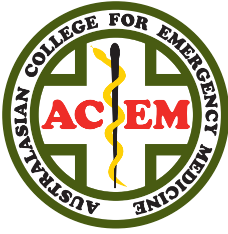

Australasian College for Emergency Medicine

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Report
June 2020

2019 Trainee ED Placement Survey

Australasian College
for Emergency Medicine

2019 Trainee ED Placement Survey

Key findings

This survey collects site specific data to ensure sites are providing a safe and supportive environment for FACEM trainees. It is a mandatory survey, conducted annually and 1550 trainees responded to the 2019 survey.

94%

of trainees agreed that their **training needs** were being **met**

Supervision

91% satisfied with the quality and availability of **DEMT support**

79% satisfied with the level of FACEM **support with WBAs**

Education

86% agreed that the **clinical teaching** at their placement optimised learning opportunities

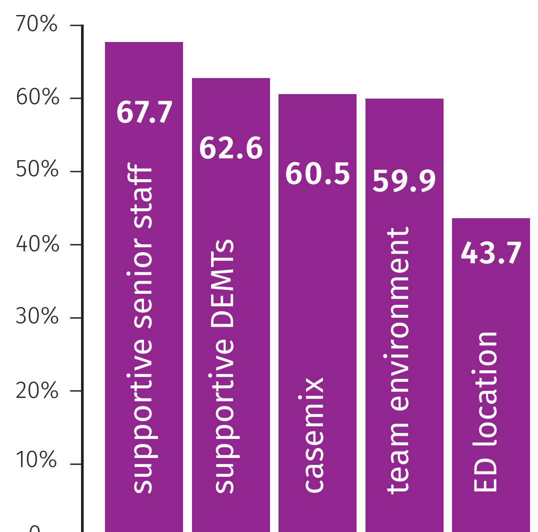
82% agreed that the **structured education program** at their site met their needs

Welfare

90% agreed that their placement provided a **safe and supportive workplace** overall

77% agreed that their placement had processes in place to identify / assist **trainees in difficulty**

Top five placement highlights



Respondents chose one or more highlights from a list of 18

For the full survey findings, please refer to:
Australasian College for Emergency Medicine (2020), *2019 Trainee Placement Survey - ED Placement* ACEM Report, Melbourne.

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1. Executive Summary

The Trainee Placement Survey is administered annually at the end of the training year to trainees enrolled in the FACEM Training Program. The key purpose of the survey is to capture site specific data to ensure that sites are providing training and a training environment, which are appropriate, safe and supportive of FACEM trainees. Further trainee perspectives were sought in the survey on the FACEM Training Program and support from ACEM. The summary of the findings from the 2019 survey for all eligible trainees undertaking an ED placement (N=1550) are presented below:

Health, Welfare and Interests of Trainees

- Nearly all (94%) trainees agreed that their training needs were being met at their ED placement.
- Rostering was viewed positively overall by 76% of trainees, with the majority agreeing that rosters were provided in a timely manner (79%), were equitable (81%) and considered trainee workload (82%). A slightly higher proportion agreed that rosters ensured safe working hours (85%), supported the service needs of the site (86%), and took into account staff leave requests (87%).
- 95% reported knowing whom to get assistance from if they experienced difficulty, but only 77% agreed that their placement had processes in place to identify/ assist trainees in difficulty. However, 89% reported knowing whom to get assistance from if they had a grievance.
- The majority of trainees (90%) agreed that their placement provides a safe and supportive workplace overall, however a smaller proportion agreed that their placement sustained their wellbeing (75%) or provided support processes other than mentoring (78%).
- 32% reported that they had experienced discrimination, bullying, sexual harassment or harassment (DBSH) from a patient/ carer whilst 10% reported experiencing DBSH from ED or hospital staff.
- Just over half (58%) agreed that they could participate in decision making regarding governance at their ED placement.

Supervision and Training Experience

- Over 90% of trainees were satisfied with the quality and availability of DEMT support.
- 90% agreed that the clinical supervision received from FACEMs met their needs, however only 72% agreed that they received regular informal feedback on their performance.
- Over three-quarters of advanced trainees were satisfied with the level of support received from their Local WBA Coordinator (76%) and FACEMs (79%) to undertake WBAs.
- Trainees agreed that the ED casemix at their placement was appropriate with respect to the number (96%), breadth (90%), acuity (86%), and complexity of cases (91%).

Education and Training Opportunities

- 86% agreed that the clinical teaching at their placement optimised learning opportunities. However only 62% agreed that they had access to formal ultrasound training.
- 82% of trainees agreed that the structured education program at their placement met their needs, but a smaller proportion (74%) agreed that rostering enabled them to attend the education sessions.
- 88% agreed that they had access to educational resources needed to meet their training requirements. A smaller proportion (74%) reported having access to clinical exam preparation courses.

Perspectives on the FACEM Training Program and Support from ACEM

- 88% agreed that the FACEM Training Program is facilitating their preparation for independent practice as an emergency medicine specialist, with 78% agreeing that they were well-supported in their training by ACEM processes.

2. Purpose and Scope of Report

The Emergency Department (ED) Trainee Placement Survey is distributed annually to advanced and provisional trainees enrolled in the FACEM Training Program, who are undertaking an ED placement in New Zealand (NZ) and Australia. Survey questions focused on three key areas that map to the ACEM Accreditation Guidelines, including Health, Welfare and Interests of Trainees; Supervision and Training Experience; and Education and Training Opportunities. In addition, this survey also sought trainees' perspectives on the FACEM Training Program and support they receive from ACEM. This report details the findings from the 2019 ED Trainee Placement Survey.

3. Methodology

Participation in the Trainee Placement Survey was mandatory, as per item B1.5 in Regulation B of the FACEM Training Program. To facilitate the completion of the survey in 2019, all eligible trainees were required to submit the Trainee Placement Survey before they could proceed with their annual training fee payment through the ACEM member portal. For the purpose of this survey, eligible trainees were defined as those who were undertaking a placement in an ACEM-accredited ED as at October 31st 2019, whilst trainees on an interruption to training at the time were excluded. Trainees undertaking a non-ED placement at October 31st, were required to complete a Non-ED Trainee Placement Survey, with the findings from that survey not included in this report.

The survey was made active on November 13th 2019, to coincide with the fee invoice generation date. An email was sent to all eligible trainees notifying them about the online fee payment process, including the requirement to complete the Trainee Placement Survey. The survey was promoted as being mandatory, and the information was communicated as part of the news items in the ACEM bulletin, DEMT Forum and in the Trainee Newsletter. The survey was closed on the 28th of Feb 2020.

Survey data are reported only in the aggregate as a percentage of total responses, or by training level, gender of trainee, region or accreditation level of the ED. All collected information was handled in confidence, with anonymity ensured in reporting.

4. Results

A total of 1550 completed surveys were received from a pool of 1554 trainees undertaking an ED placement at the 31st October, a response rate of 99.7%. All NZ trainees (100%, 134) responded to the survey, whereas four of 1420 Australian trainees did not complete the survey.

One trainee was undertaking two part-time ED placements at two different hospitals and completed a survey for each placement. Except for the demographic characteristics data which are presented for the 1549 responding trainees, all subsequent sections present findings based on the total survey responses (N=1550).

4.1 Demographic Characteristics of Respondents

Of the 1549 respondents, 47% (722) were female, with three-quarters (1158) in the stage of advanced training (Table 1). Ninety-one percent of trainees were undertaking an ED placement in Australia and the remainder (9%) were undertaking a placement in NZ. Table 1 shows the distribution of gender and training level of respondents, by each region. Provisional trainees had an average age of 32 years whereas the average age for advanced trainees was 35 years.

Table 1. Distribution of responding trainees undertaking an ED placement, by region, gender and training level.

Region	Female	Male	Total		% Female	% Advanced trainees (n=1158)	% Provisional trainees (n=391)
	N	N	*N	%			
Australia	**652**	**762**	**1414**	**91.3%**	**46.1%**	**74.5%**	**25.5%**
ACT	15	11	26	1.7%	57.7%	61.5%	38.5%
NSW	192	229	421	27.2%	45.6%	72.7%	27.3%
NT	25	14	39	2.5%	64.1%	74.4%	25.6%
QLD	170	216	386	24.9%	44.0%	74.2%	25.8%
SA	27	39	66	4.3%	40.9%	74.2%	25.8%
TAS	12	9	21	1.4%	57.1%	71.4%	28.6%
VIC	145	172	317	20.5%	45.7%	78.5%	21.5%
WA	66	72	138	8.9%	47.8%	74.6%	25.4%
New Zealand	**70**	**64**	**134**	**8.7%**	**52.2%**	**77.6%**	**22.4%**
Total no. of trainees	**722**	**826**	**1548**	**100%**	**46.6%**	**74.8%**	**25.2%**

*Note: *Excludes one trainee with no gender specified*

Table 2 presents the proportion of trainees undertaking an ED placement, by training level and ED accreditation level. Around two-thirds (63%) of the responding trainees were undertaking their placement at EDs accredited for 24 months, whilst only 4% were at EDs accredited for 6 months.

Table 2. Distribution of trainees undertaking an ED placement, by training level and accreditation level.

ED accreditation level (month)	Provisional		Advanced		Total	
	N	%	*N	%	N	%
6	14	3.6%	46	4.0%	60	3.9%
12	80	20.5%	195	16.8%	275	17.7%
18	54	13.8%	191	16.5%	245	15.8%
24	243	62.1%	727	62.7%	970	62.6%
Total no. of responses	**391**	**100%**	**1159**	**100%**	**1550**	**100%**

*Note: *One advanced trainee completed the survey for two placement sites*

4.2 Health, Welfare and Interests of Trainees

This section details the perspectives of trainees as to whether their ED placement at the time of the survey was meeting their health, welfare and interests. This includes aspects such as mentoring, rostering, trainee assistance, workplace safety and support, and opportunities to participate in governance and quality improvement activities.

4.2.1 Overall trainee needs

Nearly all (94%, n=1453) trainees strongly agreed or agreed that their training needs were being met at their ED placement, with 2% (n=36) disagreeing that their needs were being met and 4% (n=61) neutral. No differences were observed among responses provided, by gender or training level.

Those (n=97) who did not agree that their training needs were being met, were provided with the opportunity to comment on the reason(s) for their response, with 90 of them providing feedback. Key reasons trainees provided with respect to their needs not being met at their placement were a lack of clinical teaching or protected teaching time (44%), unsafe working conditions (either due to ED overcrowding or understaffing, 24%), difficulty to complete Workplace-based Assessments (WBAs, 22%), limited education and support for exam preparation (18%), and unsatisfactory senior supervision or feedback (15%). Other reasons included limited procedural opportunities (7%) and insufficient casemix or clinical rotations to optimise learning (8%).

In many instances, feedback contained more than one reason, with these reasons often interrelated. Some example responses provided by trainees included:

> *Limited supervision due to massive workload of patients; minimal bedside teaching; minimal procedural exposure due to time constraints; difficulty attending protected teaching due to burnout/exhaustion/lack of rostering onto day shifts when teaching runs due to staff shortages.*

> *Service provision takes priority over training needs. Rostering is tricky due to insufficient senior staffing levels/skill-mix. The conditions and expectations required to work in overnight is far from safe and certainly has a negative impact on trainee welfare.*

> *Little to no support for WBA, except on days off; limited exposure to resuscitation [cases].*

> *No Fellowship Exam teaching available. Not all FACEMs are willing to complete WBAs.*

> *I don't feel as though I am receiving enough support to help me grow at my stage of training. I would like more focussed and regular feedback from my DEMT.*

4.2.2 Mentoring program

Eighty-four percent (n=1302) of trainees reported that there was a formal mentoring program available at their ED placement, with 5% (n=79) reporting that there wasn't one available and 11% (n=169) who did not know whether a mentoring program was available. Of the trainees who reported there was a formal mentoring program in place, two-thirds (66%, n=855) had utilised the program, with a higher proportion of provisional trainees (69%, n=227) than advanced trainees (65%, n=628) reporting so.

For the remaining trainees (n=447) who reported not utilising the formal mentoring program at their workplace despite this program being available, 33% of them reported that they had a mentor already, while another 22% reported they were not required to participate in a mentoring program at their placement. A further 11% reported that the mentoring program did not meet their needs, and 6% reported that it was difficult to access at their placement. Other reasons (28%) provided for not utilising the formal mentoring program were mainly due to time constraints (e.g. too busy to initiate the process, prioritise exam preparation, difficult to coordinate a time for meetings) or they were more comfortable with informal mentorship. Several other reasons included that they had not found a suitable mentor, did not see the benefit of mentorship, or that they were still new in their placement and waiting for a mentor to be allocated. Some of the responses are presented below:

> *I felt it was not likely to be useful at this time as the focus of my training is preparation for Fellowship exam.*
>
> *I formed a better connection with a different FACEM other than the FACEM allocated to me and have informally used this FACEM as a mentor*
>
> *Have not worked with my mentor, and difficult to arrange meetings during their non-clinical time.*
>
> *We were asked for preferences/requests re: mentor selection, which I submitted, but these must not have been taken into account because I got assigned someone essentially the opposite.*

Over three quarters (79%, n=1225) of trainees reported that there was an ACEM Mentoring Program Coordinator at their ED placement, 4% reported that there wasn't one and 17% reported that they did not know. Trainees undertaking a placement at sites accredited for 18- and 24-months (81%, respectively) were more likely to report the availability of an ACEM Mentoring Coordinator, compared with sites accredited for 12 months (72%) or 6 months (63%).

4.2.3 Rostering

Trainees were asked to state their level of agreement with statements regarding rostering at their placement (Table 3). Over three-quarters (76%) of trainees were in agreeance that they were satisfied with the rostering at their site overall. The majority of trainees strongly agreed or agreed that rosters were provided in a timely manner (79%), gave equitable exposure to shift types (81%) and considered trainee workload, including allowing them to attend the structured educational sessions (82%). A greater proportion of them agreed that rosters at their placement ensured safe working hours (85%), supported the service needs of the site (86%), and took into account staff leave requests (87%). No gender differences were observed among responses provided, however a higher proportion of advanced trainees (ranged 77%-88%) than provisional trainees (ranged 75%-83%) were in agreeance with each of the rostering statements.

The proportion of trainees who agreed or strongly agreed to the statements regarding rostering at their ED placement are presented in Table 3, by region.

Table 3. Proportion of trainees who strongly agreed or agreed with statements regarding rostering at their ED placement, by region.

Statements regarding rostering	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Overall, I am satisfied with rostering at my site	69.2%	76.2%	92.3%	80.9%	80.3%	95.2%	**68.1%**	82.6%	68.7%	76.4%
Rosters are provided in a timely manner	76.9%	72.7%	89.7%	84.3%	84.8%	95.2%	76.3%	89.1%	**71.6%**	79.0%
Rosters give equitable exposure to shift types	**65.4%**	80.3%	97.4%	86.1%	78.8%	95.2%	72.9%	88.4%	71.6%	80.5%
Rosters consider workload as a trainee	73.1%	76.5%	97.4%	83.8%	89.4%	76.2%	84.5%	88.4%	**71.6%**	81.6%
Rosters support the needs of the site	84.6%	81.7%	92.3%	92.5%	93.9%	**76.2%**	83.9%	91.3%	79.1%	86.3%
Rosters ensure safe working hours	**73.1%**	82.7%	94.9%	92.3%	89.4%	85.7%	77.0%	89.9%	83.6%	85.1%
Rosters take into account leave requests	76.9%	87.9%	97.4%	90.7%	89.4%	100%	87.4%	79.7%	**73.9%**	86.8%
Total no. of responses	26	421	39	388	66	21	317	138	134	1550

Table 4 shows the proportion of trainees who were in agreeance with statements relating to rostering, by ED accreditation level. Consistently, trainees undertaking a placement in an ED accredited for shorter placement durations (particularly 6 months) were generally more likely to agree with all of the statements regarding rostering, compared with trainees undertaking placements in EDs accredited for 18 and 24 months.

Table 4. Proportion of trainees who strongly agreed or agreed with statements regarding rostering at their ED placement, by ED accreditation level.

Statements regarding rostering	% Strongly agreed / agreed			
	6	12	18	24
Overall, I am satisfied with rostering at my site	86.7%	78.2%	**69.8%**	76.9%
Rosters are provided in a timely manner	80.0%	80.0%	**73.1%**	80.2%
Rosters give equitable exposure to shift types	91.7%	82.9%	**75.9%**	80.3%
Rosters consider workload as a trainee	88.3%	80.0%	**75.9%**	83.1%
Rosters support the service needs of the site	90.0%	90.2%	90.6%	**83.8%**
Rosters ensure safe working hours	91.7%	87.6%	**82.0%**	84.7%
Rosters take into account leave requests	93.3%	88.0%	**84.9%**	86.6%
Total no. of responses	60	275	245	970

Trainees were given the opportunity to comment on the rostering available at their placement, with Table 5 presenting the major themes and subthemes from the trainee responses (n=348) and some example comments. Two-thirds (66%) of the comments reflected negatively on rostering at their placement, with 20% reflecting positively and 8% being mixed feedback. Another 6% of comments related to suggestions for improving the rostering at their placement.

Table 5. Themes of trainee feedback regarding rostering at their placement, with example comments.

Theme	Example comments
Positive (n=68) - Flexible and accommodating rostering - Fair allocation - Improving	*Very flexible and considerate for emergency leave. Weekly teaching days are protected and exams are always considered.* *Very reasonable and fair. Were open to feedback re rostering for access to teaching and things improved ++*
Negative (n=231) - Disproportionate amount of evening/ night/ weekend shifts - Understaffing (esp. sick leave/ resignations) - Unsafe staffing level/ lack of senior coverage at night - Insufficient break between shifts - Late issuing of roster or short notice changes - Difficulty accessing leave (incl. study leave) - Limited protected teaching/ non-clinical shifts - Inequitable rotation - Limited access to specific clinical areas (e.g. paediatric, resuscitation, fast-track etc.) - Issues with leave coordinator - Regularly on-call	*In the last term, some registrars had up to 20 night shifts due to a large number of registrars leaving/ being on maternity leave/ being on a secondment. This leads to low morale and higher burnout rates amongst trainees.* *Gross understaffing particularly with regards to seniority on night shift with minimal support for senior registrars.* *The roster at this site is highly focused on service provision. There is a predominance of evening shifts with minimal non-clinical time. Leave requests are managed centrally and are almost always rejected.* *No sick relief cover. Not able to attend teaching, courses or conferences. Significant delay and multiple changes to roster releases. Annual leave and term swaps not able to be confirmed for more than 9 months.* *It is randomly allocated and so some months you might not get any resuscitation or paeds shifts allocated to you. This can make it difficult to complete the paeds logbook/DOPs/appropriate WBAs etc.* *On call system in place increases burnout and sickness rate, causing trainees to either reduce their hours or seek alternate site for employment.*
Mixed positive and negative (n=29)	*Rostering is usually done well, however, due to constant surge and lack of registrars, we are normally called in or asked to cover extra shifts.* *Bespoke rostering - satisfies needs of trainees who request leave, but leave other trainees performing many weekends and single day on day off rosters.* *Current term roster has been challenging due to staffing shortages, but all trainee's leave requirements have been met with safe rostering hours*
Suggestions for improvement (n=20)	*We are meant to be rostered for an average for 45.5hrs/week and paid as such, however we work more than this. Either we need to move up a pay scale or the roster changed so we work less hours.* *There should be a minimum of 10 hours between ED shifts to avoid fatigue at senior decision-making level.* *Six shifts per week very frequent. Night shifts not reduced by leave. Very high levels of burnout and stress leave taken. Please help by intervening! We have been trying for years.*

4.2.4 Assistance for trainees

Nearly all trainees (95%) reported knowing whom to get assistance from at their placement if they experienced difficulty in meeting the requirements of training, with a higher proportion of advanced trainees than provisional trainees reporting so (Table 6). However, a much smaller percentage (77%) were in agreeance with the statement 'my current placement has processes in place to identify and assist trainees encountering difficulty in progressing through the FACEM Training Program'. There were no differences observed among responses between male and female trainees.

In relation to handling trainee grievances, 89% of trainees reported knowing whom to get assistance from if they had a grievance at their ED placement, with a further 6% neither agreeing nor disagreeing and 3% disagreeing with this. Likewise, a much smaller proportion of trainees (73%) were in agreeance that their placement had processes in place to manage grievances, with 10% reporting that they did not know if there were processes in place.

Table 6. Proportion of trainees who strongly agreed or agreed with statements regarding assistance for trainees in the ED, by training level.

Statements on assistance for trainees	% Strongly agreed / agreed		
	Provisional Trainees	Advanced Trainees	Total
Know who to get assistance from if falling into difficulty meeting training requirements	92.8%	96.2%	**95.4%**
ED placement has processes in place to identify and assist trainees in difficulty	74.9%	77.3%	**76.7%**
Know who to get assistance from if experiencing a grievance at ED placement	88.2%	89.2%	**89.0%**
ED placement has processes in place to manage grievances	72.1%	73.1%	**72.8%**
Total no. of responses	391	1159	1550

Table 7 presents the proportion of trainees who were in agreeance with statements in relation to trainee assistance, by region. Trainees who were undertaking a placement in the Northern Territory (NT) and Australian Capital Territory (ACT) were less likely to agree with most of these statements, in comparison to trainees from other regions.

Table 7. Proportion of trainees who strongly agreed or agreed with statements regarding assistance for trainees in the ED, by region.

Statements on assistance for trainees	% Strongly agreed / agreed								
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ
Know who to get assistance from if falling into difficulty meeting training requirements	96.2%	**93.8%**	97.4%	97.2%	95.5%	95.2%	94.6%	94.2%	97.0%
ED placement has processes in place to identify and assist trainees in difficulty	**69.2%**	76.0%	74.4%	78.1%	80.3%	81.0%	74.4%	84.8%	71.6%
Know who to get assistance from if experiencing a grievance at ED placement	**84.6%**	88.4%	**84.6%**	91.2%	89.4%	90.5%	86.1%	88.4%	93.3%
ED placement has processes in place to manage grievances	69.2%	73.6%	**59.0%**	74.7%	69.7%	71.4%	73.5%	80.4%	61.9%
Total no. of responses	26	421	39	388	66	21	317	138	134

When this was compared by ED accreditation level, trainees who undertook a placement in an ED accredited for 18 months were generally less likely to agree with all of the statements related to assistance for trainees (Table 8).

Table 8. Proportion of trainees who strongly agreed or agreed with statements regarding assistance for trainees in the ED, by ED accreditation level.

Statements on assistance for trainees	% Strongly agreed / agreed			
	6	12	18	24
Know who to get assistance from if falling into difficulty meeting training requirements	95.0%	94.5%	**93.9%**	96.0%
ED placement has processes in place to identify and assist trainees in difficulty	86.7%	78.9%	**68.6%**	77.5%
Know who to get assistance from if experiencing a grievance at ED placement	93.3%	91.3%	**86.9%**	88.6%
ED placement has processes in place to manage grievance	80.0%	73.5%	**70.6%**	72.8%
Total no. of responses	60	275	245	970

The survey further sought trainees' perspectives about the assistance or processes available at their ED placement for trainees in difficulty or with respect to handling grievances, with 82 responses received. Half (n=42) were positive comments regarding supportive FACEMs and ED environment, with 12 trainees commenting that they either did not need any assistances or were unsure whom to get assistance from for grievances. The remainder were negative comments, which mainly focused on issues raised being ignored or not handled professionally (n=13), fear of repercussions or being targeted/ labelled as a troublemaker (n=9), or they felt unsupported and/ or received unfair assessment (n=6). Some examples of these negative comments are provided in the following:

> *When grievances are brought forward, they are either dismissed or ignored. It is a toxic & unsupportive work environment & those that are supposed to be able to advocate for us, do nothing when issues are brought to them.*

> *I attempted to feedback my concerns to my DEMT but feel he then used this information against me in my next ITA.*

> *Some other trainees haven't had any issues raised with their performance until unfavourable ITAs just prior to progression points and have subsequently been remediated. This is unfortunate and could've potentially been avoided with earlier feedback and support.*

4.2.5 Safe and supportive workplace

Trainees were asked to state their level of agreement that their placement provided a safe and supportive workplace with respect to various aspects as shown in Table 9. The majority of trainees (90%) strongly agreed or agreed that their placement provided a safe and supportive workplace overall. A higher proportion of trainees were in agreeance that their placement workplace provided a safe and supportive environment with respect to personal safety (84%), clinical protocols (89%) and supervision arrangements (88%), compared with other aspects such as sustaining their wellbeing (75%), support processes other than mentoring (78%), and in the provision of a comprehensive orientation program at commencement (75%).

There were comparable proportions of both provisional and advanced trainees who were in agreeance with the individual aspects relating to a safe and supportive workplace, except advanced trainees were slightly more likely to agree that the provision of supervision arrangements and clinical protocols at their placement were aligned with a safe and supportive workplace (Table 9).

Table 9. Proportion of trainees who strongly agreed or agreed that specific aspects relating to a safe and supportive workplace were provided in their ED placement, by training level.

Placement provides a safe and supportive workplace with respect to:	% Strongly agreed / agreed		
	Provisional Trainees	Advanced Trainees	Total
Overall safety and support	89.5%	89.6%	89.6%
Personal safety (e.g. aggression directed by patients and/or carers)	83.9%	84.6%	84.4%
Sustaining my wellbeing	75.4%	75.2%	75.3%
Support processes (other than mentoring)	78.8%	77.3%	77.7%
Clinical protocols	86.7%	89.5%	88.8%
Supervision arrangements	85.4%	89.0%	88.1%
Comprehensive orientation program at commencement	73.9%	75.8%	75.4%
Total no. of responses	391	1159	1550

Female trainees were less likely than male trainees to agree that their ED placement provided a safe and supportive workplace with respect to sustaining their wellbeing (73% vs. 77%) and in the provision of support processes other than mentoring (75% vs. 80%), with these differences significant.

The proportion of trainees who strongly agreed or agreed that various aspects of a safe and supportive workplace were provided in their ED placement, are shown in Table 10 by region and Table 11 by ED accreditation level. Trainees undertaking a placement in the ACT, South Australia (SA) and Tasmania (TAS) were among those who reported the lowest agreement level for more than one aspect of a safe and supportive workplace, in comparison to trainees in other regions.

Table 10. Proportion of trainees who strongly agreed or agreed that specific aspects relating to a safe and supportive workplace were provided in their ED placement, by region.

Placement provides a safe & supportive workplace with respect to:	% Strongly agreed / agreed								
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ
Overall safety & support	84.6%	89.3%	89.7%	94.1%	87.9%	**71.4%**	85.5%	94.2%	87.3%
Personal safety	**69.2%**	81.2%	84.6%	91.2%	72.7%	71.4%	81.7%	86.2%	89.6%
Sustaining my wellbeing	80.8%	74.1%	87.2%	83.5%	69.7%	**52.4%**	67.8%	76.1%	73.9%
Support processes (other than mentoring)	73.1%	72.9%	74.4%	87.4%	**72.7%**	76.2%	74.4%	81.2%	73.1%
Clinical protocols	**69.2%**	90.5%	92.3%	92.0%	90.9%	90.5%	87.7%	88.4%	78.4%
Supervision arrangements	84.6%	87.2%	87.2%	94.3%	**81.8%**	90.5%	83.9%	89.1%	85.1%
Comprehensive orientation	73.1%	77.2%	**59.0%**	77.6%	60.6%	61.9%	76.7%	84.1%	65.7%
Total no. of responses	26	421	39	388	66	21	317	138	134

Importantly, trainees who were undertaking a placement in an ED accredited for 24 months were less likely than trainees in EDs accredited for shorter training durations to agree that their placement provided a safe and supportive workplace, except with respect to the provision of clinical protocols and a comprehensive orientation program at commencement (Table 11).

Table 11. Proportion of trainees who strongly agreed or agreed that specific aspects relating to a safe and supportive workplace were provided in their ED placement, by accreditation level.

Placement provides a safe & supportive workplace with respect to:	% Strongly agreed / agreed			
	6	12	18	24
Overall safety & support	93.3%	92.7%	92.2%	**87.8%**
Personal safety	88.3%	88.4%	86.1%	**82.6%**
Sustaining my wellbeing	90.0%	82.9%	78.4%	**71.4%**
Support processes (other than mentoring)	85.0%	80.4%	81.2%	**75.6%**
Clinical protocols	83.3%	**81.5%**	91.4%	90.5%
Supervision arrangements	91.7%	90.9%	88.2%	**87.0%**
Comprehensive orientation	85.0%	**67.6%**	81.2%	75.5%
Total no. of responses	60	275	245	970

Trainees who disagreed that their ED placement provided a safe and supportive workplace were asked to provide a reason(s) for their response, with 183 trainees providing feedback (Table 12).

Table 12. Themes of trainee responses relating to their placement not meeting aspects of a safe and supportive workplace, with example comments.

Theme	Example comments
Personal safety (n=59) *Increasing violent/ agitated patients, insufficient security, aggressive mental health patients*	*We're constantly overloaded in terms of patient to staff ratio. Lots of drug and alcohol induced aggression, both staff and security are stretched over the maximum. We've been on lockdowns more frequently; staff are getting injured more frequently as well. We'd be scared to walk to the carpark on our own unescorted after an evening shift.* *This community has a very high number of mental health and drug affected individuals. These individuals are often dumped in ED while very agitated/ aggressive/ violent. There is very little infrastructure or security presence to safely deal with these people.*
Trainee wellbeing (n=48) *Burnout, unsupportive rostering*	*Extremely heavy burden of work, particularly on night shift for team leaders- essentially 3 consultants' workloads on one trainee's shoulders.* *There are several times I have been left alone with sick patients who I feel incompetent to manage. This is not because consultants/registrars are unwilling to help, they just cannot because they also have very sick patients who are deteriorating. Several times I have gone home and cried because I felt entirely unable to get the best help for my patients.*
Orientation (n=46) *Minimal or no orientation at commencement*	*Orientation documents provided via email, but no formal orientation organised at start of term.* *There was no orientation at anytime during my time at [hospital]; I was given a 4 page print out and told to come to work early one day and orient myself by completing this form and handing back to staff.*
Supervision and mentoring support (n=27) *Limited clinical supervision, minimal feedback/ guidance*	*A distinct lack of consultant supervision on the floor with registrars managing a patient load and supervision also.* *Consultant group are busy providing assistance to interns and junior doctors which leaves the independent ACEM trainee unsupervised and this shows up as lack of meaningful feedback at the end of the term.*
Clinical protocols (n=21) *Outdated, lack of accessibility*	*Clinical protocols are lacking and outdated. It would be good if we could access the protocols of the public hospitals – as the ED protocols are lacking. For example, the protocols surrounding management of chest pain and suspected pulmonary embolism need updating to provide us with an agreed clinical decision-making tool as there is enormous variability amongst consultants on workup of these issues.*
Patient safety and quality of care (n=19) *Bed block, understaffing esp. at night shift*	*We have had an unacceptable number of near-misses due to patient number and specialist level supervision is limited.* *Current departmental congestion due to access block means the department is not a safe place for patients or staff most of the time.*
Unfair treatment (n=6)	*Lack of support shown on two different occasions gives an impression of favouritism in the department.* *Rostering was inconsistent and there seemed to be an unfair distribution of night shifts to certain residents and registrars.*

Note: Comments from respondents may fit into more than one theme

4.2.6 Discrimination, Bullying, Sexual Harassment, Harassment (DBSH)

Trainees were asked if they had experienced DBSH in their placement, with detailed definitions provided for each aspect of DBSH. When asked if they had experienced any DBSH from a patient or carer, 492 (31.7%) trainees responded 'yes', with a higher percentage of provisional trainees (141/391, 36.1%), compared with advanced trainees (351/1159, 30.3%) reporting so. A further 50 (3.2%) trainees reported 'unsure', with slightly more provisional trainees (3.5%) than advanced trainees (2.3%) reporting this.

It is important to note that there was a significantly higher proportion of female trainees (41.0%) who responded either 'yes' or 'unsure' to this question, compared with male trainees (29.8%). Some example comments from trainees on their experiences of DBSH from a patient or carer are provided below:

> *Being bullied by patients and their families is not uncommon, in a number of EDs I have worked in. I see it more as a part of the Disease process, rather than something I take personally.*
>
> *Intimidation, verbal and physical aggression from patients is clearly more commonplace these days in the Emergency Department.*
>
> *Sexism from patients is unfortunately common. Overall the hospital is supportive, and the department has a large proportion of female consultants who are good mentors and role models.*

Subsequently, trainees were asked if they had experienced any DBSH from ED or hospital staff while working in their placement. A total of 185 (11.9%) of 1550 trainees responded 'yes' (n=156) or 'unsure' (n=29), with a slightly higher percentage of female trainees (13.4%) than male trainees (10.6%) reporting so. Of 156 (10.1%) trainees who responded 'yes' to this question, a higher proportion of provisional trainees (12.0%) than advanced trainees (9.4%) was seen. Twenty-nine (1.9%) trainees responded with 'unsure' to this question, with comparable proportions of advanced trainees (2.2%) and provisional trainees (1.0%) reporting this.

Table 13 shows the proportion of trainees who responded either 'yes' or 'unsure' to both DBSH questions, by region. Nearly half (49%) of the trainees in Western Australia (WA) reported having experienced DBSH from a patient or carer while working at their placement. Whereas trainees from SA and TAS reported the highest rates of DBSH from ED or hospital staff, with 12% of trainees in SA reporting experiencing DBSH from FACEMs.

Table 13. Proportion of trainees who responded 'yes' or 'unsure' when asked if they had experienced any DBSH from a patient/ carer or from staff, by region.

	% Yes or Unsure									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Experienced any DBSH from a patient/ carer?	26.9%	33.7%	35.9%	35.1%	**39.4%**	38.1%	30.3%	**49.3%**	33.6%	35.0%
Experienced any DBSH from ED or hospital staff?	7.7%	15.7%	7.7%	8.2%	**21.2%**	**19.0%**	10.7%	12.3%	9.7%	11.9%
Experienced DBSH by FACEMs	3.8%	5.2%	5.1%	3.6%	**12.1%**	4.8%	4.4%	5.1%	3.7%	4.8%
Total no. of responses	26	421	39	388	66	21	317	138	134	1550

Trainees who reported having experienced DBSH from staff were further asked about which person(s) displayed the DBSH behaviour toward them, with in-patient staff and FACEMs the most frequently reported staff (Table 14). There were 81 (58%) of 140 placement sites that had at least one trainee report having experienced DBSH by staff, with 48 (34%) sites having at least one trainee report experiencing DBSH by a FACEM.

Table 14. Number of trainees who reported experiencing DBSH behaviour against them, by category of staff.

	Any DBSH from ED or hospital staff			
	Yes	Unsure	Total No.	% of all trainees
In-patient (other ward) staff	77	9	86	5.5%
FACEM	58	16	74	4.8%
ED nursing staff	45	2	47	3.0%
Other ED doctor	27	2	29	1.9%
*Other staff	19	6	25	1.6%

Note: Trainees could select more than one category, 47 (25%) of 185 trainees reported that they had experienced DBSH from two or more categories of staff
**Other staff included radiologists, security guards, consultants or registrars from other specialities, mental health nurse consultants, etc.*

Fifty-five trainees provided further information on their DBSH experiences. Consistent with the earlier results, the majority of DBSH incidents were exhibited by in-patient staff and FACEMs/ DEMTs. Key themes which emerged from the feedback included:

- Incidents with in-patient teams often involved registrars and consultants from other specialties, and very commonly happened during phone communication and the referral process.
- For the trainees who reported experiencing bullying from FACEMs and/ or DEMTs, this primarily related to experiences of receiving humiliating or harsh criticism on their performance, especially in front of other peers or patients.
- For the trainees who reported experiencing discrimination, this was often based on their gender (female in particular), ethnicity and family commitments.

4.2.7 Opportunities to participate

Just over half (58%) of responding trainees strongly agreed or agreed that they were able to participate in decision making regarding governance (e.g. workplace committees) at their ED placement, while a further 26% neither agreed nor disagreed, 11% disagreed or strongly disagreed, and 6% reported not knowing.

A larger proportion (72%) agreed that they were able to participate in quality improvement activities at their placement, with 19% neither agreeing nor disagreeing, and 6% disagreeing. No major differences were observed in the proportion of those who were in agreeance with this, by training level (advanced trainees, 72% vs. provisional trainees, 70%), or by gender (females, 73% vs. males, 71%).

Tables 15 and 16 present the proportion of trainees who agreed with statements relating to their opportunities to participate in decision making regarding governance and in quality improvement activities, by region and by accreditation level. In comparison to trainees in other regions, trainees in the NT were less likely to agree with both statements.

Table 15. Proportion of trainees who strongly agreed or agreed to statements relating to participation in quality improvement activities and in decision making regarding governance, by region.

Opportunities to participate	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Able to participate in decision making regarding governance (e.g. workplace committees)	61.5%	57.5%	**41.0%**	63.1%	65.2%	71.4%	56.2%	56.5%	44.0%	57.5%
Able to participate in quality improvement activities	65.4%	69.4%	**59.0%**	78.1%	74.2%	76.2%	64.7%	84.8%	66.4%	71.7%
Total no. of responses	26	421	39	388	66	21	317	138	134	1550

No specific pattern was observed with respect to the accreditation level of placement sites and opportunities to participate, although trainees undertaking a placement in an ED accredited for 12 months were slightly less likely to agree that they had opportunities to participate in governance and quality improvement activities (Table 16).

Table 16. Proportion of trainees who strongly agreed or agreed to statements relating to participation in quality improvement activities and in decision making regarding governance, by accreditation level.

Opportunities to participate	% Strongly agreed / agreed			
	6	12	18	24
Able to participate in decision making regarding governance (e.g. workplace committees)	63.3%	**53.1%**	54.3%	59.3%
Able to participate in quality improvement activities	71.7%	**66.9%**	70.6%	73.3%
Total no. of responses	60	275	245	970

4.3 Supervision and Training Experience

This section details responses relating to supervision and feedback, support for WBAs, and whether the ED placements provide an appropriate training experience when considering casemix.

4.3.1 Supervision and feedback

Trainees were asked about supervision, support and feedback provided by senior staff at their ED placement. The majority of them (90%) were satisfied with the supervision they received at their placement overall. The same proportion of trainees (91%) agreed that they were satisfied with the quality of the DEMT support and that the availability of their DEMT for guidance and supervision met their needs at their stage and phase of training (Table 17).

With respect to clinical supervision from FACEMs at their placement, 90% of trainees strongly agreed or agreed that it met their needs at their stage and phase of training. No differences were observed between male and female trainees or by trainee level.

A smaller proportion (72%) of trainees were in agreeance that they received regular, informal feedback on their performance and progress, with the same proportion of advanced trainees and provisional trainees reporting this. There were also comparable proportions of male (73%) and female (71%) trainees agreeing with this statement.

Table 17 presents the proportion of trainees in agreement with statements relating to supervision, support and feedback at their ED placement, by region. Trainees undertaking a placement in TAS were less likely to agree that they were satisfied with the quality and availability of DEMT support, whereas trainees in the NT were less likely than trainees in other regions to agree that they received clinical supervision or informal feedback that met their needs.

Table 17. Proportion of trainees who strongly agreed or agreed with statements about supervision, support and feedback provided at their placement, by region.

Statements about supervision, support and feedback	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Overall, satisfied with the supervision received	88.5%	87.4%	89.7%	94.8%	87.9%	95.2%	**86.4%**	92.8%	88.8%	89.9%
Satisfied with quality of DEMT support	96.2%	89.5%	82.1%	94.3%	90.9%	**76.2%**	90.5%	94.2%	91.8%	91.4%
Availability of DEMT for guidance and supervision meets trainee needs	96.2%	88.8%	84.6%	94.8%	87.9%	**76.2%**	88.6%	93.5%	89.6%	90.6%
Clinical supervision received from FACEMs meets trainee needs	84.6%	89.8%	**82.1%**	95.1%	89.4%	90.5%	84.5%	91.3%	88.8%	89.8%
Receive regular, informal feedback on performance and progress	65.4%	69.8%	**64.1%**	78.6%	69.7%	81.0%	68.5%	75.4%	70.1%	72.2%
Total no. of responses	26	421	39	388	66	21	317	138	134	1550

The proportion of trainees in agreeance with statements relating to supervision, support and feedback at their ED placement, are presented in Table 18 by accreditation level. Interestingly, trainees undertaking a placement in an ED accredited for 18 or 24 months were less likely to agree with most of the statements, compared with sites accredited for a shorter training duration.

Table 18. Proportion of trainees who strongly agreed or agreed with statements about supervision, support and feedback provided at their placement, by accreditation level.

Statements about supervision, support and feedback	% Strongly agreed / agreed			
	6	12	18	24
Overall, satisfied with the supervision received	95.0%	91.3%	91.4%	**88.8%**
Satisfied with quality of DEMT support	96.7%	90.5%	**90.2%**	91.5%
Availability of DEMT for guidance/ supervision meets trainee needs	96.7%	90.2%	**88.2%**	90.9%
Clinical supervision received from FACEMs meets trainee needs	91.7%	92.7%	90.2%	**88.8%**
Receive regular, informal feedback on performance and progress	86.7%	74.9%	71.4%	**70.7%**
Total no. of responses	60	275	245	970

4.3.2 Workplace-based Assessments

Advanced trainees were asked to rate the support and feedback provided by their Local WBA Coordinators, FACEMs and WBA assessors at their ED placement, with provisional trainees not required to undertake WBAs.

Three-quarters (76%) of advanced trainees strongly agreed or agreed that they were satisfied with the level of support they received from their Local WBA Coordinator, with 17% neither agreeing nor disagreeing and 7% disagreeing. A slightly higher proportion (79%) were satisfied with the level of support they received from FACEMs to complete their EM-WBA requirements. With respect to feedback, 89% of advanced trainees were in agreeance that WBA assessors/ FACEMs provided useful feedback to guide their training.

The proportion of advanced trainees who agreed that they were satisfied with the support from their Local WBA Coordinator, FACEMs and WBA assessors is provided in Table 19 by region, and in Table 20 by ED accreditation level.

Table 19. Proportion of advanced trainees who agreed that they were satisfied with the support and feedback from their local WBA Coordinator, FACEMs, and/ or WBA assessors, by region.

Statements about WBAs	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Satisfied with the level of support from Local WBA Coordinator	75.0%	71.2%	75.9%	80.2%	75.5%	93.3%	75.5%	80.6%	**68.3%**	75.6%
Satisfied with the level of support from FACEMs	75.0%	73.9%	75.9%	83.3%	**73.5%**	80.0%	78.7%	85.4%	76.0%	78.6%
WBA assessors/ FACEMs provide useful feedback	87.5%	88.6%	**82.8%**	93.4%	83.7%	86.7%	85.5%	90.3%	92.3%	89.2%
Total no. of responses	16	306	29	288	49	15	249	103	104	1159

Consistent with the earlier findings regarding supervision and feedback, trainees undertaking a placement in an ED accredited for 18 or 24 months were also less likely to agree that they were satisfied with the support and feedback from their Local WBA Coordinator, FACEMs and WBA assessors (Table 20).

Table 20. Proportion of advanced trainees who agreed that they were satisfied with the support and feedback from their local WBA Coordinator, FACEMs, and/or WBA assessors, by accreditation level.

Statements about WBAs	% Strongly agreed / agreed			
	6	12	18	24
Satisfied with the level of support from Local WBA Coordinator	78.3%	74.9%	**71.2%**	76.8%
Satisfied with the level of support from FACEMs	95.7%	80.0%	78.0%	**77.3%**
WBA assessors/ FACEMs provide useful feedback	97.8%	90.3%	**86.4%**	89.1%
Total no. of responses	46	195	191	727

Advanced trainees were also surveyed about how WBAs were organised at their site (Table 21). The majority of them reported that it was the trainee's responsibility (74%), rather than the DEMT or WBA Coordinator to schedule WBAs (30%). Trainees were also more likely to report that the WBAs were conducted on an ad hoc basis, instead of being organised through a rostered WBA Consultant or rostered WBA session.

Table 21. How are WBAs organised at sites for trainees

How are WBAs organised at your site?	Number of Respondents*	%
It is the trainee's responsibility	855	73.8%
They are scheduled by DEMT or WBA Coordinator	345	29.8%
Through rostered WBA Consultant	222	19.2%
Through rostered WBA session	89	7.7%
On an ad hoc basis	379	32.7%
Other (e.g. assessors were allocated or trainees were informed of consultant availability and used this information to initiate WBAs themselves, ad hoc initiated by FACEM on-floor, during teaching session, etc.)	24	2.1%
Total no. of respondents	1159	

*Note: *Respondents may select more than one way of how the WBAs were organised at their site, with 519 (45%) advanced trainees doing so.*

4.3.3 Casemix

Trainees were asked to rate their level of agreement that their ED placement provided an appropriate training experience when considering casemix. Overall, the majority of trainees agreed that the ED casemix at their placement was appropriate with respect to the number (96%), breadth (90%), acuity (86%), and complexity of cases (91%) (Table 22). There were no significant differences in the responses provided by advanced and provisional trainees. Trainees with an ED placement in TAS were less likely to be satisfied with their placement in providing an appropriate training experience when considering different aspects of casemix, compared with trainees in other regions (Table 22).

Table 22. Proportion of trainees who agreed that their current placement provided an appropriate training experience when considering aspects of casemix, by region.

Aspects of casemix	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Number of cases	96.2%	96.2%	94.9%	98.5%	98.5%	**90.5%**	93.4%	97.8%	96.3%	96.3%
Breadth of cases	96.2%	90.0%	89.7%	90.7%	95.5%	**85.7%**	86.8%	90.6%	90.3%	89.9%
Acuity of cases	88.5%	88.1%	82.1%	87.6%	95.5%	85.7%	**79.8%**	84.8%	86.6%	86.0%
Complexity of cases	**84.6%**	90.5%	92.3%	93.6%	92.4%	**85.7%**	88.6%	87.7%	91.8%	90.7%
Total no. of responses	26	421	39	388	66	21	317	138	134	1550

Not surprisingly, higher proportions of trainees undertaking placements in EDs accredited for 24 or 18 months agreed that the ED casemix at their placement was appropriate with respect to the number, breadth, acuity, and complexity of cases (Table 23).

Table 23. Proportion of trainees who agreed that their current placement provided an appropriate training experience when considering aspects of casemix, by accreditation level.

Aspects of casemix	% Strongly agreed / agreed			
	6	12	18	24
Number of cases	**93.3%**	95.3%	97.1%	96.6%
Breadth of cases	91.7%	**84.7%**	89.4%	91.3%
Acuity of cases	80.0%	**79.3%**	82.4%	89.2%
Complexity of cases	**85.0%**	88.7%	86.1%	92.8%
Total no. of responses	60	275	245	970

4.3.4 Supervision and training experience – further comments

There were 131 further comments provided by trainees relating to the supervision or training experience at their placement. Half (n=66) of the comments reflected on various aspects of the casemix available at their placement. Other comments comprised of both positive (14%, n=18) and negative (34%, n=45) perspectives of supervision and training experiences (Table 24). Negative comments were largely focused on the difficulty to complete WBAs, or unsatisfactory senior supervision and feedback.

Table 24. Themes of trainee comments regarding the supervision and training experience at their ED placement, with example comments.

Theme	Example comments
Negative comments	
Difficulty in completing WBAs (n=27) *Lack of time due to workload, limited access to FACEMs, unsupportive FACEMs*	*Can be difficult to get WBAs done due to workload, was previously much better with a rostered WBA consultant.* *There are a very limited number of FACEMs who actually have non-clinical time to be able to complete WBAs.* *I am struggling with WBAs badly. I have repeatedly approached multiple consultants to schedule them. I have been very flexible with coming in on days off and moving other conflicting events....and yet cannot get consultant engagement.*
Lack of senior supervision (n=10) *High workload coupled with understaffing*	*The sheer number of presentations coupled with access block and senior decision maker staff shortages means that there is generally a lack of trainee supervision on the floor and minimal feedback on assessment and management to guide training.* *Consultants are busy with [hospital] workload , either facilitating patient's movement or supporting interns and junior RMOs which leaves ACEM advanced trainees working solo and rarely supervised.*
Limited quality feedback (n=8)	*Feedback is summative i.e. during the ITA process. We meet with DEMT for ITAs only, but no other meetings or informal feedback is given.* *I had found the ITA reviews a difficult process because there were issues which were brought up that weren't mentioned anywhere during the three months prior to each ITA. And the ITA comments were vague and not very constructive as there was no particular issue which they were raising except from what they were feeling.*
Positive comments	
Supportive DEMTs or FACEMs (n=10)	*Excellent consultant workforce providing valuable feedback. Superlative DEMT and examination preparation support.* *Amazing support for FACEM exam, one on one sessions with lots of practice exam marking and going through questions, etc. I found it immensely helpful.*
Good WBA support (n=8)	*Extremely happy with the WBA system here and have plenty of opportunity to complete WBAs opportunistically.* *There has been a huge improvement in WBAs this year at [hospital]. The new coordinators are doing some good work.*
Suggestions for improvement (n=9)	*A more organized approach towards WBAs, particularly Mini-CEXs, would be very beneficial. For example, rostering the clinical support consultant on in the daytime to a registrar or to all day registrars for the purpose of Mini-CEXs.* *Having a dedicated rostered WBA consultant would allow trainees to better meet their WBA requirements.* *It would be beneficial for trainees and WBA co-ordinators if they can see which WBAs are due and by when for each trainee.*

Note: Comments from respondents may fit into more than one theme

4.4 Education and Training Opportunities

This section presents responses to survey items relating to the educational and training opportunities available at trainees' ED placements. It covers clinical teaching, the structured education program, access to educational and examination resources, simulation learning experiences, leadership and research opportunities.

4.4.1 Clinical teaching and the structured education program

The majority of trainees strongly agreed or agreed that the clinical teaching at their placement optimised their learning opportunities (86%), and that they received training for, and were provided with opportunities to use relevant clinical equipment (88%). However, only 62% of trainees were in agreeance that they had access to formal ultrasound teaching.

The same proportion of trainees strongly agreed or agreed that the structured education program met their needs at their stage and phase of training, and that it was aligned to the content and learning outcomes of the ACEM Curriculum Framework (82%, respectively). Advanced trainees (81%) however, were less likely than provisional trainees (84%) to agree that the structured education program at their placement met their needs. Trainees were asked whether the structured education sessions were provided for, on average, a minimum of four hours per week at their placement, with 88% agreeing with this statement. However, only 74% of trainees were in agreeance that the rostering at their placement enabled them to attend the structured education sessions, with a higher proportion of advanced trainees (75%) than provisional trainees (70%) agreeing with this.

Table 25 shows the proportion of trainees who strongly agreed or agreed with statements about the structured education program at their ED placement, by region. Trainees undertaking a placement in TAS or NZ were less likely to agree with each of the four statements, compared with trainees in other regions.

Table 25. Proportion of trainees who strongly agreed or agreed with statements about the structured education program available at their ED placement, by region.

Structured Education Program	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
The structured education program meets trainee's needs	92.3%	79.8%	87.2%	87.1%	81.8%	**61.9%**	79.8%	86.2%	73.1%	81.9%
Structured education sessions are provided for a minimum of four hours per week	73.1%	86.9%	94.9%	89.2%	92.4%	95.2%	93.7%	85.5%	**70.1%**	87.6%
The structured education program aligns to the content and learning outcomes of the ACEM Curriculum Framework	76.9%	80.0%	82.1%	88.7%	89.4%	**47.6%**	81.4%	85.5%	68.7%	81.9%
Rostering enables trainees to attend structured education sessions	69.2%	67.9%	84.6%	74.7%	86.4%	66.7%	83.9%	75.4%	**60.4%**	74.1%
Total no. of responses	26	421	39	388	66	21	317	138	134	1550

A higher proportion of trainees undertaking a placement in 24-month accredited sites were in agreeance with most statements relating to the structured education program at their placement, compared with trainees in EDs accredited for shorter placement periods (Table 26).

Table 26. Proportion of trainees who strongly agreed or agreed with statements about the structured education program available at their ED placement, by accreditation level.

Structured Education Program	% Strongly agreed / agreed			
	6	12	18	24
The structured education program meets my needs	81.7%	82.5%	**78.0%**	82.7%
Structured education sessions are provided for a minimum of four hours per week	**76.7%**	84.4%	87.3%	89.3%
The structured education program aligns to content and learning outcomes of the ACEM Curriculum Framework	**76.7%**	81.5%	83.3%	82.1%
Rostering enables me to attend structured education sessions	80.0%	69.8%	**68.6%**	76.4%
Total no. of responses	60	275	245	970

4.4.2 Access to educational and examination resources

A higher proportion of advanced trainees (89%) than provisional trainees (85%) were in agreeance that they had access to the educational resources that they needed to meet the requirements of the FACEM Training Program. With respect to exam courses, there were comparable proportions of trainees who agreed that they had access to exam revision courses (77% for the written exam and 75% for the clinical exam), and exam preparation courses (74%).

Table 27 shows the proportion of trainees who agreed with the statements about the availability of educational and examination resources, by region. Trainees undertaking an ED placement in SA were less likely to agree with the availability of resources, compared with trainees in other regions.

Table 27. Proportion of trainees who strongly agreed or agreed with statements about the educational and examination resources available at their ED placement, by region.

I have access to:	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Educational resources that I need to meet the requirements of the FACEM Training Program	84.6%	85.5%	94.9%	91.2%	**83.3%**	85.7%	85.5%	91.3%	89.6%	87.9%
Written exam revision courses	84.6%	74.8%	82.1%	79.1%	**71.2%**	76.2%	74.8%	79.0%	76.9%	76.6%
Clinical exam revision courses	73.1%	73.9%	84.6%	77.3%	**69.7%**	76.2%	71.6%	76.1%	76.1%	74.8%
Clinical exam preparation courses	76.9%	72.7%	76.9%	75.8%	**69.7%**	76.2%	70.3%	77.5%	73.1%	73.5%
Total no. of responses	26	421	39	388	66	21	317	138	134	1550

Trainees undertaking a placement in 24-month accredited sites were generally more likely to agree that educational and examination resources were available at their placement, compared with sites accredited for shorter durations. Trainees undertaking a placement at EDs accredited for 18 months, however, were among the least likely to agree with these statements (Table 28).

Table 28. Proportion of trainees who strongly agreed or agreed with statements about the educational and examination resources available at their ED placement, by accreditation level.

I have access to:	% Strongly agreed / agreed			
	6	12	18	24
Educational resources that I need to meet the requirements of the FACEM Training Program	91.7%	**85.8%**	86.1%	88.8%
Written exam revision courses	66.7%	67.3%	**62.4%**	83.5%
Clinical exam revision courses	70.0%	65.5%	**60.0%**	81.4%
Clinical exam preparation courses	71.7%	64.0%	**57.6%**	80.4%
Total no. of responses	60	275	245	970

Trainees who disagreed with any of the statements relating to educational and training opportunities available at their placement, were asked to comment on the reason(s) for their response. Table 29 provides the key themes from 253 responses and some example comments. Three key themes were identified, which were the absence of formal ultrasound teaching onsite (34%), unsupportive rostering which included unprotected teaching (29%), and poorly conducted education program (20%).

Table 29. Themes of trainee comments regarding the educational and training opportunities at their ED placement, with example comments.

Theme	Example comments
No formal ultrasound teaching (n=85) *Off-site, difficult to access, ad-hoc*	*No courses on site but given leave for external courses.* *We have limited ad hoc US training. On the job mostly. Occasionally the group teaching sessions.*
Rostering unsupportive of teaching program (n=74) *Teaching not protected (n=28), fatigue post night shift, no access to grand round*	*Only rostered on for 2-3 education sessions per term. This means that trainees are required to attend sessions on days off.* *If I want to attend more teaching I must come to hospital on sleep days post night shift and during rostered days off.* *Unable to get to grand rounds, trauma forums, etc. unless specifically not rostered on for that day.*
Poorly or no structured education program (n=51) *Not tailored to the level of training, only available at external sites, repetitive material*	*Approximately one hour of self-directed teaching per week. No formal teaching program. There is no 'protected' teaching time as the department is busy and understaffed.* *Much of teaching seems ad hoc for trainees. There does not seem to be a structured approach to covering all of curriculum. Department teaching didactic and onus is on trainees to do presentation.* *Majority of teaching time is mixed skill based (intern/resident/registrar). This makes it very difficult to meet educational needs for each group.*
Lack of exam preparation support (n=37) *Limited courses or resources, inexperienced FACEMs*	*No formal fellowship teaching on site, and trainees are expected to travel to another hospital for fellowship teaching.* *There is no formal primary or fellowship education program that I'm aware of. The resources are somewhat poor with old textbooks, the library not having copies of all the prescribed texts for the primary examination, and no models (for the primary viva).*
Less than 4 hours per week (n=33)	*At this stage teaching is provided for 4 hours per fortnight on a joint arrangement with intensive care.*

	I have been a provisional trainee for the last 2 years. For the last 5 months I've had 2.5 hours/week of study groups for primary exam. Prior to that I did not have any education sessions.
Minimal clinical teaching (n=12)	*Little to no bedside teaching, formal or informal. Teaching on rostered teaching days done by other registrars, not consultants.* *The department has been so busy and overcrowded there is little time on the floor for clinical teaching aside form informal chats when discussing patient presentations with consultant.*
Limited or no simulation experiences (n=6)	*There is very limited simulation and practical skills teaching with simulation/real equipment.* *Lack of simulation training is the biggest drawback in their teaching schedule. One maximum two simulation sessions in 6 months is just not adequate for the train requirements.*
Not having access to exam resources (n=6)	*Unclear what is meant by revision courses. Not offered by the department which I don't feel is unusual.*

Note: Where applicable, comments from the individual respondents were coded across more than one theme

4.4.3 Simulated learning experiences

The majority (93%) of trainees reported that simulation learning experiences were utilised at their ED placement, with 2% unsure and 5% reporting that these were not available at their placement. Trainees undertaking a placement in EDs accredited for 18- or 24-month placements (95%-96%) were significantly more likely than those in EDs accredited for six- or 12-month placements (73%-88%) to report that simulation learning experiences were utilised.

Of trainees who reported the availability of simulation learning experiences (n=1439), nearly all (96%) of them reported that they had participated in simulation learning experiences at their placement. The same proportion of provisional trainees and advanced trainees (4%, respectively) reported that they had not participated in simulation learning at their placement, and 38 of them provided a reason for not participating. The main reason given for not participating in simulation learning was due to rostering constraints (n=26), where they were either not rostered for the simulation session, or they were too busy to attend one. Other reasons included focusing on exam preparation instead (n=4), attending other teaching sessions instead (n=2), or family commitments (n=2). Four provisional trainees stated that the simulation sessions at their placement were only available for registrars.

A relatively smaller proportion (80%, n=1145) of trainees reported that they had participated in interprofessional team-based simulation training at their placement, with similar proportions of provisional trainees (79%) and advanced trainees (80%) reporting so. There were no major differences in the proportion of provisional trainees and advanced trainees who were in agreeance with statements relating to participation in team-based simulation training (Table 30).

Table 30. Proportion of trainees who strongly agreed or agreed with statements regarding participation in interprofessional team-based simulation training, by training level.

Participation in team-based simulation training at this placement:	% Strongly agreed / agreed		
	Provisional Trainees	Advanced Trainees	Total
Has improved my effectiveness in ED team-based practice	93.8%	92.7%	**93.0%**
Has contributed to my leadership development	89.7%	90.7%	**90.5%**
Has enhanced my learning and team-based practice	92.1%	90.4%	**90.8%**
Total no. of responses	291	854	1145

Of those who disagreed with any of the above statements relating to the interprofessional team-based simulation training, 24 trainees provided an explanation. Some trainees felt that team-based simulation was stressful and not truly reflective on individual ability especially when this involved a large group of participants without sufficient resources or space (n=8). A few others also commented that its benefit was often limited by infrequent (n=6) or poorly conducted (n=6) sessions (e.g. low quality debrief, constant interruptions). Others commented that it was not ED centric or helpful to improve their skills (n=4).

4.4.4 Leadership opportunities

A higher percentage of trainees strongly agreed or agreed that they were provided with opportunities to teach and supervise junior trainees (92%), compared with opportunities for leadership and management appropriate to their stage and phase of training (88%). Not surprisingly, a higher proportion of advanced trainees (93%) than provisional trainees (88%) were in agreeance that they were provided with opportunities to teach and supervise junior medical staff. Similarly, advanced trainees were also more likely than provisional trainees to agree that they were provided with leadership and management opportunities (90% vs. 84%).

4.4.5 Research opportunities

Table 31 presents responses to the statement ‘there is a designated staff member available to provide advice about the research component of the FACEM Training Program at my current placement’, by hospital accreditation level. Trainees undertaking their ED placement in hospitals accredited for 18- and 24-months of training (34% and 46%, respectively) were significantly more likely to respond that there was a designated staff member to advise on the research component, compared with six- and 12-month accredited sites (23%, respectively). However, a considerable proportion of trainees (27%) did not know if there was a designated staff member available to provide advice about the research component at their current placement – and this was consistently observed across EDs with different accreditation levels.

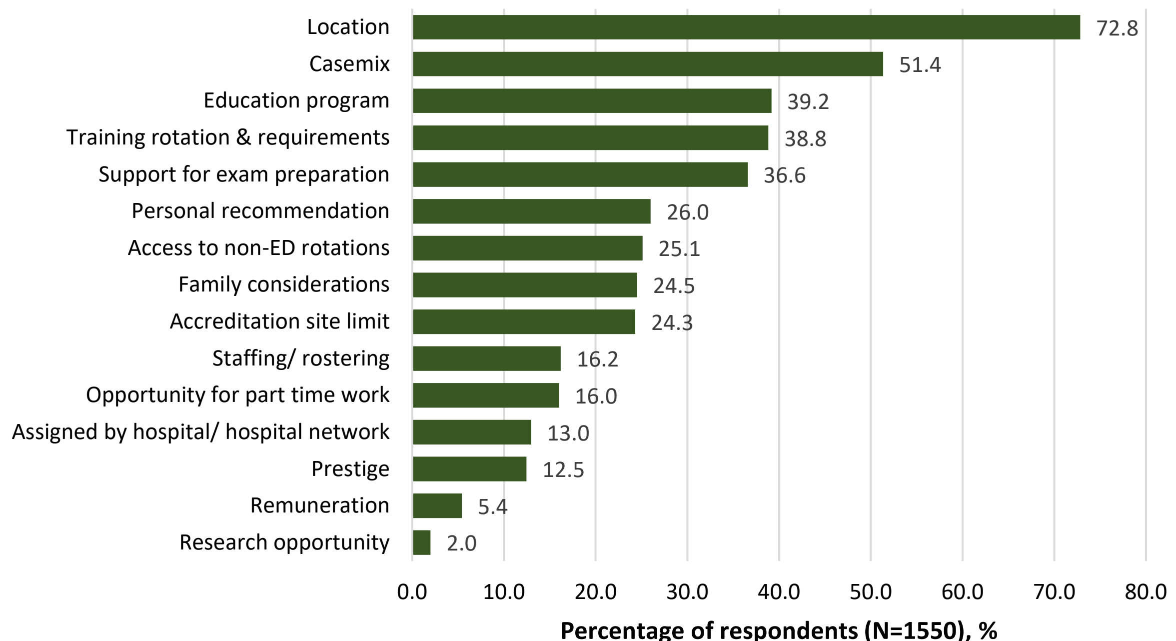
Table 31. Trainees’ responses to whether there was a staff member available to provide advice about the research component, by hospital accreditation level.

Staff member available to provide advice about research component	6	12	18	24	Total
Yes	23.3%	23.3%	33.5%	46.1%	**39.2%**
No	11.7%	8.0%	9.0%	3.7%	**5.6%**
Don’t know	20.0%	36.0%	29.4%	24.5%	**27.2%**
Not applicable (have previously completed/ not yet started research requirement)	45.0%	32.7%	28.2%	25.7%	**28.1%**
Total no. of responses	60	275	245	970	1550

4.5 Further Perspectives on Placement

From a list of potential factors, trainees were asked to select up to five key factors that they considered in arranging their training placement (Figure 1). ED location was the most considered factor when trainees arranged their placement, followed by casemix. On the contrary, remuneration and research opportunities were factors least considered by them. It is noteworthy that the availability of an education program (39%) and support for exam preparation (37%) were factors deemed of similar importance, as were training rotation and requirements (39%).

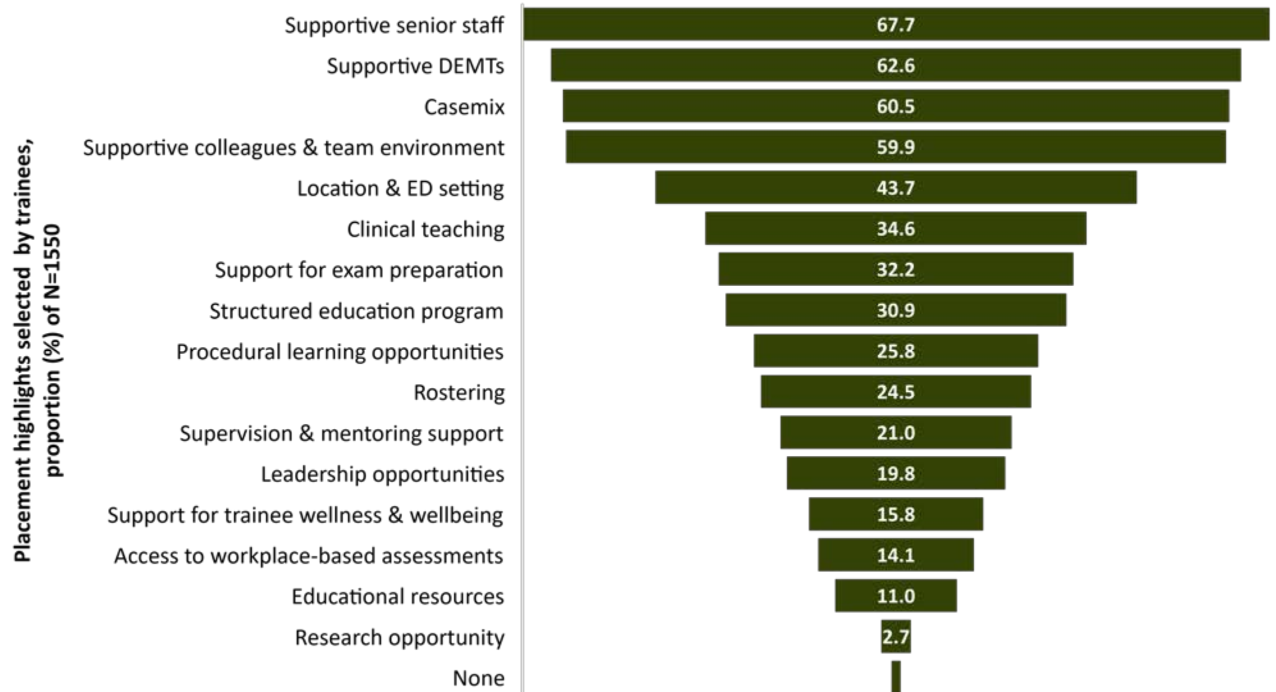
Figure 1 Factors for consideration in arranging training placement, ranked from the most important to the least important.



Note: Respondents could select up to five factors

Likewise, trainees were asked to nominate from a list the highlights of undertaking the placement, with trainees able to select as many highlights that applied. The most selected highlights included, supportive senior staff/ DEMT/ colleagues and ED casemix (Figure 2). Clinical teaching and support for exam preparation were highlights selected by around one-third of trainees. Access to WBAs, educational resources and the research opportunity, on the other hand, were the least selected highlights.

Figure 2 ED placement highlights selected by trainees, proportion of N=1550.



Note: Respondents could select more than one highlight for their placement.
No trainee selected 'Other' as one of the options in the list, whilst 13 (1%) trainees chose 'None' (i.e. no highlight in their placement)

Trainees were provided with the opportunity to detail any areas for improvement that could be made at their placement, with 255 trainees providing a response (Table 32). Improvements to the rostering (n=79, 31%), teaching/ education program (n=65, 25%), staffing and workload arrangements (n=47, 18%), and support for WBAs (n=31, 12%) were among the main areas identified by respondents.

Table 32. Themes and example comments for areas for improvement.

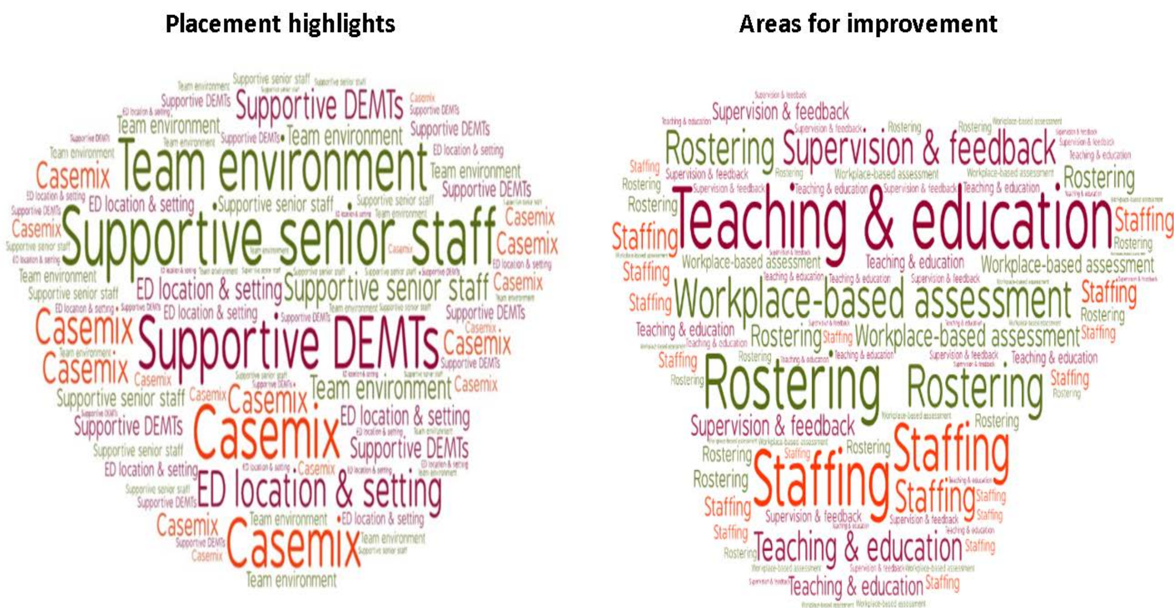
Theme	Example comments
Rostering (n=79) *Night shift, protected teaching time, non-clinical time, access to leave*	*Rostering, rostering, rostering. More mixture of shifts, rather than primarily evening or night shifts.* *More FACEMs to have access to non-clinical time to enable hopefully more of them to be engaged in our training and provide a more varied exposure of experience.* *More flexibility providing study leave prior to exams.*
Teaching/ education program (n=65) *Structured Fellowship teaching, better support for exams, ultrasound teaching, FACEM-led teaching*	*Could be more structured and aimed specifically for exams (i.e. include practice papers, exam technique etc.)* *More consultant led formal teaching sessions.* *Formal ultrasound teaching sessions or 6-month job / structured supervision for accreditation.*
Staffing and workload arrangements (n=47) *More trainees, more locum support, better staffing for night shifts, senior staff to trainee ratio*	*We need more trainees and we need equality in trainee attraction to this hospital.* *Additional funding for more consultant staff to properly supervise registrars and JMOs.* *Hire locums to fill the roster gaps if unable to recruit adequate staffing.*
Structured and better support for WBAs (n=31)	*A formal WBA process for booking in WBAs so can be undertaken as case load on floor often overtakes opportunity to complete them*

Rostered sessions, more formalised process	*WBAs need to be scheduled or rostered in a way that does not depend on a quiet shift (which is almost never).*
Senior supervision and feedback (n=29) *More informal feedback, mentoring, night shift supervision*	*More structured supervision and feedback for trainees during clinical shifts.* *More informal and regular feedback on my progress and development as a trainee to enable me to grow.*
Improve resources (n=22) *Reduce access block, increase bed capacity, security, equipment, IT systems, etc.*	*Better funding and management of our hospital so we can actually get patients up to the ward and see new ones.* *Security staff trained in code grey situations and more visible presence.*
Procedural learning experiences (n=17)	*More access to procedural opportunities. Frequently service demands mean that trainees are not given opportunity to do procedures as there is not appropriate supervision.* *I have not been given opportunities to intubate while at this placement for 9 months.*
Improve clinical teaching (n=12) *Bedside and on the floor teaching*	*Engagement for reflective teaching on shift. Supervision and on the job teaching. Currently we are all working most days in silos, getting through the workload.*
Trainee welfare and wellbeing (n=12) *Burnout, bullying, staff morale*	*Actual support for trainee's wellbeing not just on paper.* *The culture of sweeping bullying under the rug and of certain consultants making even senior, competent trainees feel incompetent, and penalising trainees for suggesting improvements because they "rock the boat".*
Access to non-ED rotation (n=11) *Clearer application process*	*No transparency with allocation of critical care or non-ED rotations. There appears to be no prerequisites (i.e. time spent working in the department) and no formal process for application/allocation.*
Leadership and junior teaching opportunities (n=10)	*Transitioning programme for senior registrars to take on more responsibility, leadership and management.*
More simulation opportunities (n=10)	*Simulation education, inter-professional education and increased training for advanced trainees separate to provisional.*
Casemix- Including opportunities to manage higher acuity patients (n=6)	*More access to high acuity cases. More resuscitation exposure.*
Research (n=4)	*Opportunities for research and time to undertake.*
Opportunities to contribute to governance, quality assurance activities etc. (n=4)	*There is no involvement of registrars (particularly senior or post exam registrars) in governance, protocols, committees or leadership within the department. Every registrar is essentially treated the same which is frustrating as you reach the end of training and are seeking ways to transition to FACEM.*
Other (n=7) *Orientation, team-building, increase accreditation level, etc.*	*Better orientation to department/role. Hospital orientation is very inadequate.* *No active team-building activities/support in place.* *Increasing the maximum training time available at this facility.*
Nothing - Great placement (n=3)	*Great hospital. Outstanding education program and excellent support.*

Note: Where applicable, comments from the individual respondents were coded across more than one theme

The five key areas for improvement identified from trainee responses were compared with trainees' feedback on highlights of their placement (Figure 3), with obvious differences observed. Whilst a supportive team environment and casemix were most commonly identified as placement highlights, rostering and staffing arrangements remained the key issues for improvement. Better support for teaching/ education program and WBAs were also consistently identified as areas to be further improved. Despite supportive senior staff/ DEMTs being the most selected placement highlight, trainees commonly reported senior supervision and feedback (both formal and informal) as needing to be improved.

Figure 3 Highlights vs. areas for improvement of placement, five key areas.



4.6 Overall Perspectives on the FACEM Training Program and Support from ACEM

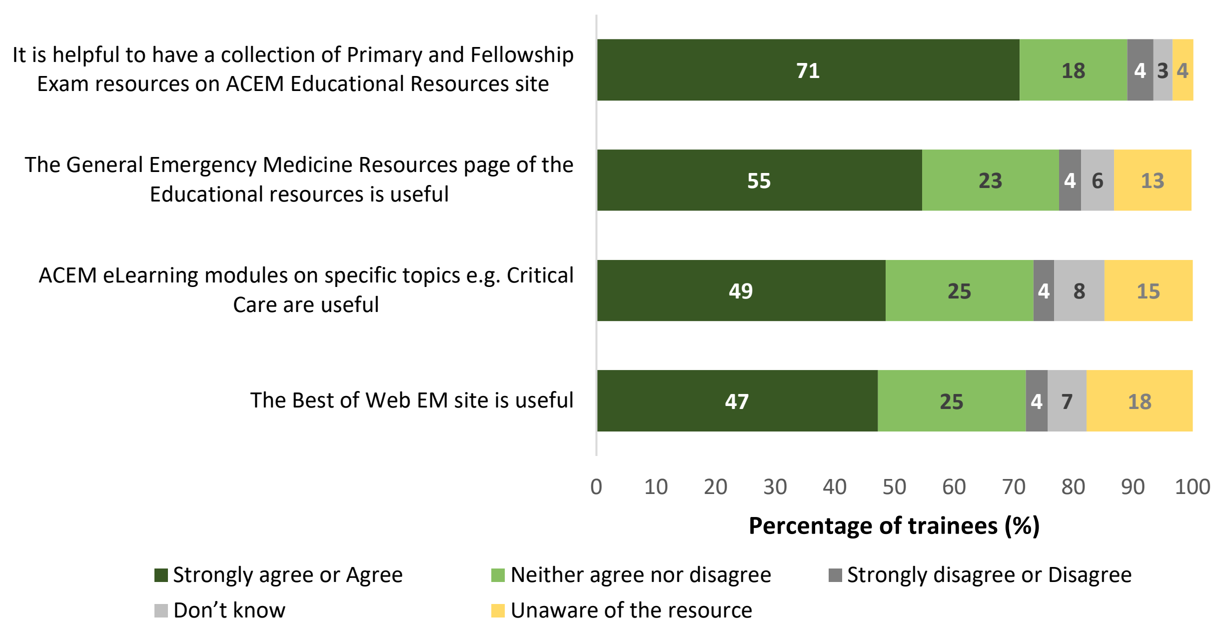
4.6.1 Perspectives on the FACEM Training Program

The majority (88%) of trainees strongly agreed or agreed with the statement that 'the FACEM Training Program is facilitating my preparation for independent practice as an EM specialist', with a comparable proportion of provisional trainees (86%) and advanced trainees (88%) reporting so. A further 9% neither agreed nor disagreed and 2% disagreed with this statement. However, a smaller proportion (78%) were in agreeance that they were well supported in their training by ACEM processes, with 17% being neutral and 5% disagreeing with this. There was also a comparable proportion of provisional trainees (79%) and advanced trainees (77%) who were in agreeance that they were well supported by ACEM processes. Female trainees were more likely than male trainees to agree that they were well supported by ACEM processes (80% vs. 76%), and that the FACEM Training Program facilitates their preparation for independent practice as an EM specialist (90% vs. 85%).

4.6.2 Available online resources for FACEM trainees

ACEM currently provides a range of resources to support FACEM trainees, with trainees asked to rate their level of agreement with statements relating to the usefulness of the listed resources (Figure 4). The collection of exam resources was found to be the most useful for trainees (71%), whereas slightly less than half of trainees found ACEM's eLearning modules on specific topics (49%) and the Best of Web EM site (47%) useful.

Figure 4 Level of agreement of respondents with statements relating to the usefulness of a range of resources to support FACEM trainees.



4.6.3 Support and resources – areas of need and interest

Trainees were asked to nominate resources and support in areas of need and/ or interest and their preferred delivery mode(s) for each selected area (Table 33), to inform the future development of appropriate resources and support. Resources and support nominated as areas of need/ interest by the largest number of respondents were the Fellowship Exam (both written and OSCE) and clinical skills.

For all resources and support that were nominated as an area of need/ interest, there was a preference for online learning modules and face-to-face training. For trainees who nominated ITAs, EM-WBAs, Fellowship exam – OSCE, communications skills, and clinical skills, the most preferred delivery mode was for face-to-face training. Whereas delivery through online learning modules was the most preferred mode for the other resources and support. There were also some preferences towards video podcasts for those who nominated examinations (Viva and OSCE), communication skills and clinical skills resources.

Table 33. Trainee response rates to resources and support nominated as an area of need and/ or interest and the preferred delivery mode(s).

Resources & Support	Respondents who nominated as area of need/ interest		Preferred Delivery Mode				
			Face-to-face training	ACEM online learning modules	Video podcasts	Web-links to external sources	How-to guide
	N	% of total	%	%	%	%	%
College updates	161	10.4%	24.2%	**41.6%**	29.8%	39.8%	19.3%
Learning Needs Analysis	166	10.7%	42.8%	**48.8%**	34.9%	24.7%	36.7%
In-Training Assessments (ITAs)	245	15.8%	**62.0%**	38.4%	31.0%	14.7%	27.3%
EM-WBAs	314	20.3%	**50.3%**	27.1%	22.9%	12.4%	22.6%
Primary Exam – written	190	48.6%*	53.7%	**80.0%**	47.4%	40.5%	33.7%
Primary Exam – Viva	192	49.1%*	69.8%	**74.0%**	52.1%	37.0%	34.4%
Fellowship Exam – written	849	54.8%	56.4%	**73.3%**	48.8%	44.9%	32.7%
Fellowship Exam – OSCE	890	57.4%	**76.6%**	62.9%	53.4%	39.0%	31.5%
Communication skills	280	18.1%	**74.3%**	47.9%	52.1%	27.9%	18.2%
Clinical skills	547	35.3%	**76.1%**	57.6%	56.9%	31.1%	28.9%
Clinical governance (HR, rostering, dealing with patient complaints)	397	25.6%	42.3%	**66.0%**	34.3%	33.5%	35.0%
Research	181	11.7%	48.1%	**51.4%**	26.5%	44.8%	41.4%

Note: Respondents may select more than one type of preferred delivery mode for each nominated resource/support
** For primary exam resources, responses from only the provisional trainees were included. The percentages reflect the proportion of 391 provisional trainees.*

Trainees were further asked if they had any suggestions for improvement to the current online resources provided by ACEM, with 60 providing a response. Two key suggestions were observed from the responses, which were to improve resources for exam preparation (e.g. more structured question banks, more past-year examples, better directed curriculum) (n=29, 48%), and ACEM website to include better search functionality, easier navigation and/ or better orientation to the resources (n=13, 22%). There were 11 (18%) other comments with suggestions for additional online resources and support, which broadly ranged from educational resources, clinical guidelines, journal access, and to support the research requirement. Five trainees provided positive comments that they were satisfied with the online resources, however two others commented that they prefer to use external resources.

5. Conclusion

Nearly all trainees agreed that their training needs were being meet at their ED placement. The majority of them reflected positively about the assistance they could seek if they experienced difficulty or a grievance, and that their placement provided a safe and supportive workplace. Trainees were more likely to report DBSH from a patient/ carer as opposed to from ED or hospital staff. Just over half of trainees agreed that they were able to participate in decision making regarding governance at their placement.

Regarding the supervision and training experiences at their ED placement, most trainees were satisfied with the quality and availability of DEMT support, as well as with the clinical supervision received from FACEMs. However, they were less likely to agree that they received regular informal feedback on their performance. Similarly, they were less satisfied with the support received to undertake WBAs. The majority reported that it was the trainee's responsibility to organise WBAs and these were usually conducted on an ad hoc basis instead of through rostered sessions.

The majority of trainees were in agreeance that clinical teaching at their placement optimised their learning opportunities, and that they had access to the educational resources that they needed. However, a smaller proportion of trainees agreed that the structured education program met their needs, and that rostering enabled them to attend the education sessions.

Placement highlights most selected by trainees were supportive senior staff, ED casemix and team environment. In contrast, teaching/ education program and support for WBAs were identified by other trainees as areas for improvement, alongside rostering and staffing arrangements.

Findings from this survey are useful to inform and support the process of ensuring ACEM-accredited EDs continue to provide training, and a training environment, which is appropriate, safe and supportive of FACEM trainees.

6. Suggested Citation

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7. Contact for Further Information

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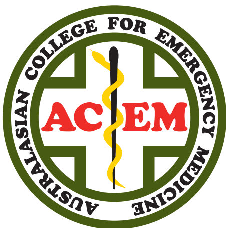

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