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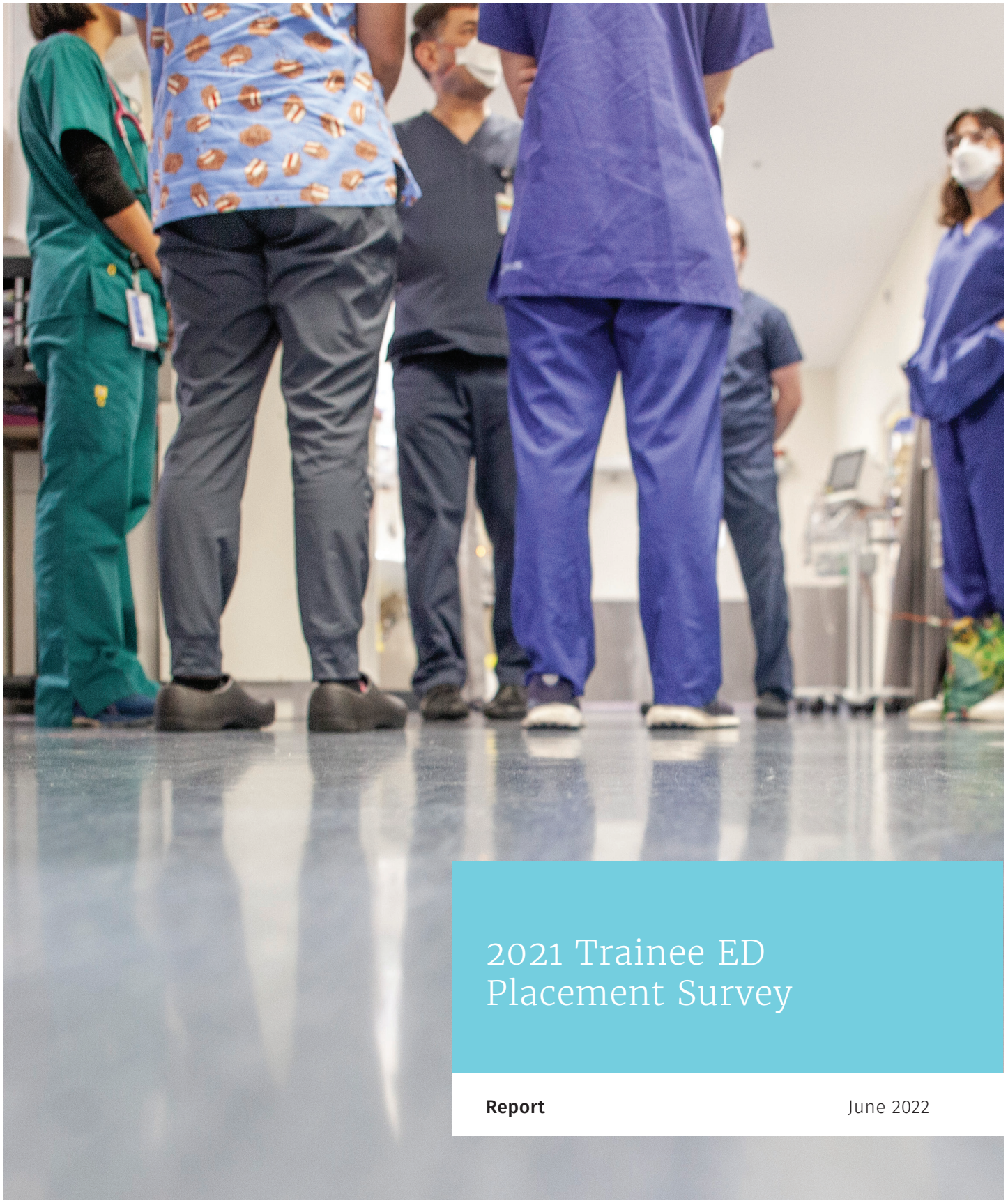


2021 Trainee ED Placement Survey

Report June 2022

Australasian College for Emergency Medicine

2021 Trainee ED Placement Survey

Key findings

This is an annual survey that captures site-specific data to ensure ACEM-accredited sites are providing a safe and supportive environment for FACEM trainees. The survey is mandatory and 1727 trainees responded to the 2021 survey.

94%

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

Supervision

92% satisfied with the quality of **DEMT support**

78% satisfied with the level of **FACEM support with WBAs**

Welfare

89% agreed that their placement provided a **safe and supportive workplace** overall

94% reported knowing where to go **for assistance** if they had difficulty meeting training requirements

Education

84% agreed that the **structured education program** at their placement met their needs

87% agreed that the **clinical teaching** at their placement optimised learning opportunities

65% agreed that they had access to **formal ultrasound training**

Placement highlights

- Supportive senior staff
- Supportive DEMTs
- Team environment
- Casemix
- ED location

Areas for improvement

- Staffing and workload
- Rostering
- Education program
- Clinical teaching
- Supervision & feedback

For the full survey findings, please refer to:
Australasian College for Emergency Medicine (2022), *2021 Trainee Placement Survey - ED Placement*. ACEM Report.

Contents

1. Executive Summary

The Trainee Placement Survey is distributed annually to trainees enrolled in the FACEM Training Program at the end of the training year. The survey captures site-specific data to ensure that sites provide training and a training environment which are appropriate, safe, and supportive of FACEM trainees. This report presents findings from the 2021 survey for all eligible trainees (N=1727) undertaking an ED placement, which are summarised as below:

Health, Welfare and Interests of Trainees

- Nearly all (94%) trainees agreed that their training needs were being met at their placement.
- Overall, rostering was viewed positively by 76% of trainees, with the highest proportion agreeing that the rosters supported the service needs of the site and ensured safe working hours (86%, respectively).
- 94% reported knowing where to go for assistance if they had difficulty meeting training requirements, compared with 90% who reported knowing where to go for assistance if they had a grievance.
- 89% agreed that their placement provided a safe and supportive workplace overall, however a smaller proportion agreed that their placement sustained their wellbeing (74%), provided a comprehensive orientation at commencement (75%), and provided support processes other than mentoring (78%).
- 27% reported experiencing discrimination, bullying, sexual harassment, or harassment (DBSH) behaviour from a patient/ carer, whilst 10% reported experiencing DBSH behaviour exhibited by ED or hospital staff, with in-patient medical staff and FACEMs being the most reported staff category.
- Just over half (58%) agreed that they could participate in decision making regarding governance, while 71% agreed that they could participate in quality improvement activities at their ED placement.

Supervision and Training Experience

- 92% of trainees were satisfied with the quality of DEMT support, and a similar proportion were satisfied with the supervision received overall (91%).
- 90% agreed that the clinical supervision received from FACEMs met their needs, however only 79% agreed that they received regular informal feedback on their performance.
- Just over three-quarters of advanced trainees were satisfied with the level of support received from their Local WBA Coordinator (76%) and FACEMs (78%) to complete Wokplace-based Assessments (WBAs).
- Trainees agreed that the ED casemix at their placement was appropriate with respect to the number (95%), breadth (88%), acuity (83%), and complexity (88%) of cases.

Education and Training Opportunities

- 87% agreed that the clinical teaching at their placement optimised learning opportunities. However only 65% agreed that they had access to formal ultrasound training.
- 84% of trainees agreed that the structured education program at their placement met their needs, with 81% agreeing that rostering enabled them to attend the education sessions.
- Comparable proportions agreed that they had access to onsite written exam revision programs (87%) and clinical exam preparation programs (88%) at their placement.

Further Perspective on ED Placement

- The most nominated highlights of their placement were supportive senior staff/ DEMT/ colleagues and ED casemix. In comparison, rostering/ staffing arrangements and the teaching/ education program were the key areas for improvement identified by trainees.

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, but a smaller proportion (76%) agreed 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 administered annually to advanced and provisional FACEM trainees undertaking an ED placement in Aotearoa New Zealand and Australia at the time of survey distribution. Survey questions focused on three key areas: Health, Welfare and Interests of Trainees; Supervision and Training Experience; and Education and Training Opportunities. The survey further sought trainee feedback on the support they received from ACEM, and potential areas for advocacy and quality improvement for the FACEM Training Program. This report details the findings from the 2021 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). All eligible trainees were required to submit the online survey before paying their annual training fees through the ACEM member portal. Eligible trainees were those who were undertaking an ED placement in ACEM-accredited sites as of 30 October 2021, excluding trainees on an interruption to their training at the time.

The survey was made active on Monday, 29 November 2021. An email was sent to all eligible trainees notifying them about the online fee payment process, including the requirement to complete the annual Trainee Placement Survey. The survey was promoted as being mandatory, and the information was communicated as part of news items in the ACEM Bulletin, DEMT Forum, and the Trainee Newsletter. The survey was closed on 28 February 2022.

All collected information was handled in confidence, with anonymity ensured in reporting and feedback provided to Accreditation staff and inspectors. Survey findings 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.

4. Results

A total of 1732 completed surveys were received from a pool of 1738 eligible trainees who were undertaking an ED placement as of 30 October 2021, a response rate of 99.7%. Six trainees who were on an interruption to training during the survey period did not respond to the survey invitation.

Five trainees were undertaking part-time ED placements at two different hospitals and completed a survey for each placement. As such, all survey findings are reported based on the total survey responses (N=1732), except for the demographic information (section 4.1) which is presented for the 1727 responding trainees.

4.1 Demographic Characteristics of Respondents

Of the 1727 responding trainees, 91% were undertaking an ED placement in Australia and the remainder (9%) were undertaking a placement in Aotearoa New Zealand (NZ). Half (n = 855) of the trainees were female, an increase from 48% in the 2020 Trainee Placement Survey.

Two-thirds (68%, n=1176) of the trainees were in the advanced stage of training (Table 1). Provisional trainees (n=551) had an average age of 32 years, compared with 35 years for advanced trainees.

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

Region	Female	Male	Total		% Female	% Advanced trainees (n=1,176)	% Provisional trainees (n=551)
	N	N	*N	%			
Australia	**778**	**793**	**1571**	**91.0%**	**49.5%**	**68.1%**	**31.9%**
ACT	7	8	15	0.9%	46.7%	60.0&	40.0%
NSW	248	240	488	28.3%	50.8%	68.6%	31.4%
NT	18	16	34	2.0%	52.9%	82.4%	17.6%
QLD	208	214	422	24.4%	49.3%	65.4%	34.6%
SA	38	44	82	4.7%	46.3%	69.5%	30.5%
TAS	19	20	39	2.3%	48.9%	74.4%	25.6%
VIC	159	179	338	19.6%	47.0%	68.3%	31.7%
WA	81	72	153	8.9%	52.9%	68.6%	31.4%
Aotearoa New Zealand	**77**	**79**	**156**	**9.0%**	**49.4%**	**67.9%**	**32.1%**
Total no. of trainees	**855**	**872**	**1727**	**100%**	**49.5%**	**68.1%**	**31.9%**

Table 2 presents the proportion of provisional and advanced trainees undertaking an ED placement, by type and accreditation level of ED. A higher proportion of advanced trainees than provisional trainees (10% vs. 2%) were undertaking an ED placement in a paediatric ED. Less than two-thirds (59%) of the responding trainees were undertaking their placement at EDs accredited for 24 months of training, while only 2% undertook placements at 6-month and 6-month linked sites, respectively.

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

	Provisional		Advanced		Total	
Type of ED	**N**	**%**	**N**	**%**	**N**	**%**
Adult/ Mixed	541	98.2%	1061	89.8%	1602	92.5%
Paediatric	10	1.8%	120	10.2%	130	7.5%
ED accreditation level	**N**	**%**	**N**	**%**	**N**	**%**
6-month linked*	11	2.0%	24	2.0%	35	2.0%
6 months	19	3.4%	23	1.9%	42	2.4%
12 months	146	26.5%	208	17.6%	354	20.4%
18 months	70	12.7%	208	17.6%	278	16.1%
24 months	305	55.4%	718	60.8%	1023	59.1%
Total no. of responses	**551**	**100%**	**1181**	**100%**	**1732**	**100%**

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

** Linked-EDs are formally linked to a fully accredited 6, 12, 18 or 24 month accredited ED allowing them to access the educational resources of that site.*

4.2 Health, Welfare and Interests of Trainees

This section presents the trainee's feedback on whether their ED placement at the time of the survey met their health, welfare and interests. This broadly covers various aspects such as mentoring, rostering, trainee assistance, workplace safety and support, and opportunities to participate in governance and quality improvement activities. The section also covers trainee's reports on their experiences of discrimination, bullying, harassment, and sexual harassment (DBSH) at their ED placement.

4.2.1 Overall trainee needs

Nearly all (94%, n=1625) trainees strongly agreed or agreed that their training needs were being met at their ED placement, with 3% (n=49) disagreeing that their needs were being met and 3% (n=58) being neutral. Provisional trainees (95%) were slightly more likely than advanced trainees (93%) to agree that their training needs were met, while more comparable proportions of female and male trainees (93% and 94%, respectively) reported so.

Those (n=107) who did not agree that their training needs were being met at their placement were provided with the opportunity to comment on their response, with 103 of them providing feedback. Key reasons trainees provided concerning their needs not being met at their placement were:

- A lack of education and support for exams (38%)
- Unsafe and busy rostering or workplace (mainly due to understaffing, frequent night shifts, or ED overcrowding that leads to trainee burnout (31%)
- Unsatisfactory senior supervision and/or feedback (27%)
- Limited on-the-floor teaching, including lacking procedural opportunities (24%)
- Difficulty in completing Workplace-based Assessments (WBAs, 17%)
- Inadequate casemix, particularly higher acuity patients (14%)
- No protected teaching time (7%)
- Difficulty in obtaining required rotation (5%)

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

> *Access block and large patient presentations mean I have had less supervision on my shifts than in previous years. I have spent a large number of shifts in respiratory care or on night shift.*
>
> *The current teaching program for primary exams was incredibly disorganised and ineffective and I felt as though I was navigating the process on my own and that the teaching program provided little material benefit.*
>
> *Trainee generally feels like a boot on the floor. Bedside teaching/teaching on the run is non-existent. Trainee gets a vibe that if trainee doesn't know something and asks for help, it's perceived as a deal-breaking deficiency.*
>
> *Limited protected teaching, limited bedside teaching, limited supervised hours due to extensive share of unsupervised after hours shifts.*
>
> *I have not been exposed to significant trauma in the last 18 months, have only intubated one person in this time. I do not feel I have had adequate exposure to resuscitations in the last 12 months.*
>
> *Difficult to do WBA. Especially the Case-based Discussions due to low acuity case mix*

4.2.2 Mentoring program

Seventy-seven per cent (n=1335) of trainees reported having an ACEM Mentoring Program Coordinator at their ED placement, and 2% reported that there wasn't one. A further 21% of trainees reported that they were not aware of this position at their placement. Trainees undertaking a placement at sites accredited for 24-months (82%) were more likely to report the availability of an ACEM Mentoring Coordinator, followed by trainees undertaking a placement at sites accredited for 18-months (71%), 12 months (70%), 6-months linked (66%), and 6 months (64%).

The majority (81%, n=1,400) of trainees reported that there was a formal mentoring program available at their ED placement, with 5% (n=78) reporting that there was not one available and 15% (n=254) of trainees reporting not knowing whether a formal mentoring program was available. Of the trainees who reported having a formal mentoring program in place, around two-thirds (63%, n=883) had utilised the program. Among those who utilised the program, there was a higher proportion of provisional (68%, n=301) than advanced trainees (61%, n=582) reporting so.

For the remaining trainees (n=517) who reported not utilising the formal mentoring program at their placement despite this program being available, 36% 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 12% reported that the mentoring program did not meet their needs, and 8% reported that it was difficult to access the mentoring program at their placement.

Other reasons (22%) provided for not utilising the formal mentoring program were mainly because of time constraints (n=21), for example, prioritising study/exam preparation, difficulties in finding times to meet with mentors, having other priorities; or a preference for informal mentorship (n=20). Trainees also mentioned other reasons for not utilising the formal mentoring program, such as they had not found a suitable person (n=12), they were still waiting for a mentor to be allocated (n=14), or that they were not ready to meet with their mentor (n=10). Six others commented that they did not need a mentor, while others mentioned that it was difficult to access formal mentorship during a short-term placement (n=4) or during the COVID-19 pandemic (n=2), and four reported being unaware of the mentoring program.

4.2.3 Rostering

Trainees were asked to state their level of agreement with statements regarding rostering at their placement. Three-quarters (76%) of trainees were in agreeance that they were satisfied overall with the rostering at their site, with similar proportions of advanced (76%) and provisional (77%) trainees satisfied. Relatively comparable proportions of advanced trainees (ranged 76%-87%) and provisional trainees (ranged 75%-85%) were in agreeance with each of the rostering statements (1-3% difference).

Table 3 shows the proportion of trainees who agreed with statements relating to rostering, by region. The highest proportions of trainees agreed that the rosters supported the service needs of the site, and that rosters ensured safe working hours (86%, respectively). On the contrary, the smallest proportions of trainees agreed that rosters were provided in a timely manner (75%) and their rostering gave them equitable exposure to day/evening/night shifts (77%). Trainees who were undertaking a placement in the Australian Capital Territory (ACT) were more likely to agree with most of the rostering statements compared with trainees from other regions.

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	93.3%	80.0%	88.2%	75.6%	76.8%	76.7%	74.6%	76.1%	67.3%	76.4%
Rosters are provided in a timely manner	73.3%	71.4%	91.2%	76.3%	70.7%	87.2%	71.7%	84.5%	78.8%	75.2%
Rosters give equitable exposure to day/ evening/ night shifts	86.7%	75.9%	79.4%	76.3%	85.4%	74.4%	74.6%	82.6%	75.6%	76.9%
Rosters give equitable shifts to all areas of the ED	100%	82.0%	82.4%	80.1%	65.9%	74.4%	74.3%	82.6%	73.7%	78.6%
Rosters consider workload as a trainee	86.7%	84.9%	91.2%	79.4%	86.6%	69.2%	89.7%	82.6%	78.2%	83.5%
Rosters support the service needs of the site	93.3%	87.1%	91.2%	84.8%	87.8%	76.9%	88.8%	87.7%	79.5%	86.2%
Rosters ensure safe working hours	100%	88.4%	91.2%	86.3%	79.3%	82.1%	86.4%	88.4%	73.7%	85.7%
Rosters take into account leave requests	93.3%	85.3%	91.2%	78.9%	80.5%	87.2%	83.8%	77.4%	59.0%	80.4%
Rosters take into account the skill mix required	93.3%	83.7%	88.2%	74.9%	84.1%	84.6%	77.9%	83.2%	71.8%	79.5%
Total no. of responses	15	490	34	422	82	39	339	155	156	1732

Note: Highest proportion is highlighted in green whilst smallest proportion is in orange

Consistently, trainees undertaking a placement in EDs accredited as 6-month linked training sites were generally more likely to agree with each of the statements regarding rostering, compared with trainees undertaking placements in other EDs (Table 4).

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-month linked	6 & 12 months	18 & 24 months
Overall, I am satisfied with rostering at my site	91.4%	77.5%	**75.7%**
Rosters are provided in a timely manner	82.9%	**72.0%**	76.0%
Rosters give equitable exposure to day/ evening/ night shifts	74.3%	**73.2%**	78.1%
Rosters give equitable shifts to all areas of ED	80.0%	80.8%	**77.9%**
Rosters consider workload as a trainee	91.4%	**82.6%**	83.6%
Rosters support the service needs of the site	88.6%	**84.6%**	86.6%
Rosters ensure safe working hours	94.3%	**83.8%**	86.1%
Rosters take into account leave requests	91.4%	**76.5%**	81.2%
Rosters take into account the skill mix required	80.0%	**74.7%**	80.9%
Total no. of responses	35	396	1301

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=418) and some example comments. Comments that reflected negatively on rostering (n=284, 67%) significantly outnumbered the positive feedback about rostering (n=62, 15%). There was a wide range of rostering issues raised, with the COVID-19 pandemic being stated as a factor that further complicated rostering at sites. A further 10% of comments were mixed feedback, and 5% of comments were 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
Negative (n=284) - Excessive evening/night shift burden - Understaffed, particularly for senior registrars - Late issuing of roster - Rigid rostering and difficulty accessing leave (incl. study leave) - Skills mix of staff is unsafe, especially overnight and over weekends - Insufficient breaks between shifts - Limited exposure to specific clinical areas (e.g., paediatrics, orthopedic) - Poor teaching roster/ limited clinical teaching time - Unpaid over-time	*My roster consists primarily of evening and night shifts. There are very few day shifts. This is exhausting and not ideal for family life and exam study.* *Rostering has been taken over by an admin person this term and that combined with how short-staffed we are now has had a negative impact. Some examples noted above - more nights, lack of training days. Three junior registrars on nights then three senior registrars on the next set instead of balancing skill mix.* *Exposure to different areas in ED is not equally distributed. Usually occurs as a first come first serve basis which is unfair. Resuscitation shifts are not rostered, so exposure to resus is fairly limited.* *Very difficult to access professional development leave.* *ACEM trainees are disproportionately rostered to the Fast Track area of the department, which is an area of lower acuity, generally not working directly with a consultant, therefore reducing direct training opportunities.* *Rosters often change with only 24 hours' notice, never take into account education/teaching sessions (except for interns), and do not seem to take into account skill mix.*
Positive (n=62) - Rostering was accommodating of annual/study leave requests. - Fair and equitable shifts - Improving	*Currently pregnant, so rosters have been very good - keeping me safe from the red zone (covid suspect) and not on nights.* *Best rostering system at any hospital I've been to - equitable, allows time for protected learning, and considers roster requests.* *Well-staffed and well-supported department, with timely provision of rosters and considerable effort into equitable rostering*
Mixed positive and negative (n=43) - Generally good, could be more flexible for short notice requests. - Fair rostering but extreme workload leading to burnout	*Very fair roster with plenty of effort put in by consultants to ensure this. Unfortunately, overtime pay is not even considered.* *The rostering in the department is variable depending on the staffing available. The department is rostered well when there are enough staff in the workforce.*
Suggestions for improvement (n=19)	*Teaching always rostered on time off i.e. before 2:00- midnight shift, meaning you are at work for > 12 hours if attending beforehand. Other places allow Registrars to leave the floor for teaching - it would be nice if this could be incorporated.* *Night shift rosters would benefit from a 3-tier category of registrars to ensure that the in-charge registrar is not paired with two very junior registrars (eg first term registrars) especially when locum cover is also not available.* *Rostering to accommodate Advanced Trainee teaching at alternative sites would be beneficial.* *Having the rostering written and released further in advance for the next term would be even better.*

4.2.4. Assistance for trainees

Nearly all trainees (94%) reported knowing where to go for assistance if they were having difficulty meeting the training requirements, with the same proportion of advanced and provisional trainees reporting so (Table 6). However, a significantly smaller percentage (77%) of trainees agreed that their ED placement has adequate 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 with respect to training, 90% of trainees reported knowing where to go for assistance if they had a grievance about their training, with a further 6% neither agreeing nor disagreeing and 3% disagreeing with this. Similarly, a much smaller proportion of trainees (71%) agreed that their placement had adequate processes to manage trainee grievances, with 11% 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 where to go for assistance if have difficulty meeting the training requirements	94.2%	93.6%	**93.8%**
ED placement has adequate processes in place to identify and assist trainees having difficulty in progressing through their training	77.5%	77.3%	**77.4%**
Know where to go for assistance if have a grievance about training	87.7%	90.7%	**89.7%**
ED placement has adequate processes in place to manage grievances	71.0%	71.1%	**71.1%**
Total no. of responses	551	1181	1732

Table 7 presents the proportion of trainees who were in agreeance with statements in relation to trainee assistance, by region.

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 where to go for assistance if have difficulty meeting the training requirements	93.3%	92.2%	97.1%	93.8%	93.9%	97.4%	94.1%	94.8%	95.5%
ED placement has adequate processes in place to identify and assist trainees in difficulty	93.3%	76.5%	79.4%	79.6	69.5%	64.1%	75.2%	83.2%	78.2%
Know where to go for assistance if have a grievance about training	86.7%	89.2%	91.2%	91.0%	90.2%	87.2%	89.4%	91.0%	87.8%
ED placement has adequate processes in place to manage grievances	73.3%	72.2%	76.5%	74.9%	61.0%	64.1%	69.0%	73.5%	64.7%
Total no. of responses	15	490	34	422	82	39	339	155	156

Note: Highest proportion is highlighted in green whilst smallest proportion is in orange

When this was compared by ED accreditation level, trainees generally reported relatively consistent agreement levels with each of the statements, except with respect to whether adequate processes were in place to manage trainee grievances, with trainees at 6- and 12-month and 18- and 24-month accredited sites less likely to agree with this (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 regarding assistance for trainees	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Know where to go for assistance if have difficulty meeting the training requirements	94.3%	93.4%	93.9%
ED placement has adequate processes in place to identify and assist trainees in difficulty	77.1%	75.8%	77.9%
Know where to go for assistance if have a grievance about training	88.6%	89.4%	89.9%
ED placement has adequate processes in place to manage grievances	82.9%	**70.2%**	**71.0%**
Total no. of responses	35	396	1301

The survey further sought feedback about the assistance or processes available at their ED placement for trainees in difficulty or for handling grievances, with 95 responses received. There was similar number of positive (n=44, 44%) and negative (n=41, 41%) comments, and a further 10 trainees commented that they either did not need any assistances or were unsure whom to get assistance from for grievances. Most of the positive comments referred to supportive and approachable senior staff, whereas the negative comments generally referred to grievances not acted upon or the poor management of grievances. Some examples of these negative comments are provided in the following:

> *Trainees at this site have had difficulties having their issues appropriately addressed for years - even after approaching both the Australian Salaried Medical Officers' Federation and ACEM. The director and department are not able to offer support or solutions and we have a high number of resignations for this reason.*
>
> *Grievances are not acted upon, rather one is made to feel apologetic for raising them.*
>
> *While on paper, there are processes and people to assist on site in regard to training, in reality issues are often met with a "We are a small department / hospital" excuse. The confidentiality about raising issues is also questionable.*
>
> *I'm not sure that grievances can be dealt with in a way that isn't detrimental to the trainee if aired, and as such, cannot think of anyone who I would be comfortable raising a grievance with.*

4.2.4 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 (89%) 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 provided a safe and supportive environment with respect to personal safety (86%), clinical protocols (88%) and supervision arrangements (86%). The other aspects such as support processes other than mentoring (78%), and the provision of a comprehensive orientation program at commencement (75%) received less agreement from trainees, with the lowest level of agreement received for the statement that their placement provided a safe and supportive workplace for sustaining their wellbeing (74%).

There was no difference between provisional and advanced trainees in their agreement about whether their placement provides a safe and supportive workplace overall (Table 9). This result differs from the 2020 report, where provisional trainees were more likely than advanced trainees (94% vs. 91%) to agree that their placement provided a safe and supportive workplace overall.

Comparable proportions of provisional and advanced trainees agreed with each of the statements regarding their placement providing a safe and supportive workplace, except advanced trainees were slightly more like than provisional trainees (75% vs. 72%) to agree that their placement supported their wellbeing.

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	90.2%	88.7%	89.1%
Personal safety (e.g. aggression directed by patients and/ or carers)	87.5%	85.9%	86.4%
Sustaining my wellbeing	71.5%	74.7%	73.7%
Support processes (other than mentoring)	76.0%	78.4%	77.7%
Clinical protocols	88.2%	87.4%	87.6%
Supervision arrangements	85.8%	86.5%	86.3%
Comprehensive orientation program at commencement	75.7%	75.2%	75.3%
Total no. of responses	551	1181	1732

Female trainees were less likely than male trainees to agree that their ED placement provided a safe and supportive workplace with respect to the supervision arrangements (85% vs. 88%) and the provision of support processes other than mentoring (76% vs. 80%).

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 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, compared 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	93.3%	90.4%	97.1%	89.3%	81.7%	79.5%	88.5%	89.7%	89.7%
Personal safety	100%	84.5%	85.3%	91.9%	78.0%	82.1%	86.7%	86.5%	80.8%
Sustaining my wellbeing	86.7%	78.2%	67.6%	74.9%	67.1%	59.0%	74.0%	69.7%	66.7%
Support processes (other than mentoring)	100%	78.4%	82.4%	80.1%	69.5%	74.4%	76.1%	80.0%	71.8%
Clinical protocols	93.3%	89.0%	100%	89.3%	87.8%	69.2%	88.2%	87.7%	78.8%
Supervision arrangements	100%	88.6%	88.2%	87.2%	82.9%	71.8%	82.6%	87.1%	87.8%
Comprehensive orientation	80.0%	76.1%	76.5%	73.0%	62.2%	64.1%	78.2%	84.5%	73.1%
Total no. of responses	**15**	**490**	**34**	**422**	**82**	**39**	**339**	**155**	**156**

Note: Highest proportion is highlighted in green whilst smallest proportion is in orange

Trainees who were undertaking a placement in a 6-month linked site were more likely to agree that their placement provided a safe and supportive workplace for all aspects (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-month linked	6 & 12 months	18 & 24 months
Overall safety & support	91.4%	89.9%	**88.9%**
Personal safety	91.4%	**85.9%**	86.4%
Sustaining my wellbeing	80.0%	74.5%	**73.3%**
Support processes (other than mentoring)	82.9%	**75.0%**	78.3%
Clinical protocols	91.4%	**80.3%**	89.8%
Supervision arrangements	88.6%	**85.4%**	86.5%
Comprehensive orientation	80.0%	**72.0%**	76.2%
Total no. of responses	**35**	**396**	**1301**

Trainees who disagreed that their ED placement provided a safe and supportive workplace were asked to provide a reason(s) for their response, with 202 trainees providing feedback (Table 12). A range of responses were obtained, including comments focused on trainee wellbeing and personal safety, a lack of orientation available and a lack of supervision.

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
Trainee wellbeing (n=60) *Unsupportive rostering, increasing workload, burnout, lack of wellbeing initiatives/programs, not feeling supported by their department*	*Well-being is largely recognised as being a personal issue rather than entrenched in the processes of working in a challenging department.* *A lot of trainees burnout due to high demands of department - even through covid - without any increases in support for an already short staffed trainee group.* *When staff are assaulted there was zero follow up from the ED management group. I expect a follow up phone call from a Consultant to check on my wellbeing. It only needs to be 1-2 mins.* *Minimal formal programs aimed at trainee wellbeing, no openly available support processes.* *There are superficial "wellbeing" things in place, but nothing that I would consider active or substantial. I'm not aware of any support processes*
Personal safety (n=54) *Insufficient security, increasing violent alcohol/drug-related or mental health patients, no duress alarm readily available for doctors*	*Whilst physical aggression is appropriately addressed, verbal aggression from patients/carers seems to be acceptable (I would say this has been the case in every department I have ever worked in).* *At night the department is totally unsafe, with security in a different building who take a long time to come to help and leave immediately after the first outburst of aggression is over.* *I have often felt at risk of being assaulted with minimal back up or support from security staff overnight during my term.*
Orientation (n=42) *Minimal or no orientation at commencement, suboptimal orientation, interrupted due to COVID-19*	*The department orientation was provided by administration staff who could not answer any questions about clinical processes or flow. The first teaching session was used to provide orientation but was after 2 weeks of work (and stress) for most new registrars.* *In this placement a lot of trainees are in charge overnight for the first time - I didn't find there was much orientation regarding expectations overnight for those that haven't done it before.* *Due to covid online general hospital induction only. No ED-specific induction.* *There was no orientation provided. I am happy to learn things on the go but NOT about covid 19 protocol, clean and dirty zones, etc.*
Supervision and mentoring support (n=31) *Especially during night shifts and on weekends*	*Supervision can be lacking. I am a senior trainee who can work independently but there is frequently only 2 consultants on an evening shift which may leave a junior registrar looking after the subacute area by themselves - expected to supervise and see their own patients* *Consultant shortages mean that Junior Registrars are running certain areas of the department "Green zone" largely unsupported on a regular basis.* *There is formal DEMT, but no fomalised supervisor for WBAs or other training requirements*
Patient safety and quality of care (n=28) *Access block, understaffing esp. at night shift*	*Felt unsafe to work when we are being rostered for around 18-20 night shifts, feeling run down with potential fear that this may affect our clinical judgement.* *Lack of medical staffing relative to patient presentations and surges in numbers (particularly over evening shift) results in a large number of patients yet to be seen at the beginning of nightshift. This creates an unsafe environment for patients.*
Clinical protocols (n=17) *Outdated, limited, unorganised, lack of accessibility,*	*Protocols are difficult to find due to lack of a single repository that is easy to navigate* *No clear set of protocols/pathways for common presentations. I think more*

lack of COVID-related protocols	*structured clinical guidelines would be helpful for out-of-hours.* *A lot of clinical protocols are circulated at a consultant level only. I am particularly concerned about COVID protocols, because what I have been told mostly is that we don't have any.*
Teaching/training structure and needs (10) *Not enough on floor teaching, service-oriented with limited focus on trainee needs*	*Supportive consultants but not enough on shift to allow for teaching opportunities* *I don't feel like weekly teaching sessions are enough to improve my clinical skills and on the floor I don't feel like there is enough teaching from certain consultants.* *The system seems disconnected and at times, can seem a bit distant and out of touch with reality. Hence not reflecting trainee needs and more focused on service.*

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

4.2.5 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. There were 468 (27%) of the 1732 trainees in an ED placement who reported experiencing at least one aspect of DBSH behaviour from a patient or carer at their placement, with 42% (n=196) of them reporting experiencing two or more aspects of DBSH behaviour. Of the 141 placement sites, 113 (80%) EDs had at least one trainee report experiencing DBSH from a patient or carer.

Trainees were more likely to report experiencing harassment (17%) and discrimination (13%) than bullying (7%) or sexual harassment (5%), from a patient or carer (Table 13). Female trainees were more likely than males to report experiencing discrimination, harassment and sexual harassment. DBSH incidents by patients or carers were also more likely to be reported by provisional trainees (30%), compared to advanced trainees (26%), who were also more likely to report experiencing most aspects of DBSH, except for bullying.

Table 13. Number and proportion of trainees who reported experiencing DBSH behaviour by a patient or carer at their placement, by gender and training level

Experienced DBSH from a patient or carer	Total trainees N=1732	Gender		Level of training	
		Female N=856	Male N=876	Provisional trainees N=551	Advanced trainees N=1181
Discrimination	225 (13.0%)	131 (15.3%)	94 (10.7%)	81 (14.7%)	144 (12.2%)
Bullying	122 (7.0%)	58 (6.8%)	64 (7.3%)	34 (6.2%)	88 (7.5%)
Sexual Harassment	80 (4.6%)	76 (8.9%)	4 (0.5%)	30 (5.4%)	50 (4.2%)
Harassment	298 (17.2%)	165 (19.3%)	133 (15.2%)	110 (20.0%)	188 (15.9%)
Overall	**468 (27.0%)**	**273 (31.9%)**	**195 (22.3%)**	**165 (29.9%)**	**303 (25.7%)**

Note: Total trainees who reported at least one aspect of DBSH, noting that each trainee may report more than one aspect of DBSH behaviour

Of the trainees who reported experiencing DBSH from patients/ carers, 248 (53%) trainees indicated having experienced the DBSH behaviour from patients, 18 (4%) from carers, and 187 (40%) from both patients and carers. Fifteen trainees who reported DBSH from a patient/ carer did not indicate the person(s) who was responsible for the incident.

The trainees who reported having experienced DBSH from a patient or carer were asked to provide further information about their experience if they were comfortable doing so, with 168 trainees providing responding. Common themes identified included female trainees experienced a lack of trust in their clinical knowledge and skills because of their gender; sexual harassment from patients was frequently reported among female trainees (which included inappropriate touching and derogatory comments about their physical appearance); and harassment and discrimination of trainees due to their ethnicity or from a non-English speaking background. Some example comments related to DBSH from a patient or carer are presented in the following:

> *Carer preferred to hear the opinions/management plan of my intern who was a male instead of my management plan as I was a female doctor.*

> *This occurs on a daily basis. It is a small thing but it gets tiring when it happens all the time that patients and their family assume you are a nurse because you are a female.*

> *Multiple occasions - drunk, impaired, delirious patients usually involved (but not always). Make sexually inappropriate comments, I have experienced [inappropriate touching] on two occasions in recent months.*

> *In front of multiple staff, an adult patient told me that they hated people from my country of origin - and that my accent had offended her.*

Correspondingly, trainees were also asked if they had experienced any DBSH from ED or hospital staff while working in their placement. A total of 168 (10%) of 1732 trainees in an ED placement reported experiencing at least one aspect of DBSH behaviour exhibited by ED and/ or hospital staff, with 43 (26%) of them reporting experiencing two or more aspects of DBSH behaviour. Seventy-three (52%) of 141 placement sites had at least one trainee report having experienced DBSH by hospital or ED staff.

Trainees were most likely to report experiencing bullying (8%) by ED/ hospital staff, with 3% and 2%, respectively reporting experiencing discrimination and harassment (Table 14). Female trainees were more likely than male trainees to report experiencing discrimination and bullying by staff, whilst similar levels of DBSH behaviour by a staff member were reported as being experienced by advanced and provisional trainees.

Table 14. Number and proportion of trainees who reported experiencing DBSH behaviour by ED or hospital staff at their placement, by gender and training level

Experienced DBSH from a hospital or ED staff	Total trainees N=1732	Gender		Level of training	
		Female N=856	Male N=876	Provisional trainees N=551	Advanced trainees N=1181
Discrimination	50 (2.9%)	33 (3.9%)	17 (1.9%)	20 (3.6%)	30 (2.5%)
Bullying	133 (7.7%)	78 (9.1%)	55 (6.3%)	41 (7.4%)	92 (7.8%)
Sexual Harassment	7 (0.4%)	7 (0.8%)	0 (0.0%)	4 (0.7%)	3 (0.3%)
Harassment	32 (1.8%)	17 (2.0%)	15 (1.7%)	13 (2.4%)	19 (1.6%)
Overall	**168 (9.7%)**	**106 (12.4%)**	**62 (7.1%)**	**57 (10.3%)**	**111 (9.4%)**

Note: Total trainees who reported at least one aspect of DBSH, noting that each trainee may report more than one aspect of DBSH behaviour

Trainees who reported having experienced DBSH by a staff member(s) were further asked about which person(s) displayed the DBSH behaviour toward them. Consistent with the findings from the 2020 survey, in-patient medical staff, ED nursing staff and FACEMs were among the most frequently reported staff category (Table 15).

Table 15. Number of trainees who reported experiencing DBSH behaviour against them, by category of staff

ED or hospital staff	Discrimination N=50	Bullying N=133	Sexual Harassment, N=7	Harassment N=32
FACEM	23	42	<4	6
DEM/ Deputy DEM	<4	4	-	<4
DEMT	8	5	-	<4
ED nursing staff	13	40	<4	8
Other ED doctor	13	10	-	-
Other ED staff *e.g., clerical, orderly, allied health)	<4	5	-	-
In-patient medical staff	15	59	<4	15
In-patient non-medical staff	-	5	-	<4
Other staff	<4	6	-	<4
Prefer not to say	13	13	<4	<4

Note: Trainees could select more than one category of staff

Table 16 presents by region, the percentage of trainees who reported experiencing DBSH from a patient or carer, from ED or hospital staff, and specifically from FACEMs. Over one-third of the trainees in Western Australia (WA, 36%) and South Australia (SA, 34%) reported having experienced DBSH from a patient or carer while working at their placement. Trainees from the ACT reported the highest rates of DBSH from ED or hospital staff, whilst the highest rates of DBSH from FACEMs were reported by trainees from Tasmania (TAS, 8%) and SA (7%).

Table 16. Proportion of trainees who reported experiencing DBSH from a patient/ carer or from staff, by region.

	% reported experiencing DBSH									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Experienced any DBSH from a patient/ carer?	33.3%	26.7%	32.4%	27.3%	34.1%	15.4%	23.0%	**36.1%**	24.4%	27.0%
Experienced any DBSH from ED or hospital staff?	**26.7%**	12.0%	5.9%	8.8%	11.0%	10.3%	8.6%	10.3%	5.1%	9.7%
Experienced DBSH by FACEMs	6.7%	3.9%	2.9%	5.0%	7.3%	**7.7%**	3.8%	4.5%	0.6%	4.2%
Total no. of responses	**15**	**490**	**34**	**422**	**82**	**39**	**339**	**155**	**156**	**1732**

Sixty trainees provided further information on their DBSH experiences from staff, with key themes identified including the following:

- Trainees most frequently reported experiencing discrimination based on their gender, particularly females. Female trainees also reported experiencing bullying because of their status as a parent or new mother.
- For trainees who reported experiencing discrimination, they reported that this was due to their ethnicity, especially trainees from non-Australian or non-English speaking backgrounds.
- A culture of bullying and harassment of trainees by nursing staff was frequently reported, and some trainees commented that this had become the norm in the ED environment.
- For the trainees who reported experiencing bullying or harassment by ED consultants, their experiences included being repeatedly openly criticised as insufficient or slow in their progress, with some trainees reporting that this was adversely impacting their wellbeing.
- Incidents of bullying and harassment exhibited by in-patient medical staff were also reported, with reports about unfair criticism and verbal and physical intimidation.
- Only female trainees reported and provided feedback about experiencing sexual harassment, with two reporting having satisfactorily had the incidents resolved. Several female trainees reported about experiencing occasional inappropriate comments or touching from (generally male) in-patient staff.
- Several comments from trainees undertaking a paediatric ED placement at a number of children's hospital reported that they were treated as inferior to other doctors exclusively trained in paediatric medicine.

4.2.6 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 (for example, workplace committees) at their ED placement, while a further 26% neither agreed nor disagreed, 11% disagreeing, and 5% reported not knowing. A higher proportion of male trainees compared with female trainees (61% vs. 56%) were in agreeance with this, with more comparable proportions seen by training level (advanced trainees compared with provisional trainees, 59% vs. 57%).

A larger proportion (71%) of responding trainees agreed that they were able to participate in quality improvement activities at their placement, with 21% neither agreeing nor disagreeing, and 5% disagreeing. No differences were seen in the proportion of those who were in agreeance with this by gender (69% for both genders) and training level (advanced trainees, 72% vs. provisional trainees, 71%).

Tables 17 and 18 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.

Table 17. 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)	73.3%	60.8%	61.8%	56.9%	**47.6%**	48.7%	54.3%	72.3%	56.4%	58.4%
Able to participate in quality improvement activities	100%	71.2%	67.6%	73.2%	63.4%	74.4%	**62.8%**	85.2%	72.4%	71.3%
Total no. of responses	15	490	34	422	82	39	339	155	156	1732

Note: Highest proportion is highlighted in green whilst smallest proportion is in orange

Not surprisingly, trainees who were undertaking a placement in EDs accredited for 18- and 24-months were more likely to agree that they had opportunities to participate in both the governance and quality improvement activities, compared with sites accredited for a shorter training duration (Table 18).

Table 18. 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-month linked	6 & 12 months	18 & 24 months
Able to participate in decision making regarding governance (e.g., workplace committees)	**48.6%**	55.3%	59.6%
Able to participate in quality improvement activities	**60.0%**	68.2%	72.6%
Total no. of responses	35	396	1301

4.3 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.

4.3.1 Supervision and feedback

Trainees were asked about supervision, support and feedback provided by DEMTs and senior staff at their ED placement. Most (91%) were satisfied with the supervision they received at their placement overall, and nearly all (95%) trainees were in agreeance that their DEMT had discussed what was expected of them at their stage and phase of training.

Only a slight difference was observed by training level (provisional, 92% vs. advanced, 90%) in their overall satisfaction with the supervision received. Likewise, similar proportions of provisional and advanced trainees agreed with the other statements on supervision, support and feedback provided at their placement. However, noticeable differences were seen in comparison by gender, with male trainees consistently reporting higher agreement levels to all of the statements, compared with female trainees (Table 19).

Table 19. Proportion of trainees who strongly agreed or agreed with statements about supervision, support and feedback provided at their placement, by gender.

Statements about supervision, support and feedback	% Strongly agreed / agreed		
	Female	Male	Total
Overall, satisfied with the supervision received	90.0%	91.6%	90.8%
Satisfied with quality of DEMT support	90.3%	93.0%	91.7%
Availability of DEMT for guidance/ supervision meets needs	89.4%	92.6%	91.0%
Clinical supervision received from FACEMs meets needs	88.2%	90.2%	89.5%
DEMT had discussed what is expected of trainee at their stage of training	94.2%	95.5%	94.9%
Receive regular, *informal feedback on performance and progress	75.5%	81.6%	78.6%
Total no. of responses	856	876	1732

*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.*

The proportion of trainees agreeing with statements relating to supervision, support and feedback provided at their ED placement is presented by region (Table 19) and accreditation level (Table 20). In comparison to trainees in other regions, trainees in Victoria (VIC) were less likely to agree with most of the statements, whereas trainees in the ACT mostly reported a high level of satisfaction with each aspect relating to supervision, support and feedback received at their placement.

Table 20. 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	100%	90.8%	94.1%	92.2%	86.6%	89.7%	86.4%	94.2%	93.6%	90.8%
Satisfied with quality of DEMT support	100%	92.2%	97.1%	90.3%	92.7%	84.6%	90.0%	93.5%	94.9%	91.7%
Availability of DEMT for guidance and supervision meets needs	100%	91.4%	94.1%	90.8%	92.7%	89.7%	89.1%	91.0%	92.3%	91.0%
Clinical supervision received from FACEMs meets needs	93.3%	90.6%	97.1%	90.8%	86.6%	92.3%	87.6%	89.7%	85.9%	89.5%
DEMT had discussed what is expected of trainee at their stage of training	100%	93.9%	97.1%	96.2%	95.1%	94.9%	92.0%	96.8%	97.4%	94.9%
Receive regular, *informal feedback on performance and progress	93.3%	80.0%	76.5%	79.1%	75.6%	79.5%	75.2%	80.6%	78.2%	78.6%
Total no. of responses	15	490	34	422	82	39	339	155	156	1732

*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.*

Compared with trainees in other EDs, trainees undertaking a placement in an ED accredited for 18 and 24 months were generally less likely to agree with most statements, particularly the statement relating to informal feedback received, with just over three-quarters reporting agreeance to receiving regular informal feedback on their performance and progress.

Table 21. 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-month linked	6 & 12 months	18 & 24 months
Overall, satisfied with the supervision received	94.3%	91.2%	**90.5%**
Satisfied with quality of DEMT support	94.3%	93.2%	**91.2%**
Availability of DEMT for guidance/ supervision meets needs	91.4%	91.7%	**90.8%**
Clinical supervision received from FACEMs meets needs	**88.6%**	90.9%	89.2%
DEMT had discussed what is expected of trainee at their stage of training	**94.3%**	95.2%	94.8%
Receive regular, *informal feedback on performance and progress	91.4%	82.8%	**76.9%**
Total no. of responses	35	396	1301

*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.*

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.

Just over three-quarters (76%) of advanced trainees were satisfied with the level of support they received from their Local WBA Coordinator to complete their EM-WBA requirements, with 16% neither agreeing nor disagreeing and 7% disagreeing. A similar proportion (78%) were satisfied with the level of support they received from FACEMs. With respect to feedback, a higher proportion of advanced trainees (88%) 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 22 by region, and in Table 22 by ED accreditation level. Trainees undertaking a placement in WA and NZ EDs were generally less satisfied with the support and feedback received for WBAs, with around two-thirds of trainees in WA satisfied with the level of support received from their Local WBA Coordinator and FACEMs to complete their EM-WBA requirements.

Table 22. 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 support and feedback for EM-WBAs	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Satisfied with the level of support from Local WBA Coordinator	88.9%	75.4%	75.0%	75.7%	75.4%	86.2%	79.7%	63.6%	79.2%	76.0%
Satisfied with the level of support from FACEMs	77.8%	81.3%	85.7%	78.3%	68.4%	86.2%	79.3%	67.3%	69.8%	77.5%
WBA assessors/ FACEMs provide useful feedback	100%	87.2%	89.3%	89.5%	89.5%	93.1%	87.5%	86.9%	83.0%	87.9%
Total no. of responses	9	337	28	276	57	29	232	107	106	1181

Note: Highest proportion is highlighted in green whilst smallest proportion is in orange

Trainees undertaking a placement in an ED accredited for 6 and 12 months were generally less likely to agree with most aspects of support and feedback for EM-WBAs (Table 23).

Table 23. 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 support and feedback for EM-WBAs	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Satisfied with the level of support from Local WBA Coordinator	79.2%	72.7%	76.7%
Satisfied with the level of support from FACEMs	91.7%	76.2%	77.4%
WBA assessors/ FACEMs provide useful feedback	91.7%	87.0%	88.0%
Total no. of responses	24	231	926

Advanced trainees were further surveyed about how WBAs were organised at their site (Table 24), with the majority reporting that it was the trainee's responsibility (70%), rather than the DEMT or WBA Coordinator to schedule WBAs (31%). They were also more likely to report that the WBAs were conducted on an ad hoc basis (38%), instead of being organised through a rostered WBA Consultant (21%) or rostered WBA session (9%).

Table 23. How WBAs are organised at sites for advanced trainees

How are WBAs organised at your site?	Number of Respondents*	%
It is the trainee's responsibility	825	70.0%
On an ad hoc basis	450	38.1%
They are scheduled by DEMT or WBA Coordinator	369	31.2%
Through rostered WBA Consultant	252	21.3%
Through rostered WBA session	106	9.0%
Other (e.g., a mixture of the above, approached by FACEMs individually; only rostered for a specific type(s) of WBA etc.)	21	2.0%
Total no. of respondents	**1181**	

*Note: *Respondents may select more than one way of how the WBAs were organised at their site, with 597 (50.6%) advanced trainees doing so.*

4.3.3 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 with respect to the number (95%), breadth (88%), acuity (83%), and complexity of cases (88%) (Table 25). Similar levels of agreement were seen between advanced and provisional trainees for each aspect relating to casemix.

Trainees with an ED placement in NZ and the NT were less likely to report satisfaction with their placement in providing an appropriate training experience when considering different aspects of casemix, compared with trainees in other regions (Table 25).

Table 245. 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	100%	95.5%	91.2%	92.9%	97.6%	92.3%	93.5%	96.8%	94.2%	94.5%
Breadth of cases	100%	88.0%	85.3%	85.1%	90.2%	87.2%	90.6%	89.7%	81.4%	87.5%
Acuity of cases	93.3%	86.9%	61.8%	79.9%	82.9%	76.9%	83.8%	85.8%	75.0%	82.6%
Complexity of cases	100%	90.4%	82.4%	86.0%	87.8%	87.2%	87.0%	88.4%	84.0%	87.6%
Total no. of responses	**15**	**490**	**34**	**422**	**82**	**39**	**339**	**155**	**156**	**1732**

Note: Highest proportion is highlighted in green whilst smallest proportion is in orange

Not surprisingly, trainees undertaking placements in EDs accredited for 18 and 24 months were most likely to agree that the ED casemix at their placement was appropriate with respect to the number, breadth, acuity, and complexity of cases (Table 26).

Table 26. Proportion of trainees who agreed that their current placement provided an appropriate training experience when considering aspects of casemix, by accreditation level.

Placement provides a safe & supportive workplace with respect to:	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Number of cases	**94.3%**	92.4%	95.1%
Breadth of cases	**80.0%**	82.6%	89.2%
Acuity of cases	**71.4%**	76.0%	84.9%
Complexity of cases	**80.0%**	81.8%	89.6%
Total no. of responses	35	396	1301

4.3.4 Further comments on supervision and training experience

There were 137 further comments provided by trainees relating to supervision or the training experience at their placement. One-third (33%, n=45) of the comments reflected on various aspects of the casemix available at their placement, with some consistent feedback being provided about having lower acuity cases with a high proportion of general practitioner (GP)-type presentations. A further 35 (25%) comments were positive feedback about supportive and approachable senior staff, well-structured training and support, and good support in organising their WBAs.

There were 65 (46%) negative comments that largely reflected on the difficulty in completing WBAs, lack of senior supervision, and limited quality feedback (Table 27). There were 11 (8%) other suggestions for improving support for WBAs, supervision, and/or feedback on performance.

Table 27. Negative perspectives and suggestions for improvement regarding the supervision and training experience at ED placements, themes with example comments.

Theme	Example comments
Negative comments	
Difficulty in completing WBAs (n=34) *Limited access to FACEMs or WBA Coordinator; no support in organising WBAs - primarily trainees' responsibility;* *WBA sessions not rostered*	*My current placement theoretically has consultants rostered on for teaching duties on the floor including WBAs. Current staffing levels mean this role is more often than not reassigned to clinical duties and this is impacting the ability to achieve WBA targets (notably mini-CEX).* *While there is often a WBA consultant rostered, they could be more proactive in seeking out trainees for WBAs. There is no non-clinical time allocated to completing Case-based Discussions (CBDs) and other non-clinical activities.* *Trainees are responsible for organising WBA in their own time - largely outside of working hours for mini-CEX and CBDs.*
Lack of senior supervision (n=22) *Insufficient number of DEMTs;* *lack of supervision for high acuity cases*	*High acuity cases are often in the late evenings/after-hours/overnight or on MET-Calls, where there isn't FACEM availability/supervision.* *Get minimal clinical supervision on the floor - I'm expected to run my own patients. The consultants will ask me what's going on when the handover occurs.*
Limited quality feedback (n=9) *No feedback was given, except for WBA/ITA; no real-time feedback;* *feedback was mixed and confusing*	*No feedback given, except for WBA/ITA. And if things need improvement, again it would be nice to be told informally, so this can be worked on.* *I found that as a trainee, you rarely receive formal feedback, and if you do, it is not constructive or very helpful. It is usually just "you're fine" or "no concerns".* *Real-time feedback from consultants would be much more useful; if I am not doing something to standard, I would get much more out*

	of being told just that at the time I was doing it.
Suggestions for improvement	
Better support for WBAs	*A rostered dedicated FACEM to organise Mini-CEX and DOPES would be great. i.e. every Tuesday, and Thursday mornings. It would help trainees complete WBAs* *FACEMs are approachable and will complete WBAs. However, there is no timetabled arrangement for CBDs, which would help. 'Core DOPS' cards were made by one trainee which has helped complete these.* *At the commencement of my term, I was not told who the coordinator for WBAs was. There needs to be more communication regarding CBDs and the best time to do these and how it is arranged.*
More supervision and/ or feedback	*It would be great if it were compulsory for consultants you are working with to give you feedback on how you could improve after every shift.* *Wish to have mix of DEMTs, change every 6 months*

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

4.4 Education and Training Opportunities

This section details responses to survey items relating to the educational and training opportunities available at ED placements. It covers clinical teaching, the structured education program, access to educational and examination resources, simulation learning experiences, and 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 (87%), and that they received training for, and were provided with opportunities to use relevant clinical equipment (87%). Only two-thirds (65%) of trainees were in agreeance that they had access to formal ultrasound teaching however as expected, the proportion of trainees who agreed with having access to formal ultrasound teaching increased as site accreditation limits increased (6-month linked sites, 54%; 6- and 12-month sites, 62%; and 18- and 24-month sites, 67%).

Similar proportions 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 (84% and 85%, respectively). There were no differences between advanced and provisional trainees in their agreement about the structured education program.

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. However, a smaller proportion of trainees (81%) were in agreeance that the rostering at their placement enabled them to attend the structured education sessions.

Trainees undertaking a placement in TAS were least likely to agree with each of the four statements related to the structured education program available, compared with trainees in other regions (Table 28). It is noteworthy that just over half of trainees in TAS agreed that the structured education program aligns with the content and learning outcomes of the ACEM Curriculum Framework, and less than two-thirds agreed that their rostering enabled attendance to structured educations sessions.

Table 28. Proportion of trainees who strongly agreed or agreed with statements about the structured education program 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 needs	93.3%	86.3%	100%	83.2%	84.1%	71.8%	80.8%	89.0%	81.4%	84.2%
Structured education sessions are provided for a minimum of four hours per week	93.3%	86.7%	97.1%	87.2%	85.4%	71.8%	93.5%	89.7%	97.1%	88.2%
The structured education program aligns to the content and learning outcomes of the ACEM Curriculum Framework	86.7%	84.1%	88.2%	85.8%	86.6%	56.4%	85.8%	86.5%	86.7%	84.6%
Rostering enables trainees to attend structured education sessions	93.3%	79.0%	100%	79.4%	80.5%	61.5%	91.4%	81.9%	71.8%	81.4%
Total no. of responses	15	490	34	422	82	39	339	155	156	1732

Note: Highest proportion is highlighted in green whilst smallest proportion is in orange

A smaller proportion of trainees undertaking a placement in 6- and 12-month accredited sites were in agreeance with all of the four statements relating to the structured education program at their placement, compared with trainees in other EDs (Table 29).

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

Structured Education Program	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
The structured education program meets needs	91.4%	**81.1%**	84.9%
Structured education sessions are provided for a minimum of four hours per week	94.3%	**84.3%**	89.2%
The structured education program aligns to the content and learning outcomes of the ACEM Curriculum Framework	85.7%	**81.3%**	85.5%
Rostering enables trainees to attend structured education sessions	91.4%	**78.3%**	82.0%
Total no. of responses	35	396	1301

4.4.2 Access to educational and examination resources

Similar proportions of advanced (89%) and provisional trainees (90%) 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 access to exam courses, there were comparable proportions of trainees who agreed that they had access to written exam revision programs (87%) and clinical exam preparation programs (88%) at their placement. Of those who reported that they had access to written exam revision programs at their placement (n=1,502), the majority (85%) agreed that they had sufficient access to the program. For trainees who reported having access to clinical exam preparation programs at their placement (n=1,527), a similar proportion (84%) agreed they had sufficient access to the program.

Table 30 shows the proportion of trainees who reported having access to written and clinical exam preparation programs onsite at their placement or at an external (linked/networked) site, by region.

Trainees undertaking an ED placement in NZ were the least likely to report having access to onsite exam programs (both written and clinical exam preparation programs), compared with trainees in other regions.

Table 26. Proportion of trainees who reported having access to written and clinical exam preparation programs onsite or offsite at another linked/ networked site, by region.

I have access to:	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Written exam revision program										
Onsite	93.3%	85.3%	97.1%	86.0%	87.8%	94.9%	89.7%	89.0%	**78.8%**	86.7%
Offsite (linked/ networked ED)	0%	8.4%	0%	5.2%	4.9%	0%	2.9%	6.5%	8.3%	5.8%
Clinical exam preparation program										
Onsite	93.3%	87.8%	100%	85.5%	89.0%	94.9%	90.6%	93.5%	**80.8%**	88.2%
Offsite (linked/ networked ED)	0%	6.3%	0%	5.7%	4.9%	0%	1.8%	3.9%	5.8%	4.6%
Total no. of responses	**15**	**490**	**34**	**422**	**82**	**39**	**339**	**155**	**156**	**1732**

Not surprisingly, trainees undertaking a placement in 18- and 24-month accredited sites were most likely to report having access to both written and clinical exam preparation programs, compared with trainees at sites accredited for shorter training durations (Table 31).

Table 31. Proportion of trainees who reported having access to written and clinical exam preparation programs onsite or offsite at another linked/ networked site, by accreditation level.

Structured Education Program	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Written exam revision program			
Onsite	88.6%	**74.5%**	90.4%
Offsite (linked/ networked ED)	5.7%	10.9%	4.2%
Clinical exam preparation program			
Onsite	88.6%	**78.8%**	91.0%
Offsite (linked/ networked ED)	2.9%	7.8%	3.7%
Total no. of responses	**35**	**396**	**1301**

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 32 provides the key themes and subthemes from 288 responses, which were primarily focused on the absence of formal ultrasound teaching onsite (44%), unsupportive rostering and a lack of protected teaching time (24%), and a poorly structured education program (24%).

Table 32. Themes and subthemes of trainee comments regarding the educational and training opportunities at their ED placement

Key themes and sub-themes
Limited or no formal ultrasound teaching (n=126) • *Informal/ ad hoc teaching and supervision* • *Difficult to access* • *Site unprepared for ultrasound teaching* • *Formal ultrasound teaching provided only to trainees on the ultrasound rotation (Ultrasound Fellows) or for senior trainees* • *Limited ultrasound uses in paediatric ED* • *Not available for provisional trainees*
Rostering unsupportive of education program (n=69) • *Teaching not protected/ rostering prevents access to education program (frequent night shift, not rostered on teaching days)* • *Teaching rostered as overtime*
Poorly structured education program (n=69) • *Generic education program, not tailored to the level of training* • *Not aligned to ACEM curriculum* • *Does not always apply directly to clinical practice* • *Inconsistent quality and relevance, repetitive, lack of structure* • *Not available online*
Less than 4 hours education program per week (n=30) • *Not achieving 4hours/week of formal education* • *Teaching days often cancelled due to staff shortages*
Minimal clinical/ on-floor teaching (n=21) • *Patient load and access block makes it hard to have clinical on floor teaching* • *Limited/not available*
Affected by COVID-19 pandemic (14) • *Cancellation of ultrasound training* • *Procedural skills/simulation teaching interrupted* • *Prolonged period of online teaching*
Lack of exam preparation support or resources (n=8) • *No exam-specific teaching available* • *Inadequate/no formal primary exam teaching*

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

4.4.3 Simulated learning experiences

The majority (90%) of trainees reported that simulation learning experiences were utilised at their ED placement, with 4% unsure and 6% reporting that this was not available at their placement. Trainees undertaking a placement in EDs accredited for 18- and 24-month placements (92%) were more likely than those in EDs accredited for shorter training durations (6-month linked, 77% and 6- and 12-month, 83%) to report that simulation learning experiences were utilised.

Of trainees who reported the availability of simulation learning experiences (n=1,556), most (94%, n=1456) of them reported participating in simulation learning experiences at their placement. A larger proportion of provisional trainees than advanced trainees (96% vs. 93%) reported that they had participated in simulation learning at their placement.

The trainees (n=100) who did not participate in simulation learning at their placement were asked to provide reason(s), with 69 trainees doing so. The main reason for not participating was that simulation learning was limited or cancelled due to COVID-19 restrictions (n= 25, 36%). Other reasons included not being rostered for simulation sessions (n=19, 28%), rostering constraints (n=14, 20%), prioritising exam preparation (n=6, 9%), or attending other teaching sessions instead (n=3, 4%).

Among the trainees who reported participating in simulation learning at their placement, over three-quarters (79%, n=1,148) reported that they had participated in multidisciplinary team-based simulation training, with a slightly larger proportion of provisional (80%) compared to advanced (78%) trainees reporting so. Advanced trainees were slightly more likely than provisional trainees to agree with all statements relating to participation in team-based simulation training (Table 33).

Table 33. Proportion of trainees who strongly agreed or agreed with statements regarding participation in interprofessional team-based simulation training, by training level.

Participation in multidisciplinary team-based simulation training at this placement:	% Strongly agreed / agreed		
	Provisional Trainees	Advanced Trainees	Total
Has improved my effectiveness in ED team-based practice	92.2%	93.5%	**93.1%**
Has contributed to my leadership development	90.9%	93.0%	**92.3%**
Has enhanced my learning and team-based practice	92.0%	93.3%	**92.9%**
Total no. of responses	**373**	**775**	**1148**

Of those who disagreed with any of the above statements relating to multidisciplinary team-based simulation training, 41 trainees provided an explanation. Most comments were related to an infrequent offering of the training, which was often cancelled due to COVID-19, or due to the business of the department or staffing limitations (n=24, 59%). Eight trainees commented that they did not find the team-based simulation training useful. Three trainees commented that they were not rostered for the team-based training, whilst three others commented that they only got the chance to observe. Three other trainees found the team-based simulation training stressful.

4.4.4 Leadership opportunities

A slightly higher percentage of trainees strongly agreed or agreed that they were provided with opportunities to teach and supervise junior trainees (91%), compared with opportunities for leadership and management appropriate to their stage and phase of training (89%). The 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 (92% vs. 89%), as well as having leadership and management opportunities (89% vs. 87%).

4.4.5 Research opportunities

Less than two-thirds (60%) of trainees reported being able to participate in research opportunities at their placement, with this proportion increasing from 46% among trainees at 6-month linked sites, to 48% at 6/12 month sites, and to 65% of trainees from 18/24 month accredited sites.

Table 34 shows the 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 accreditation level.

Trainees undertaking their ED placement in hospitals accredited for 18- and 24-months of training (43%) were significantly more likely to respond that there was a designated staff member to advise on the research component, compared with 6-month linked, and 6- and 12-month accredited sites (20% and 24%, respectively). However, one-third (34%) of trainees 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, particularly trainees from the 6-month linked and 6/12 month accredited sites (40%-43%).

Table 27. Trainees' responses to whether there was a staff member available to provide advice about the research component, by accreditation level.

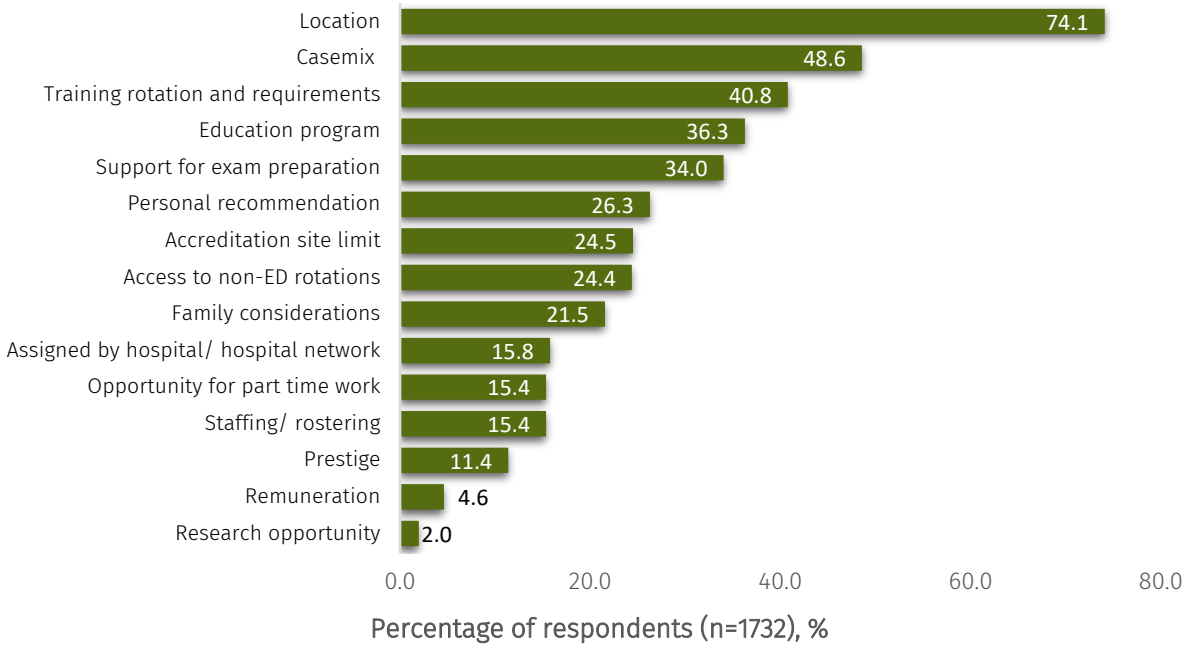
Staff member available to provide advice about research component	6-month linked	6 & 12 months	18 & 24 months	Total
Yes	20.0%	23.5%	42.7%	**37.8%**
No	2.9%	8.8%	4.0%	**5.1%**
Don't know	42.9%	40.4%	32.1%	**34.2%**
Not applicable (have previously completed/ not yet started research requirement)	34.3%	27.3%	21.3%	**22.9%**
Total no. of responses	**35**	**396**	**1301**	**1732**

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).

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. On the contrary, remuneration and research opportunities were factors least considered by trainees. It is noteworthy that the availability of an education program (36%) and support for exam preparation (34%) were factors deemed of similar importance, as were training rotation and requirements (41%).

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

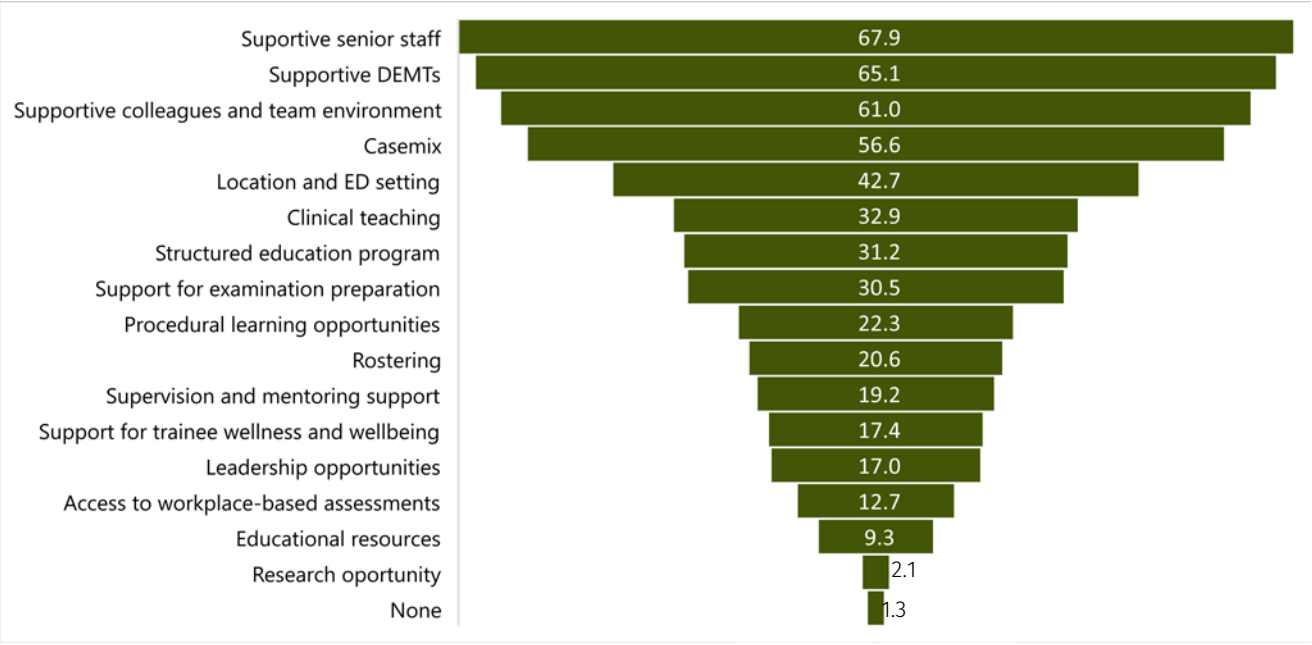


Note: Respondents could select up to five factors

Trainees were further asked to nominate highlights of undertaking an ED placement at their site, with trainees able to select as many highlights that applied.

The most selected highlights included supportive senior staff/ DEMT/ colleagues and ED casemix, which was consistent with the 2020 survey findings (Figure 2). Clinical teaching and support for exam preparation were highlights selected by around one-third of trainees. Access to WBAs, educational resources and research opportunity, on the other hand, were the least selected highlights.

Figure 2 ED placement highlights selected by trainees, proportion of N=1732.



Note: Respondents could select more than one highlight for their placement.
23 (1.3%) trainees chose 'None' (i.e. no highlight in their placement), whilst no trainee selected 'Other' as one of the options in the list.

Trainees were provided with the opportunity to outline key areas for improvement that could be made at their placement, with 216 trainees providing feedback (Table 35). Staffing and workload arrangements (n=71, 33%), improvements to rostering (n=63, 29%), the teaching/ education program (n=61, 28%), and clinical and procedural training (n=40, 19%) were among the main areas identified.

Table 35. Themes and subthemes for areas for improvement.

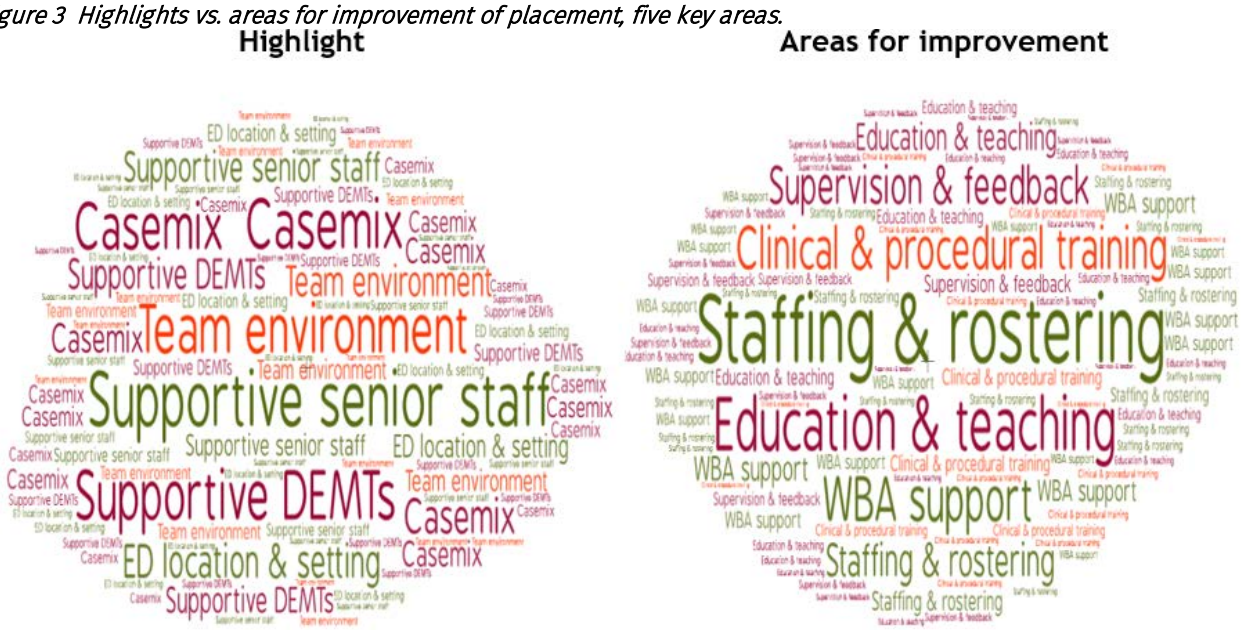
Key themes and sub-themes
Staffing and workload arrangements (n=71) • *More nursing staff to help with the flow* • *Recruitment of senior trainees* • *Presence of consultants in the evening/ night shifts* • *Improving staffing levels for night shifts* • *Sufficient registrars' skill mix* • *More defined roles among registrars* • *Better distribution of locums*
Rostering (n=63) • *Reduced night shifts* • *Allocation of non-clinical time* • *Better access to leave (including study leave)* • *Protected teaching time* • *Rostered WBAs*
Teaching/ education program (n=61) • *Structured Fellowship teaching* • *Education more aligned with the FACEM curriculum* • *Earlier introduction to leadership teaching* • *More consistent primary exam teaching* • *Integration of simulation into teaching sessions*
Clinical and procedural training (n=40) • *Improve bedside and on the floor teaching* • *Increase procedural learning opportunities* • *Regular clinical skills sessions* • *More ultrasound training* • *More resuscitation opportunities*
Senior supervision and feedback (n=33)

• *More formal and informal feedback* • *Structured feedback (incorporate positive and negative feedback)* • *Better mentoring support* • *Better engagement with other FACEMs besides DEMTs* • *Improve night shift senior supervision*
Structured and better support for WBAs (n=19) • *More formalised and structured approach to WBAs* • *Better access to WBA Coordinator* • *Rostered sessions* • *More comprehensive overview of how to do WBAs*
Trainee welfare and wellbeing (n=18) • *A wellness/wellbeing program* • *More support to reduce burnout* • *More advocacy from ACEM to improve working conditions*
Improve ED resources (n=15) • *Improve ED space to cope with access block* • *More security staff* • *More support from hospital in improving working environment*
Casemix (11) • *More exposure to procedural-related cases* • *More equitable rostering to access higher acuity cases*
Leadership and junior teaching opportunities (n=7) • *More opportunities to be involved in quality improvement initiatives* • *More autonomy for senior advanced trainees*
Improve access to non-ED rotations (n=5) • *Especially critical care rotations*
Other (n=14) • *Better access to clinical protocols* • *Better orientation program* • *Improve research support*

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

Placement highlights were compared with the areas for improvement identified (Figure 3), with obvious differences observed. The key areas for improvement were staffing arrangements and rostering, contrasted with supportive senior staff, team environment and casemix as key highlights. Although supportive senior staff and supportive DEMTs were frequently nominated as placement highlights, other trainees commonly reported teaching (both exam preparation and clinical teaching), senior supervision and feedback on their progress as areas requiring improvement.

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 further 9% neither agreeing nor disagreeing and 1% disagreeing with this statement. Female (89%, compared with male, 87%) and advanced trainees (89%, compared with provisional trainees, 86%) were slightly more likely to agree with this statement.

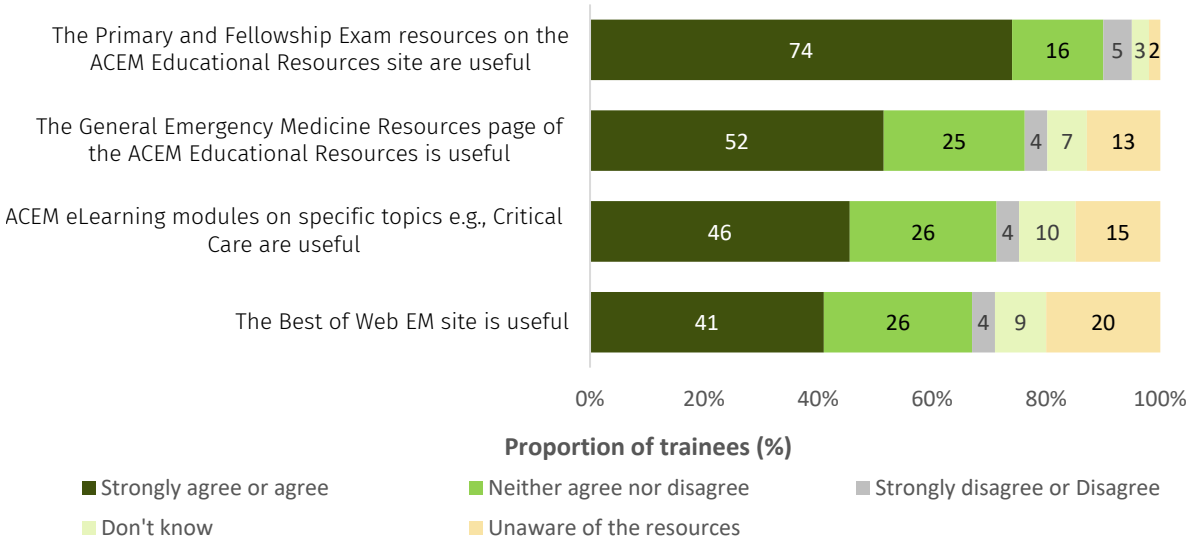
A smaller proportion (76%) of trainees agreed that they were well supported in their training by ACEM processes, with 19% neutral and 3% disagreeing. A higher proportion of provisional trainees (79%) than advanced trainees (75%) were in agreeance with this, with more comparable responses seen between male and female trainees (76% and 77%, respectively).

Trainees who disagreed that they were well-supported in their training by ACEM processes were given the opportunity to provide further details, with 43 trainees doing so. Almost half of the comments (n=21) were focused on the process relating to trainee representation (trainee's voice not heard, lacking opportunities to voice grievances, etc.), whilst other comments were about the need for more support and guidance on remediation processes and training requirements (n=10), exam implementation or support (n=9), ACEM training structure (n=8), and WBAs (n=7).

4.6.2 Online resources available for FACEM trainees

ACEM currently provides a range of resources to support FACEM trainees, with trainees asked to state their level of agreement with statements relating to the usefulness of the listed resources (Figure 4). Consistent with the 2020 trainee placement survey findings, trainees found the Primary and Fellowship exam resources to be the most useful (74%), followed by the General Medicine resources (52%). In contrast, the Best of Web EM site was rated as the least useful (41%).

Figure 4 Level of agreement of respondents with statements relating to the usefulness of a range of online 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 36), 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), followed by leadership and management skills, and clinical skills. Nearly a quarter (24%) of trainees nominated the FACEM Training Program structure and administration resources as an area of need.

For all resources and areas for 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, communication skills, leadership and management 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 areas for support. Both Web-links to external resources and How-to guide were preferred among those who nominated research as an area of need/interest.

Table 36. Trainee response rates to resources and support nominated as an area of need and/ or interest and the preferred delivery mode(s).

	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
Resources & Support	N	% of total	%	%	%	%	%
College updates	134	7.8%	27.6%	**54.5%**	39.6%	41.0%	20.1%
FACEM Training Program structure and administration	405	23.5%	37.5%	**48.6%**	37.5%	23.5%	33.1%
Learning Development Plan	181	10.5%	44.8%	**46.4%**	32.0%	20.4%	34.8%
In-Training Assessments (ITAs)	226	13.1%	**61.5%**	38.1%	30.5%	13.7%	27.0%
EM-WBAs	336	19.5%	**61.0%**	37.2%	24.7%	14.6%	27.7%
Primary Exam – Written	217	39.4%*	47.9%	**68.7%**	51.2%	37.3%	35.0%
Primary Exam – Viva	225	40.8%*	65.8%	**66.7%**	54.7%	36.9%	33.8%
Fellowship Exam – Written	844	48.9%	60.2%	**67.5%**	46.2%	40.4%	30.7%
Fellowship Exam – OSCE	852	49.3%	**74.5%**	61.2%	53.5%	36.7%	29.5%
Communication skills	270	15.6%	**74.1%**	54.1%	49.6%	25.9%	16.7%
Leadership and management skills	620	35.9%	**68.9%**	56.6%	43.1%	25.6%	15.3%
Clinical skills	569	32.9%	**75.0%**	51.1%	51.3%	26.5%	25.8%
Clinical governance (HR, rostering, dealing with patient complaints)	399	23.1%	46.4%	**61.4%**	36.6%	30.1%	30.1%
Research	159	9.2%	47.2%	**57.2%**	39.0%	48.4%	40.9%

Note: Respondents may select more than one type of preferred delivery mode for each nominated resource/support.
182 (10.5%) of trainees selected 'None', with no nomination of any resources/ support from the list.
** For primary exam resources, responses from only the provisional trainees were included. The percentages reflect the proportion of 551 provisional trainees.*

Trainees were further asked if they had any suggestions for improvement to the current online resources provided by ACEM, with 43 providing feedback. Two key suggestions were to improve resources for exam preparation (for example, more past-year examples, more mock exams using the ACEM interface, n=15) and ACEM website to be more user friendly (for example, better orientation to resources, better search functionality, n=18). Other suggestions (n=10, 22%) focused on simpler guide on training curriculum and requirements (which include assessment and research requirement), and more resources for non-clinical training or cultural competency modules.

4.7 Potential Areas for Advocacy/ Quality Improvement

This is the final section of the report, which presents the findings on three key areas of interest to inform or improve the FACEM Training Program experience, which include access to critical care rotations, telehealth for supervision and education purposes, and support for the research requirement.

4.7.1 Access to critical care rotations

Less than three-quarters (70%, n=1207) of trainees reported that they had previously undertaken a critical care (ICU/ anaesthetics) rotation, with half reporting having undertaken the rotation at the hospital they were currently undertaking their ED placement at (49%), and another half reporting that they had undertaken the rotation at another hospital (51%). Not surprisingly, the majority of advanced trainees (86%) compared with just over one-third of provisional trainees (35%) reported having undertaken a critical care rotation.

Of those who reported having undertaken critical care rotation(s), just over half (53%) reported no wait or less than 6 months wait to obtain a critical care rotation. However, nearly one-third (31%) of trainees reported that they waited for 6-12 months, and a further 16% reported they waited for more than 12 months to get a critical care rotation. For trainees who indicated that they waited 6 months or more to obtain a critical care rotation at a single hospital (n=569), 460 (81%) were at sites accredited for 18- and 24-months of ED training, followed by 96 (17%) at sites accredited for 6- and 12-months, and 13 (2%) at 6-month linked sites.

4.7.2 Telehealth for supervision and education purposes

Trainees were asked if telehealth had been used at any point of their FACEM training for remote supervision while they were working on the floor, with only 7% of trainees (n=129) reporting so. This was reported by a slightly higher proportion of advanced trainees (8%) than provisional trainees (6%).

A significantly higher proportion (42%, n=727) of trainees reported that telehealth had been used during their FACEM training for education purposes (for example, undertaking case-based discussions). A larger proportion of advanced trainees (n=536, 46%) than provisional trainees (n=191, 35%) reported that telehealth had been used for education purposes during their FACEM training.

Feedback was provided by 144 trainees on their experiences of telehealth for supervision and/or education purposes. Overall, more trainees considered their experiences of using telehealth to be positive (n=62), with only six trainees providing negative feedback, which was mainly related to technological issues or lower level of engagement via telehealth. The positive feedback included the benefits of saving time on travel and teaching being more easily accessible on non-rostered teaching days. A further 21 trainees expressed mixed views on their telehealth experiences, and despite finding telehealth useful, they still preferred face-to-face learning.

Trainees also commented that telehealth was mainly utilised for teaching/education sessions (n=56), followed by case-based discussions (CBDs) (n=26), to undertake WBAs/ITAs (n=13), and exam preparation (n=6), with it less commonly used for supervision or for the provision of feedback on progress (n=4). It is noteworthy that trainees found telehealth for CBDs helpful, particularly when this

allowed them to complete CBDs when access to in-person teaching was not possible during the COVID-19 pandemic.

Several examples of positive comments are provided in the following:

> *Fantastic. Much more interactive than onsite teaching.*
>
> *Really effective. Really enjoyed teaching over zoom. Easier to focus in a comfortable setting, where I can easily google subjects that come up as I go along.*
>
> *I found zoom (but easily could be another video resource) quite a good way to engage in a CBD outside of regular hours or a time that was mutually convenient. It promotes easy dialogue and the option to share the screen and discuss pertinent evaluation points.*

4.7.3 Support for the research requirement

Only 272 (16%) trainees reported that they had undertaken or were currently undertaking the research requirement by research project since commencing their FACEM training, with a larger proportion (38%) reporting that they had completed the research requirement, either by coursework (n=583) or by recognition of previous research and/ or publications (n=79). A further 793 (46%) trainees indicated that they had yet to commence the research requirement.

A small proportion (11%, n=29) of those who indicated that they had undertaken or were undertaking the research project reported that there were barriers to commencing or completing their research project, with 25 providing further details. The main barriers encountered were financial barriers to undertaking research-related courses (n=8) and the lack of non-clinical time allocated for the research project, which was usually very time-consuming (n=6). Other barriers included difficulty in the process of obtaining College recognition (n=4), limited support or senior guidance for research (n=3), difficulty with ethics approval (n=1), and lack of statistical infrastructures (n=1).

A further 13 commented on resources ACEM could have provided that would better support trainees in their research projects. Several trainees suggested that ACEM develop research modules (which are currently in development) or have a centralised research database (n=3), and that ACEM provides recognition for prior research experience (n=2). Other suggestions included having a clearer pathway or guidelines on the research requirement, that ACEM facilitates financial support, and that there should be dedicated research supervisors.

5. Conclusion and Implications

Nearly all trainees agreed that their training needs were being met at their ED placement, which is consistent with the findings recorded in previous years. Most trainees reflected positively on the assistance available if they experienced difficulties or a grievance(s), and that their placement provided a safe and supportive training environment. With respect to rostering, trainees were most likely to agree that the rosters at their placement supported the service needs of the site and ensured safe working hours, but were less likely to agree that the rosters were issued on time or provided equitable shifts.

Twenty-seven per cent of trainees reported experiencing DBSH from a patient or carer at their ED placement, a decrease from 32% for the 2020 trainee placement survey findings. A smaller proportion of trainees (10%) reported experiencing DBSH behaviour exhibited by ED and/or hospital staff, which was comparable to the findings from the past two years (2020, 11%; 2019, 10%). In-patient medical staff, ED nursing staff and FACEMs were most commonly reported as the perpetrators of the DBSH behaviours. Incidences of DBSH behaviour exhibited by ED staff and reported by trainees will continue to be monitored, with concerns raised with placement sites that are identified as potentially having a negative workplace culture.

With respect to the supervision and the training experiences at ED placements, most trainees were satisfied with the quality and availability of DEMT support, with nearly all trainees agreeing that their DEMT had discussed with them their expectations of the trainee at their stage of training. Areas of supervision and training experience that were rated lower than others were the level of informal feedback received and the support for workplace-based assessments.

Most trainees agreed that clinical teaching at their placement optimised their learning opportunities and that they had access to the educational and examination resources 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. Nearly all trainees reported participating in simulation learning experiences; however, a smaller proportion (two-thirds) of trainees agreed they had access to formal ultrasound teaching at their placement.

The most nominated placement highlights were supportive senior staff, the positive team environment and ED casemix. On the contrary, the teaching/ education program and senior supervision/ feedback were identified by other trainees as key areas for improvement, alongside staffing and rostering.

Several significant differences in trainee feedback based on gender was identified, and was consistent with previous years. Although the same proportion of female and male trainees reported that their training needs were met at their placement, female trainees were consistently less likely than male trainees to agree that their ED placement provided a safe and supportive workplace; that they were able to participate in decision making regarding governance and quality improvement activities; and that they received adequate senior supervision and informal feedback on their performance. More worryingly, female trainees were more likely to report experiencing DBSH behaviour from both patients/ carers and from ED/ hospital staff. The reasons behind these differences are unclear, although they may highlight conscious or unconscious gender bias among some ED staff. Research investigating gender equity issues at ACEM-accredited EDs and the impact on trainee progression and performance will be considered.

Findings from this survey, as with previous trainee placement surveys, will be used to inform quality improvement and support the process of ensuring ACEM-accredited EDs continue to provide a training environment that is appropriate, safe and supportive of FACEM trainees.

6. Suggest Citation

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7. Contact for Further Information

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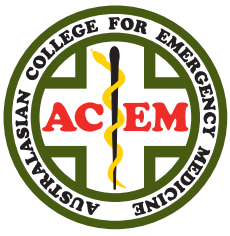

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