emergency care. An Emergency Department cannot operate in isolation and must be part of an integrated health delivery system within a hospital both operationally and structurally. The minimum standards for the four levels of emergency department are defined in ACEM S12 Statement on the Delineation of Emergency Departments. (4)

Middle-grade doctor

This term represents a group of doctors possessing a range of skill levels from that of a junior doctor having just completed pre-vocational training, to a senior registrar/pre-specialist. The more experienced middle-grade doctor may have the skills equivalent of a non-FACEM senior decision maker, and be able to provide oversight of a department during clinical shifts, with remote specialist supervision.

Non-FACEM senior decision maker

A physician who has the appropriate clinical care skills to manage a critically ill patient unsupervised – or - until a FACEM becomes available and can assist. This can encompass training (i.e. ACEM trainees), as well as non-training roles (e.g. Career Medical Officer). (5)

Rural Generalist

A rural General Practitioner, with additional skill sets in other medical specialist care in hospital and community settings, that are informed by the needs of the community they serve e.g. emergency medicine, obstetrics and gynaecology, anaesthetics. These skills can encompass both advanced procedural and non-procedural skills. (6)

Trainee

In the context of this paper (unless otherwise specified), will specifically refer to doctors undergoing medical training for Fellowship of ACEM (or trainees of the FACEM Training Program).

Scope

Although emergency medicine care is provided by a range of health and medical practitioners, this paper focuses on the emergency medicine workforce, made up of medical practitioners including:

- FACEMs/Specialist emergency physicians;
- FACEM trainees;
- ACEM EMC and ACEM EMD graduates;
- ACEM EMC and EMD trainees (and future EMAD trainees and graduates);
- Other specialist physicians, such as Fellows of the Royal Australian College of General Practitioners (FRACGP), Fellows of the Australian College of Rural and Remote Medicine (ACRRM) and Fellows of the Royal New Zealand College of General Practitioners (Division of Rural Hospital Medicine), working in rural and regional areas; and
- CMOs working in hospital emergency departments and other emergency care settings.

The scope of this paper is to:

1. summarise what we know about the workforce challenges and their underlying drivers; and
2. provide a series of suggestions for the College to address these challenges, as part of the development of the future EM workforce.

As part of this process, the paper will discuss both the FACEM and FACEM trainee workforce as well as the broader EM workforce outlined above. This will be specified throughout the paper.

The College acknowledges that, as with other medical specialties, EM grapples with many wide-ranging and complex issues that impact its workforce. Whilst this paper focuses on a balance of skills and geographic location, this intersects with a broad range of work already underway across the College.

- Wellbeing for emergency physicians across all stages of their career
- Health system advocacy, in particular around access block, including the development of revised access measures and time-based targets
- Mental health, including the development of a Mental Health strategy and Action Plans for Australia and Aotearoa New Zealand
- Equity for Māori and Aboriginal and Torres Strait Islanders peoples in EM, including Cultural Competence training, ACEM's Reconciliation Action Plan, Te Rautaki Manaaki Mana – the College's strategy for increasing equity for Māori, and the establishment of the Indigenous Health Committee
- Gender equity, including the establishment of the Advancing Women in Emergency Medicine Section and the development of a College statement on gender equity
- Equity in access to emergency care for rural, regional and remote areas, including the development of ACEM's Rural Health Action Plan

ACEM recognises that emergency departments are comprised of a range of health practitioners, including nursing staff, allied health practitioners, advanced scope emergency nurse practitioners and other hospital and administrative staff. As part of this project, ACEM is intending to undertake further work over the coming year on emergency department models of care with consideration to the broader emergency department workforce, and will seek feedback from members and trainees on these matters in future consultations.

The Impact of the COVID-19 Pandemic

The WPC recognises the impact that the COVID-19 pandemic has had on the broader health workforce, and indeed most notably on the ED workforce. This includes the immediate impacts:

- on the heath and well-being of the ED workforce, as frontline health care workers who are seeing patients everyday;
- on the health and well-being of the ED workforce, due to large numbers being furloughed due to either contracting COVID-19, suspected COVID-19 infection and/or being a close contact of an individual who has contracted COVID-19;
- on trainee progression through the FACEM Training Program, due to the impact of COVID-19 on the ability of Primary and Fellowship examinations to be undertaken; and
- of a decrease in overseas trained junior medical staff due to international travel restrictions, who were scheduled to commence work in emergency departments from August 2020.

As members and trainees will be aware, the impacts of COVID-19 on the community, the healthcare workforce and emergency departments continue to evolve, often on a daily basis and differently across each jurisdiction.

The WPC considers that while the impacts of COVID-19 continue to be felt, including the emergence of a 'new normal', the broader issues outlined in this paper remain. The impetus for the EM workforce to evolve and for ACEM to be the driver of this change also remain. COVID-19 developments and their subsequent impacts will continue to be monitored and managed by the College, as they have been throughout 2020. Any COVID-19 related information and/or impacts will also be incorporated into subsequet workforce reform strategies developed by the College.

How does this fit in with the recent review of the FACEM Curriculum and FACEM Training Program?

In commencing this important strategic work, the College recognises that, if supported, implementation of any of the solution options outlined (or indeed other options developed), will represent a significant undertaking for the College, and will take considerable time to work through.

This work is not to be confused with recent changes to the College's FACEM Curriculum and FACEM Training Program and associated Accredited Site Classification and Delineation System. These curriculum and training program changes were approved by the ACEM Board at its August 2020 meeting, and will be implemented and become operational from the 2022 clinical training year.

Consultation

It is essential that our members, including FACEMs, Certificate/Diploma Graduates and trainees continue to shape the development of solutions to workforce issues. The purpose of this consultation paper is to provide a starting point for members to engage and provide feedback. It also describes a direction the College could take to address these challenges.

We want to understand:

- Do the challenges and underlying drivers as outlined resonate with your experience? What does the reality of these workforce challenges look like in your ED, hospital or jurisdiction?
- How do you think ACEM should be addressing these issues? Are we moving in the right direction?

Consultation survey

The consultation paper is split into two parts.

What are the issues: outlines the issues impacting the emergency medicine workforce and their causes.

What are our options: outlines what ACEM could do to address the issues/potential solutions.

Through the WPC, the ACEM Board is now seeking feedback from the membership. Your feedback is sought across a range of themes.

To provide feedback, please complete the online survey here.

The consultation closes 16 December 2020 at 5pm AWST.

Next steps

The Committee will review all submissions received in response to the consultation paper. Based on member feedback, it is intended that the Committee will develop a second paper outlining an updated series of proposed options for progression. The proposed options paper will then be provided to the membership for a second round of consultation, and at this point, feedback will also be sought from external stakeholders, including jurisdictional health departments and local health services as well as other medical specialist colleges.

For any further queries or further discussion in relation to this consultation paper, please contact Fatima Mehmedbegovic (workforce@acem.org.au).

1. What are the issues?

The emergency medicine workforce needs to be geographically distributed according to the needs of the entire population and also be comprised of a range of medical practitioners that can provide emergency care to ensure that:

- there are enough FACEMs and non-FACEM senior decision makers in relation to current service needs, to enable quality care for patients . All patients should have senior medical input into their diagnostic and management plan; FACEM involvement is optimal; (5)
- there are enough FACEMs and non-FACEM senior decision makers in relation to current service needs, to make the workforce sustainable. The pressure currently placed on some emergency physicians due to insufficient numbers to provide clinical supervision and support on the "shop floor", is detrimental to the health, wellbeing and longevity of emergency physicians and contributes to the increasing interest of emergency physicians in reducing hours to work part-time or moving to alternative non-frontline clinical roles including academic or research roles;
- there are the right number and combination of FACEMs, FACEM trainees, non-FACEM specialists and other medical practitioners in relation to future service needs across the entirety of both of our countries. Specifically in relation to the FACEM workforce, we want to ensure there are enough physicians to meet service needs, but not so many that there is an oversupply. An oversupply reduces FACEM employment prospects and can lead to sometimes unsatisfactory part-time or piecemeal careers. This has a flow-on effect that reduces the attractiveness of the profession; and
- there is the right balance of trainees and FACEMs to enable a quality training experience to be delivered.

Our current workforce does not achieve this balance.

1.1 The growth of the emergency medicine speciality and demand for care

Demand for EM services continues to grow. The Australian Institute of Health and Welfare estimates that in 2018-2019, there were more than 8.4 million presentations to Australian public hospital EDs. This is a rise in presentations of 4.2% from 2017-2018. (7) Between 2014-15 and 2018-19, the number of presentations to public hospital EDs increased by 3.2% on average each year, which is greater than the average growth in population over the same period. In this time period, presentations per 1,000 population increased by 2.5% on average per year. (7, 8) Similar growth has been experienced in Aotearoa New Zealand, where there were 2.8 per cent more presentations in 2017-18 than in 2016-17, and between 2010-11 and 2014-15 there was a 10% increase in ED events. (9, 10) There has also been a significant increase over the last decade in the proportion of patients presenting to EDs with complex health needs, including older people, those experiencing mental health distress and/or indviduals with chronic health conditions. (11, 12)

Analysis suggests demand will continue to grow due to changing demographics, changes to health policy, increasing economic hardship in the pandemic era, the rising cost of private health insurance and the suitability of health infrastructure. To date, strategies to reduce ED presentations have had minimal or no impact on ED workload. In attempts to ease ED demand, governments have funded various initiatives including after-hours primary care clinics which are co-located or located near EDs, telephone triage/after-hours helplines and nurse walk-in clinics. Whilst popular with the general public, research suggests these initiatives have no impact on access block as low-acuity primary care-type patients attracted to these services are not a significant proportion of the workload for most EDs and are unlikely to require admission. (13)

Alongside the growth in demand for emergency care, there has been significant growth in the size of the EM speciality (Figure 1, Figure 2 (overpage)). Between 2011 and 2019 there was a 107% increase in the total number of FACEMs, a 126% increase in the number of new FACEMs each year, and the number of FACEM trainees increased by 17.1%. In 2019 there were 2921 active FACEMs (including 217 new FACEMs), 1800 advanced trainees and 510 provisional trainees. (1)

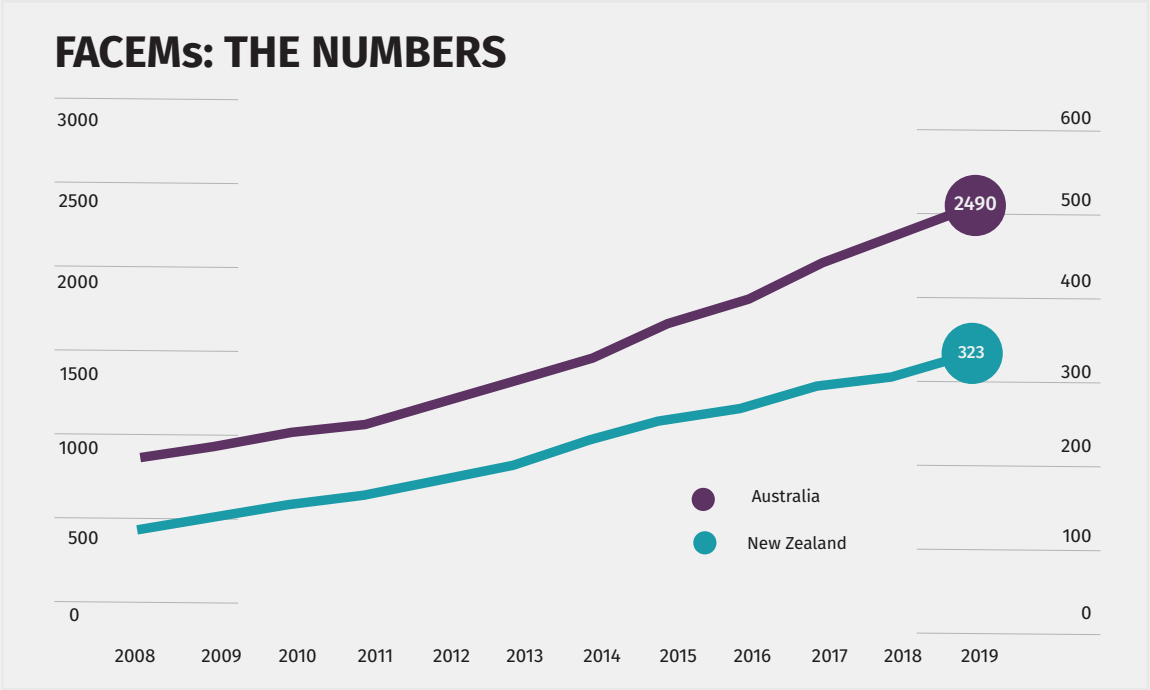


Figure 1 *Annual number of FACEMs in Australia and Aotearoa New Zealand, 2008 to 2019*

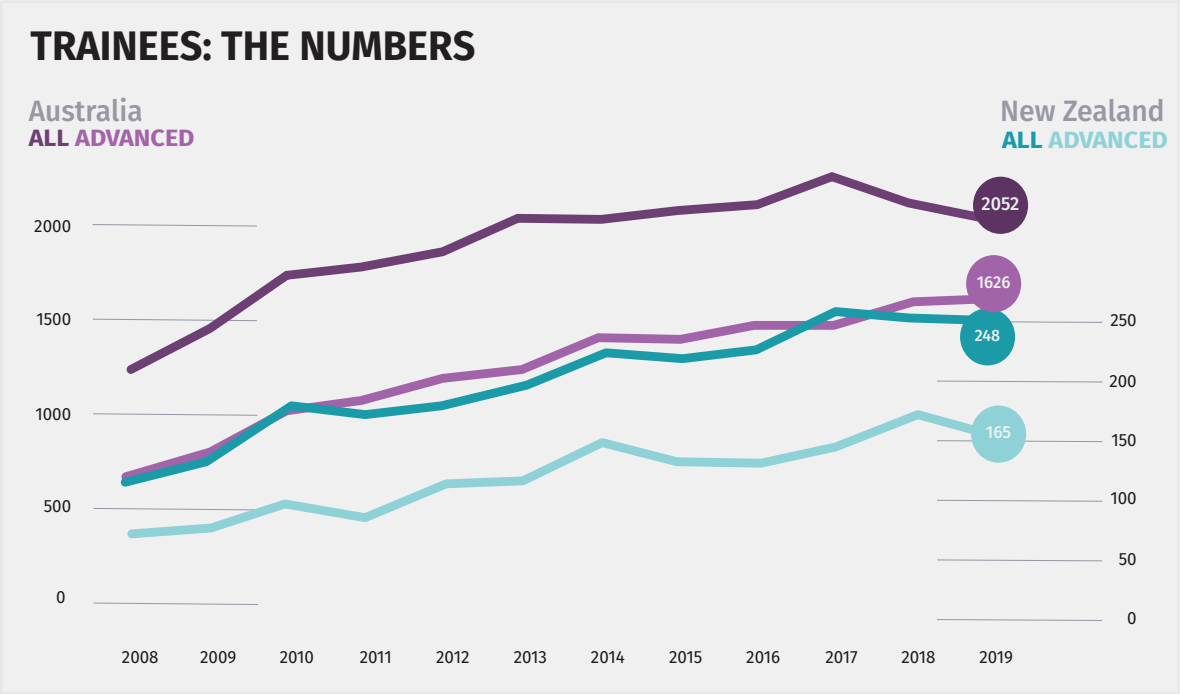


Figure 2 *Numbers of FACEM trainees versus Advanced FACEM trainees in Australia and Aotearoa New Zealand*

In 2017, the Australia Department of Health published projected requirements for EM care across several scenarios. All future scenarios predicted a substantial oversupply of EM specialists by 2030, with oversupply ranging between 1221 headcount up to 2328 headcount. (14)

The consistent outcome for all the scenarios presented by the Department is that the EM workforce will be in oversupply by 2030. However, ACEM remains cautious in relation to the demand projections, which are dependent on several questionable assumptions, such as a core assumption that the current supply of EM specialists is 'in balance'. (14) Furthermore, as noted above, it is also possible that the growth in ED demand may exceed rates seen in the last 12 years, particularly during and following the COVID-19 pandemic.

The provision of EM services 24 hours a day has become so reliant on a high number of trainees that **ED service provision has now become interchangeable with FACEM training**

1.2 Drivers of FACEM growth

Several interrelated factors have contributed to the growth in the size of the emergency medicine specialty over the past three decades.

- Interchangeable service provision and training
- Deregulated entry into the FACEM Training Program
- Predicted doctor shortages and policy changes

1.2.1 Interchangeable service provision and training

The College was established in 1981. After many decades of work and advocacy, emergency medicine was formally recognised as a medical specialty in 1993 in Australia and Aotearoa New Zealand.

In the early years of the specialty there were limited numbers of FACEMs and trainees and an obvious need to ensure a growing stream of trainees that would continue to increase the EM workforce. Over time, this has resulted in a significant reliance on FACEM trainees (the registrar workforce) to meet ED service needs (direct provision of patient care). The provision of EM services 24 hours a day has become so reliant on a high number of trainees that ED service provision has now become interchangeable with FACEM training.

Emergency departments are finding it increasingly difficult to meet staffing needs in the face of growing demand for services and changing patient cohorts and expectations. Employing trainees remains one of the main option for staffing EDs, particularly with regards to covering out-of-hours services and night shift rosters. However, this does not necessarily translate to employment opportunities for trainees once Fellowship has been achieved, with a growing proportion of new FACEMs struggling to secure full-time and/or part-time permanent employment. (15)

In a 2018 survey of trainees regarding their most recent training placement, the majority of trainees reported that their training needs were being met. However, a small group of trainees reported experiencing difficulties within their training placement, citing inadequate protected teaching time, insufficient case mix (acuity and breadth) for optimum learning, understaffing and high workload as key issues. Some trainees reported that due to understaffing and high workload, service provision would take priority over training needs. (16) With ever increasing ED demand, and a continued reliance on trainees as the middle-grade workforce, this experience could become the norm and significantly impact the delivery of the FACEM Training Program.

The College's current accreditation system, whilst ensuring that acceptable training and education standards are met, can facilitate hospitals and health services to increasingly utilise trainees for workforce needs. Individual hospital EDs (or, in some cases, networks) are accredited for a maximum period of 'training time', with trainee case-mix exposure and the extent of direct FACEM clinical supervision being critical determining factors. For example, a site must meet minimum requirements for the percentage of a trainee's clinical time spent under direct FACEM supervision, as well as minimum requirements for FACEM clinical coverage (such as direct FACEM clinical supervision for a certain amount of hours per day and per week).

In practice, this means that the number of trainees that can be trained at a site will be dependent on the number of FACEMs and their shift coverage. However, other than these practical limitations, there is no prescribed maximum number of trainees per site, and there is no prescribed maximum number or ratio of trainees per FACEMs at a site, although the Accreditation Guidelines do however provide a suggested ratio. The number of trainees an accredited site employs, is therefore at the discretion of each individual site, provided supervision requirements can be met.

1.2.2 Deregulated entry into the training program

Until recently, entry into the FACEM Training Program was deregulated. At this time the College enrolled about 300 applicants into the program each year, at almost any time throughout the calendar year. In 2018, with almost 2000 trainees enrolled in the program (and at various stages of completion), it was decided that this approach was no longer sustainable, nor in the best interests of those involved in the training process. Therefore the College introduced the Selection into Fellowship Training (SIFT) process to identify and select appropriate candidates for the training program from those junior doctors wishing to commence FACEM training.

The guiding principle of SIFT is to select those applicants who are likely to succeed in emergency medicine as trainees and, ultimately, as FACEMs, rather than any attempt to restrict the number of trainees. The year 2018 was considered appropriate to introduce SIFT for several reasons – the evolution of emergency medicine as a specialty; a clear description of the characteristics of an emergency medicine specialist; an improved public appreciation of where the specialty fits within national health systems; and ongoing implications of producing a sustainable and flourishing workforce (17). To date, SIFT has had little to no effect on the number of annual successful applicants to the FACEM Training Program.

1.2.3 Predicted doctor shortage and policy changes

Concern in the 1990s that the overall medical workforce was oversupplied resulted in a number of policy decisions aimed at reducing both the number of local medical students, and the recruitment of International Medical Graduates (IMGs). However, by the early 2000s, concerns about a subsequent undersupply of the medical workforce led to major policy changes, resulting in an increase in the number of medical schools as well as the recruitment of international doctors in both Australia and Aotearoa New Zealand.

In 2018, there were 17,052 medical students (domestic and international) in Australia. This was an increase of 11% since 2010, at an average of 3,734 new students each year. Similarly, in Aotearoa New Zealand there was a 33% increase in the number of medical students during the same time period, at an average of 541 new students per year. (18) At the same time, a range of regulatory strategies were introduced, aimed at actively recruiting, retaining and supporting IMGs and SIMGs, with a focus on workforce distribution in rural and remote regions. (19)

International Medical Graduates and SIMGs currently form a considerable proportion of the broader EM workforce, and both Australia and Aotearoa New Zealand continue to be heavily reliant on international doctors. Between 2011 to 2019, an average of 46% of new FACEMs elected were IMGs, and 13% of new FACEMS were elected via the SIMG pathway. (1)

Within both countries, there also remains a high demand for IMG recruitment into EDs, at the pre-vocational level. This has become more evident during the COVID-19 pandemic, with both health services and ACEM members expressing significant concerns regarding current international travel restrictions, and their potential substantial impact on the broader EM workforce.

1.3 Workplace culture and sustainability

The sustainability of the workforce is affected by emergency physician burnout, workplace culture and system issues as well as employment status issues. More FACEMs are reducing hours of clinical practice in favor of part-time work or moving out of direct clinical work in the ED into other clinical areas (e.g retrieval, ambulatory care), or areas not involved in direct clinical care such as academic roles, research and health service management. This is partly driven by FACEMs' experiences of ED overcrowding and access block, which FACEMs have ranked as two of the top three workplace stressors and cause of moral injury to FACEMs. (20) Sixty-one percent of FACEMs and 70% of trainees that responded to ACEM's 2019 Sustainable Workforce Survey reported that they are likely to reduce their hours of clinical practice in the next 10 years. Twenty-seven percent of FACEMs and 15% of trainees reported they are likely to leave clinical practice in the next ten years.

1.3.1 Workload

Issues of stress and burnout for the EM workforce must be understood within the context of the highly demanding nature of the ED workload. The three main characteristics that influence ED workload pressure are high volume (which is continuing to increase), complexity and variability. (21)

Emergency physicians are required to make significant decisions, often with a paucity of information, while multi-tasking. Research suggests that FACEMs perform approximately 100 discrete tasks per hour, including non-clinical tasks related to communication, direct clinical care and computer use. (22)

Furthermore, whilst operating as the hospital's front door 24/7, EDs experience significant variability in workload. Whilst there are some recognised presentation patterns, unplanned-for high demand still occurs. Whilst there are some patterns to presentations, the high demand and unpredictable nature of the ED workload presents a challenge to workforce planners, as there is little interest in supporting the stand-by capacity inherent in funding capacity for peak demand. A large portion of the EDs' workload occurs outside of regular business hours (8am to 5pm, Monday to Friday) and other hospital services often still concentrate in these weekday hours. In Australia in 2018-19, on average 41.4% of presentations to EDs Monday to Friday were outside the hours of 8am and 6pm, and 29.2% of total presentations were on a Saturday or Sunday. (7)

The sustainability of the workforce is affected by emergency physician burnout, workplace culture and system issues, as well as employment status issues

1.3.2 Access block

Sitting at the interface of community and hospital care, EDs play a key role in the provision of expert medical care for undifferentiated patients with unexpected/unplanned illnesses or injuries. However, when there are delays in access to either community-based or inpatient services, this undermines the ability of EDs to ensure timely care and compromises the capacity of EDs to work effectively. These pressures are most visible in EDs experiencing overcrowding, ambulance ramping and poor patient flow throughout the hospital, resulting in access block.[2] Access block and ambulance ramping result in a measurable increase in morbidity and mortality of patients, both directly and indirectly in an ED that is experiencing access block.

Emergency departments across Australia and Aotearoa New Zealand remain overcrowded and access blocked, and access block continues to be one of the major stressors affecting the EM workforce. (20) ACEM's access block research showed that between 2018 to 2019 there had been a 12% increase in access block across Australian hospitals. Whilst in Aotearoa New Zealand, 13% of admitted ED patients experienced access block. The data also showed that across Australia, 12% of all access blocked ED patients had experienced waits of more than 24 hours. The levels of overall ED daily demand reported were also the highest levels reported since 2016, and a 10% increase from 2018. The overcrowding associated with these access blocked inpatients was also seen to impact service provision, as evidenced from the high rates of patients who did not wait to be seen. (23)

1.3.3 Inadequate staffing

Despite the significant number of trainees entering and completing the FACEM Training Program over the past 20 years, and Australian Government projections of over-supply, ACEM members still report inadequate ED staffing across Australia and Aotearoa New Zealand.

A 2019 survey found that Directors of Emergency Medicine who felt their ED staffing was inadequate reported a number of workforce gaps, including inadequate staff to cover nights, weekends and leave. Directors also reported that more staff were needed to meet ACEM's G23 Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce (G23 Guidelines). In 2019, only 7.1% of Aotearoa New Zealand and 27.4% of Australian EDs met the minimum FACEM staffing recommended in the G23 Guidelines. No EDs in the Australian Capital Territory and the Northern Territory met the G23 Guidelines. Only three regional hospitals in Australia were meeting G23 recommendations, whilst no medium regional hospital in Australia and no regional hospitals in Aotearoa New Zealand were meeting the minimum FACEM requirements. (24)

Inadequate staffing particularly impacts emergency physician wellbeing through high levels of burn out, professional isolation and moral injury. (22) The pressures of inadequate staffing can be seen in the 2019 ACEM Sustainable Workforce Survey. (20)

[2] Whereby a patient waiting for admission to the hospital experiences a wait in the ED of more than eight hours from arrival.

Of the members that responded to the Sustainable Workforce Survey:

- 50% reported moderate to severe work-related burnout, including 57% of trainees and 48% of FACEMs. Women (55%) were more likely to experience moderate to severe levels of work-related burnout than men (46%);
- 81% reported that fatigue had impacted their performance;
- 37% disagreed that the balance between their personal and professional commitments was about right, and 65% agreed that the demands of their work interfere/interfered with their home and family life;
- of those who reported working rostered night shifts in the past 12 months, 37% reported never having the recommended rostered time off following night shift;
- 58% of all respondents never or occasionally took a meal break at work;
- 67% have worked more than 12 consecutive hours at their most recent primary workplace; and
- in the past 12 months, only 65% of respondents reported taking more than three weeks of annual leave, with FACEMs more likely to have taken more than three weeks of annual leave (69%) than trainees (52%).

1.3.4 Employment status/type

In addition to the widespread inadequate staffing of EDs, the existing workforce is not being utilised in an optimum way. Many FACEMs report they often work in multiple part-time roles, under zero-hour and/or casual contracts and/or temporary contracts. In 2019, 32% of FACEMs worked in two workplaces and 13% worked in three or more workplaces. (1) Twenty-eight percent of FACEMs worked less than full-time hours , with females more likely to work the equivalent of part-time hours than males. (1)

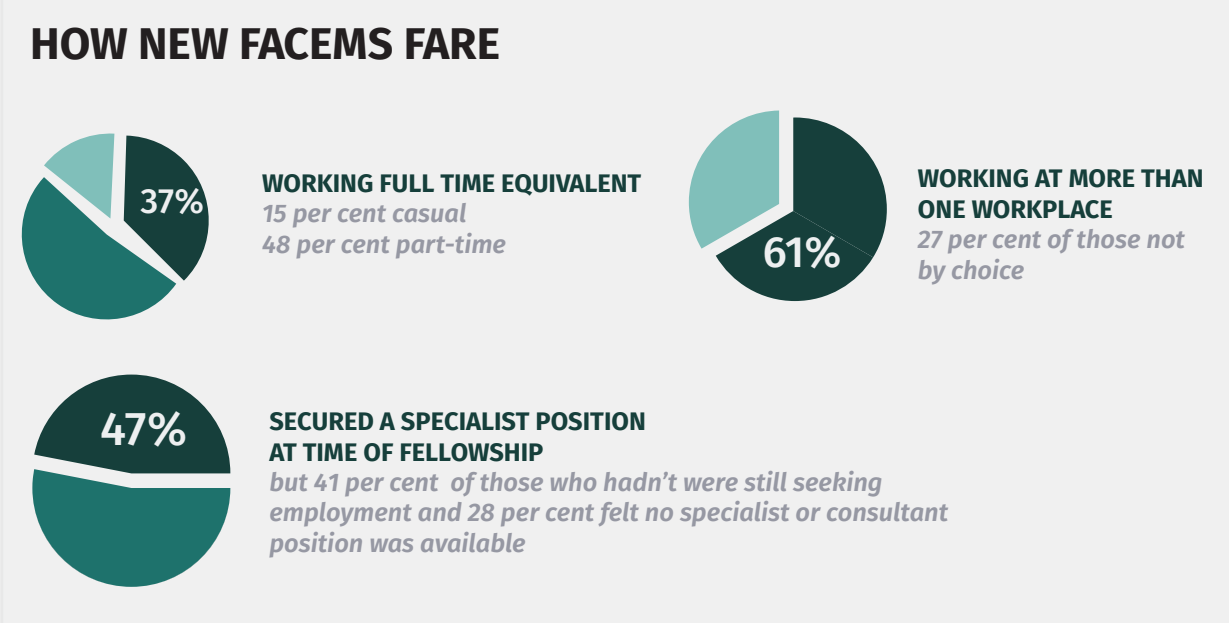


Figure 3 *The working balance of new FACEMs in their first six to 12 months post-Fellowship*

Compared to metropolitan EDs, **even fewer EDs in rural and regional areas have sufficient FACEMs and senior decision makers** when analysed against ACEM's G23 Guidelines, resulting in inequitable access to emergency care

1.4 Geographic maldistribution

Matters of workforce sustainability are exacerbated in regional, rural and remote areas by the geographic maldistribution of the existing workforce. Despite the growth of the specialty, this has not led to an equivalent increase in the number of trainees and FACEMs working in rural, regional and remote areas.

Compared to metropolitan EDs, even fewer EDs in rural and regional areas have sufficient FACEMs and senior decision makers when analysed against ACEM's G23 Guidelines, resulting in inequitable access to emergency care. By comparison, certain metropolitan sites have an oversupply of FACEMs and a high ratio of trainees to FACEMs.

Rural, regional and remote EDs also rely heavily on a locum workforce. As reported in ACEM's *2019 Annual Site Census Report*, regional EDs were more likely than others to be employing locums, with 100% of small/medium regional EDs in Australia reporting that they employed locums. (24) Overall, ED locums represent a significant portion of the ED workforce, with recent data showing that half of Aotearoa New Zealand (56%) and almost one third (31%) of Australian EDs employed locums. (24)

FACEM and FACEM trainee distribution

Across Australia and Aotearoa New Zealand, the majority of FACEMs working in a hospital setting (71% in Australia, and 51% in Aotearoa New Zealand) were working in a metropolitan[3] public hospital for their primary workplace. (1)

- 26.1% of FACEMs worked in a regional/rural area. 23% of FACEMs in Australia were working in regional/rural locations as their primary workplaces, compared with almost half (49.8%) of FACEMS in Aotearoa New Zealand. (1)
- Only 17.7% of trainees in Australia were working in regional/rural localities as their placement workplace, compared with 38.6% of trainees in Aotearoa New Zealand. (1)
- 46% of new FACEMs (6-12 months post Fellowship) worked in metropolitan areas only, 33% worked in a regional/rural/remote area only, and 21% worked in both metropolitan and regional/rural/remote areas. This has increased from 2014 when only 12.9% of new FACEMs in wereworking in regional/rural areas. (1)

[3] Within Aotearoa New Zealand, only hospitals located within Auckland, Christchurch and Wellington Hospital are considered metropolitan, with the remaining hospitals considered rural and/or regional.

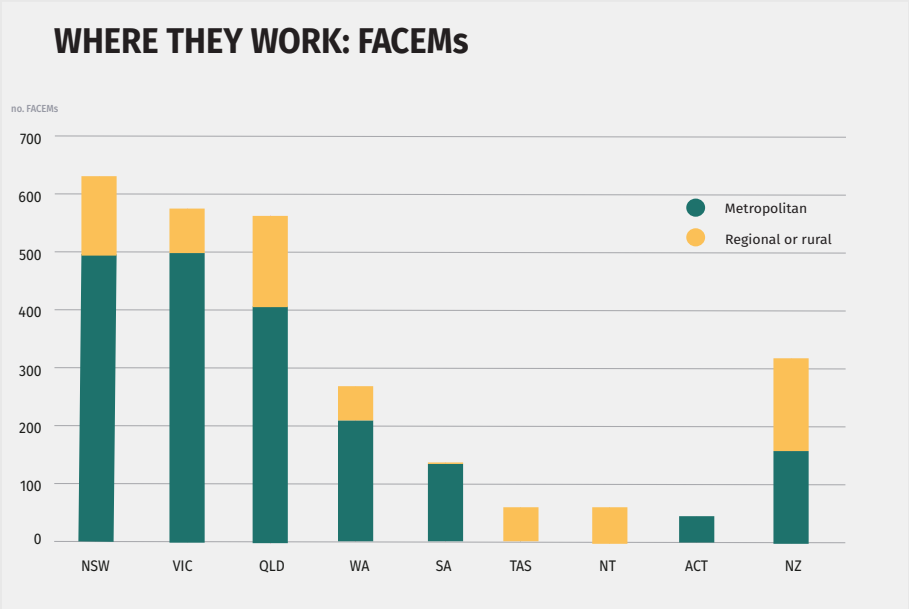


Figure 4 *Where FACEMs work, by remoteness, 2019*

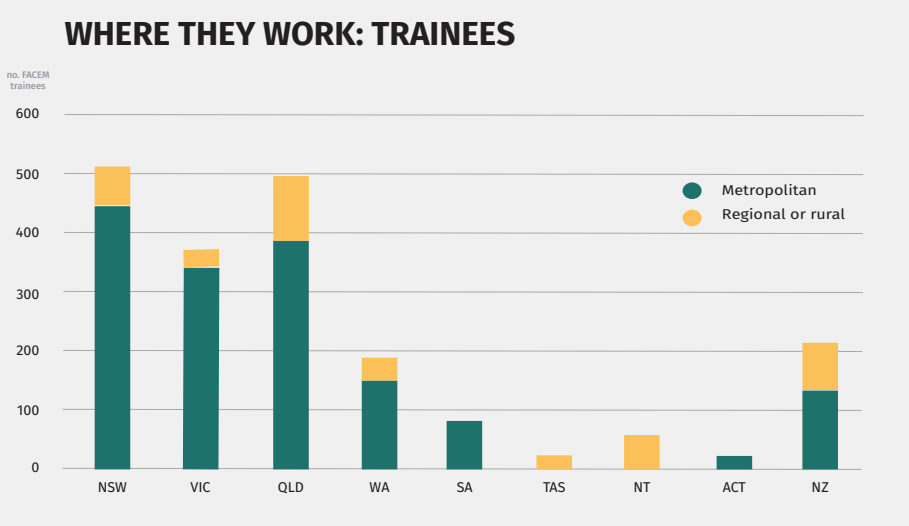


Figure 4 *Where FACEM trainees work, by remoteness, 2019*

Emergency department staffing

Just over half (51.6%) of Australian ACEM-accredited major hospital EDs were meeting ACEM's minimum FACEM staffing model (G23 Guidelines) at the time of reporting. Only 16.7% of metropolitan hospital EDs in Aotearoa New Zealand were meeting the G23 minimum FACEM staffing model. (1)

- ACEM-accredited large and medium regional hospitals (and private hospitals) in Australia had the lowest ratio of EM specialists to FACEM trainees compared to other peer groups. (1)
- In 2019, regionally-located ACEM-accredited EDs in Australia and Aotearoa New Zealand were more likely to report having unfilled FACEM FTE, with 73% of large regional and 55.6% of small/medium hospitals in Australia reporting unfilled trainee FTE. (1)

1.4.1 Factors influencing rural training and long-term practice

There can be a number of challenges in training in regional, rural and remote settings, including (but not limited to) professional isolation, access to required supervision, and financial support to attend education and/or other training in metropolitan regions.

From a training perspective, the majority of ACEM-accredited EDs across Australia and Aotearoa New Zealand are located in metropolitan and outer metropolitan areas, with less than 30% of accredited EDs located in regional, rural or remote areas. The ability to offer quality FACEM training at a regional, rural or remote site has long been considered an opportunity to increase the area's local workforce in the long- and short-term.

ACEM's FACEM Training Site Accreditation Requirements outline a comprehensive set of requirements that must be met for a site to provide a safe and quality training program. (26) One of the cornerstone requirements of training site accreditation is the provision of safe and effective supervision to trainees. The intent of supervision requirements is to ensure that trainees receive adequate specialist clinical supervision (direct and on-call) appropriate to their level of training and the site's case-mix.

Overall, this should see supervisors providing guidance and feedback on matters of professional, educational and personal development, facilitating the trainee's role as a physician in providing safe and appropriate patient care, and providing appropriate support in the event of sentinel events or adverse outcomes.

The shortage of FACEMs in regional, rural and remote areas creates a barrier to training and retaining a new specialist EM workforce in these areas. The most commonly reported barrier to increasing the number of rural training positions (across all specialties) are supervision requirements of College accreditation standards, due to the insufficient availability of FACEM supervision on-site. This creates a paradox in which an existing specialist workforce is required in order to establish a quality training site and an increase in quality training opportunities is required in order to increase the specialist workforce.

Anecdotally, stakeholders are concerned that ACEM's accreditation standards favour tertiary hospitals, particularly in relation to the requirement for face-to-face availability of supervisors. To date there has been limited work done across EM and other specialties on remote supervision for specialty training. However some trainees have reported unique learning advantages from remote supervision, such as increased independence in clinical decision making and enhanced leadership skills. (29) This is balanced with issues such as the potential for overall reduced communication with a supervisor, information technology failures and the inability for the provision of hands-on assistance. (27)

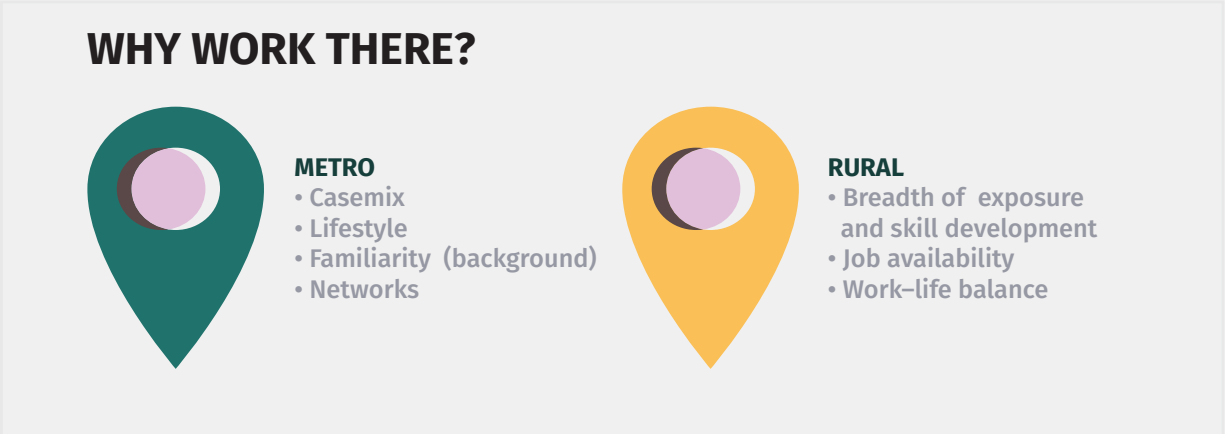


Figure 4 *Pull factors affecting member and trainee decisions to work in metropolitan or rural, regional or remote areas*

For FACEMs and FACEM trainees, in addition to the availability of positions across regional, rural and remote areas, the decision to train and/or work rurally is influenced by various factors. Disincentivising factors include preconceptions of work in rural areas, preference for a city lifestyle (with a high percentage of trainees from metropolitan backgrounds), and a preference for metropolitan/tertiary hospital case-mix. (21) Incentivising factors for new FACEMs to work in regional, rural and remote areas include job availability (or lack thereof in metropolitan areas), lifestyle factors and breadth of exposure and skill development.

Much of the existing research on factors influencing a decision to work in a rural location has focused on the primary care and general practice workforce rather than the EM workforce; nonetheless this research shows it is multifactorial and includes family needs, educational stages of children, a good work–life balance and rurality of practice. Research from General Practice suggests that procedural and hospital activity are influencing factors (e.g. non-procedural GPs have an increased risk of leaving a rural community, compared to procedural GPs).

While many medical students have positive training experiences in rural areas, progression through prevocational and vocational training often requires a return to metropolitan centres. At this point many trainees develop the personal and professional networks integral to their future life and career path and may be subsequently less inclined to return to train or practice in rural areas.

Whilst government financial incentives are generally supported by stakeholders, there remains limited evidence that they alone are effective, and they remain only one factor that can potentially influence a decision of a medical practitioner to go and/or remain practising rurally. Furthermore, demographics of the medical workforce have changed over the past decade, such that individuals are likely to be older in age upon graduating from medical school and entering specialist training. This is likely to decrease the prospect of a move to rural and regional areas. (28 - 31)

1.4.2 Rural and Regional Areas and Non-Hospital Settings

Medical staffing models in emergency care facilities where there are no FACEMs are variable, and can include CMOs, and other specialists such as General Practitioners. Of the 290 EDs across Australia and 40 EDs across Aotearoa New Zealand, only 213 and 22 respectively, have a FACEM presence. Beyond hospital EDs, there are also many smaller rural and regional hospitals and other settings with emergency care facilities.

Smaller rural and regional settings include those with small or no FACEM and/or FACEM trainee presence and/or settings where emergency care provision is delivered by GPs and/or rural generalists and nurses. These include settings such as smaller hospitals, urgent care centres and general practice clinics. While these settings typically see fewer patient presentations per year then larger regional and metropolitan hospital EDs, these facilities receive the same spectrum of patients with serious and immediately life-threatening conditions.

Doctors in these smaller settings are expected to be competent to manage critically ill and injured patients, and maintain their skills indefinitely, despite low levels of exposure to such patients on an individual provider basis and limited opportunities for skills practice at their workplace. In smaller ED settings, doctors are often not specifically trained in EM and do not always feel adequately skilled or confident to deal with the range of critically ill or complex trauma presentations.

ACEM already has a well-defined education pathway for other specialist doctors, such as FRACGP and FACRRMs, and other medical practitioners seeking to develop their EM skills, through the ACEM EMC and ACEM EMD (soon to also include the ACEM EM Advanced Diploma). These programs were developed in recognition that a need existed to provide appropriate and additional training to the doctors working in settings involved in the provision of emergency care. The EMC and EMD are now well-established qualifications, with more than 1210 EMC graduates and 64 EMD graduates to date (as of 16 July 2020).

1.4.3 Failure to translate government investment in early training into improved workforce distribution

Across all specialties, the increased volume of medical students entering the workforce, and the distribution and incentive-based interventions have had a limited overall impact on geographic maldistribution. Over the past two decades, both Australian and Aotearoa New Zealand governments have introduced a range of initiatives and incentives in an effort to increase and retain the medical (and broader health) workforce in rural, regional and remote areas, including:

- medical school programs and Rural Clinical Schools (RCSs) designed to immerse students in non-urban environments. RCSs offer both long-term and short-term rural training experiences to medical students. In addition, there are other programs that aim to give students opportunities to learn rurally, such as the John Flynn Placement Program and the New South Wales rural cadetships;
- an expansion of medical training places through initiatives such as the Specialist Training Program (STP) and its precursors and the Integrated Rural Training Pipeline (Australia only);
- Rural Junior Doctor Training Innovation Fund (Australia);
- voluntary bonded medical school placements;
- preferential entry to medical schools for rural students;
- undergraduate rural immersion programmes and rural rotations;
- rural placements during general practice vocational training;
- rural funding support; and
- various workforce retention funding programs.

There remains limited evidence that government financial incentives alone are effective. At best, these initiatives contribute to immediate service provision needs but are unlikely to significantly contribute to the development of a permanent medical workforce. Concerns have also been expressed by stakeholders about the complex landscape of training options, the lack of clear links between the different initiatives, and the lack of requirements for universities and specialist colleges to collaborate and establish clear pathways for students wanting to gain further experience in rural training settings. (31, 32)

Evidence of the impact of mandatory rural rotations is limited, and it is unclear to what extent undergraduate and graduate rural training exposure has on the decision to practice rurally. Much of the existing research has focused on medical school rotations and/or GP training. However, this research does indicate that the longer the exposure to training in a rural context, the greater the likelihood of future rural practice. (33, 34)

Overall, existing research suggests that:

- a rural background is the strongest predictor of an individual's decision to practice rurally; and
- the longer an individual's exposure to a rural training setting, the more likely they are to want to continue practising in a rural setting.

Note: ACEM is undertaking further analysis of different trainee and FACEM cohorts to determine factors which are influencing rural and regional emergency medicine practice. Further information on this will be provided in subsequent reports.

1.5 Impact on inequitable access to healthcare in regional, rural and remote areas

Geographic maldistribution of the medical workforce is one factor associated with disparities in patient access to health care, and health outcomes. Inner regional and remote areas are estimated to have potentially avoidable death rates that are 20% to 65% higher than in metropolitan regions. While these differences in health outcomes are multifactorial, and not solely due to workforce disparities, ACEM must consider how any future EM workforce strategies will contribute to more equitable health outcomes.

The workforce issues outlined in this paper have a major impact on access to specialist-led emergency care. On one hand, patients living in regional, rural and remote areas often experience shorter wait times (to be seen), lower lengths of stay (in ED and hospital) and are less likely to leave before receiving care than those living in metropolitan areas. However, as illustrated above, patients living in regional, rural and remote areas have lower access to FACEM-led care than those living in metropolitan areas.

This has a particular impact on Māori in Aotearoa New Zealand, as a greater proportion of Māori attend EDs located outside of metropolitan areas than non-Māori. In 2017-2018, 69% of Māori ED patients attended EDs located in regional locations compared with 51% of non-Māori patients. (9)

It also has a particular impact on Aboriginal and Torres Strait Islander Peoples in Australia, who are more likely to present to EDs located in regional areas as opposed to metropolitan areas. The proportion of the population that is indigenous (as compared to the proportion of the population that is not indigenous) is much higher in regional, remote and rural areas than metropolitan areas. Indigenous people represent 1.7% of the population in major cities, but represent 4.4% of inner regional, 7.9% of outer regional, 18% of remote and 47% of very remote populations. (35)

In 2014-2015, Aboriginal and Torres Strait Islander Peoples accounted for a higher proportion of all ED presentations in very remote (50%) and remote areas (35%), compared to 3% of ED presentations in metropolitan areas; however, they were overrepresented across all of these areas in comparison to their proportion in the general population — 45% of people living in very remote areas, 16% of people living in remote areas and 1.5% of people living in metropolitan areas were Indigenous. (36)

Inequitable access to FACEM-led emergency care is part of the wider issue of inequitable access to healthcare in general. Patients living in rural, regional and remote areas face difficulties in accessing treatment in a reasonable timeframe, less choice in providers and less access to specialist services. (37)

For patients this might look like:

- not having a usual GP or place of care, and needing to go to an ED because no GP is available when needed;(38)
- delayed diagnosis, transfer and treatment;(39)
- difficulties in self-managing chronic conditions;
- needing to travel long distances and undergo lengthy stays away from home to access health services; and
- compromised continuing recovery after returning home creating a "vicious cycle of increasing ill health". (40)

The impact of inequitable access to healthcare is seen in the poorer health outcomes experienced by people living in rural, regional and remote areas when compared to those living in metropolitan areas. For example:

- in Australia in 2017, potentially avoidable deaths made up 17% of all deaths in Australia. For males and females, the rate increased with remoteness. The rate for females in very remote areas was 3.3 times as high as major cities, and the rate for males in very remote areas was 2.3 times as high as major cities. (35);
- in Australia in 2015, the rate of burden of disease in remote and very remote areas was 1.4 times as high as that for major cities; (35)
- in Australia between 2013-2017, Australians living in remote and very remote areas were "about twice as likely to die from suicide when compared to Australia overall". (37) In Aotearoa New Zealand, the suicide rate is higher for those in rural areas than in urban areas; (41) and
- in Aotearoa New Zealand, people living in rural towns can have lower life expectancy than people living in cities or surrounding rural areas. (41)

1.6 Inequitable health outcomes for Aboriginal and Torres Strait Islander Peoples in regional, rural and remote areas

In general, Aboriginal and Torres Strait Islander Peoples across Australia experience poorer health outcomes than non-Indigenous people. For example, Australian Institute of Health and Welfare data suggests that patients presenting to EDs for mental-health related reasons are more likely to identify as Aboriginal and Torres Strait Islander than other patients. While Indigenous Australians make up around three per cent of the Australian population, they comprise 11 per cent of all ED mental health presentations across the country. (11)

Aboriginal and Torres Strait Islander Peoples in rural and remote areas experience significantly worse health outcomes than non-Indigenous peoples. Aboriginal and Torres Strait Islander Peoples experience greater prevalence of chronic disease compared with non-Indigenous people, including higher rates of diabetes, end-stage kidney disease and circulatory disease. Incidence of chronic disease increases with remoteness, in some cases significantly, with Aboriginal and Torres Strait Islander Australians from a remote area 60% more likely to have circulatory disease than those in major city or rural areas. (39) The AIHW's *Aboriginal and Torres Strait Islander Adolescent and Youth Health and Wellbeing Report 2018* found that Indigenous people in remote areas were more likely to report high or very high psychological distress (40% or 10,400) compared with Indigenous people in non-remote areas (32% or 35,000). (42)

1.7 Inequitable health outcomes for Māori in regional, rural and remote areas

In general, Māori experience significantly worse health outcomes than non-Māori across Aotearoa New Zealand. Some gains have been made over the last 30 years to improve health outcomes for Māori. Despite these gains, Māori continue to experience consistent and compelling disparities in health outcomes, exposure to the determinants of ill-health, lack of health system responsiveness and the under-representation of Māori in the health workforce. Māori have higher rates than non-Māori for many health conditions and chronic diseases, including cancer, diabetes, cardiovascular disease and asthma. Māori experience higher disability rates, shorter life expectancy, higher suicide rates, (especially amongst young Māori), and higher smoking rates than non-Māori. (43) Māori are over-represented in the population of those accessing mental health and addiction services at 27.7% and overrepresented in presentations to the ED (20-21% of people presenting to EDs are Māori.). However, there is a gap in the data on how many Māori ED presentations are mental-health related. (9, 44)

The Aotearoa New Zealand Health and Disability System Review found that, while data is limited, there are indications that the poorer health outcomes experienced by people living in rural towns is accentuated for rural Māori. A 2010 report by the National Health Committee found that life expectancy for rural Māori may be slightly lower than that for urban Māori. (41)

2. What are our options?

The workforce issues associated with EM and the wider healthcare system are complex and caused by structural, cultural and historical intersecting factors. In order to address these issues, the College needs to be innovative and lead development of initiatives that promote provision of the right care, in the right place at the right time.

The training and education of the EM workforce is essential to the delivery of high-quality emergency care. If the workforce issues outlined persist, it is likely to negatively impact on the quality of the FACEM training experience and subsequent FACEM professional development in the future.

The demands of clinical service delivery and a shortage of supervisory staff, exacerbated by workplace stressors, including access block and overcrowding, reduce the opportunities and time for on the job learning for trainees and the on-going professional development of senior staff. These factors may also "limit the extent to which new and existing staff have the opportunity to develop non-technical cognitive and behavioral skills needed within EDs – such as skills in complex decision-making, leadership skills and team working and interpersonal skills". (21)

In addition, a large and persistent maldistribution of both FACEMs and FACEM trainees and the broader emergency workforce persists. This is not specific to EM. Despite efforts to increase the medical workforce in rural and remote locations, there is a continued shortage of both EM and other specialists (including GPs) in these areas.

The Workforce Planning Committee understands that in exploring solutions to these issues, there may be many other solutions for consideration. The Committee therefore encourages members and trainees to provide comprehensive feedback on the solutions outlined in the following pages, as well as any additional ideas for further exploration.

2.1 Solutions to facilitate the differentiation between specialist training and service delivery

A. Accrediting individual training posts

ACEM explore the feasibility of a new system where individual training positions (posts) are accredited for training, rather than sites. Accreditation standards would be applied to identify posts of sufficient quality, including supervision, variety of experience, breadth of practice, education support etc. Training posts would be accredited as part of an individual hospital/ED site. This would mean that each individual hospital/ED site would be accredited for only a certain number of training positions, based on the accreditation standards.

B. Accredited training networks

ACEM explore the feasibility of a new integrated system of accreditation that includes a series of accredited training networks within each jurisdiction. Each network would be assessed against accreditation standards (see above), including:

- *an appropriately defined range of sites, with consideration given to the case-mix, patient presentation numbers and geographic location of each site;*
- *each site would be comprised of a set number of accredited training posts; and*
- *involving a mix of rural training settings and subsequent training positions.*

The College sets the standards required for each training program it offers and articulates this through a curriculum. A training provider translates that curriculum content into a program of work-based learning that enables each trainee to meet training requirements and complete their required assessments. Accreditation assures the College, that training is being delivered to a standard that results in the development of competent physicians, by meeting the following broad objectives:

- safeguarding of trainee, and trainee-delivered patient care;
- promotion of high-quality learning that integrates clinical practice and training; and
- supporting quality supervision.

One way of establishing a clearer distinction between training needs and workforce needs, is to move away from a 'training site' accreditation system to a 'training post' accreditation system. This would see the accreditation of a number of individual training posts at a particular site to ensure sufficient quality 'training' of trainees.

Whilst FACEM trainees in training posts would still be a part of the EM workforce delivering patient services, individual post accreditation would provide a clear delineation between training positions and positions purely dedicated to service delivery.

There is a well established precedence for this type of system. Colleges such as the Royal Australasian College of Surgeons (RACS) and the Royal Australasian College of Obstetrics and Gynaecology (RANZCOG) accredit individual training posts and/or hospital sites for a number of training positions. The process of accreditation may be initiated by a hospital or network of hospitals that wishes to undertake training for the first time or to propose a new post in addition to existing accredited posts.

Advice will be sought from the Australian Competition and Consumer Commission (ACCC), Commonwealth DOH and similar bodies in relation to this proposal, from the perspective of workforce policy and trade practices issues.

An alternative to the accreditation of individual training posts is to move away from accrediting individual sites/EDs, and instead introduce a system of accredited training networks. Accreditation for a training network is currently possible within ACEM's current Program Site Accreditation upon request, with an EM Training Network defined in the following way. (45).

> *'A group of hospitals that have formally agreed to a coordinated education and training program for emergency medicine trainees. Each hospital within the network must individually satisfy the mandatory criteria for accreditation.'*

The option to introduce a networked accreditation system would go further than this, and require the following.

- Accreditation of individual sites and individual training posts within each site
- All accredited training sites being incorporated into an accredited training network
- Each training network to have a dedicated proportion of rural and/or regional training sites accredited, within their network
- A formal agreement that the sites involved in a defined EM Training Network will work together to provide an entire training program experience and deliver safe, high-quality training

Such a system would build on the accreditation of individual training posts by still ensuring that training sites have delineation between FACEM training positions and service delivery roles. The incorporation of rural and regional training sites in each network would also facilitate a more appropriate distribution of FACEM trainees across networks.

There is much to consider with regards to accredited networked training, including:

- maintaining a degree of trainee flexibility, recognised as a much-valued feature of the FACEM Training Programs;
- concerns from trainees regarding transfer of employee entitlements between different employers within networks;
- the complexities of managing recruitment processes with large numbers of trainees across facility and health service boundaries;
- concerns regarding the rotation of trainees from 'parent' hospitals, to sites throughout the broader network, particularly to rural training positions; and
- existing formal networks established by health jurisdictions and/or existing information networks established between hospital sites.

2.2 Solutions to facilitate an increased and appropriately trained middle-grade workforce

A. Non-FACEM Senior Decision Makers

ACEM further develop detailed guidelines for health services regarding medical workforce models utilising appropriate non-FACEM senior decision makers, and further define what the expected qualifications for this role are.

All patients have the right to access high-quality, safe EM care 24-hours a day, 7-days a week. In order for this to be achieved, ACEM must further define, develop, promote and help to embed different models of care that utilise alternative senior decision makers that are suitable across a range of settings and locations.

This is important if we are to:

- move away from a reliance on trainees to underpin service provision in metropolitan regions;
- facilitate a clearer delineation between training needs and service provision; and
- make more effective use of the existing other-specialist workforce and middle-grade workforce available to deliver emergency care across all regions and settings in Australia and Aotearoa New Zealand.

ACEM must further define, develop, promote and help to embed different models of care that utilise alternative senior decision makers that are suitable across a range of settings and locations.

Most EDs have separate rosters that cohort doctors according to their individual clinical experience and skill set. This may include a FACEM roster, a middle grade roster, and a junior doctor roster. Service requirements for filling rosters are met through a range of workforce sources, including FACEM trainees, CMOs, locums and senior resident medical officers, in addition to overseas trained doctors of varying levels of experience and seniority. Depending on their level of seniority and progress through the FACEM Training Program, FACEM trainees are generally assigned to the hospital middle grade roster or junior roster.

In a number of jurisdictions, service requirements outweigh the available ACEM trainees, particularly with respect to filling the middle grade rosters. However, this could be alleviated through better integration of CMOs into the EM workforce. This is particularly important in metropolitan regions, where the need for an increased middle-grade workforce has been a large driver in increasing FACEM trainee numbers. In some rural and regional jurisdictions, the use of generalists with advanced skills in EM is available, with the growing recognition of Rural Generalism set to increase this.

Meeting service needs through an increased non-FACEM senior decision maker workforce would allow health systems to transition away from a reliance on ACEM trainees for service needs, and further expand the ability of services to deliver a high-quality training experience. It would also allow ACEM to align trainee numbers with quality training positions. As part of this, ACEM would also have a responsibility to ensure that any non-FACEM workforce (senior clinical decision makers other than FACEMs) has the appropriate skills to provide care to meet community need, through qualifications such as the EMC, EMD and EMAD (new).

ACEM's recently completed review of the EMC and EMD has considered projected workforce needs, and the need to ensure robust training and associated programs are available for all medical practitioners who provide EM care across Australia and Aotearoa New Zealand. There has been appreciation and ongoing discussion from all participating colleges regarding the evolution of rural generalism and the role of the EMD and EMAD, specifically in the education and training of rural generalists in advanced skills in EM. This includes consideration of how these qualifications will fit within the advanced skills requirements of rural generalist training, with ongoing collaboration occurring between ACEM and GP Colleges in both Australia and Aotearoa New Zealand.

However, whilst ACEM's EMC and EMD are well established qualifications amongst GPs, rural generalists and other doctors working in rural areas, they have been utilised to a much smaller degree in metropolitan settings. In 2019, across all accredited EDs, 69 EDs reported having EMC and/or EMD graduates employed, with more EDs employing EMC graduates than EMD graduates. For EDs that reported employing EMC or EMD graduates, the average number employed was small, and varied little across regions, at an average of two to four (headcount) for EMC graduates and one to two (headcount) for EMD graduates. (24)

2.3 Solutions to improve long term workforce maldistribution

A. FACEM Rural Training Pathway

ACEM develops and trials a specific FACEM Rural Training Pathway, and reserves a percentage of its training places for individuals wanting to undertake this pathway.

B. Remote Supervision Options

As part of developing Proposal 2.3(c) (below), ACEM explores the feasibility of incorporating remote supervision options, which do not compromise the quality of training placements, but do improve the range of regional, rural and remote settings capable of establishing training posts. These may include periodic rotation of FACEMs to provide onsite support to rural and remote EDs.

C. Mandatory Rural Experience

ACEM considers introducing a requirement whereby:

- *All new applicants enrolling into the FACEM Training Program must have completed at least some time working and/or studying rurally, either before entering the program or during the training program; and/or*
- *All trainees are required to complete a mandatory rural training term during some stage of their progression through the FACEM Training Program.*

These three options are not mutually exclusive to the development of options outlined in Section 2.1 and could be developed in conjunction with them.

The establishment of a FACEM Rural Training Pathway could harness the interest of a new cohort of trainees in practising outside of metropolitan settings and contribute to improved equity in emergency care access, by allowing these individuals the opportunity to remain in their preferred rural settings.

Historically, there has been a reluctance to explore the development of additional rural training site requirements that would facilitate greater numbers of rural trainees, due to concerns that rural trainees would be disadvantaged and that there may be the unintended consequence of establishing a 'two-tiered' training program. Consideration would need to be given as to how alternative models of supervision could provide greater flexibility in establishing training pathways to meet the needs of communities outside of metropolitan centres, while continuing to meet training program requirements and accreditation standards. The development of functional links between regional training networks and existing training infrastructure would be integral to this.

The College would need to consider a range of factors in developing and implementing a specific FACEM Rural Training pathway, including:

- how appropriate trainees would be selected;
- what stage of training would be most suitable to implement such a pathway;
- whether rural training pathway applicants should be prioritisied for entry into the FACEM Training Program
- what prerequisite experience and competencies would be required; and
- how the most appropriate supervisors would be identified.

In addition to supervision requirements, another key aspect of a rural training pathway would be determining suitable models that would ensure rural pathway trainees were provided with appropriate support to access opportunities for required training rotations and placements in metropolitan centres, as well as access to mentoring and networking opportunities. The establishment of rural training networks and/or networks would likely facilitate this kind of infrastructure, as would existing Rural Clinical Schools and other pre-vocational teaching infrastructure.

Mandatory rural training terms have been a topic of discussion within ACEM for a significant period of time. Many issues have been raised during these discussions, including the needs and interests of ACEM trainees, as well as the responsibility of the College to be involved in improving equity of access to emergency care. There are also considerations of feasibility. What is determined to be a 'rural' experience? Would working in a tertiary hospital in a regional location be acceptable? How does the College ensure over 2000 trainees can all obtain an adequate rural training experience? When is an appropriate time in FACEM training to require this? When would it not be an appropriate time in FACEM training to require this?

Whilst market forces to date have only had a very limited impact in improving the geographic maldistribution of the EM workforce, all indications are that there is going to continue to be an increasing saturation of FACEMs in metropolitan centres. It would, therefore, appear inevitable that more new Fellows will need to move to regional and rural areas for sustainable employment opportunities, thus it makes sense to provide and expand the training opportunities and experiences to help facilitate this.

As outlined in earlier sections, factors influencing the decision to work rurally are many; however, longer exposure and being from a rural background are currently considered to be the most important. A long-term strategy for the College to contribute to rebalancing the geographic distribution of FACEMs (and trainees), could be to require all future FACEM Training Program applicants to: (i) be from a rural background; and/or (ii) have had significant exposure to rural medicine as a junior doctor or medical student; and/or (iii) have had exposure to rural medicine during the FACEM Training Program. This could increase the likelihood that these trainees will: (i) want to complete more of their training in rural areas; and/or (ii) be more likely to want to practice rurally once attaining Fellowship.

Alternatively, or in combination, a mandated rural training term of sufficient length could also be introduced, as a mechanism to: (i) attract potential trainees to emergency medicine who are subsequently more likely to want to work and train rurally; and (ii) contribute to meeting short-term workforce needs in rural communities. Combined with the establishment of rural training pathways, the College would have a suite of mechanisms targeting those junior doctors and trainees most interested in working rurally, providing rural educational opportunities, and building a critical mass in rural locations where FACEM presence is needed.

Conclusion

A combination of factors has contributed to significant growth in the number of FACEMs in the past two decades; the emergency medicine specialty is relatively young, the number of medical students in the past decade has tripled, and entry into the FACEM Training Program has been relatively relaxed. Still, despite the significant number of trainees entering and completing the FACEM Training Program, the supply of emergency medicine specialists remains out of balance across Australia and Aotearoa New Zealand.

Furthermore, the pressures being placed on emergency physicians by the lack of floor coverage is shown to be detrimental to the health, wellbeing and longevity of clinicians and is likely to be contributing to the increasing interest by emergency physicians in part-time work, academic or research roles.

Having identified the key issues and drivers of the current EM workforce situation, this paper has sought to put forward some meaningful solutions that aim to improve the sustainability of the workforce, and how care and access to care can be improved across both countries.

These issues outlined cannot be addressed in isolation, nor are they the responsibility of any single stakeholder. They require a coordinated collaborative approach, underpinned by a strategic direction, that enables the College to move from an advocate and an influencer, to an active participant in meeting the future emergency care workforce needs of Australia and Aotearoa New Zealand.

What do you think?

Please complete the survey.

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