Australasian College
for Emergency Medicine

Statement on Night Shift Rostering of Emergency Physicians in Emergency Departments

Document review

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Version	Date	Pages revised / Brief explanation of revision
V1	Nov-2016	Approved by CAPP
V2	Nov-2025	Consequential amendments related to alignment with G23, an updated advocacy position and contemporaneous referencing

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1. Purpose and Scope

This document outlines the position of the Australasian College for Emergency Medicine (ACEM) on night shift rostering of Fellows of the College for Emergency Medicine (FACEMs) in emergency departments (EDs) and applies to all EDs in Australia and Aotearoa New Zealand.

ACEM recognises that there is wide variation of work practices and models of care between EDs and across health systems. Notwithstanding this variation, EDs should adopt rostering practices that prioritise the safety of patients, clinicians and the department.

Retrieval services are out of scope for this document due to the subset nature and distinct operational requirements of these services. Similarly, private EDs may operate under alternative models of care and funding arrangements and should adapt the principles outlined here in alignment with their service context.

This policy should be read in conjunction with ACEM's Guideline G23 Constructing a sustainable emergency department medical workforce.[1]

2. Terminology

Emergency physician

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

Access block

Access block refers to the situation where patients requiring admission to hospital from the ED have an ED length of stay greater than eight hours. This includes patients who were referred for admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital, or who died in the ED.

3. Context

EDs in Australia and Aotearoa New Zealand generally operate three core clinical shifts: day, evening and night. The exact length and timing of shifts vary between hospitals and health services; however, night shift usually starts by 11pm and finishes by 9am.

Under current staffing arrangements in the majority of EDs, FACEMs are present on the day and evening shift. This coincides with most patient presentations, with 86% of ED presentations in Australia and Aotearoa New Zealand occurring between 8am and midnight during 2022-2023.[2]

4. ACEM Position

ACEM does not support routine night shift rostering of FACEMs within the current health system. ACEM recommends that EDs follow the recommended staffing levels outlined in ACEM Guideline G23 Constructing a sustainable emergency department medical workforce. [1] To maximise the provision of safe patient care in EDs across Australia and Aotearoa New Zealand, ACEM recommends that FACEMs, as experts in the provision of EM, are rostered on day and evening shifts to align with times of greatest patient demand. ACEM recommends on-call rostering of FACEMs overnight.

1 Australasian College for Emergency Medicine. Constructing a sustainable emergency department medical workforce (G23). 2024. Melbourne: ACEM.

2 Australian Institute of Health and Welfare. Emergency department care 2022-23: Australian hospital statistics. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

4.1 Quality of Care

ACEM's priority is to ensure that the highest standards of medical care for patients are maintained in EDs across Australia and Aotearoa New Zealand.

The FACEM workforce

As experts in the provision of emergency care, FACEMs are the most senior decision makers in EDs. However, many hospital EDs across Australia and Aotearoa New Zealand do not yet meet the recommended FACEM minimum staffing levels outlined in the G23 Guideline, according to the 2024 ACEM Annual Site Census (only 5.3% of Aotearoa New Zealand EDs and 18.9% of Australian EDs meet recommended minimum FACEM staffing levels). Given that most patient presentations to EDs across Australia and Aotearoa New Zealand occur between the hours of 8am and midnight, which correspond to the standard day and evening shifts in most hospitals, hospitals and healthcare systems should prioritise ensuring adequate FACEM presence during times of the majority of patient presentations.

There are significant workforce shortages and a maldistribution of EM specialists across Australian and Aotearoa New Zealand hospitals, particularly in regional, rural and remote locations. In 2024, 66.7% of rural and remote hospitals and 60% of regional hospitals in Australia reported funded but unfilled EM specialist positions that had been vacant for more than six months. In Aotearoa New Zealand, 44.4% of Urban [2] hospitals reported funded but unfilled EM specialist positions that had been vacant for more than six months.[3] Within this context, the introduction of specialist night shift rostering has the potential to exacerbate existing access and equity issues, by further concentrating FACEMs in metropolitan areas to the detriment of regional, rural, and remote hospitals.

The combination of understaffing of EDs during day and evening shifts, together with space constraints and access block means that a significant proportion of the night shift workload consists of patients who presented during the day or evening but are still awaiting assessment or completion of treatment. A significant increase in ED and inpatient staffing, particularly at the expert and advance expertise levels (see G23 [1]) during day and evening shifts, may alleviate this backlog of patients, thereby reducing overnight workload. In addition, system-wide improvements in hospital flow, for example through extended hours of onsite inpatient specialty medical staffing over 7 days and increased inpatient bed capacity, would further contribute to a reduction in ED overcrowding, especially overnight.

The FACEM role

FACEMs are the specialist experts in EM, providing clinical leadership and oversight that ensures safe, timely, and effective patient care within EDs. As the most specialised senior decision-makers, FACEMs coordinate patient care, optimise departmental flow, and liaise with other departments and specialist teams to ensure patients receive the care they require. Within the current hospital system, EDs provide services 24/7, however only limited clinical services are provided in the wider hospital out-of-hours. Given the critical role of FACEMs in overseeing patient care and co-ordinating safe transitions from the ED to in-patient services, their expertise is most effectively utilised during daytime hours, when diagnostic, specialist and inpatient teams are fully available. In the absence of major health system reform and with current hospital staffing arrangements, there is insufficient evidence to show that rostering FACEMs overnight would lead to improved patient outcomes, particularly for those requiring admission and ongoing patient care.

In very limited, highly specialised centres, for example major trauma hospitals or quaternary referral centres with continuous critical care demand, regular night rostering of FACEMs may be considered to support the unique clinical requirements of these services. FACEM duties on these shifts will occur in collaboration with other acute specialty consultants within the hospital who are rostered overnight, ensuring equity of after-hours coverage across disciplines. Such rostering should occur only where there is a clear and sustained clinical need, supported by adequate resourcing and must not compromise overall workforce sustainability. Decisions regarding FACEM night rostering should be made by the Director of Emergency Medicine (DEM) in consultation with FACEMs and the broader ED leadership team to ensure that day and evening staffing levels remain sufficient to meet the core operational and educational functions of the department.

Another core responsibility of FACEMs is the training, mentoring and supervision of FACEM trainees and other ED staff. These activities are most effective during day and evening shifts, when patient volumes are highest

3 2024 Annual Site Census: ED staffing FTE by region. 2024. ACEM - Annual Site Census

and there is a greater presence of multidisciplinary staff and FACEMs. This environment provides greater learning opportunities, supports real-time clinical decision-making, and ensures high-quality training and professional development for the EM workforce.

4.2 ED Resourcing

ACEM is unaware of any workforce modelling that has been conducted to determine the number of emergency physicians required, or the funding necessary, for EDs across Australia and Aotearoa New Zealand to implement routine FACEM night shift rostering. If such rostering was introduced, significant additional funding would be required to cover emergency physician remuneration on-costs and associated administrative expenses. FACEMs would need to be appropriately compensated for night shift work and additional FACEM positions would be required to sustain this roster without compromising daytime coverage. To date, there has been no indication by Governments in either Australia or Aotearoa New Zealand that this level of investment or workforce expansion would be supported.

ACEM recognises that in rare and exceptional circumstances, temporary workforce shortages and increased workload may create pressure to provide senior clinical support overnight. However, ACEM does not support the routine or recurring rostering of FACEMs on night shift under any circumstance. Where extraordinary service pressures arise, departments should prioritise sustainable solutions such as locum, regional support, telehealth supervision, or redistribution of existing medical staffing, rather than rostering FACEMs to overnight clinical shifts. In the current context, investing in additional FACEM staffing during day and evening shifts – when most patient care and inter-departmental co-ordination occurs – would be a more effective and efficient strategy to improve patient access and care quality than implementing overnight rostering.

4.3 Workforce Wellbeing and Sustainability

Emergency medicine is a rewarding yet highly demanding specialty, with emergency physicians operating at the pinnacle of decision-making density within the hospital system.[4] This sustained intensity and cognitive load over the course of a career can be difficult to maintain and is recognised as a contributing factor to physician burnout. Burnout is characterised by emotional and physical exhaustion, a reduced sense of personal accomplishment and feelings of ineffectiveness. It is associated with poorer quality of care and increased risk of medical error.[5] EM specialists experience among the highest rates of burnout across all medical disciplines with rostering and clinical scheduling practices identified as significant contributors.[6]

Workplace wellbeing is critical to constructing a sustainable and effective emergency medicine workforce. Prioritising staff health and wellbeing not only supports the individuals working in EDs, but also directly enhances the quality and safety of patient care. ACEM remains deeply concerned at the long-term impacts that routine night shift rostering could have on both workforce wellbeing and the sustainability of the specialty, particularly within the current health system climate. Introducing night shift rostering is likely to exacerbate fatigue and impair performance across the span of a specialist's career, increasing the risk of burnout and reducing workforce retention over time.

In jurisdictions where routine night shift rostering for emergency physicians is standard practice, such as the United States, research has shown that the majority of emergency physicians report night shift as having a moderate to major negative influence on job satisfaction. Multiple studies have identified associations between night shift work and fatigue, poor physical health, reduced sleep quality, mood disorders, and strained personal relationships, all of which contribute to physician burn out.[7] Notably, older emergency physicians report greater difficulty recovering and higher levels of emotional exhaustion, with evidence suggesting that reducing or eliminating night shifts may help protect against early retirement and support career longevity.[8]

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