Proposed Revisions to the FACEM Training Program for trainees commencing from 1 December 2021

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1. INTRODUCTION

In order to maximise exposure to a variety of relevant experiences that facilitate the development of an appropriate breadth and depth of expertise, trainees must meet the requirements outlined below across the entire FACEM Training Program. The structure of the training program is fully aligned with the FACEM Curriculum that describes the learning outcomes expected of trainees at the end of four stages of training.

2. DEFINITIONS

Critical Care placement – training undertaken in Anaesthetics or Intensive Care Unit (ICU).

ED – Emergency Department

FACEM – A Fellow of the Australasian College of Emergency Medicine.

FEx – Fellowship Examination; W - Written, Clinical – Objective Structed Clinical Examination (OSCE).

FTE – Full-time Equivalent

ITA -In-Training Assessment

M&M – Morbidity and Mortality Review Meeting

PEM – Paediatric Emergency Medicine

PEP - Paediatric Emergency Portfolio

PER – Paediatric Emergency Requirement

PEx – Primary Examination; W – Written, VIVA – Viva Voce

PLB – Paediatric Logbook

TS – Training Stage

WBA – Workplace-Based Assessment, includes:

- CBD – Case-Based Discussion
- Mini-CEX – Mini Clinical Examination Exercise

DOPS – Direct Observation of Procedural Skill

3. TRAINING PLACEMENT REQUIREMENTS

3.1 Minimum number and type of EDs across the revised FACEM Training Program.

Under the revised Training Program, trainees must train at a minimum of two EDs including:

- A Major Referral (MR) (6 FTE months in a single adult/mixed) ED;
- A Non-Major Referral (12 FTE months in an adult/mixed) ED.

To fulfil the MR/non-MR requirement, trainees must train in adult/mixed EDs. This includes adult/mixed terms in an ED with a co-located but separately accredited Paediatric ED provided that the trainee is predominantly rostered to the adult ED.

Most trainees (89%*) currently train in more than two sites, and trainees are strongly encouraged to work in more than two sites to maximise their training experience.

**based on a cohort of 739 trainees who completed FACEM training between 2013-2018.*

To satisfy the Paediatric Emergency Portfolio, trainees must train at an ED with a minimum of 5000 paediatric presentations per year which may or may not be met by one of the two sites required above.

3.2 Placements

Of the 60 FTE months of total FACEM training time required, the following placements are mandated:

- 12 FTE months of core ED in each of Training Stages 1-3;
- Six (6) FTE months of core ED in Training Stage 4;
- Six (6) FTE months in critical care placement(s) in Anaesthetics and/or Intensive Care (adult/mixed ICU) during Training Stages 2-4;
- Six (6) FTE months in non-ED during Training Stages 1-3; and
- Six (6) FTE months elective placement (ED or non-ED) in Training Stage 4.

Given these requirements, trainees will undertake either 42 or 48 FTE months of training in ACEM-accredited EDs.

While it is strongly recommended that trainees undertake a critical care rotation in TS2 or 3, it is possible for it to be done in TS4.

Table 1 FACEM Training Program Structure for trainees commencing training after 1 December 2021

	Training Stage 1	Training Stage 2	Training Stage 3	Training Stage 4
Placement requirements	12 FTE months in adult/mixed ED	12 FTE months in ED	12 FTE months in ED	Minimum 6 FTE months in ED
				AND 6 FTE months of Elective (ED, Critical Care **or** other non-ED)*
		AND 6 FTE months in Critical Care (ICU and/or Anaesthetics)# at any time during TS2 - 4		
	AND 6 FTE months in non-ED# at any time during TS1 - 3			
Maximum time per stage	3 years	8 years		3 years
Maximum total	12 years			

* All elective placements in TS4 must meet the leadership and management learning outcomes for TS4.
# To be taken in minimum 3-month FTE terms as per all training.

3.3 Non-ED training in Training Stages 1 - 3

During Training Stages 1, 2 and/or 3, trainees must complete six (6) FTE months of training in a non-ED placement accredited by the relevant specialist medical college, or by ACEM, as per Appendix 2. The learning outcomes align with TS3, and therefore trainees are advised that while non-ED in TS1 is permitted, it is not encouraged.

Non-ED training may be undertaken in two (2) three (3)-month FTE terms, in up to two (2) non-ED disciplines, or in a six-month FTE term in a single non-ED discipline.

3.4 Training Stage 4

Training Stage 4 focuses on the development and consolidation of management and leadership skills.

Therefore, during Training Stage 4, trainees **must** complete:

- six (6) FTE months in an Emergency Department accredited by ACEM and approved for TS4 training; and
- six (6) FTE months in an elective placement in one of the following:
  - any ACEM-accredited TS4 approved ED; or
  - a Critical Care placement(s) in Anaesthetics and/or Intensive Care; or
  - any ACEM accredited non-ED placement that can address the TS4 learning outcomes (Appendix 3).

The purpose of including approved non-ED placements during Training Stage 4 is to consolidate consultant-level skills, particularly in areas of leadership and management. By the end of Training Stage 4, trainees should be confident in operational management of the floor, including patient flow, and the clinical supervision of junior staff, and departmental management, encompassing clinical governance and quality assurance. Whilst these skills should be enhanced during ED training, it is recognised that placements in appropriate non-ED settings can also provide opportunities to focus on these leadership skills.

3.5 Maintenance Time

Maintenance must be undertaken in an ACEM-accredited ED at a minimum of 0.5 FTE.

3.6 Training in Paediatric EDs

Sites are designated as Specialist Children's or Non-Specialist Children's, the latter of which includes adult EDs with a co-located but separately accredited Paediatric ED that is accredited for Paediatric Emergency Medicine training.

Trainees may undertake either:

- A dedicated paediatric ED term in either a Specialist Children's ED or non–Specialist Children's ED; OR
- An adult/mixed term, recognising that they may be proportionately rostered across all areas of the department, including the co-located paediatric ED.

The maximum core ED training time that may be undertaken in a ***single PEM accredited*** specialist children's hospital Paediatric ED is 12 FTE months. The maximum ***total core ED*** training time that trainees can undertake in Paediatric EDs is 18 FTE months.

3.7 Training in ACEM-accredited Private EDs

The maximum core ED training time allowed at a single private hospital ED is 12 FTE months of core ED training (this does not include additional training (remediation) time, maintenance time or TS4 Elective time undertaken in an ED). For most private sites, this means an increase of 6 months as Provisional trainees do not generally train at private sites.

- 12 months of core ED training time at a single private hospital ED (increase of 6 months for some, no change for others)

3.8 Linked sites (Tier 3) and Private Hospital EDs – combined limit

Due to the comparative limitation in exposure to diverse casemix and acuity, the maximum core ED training time that can be completed at a combination of both Tier 3 and private hospital EDs is limited to 18 FTE months.

3.9 Training outside of Australia and Aotearoa New Zealand.

Core ED training time in in an ACEM-approved ED outside of Australia and Aotearoa New Zealand is limited to a maximum of six (6) FTE months. Interruption to training can be taken for additional time in EDs outside Australia and Aotearoa New Zealand, or in some cases non-ED time could be accrued depending on the placement.

- Trainees may undertake a maximum of six (6) FTE months in an ACEM-approved ED outside of Australia and Aotearoa New Zealand in stage 1, 2, 3 or elective TS4.

3.10 Regional and Rural Emergency Medicine

As in the current training program, regional/rural training will not be mandated in the revised training program. This will be reconsidered in the future following the completion and recommendations of the ACEM Workforce Planning Committee's project.

4. ASSESSMENT REQUIREMENTS

The table below summarises the assessment requirements for the revised FACEM Training Program.

Table 2 FACEM Training Program Assessment Requirements for trainees commencing training after 1 December 2021

<table>
<tr><th></th><th>Training Stage 1</th><th>Training Stage 2</th><th>Training Stage 3</th><th>Training Stage 4</th></tr>
<tr><td rowspan="2">Programmatic assessment requirements</td><td>ITAs (every 3 calendar months)</td><td>ITAs (every 3 calendar months)</td><td>ITAs (every 3 calendar months)</td><td>ITAs (every 3 calendar months)</td></tr>
<tr><td>WBAs
- 8 x Mini-CEX (must include one of each Neurological, Respiratory, Cardiovascular and Abdominal)
- 1 x Communication Skills (Handover)
- 1 x Communication Skills (Referral)</td><td>WBAs
- 4 x CbD (must include 2 x medium complexity)
- 4 x Mini-CEX (must include 2 x medium complexity)
- 1 x Communication Skills (Handover)
- 1 x Communication Skills (Referral)</td><td>WBAs
- 4 x CbD (must include 3 x high complexity)
- 3 x Mini-CEX (including 2 x high complexity)
- 3 x Shift Reports</td><td>WBAs
- In ED:
• 3 x Shift In-charge Report
• 2 x Team Lead in resus/intubation
- Any time during TS4 (ED or non-ED):
• Formal teaching presentation (Grand round/ Inter- or Intra-departmental)</td></tr>
<tr><td>Maintenance (3 months)</td><td>- 3 x Mini-CEX + 1 x ITA</td><td>- 1 x CbD, 1 x Mini-CEX,
- 1 x Communication Skills + 1 x ITA</td><td>- 1 x CbD, 1 x Mini-CEX, 1 x Shift Report, 1 x ITA</td><td>- 3 x Shift In-Charge Reports,
- 1 x ITA</td></tr>
<tr><td rowspan="4">Specific training requirements</td><td colspan="2">Research requirement</td><td colspan="2" rowspan="2"></td></tr>
<tr><td colspan="2">Paediatric Emergency Requirement (6 x WBAs, 2 x DOPS, Portfolio)
NB: A maximum of 2 Paeds DOPS and 1 Paeds Mini-CEX may be completed in Training Stage 1</td></tr>
<tr><td colspan="2"></td><td colspan="2">• M&M presentation
• Guideline/Protocol Review or Audit</td></tr>
<tr><td colspan="4">Procedural Requirement (Core DOPS)</td></tr>
<tr><td rowspan="2">Examinations</td><td>PEx(W)</td><td rowspan="2"></td><td>FEx(W)</td><td rowspan="2"></td></tr>
<tr><td>PEx(VIVA)</td><td></td></tr>
</table>

4.1 ITAs and WBAs

The *In-Training Assessments* (ITAs) and *Workplace-based Assessments* (WBAs) for a given stage of training will continue to be reviewed by the relevant *Trainee Progression Review Panel* to determine whether the trainee has demonstrated they have met the standard expected for that stage of training, and may progress to the next stage of training (see also *6. Progression Points*).

4.2 Procedural Requirement

The successful completion of twelve (12) *Core DOPS* is required for all trainees. These must be signed off by the Assessor(s) as having been satisfactorily performed by the trainee independently (without supervisor intervention). This may mean repeating each DOPS until this standard is achieved.

ITAs for the revised FACEM Training Program will include an item that requires DEMTs to indicate that they are monitoring the trainee's performance and progress towards completing the twelve (12) DOPS that form the Procedural Requirement.

Note: The two (2) paediatric DOPS proposed as part of the Paediatric Emergency Requirement (PER) do not form part of the twelve (12) Core DOPs of the Procedural Requirement. The two (2) paediatric

DOPS will be reviewed as part of the Paediatric Emergency Requirement once all components of the Paediatric Emergency Requirement have been completed.

The following DOPS must be completed on adult or paediatric cases as specified, while the trainee is in an ED or non-ED placement as specified in Australia or Aotearoa New Zealand.

Table 3 Twelve (12) DOPS procedures for Procedural Requirement

	Procedure	Performed on	Assessed in
1.	Advanced airway	Adult	ED
2.	Procedural sedation	Adult	ED
3.	Regional anaesthesia (excluding haematoma block and digital nerve block)	Adult or paediatric patient	ED
4.	Emergent fracture reduction (wrist, ankle)	Adult or paediatric patient	ED
5.	Reduction of dislocated major joint (shoulder, elbow, hip)	Adult or paediatric patient	ED
6.	DC cardioversion	Adult or paediatric patient	ED
7.	Ultrasound – eFAST, AAA, Lung, FELS	Adult or paediatric patient	ED
8.	Corneal foreign body removal or nasal passage packing	Adult or paediatric patient	ED
9.	Tube thoracostomy	Adult or paediatric patient	ED or Critical Care or Trauma SSP
10.	Lumbar puncture	Adult or paediatric patient	ED or Critical Care
11.	Central venous access	Adult or paediatric patient	ED or Critical Care or Trauma SSP
12.	Arterial line insertion	Adult or paediatric patient	ED or Critical Care or Trauma SSP

4.3 Online Modules

Trainees must complete the online modules by the end of the required training stage.

Table 4 FACEM Training Program Online Module Requirements for trainees commencing training after 1 December 2021

	Training Stage 1	Training Stage 2	Training Stage 3	Training Stage 4
Online learning modules	• *Indigenous Health & Cultural Competence* • *Assessing Cultural Competence* • *Critical Care Airway Management*	• *Clinical Supervision* • *Giving Feedback*	• *Clinical Leadership*	

5. PAEDIATRIC EMERGENCY REQUIREMENT (PER)

The revised *FACEM Curriculum* includes content specific to the management of paediatric patients in the ED throughout Training Stages 1 to 4 (refer *4.1.3.21 Paediatric Presentations*). The proposed components of the *Paediatric Emergency Requirement* are designed to facilitate learning and assessment, and to optimise exposure to an appropriate breadth and acuity of paediatric emergency presentations.

Trainees will be advised to plan their training to ensure that they will have adequate access to paediatric emergency cases. The components of the Paediatric Emergency Requirement must be completed in:

i. Paediatric EDs accredited for Specialist Paediatric Emergency Medicine training, and/or
ii. mixed EDs accredited by ACEM for the Paediatric Emergency Requirement (current 'paediatric logbook accredited' sites, with a minimum of 5000 paediatric presentations annually).

The proposed Paediatric Emergency Requirement comprises eight (8) WBAs and the completion of a Paediatric Emergency Portfolio (PEP), all of which must be completed by the end of Training Stage 3.

5.1 Paediatric Workplace-Based Assessments (WBAs)

Trainees must have completed the following specified paediatric WBAs by the end of Training Stage 3 (TS3):

3 x Mini-Clinical Examination (mini-CEX)

- Paediatric patient discharge communication for common diagnosis, e.g., asthma, bronchiolitis, gastroenteritis (minimum of low complexity);
- Focussed assessment of a paediatric patient aged two (2) to twelve (12) years (verbal - communication with child) with unclear diagnosis, e.g., shortness of breath, or abdominal pain (minimum of medium complexity); and
- Focussed assessment of a paediatric patient aged less than two (2) years (non-verbal – communication with carer), with unclear diagnosis, e.g., shortness of breath, or abdominal pain (minimum of medium complexity).

3 x Case-based Discussions (CbD)

Including at least one each of:

- two (2) to twelve (12) years of age; and
- less than two (2) years of age.

Of the three (3) CbDs, at least one must be a case of medium complexity, and at least one case must be of high complexity.

2 x Direct Observation of Procedural Skills (DOPS)

- Specimen collection for lab analysis, for a paediatric patient of five (5) years or less of age for any of the following: peripheral intravenous cannula insertion, suprapubic catheter aspiration, in-dwelling urinary catheter aspiration, lumbar puncture; and
- Procedural sedation, for paediatric patient of five (5) years or less of age.

5.2 Paediatric Emergency Portfolio (PEP)

To be completed by the end of Training Stage 3, the portfolio is designed with variable training situations in mind (e.g., mixed vs Paediatric EDs). Rather than a formal piece of assessment on which progression decisions are made, the PEP provides a mechanism for recording training experiences, enabling:

- Trainees to monitor, reflect on, and direct their own learning and training appropriately;
- DEMTs to monitor and comment on the trainee's experience and performance in each ITA, ensuring it is appropriate for the relevant Training Stage;
- Facilitated discussion as part of the ITA feedback discussion; and
- ACEM to monitor the trainee's experience and the exposure to paediatric cases provided by the training site.

Trainees will be required to record a minimum of 400 cases, with at least 200 related to the management of children less than five (5) years of age, and at least 200 to the management of children of ages five (5) to fifteen (15) years.

For paediatric cases to be included in the portfolio, trainees must have provided substantive care to the patient from the outset, including taking a history, performing a physical examination and

participation in management and disposition decisions. This must be documented in the patient's clinical record by the trainee.

When all paediatric WBAs have been completed, and the minimum number of cases have been logged in the portfolio, this will trigger a review of the trainee's Paediatric Emergency Requirement at the next relevant Trainee Progression Review Panel meeting. This suite of assessment includes WBAs and the PEP (including DEMT comments).

6. RESEARCH REQUIREMENT

The Research Requirement remains unchanged from the current requirement, may be commenced in Training Stage 1 and must be completed by the end of Training Stage 3.

7. PROGRESSION POINTS

Trainees will be reviewed by the relevant Trainee Progression Review Panel at their milestone dates, as per the current program.

Trainees will be reviewed at the following progression points in training:

- Twelve (12) FTE months TS1 core ED Training time;
- Twelve (12) FTE months TS2 core ED Training time;
- Twelve (12) FTE months TS3 core ED Training time;
- Six (6) FTE months Critical Care time;
- Six (6) FTE months Non-ED time;
- Twelve (12) FTE months TS4 Training time;
- Completion of the components of the Paediatric Emergency Requirement
- End of any period of additional training time (as relevant);
- End of each six months FTE period in Maintenance Pathway, for each stage of training (as relevant); and
- Upon completion of all outstanding requirements of Maintenance prior to election to Fellowship.

7.1 ITA Timing revisions

ITAs will be generated for completion at the end of medical term dates (i.e., every three (3) calendar months), irrespective of when the trainee has commenced the placement. If the last ITA was completed five (5) or more weeks before a milestone date, another ITA will be generated for completion on the milestone date.

7.2 Additional Training Time (formerly termed Remediation)

Where concerns around trainee performance were identified as relating to the type of site, additional training time (remediation) should be undertaken in the same type of site at the discretion of the TPR panel.

Appendix 1 – FACEM Training Program structure and requirements for new trainees from 1 December 2021

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• Giving Feedback</td><td>• Clinical Leadership</td><td></td></tr>
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* All elective placements in TS4 must address the leadership and management learning outcomes for TS4.
# To be taken in minimum 3-month FTE terms as per all training.

Appendix 2 – Proposed Non-ED and Special Skills Placements

Specialty	Sites accredited by	Certified as	Approved Non-ED Training Stages 1-4
Critical Care	ANZCA	Anaesthetics	✓
	CICM	Intensive Care Medicine	✓
General Practice	RACGP	General Practice	✓
	ACRRM		✓
General Medicine	RACP	Cardiology	✓
		Clinical Pharmacology	✓
		Gastroenterology	✓
		Infectious Disease	✓
		Neonatology/Perinatology	✓
		Paediatrics	✓
		Neurology	✓
		Public Health Medicine	✓
		Others	✓
Medical Administration	RACMA	Medical Administration	✓
Pain Medicine	ANZCA - Faculty of Pain Medicine	Pain Medicine	✓
Sports & Exercise Medicine	ACSEP	Sports & Exercise Medicine	✓
Surgery	RACS	General Surgery (adult or paed.)	✓
		Orthopaedic Surgery	✓
		Neurosurgery	✓
		Otolaryngology	✓
		Plastic Surgery	✓
		Urology	✓
		Vascular Surgery	✓
Ophthalmology	RANZCO	Ophthalmology	✓
Obstetrics & Gynaecology	RANZCOG	Obstetrics & Gynaecology	✓
Pathology	RCPA	Pathology	✓
Psychiatry	RANZCP	Psychiatry	✓
Radiology	RANZCR	General Radiology	✓
Special Skills Placement	ACEM	Clinical Informatics	✓
		Drug & Alcohol Addiction Management	✓
		Emergency Medicine Research	✓
		Forensic Medicine	✓
		Geriatric Emergency Medicine	✓
		Hospital in the Home	✓
		Hyperbaric Medicine	✓
		Indigenous Health	✓
		Medical Administration/Safety & Quality	✓
		Medical Education/Simulation	✓
		Ophthalmology & ENT Emergency Medicine	✓
		Pre-Hospital and Retrieval Medicine	✓
		Rural/Remote Health	✓
		Toxicology/Addiction Medicine	✓
		Trauma	✓
		Ultrasound	✓
		Women's Emergency Care	✓

Category T accreditation of non-ED placements (e.g., Global Emergency Medicine) will continue to be assessed on a case-by-case basis, as is currently the case.

Appendix 3 – TS4 Learning Outcomes

MEDICAL EXPERTISE

- Adapt skills to any patient presentation of any complexity.
- Prepare a critically unwell patient for transfer, arrange the transfer and, when required, undertake emergency escort of unstable patients for definitive management.
- Confirm and enhance admission plans created by more junior clinicians working within the Emergency Department.

PRIORITISATION AND DECISION MAKING

- Prioritise the assessment and management of a patient with a critically acute presentation.
- Simultaneously assess and manage multiple patients of any age with complex presentations.
- Apply modified risk stratification and prioritisation processes during patient surges and disasters.
- Demonstrate continued situational awareness with increased task loading.
- Review the decisions of others to seek and address situations where either no decision or an incorrect decision has been made.

COMMUNICATION

- Adapt communication skills to any patient presentation and apply principles of appropriate and professional communication in difficult interactions with the healthcare team.
- Provide skills, advice and resources to junior doctors and other members of the ED team in order to overcome communication barriers and minimise risk to patient care.
- Communicate with patients of all ethnicities and cultural backgrounds including Aboriginal and Torres Strait Islander and Maori patients and their families/communities/whanau in a culturally safe and appropriate manner.

TEAMWORK AND COLLABORATION

- Lead resuscitation in any scenario.
- Lead a team debrief after a complex resuscitation.
- Recognise the need for additional resources to aid in debriefing, particularly in highly emotional resuscitation scenarios.
- Support junior members in routine team leader roles.
- Demonstrate understanding of and integrate considerations of cultural safety for all ethnicities and cultural backgrounds and include Aboriginal and Torres Strait Islander and Maori health workers and family/communities/whanau in patient care where possible and appropriate.

LEADERSHIP AND MANAGEMENT

- Proactively assist junior colleagues in the assessment and management of their patients.
- Facilitate the resolution of conflict involving junior staff members in the workplace.
- Apply understanding of different types of clinical supervision to the oversight of the work of junior clinicians.
- Effectively lead the staff of an ED during a shift, including managing staffing allocations to improve patient flow, particularly during times of patient surges.
- Role model appropriate leadership behaviours to junior doctors including ongoing self-reflection, active advocacy against all forms of discrimination and racism, provision of culturally safe care. Manage the process of a departmental morbidity and mortality meeting and its application in the quality cycle.
- Lead a team to collect data for quality assurance, clinical audit and other risk management activities.
- Represent the ED in a hospital-wide quality improvement activity.
- Apply principles of complaint management to responses to complaints in a timely manner, including the compilation of case reports in response to an investigation into patient care.
- Ensure lessons learnt from management of complaints are discussed at team meetings, followed by written reports highlighting concerns and advice to all staff to avoid recurrence of similar incidents.
- Handle patient complaints effectively, in a timely manner, with empathy and compassion.

HEALTH ADVOCACY

- Contribute to the creation of tailored management plans with a focus on complex patients with recurrent presentations, applying additional management strategies when patients are identified with extra vulnerability risk factors.
- Challenge individual and systemic forms of discrimination within the ED and health care service.

- Support sustained relationship with external organisations to improve the delivery of health care to patients of all ethnic and cultural backgrounds including Aboriginal and Torres Strait Islander Peoples, Maori, refugee, asylum seeker and otherwise vulnerable patients.
- Lead the discussion with patients and their family/whānau and/or carers regarding the medical decisions and goals for end of life care.
- Take responsibility for ceasing resuscitation appropriately in a complex presentation.

SCHOLARSHIP AND TEACHING

- Apply the principles of conducting workplace-based assessments to the assessment of junior trainees.
- Deliver constructive feedback to junior medical staff and peers.
- Perform a formal appraisal of a junior clinician with a consultant colleague.
- Effectively teach procedural skills and the use of equipment.
- Integrate simulation aids when delivering teaching as appropriate.
- Teach culturally safe care.

PROFESSIONALISM

- Obtain informed consent from patients for complex and high-risk interventions.
- Communicate with team members to clarify and move forward from complex ethical dilemmas arising from conflicting professionalism and clinical judgements.
- Identify and implement strategies to assist junior staff in dealing with challenging workplace situations.
- Monitor professional competence and currency of junior medical staff.
- Promote values of work-life balance to mentees and junior clinicians.
- Encourage doctors to care for self and others.
- Promote a zero tolerance for bullying and harassment