Australasian College
for Emergency Medicine

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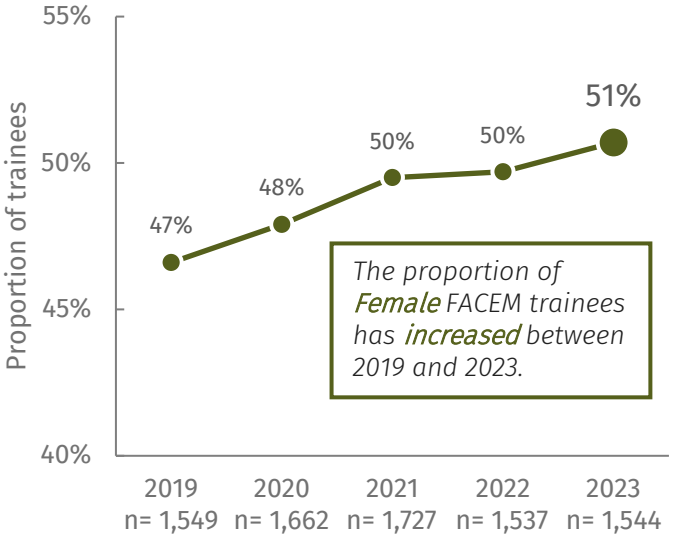
Report
June 2024

2023 Trainee Emergency Department Placement Survey

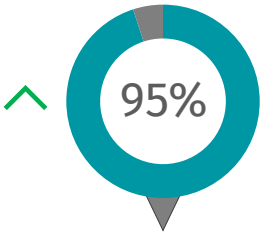
2023 Trainee ED Placement Survey

Key findings

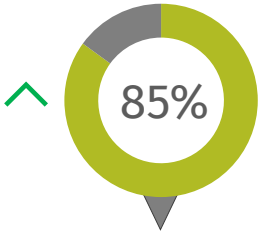
All active FACEM trainees are required to complete an annual trainee placement survey. Survey questions focus on three key areas of the ED placement: Health, Welfare and Interests of Trainees; Supervision and Training Experience; and Education and Training Opportunities. A total of 1,544 trainees responded to the 2023 survey.



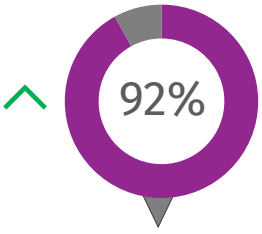
Health, Welfare and Interest of Trainees



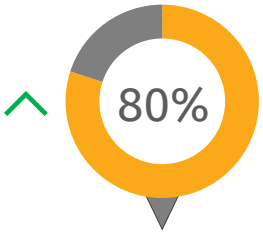
Agreed their training needs were being met.



Overall satisfied with rostering at their placement.



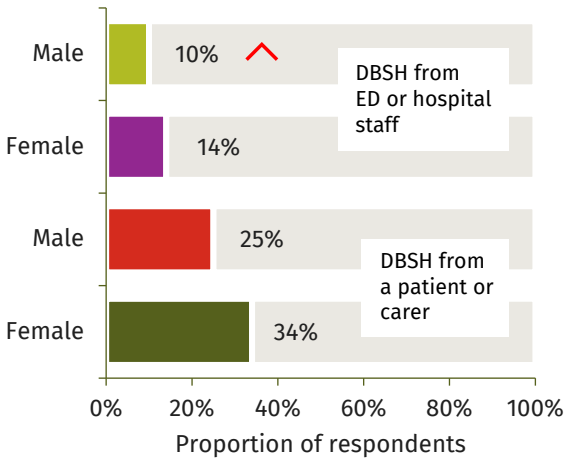
Agreed their placement provided a safe and supportive workplace.

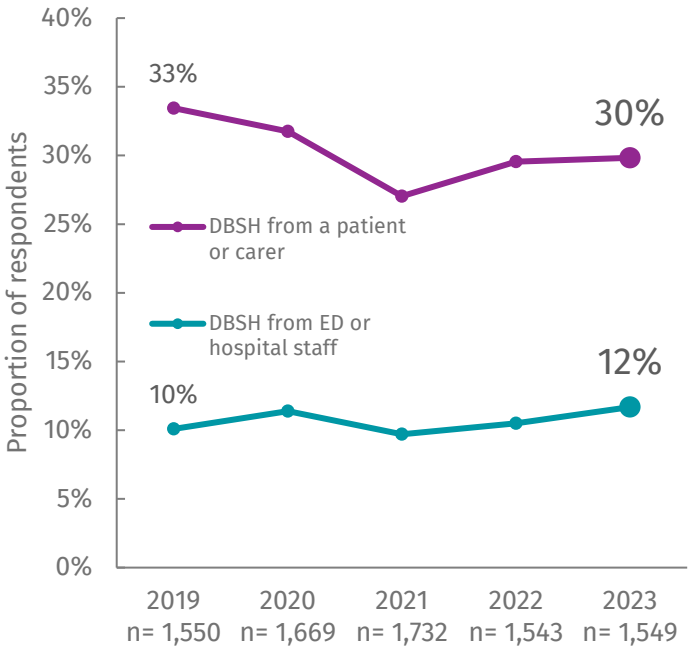


Agreed their placement sustained their wellbeing.

Discrimination, Bullying, Sexual Harassment and Harassment (DBSH)

Female trainees were more likely than male trainees to report experiencing DBSH. There was a slight decreasing overall trend in DBSH experiences from patients but an opposing trend for DBSH from ED or hospital staff.

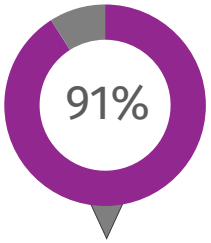




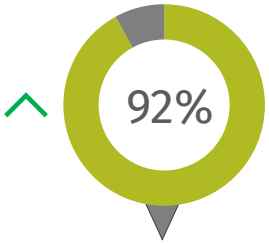
Note: ^ and ˇ indicate more than 2% change between 2022 and 2023 survey results.

2023 Trainee ED Placement Survey

Supervision and training experience

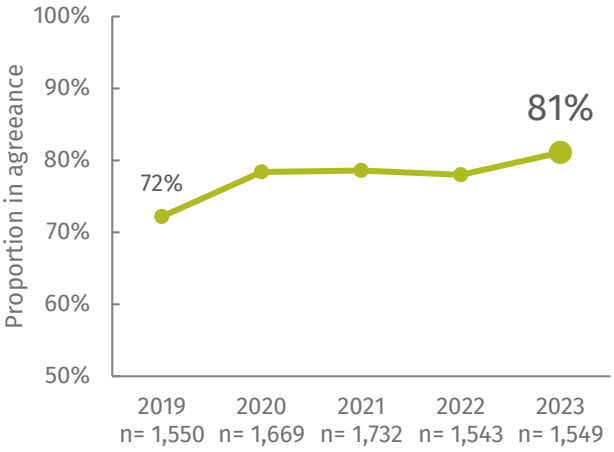


Satisfied with the quality of DEMT support.

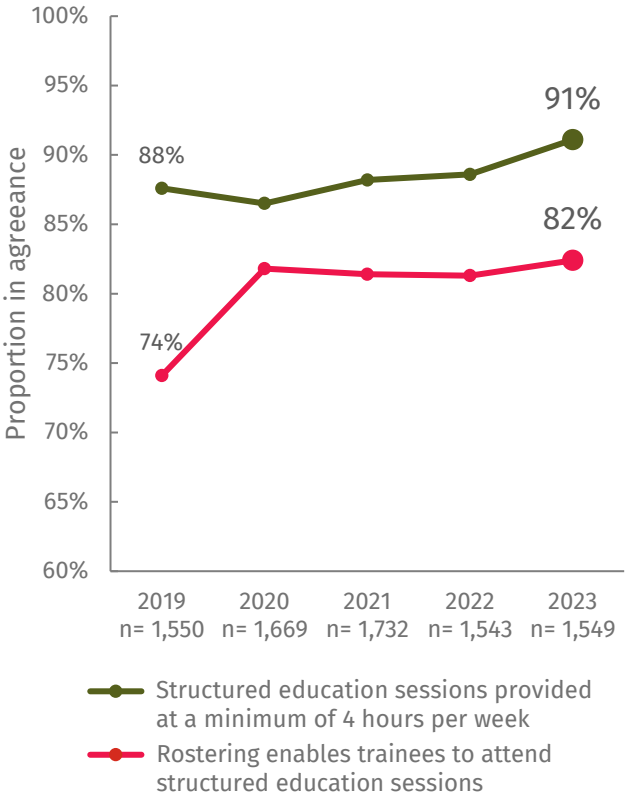


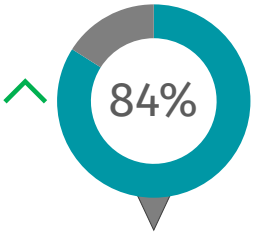
Overall satisfied with supervision received.

The proportion of trainees agreeing that they received regular informal feedback has *increased*.

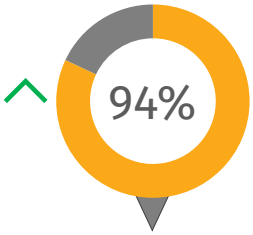


Education and training opportunities





Agreed structured education program met their needs.



Reported access to simulation learning experiences.

The proportion of trainees reporting that structured education was provided at a minimum of four hours per week has *increased*.

There was an *increase* in the proportion of trainees reporting rostering at their placement enabled their attendance at structured education sessions.

Note: ^ and ˇ indicate more than 2% change between 2022 and 2023 survey results.

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Executive Summary

The Trainee Placement Survey is an annual survey that captures site-specific data to ensure that ACEM-accredited sites provide training and a training environment that are appropriate, safe and supportive of FACEM trainees. Findings from the 2023 survey that included feedback from 1,549 trainees undertaking an ED placement are summarised below:

Health, Welfare and Interests of Trainees

- Nearly all (95%, n= 1,471) trainees strongly agreed or agreed that their training needs were being met at their ED placement.
- Most trainees (85%) agreed they were satisfied overall with the rostering at their site, with trainees most likely agreeing that rosters supported the service needs of the site (91%).
- Nearly all (97%) FACEM trainees reported knowing where to go for assistance if they encountered difficulty meeting training requirements, while 83% reported adequate processes were in place to identify and assist trainees facing difficulties progressing through their training.
- Most trainees (92%) strongly agreed or agreed that their placement provided a safe and supportive workplace overall but were least likely to agree their ED placement provided a supportive workplace which sustained their wellbeing (80%).
- One in every three FACEM trainees reported experiencing discrimination, bulling, sexual harassment, harassment (DBSH), or other unreasonable behaviour from a patient/ carer or other staff, and female trainees were more likely than males to report this.
- FACEM trainees were more likely to agree that they could participate in quality improvement activities than in decision-making regarding governance (75% vs. 64%).

Supervision and Training Experience

- Almost all (92%) FACEM trainees were satisfied overall with the supervision received, but they were less likely to agree they received regular (81%), or useful (86%) informal feedback on their performance and progress.
- Almost nine in ten FACEM trainees agreed their Workplace-based Assessment (WBA) assessors provided useful feedback (87%).
- Overall, the majority of trainees agreed that the ED casemix at their placement was appropriate concerning the number (96%), breadth (91%), acuity (89%), and complexity of cases (92%).

Education and Training Opportunities

- Most trainees (85%) strongly agreed or agreed that the clinical teaching at their placement optimised their learning opportunities, increasing from 79% in the 2022 survey.
- Comparable proportions of FACEM trainees agreed that the structured education program at their placement met their needs (84%), and rostering enabled trainees to attend the structured education sessions (82%).
- Similar proportions of trainees reported having access to written exam revision programs (94%) and clinical exam preparation programs (94%), either onsite or offsite at another linked/networked site.
- Most trainees (94%) reported the availability of simulation learning experiences, with nearly all (95%) participating.

Further Perspectives on ED Placement

- ED location was the most considered factor for trainees when choosing their ED placement, followed by casemix and training rotation requirements.
- The most common ED placement highlights included supportive senior staff, DEMT and colleagues, and ED casemix; consistent with previous survey findings.

Perspectives on the FACEM Training Program and Support from ACEM

- Most trainees (87%) agreed that the FACEM Training Program facilitates preparation for independent practice as an emergency medicine specialist, and a similar proportion (85%) agreed that they were well supported in their training by ACEM processes.

1. Purpose and Scope of Report

The Emergency Department (ED) Trainee Placement Survey is administered annually to FACEM trainees undertaking an ED placement in Aotearoa New Zealand and Australia. Survey questions focused on three key areas of the ED placement: Health, Welfare and Interests of Trainees; Supervision and Training Experience; and Education and Training Opportunities. The survey also sought trainee feedback on the support they received from ACEM.

2. Methodology

Participation in the annual Trainee Placement Survey is a mandatory requirement of the FACEM Training Program as per item B1.5 in Regulation B (FACEM trainees enrolled before 2022) and item G1.5 in Regulation G (FACEM trainees enrolled in 2022 and onwards). Eligible FACEM trainees were those undertaking an active placement in ACEM-accredited sites as of 31 October 2023, excluding trainees on an interruption to their training. All eligible trainees were required to complete the survey before paying their annual training fees through the ACEM member portal. The survey was made active on 17 November 2023 and closed on 31 January 2024.

All trainee feedback was handled in confidence, with anonymity ensured in reporting. Survey findings were reported only in the aggregate as a percentage of total responses or by training stage, gender of trainee, region, or accreditation tier of the ED. Training stage primarily compared advanced and provisional trainees, with the term 'provisional' used to represent responses for provisional and training stage 1 (TS1) trainees and 'advanced' to represent advanced and training stage 2-3 (TS2-3) trainees.

3. Results

A total of 1,549 completed surveys were received from 1,553 eligible FACEM trainees undertaking an ED placement, a nearly 100% response rate. Four active trainees did not complete the survey as of the survey closing date on 31 January 2024. Five trainees were undertaking ED placements at two hospitals and completed a survey for each placement. All survey findings were reported based on the total responses, except for the demographic information (Section 3.1), which was presented for the 1,544 individual trainees.

3.1 Demographic Characteristics of Respondents

Of the 1,544 FACEM trainees, 91% were undertaking an ED placement in Australia and the remainder (9%) were undertaking a placement in Aotearoa New Zealand. Just over half (51%, n= 782) of the trainees were female, slightly higher compared with the 2022 Trainee Placement Survey (50%). Nearly three quarters (73%, n= 1,125) of trainees were in the advanced stage of training or TS2-3 while 27% (n= 419) were provisional trainees or TS1 trainees (Table 1).

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

Region	Female	Male	Total		Female (%)	Provisional (%) (n= 419)	Advanced (%) (n= 1,125)
	n	n	n	%			
Australia	**710**	**699**	**1411**	**91.4%**	**50.4%**	**26.7%**	**73.3%**
ACT	17	10	27	1.9%	63.0%	33.3%	66.7%
NSW	211	213	425	30.1%	49.6%	26.8%	73.2%
NT	26	9	35	2.5%	74.3%	22.9%	77.1%
QLD	185	187	372	26.4%	49.7%	25.5%	74.5%
SA	41	39	80	5.7%	51.3%	26.3%	73.8%
TAS	7	10	17	1.2%	41.2%	17.6%	82.4%
VIC	144	170	315	22.3%	45.7%	28.3%	71.7%
WA	79	61	140	9.9%	56.4%	27.1%	72.9%
Aotearoa	**72**	**61**	**133**	**8.6%**	**54.1%**	**31.6%**	**68.4%**
Total no. of trainees	**782**	**760**	**1544***	**100%**	**50.7%**	**27.1%**	**72.9%**

**Total includes two trainees who did not specify their gender.*

Table 2 presents the proportion of provisional and advanced trainees undertaking an ED placement, by ED accreditation tier (i.e. accredited for 12, 24 or 36 months, or paediatric placement). Over two-thirds (71%) of the responding trainees were undertaking their placement at EDs accredited for 36 months, while less than 5% undertook placements at 12-month accredited sites. A higher proportion of advanced trainees than provisional trainees (11% compared to 1%) were undertaking an ED placement in a paediatric ED.

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

ED Accreditation Tier	Provisional		Advanced		Total	
	n	%	n	%	n	%
12 months	16	3.8%	57	5.0%	73	4.7%
24 months	86	20.5%	160	14.2%	246	15.9%
36 months	311	74.2%	786	69.6%	1097	71.0%
Paediatric – 12 months	6	1.4%	127	11.2%	133	8.6%
Total no. of trainees	**419**	**100%**	**1130**	**100%**	**1549**	**100%**

Note: Five advanced trainees completed the survey for two placement sites.

Trainees were asked to report if they were undertaking their ED placement in a part-time capacity, with one-third (33%, n= 511) reporting so. A higher proportion of female trainees than male trainees reported undertaking a part-time placement (39% vs. 28%). Almost all trainees provided reason(s) (n= 508) for undertaking part-time training, with carer responsibilities or family reasons being most common (44%, n= 226). Other main reasons for undertaking part-time training were to allow additional time to meet training requirements (25%, n= 128) and exam preparation and study (19%, n= 98). Only 5% (n= 24) of trainees reported undertaking a part-time placement due to employment availability. Other reasons for undertaking a part-time placement included improved work-life balance, mitigation of burnout or maintaining health and wellbeing (11%, n= 54), ability to undertake a concurrent placement (6%, n= 31), personal or medical reasons (4%, n= 18), other employment (medical or non-medical; 2%, n= 12), and research or further study (1%, n= 3).

3.2 Health, Welfare and Interests of Trainees

This section covers trainee needs, mentoring, rostering, trainee assistance, workplace safety and support, and opportunities to participate in governance and quality improvement activities. Trainee's feedback on their experiences of discrimination, bullying, harassment, and sexual harassment (DBSH) at their ED placement is also included in this section.

3.2.1 Overall trainee needs

Nearly all (95%, n= 1,471) trainees strongly agreed or agreed that their training needs were being met at their ED placement, with 3% (n= 52) being neutral and 2% (n= 26) disagreeing. Provisional trainees were less likely than advanced trainees (93% vs. 96%) to agree that their training needs were met.

95% of FACEM trainees agreed their training needs were met.

Trainees (n= 78) who did not agree that their training needs were being met at their placement were asked to comment on their response, with 66 of them providing feedback. Key reasons outlined by trainees concerning their needs not being met at their placement included:

- Limited on-the-floor teaching, including opportunities for procedural skills, often due to department understaffing and service provision demands (n= 19)
- Rostering limiting training and teaching opportunities, such as not being rostered to different areas, teaching not protected, or frequent night shifts (n= 16)
- Inadequate or poor-quality teaching (n= 14)
- A lack of education and teaching opportunities tailored to the stage of training (n= 13)
- Difficulty in completing Workplace-based Assessments (WBAs) or other assessments (n= 12)
- Unsatisfactory senior supervision, and/or feedback on progress or support (n= 11)
- Limited training opportunities, including due to part-time role and limited access to special skills rotations (n= 9)
- Inadequate ED casemix, particularly higher acuity and complex cases (n= 5)

Trainee feedback often contained more than one reason, with these reasons interrelated. Some examples of trainee comments included:

> *Very little time for teaching on-the-floor and frequent night shifts means minimal consultant oversight.*
>
> *Teaching is regularly cancelled last minute but I am still expected to turn up [to the education sessions] so that the hospital can look like it is achieving 75% attendance with the college.*
>
> *Inadequate supervision and exposure to teaching/skills/exam prep from FACEMs.*
>
> *There is also a paucity of on-the-floor teaching from consultants and not as nearly as many offers for WBAs - the consultant rostered to perform this duty during the week does not often make themselves known to registrars on the floor. Access to procedures can sometimes be difficult.*
>
> *Limited casemix, relatively few procedures compared to most other departments, excessive geriatric/psychiatric representation. Decreased amount of available staff leads to increased night shifts and reduced training exposure to FACEMs.*

3.2.2 Mentoring

Trainees were asked if they were involved in mentoring as a mentee in the last 12 months, with 831 reporting so (54%). Of these, 82% strongly agreed or agreed that this was beneficial for their training or workplace performance (n= 638). A smaller proportion (24%, n= 363) of trainees reported they had been a mentor in the last 12 months, and 90% of them either strongly agreed or agreed that mentoring others was beneficial for their training or workplace performance.

The majority (79%, n= 1,227) of trainees reported that there was a formal mentoring program available at their ED placement, with 4% (n= 58) reporting that there was not one available and 17% (n= 264) reporting not knowing whether a formal mentoring program was available. The proportion that reported availability of a formal mentoring program has decreased from 84% in the 2022 survey. Of the trainees who reported having a formal mentoring program, just over half (58%, n= 712) had utilised the program, which has also declined compared to the 2022 survey (63%). Provisional trainees (62%) were more likely than advanced trainees (57%) to report using the mentoring program available.

Just over half (58%) of FACEM trainees who reported their placement had a formal mentoring program used the program, declining from 63% in the 2022 survey.

For trainees (n= 515) who reported not using the formal mentoring program at their placement despite this program being available, 41% reported they did not want mentoring at the time. Others reported already having a mentor (30%) or not having time to participate (21%). Less commonly, trainees reported that the mentoring program was difficult to access (4%), or that it did not meet their needs (4%). A few trainees raised concerns about confidentiality (3%) or the mentor assigned was not a good match (3%). Some trainees provided other reasons, including intention to participate in mentoring in the future or preferring informal mentoring.

3.2.3 Rostering

Most trainees (85%) agreed they were satisfied overall with the rostering at their site, with similar proportions of advanced (85%) and provisional (84%) trainees reporting being satisfied. Comparable proportions of advanced trainees (range: 80% - 91%) and provisional trainees (range: 79% - 90%) were in agreeance with each of the rostering statements (1-3% difference).

Most (85%) FACEM trainees reported being satisfied overall with rostering at their placement.

Trainees undertaking a placement in EDs accredited for 12 months were generally more likely to agree with being satisfied with various rostering aspects at their placement than trainees undertaking placements in other accredited EDs (Table 3). Trainees undertaking a placement at paediatric EDs were less likely to agree (66%) that their placement rosters provided equitable exposure to day, evening and night shifts compared to trainees at other accredited EDs (range: 80% - 85%).

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

Statements regarding rostering	Strongly agreed or agreed (%)				
	12 months	24 months	36 months	Paediatric	Total
Overall, I am satisfied with rostering at my site	**82.2%**	85.0%	85.3%	82.7%	84.9%
Rosters are provided in a timely manner	**76.7%**	78.5%	80.6%	80.5%	80.1%
Rosters give equitable exposure to day/ evening/ night shifts	84.9%	80.5%	81.9%	**66.2%**	80.4%
Rosters give equitable shifts to all areas of ED	89.0%	**77.6%**	83.1%	78.9%	82.2%
Rosters consider workload as a trainee	86.3%	84.6%	**84.5%**	85.7%	84.7%
Rosters support the service needs of the site	93.2%	**87.8%**	90.7%	93.2%	90.6%
Rosters ensure safe working hours	91.8%	**86.6%**	90.6%	88.0%	89.8%
Rosters take into account leave requests	90.4%	**82.9%**	89.6%	87.2%	88.4%
Rosters take into account the skill mix required	86.3%	**77.2%**	83.2%	83.5%	82.4%
Total no. of responses	**73**	**246**	**1097**	**133**	**1549**

Trainees were given the opportunity to comment on the rostering available at their placement, with Table 4 presenting the major themes and subthemes from the trainee responses (n= 279) and some example comments. Comments that reflected negatively on rostering (62%, n= 173) outnumbered the positive feedback about rostering (23%, n= 64). A wide range of rostering issues were raised, with understaffing being regularly stated as a factor that further complicated rostering at sites. Many comments focused on unsafe staffing and inappropriate senior and junior staff ratios. A number of trainees also mentioned difficulty accessing leave impacting work-life balance and ability to plan. A further 10% of comments reflected mixed positive and negative feedback, and 5% were related to suggestions for improving the rostering at their placement, such as introducing a rolling roster or clearly defined blocks of shifts for planning and work-life balance.

Table 4. Positive and negative themes of trainee feedback regarding rostering at their placement, with example comments.

Theme	Example comments
Negative (n= 173) - Understaffed department - Unsafe staffing level and skills mix, especially overnight and over weekends - Excessive and inequitable evening/night shifts - Late issuing of roster - Rigid rostering and difficulty accessing leave (incl. study leave) - Insufficient breaks between shifts - Insufficient exposure to specific clinical areas - Poor teaching roster/ limited clinical teaching time	*Extremely short staffed on senior registrars means department is often understaffed, especially on night shifts.* *Registrar roster is at a deficit. Resident staffing on nights is very poor and composed mostly of interns which leads to significantly increased supervision workload.* *Leave is currently not being approved until the roster comes out, which for the last 2 terms has been only 3 weeks prior to the term starting. This makes life planning very hard.* *Sick leave is not managed, and effort is not put into finding covers for night shift sick leave. We are also so short of junior staff that the registrars do not get sufficient exposure to the role of supervision.* *We are so understaffed, particularly at a senior registrar level, that advanced trainees have to work many nights to service the department. We also rarely get shifts in subacute, so I feel I am de-skilling in this area.* *Education sessions are considered a "day off" but technically they are like a half day, especially if we have to be on site.*
Positive (n= 64) - Fair and equitable shifts - Accommodating annual/ study leave requests - Good rostering system in place	*Incredibly supportive, thoughtful, accommodating, and flexible working environment. Huge amount of effort made to provide work-life balance.* *I am very grateful to the consultants arranging the roster who have been helpful and understanding regarding requested days off to cater for my family carer responsibilities.* *In my experience, roster inflexibility has been the number one barrier in allowing for adequate work-life balance and fulfilment of external carer responsibilities, and I am immensely appreciative of the consultants at [Site] who have taken this into consideration.*

3.2.4 Assistance for trainees

Almost all trainees (97%) reported knowing where to go for assistance if they had difficulty meeting the training requirements, with comparable proportions of advanced and provisional trainees reporting so (Table 5). Over three-quarters (83%) of trainees agreed that their ED placement has adequate processes to identify and assist trainees encountering difficulty in progressing through the FACEM Training Program. Similar proportions of female and male trainees agreed they know where to go for assistance with training requirements (97% and 96% respectively); however, female trainees were less likely than male trainees (80% vs. 86%) to report their ED had adequate processes to assist trainees having difficulty progressing through their training.

Nearly all (97%) FACEM Trainees reported knowing where to go for assistance if they encountered difficulty meeting training requirements.

In relation to managing trainee grievances, 91% of trainees reported knowing where to go for assistance if they had a grievance about their training (Table 5). A further 6% neither agreed nor disagreed, and 3% disagreed that they knew where to go for assistance if they had a grievance about their training. A much smaller proportion of trainees (77%) agreed that their placement had adequate processes to manage trainee grievances.

Table 5. Proportion of trainees who strongly agreed or agreed with statements regarding assistance for trainees in the ED, by training stage.

Statements on assistance for trainees	Strongly agreed or agreed (%)		
	Provisional	Advanced	Total
Know where to go for assistance if I have difficulty meeting the training requirements	98.1%	95.9%	96.5%
ED placement has adequate processes in place to identify and assist trainees having difficulty in progressing through their training	83.8%	82.8%	83.1%
Know where to go for assistance if I have a grievance about training	92.4%	90.3%	90.8%
ED placement has adequate processes in place to manage grievances	77.3%	77.2%	77.2%
Total no. of responses	419	1130	1549

There were comparable proportions of trainees agreeing with statements regarding assistance for training and grievances between those undertaking a placement at sites accredited for 12, 24, or 36 months or paediatric sites (Table 6).

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

Statements on assistance for trainees	Strongly agreed or agreed (%)			
	12 months	24 months	36 months	Paediatric
Know where to go for assistance if I have difficulty meeting the training requirements	98.6%	98.0%	**96.1%**	96.2%
ED placement has adequate processes in place to identify and assist trainees in difficulty	**80.8%**	85.4%	82.5%	85.0%
Know where to go for assistance if I have a grievance about training	93.2%	**90.2%**	90.8%	91.0%
ED placement has adequate processes in place to manage grievances	75.3%	77.2%	77.6%	**75.2%**
Total no. of responses	73	246	1097	133

The survey further sought feedback about the assistance or processes available at ED placements for trainees in difficulty or with respect to handling grievances, with 63 responses received. More positive (n= 38) comments than negative (n= 28) comments were received (three included mixed feedback). Positive comments reflected on approachable and supportive senior staff and the Director of Emergency Medicine Training (DEMT) available for trainee assistance. Conversely, negative comments generally focused on unclear

assistance processes, poor management of grievances, or unapproachable/ unsupportive senior staff. Some examples of these negative comments are provided in the following:

> *Not really clear from the get-go who to contact if having issues with training, or with other problems with the department.*

> *It doesn't seem to matter how many times we bring grievances to the attention of seniors, it is often brushed off as not serious or we are made to feel guilty that it is somehow our fault.*

3.2.5 Safe and supportive workplace

Trainees were asked to rate their level of agreement that their placement provided a safe and supportive workplace for various aspects, as shown in Table 7. Most trainees (92%) strongly agreed or agreed that their placement provided a safe and supportive workplace overall. A high proportion of trainees were in agreeance that their placement provided a safe and supportive environment with respect to clinical protocols (91%), cultural safety practices (88%; catering for culturally diverse patients and emergency medicine (EM) workforce), personal safety (87%), and support processes other than mentoring (86%). The other aspects, including the provision of a comprehensive orientation program at commencement (80%) or placement sustained trainee wellbeing (80%) received less agreement from trainees.

FACEM trainees were least likely to report their ED placement provides a workplace environment which sustains their wellbeing.

Female trainees were less likely to agree (85%) that their placement provided a safe workplace with respect to support processes compared to male trainees (88%). Comparable proportions of female and male trainees agreed that their placement provided a safe and supportive workplace overall (92% respectively) and agreed with each other aspect (<2% difference). Likewise, comparable proportions of provisional and advanced trainees agreed their placement provided a safe and supportive workplace overall, with provisional trainees being more likely to agree their placement provided a safe and supportive workplace with respect to personal safety and sustaining their wellbeing (Table 7).

Table 7. 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 stage.

Placement provides a safe and supportive workplace with respect to:	Strongly agreed or agreed (%)		
	Provisional	Advanced	Total
Overall safety and support	92.8%	91.2%	91.7%
Personal safety (e.g., aggression directed by patients and/ or carers)	89.3%	85.8%	86.8%
Sustaining my wellbeing	82.1%	78.8%	79.7%
Support processes (other than mentoring)	85.4%	86.8%	86.4%
Clinical protocols	90.2%	91.2%	91.0%
Cultural safety practices (cater for culturally diverse patients and EM workforce)	87.4%	88.5%	88.2%
Comprehensive orientation program at commencement	81.9%	79.6%	80.2%
Total no. of responses	419	1130	1549

Trainees who did not agree they had a comprehensive orientation at commencement in the ED were given the opportunity to describe what was missing, with 78 providing comments. Most commonly, trainees stated there was no orientation provided at their placement commencement. Others described that although an orientation or induction was provided, it was brief and not comprehensive, or only a hospital-wide orientation was provided, and they did not receive an ED specific orientation. Some trainees indicated they were not given an orientation as they had previously worked at the site but expressed that an updated orientation specific to the ED setting was required.

Trainees undertaking a placement in a paediatric site were more likely to agree that their placement provided a safe and supportive workplace overall, and consistently were more likely to agree with most statements about workplace safety and support (Table 8).

Table 8. 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 ED accreditation tier.

Placement provides a safe & supportive workplace with respect to:	Strongly agreed or agreed (%)			
	12 months	24 months	36 months	Paediatric
Overall safety & support	**87.7%**	91.9%	91.3%	96.2%
Personal safety	89.0%	86.2%	**85.9%**	94.0%
Sustaining my wellbeing	83.6%	80.1%	**78.9%**	83.5%
Support processes	86.3%	**83.3%**	86.4%	92.5%
Clinical protocols	**89.0%**	89.4%	90.5%	98.5%
Cultural safety practices	**83.6%**	89.4%	87.8%	91.7%
Comprehensive orientation	80.8%	**78.0%**	79.9%	85.7%
Total no. of responses	**73**	**246**	**1097**	**133**

Trainees who disagreed that their ED placement provided a safe and supportive workplace were asked to provide a reason(s) for their response, with 108 trainees providing feedback (Table 9). Around half of the comments were about a lack of focus on trainee wellbeing (47%), followed by 39% of comments that reflected concerns about their personal safety.

Table 9. Themes of trainee responses relating to their placement not meeting aspects of a safe and supportive workplace, with example comments.

Theme	Example comments
Trainee wellbeing (n= 51) *Unsupportive rostering, increasing workload, burnout, lack of wellbeing initiatives, not feeling supported at their placement*	*Hospital and ED are grossly understaffed and under-resourced. Burnout is present in nursing and medical staff at all levels which greatly affects moral and collegiality amongst staff.* *We are down total number of registrars at the site so often are understaffed with sick leave which has a negative impact on wellbeing and stress.* *There have not been any debrief sessions organised for difficult cases or to ensure that emergency medical staff members feel supported after any difficult/traumatic cases.*
Personal safety (n= 42) *Inefficient security, increasing violent alcohol/drug-related or mental health patients, ineffective zero violence policy*	*My workplace takes safety very seriously. I'm not sure the remaining threat presented by patients/the public can be mitigated further.* *Inadequate security in/ around department, massively overcrowded waiting room, normalisation of verbal and physical aggression and pressure from nursing staff not to escalate concerns by calling police.* *No personal safety alarms - was recently threatened in the middle of the night in a back room in fast track requiring a code grey. Could have gone very badly. Security team useful, but not if no one knows you're in danger.*
Clinical protocols (n= 12) *Poor quality, limited, unorganised*	*Clinical protocols are a work in progress; significant changes and improvements have been made in areas such as paediatrics and women's health care; other areas significantly lacking including mental health and some medical subspecialties.* *[Site] provide a poor level of clinical protocols, although international and nationwide protocols are available, local protocols are lacking and there has been limited improvement to them in the 3 years I have worked here on and off.*
Cultural safety (n= 9) *Limited availability of Aboriginal Liaison Officer, lack of cultural safety awareness and training*	*I do not feel that most of us are as culturally aware as needed.* *Access to aboriginal liaison service in ED could be improved.* *No access to aboriginal health workers out of hours for patients/relatives in crisis (site/statewide issue, not specific to ED).*

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

3.2.6 Discrimination, Bullying, Sexual Harassment, Harassment (DBSH), and other unreasonable behaviour

Trainees were asked if they had experienced DBSH or other unreasonable behaviour in their placement, with detailed definitions provided for each aspect of DBSH. Overall, 516 (33.3%) FACEM trainees reported experiencing at least one aspect of DBSH or other unreasonable behaviour from patients/ carers or ED/ hospital staff in their ED placement.

One in every three FACEM trainees reported experiencing discrimination, bulling, sexual harassment, harassment, or other unreasonable behaviour.

The number and percentage of trainees that reported experiencing DBSH or other unreasonable behaviour from patients or carers are shown in Table 10. Trainees were more likely to report experiencing harassment (13%), other unreasonable behaviour (not classified as DBSH, 13%), or discrimination (12%), than bullying (5%) or sexual harassment (5%), from a patient or carer. Female trainees were much more likely than males to report experiencing DBSH from a patient or carer (34% vs. 25%). DBSH incidents by patients or carers were reported by comparable proportions of provisional and advanced trainees (30%, respectively). Of 142 ED placement sites, over three-quarters (77%, n= 109) had at least one trainee that reported experiencing DBSH from a patient or carer.

Table 10. Number and proportion of trainees who reported experiencing DBSH behaviour by a patient or carer at their placement, by gender and training stage.

Experienced DBSH from a patient or carer	Total n = 1,549	Female n = 786	Male n = 761	Provisional n = 419	Advanced n = 1,130
Discrimination	180 (11.6%)	109 (13.9%)	70 (9.2%)	53 (12.6%)	127 (11.2%)
Bullying	80 (5.2%)	44 (5.6%)	36 (4.7%)	19 (4.5%)	61 (5.4%)
Sexual Harassment	71 (4.6%)	59 (7.5%)	12 (1.6%)	19 (4.5%)	52 (4.6%)
Harassment	208 (13.4%)	121 (15.4%)	87 (11.4%)	53 (12.6%)	155 (13.7%)
#Other unreasonable behaviour	197 (12.7%)	105 (13.4%)	92 (12.1%)	50 (11.9%)	147 (13.0%)
Overall	***462 (29.8%)**	**268 (34.1%)**	**193 (25.4%)**	**127 (30.3%)**	**335 (29.6%)**

*Note: *FACEM trainees who reported at least one aspect of DBSH behaviour or other unreasonable behaviour.*
 # Unreasonable behaviour refers to other incidents not strictly classified as D,B,S, or H. For instance, 'bullying', which refers to a type of unreasonable behaviour that is repeated over time or occurs as a pattern of behaviour that creates a risk to health and safety. One incident may not be appropriately classified as bullying, and thus may be raised as other unreasonable behaviour.

Of those who reported having experienced DBSH from a patient or carer (n= 462), trainees were significantly more likely to report DBSH incidents or other unreasonable behaviour from patients only (51%), than carers only (1%), with 48% reporting experiencing DBSH from both patients and carers.

The trainees who reported having experienced DBSH from a patient or carer were asked to describe the incidents if they felt comfortable doing so, with 137 trainees responding. The key themes are similar to findings from the 2022 survey, including:

- Violence and aggressive behaviour (both verbal and physical aggression) were frequently described;
- Drug and/ or alcohol use, mental health-related presentations and incarceration were frequently reported as contributors to physical and verbal aggression incidents;
- Prolonged waiting times, access block and delayed emergency care were described as other reasons triggering patient aggression;
- Female trainees frequently reported sexism and gender-based discrimination, including experiencing a lack of trust in their clinical knowledge and skills because of their gender;
- Inappropriate comments of a sexual nature and sexual advances, harassment, and assault; and
- Harassment and discrimination due to race or ethnicity.

Some trainee comments were dismissive, implying normalisation of DBSH or other unreasonable behaviour from patients or carers, either at their placement or in the emergency medicine profession.

Trainees were also asked if they had experienced any DBSH from ED or hospital staff while working in their placement. The proportion of trainees that reported at least one aspect of DBSH or other unreasonable behaviour from ED or hospital staff was 12% (n= 181, Table 11), increasing slightly from 10% who reported this in the 2022 survey. Consistent with previous survey findings, female trainees were more likely than male trainees to report experiencing discrimination or other unreasonable behaviour by staff. Comparable proportions of provisional and advanced trainees reported having experienced DBSH or other unreasonable behaviour by staff. Trainees reported experiencing DBSH from ED or hospital staff at 77 (54%) of 142 ED placement sites.

One in every ten FACEM trainees reported experiencing discrimination, bulling, sexual harassment, harassment, or other unreasonable behaviour from ED or hospital staff.

Table 11. Number and proportion of trainees who reported experiencing DBSH behaviour from ED or hospital staff at their placement, by gender and training stage.

Experienced DBSH from ED or hospital staff	Total n = 1,549	Female n = 786	Male n = 761	Provisional n = 419	Advanced n = 1,130
Discrimination	41 (3%)	31 (4%)	10 (1%)	11 (3%)	30 (3%)
Bullying	63 (4%)	32 (4%)	31 (4%)	18 (4%)	45 (4%)
Sexual Harassment	3 (<1%)	1 (<1%)	2 (<1%)	1 (<1%)	2 (<1%)
Harassment	28 (2%)	17 (2%)	11 (2%)	6 (1%)	22 (2%)
Other unreasonable behaviour	85 (6%)	55 (7%)	30 (4%)	21 (5%)	64 (6%)
Overall	***181 (12%)**	**107 (14%)**	**74 (10%)**	**47 (11%)**	**134 (12%)**

*Note: *FACEM trainees who reported at least one aspect of DBSH behaviour or other unreasonable behaviour.*

Trainees who reported experiencing DBSH from ED or hospital staff were further asked which person(s) displayed the DBSH behaviour toward them. Consistent with survey findings from previous years, FACEMs, ED nursing staff and in-patient medical staff were the most commonly reported perpetrators of DBSH incidents (Table 12). DBSH from a FACEM was reported by 54 trainees and eight trainees reported experiencing DBSH by a Director of Emergency Medicine (DEM) or DEMT.

Table 12. Number of trainees who reported experiencing DBSH or other unreasonable behaviour against them, by category of staff.

ED or hospital staff	Discrimination n = 41	Bullying n = 63	Sexual Harassment n = 3[t]	Harassment n = 28[t]	Unreasonable behaviour n = 85
FACEM	15	18	1	11	24
DEM/ Deputy DEM	0	2	0	1	1
DEMT	1	3	0	1	3
ED nursing staff	18	19	0	10	15
Other ED doctor	6	7	1	3	5
Other ED staff *	6	2	0	1	3
In-patient medical	10	30	0	12	49
In-patient non-medical staff	2	7	0	2	4
Other staff	2	2	0	0	3
Prefer not to say	12	4	0	2	8

Note: Trainees could select more than one category of staff.
[t]Some trainees did not disclose the person who displayed DBSH behaviour against them.
**Other ED staff includes clerical, orderly and allied health.*

Trainees who reported having experienced DBSH are displayed by region in Table 13. The Australian Capital Territory observed the highest proportion of trainees reporting DBSH from patients or carers, as well as from ED or hospital staff compared with trainees undertaking an ED placement in other regions. Trainees in the Northern Territory and Tasmanian EDs also reported a high rate of DBSH from patients or carers. Whereas trainees in South Australia reported the second highest rate of DBSH from ED or hospital staff.

Table 13. Proportion of trainees who reported experiencing DBSH or other unreasonable behaviour, by region.

Experienced DBSH from:	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aotearoa	Total
Patients or carers	**59.3%**	27.0%	42.9%	32.0%	37.5%	41.2%	23.7%	35.0%	26.7%	29.8%
ED or hospital staff	**18.5%**	13.6%	11.4%	9.9%	16.3%	5.9%	10.4%	12.1%	9.6%	11.7%
Total no. of responses	**27**	**426**	**35**	**372**	**80**	**17**	**317**	**140**	**135**	**1549**

Fifty-one trainees provided further information on their DBSH experiences from staff, with key themes including:

- Discrimination based on gender from all staff categories, with female trainees frequently reporting their medical opinion being ignored or being overlooked for opportunities;
- Other forms of discrimination like being singled out and treated differently by staff or favouritism;
- Bullying, harassment and unreasonable behaviour from ED nursing staff and in-patient medical/non-medical staff, including rude, condescending, and hostile behaviour;
- Harassment by FACEMs included humiliation and repeatedly inappropriate referencing of trainees' personal life;
- Discrimination, bullying, harassment and other unreasonable behaviour towards junior staff by FACEMs, DEMs or DEMTs, including demeaning behaviour towards and disregard of junior staff.

3.2.7 Opportunities to participate

Sixty-four per cent of trainees strongly agreed or agreed that they were able to participate in decision-making regarding governance (for example, workplace committees) at their ED placement, increasing slightly from 60% in the 2022 survey. A further 24% neither agreed nor disagreed, 8% disagreed, and 4% reported not knowing. Consistent with previous survey findings, a higher proportion of male trainees than female trainees (66% compared to 62%) were in agreeance with this. Advanced trainees were more likely to agree compared to provisional trainees (65% and 60% respectively).

Three-quarters (75%) of trainees agreed that they were able to participate in quality improvement activities at their placement. From the remaining trainees, 18% neither agreed nor disagreed, 4% disagreed and 3% did not know. A slightly higher proportion of male trainees compared with female trainees (76% compared to 74%) agreed they could participate in quality improvement activities, and advanced trainees were more likely than provisional trainees to agree (76% compared to 72%).

FACEM trainees were more likely to agree that they could participate in quality improvement activities than in decision-making regarding governance (75% vs. 64%).

Trainees undertaking a placement in EDs accredited for 36 months and paediatric sites were more likely to agree that they had opportunities to participate in both the governance and quality improvement activities, compared to trainees at sites accredited for 12 months and 24 months (Table 14).

Table 14. Proportion of trainees who strongly agreed or agreed to statements relating to participation in quality improvement activities and decision-making regarding governance, by ED accreditation tier.

Opportunities to participate	Strongly agreed or agreed (%)				
	12 months	24 months	36 months	Paediatric	Total
Able to participate in decision-making regarding governance (e.g., workplace committees)	58.9%	**56.5%**	66.1%	63.2%	64.0%
Able to participate in quality improvement activities	74.0%	**69.9%**	75.6%	77.4%	74.8%
Total no. of responses	**130**	**282**	**1131**	**133**	**1549**

3.3 Supervision and Training Experience

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

3.3.1 Supervision and feedback

Trainees were asked about supervision, support and feedback provided by DEMTs and senior staff at their ED placement. Overall, most (92%) reported being satisfied with the supervision they received at their placement, an increase from 89% in the 2022 survey. Consistent with previous findings, nearly all (95%) trainees agreed that their DEMT had discussed what was expected of them at their stage and phase of training.

Most (92%) FACEM trainees were satisfied overall with the supervision received, but they were less likely to agree they received regular or useful informal feedback on their performance and progress.

No difference was observed in the satisfaction rate between provisional and advanced trainees regarding the supervision received at their ED placement (92%, respectively). Similar proportions of provisional and advanced trainees agreed with the other statements on supervision, support and feedback provided at their placement (difference between <1% and 2%). In previous surveys, male trainees consistently reported higher levels of agreement with supervision, support and feedback statements, compared to female trainees. The findings from this survey, on the contrary, show more comparable levels of satisfaction by gender (differences <2%), and female trainees were more likely to agree that clinical supervision from consultants met their needs (92%, compared to 89% of male trainees). Trainees undertaking a placement at a paediatric ED were generally more likely to agree with statements about supervision, support and feedback, compared with those at other accredited EDs (Table 15).

Table 15. Proportion of trainees who strongly agreed or agreed with statements about supervision, support and feedback provided at their placement, by ED accreditation tier.

Statements about supervision, support, and feedback	Strongly agreed or agreed (%)				
	12 months	24 months	36 months	Paediatric	Total
Overall, satisfied with the supervision received	**89.0%**	91.9%	91.4%	95.5%	91.7%
Satisfied with quality of DEMT support	93.2%	91.5%	**91.2%**	92.5%	91.4%
Availability of DEMT for guidance/ supervision meets needs	94.5%	**91.9%**	**91.9%**	94.0%	92.2%
Clinical supervision received from consultants meets needs	90.4%	90.7%	**90.1%**	96.2%	90.7%
DEMT had discussed what is expected of trainee at their stage of training	**94.5%**	94.7%	**94.5%**	96.2%	94.7%
Receive regular, *informal feedback on performance and progress	89.0%	**79.7%**	80.5%	84.2%	81.1%
Receive useful *informal feedback on performance and progress	89.0%	**81.7%**	86.1%	87.2%	85.6%
Total no. of responses	73	246	1097	133	1549

*Note: *Informal feedback includes any interaction with FACEMs or FRACPs (paediatric EDs) such as on the floor discussion, suggestions, and advice regarding clinical/ non-clinical matters, coaching and expressions of appreciation.*

The proportion of trainees agreeing with statements relating to supervision, support and feedback provided at their ED placement is presented by region in Table 16. Compared to trainees in other regions, South Australia regularly saw a lower proportion of trainees who agreed with supervision, support, and feedback statements.

Table 16. 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 or agreed (%)								
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aotearoa
Overall, satisfied with the supervision received	85.2%	91.8%	88.6%	93.8%	**82.5%**	100.0%	92.1%	90.7%	92.6%
Satisfied with quality of DEMT support	96.3%	91.3%	85.7%	93.5%	82.5%	**82.4%**	92.7%	87.9%	93.3%
Availability of DEMT for guidance/ supervision meets needs	96.3%	91.5%	91.4%	94.6%	87.5%	88.2%	92.7%	**87.1%**	94.1%
Clinical supervision received from consultants meets needs	88.9%	91.5%	91.4%	93.0%	**78.8%**	94.1%	88.6%	92.9%	91.1%
DEMT had discussed what is expected of trainee at their stage of training	96.3%	94.1%	94.3%	96.8%	**88.8%**	94.1%	95.3%	92.1%	95.6%
Receive regular, *informal feedback on performance and progress	77.8%	81.0%	88.6%	81.7%	**68.8%**	82.4%	84.2%	77.9%	81.5%
Receive useful *informal feedback on performance and progress	88.9%	84.3%	94.3%	86.8%	**75.0%**	88.2%	89.0%	85.0%	82.2%
Total no. of responses	**27**	**426**	**35**	**372**	**80**	**17**	**317**	**140**	**135**

*Note: *Informal feedback includes any interaction with FACEMs or FRACPs (paediatric EDs) such as on the floor discussion, suggestions, and advice re clinical/ non-clinical matters, coaching and expressions of appreciation.*

3.3.2 Virtual supervision, assessment and education

Trainees were asked if virtual supervision, assessment and education had been utilised at any point at their ED placement. Just under three-quarters of trainees (74%) reported no virtual supervision or assessment were utilised at any point during their ED placement (Table 17). Less than 20% of trainees reported online training assessments or online education activities, and very few reported virtual clinical supervision (1%) was provided while they were working on the floor. Comparable proportions of provisional and advanced trainees reported having virtual supervision or online education activities at their placement (differences <2%), however advanced trainees were more likely than provisional trainees (20% vs. 15%) to report having training assessments completed online.

Table 17. Proportion of trainees who reported virtual supervision, assessment, and education were utilised at their placement, by ED accreditation tier.

Virtual supervision, assessment and education	12 months	24 months	36 months	Paediatric	Total
Virtual clinical supervision while working on the floor	1.4%	**1.6%**	1.0%	0.8%	1.1%
Training assessment(s) completed online	17.8%	22.4%	17.0%	**22.6%**	18.4%
Online education activities other than formal education sessions, e.g., undertaking case-based discussions	16.4%	11.8%	13.0%	**17.3%**	13.4%
No virtual supervision, assessment, or education	72.6%	70.7%	**74.9%**	69.2%	73.7%
Total no. of responses	**73**	**246**	**1097**	**133**	**1549**

Note: Trainees could select more than one option for either virtual supervision, assessment or education.

Trainees were given the opportunity to comment on their virtual supervision, assessment and education experiences, with 42 commenting. Twenty trainees commented on how virtual supervision, assessment and education were used, including online/virtual meetings (n= 17) and by phone (n= 3). Others described the purpose of the virtual supervision, assessment and education opportunities in their placement which included for case-based discussions (n= 9), clinical supervision or guidance (n= 7), WBAs and ITAs (n= 7), education sessions such as exam preparation (n= 4), and shift reports (n= 2). More commonly, trainees

reflected positively on their experiences with virtual supervision, assessment and education (n= 31) as they found the virtual option helpful, suitable, more accessible and convenient, it improved work-life balance, and some reported feeling more supported. A few others did not find virtual supervision, assessment and education appropriate or preferred in-person sessions (n= 6), and three reported technical issues with virtual methods.

3.3.3 Workplace-based assessments

Advanced trainees and those in TS1-TS3 were asked to rate the support and feedback provided by their Local WBA Coordinators, consultants and WBA assessors at their ED placement, with provisional trainees not required to undertake EM-WBAs. Over three-quarters (79%) of TS1-3 and advanced trainees were satisfied with the level of support they received from their Local WBA Coordinator to complete their EM-WBA requirements. A slightly higher proportion (81%) were satisfied with the level of support they received from the consultants at their ED. A much larger proportion (87%) were in agreeance that WBA assessors provided useful feedback to guide their training.

Almost nine in ten FACEM trainees agreed their WBA assessors provided useful feedback (87%).

The proportion of trainees who agreed that they were satisfied with the support from their Local WBA Coordinator, consultants and WBA assessors is provided in Table 18, by ED accreditation tier. Consistent with the 2022 survey findings, trainees undertaking a placement in an ED accredited for 12 months and paediatric sites were generally more likely to agree with most aspects of support and feedback for EM-WBAs (Table 18).

Table 18. Proportion of TS1-3 and advanced trainees who agreed that they were satisfied with the support and feedback from their Local WBA Coordinator, consultants and/ or WBA assessors, by ED accreditation tier.

Statements about support and feedback for EM-WBAs	Strongly agreed or agreed (%)				
	12 months	24 months	36 months	Paediatric	Total
Satisfied with the level of support from Local WBA Coordinator	84.5%	78.8%	**77.5%**	85.6%	78.8%
Satisfied with the level of support from consultants	85.8%	**78.0%**	80.0%	87.2%	80.5%
WBA assessors provide useful feedback	92.6%	**85.5%**	85.8%	91.6%	86.6%
Total no. of responses	**71**	**231**	**1016**	**127**	**1445**

Support from their Local WBA Coordinator, consultants and WBA assessors is summarised in Table 19 by region. Trainees undertaking a placement in the Australian Capital Territory and South Australian EDs were generally less satisfied with the level of support and feedback received for EM-WBAs.

Table 19. Proportion of TS1-3 and advanced trainees who agreed that they were satisfied with the support and feedback from their local WBA Coordinator, consultants and/ or WBA assessors, by region.

Statements about and feedback for EM-WBAs	Strongly agreed or agreed (%)								
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aotearoa
Satisfied with the level of support from Local WBA Coordinator	**48.0%**	78.9%	79.4%	81.5%	60.5%	88.2%	84.9%	79.4%	71.0%
Satisfied with the level of support from consultants	**44.1%**	82.6%	86.8%	80.6%	65.8%	88.5%	84.6%	87.0%	70.4%
WBA assessors provide useful feedback	74.3%	85.5%	90.7%	89.3%	**70.6%**	93.8%	89.8%	88.7%	81.9%
Total no. of responses	**25**	**389**	**34**	**346**	**76**	**17**	**298**	**136**	**124**

TS1-3 and advanced trainees were further surveyed about how WBAs were organised at their site (Table 20), with most reporting that it was the trainee's responsibility (69%), rather than the DEMT or Local WBA Coordinator to schedule WBAs (30%). One-third of trainees reported WBAs were conducted on an ad hoc basis (34%). While fewer trainees reported WBAs were organised through a rostered WBA Consultant (26%) or rostered WBA session (11%).

Table 20. How EM-WBAs are organised at ED placement sites for TS1-3 and advanced trainees.

How are EM-WBAs organised at your site?	n	%
It is the trainee's responsibility	972	69.1%
On an ad hoc basis	474	33.7%
They are scheduled by DEMT or Local WBA Coordinator	422	30.0%
Through rostered WBA Consultant	364	25.9%
Through rostered WBA session	149	10.6%
Other (e.g., only rostered for a specific type(s) of WBA etc.)	23	1.6%
Total no. of respondents	**1406**	

Note: Respondents may select more than one way WBAs were organised at their site. Excludes trainees that selected 'Not applicable'.

3.3.4 Casemix

Trainees were asked if 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 concerning the number (96%), breadth (91%), acuity (89%), and complexity of cases (92%). The level of agreement increased from the previous survey findings for each aspect of casemix. Similar levels of agreement were seen between advanced and provisional trainees for each aspect relating to ED casemix (difference <1%).

Trainees undertaking placements in EDs accredited for 36 months and paediatric EDs were generally more likely than trainees in EDs accredited for 12 months and 24 months to agree that the ED casemix at their placement was appropriate with respect to the number, breadth, acuity, and complexity of cases (Table 21).

Table 21. Proportion of trainees who agreed that their current placement provided an appropriate training experience when considering aspects of casemix, by ED accreditation tier.

Aspects of casemix	Strongly agreed or agreed (%)				
	12 months	24 months	36 months	Paediatric	Total
Number of cases	**93.2%**	93.5%	96.8%	97.0%	96.1%
Breadth of cases	93.2%	**86.6%**	91.4%	94.7%	91.0%
Acuity of cases	84.9%	**80.1%**	92.0%	88.0%	89.4%
Complexity of cases	89.0%	**83.7%**	93.6%	91.0%	91.6%
Total no. of responses	**73**	**246**	**1097**	**133**	**1549**

3.3.5 Further comments on supervision and training experience

There were 68 comments provided by trainees relating to supervision or the training experience at their placement. Many comments reflected on various aspects of the casemix available at their placement (n= 42), such as diverse casemix creating learning and training opportunities, or the lack of high acuity patients and factors impacting casemix at their ED (e.g. demographics of the population, close to major-referral hospital, not a trauma centre). Other comments reflected positive feedback about the quality of training and supervision (n= 5) and supportive and approachable senior staff (n= 5).

On the contrary, negative comments largely reflected on access block or high ED demand limiting training opportunities (n= 9), rostering limiting access to training and teaching (n= 5), or the difficulty in completing WBAs (n= 2).

3.4 Education and Training Opportunities

This section covers clinical teaching, the structured education program, access to educational and examination resources, simulation learning experiences, and leadership and research opportunities.

3.4.1 Clinical teaching and structured education program

Most trainees (85%) strongly agreed or agreed that the clinical teaching at their placement optimised their learning opportunities, improving compared with the 2022 survey findings (79%). A comparable proportion of trainees also agreed that the structured education program met their needs at their stage and phase of training. A larger proportion of trainees agreed that they received training for and were provided with opportunities to use relevant clinical equipment (91%). However, a smaller proportion (71%) of trainees were in agreeance that they had access to formal ultrasound teaching. Of those who reported no formal ultrasound teaching at their placement (n= 454), the majority indicated they had access to informal ultrasound teaching (79%, n= 357) and 97 (21%) reported no access to ultrasound teaching.

More comparable proportions of trainees agreed that they have access to the educational resources needed to meet the requirements of the FACEM Training Program, and that the structured education program at their placement was aligned to the content and learning outcomes of the ACEM Curriculum Framework (91% and 88%, respectively). Trainees were asked whether the structured education sessions were provided for, on average, a minimum of four hours per week at their placement, with 91% agreeing. However, a smaller proportion of trainees (82%) were in agreeance that the rostering at their placement enabled them to attend structured education sessions.

Comparable proportions of FACEM trainees agreed that the structured education program at their placement met their needs (84%) and rostering enabled trainees to attend education sessions (82%).

No major differences were observed in the agreement level between provisional and advanced trainees with statements regarding clinical teaching and the structured education program (differences <3%). A higher proportion of provisional than advanced trainees (73% vs. 70%) agreed they had access to formal ultrasound teaching at their placement.

Trainees undertaking a placement at paediatric and 12-month accredited EDs were generally more likely to agree to all statements about clinical teaching and the structured education program compared to those at other EDs (Table 22).

Table 22. Proportion of trainees who strongly agreed or agreed with statements about the clinical teaching and structured education program at their ED placement, by ED accreditation tier.

Statement on teaching and education	Strongly agreed or agreed (%)				
	12 months	24 months	36 months	Paediatric	Total
My current placement provides clinical teaching that optimises learning opportunities (including bedside and on-floor teaching)	84.9%	**82.5%**	84.0%	93.2%	84.6%
I have access to the educational resources that I need to meet the requirements of the FACEM Training Program	91.8%	**87.0%**	91.1%	92.5%	90.6%
I receive training for, and am provided with, opportunities to use relevant clinical equipment	90.4%	**90.2%**	90.4%	95.5%	90.8%
The structured education program meets needs	87.7%	**80.9%**	83.8%	88.7%	83.9%
Structured education sessions are provided for a minimum of four hours per week	94.5%	90.7%	**90.3%**	96.2%	91.1%
The structured education program aligns to the content and learning outcomes of the ACEM Curriculum Framework	90.4%	**85.0%**	88.2%	91.0%	88.1%
Rostering enables trainees to attend structured education sessions	87.7%	83.7%	**81.6%**	83.5%	82.4%
Total no. of responses	**73**	**246**	**1097**	**133**	**1549**

Trainees who disagreed with any statements relating to educational and training opportunities available at their placement were given the opportunity to comment on the reason(s) for their response. Most comments (n= 184) primarily focused on unsupportive rostering and lack of protected teaching time, structured education programs that did not meet the needs of the training phase or stage, or poorly structured education programs at their ED placement site.

3.4.2 Access to examination resources

Trainees were asked if they have access to exam preparation resources either onsite at their placement or at another site (linked or networked ED). The same proportion of trainees reported having access to written exam revision programs and clinical exam preparation programs (94% respectively), with varying proportions indicating onsite or offsite availability (Table 23). Of those who reported they had access to written exam revision programs (n= 1,455), the majority (82%) agreed that they had sufficient access to the program. For trainees who reported having access to clinical exam preparation programs (n= 1,460), a similar proportion (80%) agreed they had sufficient access to the program.

Trainees undertaking a placement at EDs accredited for 36 months were most likely to report having access to both written and clinical exam preparation programs, compared with trainees at other EDs (Table 23).

Table 23. Proportion of trainees who reported having access to written and clinical exam preparation programs onsite or offsite at another linked/ networked site, by ED accreditation tier.

I have access to:	Reported yes (%)				
	12 months	24 months	36 months	Paediatric	Total
Written exam revision program	90.4%	88.2%	95.8%	91.0%	93.9%
Onsite	82.2%	75.2%	92.0%	69.2%	86.9%
Offsite (linked/ networked ED)	8.2%	13.0%	3.8%	21.8%	7.0%
Clinical exam preparation program	90.4%	89.8%	95.9%	91.0%	94.3%
Onsite	82.2%	78.8%	93.6%	72.9%	89.0%
Offsite (linked/ networked ED)	8.2%	11.0%	2.3%	18.1%	5.3%
Total no. of responses	**73**	**246**	**1097**	**133**	**1549**

3.4.3 Simulated learning experiences

The majority (94%) of trainees reported that simulation learning experiences were utilised at their ED placement, 3% reported being unsure whether it was available and another 3% reported that it was unavailable at their placement. Trainees undertaking a placement in paediatric EDs (97%) and EDs accredited for 36 months (96%) were more likely than those in EDs accredited for 12 months or 24 months (84% and 88%, respectively) to report that simulation learning experiences were utilised.

Of trainees who reported the availability of simulation learning experiences (n= 1,459), 95% reported participating in simulation learning experiences at their placement (n= 1,391). A slightly larger proportion of provisional trainees than advanced trainees (97% vs. 95%) reported participating in simulation learning at their placement.

94% of FACEM trainees reported the availability of simulation learning experiences at their placement, with nearly all of them participating (95%).

The 68 trainees who did not participate in simulation learning at their placement were asked to provide reason(s), with 47 trainees doing so. Similar to previous surveys, the main reason for not participating was that they were not rostered on when simulation sessions were conducted.

Among the trainees who reported participating in simulation learning at their placement, over three-quarters (83%, n= 1,153) reported that they had participated in multidisciplinary team-based simulation training, with similar proportions of advanced (83%) and provisional (82%) trainees reporting so. Both advanced and provisional trainees reported high levels of agreement relating to the benefits of participation in multidisciplinary team-based simulation training (Table 24).

Table 24. Proportion of trainees who strongly agreed or agreed with statements regarding participation in multidisciplinary team-based simulation training, by training stage.

Participation in multidisciplinary team-based simulation training at this placement:	Strongly agreed or agreed (%)		
	Provisional	Advanced	Total
Has improved my effectiveness in ED team-based practice	93.9%	94.3%	94.2%
Has contributed to my leadership development	92.0%	93.2%	92.9%
Has enhanced my learning and team-based practice	92.3%	91.7%	93.5%
Total no. of responses	313	840	1153

Trainees were asked to comment on their participation in multidisciplinary team-based simulation training. Most comments were positive, reporting simulation as beneficial and useful. A few negative themes trainees expressed included infrequent simulation sessions, or that simulation did not suit their learning style and they therefore did not find it beneficial.

3.4.4 Leadership opportunities

Most trainees strongly agreed or agreed that they were provided with opportunities to teach and supervise junior trainees (92%). A similar proportion agreed they were provided with opportunities for leadership and management appropriate to their stage and phase of training (90%). Advanced trainees were only slightly more likely than the provisional trainees to agree that they were provided with opportunities to teach and supervise junior medical staff (93% compared to 92%), as well as having leadership and management opportunities (91% compared to 88%). There were no noticeable differences between female and male trainees who agreed with either teaching/ supervision or leadership opportunities.

3.4.5 Research opportunities

Over two-thirds (68%) of trainees reported being able to participate in research opportunities at their placement, increasing from 64% in the 2022 survey. Trainees at paediatric sites (74%) and sites accredited for 36 months (71%) were more likely to report having research opportunities than trainees at sites accredited for 24 months (56%) and 12 months (55%).

Table 25 displays the proportion of trainees who indicated there was a designated staff member available to provide advice about the research component of the FACEM Training Program at their placement. Trainees undertaking their ED placement at paediatric sites (47%) or sites accredited for 36 months (46%) were much more likely to report there was a designated staff member to advise them on the research component. However, over one-third (36%) of trainees did not know if a designated staff member was available to provide advice about the research component at their current placement, which was consistently seen across all ED accreditation tiers.

Table 25. Availability of a staff member to provide advice about the research component of the FACEM Training Program, by ED accreditation tier.

Staff member available	12 months	24 months	36 months	Paediatric	Total
Yes	23.3%	28.9%	46.2%	47.4%	42.5%
No	11.0%	8.1%	3.5%	2.3%	4.5%
Don't know	39.7%	44.7%	33.7%	30.8%	35.5%
*Not applicable	26.0%	18.3%	16.6%	19.5%	17.6%
Total no. of responses	73	246	1097	133	1549

*Note: *Not applicable includes trainees who have previously completed or have not yet started the research component.*

3.5 Further Perspectives on Placement

From a list of potential factors, trainees were asked to select up to five key factors they considered in arranging their training placement (Figure 1). The nominated key factors were consistent with those identified in previous survey iterations, where ED location was the most considered factor when trainees arranged their placement, followed by casemix. Also consistent with previous years' findings, remuneration and research opportunities were least considered by trainees.

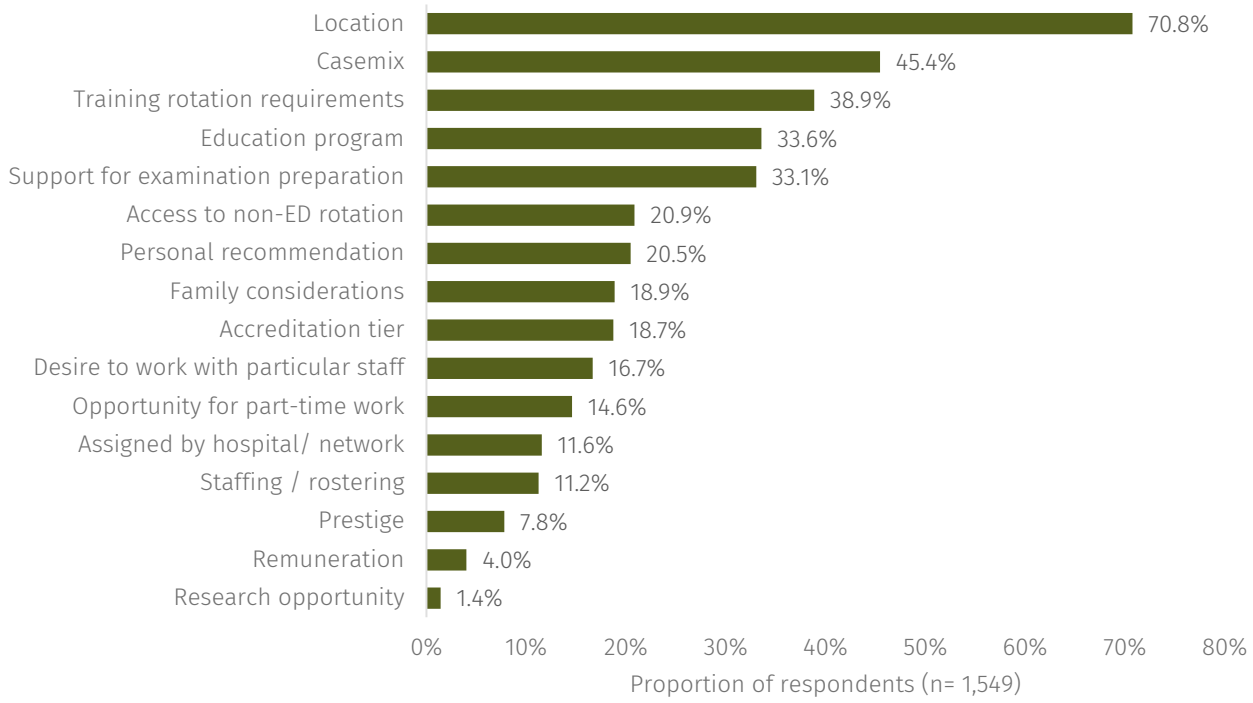

Figure 1. Factors for consideration in arranging training placement, ranked from the most important to the least important.

Note: Trainees could select up to five factors.

Trainees were asked to nominate highlights of their ED placement, with trainees able to select as many highlights that applied. The four most rated highlights included supportive senior staff, supportive DEMT, the casemix, and supportive colleagues/ team environment (Figure 2). These highlights were consistently rated the highest over the previous survey iterations. Approximately one-third of trainees selected clinical teaching, structured education program and support for examination preparation as their placement highlights.

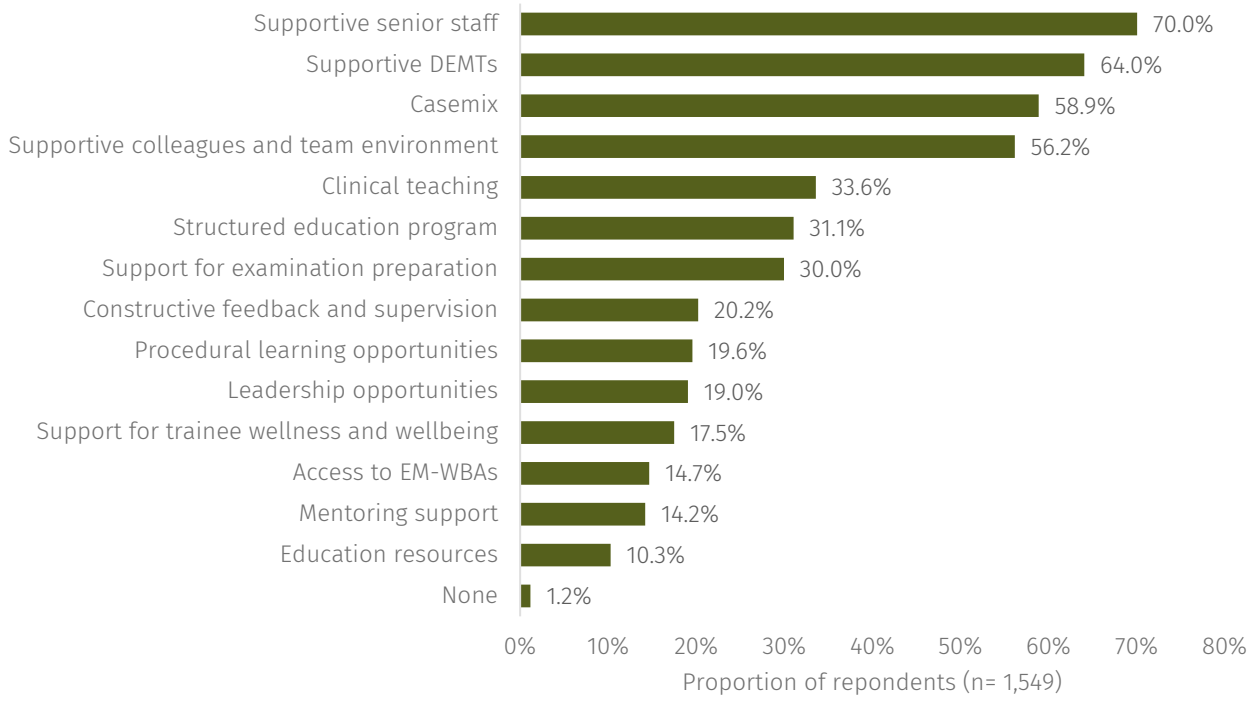

Figure 2. ED placement highlights ranked from most common to least common.

Note: Respondents could select more than one highlight for each placement.
'None' refers to no highlight in their placement, whilst no trainee selected 'Other' as an option.

Trainees were provided with the opportunity to outline key areas for improvement that could be made at their placement, with 122 trainees providing feedback (Table 26). Rostering and staffing were the most commonly identified areas for improvement, either independently or associated with impacting other areas, such as the availability of and access to teaching, education and training.

Table 26. Themes and subthemes for areas for improvement.

Key themes and sub-themes
Rostering / Staffing • *Improved support and safer staffing on night shifts* • *Better access to leave* • *Increase recruitment of nursing and medical staff to meet department demand* • *Improve staffing/rostering to facilitate on-floor teaching* • *Rostered WBAs and increased access to WBA opportunities* • *Specific rostering to resuscitation and trauma exposure*
Teaching / education program • *Structured, examination-specific education and teaching program* • *Formalised bed-side teaching of complex cases* • *Better access to examination preparation*
Clinical and procedural training • *Increase procedural learning opportunities or workshops for skills development* • *More resuscitation and trauma opportunities*
Structured and better support for WBAs • *Formalised WBAs, including rostered and structured assessment* • *Better assistance in completing WBAs*
Senior supervision and feedback • *More structured, constructive and ongoing feedback (incorporate positive and negative feedback)* • *Better support from senior staff and leadership*
Trainee welfare and wellbeing • *Greater focus on trainee wellbeing* • *Improve unsustainable staffing level to reduce staff burnout*

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

3.6.1 Perspectives on the FACEM Training Program

Most trainees (87%) strongly agreed or agreed with the statement 'the FACEM Training Program is facilitating my preparation for independent practice as an EM specialist', with a further 10% neither agreeing nor disagreeing, 2% disagreeing with this statement and 1% reported they don't know. Female trainees (89%, compared with male trainees, 87%) and provisional trainees (88%, compared with advanced trainees, 87%) were slightly more likely to agree with this statement.

87% of FACEM trainees agreed that the FACEM Training Program facilitates their preparation for independent practice as an EM specialist.

A similar proportion (85%) of trainees agreed that they were well supported in their training by ACEM processes, considerably increasing from 75% in the 2022 survey. There was no difference observed between provisional and advanced trainees (85%, respectively) and a similar proportion of female and male trainees (86% vs. 85%) were in agreeance with this.

Trainees who disagreed that they were well-supported in their training by ACEM processes were given the opportunity to provide further details, with 154 trainees doing so. Most comments focused on examinations, including the need for improved support and resources for examination preparation, issues with the number of allowable attempts at exams, the need for greater support for those who were unsuccessful, and the relevance of examination content. Other comments were regarding transitioning to the new FACEM Training Program, which included requests for more transparent communication, and increased guidance and support regarding requirements. Some trainees expressed difficulty in completing WBAs and others requested more support in obtaining other rotations, such as critical care.

3.6.2 Online resources available for FACEM trainees

Trainees were asked to express their level of agreement with statements relating to the usefulness of the listed resources that ACEM provides to support FACEM trainees. (Figure 3). Consistent with the 2022 survey findings, more trainees found the Primary and Fellowship exam resources to be useful (74%), compared with other online resources (46% - 60%). An increase in reported usefulness was seen for each of the resources listed, with the ACEM eLearning modules observing the greatest increase from 54% in the 2022 survey to 60%.

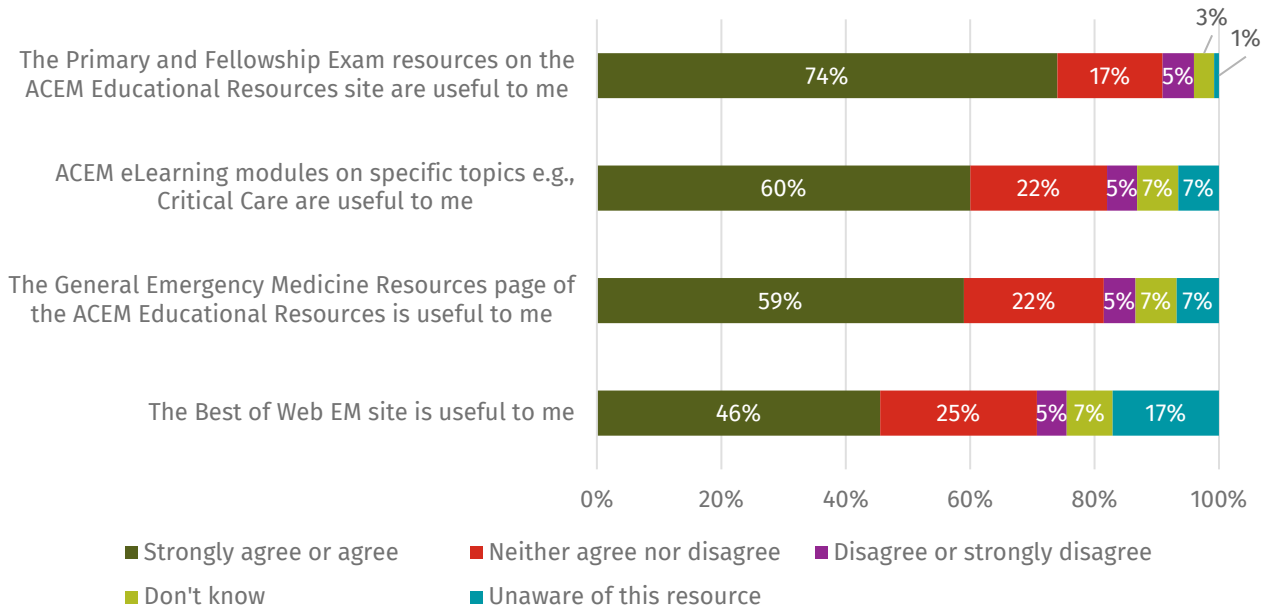

Figure 3. Level of agreement of respondents with statements relating to the usefulness of a range of online resources to support FACEM trainees.

3.6.3 Support and resources – areas of need and interest

Trainees were asked to nominate areas of need and/ or interest for resources and support and their preferred delivery mode(s) for each selected area (Figure 4, Table 27) to inform the future development of appropriate resources and support. Examination resources (written or practical) were the most nominated and were rated much higher than all other resources or support. In previous surveys, examination resources were consistently rated highly as an area of need or interest. Also consistent with findings from the previous surveys, resources for leadership and management skills and clinical skills were the next most rated areas of need.

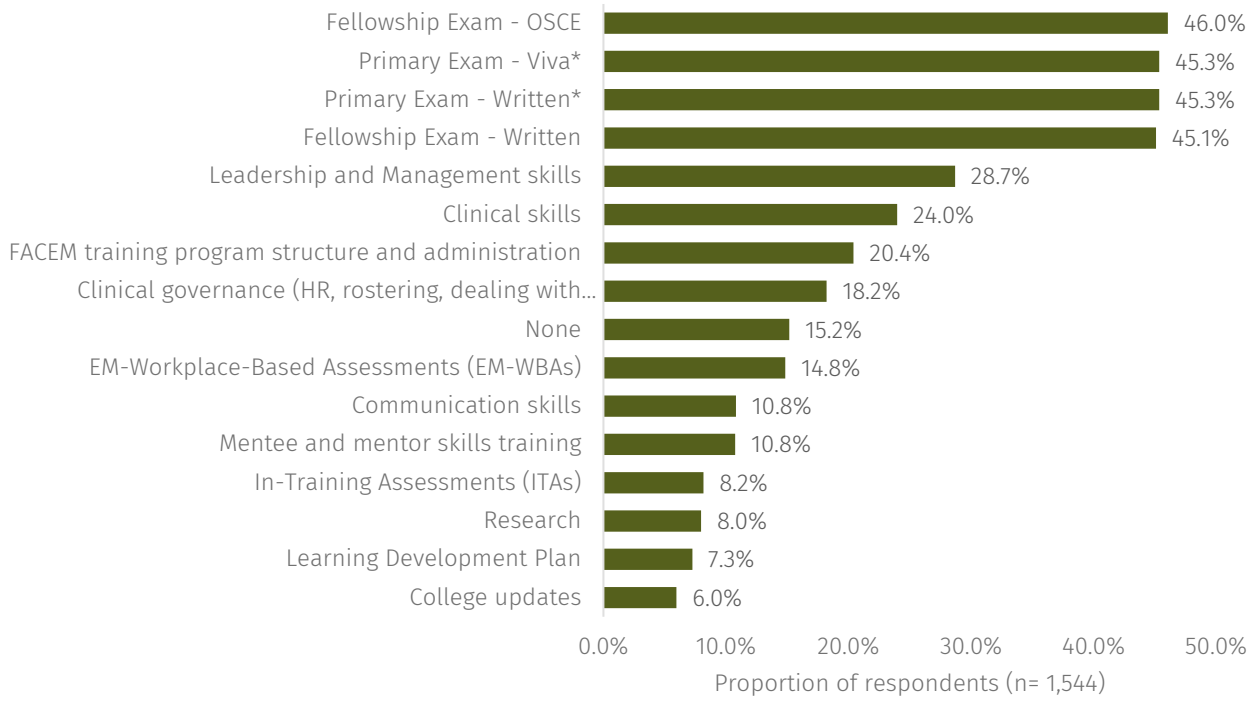

Figure 4. Trainee response rates to resources and support nominated as an area of need and/ or interest.

Note: Trainees were able to select 'None', with no nomination of any resources/ support from the list (n= 234, 15.2%).
For 'Primary exam' resources (Written and Viva), responses from only provisional trainees were included. The percentages reflect the proportion of 419 provisional trainees.

There was a preference for face-to-face training over other delivery methods for most resources and support that were nominated as an area of need/ interest (nine out of 15). Delivery through online learning modules was generally the preferred mode for other resources and areas for support.

Table 27. 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	%	%	%	%	%
College updates	92	25.0%	40.2%	22.8%	**43.5%**	18.5%
FACEM training program structure and administration	315	37.1%	**48.6%**	31.1%	20.0%	35.9%
Learning Development Plan	112	**45.5%**	44.6%	19.6%	5.4%	31.3%
In-Training Assessments (ITAs)	126	**52.4%**	42.1%	21.4%	8.7%	23.8%
EM-Workplace-Based Assessments (EM-WBAs)	229	**59.8%**	33.6%	24.0%	10.0%	28.8%
Primary Exam - Written	222	53.2%	**62.2%**	42.3%	35.1%	28.4%
Primary Exam - Viva	222	**65.8%**	59.9%	43.7%	34.2%	31.5%
Fellowship Exam - Written	696	60.1%	**69.4%**	43.7%	37.4%	34.8%
Fellowship Exam - OSCE	711	**72.0%**	63.6%	49.2%	36.1%	32.8%
Communication skills	167	**81.4%**	45.5%	46.1%	22.8%	19.2%
Leadership and Management skills	443	**73.4%**	56.7%	40.2%	26.0%	19.2%
Clinical skills	370	**78.6%**	53.5%	39.7%	20.5%	24.1%
Clinical governance (HR, rostering, dealing with patient complaints)	281	45.2%	**66.2%**	40.2%	32.4%	36.3%
Research	123	43.9%	**53.7%**	26.8%	40.7%	41.5%
Mentee and mentor skills training	166	**60.8%**	53.6%	35.5%	30.1%	31.3%

Note: Respondents may select more than one type of preferred delivery mode for each nominated resource/support.
For 'Primary exam' resources (Written and Viva), responses from only provisional trainees were included. The percentages reflect the proportion of 419 provisional trainees.

Trainees were asked if they had any suggestions for improvement to the current online resources provided by ACEM, with 45 providing feedback. Consistent with the 2022 survey findings, examination preparation was the main theme identified, including updated resources for exam preparation, more past examination examples, study guide for examinations, and the provision of example questions with answers. The other key theme was improvements to the ACEM website, including updating the user interface and reorganising the structure for easy access to online resources. Other comments included: requests for personalised and more regular training support; improved ACEM oversight of education programs, including standardising ITAs and WBAs across sites; and requests for resources relating to medicolegal aspects of emergency medicine.

4. Conclusion and Implications

Almost all trainees reported their training needs were being met at their ED placement, a finding that is consistently seen in past survey iterations (ranging from 93% to 95% between the 2019 and 2023 surveys). Likewise, nearly all trainees reported knowing where to go for assistance if they experienced difficulties in meeting FACEM training requirements or experienced grievances. Trainees were less likely to agree there were adequate support processes to assist them in progressing through their training, although improvement has been seen over the years (77% in 2019 to 84% in 2023). Since 2019, trainees have been more likely to agree that they were satisfied overall with the rostering at their placement (76%, increasing to 85% in 2023).

Overall, comparable proportions of female and male trainees agreed that their ED placement provided a safe and supportive training environment. However, female trainees were more likely than male trainees to report experiencing DBSH from patients/ carers or other staff. Almost one in three trainees reported experiencing DBSH from a patient or carer at their ED placement in 2023. Over the last five years, a slight decrease in the proportion of trainees who reported experiencing DBSH from patients and carers was observed (from 33% in 2019 to 30% in 2023). A smaller proportion of trainees (12%) reported experiencing DBSH or other unreasonable behaviour from ED and/or hospital staff, however the proportion has slightly increased over the previous survey iterations (2021: 10%; 2022: 11%; 2023: 12%). Consistent with the previous survey findings, in-patient medical staff, ED nursing staff and FACEMs were most frequently reported as the perpetrators of DBSH from staff. While the level of DBSH from staff is notably lower than DBSH from patients and carers, trainee descriptions of DBSH will continue to be monitored, and concerning workplace culture and DBSH incidents will be raised with the relevant placement sites.

Trainees reported they were overall satisfied with the supervision received from DEMTs and consultants. Nearly all trainees agreed that their DEMT had discussed their expectations of the trainee at their stage of training, and they were satisfied with the quality of support from their DEMT. Trainees were less likely to agree they received regular, informal feedback on their performance and progress; notably however, improvement has been seen over the years, with an increasing proportion of trainees agreeing with this (72% in 2019 and 81% in 2023). Another improvement observed was the support trainees received from the Local WBA Coordinator, with an increasing level of satisfaction reported by trainees (from 76% in 2019 to 79% in 2023).

The majority (85%) of trainees reflected positively on the clinical teaching at their placement, increasing from 79% in 2022, agreeing that their ED placement provided clinical teaching that optimises learning opportunities. Over the five years from 2019 to 2023, a high proportion of trainees (range: 87% - 91%) agreed their ED placement provided structured education sessions for a minimum of four hours per week; however, a smaller proportion (range: 74% - 82%) agreed that rostering enabled them to attend the sessions.

Almost all trainees reported participating in simulation learning experiences and were provided with leadership opportunities. Gender differences as reflected in trainee feedback were less common, improving compared to previous survey findings. Comparable proportions of female and male trainees agreed they were provided with opportunities to supervise junior trainees and other leadership opportunities. Likewise, similar proportions of female and male trainees were satisfied with the supervision, support and feedback received from their DEMTs and consultants.

Supportive senior staff, DEMT and colleagues, and ED casemix remained the most nominated placement highlights. Whereas rostering and staffing arrangements were most commonly described as needing improvement. Other areas for improvement included accessibility to the teaching and education program as well as clinical and procedural training, which were often associated with rostering and staffing issues.

The findings from annual training placement surveys will continue to inform quality improvement and support processes to ensure ACEM-accredited EDs provide a training environment that is appropriate, safe and supportive of FACEM trainees.

5. Suggested Citation

Australasian College for Emergency Medicine. (2024). *2023 Trainee Placement Survey Report – ED Placement.* ACEM Report: Melbourne.

6. Contact for Further Information

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