Australasian College
for Emergency Medicine

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Workforce Planning Recommendations

for consultation

August 2021

About

The Australasian College for Emergency Medicine

The Australasian College for Emergency Medicine (ACEM) is the not-for-profit organisation responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. For the last two decades, ACEM has supported locally-led capacity development of low and middle-income countries (LMICs) to deliver safe and effective emergency care (EC), with a focus on the Indo-Pacific Region.

Our vision is to be the trusted authority for ensuring clinical, professional and training standards in the provision of quality, patient-focused emergency care.

Our mission is to promote excellence in the delivery of quality emergency care to all of our communities through our committed and expert members.

Workforce Planning Committee members

The ACEM Board approved the establishment of the Workforce Planning Committee (WPC; the Committee) at its August 2018 meeting. The Committee reports directly to the ACEM Board and is currently chaired by President Dr John Bonning. It is the Committee's role to oversee the College's existing workforce-related policies and develop and deliver long-term solutions to address the significant issues outlined in this and in previous consultation papers.

John Bonning
Sally McCarthy
Niall Small
Kate Field
Didier Palmer
John Zorbas
Kimberly Humphrey
Julia Peters
Lynda Vine (2018–2020)
Simon Judkins
Clare Skinner
Gabrial Lau (2018–2020)

Executive summary

Despite significant growth in the specialist emergency medicine (EM) workforce in both Australia and Aotearoa New Zealand over time, as well as consistently high demand for entry to EM speciality training, there is persistent geographic maldistribution of the specialist EM workforce, with high concentration of EM specialists and trainees in major referral hospitals, lower numbers in urban district hospitals, and even lower numbers across rural, regional and remote areas. This contributes to inequitable access to healthcare and worse health outcomes in regional, rural and remote areas, particularly for Māori and Aboriginal and Torres Strait Islander peoples. Hospitals and emergency departments (EDs) in rural, regional and remote areas have:

- lower ratios of EM specialists to FACEM trainees compared to other peer groups;
- lower ratios of EM specialists to prevocational medical officers than peer;
- more unfilled FACEM and trainee FTE; and
- less EM specialists and trainees per ED attendances.

Notwithstanding the workforce growth over the last decade, the overall sustainability of a long-term EM specialist career has also been impacted by increasing pressure placed on the emergency care system, due to extreme workload, ED overcrowding, hospital access block and inadequate staffing. This is contributing to workforce burnout, detrimental effects on wellbeing and a reduction in working hours and career longevity.

EDs are finding it increasingly difficult to meet staffing needs in the face of growing demand for services and changing patient expectations. Employing increasing numbers of specialist trainees remains the primary strategy for staffing EDs at the middle-grade level, particularly with regard to covering out-of-hours services and night shift rosters. This is not translating into employment opportunities once specialist recognition has been achieved. Newly qualified specialists are increasingly struggling to secure full-time and/or permanent part-time employment in their preferred locations

As the peak professional organisation for EM whose Fellowship confers eligibility for specialist recognition on medical practitioners in Australia and Aotearoa New Zealand, the Australasian College for Emergency Medicine (ACEM; the College) has unique access to the experiences of the EM profession to enable the development of possible solutions aimed at improving access to high quality emergency care (EC) for all communities in Australia and Aotearoa New Zealand. To facilitate this work, the College, through its Workforce Planning Committee (WPC) has undertaken a Workforce Planning Project, the first stage of which was undertaken between October to December 2020 through the Workforce Issues Paper Consultation with College members and trainees.

Following this consultation, the WPC has reviewed the member feedback and developed a series of recommendations for further consultation, via this Recommendations Paper, the scope of which was to:

1. Report on the results on the Workforce Issues Paper; and
2. Provide a set of recommendations to address the workforce planning issues identified.

This Paper focuses on the EM workforce as being comprised of medical practitioners with a wide range of skills, and as such, makes five recommendations intended to improve the training and experience of specialist EM physicians and clarify the roles of the wide range of medical practitioners who participate in the provision of EM care across Australia and Aotearoa New Zealand.

Recommendation 1

Accredited Training Networks

ACEM will establish a new integrated system of **FACEM training site accreditation t**hat includes a series of accredited training networks within each jurisdiction. Each network would be assessed against ACEM training site accreditation standards, and include an appropriately defined range of sites, with consideration given to the case-mix, patient presentation numbers and geographic location of each site and the overall network training experience.

Each of the sites that make up the networks will comprise of a set number of accredited training posts, the numbers to be developed through consultation with jurisdictional stakeholders as employers and funders of the system.

There will be a formal agreement that the sites involved in a defined EM Training Network will work together to provide an integrated and comprehensive training program experience and deliver safe, high-quality quality training.

In addition, rather than create a separate rural training pathway, the College will encourage where relevant, the formation of networks that contain a combination of sites that allow for predominantly rural training. As such, a significant range of regional and rural health services can choose to provide an integrated FACEM training experience across a range of regional, rural and remote (RRR) sites.

To receive ACEM accreditation, each network will need to demonstrate that they are able to provide an adequate depth and breadth of sites and experiences that will allow a trainee to meet all FACEM Training Program requirements within that network, throughout the length of the training pathway. They may be tailored to meet differing jurisdictional needs.

Recommendation 2

Incorporation of Rural Training into Training Networks

As part of establishing a new integrated system of accreditation that includes a series of accredited training networks within each jurisdiction, it is recommended that each network will be required to have a minimum dedicated proportion of rural, regional and/or remote training sites within their network.*

Recommendation 3

Mandatory Rural Training Within Each Network

All future FACEM trainees (date to be determined) will be required to undertake a minimum six-month rural training placement within an accredited training network.

As part of each training network's dedicated proportion of rural training sites, each network will be expected to facilitate and ensure the appropriate rotation of FACEM trainees through their respective RRR training sites.

* The minimum proportion of RRR sites within a network will be determined by a project Working Group, who will undertake detailed development of the networked accreditation model.

Recommendation 4

Remote Supervision

As part of improving access to rural FACEM training opportunities, it is recommended that the feasibility of a blended supervision model is explored, which sees traditional face-to-face clinical supervision supported with some remote clinical supervision.

Any remote supervision should not compromise patient nor trainee safety, or the quality of training placements, but instead be a mechanism to improve the range and variety of RRR settings capable of establishing FACEM training posts / achieving ACEM accreditation.

It is recommended that this work is undertaken through a pilot blended supervision model. To establish the resources and tools required to implement and sustain a blended supervision training post, this pilot will be trialled via a network of accredited rural training sites.

Recommendation 5

Non-FACEM senior decision makers

As part of improving access to the non-FACEM consultant level (e.g. FACCRM/FRACGP/Rural Generalist) and non-FACEM middle grade EM workforce, it is recommended that ACEM develop detailed guidelines for health services regarding medical workforce models utilising appropriate non-FACEM senior decision makers, and further define what the expected qualifications for this role are.

This will further define, develop, promote and help to embed different models of care that utilise alternative senior decision makers that are suitable across a range of settings and locations.

Contents

Abbreviations and acronyms

ACEM	Australasian College for Emergency Medicine
CAPP	ACEM Council of Advocacy, Practice and Partnerships
CMO	Career Medical Officer
COE	ACEM Council of Education
ED	Emergency Department
EMC	ACEM Emergency Medicine Certificate
EMD	ACEM Emergency Medicine Diploma
EMAD	ACEM Emergency Medicine Advanced Diploma
EMET	Emergency Medicine Education and Training
FACEM	Fellow of the Australasian College for Emergency Medicine
IRTP	Integrated Rural Training Pipeline
RRR Committee	ACEM Rural, Regional and Remote Committee
SDM	Senior Decision Maker
WPC	ACEM Workforce Planning Committee

List of Definitions

Appendix A contains a list of terminology and their definitions. Readers are advised to consult this list to assist with their consideration of the contents of the document.

Foreword

Firstly, we appreciate you taking the time to read this Recommendations Paper. We would also like to thank the members and trainees who took part in the first consultation phase of this project in late 2020. This Paper represents an important next step in the College's journey, with key reforms to improve the FACEM training pipeline and the future emergency medicine workforce.

As you will read, the College, through the Workforce Planning Committee, is recommending significant reforms to our accreditation system to enable improved collaboration between hospitals, health services and the College. These include extending the reach of emergency medicine training and workforce to a wider range of settings, in particular regional and rural communities. As we work towards training the next generation of specialist emergency physicians, we will be aiming to see greater collaboration between stakeholders while also meeting the needs of the diverse populations we serve. We acknowledge that this is a significant shift from how the system has been operating to date.

We need to work with colleagues from other specialties to develop and advocate for workforce models that apply across a broad range of settings, while ensuring that all emergency clinicians have the skills they need to deliver quality emergency care.

The COVID-19 pandemic has accentuated acute workforce challenges across all regions. There are widespread staffing shortages in hospitals with medical practitioners not able to travel. These challenges have greatest impact on workforce for regional, rural and remote areas.

Of course, these issues cannot be immediately resolved and that is why the recommendations outlined in this paper are not designed to be implemented tomorrow. Instead, we are putting forward a range of measures to be put in place over the medium and long-term.

Our vision is that everyone across Australia and Aotearoa New Zealand has access to the right emergency care, in the right place and at the right time. Emergency clinicians should be trained and able to work in the widest range of emergency care settings. We encourage you to provide feedback and thank you for participating in this consultation process.

John Bonning
ACEM President

Clare Skinner
ACEM President-Elect

Introduction

1. Introduction

1.1 Overview

This Recommendations Paper progresses the project work being undertaken by ACEM's Workforce Planning Committee (WPC) following the Workforce Issues Paper Consultation, undertaken between October to December 2020.

In late 2020 ACEM sought feedback from its membership on the key issues facing the Emergency Medicine (EM) specialty and its workforce. This consultation process confirmed that the following factors were severely impacting both the delivery of emergency care across Australia and Aotearoa New Zealand and the wellbeing of the wider EM workforce. FACEM and FACEM-trainee workforce:

- Persistent issues of geographic maldistribution resulting in fewer EM specialists and trainees in RRR areas, impacting health equity for RRR communities, as well as the wellbeing of members and trainees working in these areas;
- Extreme workloads for all members and trainees, with continued hospital access block and ED overcrowding, leading to significant burn-out and impacts on the longevity of a FACEM career. This was coupled with increasingly more casual and/or fractional employment options for new FACEMs, resulting in increased uncertainty regarding job security, and a reluctance to leave metropolitan regions; and
- The unique challenges of the interaction between the FACEM Training Program with jurisdictional workforce needs, such that services have become reliant on high numbers of ACEM-trainees commencing the FACEM Training Program each year, particularly with regard to staffing out-of-hours and night-shift rosters.

The workforce issues associated with EM and the wider healthcare system are complex and caused by intersecting structural, cultural and historical factors. In order to address these systemic issues, the College needs to lead the development and implementation of initiatives that promote provision of the right EM care, in the right place at the right time.

ACEM has had a significant role over the last decade in setting and advocating for workforce staffing standards across Australasian emergency departments (EDs). The College acknowledges that the time has now come for a more direct and substantial role in determining what the future EM workforce will look like. This includes taking the lead in developing solutions that contribute to developing an EM workforce our communities require.

There must be a greater focus on the current maldistribution in regional and rural areas and examining how the ACEM training experience can be enhanced to improve the number of trainees and new FACEMs wanting to grow their careers in rural and regional areas. The College must also look to set the standard of emergency care delivery, ensuring a consistent level of quality of care is delivered across all regions. It is clear that there is a need for collaboration with major stakeholders, clearer guidance on how ED services should be safely staffed, and what models of care are appropriate for a variety of health care settings.

This paper, presented by ACEM's Workforce Planning Committee, outlines a series of recommendations aimed at addressing these needs.

1.2 Guiding principles for this Consultation

In undertaking this consultation, ACEM is guided by the following principles.

1. The long-term focus is on improving ACEM's approach to workforce planning; intricately linked to the specialist training and the medical training pipeline. The recommendations outlined are primarily concerned with improving emergency medicine training and the experience of trainees.
2. It is not concerned with the current or future numbers of trainees.
3. ACEM is the College *for emergency medicin*e, not the college *for emergency physicians*. As such, it exists to define the standards for emergency care in Australia and Aotearoa New Zealand, rather than purely for the betterment of its members.

4. To recognise the different roles and responsibilities of the people that make up its membership. Conflation of different job types under a single banner does not accurately reflect the experiences of members or the patients that they treat.

5. Emergency physicians are specialists in emergency medicine, regardless of the environment that they practice in. Importantly, many emergency physicians practice EM outside public hospital EDs.

6. The College must continue to update its curriculum to improve the skills of all emergency physicians in the nuances of practicing emergency medicine in rural and remote locations.

7. The College must define the limits of its jurisdiction and only work within its remit.

8. The College must identify potential roadblocks and anticipate solutions to those problems.

9. The College does not agree with the magnitude of Commonwealth predictions that there will be a major oversupply of FACEMs in the coming decade. Whilst there has been significant growth in the number of trainees and resultant FACEMs over the last decade, the fundamental issue remains that there is a mismatch between the number of specialist emergency physicians and positions in which they work. This has been further compounded by industrial issues, presenting differently in each jurisdiction, but resulting in fewer full-time permanent positions being offered to new FACEMs. Evidence, both statistical and anecdotal, suggests this is not due to the lack of demand for specialist EM staff, but rather a lack of signiifcant increase in the numbers of permanent full-time contracts for newer FACEMs and an over-reliance on a casual or locum EM specialist workforce. There has also been inadequate recognition by health service planners of the growing scope of the FACEM role in non-ED settings.

1.3 Scope

The scope of this Recommendations Paper is to:

1. Report on the results on the Workforce Issues Paper; and

2. Provide a set of recommendations to address the workforce planning issues identified.

Although medical care is provided by a range of health and medical practitioners, this paper focuses on the EM workforce, made up of medical practitioners, including:

- FACEMs/Specialist emergency physicians;
- FACEM trainees;
- ACEM EMC and ACEM EMD graduates;
- ACEM EMC, EMD and EMAD trainees; and
- Other specialists, such as Fellows of the Royal Australian College of General Practitioners (FRACGP), Fellows of the Australian College of Rural and Remote Medicine (ACRRM) and Fellows of the Royal New Zealand College of General Practitioners (Division of Rural Hospital Medicine), working in rural and regional areas;
- Career Medical Officers (CMOs) working in hospital EDs and other emergency care settings; and
- Prevocational and non-streamed middle grade doctors.

This Recommendations Paper discusses both the FACEM and FACEM trainee workforce as well as the broader EM workforce outlined above.

As with other medical specialities, EM grapples with many wide-ranging and complex issues that impact its workforce. Whilst this paper focuses on a balance of skills and geographic location, this intersects with a broad range of work already underway across the college to address:

- wellbeing and work/life balance for emergency physicians across all stages of their career;
- health system advocacy, in particular around access block, including the development of revised access measures and time-based targets;

- improved care of people presenting to EDs with mental health problems, including the development of a Mental Health Strategy and Action Plans for Australia and Aotearoa New Zealand;
- equity for Māori and Aboriginal and Torres Strait Islanders peoples in EM, including Cultural Competence training, ACEM's Reconciliation Action Plan, Te Rautaki Manaaki Mana – the College's strategy for increasing equity for Māori, and the Indigenous Health Committee;
- gender equity, including the ACEM Advancing Women in Emergency Medicine Section; and
- measures to improve inclusion and address racial discrimination and bias in college and ED processes and practice;
- training and research to develop the leadership skills of current and aspiring directors of emergency medicine;
- equity in access to emergency care for rural, regional and remote areas, including the establishment of ACEM's Rural Health Action Plan.

ACEM recognises that emergency department workforces are comprised of a range of health care workers, including nurses and emergency nurse practitioners, allied health professionals, and other hospital and administrative staff. However, for the purposes of this Recommendations Paper, nursing, allied health, and other members of the health workforce are considered out of scope for the work of this paper.

1.4 The role of FACEMs across Aotearoa New Zealand and Australia

Emergency Medicine is defined by the International Federation for Emergency Medicine as:

> *a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.*

During the FACEM Training Program, medical practitioners gain clinical experience in a wide variety of emergency departments (EDs) and hospital settings, including both major referral and urban district sites and regional and rural EDs, critical care including intensive care units and anaesthetics, and a broad variety of other clinical practice settings.

The practice of emergency medicine extends well beyond EDs. As acute generalist (broad spectrum) clinicians and decision-makers, FACEMs have diverse roles in hospitals and the broader health system. FACEMs work across a variety of health care settings in metropolitan, regional, rural and remote Australia, Aotearoa New Zealand, and internationally. These include:

- hospital EDs including mainly mixed, but also adult and paediatric departments; general and specialist departments (public and private);
- emergency department observation units, for example ED short stay units (EDSSUs), emergency medicine units (EMUs) or clinical decision units (CDUs);
- hospital acute admission units, for example, medical admission units (MAUs), acute medical units (AMUs) or medical assessment and planning units (MAPUs);
- specialist inpatient services including but not limited to toxicology, intensive care, high dependency units and hyperbaric medicine (additional qualifications to FACEM may be required for these roles);
- urgent care centres (public and private);
- rural multi-purpose centres (co-located emergency, inpatient, aged care services);
- hospital-in-the-home (HITH) services and clinical outreach teams;
- patient flow and transfer units;
- pre-hospital and medical retrieval services (aeromedical and road);
- telemedicine and virtual care services (public and private);
- medical administration and health service planning;
- academia including medical education and research;

- Major incident and disaster planning medicine;
- Defence force medicine (permanent and reserves);
- Global health care and coordination;
- Medical support for major entertainment and sporting events;
- Public health and health promotion/communications;
- Forensic medicine including police medical officers;
- Quality and safety roles;
- Clinical product design;
- Government and policy roles; and
- Clinical leadership.

1.5 The Impact of the COVID-19 Pandemic

The impacts of COVID-19 on the community, the healthcare workforce and EDs, continue to evolve, often on a daily basis, and differently across each jurisdiction.

The immediate impacts of the COVID-19 pandemic on the ED workforce most notably, as well as the broader health workforce include:

- the health and well-being of ED workforce, as frontline health care workers treating patients daily;
- the health and well-being of ED workforce, due to large numbers being furloughed due to either contracting COVID-19, suspected COVID-19 infection and/or being a close contact of an individual who has contracted COVID-19;
- the work routines of health care workers who were redeployed to other roles due to vulnerable worker status (e.g. age, medical comorbidities, etc)
- trainee progression through the FACEM and other training programs; and
- a decrease in the numbers of overseas trained junior medical staff due to international travel restrictions, who were scheduled to commence work in EDs in 2020-2021.

Despite these impacts, and as the emergence of a 'new normal' develops, the broader issues outlined in this paper remain. These broader issues were evident prior to the COVID-19 pandemic. The impetus for the EM workforce to evolve and for ACEM to be the driver of this change, also remains.

ACEM will continue to monitor COVID-19 develpments and impacts. Any COVID-19 related information and/or impacts will be incorporated into subsequent workforce reform strategies.

1.6 Relationship with the recent review of the FACEM Curriculum and the FACEM Training Program

This work is not to be confused with recent changes to ACEM's FACEM Curriculum, FACEM Training Program and the associated Accredited Site Classification and Delineation System. Those changes were approved by the ACEM Board in August 2020, and are scheduled for implementation in the 2022 clinical training year.

1.7 The Rural Health Action Plan

In June 2021, ACEM launched its inaugural Rural Health Action Plan (RuHAP). The RuHAP provides the ACEM with a strategic vision that brings together its work and embeds a focus on rural health across its operations. The Action Plan articulates our role in addressing health equity in rural areas and aims to strategically coordinate work across the College to maximise the impact of our work to improve health equity.

The RuHAP focuses on building the foundations for understanding how best to strengthen emergency medicine in rural areas, particularly workforce, research, collaboration and service provision, planning and development. As such, activities undertaken as part of the RuHAP, are expected to feed into and complement outcomes that arise out of this Recommendations Paper.

1.8 The Consultation Process

The purpose of this consultation paper is to seek feedback from ACEM members, trainees and external stakeholders on a set of recommendations which outline our proposed direction for addressing emergency medicine workforce planning.

ACEM seeks:

1. to understand the extent of support for the recommendations as outlined, and
2. suggestions on how these recommendations should be implemented.

It is vital that as many members, trainees and organisations take part in this consultation as possible. The level of support for these proposals will inform future decisions.

This consultation is open to all ACEM members and trainees, as well as all external stakeholders.

The consultation will be open from **17 August until 9:00pm 26 September 2021 (AEST)**.

To provide feedback please click here to complete the consultation survey.

For organisations or individuals who would like to provide a written submission to the consultation questions, these can be submitted to workforce@acem.org.au.

The ACEM WPC will review all submissions and develop a set of final recommendations to the ACEM Board for their consideration.

All members and external stakeholders who respond to the consultation process will be kept informed of the progress of this work.

Any queries in relation to the consultation may be made through workforce@acem.org.au

Background

2. Background

2.1 October 2020 - Workforce Issues Paper Consultation

In October 2020, ACEM sought feedback from its membership on the key issues facing the EM specialty and its workforce. The consultation was sent to the whole of the ACEM membership, including FACEMs, Certificate/Diploma Graduates and trainees.

Aims

The two aims of the 2020 consultation were to:

1. Summarise what we knew about workforce challenges and their underlying drivers; and
2. Provide a series of suggestions for ACEM to address these challenges, as part of the development of the future EM workforce.

The issues discussed in the 2020 Workforce Issues Paper will not be covered in depth in this consultation paper. Whilst the issues will be referred to, for comprehensive information and data on these matters, please refer to the 2020 Workforce Issues Paper here.

Responses

The College received 347 responses to the 2020 consultation and confirmed the following factors as severely impacting both the delivery of emergency care across Australia and Aotearoa New Zealand and the wellbeing of the wider EM workforce:

- Persistent issues of geographic maldistribution resulting in fewer EM specialists and trainees in RRR areas, impacting health equity for RRR communities, as well as the wellbeing of members and trainees working in these areas;
- Extreme workloads for all members and trainees, with continued hospital access block and ED overcrowding, leading to significant burn-out and impacts on the longevity of a FACEM career. This was coupled with increasingly more casual and/or fractional employment options for new FACEMs, resulting in increased uncertainty regarding job security, and a reluctance to leave metropolitan regions; and
- The unique challenges of the interaction between the FACEM Training Program with jurisdictional workforce needs, such that services have become reliant on high numbers of ACEM-trainees commencing the FACEM Training Program each year, particularly with regard to staffing out-of-hours and night-shift rosters.

Other key results included:

- The feasibility of implementing an accreditation system that supports networks of EM training should be explored;
- Detailed guidelines for health services regarding the role of non-FACEM senior decision makers in EDs and the requisite qualifications for these roles should be developed; and
- Different mechanisms – including mandatory rural training and a rural training pathway – to improve the long-term geographic distribution of the workforce should be explored.

Recommendations 1–3

Recommendation 1

Accredited Training Networks

ACEM will establish a new integrated system of FACEM training site accreditation that includes a series of accredited training networks within each jurisdiction. Each network would be assessed against accreditation ACEM training site accreditation standards, and include an appropriately defined range of sites, with consideration given to the case-mix, patient presentation numbers and geographic location of each site and the overall network training experience.

Each of the sites that make up the networks will comprise of a set number of accredited training posts, the numbers to be developed through consultation with jurisdictional stakeholders as employers and funders of the system.

There will be a formal agreement that the sites involved in a defined EM Training Network will work together to provide an integrated and comprehensive training program experience and deliver safe, high-quality quality training.

In addition, rather than create a separate rural training pathway, the College will encourage where relevant, the formation of networks that contain a combination of sites that allow for predominantly rural training. As such, a significant range of regional and rural health services can choose to provide an integrated FACEM training experience across a range of RRR sites.

To receive ACEM accreditation, each network will need to demonstrate that they are able to provide an adequate depth and breadth of sites and experiences that will allow a trainee to meet ALL FACEM Training Program requirements within that network, throughout the length of the training pathway. They may be tailored to meet differing jurisdictional needs.

Recommendation 2

Incorporation of Rural Training into Training Networks

As part of establishing a new integrated system of accreditation that includes a series of accredited training networks within each jurisdiction, it is recommended that each network will be required to have a minimum dedicated proportion of rural, regional and/or remote training sites within their network.*

Recommendation 3

Mandatory Rural Training Within Each Network

All future FACEM trainees (date to be determined) will be required to undertake a minimum six-month rural training placement within an accredited training network.

As part of each training network's dedicated proportion of rural training sites, each network will be expected to facilitate and ensure the appropriate rotation of FACEM trainees through their respective RRR training sites.

* The minimum proportion of RRR sites within a network will be determined by a project Working Group, who will undertake detailed development of the networked accreditation model.

3. Recommendations 1, 2 and 3

3.1 Introduction

The first three recommendations seek to:

- Ensure a high-quality training experience and a more equitable distribution of trainees across regions of Australia and Aotearoa New Zealand.
- Increase access to rural training opportunities, with a view to contributing to a long-term increase in the FACEM workforce in rural and regional areas.
- Improve health equity by increasing access to a high level of emergency care across all regions of Australia and Aotearoa New Zealand.
- Improve ACEM's recommendations regarding ED models of care and constructing an ED workforce consisting of appropriate FACEM and non-FACEM senior-decision makers.

As part of the 2020 Workforce Issues Paper consultations, the suggested solution of 'exploring the feasibility of establishing accredited training networks' was well supported, with 70% of respondents agreeing with this suggestion.

A higher proportion of respondents strongly agreed or agreed with the proposed solution to accredit networks of EM training (comprised of accredited training posts) than to accredit 'individual training posts', with just over half (51%) of the respondents agreeing with the proposal of accrediting individual training posts.

Qualitative comments revealed that the main themes underlying this support were that networked training would improve the training experience and result in a more equitable distribution of trainees across various regions and hospital sites (Refer to **Appendix B**).

The majority of respondents were also in agreeance that 'ED service needs were a major driver of FACEM trainee numbers' (64%), and almost three-quarters of respondents agreed that 'service needs were often prioritised over training needs'.

With regard to increasing rural training opportunities, 74% of respondents agreed with the proposed solution that ACEM introduce a mandatory rural training term for all new FACEM trainees. Whilst there was slightly less support, over half of respondents agreed with both suggestions to develop and pilot a rural training pathway (58%)[1].

3.2 The rationale for change

The following factors have informed the WPC's choice for the three recommendations outlined above.

A clearer delineation between FACEM training and ED service

The WPC considers that the recommended network model, which includes a set number of training positions per site and a set number of sites per network, will introduce a clearer distinction between what are 'training' positions, and what is the broader ED workforce (this issue is discussed at length in the Workforce Issues Paper, available here).

Whilst significant work has been done over the last three years to improve the selection process into the FACEM Training Program, consultation survey results and anecdotal feedback demonstrate that the current ED 24/7 model of care relies heavily on recruiting FACEM trainees, with some trainees encouraged towards speciality training, despite EM not necessarily being their preferred choice.

While the flexibility of the FACEM Training Program is a much-lauded feature, the WPC strongly believes that the introduction of accredited networks will reduce fragmentation and improve the overall consistency of the FACEM training experience. In addition, it should help shift employers/hospital sites from employing large numbers of trainees purely for service provision without adequate consideration of their non-ED training requirements or job prospects on completion of training.

Reduce reliance on trainees and increase the non-FACEM senior-decision maker workforce

The WPC also considers that the recommendation of networked training will facilitate the growth of a non-specialist middle-grade workforce, by reducing the reliance on large FACEM trainee numbers in order to ensure service rosters are covered. This is further discussed in Section 5. However, it is clear that the College must develop solutions that can facilitate an increase in appropriately trained and skilled senior decision makers, beyond that of FACEM trainees.

Facilitate a more equitable distribution of trainees across regions and improve long-term workforce distribution

Trainees seek employment in major referral hospitals to facilitate streamlined completion of their training, progression to Fellowship and ensure their future competitiveness. Major referral EDs, in turn, rely heavily on FACEM trainees to make up their middle grade workforce, with limited employment of non-specialist doctors. This leads to a maldistribution of the workforce, which is impacting the community's equitable access to high-quality care. Networks will help coordinate and improve trainee distribution by ensuring a range of ED locations, including urban district, regional and rural hospitals, are available to help trainees meet their training needs, assist smaller departments to attract trainees and shift the current concentration of FACEM trainees from major referral centres.

Regional, Rural and Remote (RRR) EDs in particular still rely heavily on a locum workforce. As reported in ACEM's 2018 Annual Site Census Report, regional EDs were more likely than others to be employing locums, with 100% of small/medium regional EDs in Australia reporting that they employed locums[2]. Overall, ED locums represent a significant portion of the ED workforce, with recent data showing that half of Aotearoa New Zealand (56%) and almost one third (31%) of Australian EDs employed locums[2].

The WPC considers that the recommended networked accreditation model, combined with a mandatory rural training term, will significantly support the development of a critical mass of the FACEM workforce in RRR regions, in the long term. Importantly, this will then expand the number of RRR training opportunities by improving the likelihood of more ED sites being able to reach the level required by ACEM accreditation standards. In turn, this will assist in decreasing the concentration of FACEM trainees in major referral hospitals and contribute to a more diverse range of training opportunities.

By building this into a networked accreditation model, it is anticipated that major referral centres will also be able to contribute to more sustainable recruitment of trainees, particularly senior trainees/senior decision makers, to regional and rural sites, as well as urban district sites.

Different solutions for each jurisdiction

The WPC recognises that it is unlikely that a one-size-fits-all networked accreditation approach will be possible. Tailored solutions will need to be developed depending on the needs and processes within each jurisdiction and health region.

For example, South Australia currently has no FACEM training available in RRR areas – all EM specialist training sites are located in metropolitan areas. How RRR sites in South Australia are therefore supported to become part of a network, and how trainees are rotated to these placements may need to be different to that of training networks in other jurisdictions.

Employment and industrial arrangements will also differ in each jurisdiction and across jurisdictional borders. The nuances of these will need to be carefully considered during the design and implementation of these recommendations.

3.3 Proposed Next Steps

Development and implementation of the requirements associated with these recommendations represents a significant piece of work; this will be a long-term project.

To progress these recommendations the WPC recommends the following process is undertaken:

1. A project Working Group is formed, reporting to the WPC.
2. This Working Group be comprised of representatives from the Council of Education (COE), the Council

of Advocacy, Practice and Partnerships (CAPP), Rural, Regional and Remote (RRR) Committee, FACEM trainees and Directors of Emergency Medicine Training (DEMTs), with appropriate representation across each of the different jurisdictions of Australia and Aotearoa New Zealand.

3. The Working Group be tasked with undertaking the following activities:

   (a) **Network mapping.** ACEM must work collaboratively with jurisdictions and health boards across Australian and Aotearoa New Zealand to undertake comprehensive planning and development of how such networks will be formed and operated. This will include collaborating with jurisdictions and health services to identify existing formal and/or informal networks that exist, how these currently function, and how they would map over into a structure of new ACEM training networks.

   (b) **Non-Emergency Department term mapping.** To ensure each network has adequate access to required and optional non-ED rotations, and to describe and streamline common training pathways while allowing fair and transparent access to special skills and "boutique" placements.

   (c) **Rural Training Requirement Details.** Undertake modelling to map the required number of RRR training positions required, as well as the stage of the training pathway for which the rural rotation will be appropriate to be completed.

   (d) **New accreditation standards.** Commence the development of network accreditation standards. It is intended that existing site accreditation standards will be utilised as the underpinning requirements for individual sites.

   (e) **Trainee rotation and placement processes.** Collaborate with jurisdictions to address the following key issues:

      (i) Developing processes to match training numbers to workforce need with regards to the number of accredited training posts each site within a network will have;

      (ii) Centralising recruitment of trainees;

      (iii) Developing processes on how trainees are appointed and employed to positions;

      (iv) Developing central training coordination roles e.g. network DEMT and medical education officer; and

      (v) Developing processes on how trainees are able to move between networks, without being disadvantaged.

   (f) **Transition arrangements.** Providing advice on transition arrangements, regarding the implementation of a new networked accreditation system.

   (g) **Engagement with the ACEM membership.** Throughout the project period, the Working Group would be expected to undertake extensive consultation with members on the accreditation standards and associated processes being developed.

Such a significant shift in the ACEM training site accreditation model and the introduction of a mandatory rural training term will need to be undertaken with care and consideration. These concerns would be incorporated into the project work to be undertaken, as part of the steps outlined above.

3.4 Other issues to be addressed

Flexibility of training program

There will be trainee concerns (both for current and potential future trainees) with any potential loss of flexibility of their ability to undertake and complete the requirements of the FACEM Training Program.

Flexibility is an attractive feature of the current FACEM Training Program and the WPC would recommend that this element is retained. The Committee would not want to see a situation where trainees were not able to move between networks, or access to limited special skills terms, should they choose to. Whilst the College does not set employment conditions, it will continue to work with jurisdictions to ensure that no trainees are disadvantaged, particularly with regards to movement/transfer of employment entitlements when a trainee should choose to move training networks.

Transition arrangements

As with any large change management project, comprehensive transition arrangements would need to be established. This may require that ACEM operate two concurrent accreditation systems for a short period of time. Adequate notice of change must be provided to current and potential future trainees.

Unaccredited posts

The introduction of 'accredited training-posts' will likely raise concerns about the potential generation of what are referred to as 'unaccredited posts'. The WPC notes that there are some medical specialties where the use of accredited posts is seen as significantly disadvantageous for some doctors, who will work in 'unaccredited posts' for many years, whilst attempting to enter a particular medical specialist training program.

ACEM does not anticipate this to be a significant issue for FACEM training. FACEM trainees are a large part of the EM workforce, however, the College must work towards facilitating a more balanced approach to constructing ED models of care, which includes an appropriate distribution of doctors with a range of skills in EM. This includes a non-specialist senior-decision maker workforce that is skilled in providing emergency medical care, beyond FACEM trainees. This is discussed in more detail in **Section 5**, as part of the development of new ACEM guidelines regarding the construction of various ED staffing profiles.

Fair processes for rotating trainees through network sites

In constructing systems and processes, there needs to be fairness in how large numbers of trainees are rotated across training sites and across service boundaries within any given network. This includes concerns regarding the rotation of trainees from potential 'hub' or 'parent' hospitals, to sites through the broader network, particularly with regards to RRR training positions. Mechanisms will need to be in place that ensure metropolitan and/or major referral hospital sites do not limit rotation of trainees to RRR sites.

In addition, issues of gender equity, racial and cultural inclusion, and support for trainees with caring responsibilities will need to be considered and accounted for. The WPC recognises that in recommending a mandatory rural training rotation, there will be a small number of trainees with legitimate reasons for being unable to relocate to RRR regions due to family, carer or cultural requirements. These issues will need to be incorporated into regulations regarding matters of special consideration requests.

Specialty placements

Consideration will need to be given to ensuring that rotations to speciality hospitals e.g. children's hospitals, eye and ear hospital, women's hospital etc and special skills terms e.g. retrieval, medical education, ultrasound skills etc remain accessible to trainees. The Committee considers that appropriate mechanisms will need to be put in place to ensure that each network has access to such sites or placements. This will likely include single specialty hospitals and special skills terms being available to trainees across multiple networks, such as they currently are.

Availability of rural training sites

During the initial implementation of accredited training networks, there will be some jurisdictions and/or regions of jurisdictions where there is limited access to rural training. Options that will need to be explored include the ability for individual hospital sites to be part of multiple networks and/or cross-jurisdictional networks, particularly for those regions where existing relationships exist. For example, trainees based in the Australian Capital Territory currently undertake training rotations in both rural and regional Victoria and New South Wales.

3.5 Consultation Questions

Recommendation 1

Establish accredited networks of training

	Question
1	Do you support Recommendation 1?
2	With regard to the implementation challenges outlined, do you have any suggestions for how the College can minimise these / manage these?
3	Other than those challenges already outlined, do you foresee any additional challenges in implementing this recommendation?

Recommendation 2

Incorporation of Rural Training into Training Networks

	Question
1	Do you support Recommendation 2?
2	With regard to the implementation challenges outlined, do you have any suggestions for how the College can minimise these/manage these?
3	Other than those challenges already outlined, do you foresee any additional challenges in implementing this recommendation?

Recommendation 3

Mandatory Rural Training Within Each Network

	Question
1	Do you support Recommendation 3?
2	At what stage of the FACEM Training Program do you think trainees should undertake a rural training placement?
3	With regard to the implementation challenges outlined, do you have any suggestions for how the College can minimise these / manage these?
4	Other than those challenges already outlined, do you forsee any additional challenges in implementing this reccomendation?

Recommendation 4

Recommendation 4

Remote Supervision

As part of improving access to rural FACEM training opportunities, it is recommended that the feasibility of a blended supervision model is explored, which sees traditional face-to-face clinical supervision supported with some remote clinical supervision.

Any remote supervision should not compromise patient nor trainee safety, or the quality of training placements, but instead be a mechanism to improve the range and variety of RRR settings capable of establishing FACEM training posts / achieving ACEM accreditation.

It is recommended that this work is undertaken through a pilot blended supervision model. To establish the resources and tools required to implement and sustain a blended supervision training post, this pilot will be trialled via a network of accredited rural training sites.

4. Recommendation 4

As part of the 2020 Workforce Issues Paper consultations, the suggested solution of 'exploring the feasibility of establishing accredited training networks' was supported by over half of respondents (55%).

Qualitative comments revealed that the main themes underlying this support were that ACEM needed to at least pilot or explore remote clinical supervision models for *some* aspects of training, in order to determine whether it was possible. Respondents' comments also noted that much like telemedicine, which is now considerably more accepted by the workforce as a viable way to deliver health care and some emergency care in particular situations, remote supervision is also likely to be utilised to a greater extent in the coming decade. The College should therefore be leading the testing and development of this skill in relation to FACEM training.

"Like telemedicine (which we have all gotten better at during the pandemic), remote supervision will work well for some aspects of training. For instance, there is no reason why a trainee seconded to a remote location (as part of a training network) could not continue to attend teaching sessions via a secure online platform.

As a matter of fact, looking beyond 2020, there is no excuse for teaching sessions not to be broadcast online/recorded as it is simply so easy to do. It is entirely wasteful for someone to prepare a solid presentation, deliver it once and for it to then 'disappear forever' when other trainees can benefit from (re)watching it. Similarly, remote case discussion (to review a case or get advice) can also work well with modern communication platforms[1]."

Respondents in support of trialling remote supervision, however, also noted that any such development would need careful planning and implementation to ensure quality of patient care is not compromised, and trainees continue to work within supported and safe environments. Remote supervision should only be used to support trainee access to clinical opportunities that enhance their training in a safe environment as part of their overall training in a network arrangement. Each placement and supervision arrangement would need to be carefully evaluated and monitored.

For those respondents not in support of such a proposal, the importance of 'real-time/face-to-face supervision' was determined to be critical, particularly in relation to procedures and/or critical care presentations[1].

Following review of the 2020 consultation feedback and further discussion, the WPC recommends a trial of a blended supervision model comprising of traditional face-to-face clinical supervision and remote clinical supervision.

4.1 The Rationale for Change

Over the last 18-months and the COVID-19 pandemic, the role of telemedicine in healthcare delivery has expanded significantly, most notably within General Practice (GP) and secondary care. During the COVID-19 pandemic, video conferencing and similar systems have been used to provide health care programs for people who are hospitalised or in quarantine to reduce the risk of exposure to others and employees[3]. Physicians who are in quarantine have also been able to employ these services to take care of their patients remotely[4, 5]. Telemedicine services providing emergency medicine/care advice have also expanded (although to a lesser degree), with organisations such as the WA Country Health Service now providing telephone and/or video-consultations as part of jurisdictional support for EDs, paramedicine and inter-hospital transfer planning.

Most importantly, there has been a significant increase in the use of telemedicine infrastructure to deliver components of medical education and training, including the FACEM Training Program. During much of 2020, due to restriction of movement across multiple hospital sites and the need for isolation and/or quarantine due to COVID-19 exposure and/or infection, many ACEM accredited training sites (and education networks) shifted the delivery of their structured education programs to online virtual platforms.

These changes have resulted in both improvements in telemedicine infrastructure across services, and the need to develop innovative approaches within rapid timeframes to see the continued delivery of patient care and specialist medical education and training during times of societal upheaval.

This presents a unique opportunity for ACEM to harness current momentum, and definitively address the issue of remote clinical supervision, and whether it has a place in emergency medicine training.

Supporting expansion of RRR training opportunities and building the long-term workforce

If proved to be feasible, blended models of supervision would provide greater flexibility in establishing training pathways to meet the needs of communities outside of metropolitan centres, while continuing to meet training program requirements and accreditation standards.

Trialling a blended supervision model is inherently linked to Recommendations 1, 2 and 3, and the development of functional links between regional training networks and existing training infrastructure. As outlined in **Section 3.1** above, this would make more ED training sites in RRR accessible to FACEM trainees.

4.2 Proposed next steps

This recommendation represents a significant piece of work, and that there are currently differing views amongst the membership as to the merits of remote clinical supervision. Nonetheless, in order to properly determine the feasibility and practicalities of delivering a blended supervision model incorporating traditional on-site supervision with a proportion of remote supervision, the WPC has determined that a pilot project should be undertaken.

There have been some early trials of remote supervision of FACEM trainees, most notably by the ED team at Barwon Health, who undertook a trial of a remote trainee placement and supervision within Urgent Care Centres (UCC) in rural Victoria[6].

Participating trainees highlighted both positive and negative aspects of the trial. The remote placement was noted for its ability to facilitate development of communication skills, skill in negotiation of inter-professional boundaries, roles and responsibilities and independent practice. The issues highlighted included the inability to have hands-on assistance with both physical examinations and/or procedural skills. It is also more challenging to monitor trainee wellbeing and provide regular informal feedback on performance and there is also a loss of informal learning opportunities[6].

To progress this recommendation the WPC recommends the following process is undertaken:

1. A project Working Group is formed, reporting to the WPC.
2. As part of this project, selected jurisdictions will be approached to partner with ACEM on a pilot project to assess and evaluate the quality, safety, resources and support required and overall feasibility of a blended face-to-face/remote supervision model, for FACEM Trainees.
3. The Working Group will develop a blended face-to-face/remote supervision model for piloting, with a focus on the following features:
    (a) Criteria for the appropriate selection of a small number of trainees. This includes what stage of training would be considered optimal for such a training experience, the prerequisite experience and technical skills of the trainee;
    (b) In addition to standard requirements, the particular supervision needs of the trainee;
    (c) Criteria for selecting the most appropriate supervisors;
    (d) Identification of additional training for supervisors that may be required;

(e) Criteria for accrediting a suitable type of rotation i.e. will other critical care specialists and/or other specialists be available on-site;

(f) Processes for pre-placement orientation;

(g) Proportion of training that would be suitable to be delivered remotely;

(h) Processes regarding the management of critical care scenarios;

(i) Presence of non-FACEM/other critical care specialists to provide oversight of critical care procedures;

(j) Structured face-face contact;

(k) Relevant environmental factors to minimise impact on trainee wellbeing e.g. social networks and connections to community;

(l) Detailed criteria regarding technological considerations, and how disruptions will be managed; and

(m) Completing an evaluation of the pilot project and providing a report back to the ACEM Board, COE, CAPP and the broader ACEM membership.

Such a significant shift in the clinical supervision model will need to be undertaken with care and consideration. These concerns would be incorporated into the project work to be undertaken.

4.3 Other issues that will need to be addressed in progressing Recommendation 4

Two-tiered training program

Historically, there has been a reluctance to explore the development of additional rural training site requirements such as remote supervision, due to concerns that rural trainees would be disadvantaged and experience a 'lesser' version of the FACEM Training Program, thereby creating a 'two-tiered' training program.

There are a number of factors that could lead to this effect, including:

1. The inability of the remote supervisor and registrar to meet regularly, due to ICT failures;
2. Compromises to patient safety;
3. Negative impact on trainee wellbeing;
4. Failure of the trainee to know when to seek support and/or supervision i.e. not seeking assistance when it is required.

These factors can be appropriately mitigated through the development of (by the Project Working Group) a range of risk management strategies. It is of importance to note that a training rotation would not be deemed to be suitable if there was not sufficient presence of other critical care and/or medical specialists on site and working with the trainee in the ED. The pilot project is the vehicle by which successful management of these risks would be evaluated, and would help to inform the implementation, or not, of any longer-term blended supervision model.

Will there be enough interest from trainees?

A training rotation with a blended model of supervision will not be suitable for all trainees. Again, an aim of any pilot project(s) would be to determine both trainee and supervisor characteristics that would contribute to a successful rotation. As part of the pilot project, the WPC anticipates an Expression of Interest (EOI) process will be undertaken to identify the trainee participants.

Should the pilot project be successful and new accreditation standards are introduced for training rotations with blended face-to-face / remote clinical supervision, the WPC considers that this option will only be available to those trainees deemed suitable, via an established selection and development process.

4.4 Consultation Questions

Recommendation 4

Remote Supervision

	Question
1	Do you support Recommendation 4?
2	With regard to the implementation challenges outlined, do you have any suggestions for how the College can minimise these/manage these?
3	Other than those challenges already outlined, do you foresee any additional challenges in implementing this recommendation?

Recommendation 5

Recommendation 5

Non-FACEM senior decision makers

As part of improving access to the non-FACEM consultant level (e.g. FACCRM/FRACGP/Rural Generalist) and non-FACEM middle grade EM workforce, it is recommended that ACEM develop detailed guidelines for health services regarding medical workforce models utilising appropriate non-FACEM senior decision makers, and further define what the expected qualifications for this role are.

This will further define, develop, promote and help to embed different models of care that utilise alternative senior decision makers that are suitable across a range of settings and locations.

5. Recommendation 5

The 2020 Workforce Issues Paper consultation found that the majority of respondents supported ACEM developing detailed guidelines for health services regarding medical workforce models utilising appropriate non-FACEM senior decision makers, and to further define what the expected qualifications for this role are. Developing such guidelines will require extending and rewriting ACEM's G23 guidelines, and will, in effect, formalise a middle grade workforce that ACEM will be responsible for training.

Of those who provided qualitative feedback, the main theme that emerged for those who agreed with the suggested solution was that clarity regarding acceptable standards for non-FACEM and non-FACEM trainees working in the ED, was critical.

"We need some basic standards for who can work on an ED middle grade roster and a good assessment process to determine that - currently highly variable across sites, especially in the locum market[1]."

Consideration of the 2020 consultation feedback resulted in the WPC recommending that ACEM commit to undertaking work that defines non-FACEM senior decision makers and assists in the development of models of care that utilise these personnel across a range of settings and locations.

5.1 The Rationale for Change

There are a number of compelling reasons for formalising and facilitating the growth of a non-FACEM workforce. For FACEM trainees this will mean that they will no longer be relied upon to ensure that rosters are covered, with the clearer delineation between training needs and service provision enabling them to receive more protected training time.

ACEM's current G23 Guidelines makes recommendations on the number of non-FACEM senior decision makers that should be present in the ED overnight.

In practice, this has resulted in large numbers of emergency medicine trainees on night shifts. FACEM trainees have cited this as a difficulty in their training placements, with some trainees experiencing inadequate protected teaching time, insufficient case mix (acuity and breadth) for optimum learning, understaffing, and high workload. Career Medical Officers (CMOs) make up the remainder of night shift roles.

Formalising standard training and skills required of the middle-grade ED workforce will enable effective use of the existing other-specialist workforce and middle-grade workforce available to deliver emergency care across all regions and settings in Australia and Aotearoa New Zealand. A dedicated middle-grade workforce will also contribute to addressing the significant increase in patient presentations and subsequent service requirements. In practice this will also lead to an improvement in the quality of patient care by setting clear standards for what emergency medicine skills are required for this cohort of doctors.

Setting these guidelines is critical to reducing variability in the quality of emergency care delivered, particularly for those regions where currently, there is a heavy reliance on a non-FACEM locum workforce.

5.2 Proposed Next Steps

Enacting any change in this area will require an update and extension of ACEM's G23 Guidelines (Constructing and retaining a Senior Workforce).

In 2020, ACEM completed a review of the Emergency Medicine Certificate (EMC) and Emergency Medicine Diploma (EMD). As part of this review, a new program was also introduced – the Emergency Medicine Advanced Diploma (EMAD).*

A membership category (requiring participation in an CPD program) and a CPD program are already established. A clear structure and pathway for maintenance of EMC, EMD and EMAD skills therefore exists, and these members of the middle-grade workforce can be well integrated into College structures.

* Holders of the previous EMD are being transitioned to the EMAD.

While the EMC is aimed at enabling doctors to deliver safe patient care in a modern emergency care system with access to significant experienced support, the EMAD qualification provides the skills for a medical officer to work as the senior decision maker, provide critical care support and/or a director of a smaller Emergency Department. In larger Emergency Departments (accredited by ACEM for fellowship training) the holder of the EMAD qualification is equipped to work as a senior decision maker at middle grade (registrar) level.

Given the availability of these programs and the range of skills that can be offered by the doctors who complete them, as well as other CMO doctors who have accumulated experience over time without completing formal additional training in EM, the WPC is recommending that the revised guidelines provide guidance on middle-grade and senior staffing specific to different streams of ED activity, as well as different delineations of EDs and geographic locations.

5.3 Other issues to be addressed in progressing Recommendation 5

As the minimum standard required for working in EDs, ACEM will need to actively promote the EMD and EMAD and ensure that there is enough uptake of these training programs for a formally-trained EM middle-grade workforce to be feasible in practice. Careful consideration must be given to ensure there is enough capacity in the training system to accommodate any increase in numbers of trainees undertaking the EMD or EMAD training programs, while also maintaining capacity for the FACEM Training Program. This is most relevant for the critical care components of the EMAD.

Introducing such a large-scale change to the G23 Guidelines will have significant reporting and benchmarking ramifications for a vast majority of EDs in Australia and New Zealand. It is vital that before undertaking such changes, ACEM has ensured that there has been engagement with members, services and jurisdictions. It is very likely that any revision to these guidelines will have industrial implications.

Based on feedback to the 2020 consultation, it is likely members will have concerns regarding the promotion of non-FACEM qualifications and the dilution of the FACEM and FACEM trainee role in EDs. These are valid concern; these changes will impact both the practitioners and consumers of the specialty of emergency medicine. Clear explanation of what the changes will mean for FACEMs, FACEM trainees, and other stakeholders will be necessary, as well as as emphasis on the benefits of the revisions.

5.4 Consultation Questions

Recommendation 5

Revise G23 to incorporate more comprehensive guidance on ED models of care and the non-FACEM senior decision maker workforce.

	Question
1	Do you support Recommendation 5?
2	With regard to the implementation challenges outlined, do you have any suggestions for how the College can minimise these/manage these?
3	Other than those challenges already outlined, do you foresee any additional challenges in implementing this recommendation?
4	ACEM's G23 Guidelines on Constructing and Retaining a Senior EM workforce currently outlines recommended senior staffing levels, applied 7-days/week. It encapsulates the number of FACEMs and non-FACEM senior decision makers required on the floor, during each shift, depending on presentation numbers. The WPC is requesting feedback on what members would like to see included in a revised ED staffing guideline. For example, should there be guidance for different streams of ED activity? Should the revised guideline provide recommended models for different types and geographic locations of EDs?

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Appendix A – Terminology

A. Terminology

ACEM Member

ACEM has a range of Membership categories, the requirements of which are set out in the College Constitution and associated regulations. The terms 'ACEM Members' and 'Members' include (but are not limited to):

- **ACEM Fellows/FACEMs**. A Fellow of ACEM (FACEM) has either:
  - completed the FACEM Training Program; or
  - completed all requirements as a Specialist International Medical Graduate (SIMG) under the College's Specialist Pathway.
- **ACEM Diplomates.** An ACEM Diplomate (Dip EM (ACEM)) has satisfactorily completed the requirements of the College's Emergency Medicine Diploma (EMD) Training Program and been formally admitted to Membership of the College.
- **ACEM Certificants.** An ACEM Certificant (Cert EM (ACEM)) has satisfactorily completed the requirements of the College's Emergency Medicine Certificate (EMC) Training Program and been formally admitted to Membership of the College.
- **ACEM EMAD Diplomates.** An ACEM EMAD Diplomate has satisfactorily completed the requirements of the College's Emergency Medicine Advanced Diploma (forthcoming) and has been formally admitted to Membership of the College.

A full list of the ACEM Membership categories is available on the ACEM website.

Emergency Medicine Networks

There are many types of formal and informal 'networks' relevant to emergency medicine, including clinical/service delivery networks where a larger hospital may accept referrals from and support smaller regional hospitals, as well training networks where trainees may be rotated through a group of hospitals to gain the requisite clinical experience required for training. Hence, the use of the term 'network' may differ depending on the context and jurisdiction.

The formal networks referred to in this consultation include:

- **An Emergency Medicine Network (EM Network).** An EM Network is comprised of a Level 1 (large, multifunctional tertiary or major referral) or Level 2 (major regional, metropolitan or urban) hospital providing outreach services to non-specialist providers of emergency care in other medical settings.

  An EM Network is a model where ED services are planned in a hub and spoke model such that a larger ED (usually Level 1 or Level 2) provides clinical support to smaller EDs within the network. This may be through shared staffing, clinical advice via telephone or telemedicine, or transfer of patients for clinical assessment, diagnostic testing, or specialist team consultation or admission.
- **Emergency Medicine Training Network (EM Training Network).** As currently structured, an EM Training Network is defined as a group of hospitals that have formally agreed to a coordinated education and training program for emergency medicine trainees. Each hospital within the network must individually satisfy the mandatory criteria for accreditation. For detailed criteria and network requirements, please refer to ACEM's **FACEM Training Program Site Accreditation - Requirements (AC549)**.

  Under arrangements proposed in this recommendations paper (refer Recommendations 1 and 2), an EM Training Network will be defined as a group of hospitals that have formally agreed to provide a coordinated education and training program for emergency medicine trainees.
- **The Emergency Medicine Education and Training (EMET) network.** The EMET Network refers to the 49 EMET Hubs supported by ACEM to facilitate and support roll-out of the EMC, EMD (and EMAD), and deliver training and supervision to doctors who do not have specific emergency medicine training, and the teams they work with in hospitals and health services with EDs or emergency services.

Emergency medicine workforce

ACEM recognises that Emergency Departments (EDs) are staffed by a range of health care workers. The emergency medicine workforce includes:

- FACEMs;
- FACEM trainees;
- ACEM Diplomates and ACEM Certificants;
- ACEM EMC and EMD trainees;
- in the future, ACEM EMAD trainees and diplomates;
- Specialists and trainees of other colleges, such as Fellows of the Australian College of Rural and Remote Medicine and Fellows of the Royal Australian College of General Practitioners, and Fellows of the Division of Rural Hospital Medicine in Aotearoa New Zealand (Royal New Zealand College of General Practitioners);
- Career Medical Officers (CMOs) and other non-specialist medical officers working in hospital EDs and other emergency care settings;
- Prevocational (PGY1/2) and middle-grade doctors (PGY3+) who are yet to join a specialist training program who are allocated to ED terms on a rotating basis;
- Nursing staff, including Emergency Nurse Practitioners and advanced practice nurses;
- Allied Health Practitioners in primary and consulting roles; and
- other hospital support and administrative staff.

Middle-grade doctor

This term represents doctors with a range of skill levels from immediately post pre-vocational training (usually PGY3) to a senior registrar/pre-specialist. The more experienced middle-grade doctor may have skills equivalent to a non-FACEM senior decision maker and be able to provide oversight of a department during clinical shifts, including oversight of more junior medical staff, with remote specialist supervision.

Non-FACEM Senior Decision Maker

A medical practitioner who has clinical experience and skills sufficient to manage a critically ill patient without supervision or until a FACEM becomes available and can assist. This can encompass doctors in training (i.e. ACEM trainees), trainees of other colleges (eg ACRRM/RACGP), as well as non-training roles (e.g. Career Medical Officer).

Telehealth

For the purposes of this paper, 'telehealth' is the delivery of health care services by health care professionals, where distance is a critical factor, through using information and communication technologies (ICT) for the exchange of valid and correct information. Telehealth services are using real-time or store-and-forward techniques[7].

Trainee

- **FACEM trainees.** A FACEM trainee is a medical practitioner undertaking the ACEM Specialist Training Program. Successful completion qualifies practitioners for registration as a Specialist Emergency Physician in Australia and New Zealand and the award of Fellowship of the Australasian College for Emergency Medicine (FACEM).
- **ACEM EMC trainees.** An ACEM EMC trainee is a medical practitioner training in emergency medicine to develop the knowledge and skills to manage and treat patients with common emergency department presentations.
- **ACEM EMD trainees.** An ACEM EMD trainee is a medical practitioner training in emergency medicine to develop adequate knowledge and sufficient clinical experience to be safe and efficient EM practitioners.
- **ACEM EMAD trainees.** An ACEM EMAD trainee is a medical practitioner that has successfully completed the ACEM EMD programme. The EMAD builds upon the trainee's EM knowledge and skills to enable them to independently manage and treat a wider variety of and higher complexity emergency presentations, with telephone support from emergency specialists within the ED network, when required.

Rural Generalist

A Rural Generalist is medical practitioner working in rural General Practice with additional skills in other medical specialist fields required in hospital and community settings, that are informed by the needs of the community they serve e.g. emergency medicine, obstetrics and gynaecology, anaesthetics. The Rural Generalist scope of practice can encompass both advanced procedural and non-procedural skills.

Rural, regional and remote classification

As noted in ACEM's position statement on rural emergency care, there are multiple classification systems for defining hospitals and/or EDs and/or geographic location, both within ACEM and by Australian and Aotearoa New Zealand governments. The different definitions are context specific (for example, training and education, accreditation, ED delineation) and articulate different factors such as geographic distance, population and access to major referral hospitals.

The term 'rural, regional and remote' (RRR) includes:

- within Australia, all locations outside of Australia's capital cities without easy access to a major referral hospital; and
- within Aotearoa New Zealand, all locations outside of greater Auckland, Christchurch, Hamilton or Wellington. All EDs within greater Auckland, Christchurch, Hamilton or Wellington are classified as metropolitan.

The definition is not intended to be exclusive but rather to broadly capture non-metropolitan areas experiencing lesser access to emergency care.

Workforce Planning Committee

The ACEM Board approved the establishment of the Workforce Planning Committee (WPC; the Committee) in August 2018. The Committee reports directly to the ACEM Board and is currently chaired by ACEM President Dr John Bonning. It is the Committee's role to oversee the College's existing workforce-related policies and develop and deliver long-term solutions to address the significant issues outlined in this and in previous consultation papers.

Appendix B – Workforce Issues Paper Consultation Feedback Report

B. Workforce Issues Paper Consultation Feedback Report

Contents

1. Executive Summary

Part 1 – Workforce Issues & Their Primary Drivers

Geographical maldistribution

- Over 90% agreed that there is persistent geographical maldistribution of the emergency medicine (EM) workforce, and that maldistribution contributes to inequities in health outcomes and healthcare access.
- Most feedback focused on the lack of employment opportunities in metropolitan EDs and a contrary struggle in rural regional (RR) EDs to fill job vacancies.
- Lack of senior decision makers and heavy reliance on locums in the RR setting negatively impacts the quality of patient care/ health outcomes, staff wellbeing and support for training.

Training needs vs. service needs

- 70% were in agreeance that ED service needs are often prioritised over FACEM training needs, with FACEM trainees more likely than FACEM (80% vs. 67%) to agree with this.
- Slightly over half (56%) of respondents agreed that the reliance on high numbers of trainees to staff EDs has resulted in limited permanent employment opportunities once Fellowship is obtained, with those working in metro/urban locations more likely than those in RR (62% vs. 50%) to agree with this.
- FACEM trainees were also more likely than FACEMs to agree that heavy reliance on trainees to staff EDs will have a negative impact on the quality of FACEM training experience (57% vs. 47%).
- Major themes related to this focused on trainees deemed as being more cost-effective to staff the middle grade workforce roster and to cover night shifts.

Sustainability of a FACEM career

- 77% agreed that overall sustainability of a FACEM career has decreased due to the increasing pressures on the emergency care system.
- Feedback was mainly focused on ever-increasing ED demands and its impact on staff burnout and low morale, and reduced sustainability of full-time employment and/or longevity of EM career.

Part 2 – Potential Solutions

Alternative accreditation models

- Accreditation of networks of EM training was a preferred solution, compared with accreditation of individual training posts (70% vs. 51%).
- EM networks were deemed useful to improve the training experience and workforce distribution to RR sites, however maintaining equity across networked sites was seen as key to ensure the success of this model.

Building the non-FACEM senior decision maker workforce

- Two-thirds (65%) agreed with the proposal that ACEM would develop detailed guidelines for health services regarding the role of non-FACEM senior decision makers in EDs.
- A guideline re. requisite qualifications for non-FACEM senior decision makers in EDs was perceived to be useful to standardise responsibilities and expectations of the roles, which was seen as crucial to supporting this workforce long term.

Improving rural training opportunities and addressing geographical maldistribution

- The most preferred proposed solution was that ACEM introduces a mandatory rural training terms to all new FACEM trainees (75%), with both FACEMs (77% vs. 59% trainees) and those working in RR locations (86% vs. 61% metro/ urban location) more likely to agree with this.
- 62% agreed with the proposal that ACEM imposes a mandatory rural experience to all new FACEM training Program applicants, whilst a smaller proportion agreed with the proposed solution that ACEM develops and pilots a Rural Training Pathway (58%) or ACEM explores the feasibility of incorporating remote supervision options (55%).
- Key themes from responses of those who agreed with the mandatory rural terms/ experiences consistently focused on promoting interest to work rurally, and that rural exposure is crucial for every FACEM trainee to become all rounded EM specialist.

2. Demographics and Workplace Details

A total of 347 responses were received, 80% of respondents were FACEMs and 20% were FACEM trainees (Table 1). A smaller proportion of respondents were female (44%, respectively for FACEM and trainee respondents), which was comparable to the proportion of female FACEMs (37%) and FACEM trainees (49%) in the whole FACEM and FACEM trainee population.[1] Similarly, the age distribution of both FACEM and FACEM trainee respondents was representative of those in the larger cohort [i.e., 40-49 years was the largest age group for FACEMs (44%), compared with 30-39 years among FACEM trainees (69%)][1]

Less than 1% of respondents were self-identified as Aboriginal and Torres Strait Islanders (ATSI, n=1) or Māori (n=2), which were slightly underrepresented compared with the wider population of FACEMs and FACEM trainess.[1]

The majority (84%, n=294) of respondents reported working in Australia, 14% (n=48) in Aotearoa New Zealand, one FACEM in overseas, and three others reported not currently working. (Table 1). Overall, over one-third (34%) of respondents (N=347) were International Medical Graduates (IMG, i.e. obtained primary medical degree from another country - not in Australia or New Zealand). A slightly smaller proportions of IMG were seen among FACEM (33%), compared with trainee respondents (39%). Of those with primary workplace in New Zealand, half (50%) of them were IMGs, compared with one-third (32%) of respondents who primarily working in Australia.

More than half (52%) of the FACEM respondents reported working outside the major cities in Australia, with a smaller proportion (42%) of trainee respondents reported so. Both proportions were overrepresented compared with 23% of FACEMs and 18% of FACEM trainees in the wider population with their primary workplace in a regional or rural location.[1] Whereas a smaller proportion of New Zealand FACEM respondents (47%) reported their primary workplace outside of metro/urban location, compared with FACEM trainee respondents (54%). The proportions were relatively comparable with those reported working in a regional or rural location among wider population of NZ FACEMs (50%) and FACEM trainees (39%).[1]

Table 1 Demographics, workplace distribution, and employment status of respondents

	Total, [a]N=347		FACEM, n=276		FACEM Trainees, n=69	
	No.	%	No.	%	No.	%
Demographics						
Female[b]	153	44.1%	122	44.2%	30	43.5%
Age group (years)[c]						
<30	11	3.2%	1	0.4%	10	14.5%
30 – 39	124	35.7%	76	27.5%	48	69.6%
40 – 49	121	34.9%	111	40.2%	9	13.0%
50 – 59	72	20.7%	71	25.7%	1	1.4%
60+	15	4.3%	15	5.4%	0	0%
Primary workplace jurisdiction[d]						
Australia	294	84.4%	239	86.2%	55	79.7%
ACT	6	2.0%	4	1.7%	2	3.6%
NSW	73	24.8%	58	24.3%	15	27.3%
NT	11	3.7%	11	4.6%	0	0%
QLD	84	28.6%	72	30.1%	12	21.8%
SA	14	4.8%	11	4.6%	3	5.5%
TAS	13	4.4%	11	4.6%	2	3.6%
VIC	74	25.2%	56	23.4%	18	32.7%
WA	19	6.5%	16	6.7%	3	5.5%
New Zealand	48	14.1%	34	12.7%	13	18.8%
Overseas	1	0.3%	1	0.4%	0	0%
Primary workplace location						
Australia, n=294						
Major city	146	49.7%	114	47.7%	32	58.2%
Regional	127	43.2%	106	44.4%	21	38.2%
Remote	21	7.1%	19	7.9%	2	3.6%
New Zealand, n=48						
Metro/ Urban	24	50.0%	18	52.9%	6	46.2%
Regional Rural	24[e]	50.0%	16	47.1%	7	53.8%
Employment status						
No. of workplaces[f]						
One	188	54.2%	136	49.3%	51	73.9%
Two	114	32.9%	99	35.9%	14	20.3%
Three or more	41	11.8%	38	13.8%	3	4.3%
Type of employment[g]						
Full-time	207	59.7%	152	55.1%	54	78.3%
Part-time	133	38.3%	118	42.8%	14	20.3%
VMO contract	29	8.4%	28	10.1%	0	0%
Casual/ locum	40	11.5%	35	12.7%	5	7.3%
Sessional	3	0.9%	3	1.1%	0	0%

Note:

[a] 1 SIMG applicant, 1 did not provide a response to this, none were EMC/D, EMC/D trainee or Educational Affiliate

[b] For gender, 10 preferred not to say and 1 reported being non-binary

[c] For age group, 4 preferred not to say

[d] Three reported not currently working and 1 did not provide a response re workplace location

[e] One of them was SIMG applicant

[f] Four did not provide a response

[g] Respondents may select more than one option if they are employed across more than one workplace, therefore the percentage doesn't add up to 100%

[1] *FACEM and FACEM Trainee Demographic and Workforce 2019 Report*

3. Part 1 – Workforce Issues & Their Primary Drivers - Member Feedback

This section outlines the member feedback received in response to *Part 1* of the Workforce Issues Paper. This section of the paper summarised the key workforce issues and their primary drivers. As part of the consultation survey, members were then asked to rate their agreement to a series of statements on these issues.

3.1 Geographic Maldistribution

Over 90% of respondents strongly agreed or agreed with the both the statements that 'despite the growth in FACEMs and FACEM trainee numbers, there is persistent geographic maldistribution of the EM workforce' (92%) and that this geographic maldistribution, 'contributes to inequities in health outcomes and healthcare access for communities across Australia and New Zealand' (90%). Figure 1 shows three subgroup comparisons for those who were in agreeance with the statements. FACEMs were more likely to agree with both statements compared with FACEM trainees. Similarly, a higher proportion of respondents with their primary workplace in Australia (vs. New Zealand) and in a Regional-Rural location (vs. metro/ urban) were in agreeance with both statements re geographical maldistribution of EM workforce.

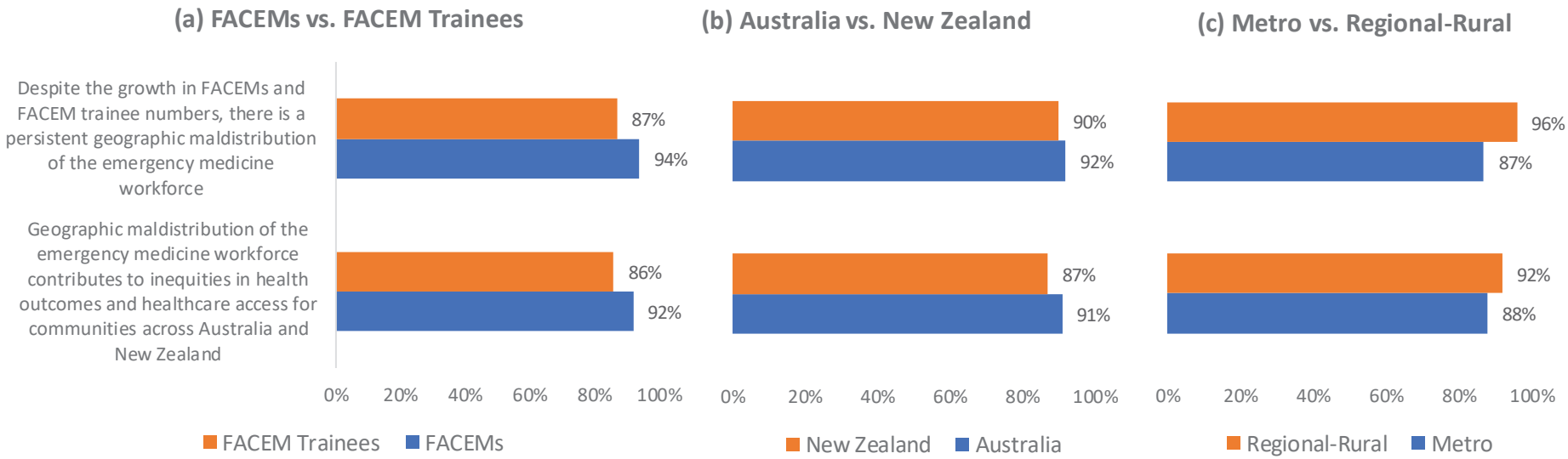

Figure 1 Proportions who were in agreeance with the statements, comparing (a) FACEMs vs. FACEM trainees, (b) Australia vs. New Zealand, (c) Metropolitan vs. Regional Rural

Qualitative Feedback – Geographic Maldistribution of EM Workforce

When respondents were asked to provide a reason(s) for their response to the statement ***'Despite the growth in FACEMs and FACEM trainee numbers, there is a persistent maldistribution of the emergency medicine workforce'***, 301 respondents provided a reason(s) for their responses. Of these 301 respondents, 281 strongly agreed/agreed with the statement. Table 2 below outlines the themes of these comments and provides representative comments for each theme.

Most of the comments overall were focused on the lack of and/or less FACEMs and/or FACEM trainees in rural and regional (RR) areas, the lack of permanent FACEM employment opportunities in metropolitan regions, with large numbers of job vacancies in RR areas, and difficulty recruiting to jobs in RR areas. The desire for a work-life balance and family needs also emerged as a theme.

Table 2 Themes and representative comments among respondents who were in agreeance with the statement 'Despite the growth in FACEMs and FACEM trainee numbers, there is a persistent maldistribution of the emergency medicine workforce.

Theme	Representative comments
Limited FACEM employment in metropolitan areas (99) *Oversupply of FACEMs/ FACEM trainees* *Maldistribution – lots of jobs in RR area*	Continue to see 0 FTE VMO contracts in major metro EDs & many emails from locum agencies looking for FACEMs in rural regional EDs Metro centres are rostering FACEMS for night shifts so they can give the new FACEMs graduating jobs, while many rural and regional departments are just trying to cover rosters.
Insufficient FACEMs and/or FACEM trainees in RR areas (61)	Working in a regional centre we (along with our colleagues in similar facilities) face difficulties in attracting and retaining FACEM trainees with most of our middle grade positions filled by often relatively junior non-training PHOs. Increase in trainee and FACEM numbers not seen at regional sites. Locums required to staff departments. Inadequate decision makers, not meeting targets as per ACEM guidelines.
Difficulty recruiting to RR areas (45)	Despite increasingly large numbers of FACEMs qualifying, there are still shortages of good quality permanent FACEMs in non-tertiary, regional and rural EDs. Many regional and rural centres have to rely on locums, causal and fractional staff. Recruitment into rural and regional areas has been very challenging for many years and there is an ongoing demand as indicated by call outs for FACEM locums…
Work-life balance (26) *Family commitment* *Preference of city lifestyle*	The decision to work remotely may be in appealing in nature but impractical in practice when it comes to balancing family / spouse / schooling etc. Unless the whole family can readily relocate to the country then it is not really a workable option, hence why the majority of people remain in urban centres post training.
Metrocentric training program / training requirements 'easier' to fulfill at metro sites (24)	A training program that historically has not required or really promoted smaller regional and rural placements perhaps has led to this - trainees have neither the personal exposure to these environments (which can lead to later wanting to move to smaller places) or the clinical skills breadth to work in them.
Reliance on locums in RR(23)	Rural hospitals don't have emergency trained staff to cover their shifts.
Funding differences (15) *Less resource/ financial support in non-tertiary and/or RR EDs*	There are also issues with funding in regional centres – some FACEMs would happily work in more regional areas but they would only be employed as an SMP, and not have the full FACEM remuneration they would be entitled to in an urban setting.

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

Of those respondents who disagreed, 10 provided comments. Overall, these comments indicated a general disagreement with the statement and/or that a smaller specialist workforce in RR areas was due to smaller populations in RR areas. For those respondents who were neutral or did not know, 9 provided comments. These comments specified that the respondents did not have experience and/or knowledge of the workforce profiles in RR areas.

Of the 281 respondents who agreed with the statement *'Despite the growth in FACEMs and FACEM trainee numbers, there is a persistent maldistribution of the emergency medicine workforce'*, they were also asked to outline *'How does this issue present in your ED/Hospital/local health network/jurisdiction'*. A total of 271 provided comments, with some themes already reported on in Table 2. There were however a number of

comments relating to (i) the impact on quality of care, (ii) increased burnout, and these themes are summarised below in Table 3.

Table 3 Themes and representative comments relating to statement 'How does this issue i.e. geographic maldistribution - present in your ED/hospital/local network/jurisdiction'

Theme	Representative comments
Impact on clinical coverage/ Lack of Senior Decision Makers (101)	There is little continuity of staff, lack of ability to develop non clinical and departmental resources and ultimately a non-economically viable way of providing health care to a large regional and remote population. On occasions when the vacant FACEM shift is covered by a non-FACEM, though of some help in decreasing personal patient load, often doesn't negate the FACEM's role in decision making.
Can't attract staff/ Difficulty recruiting (44)	Outer-metro hospitals also find it harder to attach staff compared to the inner city hospitals even though we have a great case mix. It can be a struggle to recruit trainees to some hospitals, despite these hospitals being able to offer terms in retrieval, anaesthesia, ICU, paeds, medicine. There is a reliance on GPs and locums to cover rural and regional EDs.
Impact on quality of care (42)	Many fractional appointees on casual contracts or zero hours VMO - impacts on inability to improve clinical support aspects on the ED. Inadvertently increases the number of referrals to major hospitals, also reduces the overall level of referral, adding to workload in major centres and retrieval teams/ etc.
Reliance on locums and increased fragmentation of care (35)	Rural hospitals in our region are unable to staff their ED; 50% of their weekly roster is filled by locums. Constant registrar roster issues. Persistent locum burden and the potential detrimental effects of this - having unfamiliar staff working in an unfamiliar environment.
Burnout (22)	Chronically working with low level consultant cover which is a negative impact on patient care, training of all JRMO's and trainees and is poor for staff morale.
Increased patient transfers (14)	Large numbers of transfers in from remoter areas, late presenting disease

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

Qualitative Feedback – Inequities in Health Outcomes

When respondents were asked to provide a reason(s) for their response to the statement '***Geographic Maldistribution of the EM Workforce contributes to inequities in health outcomes and health access for communities***', 242 respondents provided a response. Of these, 221 strongly agreed/agreed with the statement, with Table 4 outlining the main themes of these comments, and representative comments for each theme.

Table 4 Themes and representative comments for respondents who were in agreeance with the statement 'Geographic maldistribution of the EM workforce contributes to inequities in health outcomes and health access for communities'.

Theme	Representative comments – Strongly Agree / Agree
Lack of specialist workforce (137) *Junior/ less skilled workforce*	Less senior decision makers --> increased risk of suboptimal care/clinical mistakes. It also leads to burnout and apathy in staff which is also a risk factor for suboptimal clinical care Lack of specialist workforce and oversight in rural and remote areas results in lower levels of care being delivered to an already disadvantaged group.
Variable care and/or poorer patient outcomes (81)	Impacts on health outcomes for patients who do not get the benefit of early FACEM decision making input causing delays in care and poorer experience overall. Rural and regional hospitals often have either high turnover locum staff that do not have an understanding of local health needs, or who often do not have the skills required for more generalist practice;
Increased transfers (10)	Rural communities still have reasonable and timely access to critical care / tertiary level services when needed, however a number of retrievals could be avoided if you had higher

	levels of expertise in the rural areas. Patients don't really want to have to come into big urban areas unless they have to.
Limited access to required health care (10)	It is not just the emergency medicine workforce that is maldistributed. Many community health services are as well such as dialysis, chronic disease management clinics, GP clinics, imaging services. All of this leads to a community who have nowhere else to go to access primary healthcare so they present to the ED.
Fewer resources and/or less funding for RR areas (10)	This has more to do with lack of government funding of cathlabs, vascular OTs, MRIs and neurosurgical OTs in regional and rural areas. People living here don't get the same options as those living in metro areas.
Other (29) *Multifactorial, not solely due to workforce maldistribution* *General agreement with the statement*	This is beyond staffing. It's about models of care, lack of critical care capability, geography and timeliness of presentation to the hospital for care, as well as capability at site (ie interventional radiology). I agree we need a highly trained workforce but that alone can't undo all the inequity.

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

Of those respondents who disagreed, 10 provided comments. Overall, these comments indicated a general disagreement with the statement, and that inequities in healthcare and healthcare access for RR populations were multifactorial. For the respondents who reported being neutral or not knowing, 10 provided comments. These comments were varied in nature, with some noting that nursing shortages were a bigger issue in RR areas, while others commented that the multifactorial nature of access issues in RR areas.

Of the 242 respondents who agreed with the statement *'Despite the growth in FACEMs and FACEM trainee numbers, there is a persistent maldistribution of the emergency medicine workforce',* they were asked to outline *'How does this issue present in your ED/Hospital/local health network/jurisdiction'*. The themes that emerged from these responses were largely similar with those outlined in Table 4 and included (i) variable care and/or poorer outcomes; (ii) increased waiting times and number of patient transfers; and (iii) lack of a specialist workforce.

3.2 Training Needs vs Service Needs

Of the four statements regarding training vs. service needs, the largest proportion (70%) of respondents were in agreeance with the statement that the ED service needs are often prioritised over FACEM training needs. Whereas just about half of the respondents were in agreeance with statements that heavy reliance on high number of trainees to staff EDs will have a negative impact on quality of FACEM training experience (48%) or has resulted in limited permanent employment opportunity for FACEMs (56%).

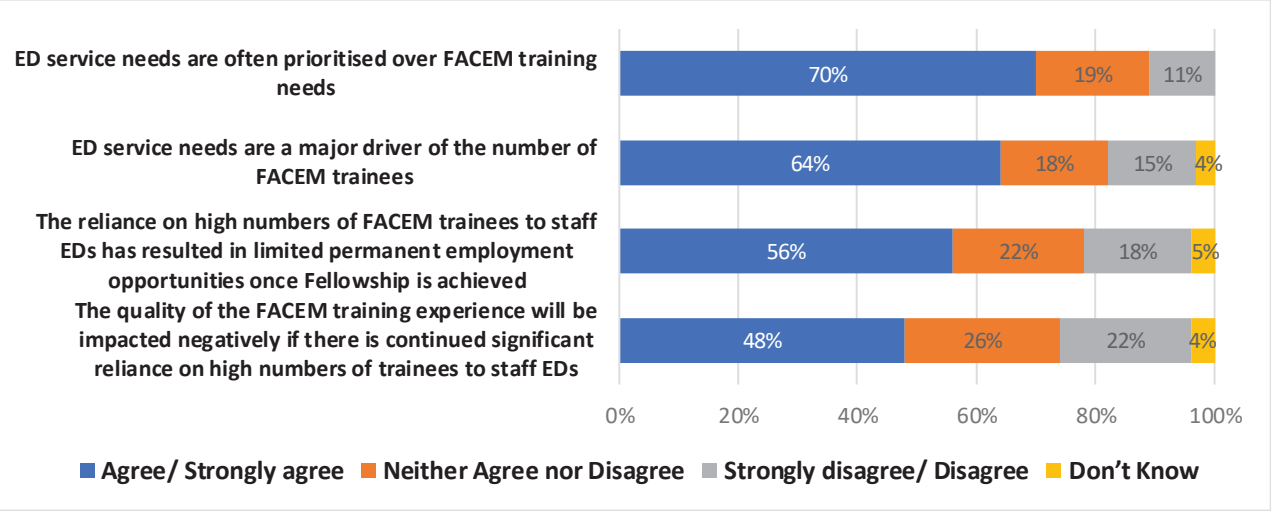

Figure 2 Level of agreement of respondents with the four statements relating training and service requirements/ needs

Note: Between 15-28 respondents did not provide a response re agreement level with the statements, and were excluded from the analysis

FACEM trainees were significantly more likely than FACEMs to agree with the statement that ED service needs are often prioritised over their training needs (80% vs. 67%) (Figure 4a). They were more likely than FACEMs to agree with statements that the quality of FACEM training experience will be negatively impacted (57% vs. 47%) or there will be limited permanent employment opportunity for FACEMs (61% vs. 55%) if there is ongoing significant reliance on high number of trainees to staff EDs. Respondents who reported currently working in a Regional- Rural location were significantly more likely than those reported working in the metro/urban locations to agree that the reliance on high number of trainees to staff EDs has resulted in limited permanent employment opportunities once Fellowship is obtained (62% vs. 50%), and that ED service needs are a major driver of the number of FACEM trainees (68% vs. 60%) (Figure 4c).

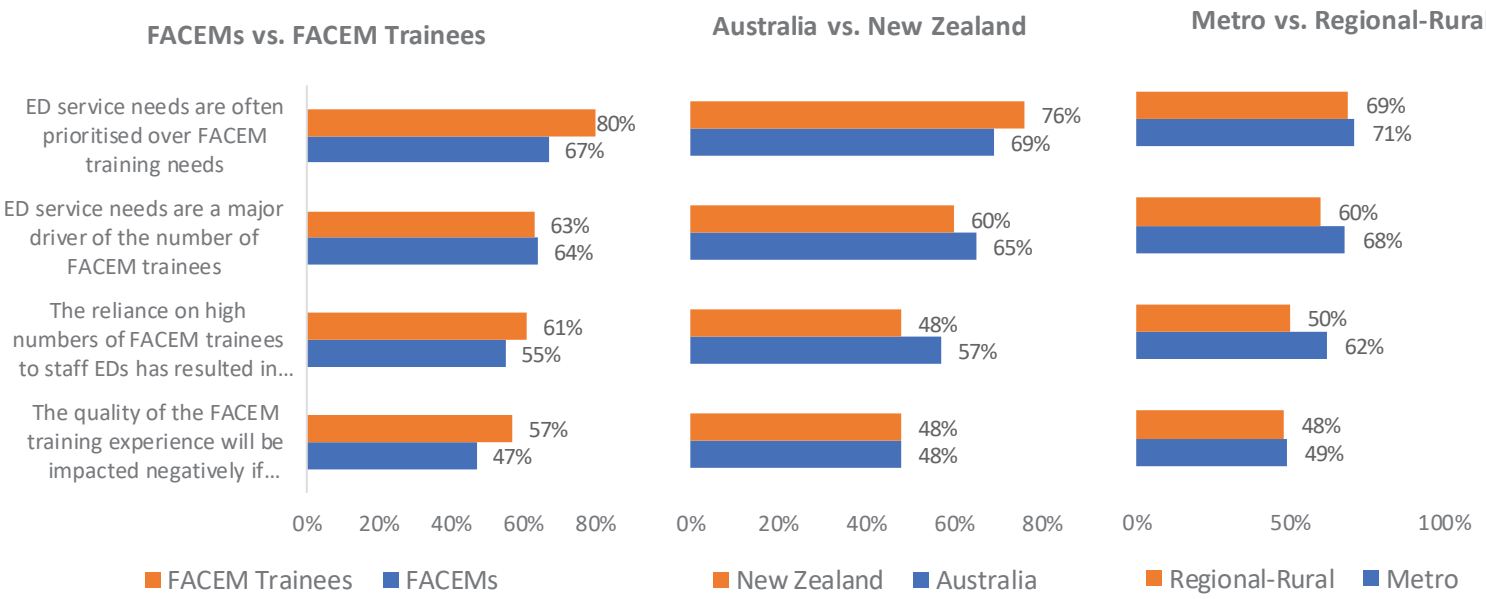

Figure 3 Proportions who were in agreeance with the statements re training and service needs, comparing (a) FACEMs vs. FACEM trainees, (b) Australia vs. New Zealand, (c) Metropolitan vs. Regional Rural

Qualitative Feedback – ED Service Needs Driving Trainee Numbers

When respondents were asked to provide a reason(s) for their response to the statement *'**Emergency Department Service Needs are a Major Driver of the number of FACEM Trainees**'*, 241 responded. Of these respondents, 211 strongly agreed/agreed with the statement, and 156 provided a reason for this. Table 5 outlines the main themes of these comments and representative comments for each theme.

Table 5 Themes and representative comments for respondents who 'Strongly Agreed/Agreed' to the statement 'ED Service Needs are a Major Driver of the Number of FACEM Trainees'.

Theme	Representative comments – Strongly Agree / Agree
Trainee number is matched with the roster requirements (83) *Prioritised service provision over training* *Loss of procedural training opportunity in busier ED*	The busier the ED, the more junior staff that are required. Unfortunately, hospitals equate service needs with trainee numbers. This should not be the case Service provision is an increasing focus, particularly of the larger centres. Ironically, it is often easier for trainees to get procedural skills exposure in smaller facilities where it's not possible for eg the CVC to be left for ICU to do. The bulk of the clinical work is done by the middle range registrar body. This is most evident in the continuation of night shift rostering being allocated to registrars, despite the disappearance of the traditional 'lull' of presentations in night shift hours.
Trainees to staff middle-grade workforce roster (40) *An alternative to CMO workforce* *As senior decision maker especially during night shifts*	EDs need senior trainees to act as senior decision makers, particularly overnight from the service provision point of view.
Trainees are required to cover night-shift (16)	The trainees make up a large proportion of the medical workforce and particular reliance on night cover. This is a greater issue when trainees, particularly those in advanced training are rotated to smaller sites. They are at risk of being rostered a greater proportion of night and even shifts.

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

Fifty respondents strongly disagreed/disagreed with the statement, and 44 provided comments. Comments were varied and included reference to (i) emergency departments being staffed by a variety of practitioners; (ii) junior medical officers making up the majority of ED rosters; (iii) emergency medicine as a popular specialty; and (iv) a good workplace culture attracting more staff. Of the respondents who reported being neutral or not knowing, 19 provided comments. The majority of these comments noted that high numbers of FACEM trainees were not representative of the situation in RR areas.

For the 211 respondents who strongly agreed/agreed with the statement *'Emergency department service needs are a major driver of the number of FACEM trainees*, they were also asked to outline ***'How does this issue present in your ED/Hospital/local health network/jurisdiction'.*** The themes that emerged from these responses were again the same as those outlined in Table 5, however two additional themes emerged – (i) anxiety for advanced trainees regarding FACEM job prospects; and (ii) trainees experiencing burnout due to busy workload and increased nightshifts.

Qualitative Feedback – ED Service Needs are Prioritised

When respondents were asked to provide a reason(s) for their response to the statement '***ED service needs are often prioritised over FACEM training needs***', 260 responded. Of these respondents, 188 strongly agreed/agreed with the statement. Table 6 outlines the main themes of these comments and provides representative comments for each theme.

Table 6 Themes and representative comments for respondents who 'Strongly Agreed/Agreed' to the statement 'ED Service needs are often prioritised over FACEM training needs'.

Theme (context of comments)	Representative comments – Strongly Agree / Agree
Supervision and teaching impacted (70)	Due to work load and low levels of FACEM supervisors trainees get minimal supervision and most procedures get pushed to happen in other places (ICU/Anaesthesia) or the doctors of other specialities are being called to do them as the focus is on getting the ED work force to 'assess' as many cases as possible and ref them on rather than treat them. FACEMs rarely get to teach a junior procedures eg central lines or intubation. As ED workload has increased there has been less opportunity for teaching in the clinical environment. FACEMs are so stretched with workload demands that they cannot spend as much time supervising trainees on clinical shifts. Protected teaching time is often cancelled as ED workload takes priority. Most EDs are forced to run with no redundancy in their rosters for sick leave, parental leave, exams etc which means that the only redundancy comes from cancelling protected teaching time & limiting access to annual leave. Unfortunately due to the ED's becoming busier and not enough staffing the trainees are not getting the bedside/detailed feedback.
Significant increase in ED workload (52)	We have a model of care that is left over from the days when ED were staffed by whoever was left over once all the other specialties were full. Because it seems cheaper, we have chosen to staff our EDs with a large number of junior doctors and a smaller number of consultants. = We need senior people after hours....i.e. registrars. The only way (at present) to get registrars is by offering ACEM training. The college needs to consider how else one may work in a middle grade position in an ED - eg CMOs, EMDs.
Service is prioritised (45)	Rostering reflects needs of the ED ie majority evening and night shifts rather than rostering best practice. Trainees often cannot be supervised to the best extent as their simply aren't enough senior staff to attend to all their patients. Departmental staffing completely replies on trainee availability to staff the department - and if they do not have enough trainees this falls over and their department cannot meet the requirements to see the numbers of patients safely. When FACEMs are the sole senior clinical decision maker in the department, and the sole provider of complex procedural skills, there is little time or cognition to devote to training without increasing patient wait times, reducing FACEM oversight of the department as a whole.
KPIs are the priority (25)	The demands of time based management targets and referral based disposition, effects development of broader EM skills, cognitive ability and procedural skills. Access block and overcrowding alongside increasing demand (and patient expectations) do not often allow the opportunity for bedside teaching.
Ability for trainees to access procedures is impacted (13)	Procedures that are commonly performed in ED are often delayed, or referred to inpatient units for management as there is insufficient FACEM/senior staff to supervise and support FACEM trainees/other junior doctors performing these procedures.

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

For the respondents who strongly disagreed/disagreed, 30 provided comments, with these comments primarily highlighting that teaching time within their site was prioritised and/or protected. Of the respondents who reported being neutral/ not knowing, 42 provided comments. These comments also noted that teaching time was protected and/or the impact on training was minimal/didn't happen often. Other respondents suggested that the intertwined nature of specialist training and service provision was to be expected.

Of the 188 respondents who agreed with the statement *'ED service needs are often prioritised over FACEM training needs'*, they were also asked to outline ***'How does this issue present in your ED/Hospital/local health network/jurisdiction'***. The themes that emerged from these responses were the same as those outlined in Table 6 and included (i) the quality of training being impacted; (ii) a focus on KPIs; and (iii) staff shortages exacerbating the impact on training.

Qualitative Feedback – High Trainee Numbers have Limited Permanent FACEM Employment

When the respondents were asked to provide a reason for their response to the statement ***'The reliance on high numbers of FACEM trainees to staff emergency departments has resulted in limited permanent employment opportunities once Fellowship is achieved'***, 237 did so (Table 7). Generally, most of the comments were focused on workforce maldistribution issues, where this is primarily an issue in metropolitan areas with still plenty of jobs available in rural remote areas. The disproportionate increase of trainee numbers each year has caused a shift in workforce trends (e.g. increases to the number of zero hour contracts, those working part-time or as locums, and an increase in dual-specialisation), particularly in metropolitan or major EDs. Whilst trainees may be preferred as a cheaper workforce, large numbers of trainees were perceived as essential to serve as the middle-grade workforce (primarily to cope with increasing ED presentations) and to cover evening/ night/ weekend shifts. There was also feedback about expanding the roles of FACEMs and that ACEM should play a key role in advocating for more FACEM positions and mandating the G23 staffing guidelines.

Table 7 Themes and representative comments relating to the statement' 'The reliance on high numbers of FACEM trainees to staff emergency departments has resulted in limited permanent employment opportunities once Fellowship is achieved'.

Theme	Representative comments
Mainly an issue in metropolitan or major centres (99)	Given that FACEMs are focussed within the Metropolitan environment and there is an increased number of trainees with over 1 trainee per currently employed FACEM there will not be a full-time job for each graduating FACEM. This will create a bottleneck. It is true only for capital city employment. There remain many opportunities for employment in other locations. We still don't have enough local trainees to fill our permanent positions and are still relying on SIMGs.
Disproportionate increase of trainees to FACEM job availability (27)	The time it takes to get a job coming out of fellowship is clearly rising, and many FACEMS are increasingly under employed or not employed efficiently. As Fellowship candidates rise year on year, this problem will only become more unsustainable...
Compromise for below specialist position or zero hour contract (21)	There are very few substantive ED consultant posts in metro or regional areas. 6-month locum contracts are used with no access to sick leave/mat leave etc. The likelihood is this is how the next generation of FACEM's are going to be employed over the next 10 years.
ACEM plays a role (18) *Advocate for more FACEM positions/ mandate G23 (8); match new trainee uptake with workforce need (7); higher standard for Fellowship (3)*	Only a minority of EDs are actually staffed to the ACEM recommended G23 level so there is a lot of FACEM positions that could be potentially created if funded but I can't see that situation changing unless ACEM mandates G23 level of staffing... ACEM should focus on a more 'distilled' cohort of highly motivated and high-quality trainees with realistic career prospects, and ensure equitable distribution of this workforce across metro and non-metro areas. Quality over quantity.
Cost consideration (17) *More cost effective to recruit trainees*	This is because trainees are a cheaper workforce than FACEMs! The need for trainees to see patients, doesn't translate into FACEMs seeing patients either. Once fellowed, FACEMs tend to stop seeing patients, so our role in service provision becomes less. This is the difference between FACEM led or FACEM delivered services.

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

3.3 Sustainability of a FACEM Career

Over three-quarters (77%) of respondents were in agreeance with the statement that the overall sustainability of a FACEM career has decreased due to the increasing pressures on the emergency care system, however 10% disagreed with this statement and another 12% were neutral (Table 8). Relatively comparable responses were shown in various subgroup comparisons.

Table 8 Level of agreement of respondents with the statement relating to the sustainability of a FACEM career, overall responses and subgroup comparisons.

	The overall sustainability of a FACEM career has decreased due to the increasing pressures on the emergency care system						
	Overall response, n (%)	FACEMs (%)	FACEM Trainees (%)	Australia (%)	New Zealand (%)	Metro/ urban (%)	Regional-Rural (%)
Strongly agree/ Agree	244 (77%)	78%	74%	77%	82%	78%	76%
Neither agree nor disagree	39 (12%)	12%	15%	13%	7%	12%	13%
Strongly disagree/ Disagree	32 (10%)	10%	11%	10%	11%	10%	10%
Don't know	2 (0.6%)	0.4%	0%	0.4%	0%	1%	1%

Note: 30 respondents did not provide a response, and were excluded from the analysis

Qualitative Feedback – Sustainability of a FACEM Career

Respondents were asked to provide a reason(s) for their response to the statement '***The reliance on high numbers of FACEM trainees to staff emergency departments has resulted in limited permanent employment opportunities once Fellowship is achieved***'. Table 9 provides a representative sample of comments from the main themes that emerged.

Table 9 Themes and representative comments relating to the statement' 'The overall sustainability of a FACEM career has decreased due to the increasing pressures on the emergency care system'.

Theme	Representative comments
Burnout/ Stress/ Low morale (96)	A lot of us are burned out or nearly burned out. Access block, bed pressures and staffing issues are key issues that lead to anxiety, stress and subsequent burnout. Feeling overwhelmed and like the department/patient care is out of control is a key contributor to work stress and workplace negative interactions. Burnout is a major issue. Covid has brought a reprieve, but usual presentation numbers, complexity, interruptions and staffing shortfalls = high burnout specialty.
Sustainability of work (Full time) (91)	I can't imagine being a FACEM at 60. Our role is mentally very demanding, as well as the physical implications of long term shift work. It is non sustainable up until retirement age unless working reduced hours or more non-clinical... As there seems to be increase forthcoming in terms of more staff numbers on the floor at any one time, or beds in the hospital, the only way to diffuse this is to work less shifts allowing more recovery time.
Workload/ increasing presentation numbers (75)	Busier EDs every year with higher number of presentations, more complex and sicker patients, more access and bed block, COVID pandemic, climate change = all new and added stressors, reducing the sustainability of a FACEM career. Workloads are increasing faster than staffing is increasing, such that each FACEM is working harder than the previous generation. Absence of downtime, meal breaks, or even ability to speak to one's team degrades the work experience and makes one less likely to continue

Access block / overcrowding (37)	A focus on improving access block across metropolitan centres would help to alleviate this stressor and improve workforce sustainability.
Under-staffed (31)	Hiring of FACEMS based on financial criteria rather than need.
Responsibility for KPIs (26)	There is a focus on the patient numbers coming through the ED, and how quickly they are managed etc. The pressure to 'churn' is increasing.

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

4. Part 2 - Potential Solutions – Member Feedback

This section outlines the member feedback received in response to *Part 2* of the Workforce Issues Paper. This section of the paper outlined a number of potential solutions, to address the issues outlined in Part 1. As part of the consultation survey, members were then asked to rate their agreement to the proposed solutions.

4.1 Alternative accreditation models – Accreditation of Individual Training Posts and/or Establishing Accredited Training Networks

A significantly higher proportion of respondents strongly agreed or agreed with the proposed solution to accredit networks of EM training (comprised of accredited training posts), compared with the proposal to accredit 'individual training posts' (70% vs. 51%) (Figure 5).

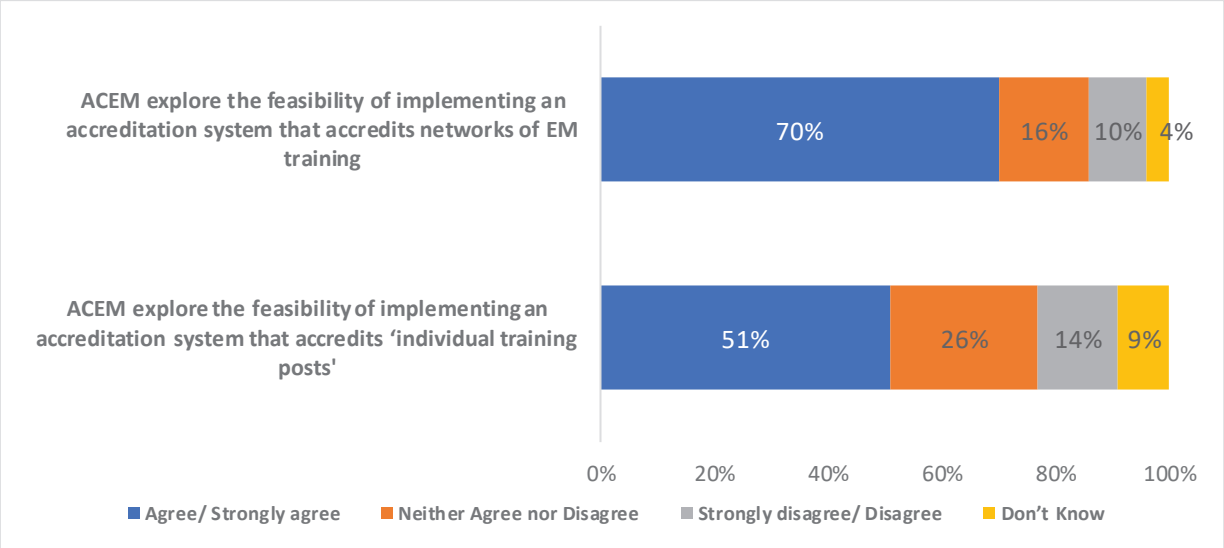

Figure 4 Level of agreement of respondents with the statements relating to proposed accreditation of individual training posts or networks of EM training

Note: Between 46 and 53 respondents did not provide a response re. agreement level with the above statements, and were excluded from the analysis

FACEMs were more likely to agree with both proposals than FACEM trainees, however this was partly due to trainees being more likely to report 'don't know' in their responses (Table 10). More comparable agreement levels were seen when this was compared by country or workplace location of respondents' primary workplace.

Table 10 Respondents' agreement levels with proposals to accredit 'individual training post' and/ or networks of EM training, comparing FACEMs vs. FACEM trainees, Australia vs. New Zealand, and Metropolitan vs. Regional Rural

	[a] ACEM explore the feasibility of implementing an accreditation system that accredits 'individual training posts'						[b] ACEM explore the feasibility of implementing an accreditation system that accredits networks of EM training					
	FACEMs (%)	FACEM Trainees (%)	Australia (%)	New Zealand (%)	Metro/ urban (%)	Regional -Rural (%)	FACEMs (%)	FACEM Trainees (%)	Australia (%)	New Zealand (%)	Metro/ urban (%)	Regional -Rural (%)
Strongly agree/ Agree	**54%**	**42%**	51%	56%	50%	53%	**72%**	**62%**	70%	71%	70%	70%
Neither agree nor disagree	25%	29%	26%	28%	25%	27%	17%	15%	15%	21%	18%	15%
Strongly disagree/ Disagree	15%	11%	15%	7%	16%	13%	10%	13%	11%	5%	9%	11%
Don't know	**6%**	**18%**	8%	9%	10%	8%	**3%**	**11%**	5%	2%	4%	5%

[a] 46 did not provide a response re agreement level with the statement; [b] 53 did not provide a response re agreement level with the statement

Qualitative Feedback – Accrediting Individual Training Posts

Respondents were asked to provide a reason(s) for their response to the proposal '***ACEM explore the feasibility of implementing an accreditation system that accredits individual training posts***'. Table 11 outlines a representative sample of comments from the top themes that emerged.

Table 11 Themes and representative comments relating to the statement' 'ACEM explore the feasibility of implementing an accreditation system that accredits individual training posts'.

Theme	Representative comments
STRONGLY AGREE / AGREE	
Improve training experience (33)	Means that ACEM is in control of training experience rather than hospital employing a workforce to for service provision at expense of training. It will provide a certain 'protection' for the trainee and stop departments employing large numbers of registrars simply because they need feet on the ground to do the work.
Result in equitable distribution between metro and rural-regional EDs (25)	It might stop hoarding of trainees in the bigger and more geographically popular centres. A downside is that it may make FACEM training less popular overall. This is good for trainees and good for regional hospitals and hospitals that struggle to adequately staff. However it also takes away an incentive for a hospital to do a good job of training (i.e it won't result in people coming back/adequate staffing).
Limit the number of trainees (15)	It potentially provides a means of managing trainee numbers, as well as hopefully ensures that trainees get quality training, rather than just being used as a workforce to churn numbers.
Worth exploring (13)	I'm not sure about the pros and cons of doing individual training posts, however it is a question worth asking as long as the potential advantages (and disadvantages) are well enough understood prior to a decision to proceed.
STRONGLY DISAGREE / DISAGREE	
Issues with non-accredited positions (15)	There will be an impact on the junior medical workforce, the risk of bullying from newly created power structures with departments .
Administration/ governance (9)	Given the complexity of each department, and the rules and regulations surrounding site accreditation, adding further red tape to each worksite will take more FACEMs from the floor and provide less supervision to trainees. This would be especially true in smaller departments.
Cause further inequity (rural) (6)	This will entrench, rather than fix inequity and maldistribution. The places that get training sites based on accreditation standards are likely to be big tertiaries.
Logistics (6)	I'm not sure we have the tools yet to accurately measure the quality of a specific training experience and determine how many trainees could reasonably be accommodated at a particular site. Would be very clunky.

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

Respondents who agreed with the proposal were also asked to provide comment on the ***'Challenges that implementing this solution would present'***. Table 12 outlines a representative sample of comments from the main themes that emerged from these responses.

Table 12 Themes and representative comments relating to the 'Challenges that implementing the accreditation of individual training posts would present'

Theme	Representative comments
Buy-in (32)	There will be a lot of backlash from individual departments due to what they see as an impact on their staffing levels. There would need to be a lot wo work from the College to come up with a plan that allows a fair distribution of trainees across metro and regional areas based on patient needs/number of presentations and the department's ability to train these trainees. Persuading trainees that moving is OK and that they just may enjoy being out of their comfort zone. Impact on families. Setting an expectation that a variety of workplaces is good

	for training.
Administration/ governance required (19)	It will need ongoing monitoring and regulation of the training posts, to ensure that they meet the training requirements.
Issues with non-accredited positions (12)	It may create a tiered system in departments, where non-trainee ED registrars may not get access to appropriate education and training, and instead used purely to churn through the workload.
Adequate supervision (Accredited, non-accredited registrars, telehealth, FACEMs to supervise) (11)	Also, the number of non-trainees who also need to be supervised (it could be said they need more intense supervision than trainees) needs to be considered. Mainly cost to hospitals - would need to employ additional FACEMs to ensure adequate supervision and training.

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

Qualitative Feedback – Accrediting Training Networks

Respondents were asked to provide a reason(s) for their response to the proposal '***ACEM explore the feasibility of implementing an accreditation system that accredits networks of EM training***. Table 13 outlines a representative sample of comments from the main themes that emerged.

Table 13 Themes and representative comments relating to the statement' 'ACEM explore the feasibility of implementing an accreditation system that accredits networks of EM training.

Theme	Representative comments
STRONGLY AGREE / AGREE	
Improve training experience (50)	Different skills are to be gained in different levels of ED as both presentations and resources differ. A network allows trainee exposure to this. This is generally a good idea and would allow networks that offer comprehensive training across multiple sites that each offer something different to flourish, as well as give continuity to trainees
Improve equity/ workforce at rural sites (46)	Helps support regional & rural EDs who can't attract senior trainees. Spanning training and the FACEM workforce across multiple sites (especially when that includes rural/regional centres) has many advantages. You build professional relationship across hospitals which helps for the transfer of critical patients. Regional/rural sites gain increased access to FACEMs and trainees. It provides trainees with their required rural time.
Support the concept (37)	Agree in principal but it depends on the clustering of sites. An accredited network of training that consists of a balanced representations of metropolitan, regional and rural centres will be an excellent way of addressing multiple issues raised in part 1 particularly in association with accredited training posts in individual hospitals.
Improve equity/ workforce distribution across sites in network (21)	This is an option that would see more trainees evenly distributed. However all networks must be seen as equal or near equal. There must be a sufficient number of trainees in each network. Base sites cannot be disadvantaged if there are shortages.
Already happening to differing degrees (15)	To some extent I feel this approach is already in place with networks sharing registrars between rural and urban hospitals to ensure trainees can meet current training requirements for tertiary and rural/district hospital exposure.
Improve cooperation between sites (12)	Hub and spoke models already exist without formal acknowledgement, making this formal will change the way directors, FACEM, and trainees view smaller sites 'networked' to a larger site
Should include rural sites (12)	Each big teaching hospital needs to be attached to a rural site and all trainees should have to rotate there.
Streamline processes, training/ reduce duplication (11)	It also allows the departments to share training resources across the network. This will be more efficient - less time recruiting, less time DEMTs spend on admin, ability for trainees' procedural credentials to travel with them.

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

Respondents who agreed with the proposal were also asked to provide comment on the ***'Challenges that implementing this solution would present'***. Table 14 outlines a representative sample of comments from the main themes that emerged from these responses.

Table 14 Themes and representative comments relating to the 'Challenges that implementing the accreditation of networks of EM training would present'

Theme	Representative comments
Buy-in (39)	Again possibly some reluctance from trainees in some areas who do not want to have to move with training. A willingness of health services to form these liaisons.
Ensure cooperation between sites (major/ tertiary and smaller sites) (38)	Getting an equal voice from each health service in the network. Will need a robust system of ensuring networks function, that commitments to rotate are completed, can't be seen as 'voluntary' by the larger centres.
Loss of flexibility (24)	This would severely limit the flexibility that we all love about the ACEM program. It would probably result in more trainees working in places they don't really want to.
Maintaining equity across sites in network (18)	A major challenge would be to ensure that equitable training time is allocated to participant sites in a network to ensure adequate exposure to regional and rural emergency medicine trainees to ensure a well-rounded EM training.
Resources & logistics to implement/ manage (16)	The difficulty will be determining which site is linked to another site. Is it based on health service district? Who determines this? Logistical difficulties in managing a large cohort of trainees across multiple sites.
Impact workforce at rural sites (8)	Coordination, ensuring that rural sites are not left out as second class citizens

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

4.2 Building the non-FACEM Senior Decision Maker Workforce

In response to the proposal that ACEM develop detailed guidelines for health services regarding the role of non-FACEM senior decision makers in EDs and the requisite qualifications for these roles, two-thirds (65%) of respondents strongly agreed or agreed with this (Table 15). In the subgroup comparisons, FACEMs showed a higher level of agreement to this statement, whilst FACEM trainees were more likely to report 'neither agree nor disagree' or 'don't know'. Respondents who worked primarily in Australia were more likely than those in New Zealand to agree with this proposal, whilst more comparable levels of agreement were seen when this was compared by workplace location (ie metro/urban vs. regional-rural).

Table 15 Respondents' agreement levels with proposal to define the non-FACEM senior decision maker workforce, overall responses and subgroup comparisons

	ACEM develops detailed guidelines for health services regarding the role of non-FACEM senior decision makers in EDs and the requisite qualifications for these roles						
	Overall response, n (%)	FACEMs (%)	FACEM Trainees (%)	Australia (%)	New Zealand (%)	Metro/ urban (%)	Regional-Rural (%)
Strongly agree/ Agree	189 (65%)	67%	53%	66%	54%	66%	63%
Neither agree nor disagree	56 (19%)	18%	26%	18%	29%	18%	21%
Strongly disagree/ Disagree	33 (11%)	13%	4%	11%	15%	12%	11%
Don't know	15 (5%)	2%	18%	6%	2%	4%	6%

Note: 54 respondents did not provide a response re agreement level with the statement, and were excluded from the analysis

Qualitative Feedback – Defining the non-FACEM Senior Decision Maker Workforce

Respondents were asked to provide a reason(s) for their response to the proposal '***ACEM develops detailed guidelines for health services regarding the role of non-FACEM senior decision makers in EDs and the requisite qualifications for these roles***'. Table 16 outlines a representative sample of comments from the main themes that emerged.

Table 16 Themes and representative comments relating to the statement' 'ACEM develops detailed guidelines for health services regarding the role of non-FACEM senior decision makers in EDs and the requisite qualifications for these roles'.

Theme	Representative comments
STRONGLY AGREE / AGREE	
Standardise responsibilities and expectations (49)	Clarity of the level of experience/ acceptable qualifications would be absolutely necessary. Help in clarifying qualifications needed for staff to fill these roles.
Improve workforce stability/sustainability (18)	I believe this role is essential in the future workforce and ACEM should guide how this is structured to aid the ED in supporting and retaining these staff. Hope that this would result in a more stable workforce - with opportunity to provide consistent staffing during protected teaching times, weekends etc.
Enhance quality care (14)	This would be a realistic end goal to achieve good standards of care across Australia and NZ regional EDs.
Provide clarity to staff & health services (11)	There is a lot of individual disagreement about who this describes, and what their role is particularly on a night shift in the emergency department. If ACEM were to produce guidelines, after consultation, this may produce better agreement.
Agree but will be difficult to coordinate/get buy-in (9)	By having a framework, this would assist departments. However, I am not entirely convinced they will be enforceable by the individual hospital.
Agree but could devalue FACEM qualification (4)	I would caution though as some institutions would consider this as a way to cut costs and to replace FACEM FTE with Non-FACEM senior decision makers...
STRONGLY DISAGREE / DISAGREE	
Not ACEM's role (13)	ACEM's role is to train people to manage healthcare emergencies. It is within scope to define the attributes of a senior decision make but it not within scope to tell the health system how to structure their ED.
Non-FACEM SDMs are not the solution (11)	It also does not address the underlying problem. If we create positions for non FACEM SMO's they will just be competing with FACEM's for these senior positions.
Disenfranchise health services/ doctors (6)	ACEM defining guidelines for health services regarding requisite qualifications is likely to dis-enfranchise a large proportion of non-FACEM Doctors who already provide a lot of the EM service in non-FACEM staffed hospitals.

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

Respondents who agreed with the proposal were also asked to provide comment on the ***'Challenges that implementing this solution would present'***. Table 17 outlines a representative sample of comments from the key themes that emerged from these responses.

4.3 Improving Rural Training Opportunities and Addressing Geographic Maldistribution

Four proposed solutions were put forward with the aim to improve the long-term geographical distribution of the workforce, and the agreement levels of respondents are shown in Figure 6. The most preferred proposed solution was that ACEM introduces a mandatory rural training term to all new FACEM trainees (74%). In comparison, only 62% agreed on a mandatory rural experience imposed (working and/ or studying rurally) to all new FACEM Training Program applicants, with nearly one quarter (23%) of respondents disagreeing with this. The least preferred suggestions were that ACEM develops and pilots a Rural Training Pathway (58%) or ACEM explores the feasibility of incorporating remote supervision options (55%).

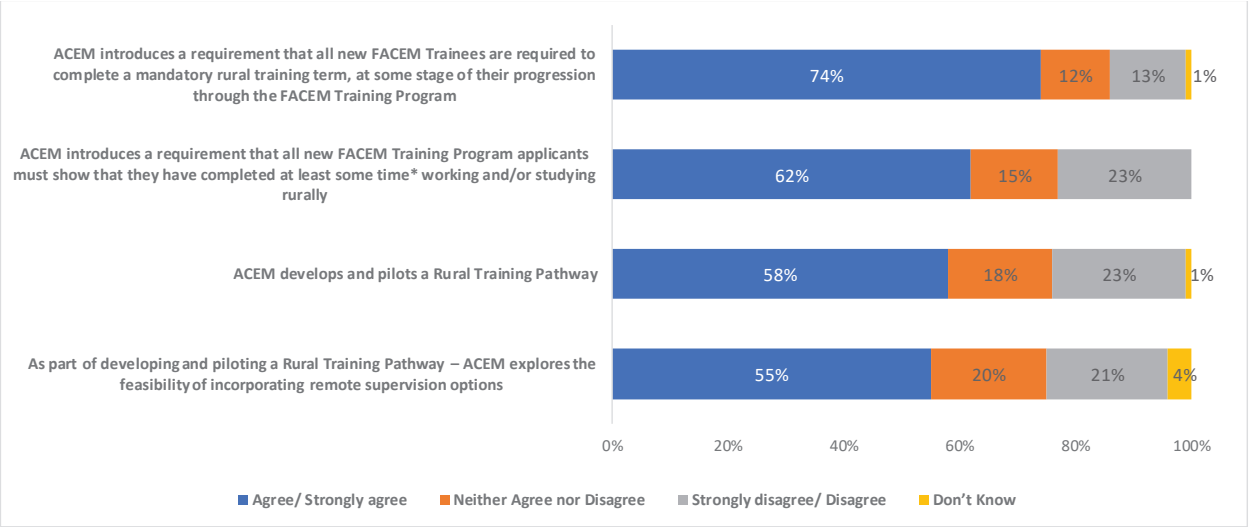

Figure 5 Level of agreement of respondents with the statements relating to proposed solutions to improve long-term geographical distribution of the workforce

Note: Between 54-61 respondents did not provide a response re agreement level with the statements, and were excluded from the analysis.

FACEMs were more likely than FACEM trainees to agree with all of the four proposed solutions (Figure 7a), particularly for the proposal about a mandatory rural training term to all new FACEM trainees. No specific patterns of preference were noted for comparison by workplace country (Figure 7b), with similar percentages indicating agreement with the mandatory rural training terms. Respondents who worked primarily in New Zealand however were less likely to agree with mandating new FACEM Training Program applicants to have prior experience working and/or studying rurally, or that ACEM develops and pilots a Rural Training Pathway. Whereas when assessing this by workplace location (Figure 7c), respondents who worked primarily in a regional-rural location were significantly more likely than those who worked in a metro/ urban location to agree with introducing a mandatory rural training term (86% vs. 61%) or mandatory rural experience for all new FACEM Training Program applicants (75% vs. 49%).

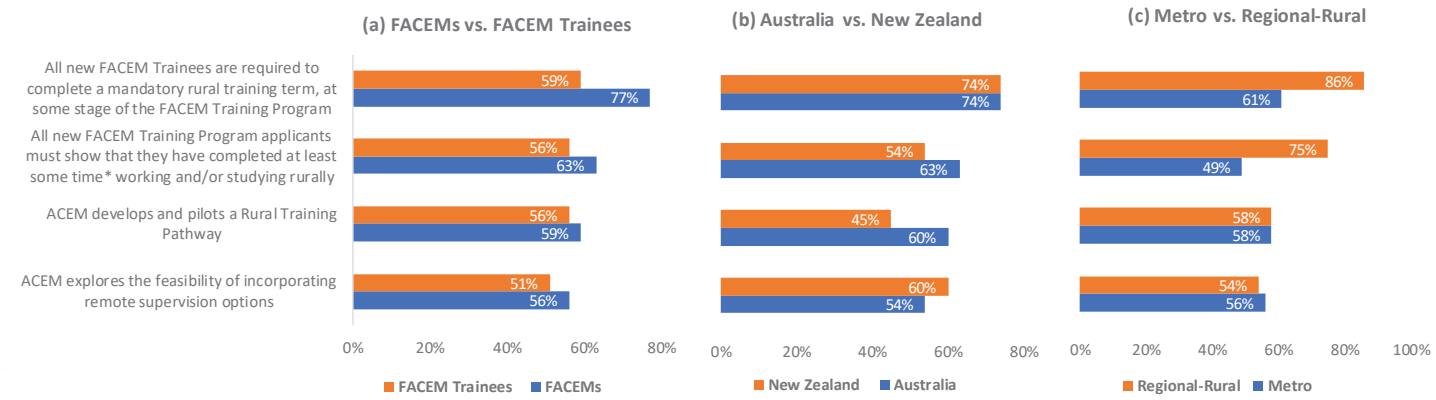

Figure 6 Proportions who were in agreeance with the statements re proposed solutions for long term geographical distribution of workforce, comparing (a) FACEMs vs. FACEM trainees, (b) Australia vs. *New Zealand, (c) Metropolitan vs. Regional Rural*

Qualitative Feedback – ACEM Develops and Pilots a Rural Training Pathway

Respondents were asked to provide a reason(s) for their response to the proposal '***ACEM develops and pilots a Rural Training Pathway***'. There were 206 respondents who provided a reason(s) for their response to the statement, with the key themes being shown in Table 18.

Table 18 Themes and representative comments relating to the statement' 'ACEM develops and pilots a Rural Training Pathway'.

Theme	Representative comments
STRONGLY AGREE / AGREE	
Reduce maldistribution (35) *Improve rural staffing, improve rural health services*	Totally agree as this will force/encourage trainees to widen their experience in emergency medicine plus provide service delivery to the often neglected rural EDs. Rural pathway will ensure that rural trainees are not disadvantaged by being forced to uproot for their metro tertiary training time. It will improve the stability for the rural workforce, increase relationship and improve long term retention of FACEM in rural and regional Australia.
Different skillset of rural regional training (21) *Low resource setting, more procedural/ hands-on*	Rural practice carries significant and unique challenges that metropolitan training insufficiently prepares FACEMs for. There is sufficient rural health need that this should be a unique sub-specialty pathway of its own. I support this in the context of allowing a trainee to complete almost all of their training in rural and regional sites with the exception of 6 months of tertiary time so that they understand how the big system works. Trainees will get a much broader exposure to emergency medicine in rural and regional sites and have more opportunities to do procedures, etc.
Stay on once connected to rural community (19) *Appreciate the attractiveness of rural health*	If people have connections to rural communities, they are more likely to return and stay.
Generally support this proposal (18)	I whole heartedly feel that this is the way forward. There should be monetary or incentives given to people who embark on a rural training pathway.
STRONGLY DISAGREE / DISAGREE	
Overlapping with other medical colleges – partnership/ joint program instead (24) *e.g. ACRRM, RACGP*	Perhaps partnering with ACRRM to have a joint qualification like PEM would be better than having our own independent qualification. ACRRM has a large workforce of rural practitioners, many of whom undertake EM training pathways already.
Important to have both metropolitan and rural components (18)	It would be best to incorporate rural/regional settings within training networks so that the knowledge/experience of working in a tertiary centre is not lost.
More proactive role from ACEM (18) *Incorporate rural term to existing training, provide better incentive or promotion*	A rural term should be required prior to entry to ACEM (this is possible even in metro areas as they have rural links), and minimum 6 months during training. The ACEM website should make it easier for rural sites to attract trainees- maybe a link to each rural site with who to approach for trainee jobs e.g. DEMT email, HR email, and details of their local area.
Mandatory rural term or network rotations more effective (15)	The solution, in my opinion, is a mandatory 6 month rural rotation and a mandatory 1-2 month remote rotation. By exposing all trainees to regional/rural practice, a number of them will 'fall in love' and consider practising there (especially if meaningful incentives exist).

DON'T KNOW / NEUTRAL	
Two-tiered system (33) *Less qualified applicants to opt for rural pathway, deemed inferior, tied to rural job as no metropolitan experiences*	This is potentially a great idea for those with a genuine interest in rural medicine, which there are a few. However, my fear is that it would create a 2-tier system. Concern that a specific rural training pathway will create 2 levels of FACEM qualification that will not be easily transferable across metro and non-metro areas A separate pathway is not sensible, as it limits metropolitan FACEMs to the cities, and rural FACEMs to the bush, and risks a long term division of skills and knowledge.

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

Respondents who agreed with this proposal were also asked to provide comment on the ***'Challenges that implementing this solution would present'***. Table 19 outlines a representative sample of comments from the key themes that emerged from these responses.

Table 19 Themes and representative comments relating to the 'Challenges that developing and piloting a Rural Training Pathway would present'

Theme	Representative comments
Low uptake (22) *Lack of incentive, not an attractive option given no entry limit to training program*	What is the incentive for trainees to go down this path?? Are they guaranteed employment post FACEM? Finding enough willing trainees maybe difficult. It would likely need to be incentivised.
Lack of senior supervision and support (19) *Including limited education opportunity*	Adequate supervision using current processes. Need to move beyond direct supervision and look at telemedicine support by the right people. What level of support will be given? Again, studying for exams without the same structure and resources as our tertiary peers makes it much less appealing.
Trainee with family commitment (15)	Yes, it is difficult to uproot a young family, which many senior trainees will have, so we have to find ways to make this work, or different options for trainees to undertake.
Logistic planning for rural placement (11) *Ensure sufficient rural posts, accessibility to rural EDs (e.g. SA), revisit definition for 'rural'*	Getting trainees to engage in them and having enough places in all jurisdictions. Making sure you do define what truly is rural, because not all rural sites are equivalent, and some have continued attractive entities such as beaches where others do not.

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

Qualitative Feedback – ACEM Explores the Feasibility of Incorporating Remote Supervision Options

Respondents were asked to provide a reason(s) for their response to the proposal '***ACEM explore the feasibility of incorporating remote supervision'***, with 167 respondents providing a response. The key themes identified were broadly divided by those who agreed vs. disagreed with the proposal (Table 20).

Table 20 Themes and representative comments relating to the statement' 'ACEM explores the feasibility of incorporating remote supervision options'.

Theme	Representative comments
STRONGLY AGREE / AGREE	
Is the way going forward (18) *Match reality of remote practice, post-covid world, advancement of IT*	Like telemedicine (which we have all gotten better at during the pandemic), remote supervision will work well for some aspects of training. For instance, there is no reason why a trainee seconded to a remote location (as part of a training network) could not continue to attend teaching sessions via a secure online platform. As a matter of fact looking beyond 2020, there is no excuse for teaching sessions not to be broadcast online/recorded as it is simply so easy to do. It is entirely wasteful for someone to prepare a solid presentation, deliver it once and for it to then 'disappear forever' when other trainees can benefit from (re)watching it.
Proper planning to ensure adequate support (10)	We already practice this sort of supervision over the night shift and feel that it could be increased during the day to some sites. There would need to be adequate supervision requirement supported by infrastructure, but it is feasible with the right investment
Proven to be practical (9)	ACRRM are already doing it, so it makes sense. Not only from a supervision point of view, but also education & teaching, even if there's not a training network per se, having a teaching network is important & very easy to execute.
Effective in networked sites (8) *Including teaching network*	Remote supervision for mentoring and to join training sessions remotely should be incorporated but this would be best as part of a larger network and not solely within a Rural Training Pathway.
More widespread use of telehealth (7)	Telehealth is an interesting option here. We could have international experts offering fantastic opportunities for supervision and observed practice and learning. This is underexplored in our specialty and education in general.
More practical in advanced training stage (6)	It is likely that remote supervision would only be useful for late phase advanced trainees who have reasonable level of independence already.
STRONGLY DISAGREE / DISAGREE	
Direct or real-time supervision/ advice is crucial (28)	Nothing beats being able to watch trainees interact with patients, hear them present multiple cases, interact with them in teaching and see how they get on with nurses, allied health, patients. this is very hard to achieve through remote supervision. Supervision for all but the most senior trainees needs to be on-site and readily available - the unpredictable and broad-based nature of EM work means that supervisory requirements for clinical work cannot be adequately planned beforehand.
Compromise the quality of training (17) *Including quality of patient care*	As a clinician, to supervise a trainee, you often need to see a patient yourself, in real time. Failure to have onset site senior supervision will comprise trainee learning, and patient care. The strength of the FACEM training program is its ability to provide on the floor immediate supervision and assistance to trainees (including consultants on call). The inability to do this by doing remote supervision would decrease the standard of our training program.
Impractical for hands-on procedural skill (10)	I don't think having someone on the telephone can adequately help a trainee halfway through a procedure if it's not going well or has a complication.

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

Respondents who agreed were also asked to provide comment on the ***'Challenges that implementing this solution would present'***. Table 21 outlines a representative sample of comments from the main themes that emerged from these responses.

Table 21 Themes and representative comments relating to the 'Challenges developing and incorporating Remote Supervision Options would present'

Theme	Representative comments
Logistics/ planning (20) *Right ratio trainee: supervisor, supervision time, sufficient partnership with metro etc.*	Finding appropriate supervisors; type of communication (in person, online); limitations with supervision on the floor (e.g. procedures, floor management)... Determining which metro site has 'responsibility' for these rural trainees.
IT infrastructure (15) *Including internet and secure network*	Skill sets in telehealth and remote learning. Infrastructure, internet, computer equipment, secure networks. Privacy rules. Having someone being paid to sit and be available to do this.
Overcome the limitation of remote supervision (15) *Hybrid model, complement with site visits*	Even with 'remote supervision' there is a requirement for a certain degree of FACEM presence at rural sites to ensure good quality health care delivery and an educational environment.
Source of funding or incentive (11)	Ensuring that these remote sites remain adequately funded/ resourced/ staffed to provide the long-term training and service provision invested in.
Standardisation of supervision quality (5)	Making sure that supervision is adequate and consistently available.
Medicolegal implication of remote advice (3)	Considerations around the medicolegal implications on advice given remotely

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

Qualitative Feedback – ACEM introduces a requirement that all new FACEM Training Program applicants must show that they have completed at least some time working and/or studying rurally

Respondents were asked to provide a reason(s) for their response to the proposal '***ACEM introduces a requirement that all new FACEM Training Program applicants must show that they have completed at least some time working and/or studying rurally.*** There were 210 respondents who provided a response, with the key themes being broadly divided by those who agreed vs. disagreed with the proposal (Table 22).

Table 22 Themes and representative comments relating to the statement' 'ACEM introduces a requirement that all new FACEM Training Program applicants must show that they have completed at least some time working and/or studying rurally'.

Theme	Representative comments
STRONGLY AGREE / AGREE	
Promote interest to work rurally (25)	I am a direct product of positive rural experiences producing a desire to work rurally. Stipulating mandatory rural experiences provides trainees with the opportunity to have these positive rural experiences. Greater involvement and visibility will reduce some of the stigma of being a regionally practicing FACEM. Also - we cannot become what we cannot see. If trainees don't see rural they won't think to try it.
All rounded EM specialist (22) *Metro FACEMs may not be capable for rural practice*	Australia is predominantly rural, its FACEM trainees should have expertise in rural medicine and transfer skills between regional/rural and metro This is not just about workforce maldistribution, this is about training. Trainees need a diverse and well-rounded experience, which they cannot get if they only work in a department where there is a cue for procedures, a team for every type of emergency presentation,
Understand the challenges in	People who have never been on the 'sending' end of a critically unwell patient don't truly appreciate what it's like, nor the barriers when attempting to transfer patients or access

resource limited rural EDs (21) *Transfer process, whole system*	other specialists. Rural depts. provide depth/breadth pts and a different perspective. No cath lab on site means you have to do things differently.
Improve rural workforce (13) *Provide better doctor coverage*	Would improve the quality of applicants and increase the chances of some moving rurally later, as well as go some of the way to staffing these areas with junior doctors.
Revisit the definition of 'Regional and Rural' (9) *Truly in the rural location*	The definition of what amounts to rural experience is not clear. Although the requirement of doing a rural term may help move trainees into regional and rural areas it may not add anything meaningful in terms of their experience of 'rural' medicine or living.
STRONGLY DISAGREE / DISAGREE	
Should introduce DURING training, not pre-training (17)	The rural time would need to be at some point during advanced training for it to really have impact and effect.
Don't think it is beneficial (16)	I can't see how showing prior participation will aid at all in promoting regional and rural work in the future as long-term prospects.
Should not mandate this (16) *A reward system instead*	It should attract more points in the SIFT process, but not be made mandatory. Making it attract more points as part of application, means it will become attractive to those trainees who feel they want to maximise their chances of obtaining entry to the training program.
Barriers for those with family commitments (16)	A significant number of trainees will have partners and families, and moving rurally, especially when they have not been guaranteed a training position, is not fair or reasonable.
Not to replace mandatory rural term for trainees (13)	Not necessary - creates artificial barriers which may not make any difference. Rather, each EM trainee should complete rural-based supervised training time - this is more likely to provide trainee with realistic role model of rural EM practice.
Unfair/ discriminative (12) *Females, ATSI, no rural EDs for SA and ACT*	This will be a significant barrier to completing training for those with caregiving responsibilities that do not allow them to move - it will disproportionately affect female, Indigenous, and Torres Strait and Pacific Island trainees.
Mandatory will cause resistance (11)	Forcing recent graduates to work in various locations is not in their best interests, nor will it improve their training. There are other ways of encouraging the eventual take-up of rural positions.

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

Respondents who agreed with this proposal were also asked to provide comment on the ***'Challenges that implementing this solution would present'***. Table 23 outlines a representative sample of comments from the main themes that emerged from these responses.

Table 23 Themes and representative comments relating to the 'The potential challenges of ACEM introducing a requirement that all new FACEM Training Program applicants must show that they have completed at least some time working and/or studying rurally'

Theme	Representative comments
Family commitment to move rural (20) *Support via remuneration, accommodation etc.*	Those with kids/ pets/ caring responsibilities will find this very difficult. If mandatory there may need to be a solution to provide accommodation suitable for kids/ pets and consider travel from rural area back to 'home' if partner is unable to move due to their job.
Difficult to retain rural workforce (8) *Esp those with city centric mindset*	Financial costs of moving. Placements will be scarce. How do you ensure you can come back if you don't want to stay there?
Clearly work out the conditions of the requirement (8)	Defining what is a reasonable duration and working out why this is valuable. There is no point in creating hurdles for hurdles sake. The rural time must reflect some sort of evidence-based level of engagement which will result in meaningful improvement to the distribution

Reasonable duration, level of rural engagement, remove 'study' in the clause	of healthcare delivery in the future. Defining rural. Probably need to define rural emergency medicine, not just rural exposure - many interns do rural ward-based jobs.
Exemptions/ options to make up later in training (6)	There will be good candidates with no rural/remote exposure at all, but they could just do an additional 6 months rural / remote training. Equitable access for candidates/trainees with families, particularly female candidates.

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

Qualitative Feedback – ACEM introduces a requirement that all new FACEM Trainees are required to complete a mandatory rural training term, at some stage of their progression through the FACEM Training Program

Respondents were asked to provide a reason(s) for their response to the proposal '*ACEM introduces a requirement that all new FACEM are required to complete a mandatory rural training term, at some stage of their progression through the FACEM Training Program'*, with 179 responding. The key themes have been broadly divided by those who agreed vs. disagreed with the proposed solution (Table 24).

Table 24 Themes and representative comments relating to the statement' 'ACEM introduces a requirement that all new FACEM trainee are required to complete a mandatory rural training term'.

Theme	Representative comments
STRONGLY AGREE / AGREE	
Rural exposure essential for every trainee (54) *Better decision maker, good understanding of the RR setting, all-rounded FACEMs*	This will provide a valuable training experience in many ways in contrast to just being hot housed through city centre trading programs PLUS increased empathy to difficulties faced by rural colleagues when discussing referrals etc. Emergency Physicians are expected to be able to provide care to communities in diverse settings including those with resource constraints like rural and regional centres. A mandatory training term in accredited regional/rural sites is essential for a well-rounded emergency physician and might also assist in addressing workforce maldistribution It improves clinical performance working in resource poor and rural environments and also allows you to relate to referrals if working in metropolitan centres.
Promote interest for rural practice (18) *Return to RR as a FACEM*	Such good exposure for improving clinical skills, cultural competency, networking, as well as trying out the rural way of life - FACEMs will never be persuaded to move out of the cities unless they've actually tried it for themselves.
Serve the rural community (15)	Mandatory rural terms could help galvanise future FACEMS into becoming vocal advocates for health equity. If the majority of our trainees are unaware of the gaping discrepancies in health outcomes for rural and remote Australian in a tangible way, they will not feel compelled to participate in a solution. There is no reason people should not be trained across a representative spectrum of EDs, when 20-30% of the population presents to rural EDs. Many other colleges mandate particular rotations including rural; our trainees should explicitly understand/ be taught they all have a service role to the communities of Aus and NZ; and training should occur where the ED population presents to ED
Inconsistency in existing Rural classification (13)	Having to relocate for a rural position disadvantages some trainees disproportionally compared with others.
Help with rural workforce (11)	Helps us rurally with staffing, shows trainees, especially from the city, that it is really good working out here and standards are high, may encourage more to move out rurally.
Minimum 6-month term (11)	Minimum 6 months as it takes the first 3 months to get settled in...Given lack of anaesthetic/ICU options in the city, tying regional time with these positions would be a sensible option. Trainees could go to regional/rural hospital for 6 months ED and 6 months

At least 3mo just to settle in, link with critical care rotation	anaesthetics
Must make it mandatory (10)	If every trainee has to do a rural term, then it will achieve greater acceptance. It will open their eyes, give them better understanding of rural communities and physicians, and open job possibilities for later
Provide incentive/ promote attractiveness of RR (8)	Carrots are better than sticks – make it easy and attractive to do a rural rotation through networking, educational support, streamlined training pathways with all rotations mapped out etc. Trainees are people with real lives - some will have genuine reasons not to do this.
STRONGLY DISAGREE / DISAGREE	
Mandatory for all is not practical (16) *Not sustainable to solve workforce issue- resistance, Disincentive to opt for EM training*	I don't think this will solve the problem of addressing workforce redistribution. It will adversely impact those trainees who are primary caregivers of small children, and overall will decrease the desirable flexibility of FACEM training pathway. This will not increase the permanent rural workforce. It could significantly impact the wellbeing of trainees, who have families and partners and other life commitments. It could be an option, especially if there were some incentive, but should not be mandatory.
Discriminative/ Unfair (12) *Family commitment, females etc.*	It is not practical. There will be many special consideration applications from trainees as to why they cannot go e.g. health issues, disturbance to their families, etc. It will particularly affect female trainees.
Negatively impact on trainee welfare and wellbeing (7)	It is purely workforce driven rather than helping the trainee. Mandating a rural term is a small part of addressing workforce needs and ignores the trainees needs + wellbeing.
Lack of supervision and senior support (4)	Currently there is a lack of appropriately supervised rural placements for trainees to undertake a mandatory rural placement as part of training.
Rural rotation for FACEMs instead (2)	Normalises FACEM work rurally providing a place for our massive number of new FACEMs (without work) to work.

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

Respondents who agreed with the proposal were again asked to provide comment on the ***'Challenges that implementing this solution would present'***. Table 25 outlines a representative sample of comments from the key themes that emerged from these responses.

Table 25 Themes and representative comments relating to the Potential Challenge of 'ACEM introducing a mandatory rural training requirement'

Theme	Representative comments
Trainee uptake (26) *Esp those from metro, complaints, resent etc.*	Negative impact on trainees being "forced" to work regionally may lead to resentment and lack of motivation which would be felt in the regional sites.
Social issues (22) *Family, isolation etc.*	Although many other colleges have this as a requirement, it would require a culture change. The network would have to encompass more than one choice, so maybe they may already have friend or family in that location to stay with/support them whilst away from home.
Ensure sufficient accredited sites/positions (17)	Trainee competition for rural training positions, could potentially contribute to an inability to complete training if rural rotations are a mandatory requirement and these are limited/in demand.
Lack of supervision (13) *Incl exam prep, steeper learning curve*	The main challenge is to ensure that the trainees are well supported during the mandatory regional/rural mandatory and take away rich educational experiences.
Acceptance by key stakeholders (11) *Esp metro FACEMs*	There may be resistance from larger EDs who would potentially have to give up some of their current large pool of trainees.

Make it mandatory for all (10) *Allow case-by-case exemptions*	If a compulsory rotation were to occur, there needs to be some degree of flexibility e.g. WHEN it is undertaken, where, and have a process to apply for exemption in some circumstances.
Financial (9) *Relocation cost*	There needs to be the infrastructure to support the trainee - housing, moving costs, etc. Would need to ensure that trainees are not financially worse off (e.g. free accommodations, travel + moving costs paid for by the employer).
Revise the definition of 'Rural' (8) *Urban or regional may not equal to real rural, gaming*	Clear definitions of regional/rural sites are also essential to avoid 'gaming' of suburban sites as regional/rural training sites.

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

Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au