Australasian College
for Emergency Medicine

Pilot of Blended Supervision in Emergency Medicine Training

Evaluation Report

March 2025

acem.org.au

Contents

1. Acknowledgements ... 3
2. Glossary ... 3
3. Abbreviations ... 4
4. Executive Summary ... 5
   - 4.1 Background ... 5
   - 4.2 Methods ... 5
   - 4.3 Findings ... 5
   - 4.4 Conclusion ... 6
5. Recommendations ... 6
6. Introduction ... 9
7. Background ... 9
8. Project Purpose and Aims ... 10
9. Project Approach ... 11
10. Phase 1 – Project Planning ... 11
11. Phase 2 – Protocol Development and Site Recruitment ... 12
    - 11.1 Blended Supervision Model ... 12
      - 11.1.1 Supervision responsibilities: ... 12
    - 11.2 Site Recruitment ... 13
    - 11.3 Trainee Criteria ... 13
    - 11.4 Supervisor selection ... 14
12. Phase 3 – Implementation – Orientation and Placements ... 14
13. Phase 4 – Evaluation ... 15
    - 13.1 Methods ... 15
      - 13.1.1 Desktop review ... 15
      - 13.1.2 Interviews ... 15
14. Desktop Review ... 16
15. Interview Findings ... 16
    - 15.1 Impact of blended supervision on trainees ... 16
      - 15.2 Challenges experienced by trainees in the Pilot ... 18
      - 15.3 Trainee support and learning environment ... 20
      - 15.4 Trainee wellbeing, confidence and support ... 21
      - 15.5 Assessment and feedback processes ... 23
      - 15.6 Sustainability of the model ... 25
16. Discussion ... 27
17. Limitations ... 31
18. Conclusion ... 32
19. References ... 33
20. Appendices ... 34
    - 20.1 Appendix A: Program Logic Model ... 34
    - 20.2 Appendix B: Desktop Review – The Sax Institute ... 35

Copyright
2025. Australasian College for Emergency Medicine. All rights reserved.

1. Acknowledgements

The Australasian College for Emergency Medicine (ACEM, 'the College') acknowledges the Wurundjeri people of the Kulin nation as the Traditional Custodians of the lands upon which the College Premises are located and the Traditional Custodians of the lands upon which all Australian emergency departments are located. The College pays their respects to Elders past, present and future; for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia. As a bi-national College, ACEM also acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

The College acknowledges and sincerely appreciates the funding support provided by the Australian Government Department of Health and Aged Care (DoHAC) under the Flexible Approaches to Training in Expanded Settings (FATES) grant scheme 2021-2025. This support has been instrumental in enabling the development, implementation and evaluation of the Blended Supervision Pilot project initiative.

ACEM also acknowledges and appreciates the substantial contributions of the Sax Institute in conducting the desktop review and interviews, which have played a crucial role in shaping the findings of this evaluation report. Their expertise and thorough analysis have provided valuable insights that enhance the understanding of the program's impact and effectiveness.

2. Glossary

These terms have been used for the purposes of the Blended Supervision Pilot project and throughout this report:

Onsite supervision - Clinical and training supervision provided by onsite supervisors (including FACEMs, GP anaesthetists, ICU specialists, and rural generalists). This includes when a supervisor may be off-site but on-call and available to attend the site e.g. for nightshift.

Local Supervisor - The nominated supervisor/s (FACEM, FACRRM) at the placement site who is/are responsible for coordination of training and assessment at the placement site.

Remote supervision - Training supervision provided by a Director of Emergency Training (DEMT) at a site accredited for FACEM training that is separate from the BSP site.

3. Abbreviations

AACEM	Associateship in Advanced Emergency Medicine
ACEM	Australasian College for Emergency Medicine
ACRRM	Australian College of Rural and Remote Medicine
AMC	Australian Medical Council
ARST-EM	Additional Rural Skills Training in Emergency Medicine
AST-EM	Advanced Specialised Training in Emergency Medicine
ATN	Accredited Training Networks
BSP	Blended Supervision Pilot
CbD	Case-Based Discussion
DEMT	Director of Emergency Medicine Training
DoHAC	Department of Health and Aged Care
ED	Emergency Department
EM	Emergency Medicine
FACEM	Fellow of ACEM
FACRRM	Fellow of ACRRM
FATES	Flexible Approaches to Training in Expanded Settings
FRACGP	Fellow of RACGP
FRACP	Fellow of RACP
FTE	Full-Time Equivalent
ITA	In-Training Assessment
LDP	Learning Development Plan
M&M	Morbidity and Mortality
MBA	Medical Board of Australia
MCNZ	Medical Council of New Zealand
MMM	Modified Monash Model
PER	Paediatric Emergency Requirement
RACP	The Royal Australasian College of Physicians
RACGP	The Royal Australasian College of General Practitioners
RRR	Regional, Rural and Remote
TS	Training Stage
WBA	Workplace-Based Assessment

4. Executive Summary

4.1 Background

The Australasian College for Emergency Medicine (ACEM) is the not-for-profit organisation responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. ACEM is accredited by the Australian Medical Council (AMC) on behalf of the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) to train doctors throughout Australia and Aotearoa New Zealand as specialist emergency medicine physicians. The College also offers Associateship training programs in Foundational, Intermediate and Advanced Emergency Medicine and an Associateship in Pre-Hospital and Retrieval Medicine.

The Blended Supervision Pilot (BSP) project, supported by the Australian Department of Health and Ageing FATES funding (Flexible Approach to Training in Expanded Settings), is designed to address critical challenges in training and retaining a specialist emergency medicine workforce in regional, rural and remote settings. The pilot aimed to improve the accessibility and quality of training in these areas through a blended supervision model combining onsite clinical supervision and remote training supervision in Emergency Departments that do not fulfil requirements for accreditation for training. This approach aligns with the College's strategic priorities to enhance workforce sustainability and equitable health outcomes in under-served regions.

The model was piloted in three emergency departments (EDs) across Western Australia and New South Wales for eligible trainees in Training Stages 2 or 3.

The evaluation aimed to assess the feasibility and effectiveness of the blended supervision model, focusing on:

- ensuring the safety of trainees and patients,
- delivering effective supervision through innovative hybrid methods, and
- demonstrating suitability for broader implementation in the FACEM training program.

4.2 Methods

A literature review, desktop review and semi-structured interviews were undertaken as part of the project delivery. The literature review was conducted to assist with project scoping and to explore the landscape of current supervision models and its feasibility to support the structure of FACEM training. The desktop review focused on evaluation reports and research literature published about remote supervision models in medical training, both within Australia and internationally, and ways in which remote supervision is being delivered by other medical specialty colleges. For the pilot evaluation, 10 individuals including three trainees and seven Local Supervisors and Directors of Emergency Medicine Training (DEMTs), were interviewed about their perceptions and experiences of the pilot.

4.3 Findings

The blended supervision model has strong potential to address FACEM supervision and education program challenges in regional, rural and remote healthcare settings. By integrating onsite clinical supervision with remote training oversight, the pilot expanded the reach of traditional supervision, providing greater flexibility and broader clinical exposure. This approach fostered trainee autonomy, independence, and skill development. While trainees appreciated the increased responsibility, they also experienced cognitive burden and isolation. The absence of immediate FACEM oversight sometimes led to hesitation in decision-making, with retrospective case discussions with FACEMs providing opportunities for learning, though less effectively than real-time supervision.

The pilot demonstrated strong potential for scalability, suggesting adaptability across diverse healthcare settings. It contributed to a positive regional, rural and remote medical education culture by highlighting the unique opportunities of rural practice and fostering supportive learning environments. Furthermore, the model aligned with the rigorous requirements of the ACEM Fellowship training program, ensuring high-

quality training standards. Barriers such as professional isolation and logistical challenges remain inherent in rural practice. However, the pilot showed promise in alleviating some of these difficulties by creating a more structured and supportive training environment, potentially encouraging more trainees to pursue careers in RRR emergency medicine. Participants suggested that a peer support network would be of benefit.

Despite its successes, the evaluation identified areas for improvement. Key considerations include refining the model, ensuring supervision consistency, enhancing IT systems, and developing strategies to reduce trainee isolation. These insights highlight the need for ongoing evaluation to maintain the model's effectiveness and long-term viability. Continuous evaluation and adaptation will be essential to maximising its impact and ensuring its sustainability in addressing the challenges of regional, rural and remote emergency medicine training.

4.4 Conclusion

The evaluation findings demonstrate that blending remote training and onsite clinical supervision is effective for delivering high-quality FACEM training program placements. Successful scaling up and sustainability of the blended supervision model will require several key refinements to be made, including enhanced use of telehealth and digital tools, structured training for non-FACEM supervisors, and streamlined assessment processes. It will also be necessary to prioritise hospital sites with strong existing training infrastructure and experienced Local Supervisors. These recommendations, including trialling the model at additional sites throughout 2025, are outlined in the report. Overall, the pilot provides a promising framework for addressing workforce distribution challenges and ensuring equitable healthcare access in underserved regions.

5. Recommendations

Recommendation 1: Trial the blended supervision model (including part-time option) at additional sites during the 2025 training year

While the blended supervision model has demonstrated effectiveness and flexibility in delivering high-quality specialist emergency medicine training, additional pilot placements that include part-time trainees are recommended. This will ensure necessary refinements are identified and challenges addressed before broader adoption, thereby enhancing the model's sustainability and alignment with trainee and supervisor needs.

Recommendation 2: Consider expanding Workplace-Based Assessment (WBA) completion to all Fellows at BSP Sites

In the pilot model, only the remote DEMT, nominated Local Supervisor and FACEMs were permitted to complete WBAs. This was to optimise calibration of assessments and feedback. To ensure sufficient opportunities for trainees to complete WBAs, the assessor group could be expanded to include Fellows of RACGP or ACRRM, alongside FACEMs in the emergency department. This broader pool of assessors has the potential to enhance the trainee learning experience and support progression through the training program. Implementation would require a nomination and orientation process, along with regular monitoring to identify and address any concerns about the WBA process.

Recommendation 3: Support specialists at BSP sites to improve feedback delivery for better learning outcomes for trainees

Effective assessment and feedback are critical to trainee development, ensuring they receive timely, constructive insights to improve their skills and performance. However, as discovered during the pilot evaluation, feedback can often be inconsistent and delayed, therefore reducing its impact. It is recommended that the following measures are considered:

- Introduction of real-time observation and feedback methods, such as real-time video-conferenced assessments, video-recorded assessments for later review, virtual case discussions

or use of a mobile app to record feedback on trainee performance could assist in enhancing the quality of the feedback provided.
- Structured training for supervisors and assessors to assist in improving the consistency of feedback delivery, ensuring it is clear, actionable and effective across both in-person and remote settings.
- Facilitation of structured debriefing sessions following complex cases to provide both clinical and psychosocial support.
- Development of regional or BSP peer discussion groups to provide trainees with informal support networks and opportunities to share experiences.

Recommendation 4: Consider alternative approval criteria for Paediatric Emergency Requirement (PER) accreditation for BSP sites

It is recommended that the criteria for PER accreditation approval (including min 5000 paediatric cases) be reviewed for BSP sites to enable trainees to count their paediatric cases towards logbook requirements.

One area for potential consideration is shifting the focus from the total number of paediatric emergency presentations to the proportion of paediatric presentations relative to overall emergency department activity. This approach acknowledges that trainees in lower-volume paediatric sites, particularly those with fewer trainees overall, may still have substantial exposure to paediatric cases despite the site not reaching strict numerical thresholds.

Recommendation 5: Refine the BSP site criteria for clarity

To enhance the effectiveness and sustainability of the BSP, it is essential to refine the selection criteria for participating sites. This will ensure that sites are well-equipped to support trainees, provide quality education, and offer a diverse clinical experience. The following key areas should be considered:

- Education: Enforce minimum requirements for BSP structured education program
- Supervision: Restrict on the floor supervision (to meet the 50% requirement) to:
    - FACEMs
    - Fellows of RACGP/ACRRM who hold an Associateship in Advanced Emergency Medicine (AACEM), Advanced Specialised Training in Emergency Medicine (AST-EM) or Additional Rural Skills Training in Emergency Medicine (ARST-EM)
- Rostering: Work with prospective sites to develop appropriate rostering for trainees.
- Case-Mix: Define minimum case-mix requirements - to ensure trainees gain exposure to a broad spectrum of emergency presentations, including high-acuity cases and a variety of patient demographics.

Recommendation 6: Implement BSP model in April 2026 (pending additional placement evaluation)

The initial evaluation strongly suggests that the blended supervision model provides a feasible, scalable, and sustainable approach to emergency medicine training in regional, rural and remote areas. Its integration into the FACEM training program would enhance equity by ensuring all trainees, regardless of location, have access to consistent, high-quality supervision. This aligns with ACEM's strategic goals of addressing workforce distribution challenges and strengthening training capacity in regional, rural and remote healthcare settings. Following a comprehensive review of evaluation findings from the 2025 placements, it is recommended that the Council of Education consider the implementation of the blended supervision model as part of the FACEM Training Program.

Recommendation 6A: Update the accreditation process to include BSP sites

Investigate the introduction of a new tier of accreditation for BSP sites in light of the AMC Accreditation Model Standards. Such a tier would formalise expectations and support for blended supervision placements, ensuring they meet the quality and educational standards required for FACEM training.

Recommendation 6B: Develop an application guide for BSP sites

Key components of the application guide should include:

- Implementation and support information – Step-by-step guidance on setting up the blended supervision model, including IT requirements, communication and escalation protocols, and available ACEM support resources.
- Clear documentation requirements – A checklist outlining all required documentation (e.g., rostering supervision model, access to formal protected education sessions, WBA opportunities, trainee support plans)

Clear guidelines and documentation will enhance transparency, reduce administrative burden, and ensure that all participants are fully informed and prepared.

Recommendation 6C: Recruit additional BSP sites

To facilitate expansion of BSP sites, targeted promotion of the model is essential. ACEM should actively engage with key personnel from hospitals, Local Hospital Networks and government to highlight the benefits of blended supervision, including its capacity to deliver high-quality training and support workforce sustainability. This should include sharing successful case studies, facilitating knowledge exchange between sites, and providing clear guidance on implementation. The BSP has demonstrated its effectiveness in supporting local workforce development at RRR sites, whilst also providing trainees with valuable experience that enhances their skills and sense of autonomy in clinical practice.

Implementation of blended supervision should be prioritised at hospital sites with strong existing training infrastructure and experienced Local Supervisors.

Recommendation 6D: Provide comprehensive orientation for all BSP trainees, supervisors anassessors

A comprehensive and structured orientation program for all BSP trainees, supervisors, and assessors is essential to ensuring the successful implementation of the blended supervision model.

- Clear and proactive communication with sites, integrated into the orientation process, will help establish site-level measures that facilitate seamless collaboration between Local Supervisors and the remote Director of Emergency Medicine Training (DEMT).
- Trainee wellbeing resources, including comprehensive pre-placement information provided well ahead of commencement. This should cover training expectations, assessment requirements, detailed information about the hospital site and local context, and logistics such as housing, transport and community engagement opportunities, as well as peer support (Rec 3).
- Provide further guidance on roles, responsibilities, and expectations to all participants, ensuring a shared understanding of supervision structures, assessment processes, and feedback mechanisms.
- Develop a tailored training package for non-FACEM supervisors to ensure there is consistency in teaching and assessment between FACEM and non-FACEM supervisors and assessors, alignment with ACEM's requirements and standards, and confidence in navigating ACEM's assessment instruments and processes.

Recommendation 7 Align placements with the proposed Accredited Training Networks and DEMTs

Develop a formal proposal to continue to promote the blended supervision model as part of the Emergency Medicine Accredited Training Networks (ATN) initiative. Both projects aim to enhance access to FACEM training opportunities, particularly in RRR areas. By integrating blended supervision sites within the ATN framework, ACEM can promote greater coordination between the two initiatives, creating more cohesive and effective training pathways. This integration could optimise training rotations, improve resource allocation, and foster collaboration among sites within the same network, ultimately expanding opportunities for trainees to train and ultimately providing potential avenues for future employment in under-served sites.

6. Introduction

The Blended Supervision Pilot (BSP) supports workforce sustainability and community healthcare goals by expanding high-quality training opportunities in regional, rural and remote (RRR) areas. This initiative aligns closely with the National Medical Workforce Strategy 2021–2031[1], which emphasises the need for sustainable and well-distributed medical training pathways to address workforce shortages.

The BSP is part of improving access to FACEM training opportunities in RRR areas and aims to redress the deficit of FACEMs located in Australia's more remote locations. As limited supervision is recognised as a key impediment achieving this, ACEM believes that a blended, or hybrid, trainee supervision model with some training supervision provided remotely may help to address this. By incorporating remote supervision, the BSP enhances access to FACEM training in under-recruited regions and helps build a specialist workforce equipped to deliver high-quality emergency care.

Developed as part of ACEM's Workforce Planning Committee initiatives, the BSP also informs broader accreditation reforms aimed at strengthening collaboration between hospitals, health services, and the College. These efforts may include accredited training networks and a core rural training term to support specialist development in rural settings.

Although rural EDs see fewer patient presentations than metropolitan hospitals, they manage a similar range of critical cases, requiring doctors to maintain essential skills despite limited exposure[2,3]. Increasing trainee placements in RRR areas is a priority for ACEM to address workforce shortages while ensuring training rotations provide the necessary breadth and depth for specialist development. By improving training accessibility and retention, the BSP helps correct the imbalance in specialist distribution and strengthens the emergency medicine workforce in underserved regions.

7. Background

ACEM, established in 1983, is the primary professional body responsible for the training and education of emergency medicine (EM) specialists in Australia and Aotearoa New Zealand. ACEM oversees a rigorous training program, leading to Fellowship of ACEM (FACEM), that ensures its graduates deliver high-quality, evidence-based emergency care.

To achieve Fellowship, trainees undertake rotations at ACEM accredited sites in ED, non-ED and critical care (anaesthetics and/or intensive care). The program offers flexibility, allowing trainees to undertake their training either part-time or full-time, with a minimum duration of five years and a maximum of 12 years. Trainees generally rotate across various health services comprising large teaching hospitals, metropolitan, and regional, rural and remote EDs. The Director of Emergency Medicine Training (DEMT) at each accredited ED provides overall training supervision and may oversee multiple hospitals within a network. Currently, the majority of ACEM-accredited EDs are in metropolitan and outer metropolitan regions, with less than 30% located in RRR areas.

The demand for emergency care has increased significantly due to population growth, ageing demographics, and increasing burden of disease. In 2021-22, approximately 3 million emergency department presentations (or 35%) were in EDs outside of major cities in Australia[5]. Similar trends are observed in rural communities across Aotearoa New Zealand[6]. Geographic imbalances exist in the distribution of FACEMs and other healthcare professionals, with metropolitan areas having a much higher concentration of specialists compared to RRR locations[1].

RRR EDs face challenges that hinder their ability to deliver equitable and sustainable care:

- Shortage of EM Specialists: Difficulties in recruiting and retaining senior decision makers.
- Retention Issues: Increased workloads, professional isolation, and perceived limited career advancement opportunities.
- Resource Limitations: Staffing shortages, limited access to diagnostics, and inadequate funding.

These challenges lead to a range of negative consequences:

- Inconsistent Access to Emergency Care: Patients in RRR areas often experience delays in receiving critical care or must travel long distances to access specialised services.

- Higher Mortality and Morbidity Rates: Geographic disparities in emergency care contribute to poorer health outcomes for RRR populations, particularly for time-sensitive conditions such as trauma or cardiac emergencies.

- Increased Pressure on RRR Healthcare Workers: The workforce is often overburdened, leading to heightened levels of burnout and stress, which further exacerbate workforce shortages[7].

The uneven distribution of healthcare professionals, including FACEMs, has exacerbated disparities in access to quality care. ACEM has recognised the growing need to address challenges in emergency medicine workforce distribution, as outlined in its Rural Health Action Plan[4]. Expanding FACEM training opportunities at RRR sites is widely recognised as a key strategy for building a sustainable local workforce. In addition, placements in RRR EDs offer unique learning benefits. These benefits may include increased autonomy in clinical decision-making and greater opportunities to develop leadership skills, particularly in acute situations.

However, core ED training opportunities may be limited due to accreditation requirements including FACEM supervision, non-clinical time for DEMTs and education programs. Training in RRR settings also presents several challenges, including isolation, difficulties relocating, potentially limited access to supervision, and financial barriers to attending education, professional development, or other training opportunities often located in metropolitan areas.

ACEM's FACEM Training Site Accreditation Requirements[8] outline the standards necessary for delivering safe and effective training, with robust trainee supervision essential to supporting development. While designed to ensure appropriate FACEM supervision and access to education programs, the requirements may constrain training opportunities in RRR areas. Addressing these accreditation barriers is critical to enhancing rural training capacity and fostering a sustainable, equitable emergency medicine workforce, ensuring RRR communities receive the same quality of care as metropolitan populations.

8. Project Purpose and Aims

The Blended Supervision Pilot project's overarching goal is to increase the accessibility and quality of training in RRR locations through a blended supervision model, providing additional pathways for trainees and supporting workforce sustainability and equitable health outcomes.

To date, there has been limited exploration of remote supervision within EM and other medical specialties for specialist training. However, EM registrars have previously reported numerous benefits of remote supervision, including increases in confidence and independence, opportunities to develop leadership and inter-personal relationship skills, greater access to healthcare for the community, and improved access and relationships with supervisors[9].

This project assesses the feasibility of combining onsite and remote supervision in a blended supervision model and its ability to:

- Ensure the safety of both trainees and patients,

- Facilitate effective supervision through a combination of onsite clinical supervision and remote training supervision, and

- Demonstrate its suitability for implementation within the FACEM Training Program

9. Project Approach

The project was delivered in four phases:

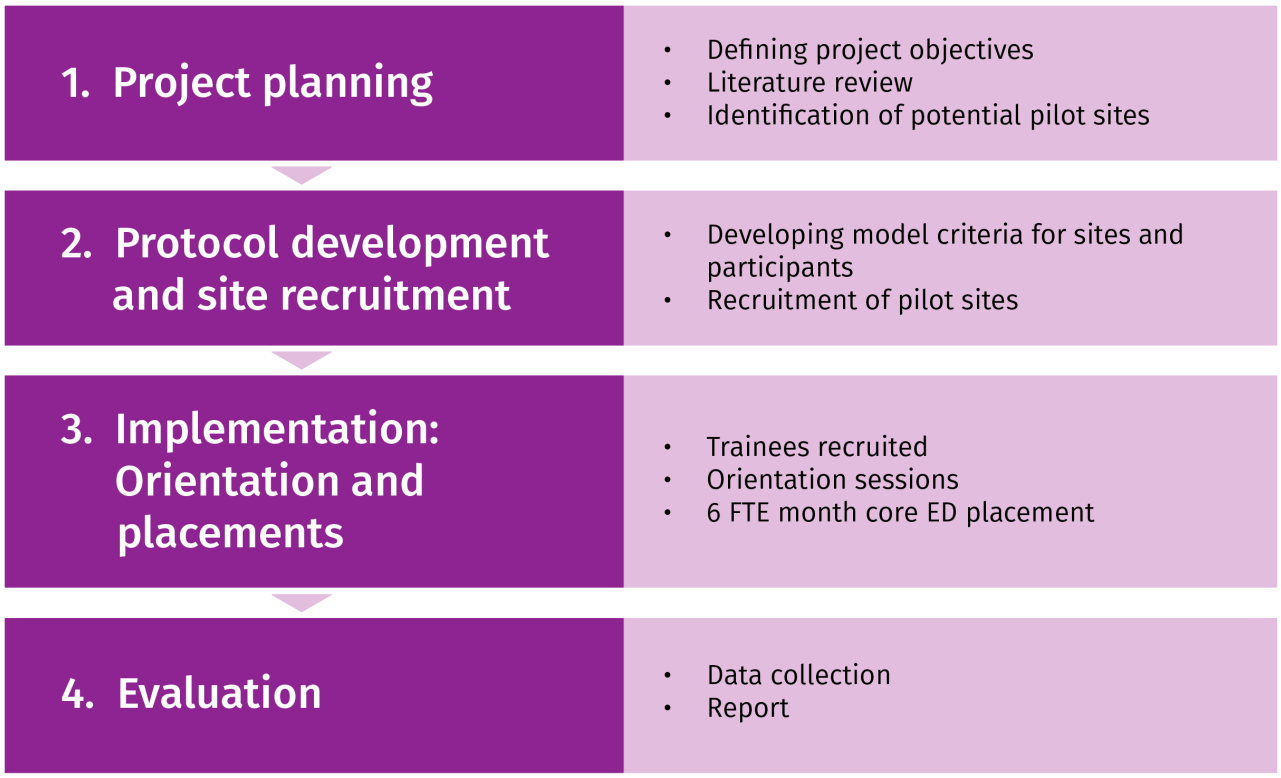


Figure 1. Project Milestones of the Blended Supervision Project

10. Phase 1 – Project Planning

The College contracted a consultant to undertake a literature review exploring the current landscape of how virtual emergency medicine was being delivered in Australia, and whether the current infrastructure could support remote supervision of FACEM trainees.

Scoping revealed that there is an emerging role for remote supervision:

- Opportunities highlighted by the COVID-19 pandemic: Increased awareness, acceptance and practice of telehealth, suggesting the potential for virtual supervision models to provide safe and high-quality care[10]
- Educational potential: Remote interactions often double as educational opportunities, highlighting the potential for guidance for clinical scenarios and staff capabilities
- Existing trials and models: Only limited experience with remote supervision of FACEM trainees exists (e.g., Southwest Victoria trials). However, other organisations including RACGP and ACRRM have over 30 years of experience in RRR training, including in emergency and urgent care in isolated settings.
- Curriculum adaptation: Training must address local community needs and environments, incorporating both formal and informal education.
- Scalable and flexible structures: There is no universal model; instead, programs must mix and match supervision and assessment methods to suit the unique demands of RRR placements.
- Workforce challenges: RRR areas lack consistent access to FACEM-level supervision, necessitating innovative training solutions to maintain quality and safety.

In summary, the landscape of virtual emergency medicine and existing remote training programs underscore the feasibility and necessity of adapting FACEM training to include remote supervision models. This approach addresses workforce shortages while maintaining high training and care standards in regional and remote Australia.

11. Phase 2 – Protocol Development and Site Recruitment

The planning phase of the Blended Supervision Project was guided by a program logic framework (Appendix A) that provided a structured approach. The program logic provided a clear pathway from project inputs to outcomes, aligning resources, activities and outputs with the desired objectives.

Development of the project protocol was a critical step in ensuring the project would meet the needs of stakeholders and the project itself. The protocol defined the required necessary criteria for sites, trainees and placements for effective implementation of the pilot. It was designed to address FACEM Training Program accreditation requirements and provide the flexibility needed for regional, rural and remote settings. This included ensuring adequate supervisory support, trainee access to learning opportunities, and robust mechanisms for evaluation and feedback. Specific attention was given to utilising ACEM's current assessment systems to optimise the experience for all participants.

11.1 Blended Supervision Model

The Blended Supervision Pilot Project enabled RRR sites not currently accredited for FACEM Core ED training to provide a single 6 month full-time equivalent (FTE), 100% ED training placement for a FACEM Trainee.

Site Criteria:

- Modified Monash Model (MMM) 3+
- An on-site nominated Local Supervisor
- A nominated, remote DEMT
- Minimum 50% on-site supervision of the trainee by Fellows (FACEM, FRACGP, FACRRM or FRACP)
- Adequate on-call supervision arrangements
- Sufficient clinical load to complete FACEM Training Program Assessments
- Structured, protected education for an average of 4 hours per week. Up to 50% of this could be delivered by a remote site.

11.1.1 Supervision responsibilities:

- Onsite supervision: Nominated Local Supervisor/s at the placement site responsible for coordination of the training, education and WBAs. Ideally a FACEM but if not feasible, must hold Fellowship RACGP or ACRRM. All Fellows must have a minimum of 3 years of experience post-fellowship.
- Remote supervision: A current DEMT at an accredited ED[8] responsible for support, completion of a Case-Based Discussion (CbD) and the 3 monthly In-Training Assessments (ITAs).

While there is some precedence for a remote DEMT in the FACEM Training Program, the Local Supervisor role and eligibility was a key innovation for this pilot.

The BSP has expanded on the usual FACEM supervision required as part of ACEM's accreditation standards, allowing a supervisor that is a Fellow of ACEM, RACGP or ACRRM to supervise and complete assessments. This adaptation aimed to better reflect the workforce structures in regional, rural and remote hospitals, enhancing the feasibility and sustainability of supervision in these settings.

11.2 Site Recruitment

Early and proactive engagement with stakeholders played a pivotal role in recruiting pilot sites for the BSP. Initial discussions built awareness and generated interest in the project. Prospective sites then completed an application form. Further information was requested as required, particularly around the education program and rostering to ensure all sites could provide adequate support and supervision for trainees.

Six (6) sites were recruited, representing multiple jurisdictions. Each site would operate under a slightly different blended supervision model, showcasing the flexibility of the model while being representative of the staffing structures within each of the hospitals.

Participating sites

1. Busselton Hospital – Western Australia
2. Broome Hospital – Western Australia
3. Macksville District Hospital – New South Wales
4. Northeast Health Wangaratta – Victoria*
5. Warwick Hospital – Queensland*
6. Tennant Creek Hospital – Northern Territory**

*Participating from Feb 2025
**Unable to recruit a trainee for pilot period

Figure 2. Map of participating Blended Supervision Pilot sites

11.3 Trainee Criteria

Trainee/Placement Criteria

- 6 FTE month placement, 100% ED
- Training stage 2 or 3
- Attend 70% of the protected, rostered education sessions, duration of which is 4 hours per week (average)
- Complete a Learning Development Plan (LDP) within the first 2 weeks of the placement

Assessments:

- Complete an **In-Training Assessment (ITA) after each three-month placement period** (conducted by the DEMT and Local Supervisor)
- Complete a minimum of **5 Workplace-Based Assessments (WBAs)**, including a **Case-Based Discussion ((CbD)**, conducted by the DEMT and Local Supervisor))

Trainees undertaking additional training time were not eligible to enrol in a BSP placement.

The decision to limit the pilot to training stages (TS) 2 or 3 was to ensure that trainees had adequate experience to work in a RRR setting, were in a position to take on greater clinical responsibility and

decision-making roles and were not required to be in a TS4 accredited site or preparing for the Fellowship Clinical Examination. By focusing the pilot on TS 2 and 3, the initiative ensures an optimal match between the trainee's developmental needs and the objectives of the blended supervision model. This alignment maximises the potential for meaningful learning experiences and impactful outcomes for both trainees and supervisors.

The College worked closely with placement sites to recruit appropriate trainees suitable to undertake the pilot placement. Trainees were reviewed to identify any risk of noncompliance with WBAs or challenges that could adversely affect their progression in the program.

Due to delays in trainee recruitment, Northeast Health Wangaratta and Warwick Hospital were unable to participate in the initial pilot. The College will continue to run pilot placements, enabling them to commence their pilot placements in February 2025. Tennant Creek hospital was unsuccessful in recruiting a trainee for the pilot period.

All trainees were required to meet the mandatory requirements of the FACEM Training Program. This included fulfilling specific placement expectations (WBA completion) designed to ensure a consistent and high-quality training experience. Eligible trainees had the opportunity to include paediatric logbook cases toward their training requirements, provided their training site satisfied the criteria outlined in the Paediatric Emergency Requirements (PER) framework.

11.4 Supervisor selection

The College collaborated with placement sites to identify suitable Local Supervisors and remote DEMTs. The role of the supervisors was to ensure all College assessment, training, administration and feedback times were met as required, and to ensure the supervision conducted at the site was in line with the requirements.

Sites had the opportunity to nominate a co-Local Supervisor, which opened up greater flexibility for rostering and supervision and more opportunities for the trainees to complete assessments.

The DEMT was nominated by the placement site and was to be a principal point of contact for the trainee and be located at a remote linked accredited site. The DEMT was required to provide guidance at the start of the placement in relation to a trainee’s learning plans and desired training outcomes, as well as providing regular feedback, guidance and support to trainees as they progress through their training.

12. Phase 3 – Implementation – Orientation and Placements

Implementation of the blended supervision model was carried out through a structured orientation process for Local Supervisors, DEMTs and trainees prior to the commencement of the pilot placements. These orientation sessions were designed to equip all participants with a clear understanding of their roles and expectations during the pilot. By providing targeted guidance and resources, the sessions aimed to foster a smooth transition into the pilot, ensuring that both supervisors and trainees felt adequately prepared to navigate the challenges and opportunities presented by the blended supervision approach.

A structured orientation program was developed to provide participants with essential information, including:

- Overview of the FACEM training program, with an emphasis on EM-WBA requirements.
- Introduction to the expectations and goals of the placement, including learning outcomes and assessment requirements.
- Clarification of roles and responsibilities
- Tools and resources to support trainee assessment and feedback
- Familiarisation with local and remote supervision

- Support systems available to participants

Orientation sessions were delivered both in person during the RRR Conference in Darwin, July 2024, and virtually. These sessions offered insights into potential modifications or adaptive strategies to address emerging challenges.

Pilot placements were conducted from August 2024 to February 2025. Learning Development Plans (LDPs) were completed at the commencement of placements to define individual learning outcomes and guide the participants' progress throughout the pilot. To ensure ongoing support during the placements, regular meetings were scheduled between DEMTs and trainees during the first month, offering opportunities for feedback and guidance.

Trainees' performance against learning outcomes was monitored through the assessment and training requirements outlined in the ACEM Training Program. Routine monitoring of assessments maximised compliance and consistent access to WBAs.

13. Phase 4 – Evaluation

The evaluation plan was developed to provide a formative and summative perspective. Formative, continuous participant feedback from the commencement of the placement ensured any interruptions to training would not result in a loss of evaluation data. The summative evaluation relied on discussions at the conclusion of the placements and is a composite of participant input and reflections. For the latter, the Sax Institute were engaged as an independent evaluator for the Blended Supervision Pilot project and were responsible for conducting the desktop review and interviews with participants.

13.1 Methods

13.1.1 Desktop review

The Sax Institute examined evaluation reports and publicly available information from medical colleges in Australia and Aotearoa New Zealand that provide remote training or supervision programs to explore how these programs are implemented and experienced across different specialties. A brief literature review was also conducted to identify key research on the effectiveness of remote specialty medical training and supervision in these regions. Remote supervision was defined as cases where a trainee's supervisor, from the same medical specialty, is not physically present or unable to respond immediately when on call, such as in RRR settings.

13.1.2 Interviews

The development of the interview discussion guide was informed by findings from the desktop review, data from the 2023 trainee placement survey and the 2023 DEMT survey, and input from the ACEM project team and relevant stakeholders.

Participating trainees, Local Supervisors and DEMTs were invited via email to participate in a semi-structured interview to gain insights into the views and experiences with remote supervision and any suggestions for improvement. Interviews were between 45-60 minutes in duration and conducted remotely using Microsoft Teams, recorded, transcribed (using the Microsoft Teams transcription function), and analysed using NVIVO to identify key themes.

Interviews were conducted with a total of 10 individuals involved in the pilot across the three participating hospital sites, three trainees and seven Local Supervisors or Directors of Emergency Medicine Training (DEMTs). Interviews were only conducted for sites that participated in the BSP from August 2024 – February 2025. All material was deidentified to protect the privacy of all participants. All of the supervisors and DEMTs (grouped together to ensure their confidentiality) were directly involved in implementing and overseeing the blended supervision model, providing advice and guidance to trainees, and working to refine the supervision and training structure at their respective sites.

14. Desktop Review

The desktop review conducted by the Sax Institute has been added to Appendix B of this report. Findings highlighted various approaches to managing remote supervision and its effectiveness in supporting specialty medical training.

15. Interview Findings

Six key areas were identified from the data provided by the BSP participants. The detailed findings provided by the Sax Institute are presented below.

15.1 Impact of blended supervision on trainees

The main characteristic of the blended supervision model in this Pilot was the involvement of non-FACEM supervisors, including GP anaesthetists, ICU specialists, and rural generalists, who provided onsite supervision to the emergency medicine trainees for up to 50% of the time. This was generally valued highly by the trainees as it broadened their clinical knowledge, thinking and skills, and accelerated the development of their problem-solving abilities and confidence in decision-making. However, it introduced variability in the teaching and assessment of the trainees, some of whom had difficulty aligning their supervision with ACEM's specific training requirements.

Clinical decision-making and autonomy

When trainees did not have regular access to bedside or on-the-floor teaching and advice from FACEMs, they tended to take more ownership of clinical decisions before seeking senior input. Many reflected on this as a highlight of their placements as it forced them to consider and prioritise investigations and treatments themselves, which was an intense but rewarding learning experience, and a significant change from their previous metropolitan-based placements:

> *"In a metro hospital, you can call a FACEM anytime. Here, I had to make a decision first, then justify it later. That's a big change in how you operate."*

One of the supervisors echoed this and highlighted how working in a resource-limited environment without immediate FACEM oversight accelerated trainees' clinical reasoning skills:

> *"It makes you think harder about what's actually needed. That's an incredibly valuable skill for emergency physicians."*

During their placements, trainees reported situations that required immediate action when a FACEM was not present at the hospital. While other, non-FACEM senior ED doctors were present, they were not specialists in emergency medicine. This helped to reinforce the trainees' abilities to manage time-sensitive and high-risk cases independently. One trainee recounted stabilising, with limited resources, a critically unwell trauma patient before retrieval:

> *"There wasn't anyone to take over immediately or time to wait for someone. I had to use the blood products we had, manage pressors, and make sure the patient was as stable as possible before transfer. It was a lot of responsibility, but it also showed me I was capable of handling it."*

Limited access to timely specialty input also appeared to influence clinical decision-making during the Pilot, with trainees needing to balance decisions on when to escalate care, when to seek specialist input, and when to manage cases conservatively due to resource constraints. Most of the trainees described having to adjust their expectations of specialist involvement, particularly for cases where a referral might be delayed or declined due to capacity issues. One trainee reflected on how the need to justify referrals in a regional, rural and remote hospital helped strengthen their diagnostic reasoning skills:

> *"In a metro ED, you can refer someone to a specialty team fairly easily. Here, you have to be more selective and make sure your reasoning is sound because the specialist might not be able to see the patient straight away."*

Trainees in this Pilot were also required to take on greater responsibilities when managing patient transfers, working with retrieval teams, stabilising patients, and determining whether a patient could be safely managed locally or required urgent transfer. In some cases, trainees had to keep patients for longer than they would have liked due to resource limitations at receiving hospitals. A supervisor noted that these experiences provided trainees with important skills in logistical problem-solving and critical thinking:

> *"Managing a transfer isn't just about making the referral. It's about assessing whether the patient can be managed locally for a few more hours and ensuring they're stable enough to travel. That's a skill that rural trainees develop much earlier than metro trainees."*

Accelerating the development of confidence in decision-making and procedural skills

One of the most widely reported benefits of blended supervision and working at a rural or remote hospital site was the way it fostered trainee confidence in managing high-acuity cases and performing advanced critical care procedures. With fewer senior staff and sometimes no FACEM available on-site, trainees were required to 'step up', make decisions independently, and escalate cases only when necessary, which was a shift that many described as both daunting and empowering. One of the trainees found that reduced competition for procedures significantly accelerated his hands-on experience in emergency medicine:

> *"In a tertiary hospital, you might wait weeks or months for the chance to perform an intubation or insert a central line because there are so many other trainees. Here, if something needs to be done, I do it. You're expected to step up, and that builds confidence fast."*

Another trainee recalled a case where he had to stabilise a shocked trauma patient:

> *"I had to make quick decisions, like how much blood to give, whether to start pressors, and what my airway plan would be if things deteriorated. I wasn't just assisting; I was leading. That experience forced me to trust my own skills rather than waiting for someone else to take over."*

Supervisors also highlighted how the model shifted trainees from passive participation to active decision-making. One supervisor described how trainees were initially guided through every case but were gradually given more responsibility as their confidence grew:

> *"At the start, they discuss everything with us. But as they demonstrate competency, they start managing cases independently, with us available in the background for support. That progressive autonomy builds confidence."*

Adopting a broader view of patient care and adjusting to differences in case management

Trainees valued learning from and being challenged by working with non-FACEM supervisors, including GP anaesthetists, ICU specialists, and rural generalists, some of whom had different ways of thinking and managing patients. For example, one trainee found that the GP supervisors provided valuable insights into primary care and holistic patient management but noted that their approach sometimes differed from emergency medicine physicians:

> *"GP supervisors bring a different perspective – they focus on long-term management. But sometimes, that approach doesn't align exactly with how emergency physicians manage critically ill patients."*

Trainees felt they had to adopt a broader view of patient care and consider the longer-term management and system constraints beyond the acute phase. One of the trainees also noted that emergency medicine in rural, regional and remote areas often involved additional responsibilities:

> *"In a metro hospital, you hand the patient off to another team quickly. Here, you're also thinking about follow-up, transport logistics, and managing more cases within the ED because referrals aren't always possible."*

While the need for trainees to be more independent and adopt a more holistic approach fostered stronger clinical reasoning and adaptability, some supervisors observed that trainees struggled in the early phases of their placements. A DEMT said:

> *"Some trainees are used to a high level of supervision at their metro placements and struggle when they have to make more independent decisions. It takes time to transition into that way of thinking."*

Another supervisor commented that where possible they avoided having trainees manage the more difficult and complex cases without on-site supervision by a FACEM at the start of their placements and supported them to gradually increase clinical independence as their placements progressed.

Maintaining ACEM standards in a blended supervision model

All three trainees that participated in this pilot demonstrated a strong commitment and appeared to have effectively upheld ACEM's core values[11] and clinical standards[12] in their practice, according to their supervisors/DEMTs and the ways in which the trainees spoke about their experiences. For most trainees, however, this required them to adopt a more proactive approach, particularly in situations when they did not have immediate feedback or oversight from an on-site FACEM supervisor. Trainees often took initiative to ensure their decision-making and treatments were in line with what they understood to be best practice in emergency medicine and sought guidance from their FACEM supervisors through structured case discussions, morbidity and mortality (M&M) reviews, and virtual meetings. These provided a valuable forum for trainees to critically review their cases, reflect on their decision-making and better understand how to translate ACEM's core values and clinical standards into practice, as one supervisor stated:

> *"These discussions force trainees to evaluate their approach, ensuring consistency with ACEM guidelines."*

Trainees who did not have consistent on-site supervision from FACEMs also relied on these sessions to supplement the advice and support they received from on-site non-FACEM supervisors and other senior doctors. A trainee recounted consulting senior doctors at the major hospital for complex cases and later reviewing the decisions during the scheduled meetings, noting that this provided the desired ACEM-level input.

Despite these efforts, some supervisors observed that the retrospective nature of this remote supervision limited the ability to provide immediate corrections to clinical practice. One of the DEMTs commented that while case reviews were valuable, they did not always capture the nuances of in-the-moment decision-making:

> *"With direct supervision, you can see a trainee's thought process in real time and adjust it if needed. With remote supervision, we rely more on post hoc discussions, which don't always allow for immediate course correction."*

15.2 Challenges experienced by trainees in the Pilot

Challenges of blended supervision and perceived safety concerns

While most trainees reported feeling well-supported, some acknowledged that working without direct FACEM supervision support introduced challenges, particularly in high-acuity situations. Trainees at smaller regional, rural and remote hospital sites sometimes had to navigate the balance between independent decision-making and knowing when to escalate cases. One trainee reflected on the challenge of deciding when to call a FACEM for advice:

> *"You don't want to wake your supervisor at 2 AM unless absolutely necessary, but sometimes you're sitting there thinking, 'Is this something I can handle myself, or should I escalate now?'"*

On occasions when a FACEM was not available for direct supervision and review of trainees' decision-making in real-time, some trainees found themselves having to be self-reliant in clinical decisions more often. While trainees always knew they could call their FACEM supervisors anytime, it was not the same as approaching an on-site FACEM:

"You know there's someone on the phone if you need them, but you don't want to call for every little thing. That means sometimes you sit on a case longer, double-checking your own decisions before escalating."

Despite these concerns, trainees generally felt supported as they knew they always had access to on-site Fellows from other medical specialties and remote FACEMs and senior registrars at the major hospitals if they needed support and FACEM supervisors were not on-site. While independent decision-making was challenging, most trainees found that the experience ultimately strengthened their ability to manage complex cases safely.

For some trainees, the absence of real-time supervision created uncertainty during high-risk procedures. They found that while remote supervision was helpful, it did not fully replicate having a FACEM in the room:

"When you're doing a procedure like a chest drain or an intubation, having someone there to guide you in real time makes a difference. Doing it alone and debriefing later is a different experience."

Supervisors also recognised the limitations of not having a supervisor on-site all the time. One DEMT noted that remote supervision relied on retrospective case discussions, which were less effective than concurrent supervision in ensuring immediate patient safety:

"With on-site supervision, you see how a trainee thinks in the moment and can correct their approach immediately if needed. With remote supervision, we're often discussing cases after the fact, which isn't always as effective for patient safety."

Some of the supervisors, including DEMTs, discussed some of the difficulties of trainees having non-FACEM oversight in meeting ACEM training requirements. Not all non-FACEM supervisors were familiar with ACEM training requirements, which sometimes resulted in confusion for the trainees and at other times created barriers in completing the mandatory assessments of the trainees:

"Our GP anaesthetists and rural generalists have decades of experience but they don't always know what an ACEM trainee specifically needs to demonstrate in their assessments. That means training experiences can vary depending on who's supervising. Also they don't necessarily know what an ACEM trainee needs to be signed off on which leads to some assessments take longer to complete."

Trainees also reported occasional difficulties in obtaining required ACEM assessments, as not all supervisors were qualified to sign off on emergency medicine-specific competencies. One of the trainees described this as a logistical barrier:

"Some of my assessments required a FACEM sign-off, but they weren't always around. That meant delays in getting my requirements completed."

To address this, supervisors suggested that ACEM could provide clearer guidance and additional training for non-FACEM supervisors as a better understanding of ACEM's training requirements would enhance consistency:

"If we want blended supervision to be sustainable, we need better alignment between ACEM expectations and what non-FACEM supervisors are comfortable assessing, and equip non-FACEM supervisors better so they understand what an ACEM trainee needs to demonstrate."

Challenges in receiving timely specialty input

Some trainees reported difficulties in securing timely specialty advice, particularly for high-acuity cases requiring urgent intervention. Unlike larger metropolitan hospitals where multiple specialty teams were available 24/7, regional, rural and remote hospitals often relied on a single on-call specialist to cover several sub-specialties, sometimes leading to delays in assessment and decision-making. One trainee described how overnight shifts could be particularly challenging when procedural support was required:

"If I needed an anaesthetist for an airway issue in the middle of the night, I sometimes had to wait because they were tied up in theatre. In a metro hospital, you'd have a whole team available, but here, it's just one person covering multiple areas."

Delays in transferring patients to ICUs in referral hospitals was another common concern, especially transfers from hospitals that did not have high-dependency units. Some trainees found that retrieval processes were complicated by a lack of available ICU beds in referral hospitals, forcing them to manage critically unwell patients for extended periods while awaiting transfer. One trainee described how a prolonged delay in ICU acceptance for a patient requiring mechanical ventilation placed significant demands on the team:

"We had a patient who clearly needed ICU care, but the nearest ICU was full, and we had to manage them in our ED for hours before a bed became available. From my experience, that's something I feel you might not deal with as much in a metro setting, and it definitely added to the stress of managing the case."

Supervisors, including DEMTs, acknowledged that resource limitations in regional, rural and remote hospitals could make specialist access unpredictable, requiring trainees to become comfortable managing patients for longer periods before escalation and/or handover was possible. One supervisor reflected that while this was demanding, it was also a valuable learning experience for the trainees:

"The reality of rural medicine is that you can't just send a patient to ICU immediately. You have to stabilise, optimise, and manage them as best as you can until a bed opens up. It's challenging, but it also teaches you resilience and adaptability."

15.3 Trainee support and learning environment

Trainees generally valued the support they received and their learning environments. While they felt they had less structured teaching opportunities compared to their previous placements at metropolitan hospitals, most of the trainees found the interdisciplinary learning opportunities and close collaboration with non-FACEM specialists to be highly beneficial.

Access to structured teaching and education

The reduced access to regular on-site structured teaching opportunities was another challenge experienced by trainees in this Pilot. Unlike tertiary hospitals where FACEM-led education sessions were regularly scheduled, regional, rural and remote hospitals often had fewer available supervisors and presented more competing clinical demands, leading to fewer formal teaching opportunities for trainees. One of the trainees observed that while the quality of education remained high, the frequency of sessions was lower than in his previous placements:

"The teaching here is great, but there's just less of it. The FACEMs are busy, and they can't always run as many sessions as you'd get in a metro ED."

Trainees often participated remotely in teaching sessions held by tertiary hospitals via videoconferencing although this caused some difficulties. One of the supervisors noted logistical challenges faced by trainees, including scheduling conflicts and internet disruptions, that occasionally limited engagement:

"We connected trainees to the [metropolitan teaching hospital] teaching program through Teams, which worked well most of the time. But there were always hiccups like scheduling conflicts, internet dropouts, or occasionally just being too busy on the floor to attend."

Additionally, some trainees found that locally available education sessions were tailored more towards GP registrars than ACEM trainees, which required them to take greater initiative in ensuring they fulfilled ACEM's training requirements.

Benefits of interdisciplinary collaboration and learning

Trainees widely recognised the value of working closely with non-FACEM specialists at regional, rural and remote hospitals, particularly GP anaesthetists, intensivists, and paediatricians, who played a crucial role in managing critically ill patients and assisting with complex procedures. Many reported that these specialists provided valuable teaching and guidance, helping them develop a broader understanding of multidisciplinary care. For example, one trainee noted that having access to experienced GP anaesthetists significantly enhanced his airway management skills and procedural confidence:

> *"The GP anaesthetists here are fantastic. I've had more opportunities to practise airway management with their guidance than I ever did in a metro hospital, where anaesthetics teams are often too busy to supervise trainees directly. They're always happy to teach, and that's been a huge benefit."*

Similarly, another trainee described how working closely with intensivists on retrieval cases gave them a more comprehensive understanding of the key principles of critical care. They found that the close working relationship between emergency medicine and ICU teams in smaller hospitals meant they were more actively involved in patient management decisions than they would have been at a larger hospital:

> *"In a metro ICU, you hand over a critically unwell patient and that's it, you're done. Here, you're actively involved in their ongoing care, discussing ventilator settings, fluid management, and escalation plans with the ICU team. It's a great learning experience."*

Supervisors also highlighted the benefits of interdisciplinary learning, particularly in regional, rural and remote settings where smaller hospital structures required trainees to engage more actively with specialists. A supervisor explained that this model of care provided a unique training advantage:

> *"In a rural ED, you don't just refer a patient and forget about them. You're involved in every stage of their care, working alongside anaesthetists, ICU physicians, and paediatricians to ensure the best outcome. That's a huge advantage for training."*

For many trainees, the close working relationships with other specialists helped compensate for the times when a FACEM was not available on-site, ensuring they still received valuable clinical input and hands-on teaching from other senior clinicians during those periods.

15.4 Trainee wellbeing, confidence and support

Trainees who participated in this pilot generally found the experience rewarding, with many reflecting positively on the growth in confidence and clinical independence that came with managing patients more autonomously. However, the trainees faced a number of difficulties, particularly in relation to stress, professional isolation, and fatigue. Several trainees described the relatively heavy cognitive and emotional burden of making critical decisions without immediate senior support, while others spoke about the emotional toll of managing complex cases without real-time reassurance or debriefing. Supervisors recognised these pressures and highlighted the need for structured mechanisms to support trainee wellbeing, including improved shift rostering, more regular debriefing, and stronger peer networks.

Emotional burden of increased responsibility

A key concern discussed in the interviews was the impact of reduced on-site supervision on trainees' stress levels, particularly in high-acuity cases. One trainee recounted managing a critically ill paediatric patient before retrieval, describing it as both an empowering and overwhelming experience:

> *"I had remote support, but in the moment, the responsibility was entirely mine. That realisation stays with you long after the case is over."*

Another trainee noted that while blended supervision accelerated their confidence in independent decision-making, the lack of immediate validation by a FACEM meant they often spent longer second-guessing their choices, even when they were convinced they had made the right clinical decisions. A DEMT based at a metropolitan hospital observed that trainees there often benefited from real-time feedback, which could be reassuring after difficult cases, whereas at regional, rural and remote hospitals, that

reassurance was often delayed, leading to unnecessary self-doubt and stress.

Trainees highlighted the need for more structured debriefing sessions after high-acuity cases to provide both clinical feedback and emotional reassurance. One trainee found such debriefs to be particularly helpful in processing difficult cases, even if feedback was provided retrospectively:

> *"Even when the debrief wasn't immediate, just sitting down and reviewing my decisions later was incredibly reassuring."*

However, they noted that these sessions were often informal and ad hoc, suggesting that a more structured approach would provide greater consistency and support.

Impact of professional isolation on trainee wellbeing

Trainees also spoke about their perceived relatively high level of professional isolation that came with working at the regional, rural and remote hospitals, largely because on-site supervision and peer support were less readily available. They explained that during their previous placements at larger hospitals, checking in with a FACEM for quick reassurance between cases was common practice, but during this pilot, access to senior support was less frequent and more structured, meaning they sometimes sat with their doubts for longer than they would have liked. One trainee commented:

> *"I know I could always call a FACEM for advice but the threshold for doing so feels higher here so I feel more hesitant to escalate cases than I did when I worked at a metro hospital."*

Some of the supervisors observed this reluctance and added that trainees may have felt they needed to be more selective about when they called a remote FACEM, as they were not physically present and had to rely entirely on the trainee's interpretation of the situation. This differed from placements at larger metropolitan hospitals where senior clinicians could observe patients directly and provide immediate input. Additionally, a couple of the supervisors suggested that trainees may also have felt they were expected to be more self-sufficient, even when dealing with highly complex cases, at the regional, rural and remote hospitals. A supervisor reflected that without proactive check-ins, trainees might delay seeking support until they reached a breaking point rather than addressing concerns as they arose.

Supervisors recognised that a lack of clarity could create patient safety risks and suggested that clear escalation protocols should be a mandatory part of any blended supervision model. One of the supervisors proposed a standardised approach:

> *"We need a simple, clear guideline that tells trainees: If you're unsure, call the FACEM. No second-guessing, no hesitation. That should be non-negotiable."*

Additionally, trainees highlighted a need for stronger peer networks which would allow them, and other trainees in blended supervision placements, to connect with others in similar situations. One trainee suggested that regional peer discussion groups could provide much-needed opportunities to share experiences, discuss challenging cases, and offer informal emotional support:

> *"Having a space where we could check in with each other, without the formal structure of a supervisor meeting, would help reduce the sense of isolation."*

Fatigue experienced by trainees

Concerns about shift intensity were raised during the interviews, with some trainees commenting on the difficulty of taking adequate breaks during busy periods, particularly in hospitals with limited staff coverage. One trainee described shifts where they barely had time to step away, contributing to mental and physical exhaustion over time. Supervisors acknowledged that while placements at rural and remote hospitals often involved higher levels of responsibility compared to those at larger metropolitan hospitals, rostering policies need to ensure trainees were not working excessive hours without adequate downtime:

> *"While rural and remote placements naturally involve greater responsibility, there should still be safeguards to prevent trainees from becoming overwhelmed by workload pressures."*

15.5 Assessment and feedback processes

Assessment and feedback processes played a critical role in maintaining safe clinical practice and supporting trainee development. Trainees relied heavily on formal feedback sessions with their FACEM supervisors, such as case-based discussions and debriefs. While most of the trainees valued the insights gained through formal and informal feedback, they experienced some difficulties with accessing timely assessments, managing logistical barriers, and navigating variability in feedback quality. Supervisors recognised these issues and emphasised the need for clearer assessment pathways, particularly in regional, rural and remote settings where the availability of FACEMs and real-time supervision was often limited.

The role of feedback in reinforcing safe practice

Given the nature of blended supervision, trainees relied heavily on formal feedback mechanisms to ensure their clinical practice remained aligned with ACEM standards. Regular case-based discussions, structured debriefs, and retrospective case reviews were crucial in helping trainees refine their decision-making and procedural skills. One of the trainees found that debriefs with their remote FACEM supervisor soon after complex clinical situations were invaluable for reinforcing safe clinical practice:

> *"After a tough case, we'd sit down and go over everything – what went well, what could have been done differently. That kind of feedback was incredibly useful."*

Another trainee described how weekly case discussions helped strengthen his approach to patient management:

> *"We'd go through my cases, and my supervisor would highlight what I did well and where I could improve. Those discussions really helped reinforce safe decision-making."*

Trainees found, however, that obtaining assessor sign-offs for direct observations of procedural skills (DOPS) was particularly challenging at times due to the limited availability of FACEMs and the nominated Local Supervisor/s. One trainee noted that while they and their supervisors felt confident in their procedural skills, the process of formal assessment was not always straightforward:

> *"There were times when I needed a FACEM to sign off on a procedure, but they weren't around. That meant waiting or finding someone later to confirm my competency."*

Supervisors also acknowledged the need for improved feedback and assessment mechanisms, particularly for procedural skills and suggested that clearer processes and opportunities for non-FACEM supervisors to assess procedural competencies could help address this challenge.

Trainees who participated in this Pilot had mixed experiences with workplace-based assessments (WBAs) and feedback, with some finding the process well-integrated and supportive, and others encountering delays in obtaining assessments, inconsistencies in feedback quality, and challenges in meeting ACEM's competency requirements. At the hospital sites where FACEMs were not always immediately available for direct supervision, trainees and supervisors adapted by incorporating remote assessments, retrospective sign-offs, and alternative assessors such as GP anaesthetists and intensivists. While these adjustments ensured assessments could still be completed, they also introduced variability in how performance was evaluated and how feedback was delivered.

While most trainees felt that their clinical performance was appropriately assessed, concerns were raised about the logistical barriers to obtaining timely sign-offs, the differences in feedback quality depending on the supervisor, and the limitations of remote supervision in assessing practical skills and clinical decision-making in real-time. Supervisors acknowledged these difficulties and emphasised the need for clearer processes to ensure that WBAs were both accessible and meaningful in supporting trainees' development.

Delays and logistical barriers in completing assessments

For most of the trainees, the biggest challenge in completing WBAs was the availability of supervisors to conduct assessments in real time. In larger metropolitan hospitals, assessments could often be arranged on the spot, but at the regional, rural and remote hospitals, trainees needed to be more proactive in planning their WBAs, particularly for procedural skills that required direct observation by a FACEM. One

trainee described how delays in getting procedural assessments signed off created uncertainty around their progress:

> *"I knew I was getting plenty of experience with procedures like chest drains and intubations, but the challenge was getting them assessed. If the FACEM wasn't available when I did it, I had to wait for another opportunity, and sometimes that took longer than I expected."*

Similarly, another trainee found that coordinating WBAs with remote supervisors added an extra layer of complexity.

> *"I had to do a case-based discussion with my remote DEMT, which meant setting up a time outside of my usual shifts. It wasn't a huge issue, but it did mean that assessments sometimes got pushed back, and that made me a bit anxious about keeping up with my training requirements."*

Supervisors/DEMTs recognised that blended supervision required trainees to take greater responsibility for tracking their own assessments. One DEMT explained that while WBAs were still achievable, they required forward planning:

> *"We tell trainees from the start that they need to be organised and plan their assessments ahead of time because in a rural setting, you can't always just grab a FACEM and ask for a WBA on the spot. It requires more forward planning, but it's manageable if they stay on top of it."*

While these logistical hurdles did not prevent trainees from completing their required assessments, they required additional coordination and self-management, which sometimes added more stress to an already demanding training environment.

Variability in feedback quality and frequency

Trainees reported differing experiences in the quality and frequency of feedback they received, with some benefiting from detailed, structured discussions while others found feedback to be inconsistent or overly general. These differences were largely shaped by the availability of supervisors, the format of assessments, and whether feedback was delivered in real time or retrospectively.

One trainee noted that working closely with a small group of supervisors meant they received regular, meaningful feedback that helped refine their clinical skills:

> *"Because the team is smaller here, my supervisors know me well and can give me specific feedback about how I'm progressing. I feel like they see how I work every day, so their feedback is meaningful and tailored to me."*

Others found that when assessments were conducted remotely or based on case discussions rather than direct observations, the feedback was sometimes less detailed. Another trainee described how remote assessments, while useful, lacked the depth of in-person supervision:

> *"When I had a case-based discussion with my remote DEMT, it was useful, but it wasn't quite the same as having someone observe me managing a patient in real-time and giving me feedback on the spot."*

Supervisors also observed that feedback quality varied depending on whether the assessor was a FACEM or another senior clinician. One DEMT noted that while GP anaesthetists and ICU physicians were excellent teachers, they were sometimes less familiar with ACEM's assessment framework:

> *"The GP anaesthetists and ICU physicians we work with are fantastic teachers, but they don't always know exactly what an ACEM trainee needs to demonstrate for a WBA. That's something we're working on improving."*

Remote supervision in performance evaluation

Trainees reported that they regularly engaged in virtual check-ins, case discussions, and retrospective assessments with their supervisors and DEMTs and they generally found these interactions helpful for reflecting on their practice and identifying areas for improvement. One trainee commented:

> *"Even though my DEMT wasn't on-site, we had structured meetings where we'd go through cases and discuss what I could improve. That kind of feedback was still really useful, even if it wasn't happening in real-time."*

Some of the trainees felt that remote assessments lacked the depth of face-to-face evaluations, particularly when it came to assessing practical skills, leadership, and bedside manner. For example, one trainee noted that remote supervision sessions sometimes felt less engaging compared to in-person assessments:

> *"When you're talking through a case over video, it's different from having someone physically there watching how you interact with patients. I sometimes felt like my supervisors didn't get a full picture of how I was working day to day."*

Supervisors recognised that remote assessments had limitations, particularly in evaluating soft skills such as teamwork, situational awareness, and communication under pressure. One supervisor suggested that incorporating more structured methods of remote observation, such as live case discussions or video-recorded assessments, could help address these gaps.

> *"There are certain things you just can't evaluate remotely as well as you can in person. We're looking at ways to incorporate more structured real-time observation into remote supervision."*

These reflections highlight that while remote supervision offers necessary flexibility, refining assessment methods could improve its effectiveness in evaluating trainees' overall performance.

15.6 Sustainability of the model

The blended supervision model was widely seen to be a valuable and feasible approach to emergency medicine training, particularly in expanding training opportunities in rural and regional hospitals where there is often a lack of FACEMs who are able to provide on-site supervision. One DEMT explained:

> *"We're never going to have enough FACEMs in every regional ED, but blended supervision means we can still provide high-quality training in these locations. As long as trainees have remote access to experienced supervisors and good local support, this model can work long-term."*

Most of the trainees and supervisors/DEMTs also felt that while the model provided excellent opportunities for trainees to further develop their clinical knowledge and skills, foster greater autonomy and independence in decision-making and case management, learn from other medical specialties, and accelerate the development of confidence and experience in procedural skills, sustaining and scaling up its implementation would not be without difficulties.

Challenges to expanding the model on a larger scale

Trainees and supervisors/DEMTs felt implementing the blended supervision model across a broader range of hospitals would have several challenges, including variability in the local supervision provided to the trainees, logistical difficulties in coordinating remote assessments, and ensuring adequate FACEM oversight across multiple sites.

One of the primary concerns was the inconsistency in local supervision, with some trainees and supervisors/DEMTs reporting strong support from GP anaesthetists and rural generalists, while others found that competing clinical demands limited their ability to receive feedback and structured teaching. One trainee reflected on the variability between hospital sites:

"In some placements, the local GP anaesthetists and rural generalists were great at teaching and really invested in our training. In others, they were stretched thin with their own workload, and that made getting regular feedback harder."

Another significant challenge was maintaining consistent assessment and feedback processes, particularly when trainees relied on remote evaluations. Some reported delays in obtaining sign-offs for WBAs, leading to concerns about meeting ACEM training requirements. A supervisor emphasised that without structured systems, assessment delays could create barriers to successful implementation of blended supervision:

"The main issue with scaling blended supervision isn't whether trainees can get good clinical experience, it's whether we can ensure they get timely assessments and structured feedback, regardless of which site they're at."

Supervisors/DEMTs also questioned whether the current workforce could sustain an expansion of the model, particularly in ensuring that remote supervision was accessible across multiple sites, as one DEMT explained:

"Remote supervision works well when there are enough FACEMs available to engage with trainees regularly. But if we were to expand this model significantly, we'd need to make sure we have the workforce capacity to support it properly."

These concerns highlight that while blended supervision appears to be an effective training model, expanding it successfully will require careful planning to ensure trainees at different hospital sites receive adequate support from FACEMs and similar clinical experiences that meet ACEM's standards.

Improved infrastructure and support systems are needed

For blended supervision to be successfully scaled across a wider range of hospital sites, several key improvements to the infrastructure and support systems were identified by the trainees and supervisors/DEMTs. These included improving digital platforms for remote supervision, providing more structured training for non-FACEM supervisors, and enhancing the coordination of assessments and feedback mechanisms.

One of the most frequently suggested improvements was expanding telehealth capabilities to facilitate real-time supervision, case reviews, and assessments with remote FACEMs. One trainee noted that improving use of digital tools could make it easier for trainees to access feedback and support from their FACEM supervisors:

"If we had more structured digital platforms where we could do case reviews or even live assessments with remote FACEMs, it would make a big difference in how we engage with supervision."

Supervisors highlighted the importance of structured training for non-FACEM supervisors, ensuring that GP anaesthetists, ICU specialists, and rural generalists involved in training were familiar with ACEM's assessment and competency requirements. A supervisor suggested that formal guidelines and training workshops could help standardise supervision quality across different hospital sites:

"Our GP supervisors are fantastic, but they aren't always familiar with what an ACEM trainee specifically needs to demonstrate. If we want blended supervision to work at scale, we need to provide clear guidance to all supervisors involved."

Another important consideration was improving the coordination of assessments and feedback to ensure all the trainees at different hospital sites had access to and were able to complete the required evaluations efficiently and in a timely manner. A supervisor proposed a centralised system for tracking and collating feedback (from sites to DEMTs) to streamline the process:

"If trainees had a structured, standardised way to log assessments and feedback across all the hospital sites, it would help ensure consistency and reduce delays in completing the evaluations and other paperwork."

Supervisors emphasised that thoughtful implementation and appropriate resource allocation would be critical in ensuring longer-term sustainability of the blended supervision model. One suggested that as a next step, ACEM should prioritise implementing the model at hospitals in other regional, rural and remote hospitals that have strong existing training infrastructure:

> *"Expanding blended supervision needs to be done in a way that ensures quality. Sites with good clinical governance and experienced supervisors should be the priority for scaling."*

16. Discussion

The pilot sought to explore the feasibility of creating a unique training opportunity via a blended supervision model, which combines the face-to-face clinical supervision with remote training supervision. Funded under the DoHAC FATES initiative, the pilot enabled approved placement sites to run a 6 FTE month, core ED placement for a single FACEM trainee.

Findings demonstrated significant effectiveness and adaptability of the model, showcasing its potential as a forward-thinking solution to the challenges of supervision in RRR healthcare settings. This approach not only created opportunities for growth but also fostered a platform for autonomy, encouraging trainees to take ownership of their learning and decision-making. These findings were echoed in the interviews conducted by the Sax Institute, with many trainees indicating that the BSP contributed to accelerating their development as emergency physicians, particularly as they had more opportunities to develop procedural skills than they typically would at a metropolitan hospital:

> *By operating in a dynamic and ever-changing environment, trainees were continuously challenged to think critically, adapt to unforeseen circumstances, and develop resilience. This exposure helped refine their clinical reasoning, problem-solving abilities, and confidence in managing complex cases independently. Additionally, it prepared them for the realities of emergency medicine, where quick thinking and adaptability are essential for effective patient care. In contrast, the increased independence associated with remote supervision also brought a greater emotional and professional burden. This aligns with findings from established remote training models, which highlight the challenges of professional isolation, the lack of immediate validation and feedback, and the heightened responsibility placed on trainees. These factors collectively contributed to increased stress levels.*
>
> *Interview responses reinforced these concerns, with trainees describing the psychological impact of managing complex cases without on-site FACEM support. Although remote FACEMs were accessible via telehealth or virtual consultations, trainees reported a tendency to hesitate before escalating cases unless absolutely necessary. This suggests that physical distance introduces a psychological barrier, subtly altering decision-making processes compared to the traditional, more immediate interactions with an on-site supervisor. Over time, this could affect trainees' confidence and willingness to seek guidance, potentially influencing both patient outcomes and professional development.*
>
> *While the desktop review highlighted that remote supervision could provide comparable training outcomes to traditional supervision, it also outlined some potential drawbacks, such as a lack of immediate feedback, difficulties in assessing practical skills, and challenges in maintaining consistent supervision quality. These limitations were reinforced by interview findings, where trainees and supervisors/DEMTs noted that the absence of real-time FACEM oversight sometimes led to increased hesitation in decision-making. Trainees and supervisors/DEMTs acknowledged that while retrospective case discussions were useful for reflective learning, they were not always an adequate substitute for real-time, on-site supervision, particularly for procedural assessments and high-acuity cases. Similar to findings in the research literature, some trainees also found that they second-guessed their decisions more frequently in the absence of an immediate senior presence, which suggests that remote supervision can contribute to increased cognitive burden and stress for trainees.*
>
> *Addressing these challenges requires strategies to bridge the perceived gap between remote and on-site supervision. Enhancing structured debriefing opportunities, and promoting clear*

escalation protocols could help mitigate feelings of isolation and ensure that trainees feel supported in their clinical decision-making.

The desktop review found that effective remote supervision models relied on structured feedback mechanisms and clear escalation pathways to ensure patient safety and trainee confidence. However, both the research literature and interview findings indicated that such structures were not always well established. Trainees in the Pilot reported variability in how feedback and assessments were delivered, with some experiencing delays in completing WBAs due to limited access to FACEM supervisors. The involvement of non-FACEM supervisors, including GP anaesthetists and ICU specialists, was beneficial in broadening clinical exposure and providing procedural guidance, but some trainees noted that these supervisors were not always familiar with ACEM's assessment requirements. The desktop review confirmed that other medical colleges with remote supervision models, such as ACRRM and RACGP, have implemented structured frameworks for non-specialist supervisors to help ensure alignment with the Colleges' training standards.

The participating sites demonstrated a diverse range of supervision models, each offering distinct perspectives. Sites with rotating FACEMs provided a supervision experience closely resembling the traditional model trainees encountered in other placements. In contrast, supervision by other Fellows introduced a different approach to case management, presenting both a learning curve and a valuable perspective that enriched trainees' education. This, in turn, offered an authentic insight into the operational realities and varied structures of rural hospitals.

The structure of the pilot fostered increased flexibility and authenticity in training delivery, offering trainees a comprehensive and practical experience. This structure often enhanced trainee independence and broadened their clinical exposure, equipping them with valuable skills and insights that are particularly relevant to RRR healthcare contexts.

The pilot not only facilitated the delivery of high-quality supervision at currently unaccredited sites but also highlighted the potential for scalability and adaptation of similar models across diverse healthcare settings.

The Sax Institute desktop review pointed to several factors that influence the long-term success of remote supervision programs, including the availability of experienced supervisors, the use of digital supervision tools, and the alignment of training requirements with local workforce capacity. Interviews supported these findings, with both trainees and supervisors/DEMTs agreeing that the blended supervision model could be expanded to other RRR hospitals, provided that key structural improvements were made. Supervisors/DEMTs emphasised that ensuring the availability of adequate FACEM oversight was critical to preventing supervisor fatigue and maintaining training quality. Provision of structured training for non-FACEM supervisors would also ensure that trainees would receive consistent and high-quality supervision across different hospital sites.

By combining innovative strategies with traditional supervisory practices, the BSP represents a positive step toward strengthening workforce capacity and resilience in under-resourced areas. Enhanced use of telehealth and recorded assessments could further improve the model by facilitating real-time supervision, enabling more comprehensive feedback, and streamlining assessment processes. These advancements would not only support trainees in enhancing clinical competency but also help mitigate some of the supervision challenges characteristic of regional, rural and remote settings, ensuring a more effective and sustainable training framework.

Outside of the emergency medicine environment, the blended supervision model demonstrates potential for scalability to other locations and specialties. The model's flexibility makes it suitable for adaptation by other medical colleges, particularly those facing similar workforce distribution challenges in RRR areas. Through promotion of consistent and high-quality supervision, the model enhances the overall training experience in RRR settings, which can positively impact on future trainee recruitment and retention of specialists in these areas. Understandably, the model would require a tailored approach for different specialties due to unique supervision requirements and regulatory standards.

The outcomes of the project are described in response to the outlined objectives in the Program logic model and the greater FATES grant objectives. By mapping the findings against these established frameworks, the report provides a clear and comprehensive assessment of the project's effectiveness in

meeting both its specific and overarching aims.

Program Logic Model aims:

1. Completion of training rotation. Patient safety and trainee welfare are maintained:

Placements under the BSP were successfully completed in line with the requirements of the FACEM Training Program. Key achievements included:

- Structured support: The pilot structure incorporated regular supervisor meetings and consistent correspondence with the College. These measures ensured that trainees were well supported, with any arising issues promptly addressed.

- Safety measures: Site applications were designed to maximise patient safety and trainee wellbeing. Appropriate information relating to hospital structure and on-call procedures were required to be documented to ensure the site was suitable to participate. This requirement was particularly crucial in rural environments, where high-complexity cases are common. The structured oversight reinforced a culture of safety and ensured that both patient and trainee needs were effectively met.

- Dedicated Supervisor Engagement: Supervisors were well informed of their roles and responsibilities, operating as a highly functional support system for the trainees. Regular feedback loops were implemented to monitor performance and to address any potential risks. This engagement helped align the placement with the trainee's intended learning outcomes.

2. Trainees who have completed the blended supervision program develop strong clinical skills

Trainees who participated in the BSP demonstrated significant improvement in their clinical skills:

- Learning outcomes: ITAs conducted at the conclusion of each placement period confirmed that trainees consistently met or exceeded standards across key categories, including medical expertise, prioritisation and decision-making, communication, teamwork, leadership, health advocacy, scholarship, and professionalism. These competencies collectively underpin strong clinical skills.

- Broad exposure: The placement created great exposure to a diverse range of cases, enabling the development of essential skills across a wide spectrum of clinical scenarios. This depth of experience contributed significantly to their professional growth.

3. Increased professional development for trainees and improved ability to safely treat a variety of patients upon completion of their fellowship

The BSP facilitated increased professional development opportunities, preparing trainees to safely and competently manage a diverse range of patient presentations upon fellowship completion. Specific outcomes include:

- Enhanced opportunities: The BSP provided opportunities for trainees to engage in procedures and case management experienced that are less frequent in metro hospitals. The lower trainee-to-patient ratio at these sites allowed trainees to work towards fulfilling additional training requirements. Eligible trainees were also able to log paediatric cases as part of completing their paediatric emergency requirements, further highlighting the breadth of exposure.

- Tailored learning plans: LDPs were created to establish individual learning objectives. Progress was regularly reviewed to ensure alignment with both trainee goals and FACEM training standards.

- Exposure to multidisciplinary teams: Trainees collaborated closely with diverse healthcare professionals and became a valuable addition to the workplace, fostering a holistic approach to patient care and enhancing their teamwork skills.

4. Short term increase of the emergency medicine capacity of secondary hospitals

- Positive clinical contributions: Trainees brought valuable skills and enthusiasm to their placements, enhancing the clinical experience for them and the hospital staff
- Resource awareness: Exposure to resource-limited environments fostered a deeper understanding of the challenges inherent to rural healthcare. This experience cultivated respect for local patient care practices and encouraged innovative problem-solving.
- Leadership development: Trainees were often placed in positions to exhibit leadership qualities within the emergency department, providing them with valuable experience in managing teams and resources effectively.

FATES Objectives

FATES Objective 1 - Improve and promote a positive rural and remote medical education culture

The BSP significantly contributed to fostering a positive rural and remote medical culture through introduction of the blended supervision model. This model combined on-site and remote supervision, ensuring that trainees in RRR locations felt connected and supported. Through early engagement with interested sites and engaging supervisors with a strong background and enthusiasm for RRR practice, the project created a supportive learning environment that highlighted the unique opportunities and rewards of working in these settings. These efforts were further enhanced by flexible feedback mechanisms, enabling trainees to share their insights and suggestions, ensuring that the education culture remained adaptive and trainee focused.

FATES Objective 2 - Provide quality specialist medial training in rural and remote Australia

Outcomes of the BSP highlighted a high standard of specialist medical training in RRR Australia by delivering a structured program that maintained alignment with the rigorous requirements of the FACEM training program. Competency-based assessments ensured that both technical and non-technical skills were developed. Additionally, the incorporation of remote training supervision facilitated meaningful and effective support, as well as case-based discussions, enabling trainees to access quality learning experiences regardless of geographical barriers.

FATES Objective 3 - Reduce barriers and improve incentives for junior doctors entering rural and remote medical practice.

The BSP took a proactive approach to breaking down the barriers and incentivising registrars to pursue RRR emergency medicine. The pilot offered trainees an opportunity to undertake training in a rural or remote hospital whilst also being accredited for core ED training time, which is advantageous in contributing to their training progression. Accessibility challenges were mitigated through the blended supervision model, which reduced feelings of professional and logistical isolation. The BSP showcased the opportunities that can come out of working in rural hospitals, and how it could contribute to a trainee's professional; development, encouraging more trainees to take the leap in joining the rural workforce.

FATES Objective 4 - Improve the imbalance of distribution of the non-GP specialists medical training agreements and workforce, particularly in areas of unmet needs

The BSP directly addressed the imbalances in workforce distribution through the strategic placement of trainees in RRR hospitals, an area of significant unmet need. Collaborations with RRR hospitals ensured that training opportunities were aligned with local workforce demands, creating mutually beneficial arrangements. Through integrating trainees into multidisciplinary teams, the project not only strengthened the local healthcare workforce but also built capacity and resilience within these teams. The blended supervision model encouraged greater flexibility and vast opportunities for professional development, which is effective in encouraging retention of trainees and makes a strong case for them to continue to work in RRR settings followship the completion of their training.

17. Limitations

The evaluation of the pilot acknowledges several limitations. Delays in the recruitment of trainees for the pilot affected the timely commencement of the program and underscore persistent barriers to attracting trainees into RRR emergency medicine. These delays highlight the need to address recruitment challenges, such as perceptions of RRR practice and logistical complexities, to support the scalability and sustainability of similar initiatives.

Consequently, the limited number of participants in the pilot impacted the significance of the findings and restricted exposure to the full range of variability in clinical situations. A larger sample size would enhance the generalisability of the results and provide a more comprehensive understanding of the model's effectiveness across diverse clinical contexts.

All participating trainees resided in reasonable commuting distance to the placement sites, limiting the evaluation's ability to consider the experiences of those required to relocate. Evaluating trainees who relocate for RRR placements could provide additional insights into the individual and social impacts of the model, particularly regarding adaptation to new environments and the support structures required for success. Trainees with prior experience at placement sites may have felt a greater sense of security and support, benefiting from previously established relationships with supervisors and staff on the floor. The diversity of pilot sites and trainee cohorts could introduce complexities in evaluating the effectiveness of blended supervision. Variations in outcomes may stem from differing local resources, supervision structures, or trainee needs. Future evaluations should adopt robust methodologies to identify best practices for broader implementation.

The desktop review indicated that remote supervision could deliver training outcomes comparable to traditional supervision but also identified several challenges, including delayed feedback, difficulties in evaluating practical skills, and inconsistencies in supervision quality. The involvement of non-FACEM supervisors, such as GP anaesthetists and ICU specialists, expanded clinical exposure and provided valuable procedural guidance. However, some trainees reported that these supervisors were not always familiar with ACEM's assessment requirements. The review also found that other medical colleges with remote supervision models, such as ACRRM and RACGP, have implemented structured frameworks to support non-specialist supervisors in aligning with their training standards.

These limitations were reinforced by interview findings, where trainees reported that limited onsite FACEM supervision impacted their confidence and their perceived level of support, particularly during complex or high-stakes clinical scenarios. As a result, the absence of real-time FACEM oversight sometimes led to hesitation in decision-making. Further evaluation of non-FACEM supervision is necessary to address these concerns and ensure trainees feel adequately supported at all times.

Inadequate levels of supervision or support could also contribute to feelings of isolation or disconnection among trainees. Strategies to enhance the integration of remote and on-site interactions, such as structured communication opportunities and team-building initiatives, could help mitigate this risk.

In terms of building a sustainable model, the current site application process would benefit from further refinement. A standardised requirement for supplementary documentation — such as educational frameworks, supervisory structures, and resource capabilities — should be incorporated to ensure a comprehensive assessment of site readiness.

Differences in IT systems across pilot sites created challenges in verifying assessment-related information, particularly for logbook cases, leading to delays and increased administrative workloads. Standardised IT or process solutions or robust support mechanisms should be explored to mitigate these inefficiencies and streamline processes.

Structural challenges, including limited funding and staffing at sites, may constrain the long-term sustainability of the BSP. Addressing these constraints through targeted advocacy and resource allocation is critical to ensure the program's continuation and scalability.

18. Conclusion

Under the FATES funding program, the Blended Supervision Pilot project has sought to explore the barriers and enablers of RRR supervision for FACEM trainees by piloting a model combining onsite clinical and remote training supervision. The evaluation has sought to determine the potential for the blended supervision model to be implemented in the FACEM training program.

Findings have detailed the success of the project, through its ability to provide a supportive and effective experience for the trainee, whilst also being a rewarding experience for professional development. Overall, the blended supervision model provides a viable framework for trainee supervision in RRR settings, despite the inherent supervision, social, and emotional challenges that come with working in these environments. This report suggests recommendations necessary for a sustainable blended supervision model without the presence of future FATES funding. Ongoing evaluation is required to monitor the continued effectiveness of the model, to ensure it remains a structure that is fit for purpose.

19. References

1. Australian Government Department of Health, 2021. National Medical Workforce Strategy 2021-2031. Available from: https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf

2. Baker, T. and Dawson, S.L., 2014. Small rural emergency services still manage acutely unwell patients: A cross-sectional study. Emergency Medicine Australasia, 26(2), pp.131-138.

3. McCarthy, S., Gosbell, A., Wood, A. and Jovanoska, V., EMET: providing emergency medicine educating and training for rural emergency department teams.

4. ACEM (2021) Rural Health Action Plan. Available from: https://acem.org.au/getmedia/9639d829-6f60-4523-a5a3-784081b74426/RuHAP

5. Australian Institute of Health and Welfare (AIHW). Emergency department care. 2022; Available from: https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care.

6. Whitehead, J., Davie, G., de Graaf, B., Crengle, S., Lawrenson, R., Miller, R. and Nixon, G., 2023. Unmasking hidden disparities: a comparative observational study examining the impact of different rurality classifications for health research in Aotearoa New Zealand. BMJ open, 13(4), p.e067927.

7. Clough, B.A., Ireland, M.J., Leane, S. and March, S., 2020. Stressors and protective factors among regional and metropolitan Australian medical doctors: A mixed methods investigation. *Journal of clinical psychology*, *76*(7), pp.1362-1389.

8. ACEM (2023). Accreditation Requirements. Available from: https://acem.org.au/getmedia/003f59d2-b5c9-433f-9ff5-bb0843b2f950/AC549_FACEM_Training_Program_Site_Accreditation_Requirements-v1-02.aspx

9. Gill, S.D., Stella, J., Blazeska, M. and Bartley, B., 2020. Distant supervision of trainee emergency physicians undertaking a remote placement: a preliminary evaluation. Emergency Medicine Australasia, 32(3), pp.446-456.

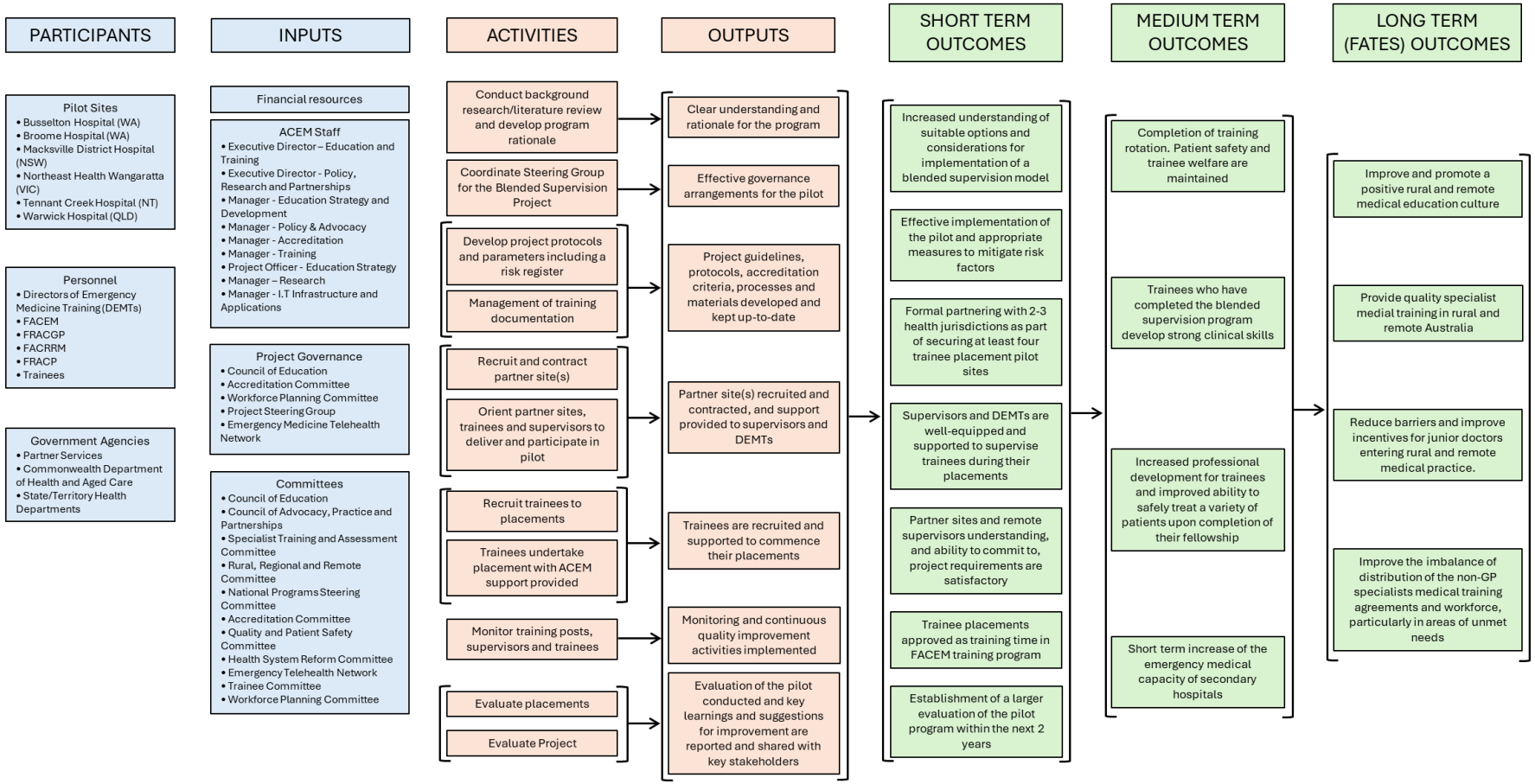
10. Looi, J.C., Maguire, P., Bonner, D., Reay, R.E., Finlay, A.J., Keightley, P., Tedeschi, M., Wardle, C. and Kramer, D., 2021. Conduct and evaluation of final-year medical student summative assessments in Psychiatry and Addiction Medicine during COVID-19: an Australian University Medical School experience. Australasian Psychiatry, 29(6), pp.695-698.

11. ACEM's Core Values. Available at: https://acem.org.au/Content-Sources/About/ACEM-Core-Values

12. ACEM Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services. Available at: https://acem.org.au/getmedia/f4832c56-2b59-4654-815b-cdd1a66b27a8/ACEM_QualityStandardsEDs_Report

20. Appendices

20.1 Appendix A: Program Logic Model



20.2 Appendix B: Desktop Review – *The Sax Institute*

Remote supervision in the research literature

In the context of clinical training, *blended supervision* refers to the supervision of a trainee by a combination of supervisors who are variously located in the trainee's current clinical service setting and away from it. Because the trainee is working at some distance from an identified supervisor, blended supervision inevitably involves *remote supervision*, at least partially, and usually draws partially on senior clinical support from specialists in fields other than the trainee's specialty. While the research literature distinguishes between blended supervision and remote supervision, it concentrates less on organisational structure and location and more on the nature of supervision, the dynamics of the interaction between supervisor and trainee, and trainees' needs. Much of the literature consists of studies using rigorous qualitative research methods to examine the experience of supervisors in remote and blended supervision roles. No reports appear to be available on the associations between specific supervision or training methods and intended training outcomes. From a policy perspective, the most important outcomes might include measures of trainees' development of site-appropriate clinical independence, confidence, self-sufficiency and competence, and recruitment to and retention of a regional, rural and remote emergency medicine workforce.

Benefits of remote supervision

Benefits of remote supervision have been documented in several research articles, with assessments of the attainment of these benefits mostly relying on supervisors' observations rather than attempts to validate consequential changes in trainees' attitudes and capabilities. Benefits of remote supervision have been observed at several levels: the trainee; the ED; the local health service; and local and regional communities. For trainees, an evaluation of a remote supervision placement for emergency trainees in rural Victoria suggested that remote supervision programs developed communication skills, capacity and confidence for independent practice, and their leadership, advocacy and professional inter-personal skills[1]. For EDs, remote supervision programs have both short and long-term benefits in increasing the availability of specialist medical skills and quality of health care in regional, rural and remote areas.

The volume of literature evaluating the benefits of remote supervision for emergency medicine trainees is small. Much more has been published on the benefits of remote training for general practice (rural generalist) trainees[2,3], and it seems reasonable to assume that similar benefits would apply in emergency medicine. The presence of trainees creates a culture of education and enquiry in clinical departments, contributes to the clinical expertise that advanced trainees themselves bring, and enhances the practice of others in multi-disciplinary teams. It is also asserted that positive experiences of remote supervision increase the likelihood of a trainee returning to a rural or remote area after the completion of their training program. Remote supervision can allow trainees to practice in more locations that are suitable or of interest to them[4].

Disadvantages of remote supervision

In their evaluation of remote supervision of emergency medicine trainees in Victoria, Gill and colleagues noted some downsides[5]. Most of these related to communication between trainees and distant supervisors: reduced quality and quantity of information communicated; reduced opportunities for informal teaching and learning; reduced opportunities for mentoring, de-briefing and pastoral care; and the likelihood that communications with the supervisor would be more formal and stressful. Other disadvantages related to the need to use information and communication technology (ICT). In clinical

---

[1] Gill SD, Stella J, Blazeska M, Bartley B. Distant supervision of trainee emergency physicians undertaking a remote placement: a preliminary evaluation. Emergency Medicine Australasia. 2020 Jun;32(3):446-56.

[2] Wearne SM, Teunissen PW, Dornan T, Skinner T. Physical isolation with virtual support: Registrars' learning via remote supervision. Medical Teacher. 2015 Jul 3;37(7):670-6.

[3] Wearne SM, Dornan T, Teunissen PW, Skinner T. Supervisor continuity or co-location: which matters in residency education? Findings from a qualitative study of remote supervisor family physicians in Australia and Canada. Academic Medicine. 2015 Apr 1;90(4):525-31.

[4] Wearne S. Remote supervision in postgraduate training: a personal view. Medical Journal of Australia. 2013;198(11): 633:634.

[5] Gill SD, Stella J, Blazeska M, Bartley B. Distant supervision of trainee emergency physicians undertaking a remote placement: a preliminary evaluation. Emergency Medicine Australasia. 2020 Jun;32(3):446-56.

situations, communicating via ICT required the trainee and supervisor to manage the ICT as well as the clinical problem; and ICT equipment could be unreliable. Overall, trainees expressed concerns that the quality of care was reduced in the absence of on-site supervision.

Key issues for consideration

The research literature identified several key issues to be considered when designing and implementing training programs that rely on remote supervision of trainees. Again, these are mostly drawn from evaluations of general practice rather than emergency medicine training. They include significant medico-legal matters affecting the trainee, the supervisor and the clinical department that should be examined and resolved with ACEM when remote supervision is introduced at each training site[6,7]. The literature also highlights the importance of ensuring that training sites, supervisors and trainees have the right combination of traits to ensure that safe and successful training and clinical service are delivered. This includes a need for trainees to have a range of clinical skills and competencies to practice safely in an independent context[8]. It also includes a need for supervisors to be appropriately briefed and oriented for their supervisory role, and for supervisors and trainees to be aware of their interpersonal dynamics and the effects that they have on each other and on others in typical multi-disciplinary healthcare teams. Because clinical departments in in rural and remote areas have relatively small numbers of staff, interpersonal dynamics tend to be more evident than in larger departments, and necessities for staff to perform multiple functions can have a compounding effect.

Remote supervision delivered by speciality medical colleges

Medical specialty colleges in Australia and Aotearoa New Zealand have developed a range of remote supervision models to support trainees in rural and remote areas, reflecting the need for flexible yet rigorous training arrangements outside metropolitan centres. While approaches vary between colleges, most address key domains such as trainee health and welfare, supervision and support structures, educational and clinical training opportunities, and the availability of resources and facilities.

Some colleges appear to have a strong focus on training and supervision in rural and remote areas, such as the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP), and have developed formal frameworks for remote supervision that integrate clear accreditation processes, structured assessment requirements and pastoral support for trainees. Other colleges, such as the Royal Australasian College of Physicians (RACP), seem to be relying on traditional on-site supervision models but are beginning to explore different strategies to increase access to training and supervision in rural and regional settings. The key approaches taken by some of the specialty medical colleges are outlined below.

Australian College of Rural and Remote Medicine (ACRRM)

ACRRM has developed one of the most comprehensive and structured remote supervision frameworks in Australia, reflecting its core mission to support rural and remote medical training. The College's approach recognises that many training sites in non-metropolitan areas lack regular on-site supervisors, requiring innovative supervision models that maintain training quality while ensuring patient safety.

Through a structured, tiered approach to supervision, ACRRM supports trainees at various stages of their careers, from early registrars requiring close supervision to experienced trainees working in highly independent roles. ACRRM has produced remote supervision guidelines for rural generalist trainees[9] that fulfil the College's Supervisors and Training Posts Standards[10]. The guidelines outline various supervision models, allowing training to be adapted based on the trainee's experience, the location's resource availability, and the supervision capacity of the facility. These models include:

---

[6] Martin P, O'Sullivan B, Taylor C, Wallace G. Blended supervision models for post-graduate rural generalist medical training in Australia: an interview study. BMC Medical Education. 2022;22(1):478.

[7] Wearne S, Dornan T, Teunissen PW, Skinner T. Twelve tips on how to set up postgraduate training via remote clinical supervision. Medical Teacher. 2013 Nov 1;35(11):891-4.

[8] Martin P, Sen Gupta T, Bond D, Douyere J, Mills K. Rural competencies in emerging medical practitioners: beyond clinical skills. Australian Journal of Rural Health. 2019 Oct;27(5):427-32.

[9] Australian College of Rural and Remote Medicine. Safe and Effective Rural Generalist Training Using Remote Supervision: Guidelines. ACRRM, 2023; www.ACRRM.org.au/resources/training/handbooks-guides.

[10] Australian College of Rural and Remote Medicine. Supervision and Training Posts: Standards. ACRRM, 2020; www.ACRRM.org.au/resources/training/standards.

- Remote supervision – The trainee works independently at a remote site with off-site supervision provided by an accredited supervisor, who is available via telehealth, phone, and video conferencing. Regular case discussions, structured debriefs, and real-time consultations help bridge the gap between in-person and remote learning.

- Blended supervision – A combination of on-site and remote supervision, where the trainee benefits from periodic in-person supervision while receiving ongoing remote support. This model is often used in settings where a supervisor visits the site intermittently or where a team-based supervision approach is in place.

- Satellite supervision – The supervisor is based in a nearby location and provides both face-to-face and remote supervision. This model ensures that trainees have some access to in-person mentorship while maintaining a level of independent practice.

- Group supervision – A single supervisor oversees multiple trainees across different locations, facilitating structured group learning sessions, case discussions, and regular check-ins to support peer learning and reflective practice.

- Supervisor leave cover – When a primary supervisor is unavailable, a secondary off-site supervisor provides temporary coverage, ensuring continuity of support and oversight during the absence.

Each of these models includes clearly defined responsibilities for supervisors, ensuring continuity of support, structured learning opportunities, and formal case-based feedback that aligns with ACRRM's Rural Generalist Curriculum.

Key features of ACRRM's remote supervision approach

1. Structured Supervision and Accreditation Requirements

ACRRM has strict accreditation requirements for both training sites and supervisors, ensuring that trainees receive high-quality clinical oversight and educational support, regardless of their location. Supervisors must:

- Complete ACRRM's approved supervisor training course or an ACRRM-endorsed equivalent.

- Participate in regular accreditation reviews to ensure they meet the College's supervision and teaching standards.

- Be actively involved in case discussions, workplace-based assessments (WBAs), and structured debriefs, even when supervising remotely.

2. Pastoral Support and Trainee Wellbeing

Recognising the unique challenges of working in professional isolation, ACRRM has integrated pastoral care and mental health support into its supervision model. Key initiatives include:

- Dedicated Training Officers, Regional Directors of Training, and Registrar Liaison Officers who provide one-on-one support to registrars, addressing both professional and personal challenges.

- Peer support networks, enabling trainees working in isolated locations to stay connected with colleagues and receive informal mentorship.

- Formal debriefing processes, particularly after high-acuity or distressing cases, ensuring that trainees have access to emotional support and reflective learning opportunities.

3. Integration of Technology and Digital Supervision

To bridge the gap between remote and on-site supervision, ACRRM emphasises the use of technology in delivering effective supervision. This includes:

- Telehealth platforms for real-time case discussions and virtual assessments.
- Secure messaging and video conferencing tools to facilitate immediate clinical decision-making support.
- Structured digital learning modules and online education resources, ensuring that trainees in remote areas receive high-quality educational content equivalent to their urban counterparts.

These initiatives ensure that trainees, regardless of their geographical location, receive continuous support, structured feedback, and access to high-quality learning experiences.

4. Workforce development and rural retention

Beyond training delivery, ACRRM's approach plays a key role in addressing workforce shortages and improving rural retention. The College actively promotes long-term career opportunities in rural medicine and is trying to implement remote supervision as a sustainable workforce strategy. Key initiatives include:

- Financial incentives and government stipends for rural and remote trainees.
- Medicare eligibility for training sites, allowing host practices to receive funding support for employing registrars.
- Career development and mentorship programs, ensuring that trainees remain engaged in long-term rural practice after completing their training.

Royal Australian College of General Practitioners (RACGP)

RACGP has established a structured framework for remote supervision within its Rural Generalist (RG) Program[11], which provides a dedicated training pathway for general practitioners working in rural and remote Australia. The program is designed to equip trainees with advanced skills to meet the diverse healthcare needs of regional communities, including emergency medicine, anaesthetics, obstetrics, and mental health. Key components of the program include:

- Accredited Training Sites and Supervisors – All placements must be in RACGP-accredited training sites, ensuring that registrars have access to appropriate supervision and training resources. Supervisors must also be accredited by RACGP and are responsible for overseeing trainees' clinical practice, providing educational support, and conducting assessments.
- Additional Rural Skills Training (ARST) – Rural Generalist trainees must complete an Advanced Rural Skills Training (ARST) post, which provides focused training in an extended skill such as emergency medicine, anaesthesia, obstetrics, Aboriginal and Torres Strait Islander health, or palliative care.
- Integration with Emergency Medicine Training – RACGP collaborates with ACEM to offer structured emergency medicine training through the ACEM Associateship in Advanced Emergency Medicine Training Program (AEMTP). This ensures that rural generalists gain specialist-level emergency medicine skills to manage high-acuity patients in remote settings.

Similar to ACRRM, RACGP recognises the need for flexible training options and has developed a range of remote supervision models that cater to the needs of trainees in different rural and remote settings[12]. These include the following:

- Direct supervision – A supervisor is physically present in the training site and provides continuous in-person oversight of the trainee. This is typically required for less experienced registrars.

[11] Royal Australian College of General Practitioners (RACGP) Rural Generalist Program. Available at: https://www.racgp.org.au/the-racgp/faculties/rural/rural-generalist-fellowship/become-a-rural-generalist-with-the-racgp

[12] The Royal Australian College of General Practitioners. Rural Supervision: Guidelines for Safe and Effective General Practitioner Training Utilising Remote Supervision. RACGP, East Melbourne, Victoria, 2022.

- Near-peer supervision – A more senior trainee or a local general practitioner with appropriate experience provides on-site supervision, with additional support from remote supervisors as needed.

- Remote supervision – The trainee works more independently, with off-site supervision provided via telehealth, phone, or video conferencing. Supervisors remain available for case discussions, debriefing, and structured assessments. This model is typically reserved for more experienced trainees.

- Blended supervision – A combination of on-site and remote supervision, where the trainee has periodic face-to-face interactions with a supervisor while receiving ongoing remote support.

- Group supervision – A single supervisor oversees multiple trainees remotely, facilitating group learning sessions, case discussions, and structured educational meetings.

To ensure the safety and effectiveness of remote supervision, RACGP requires that:

- Trainees undergo comprehensive orientation to prepare them for remote supervision.

- Supervisors complete RACGP-approved training to ensure they are equipped to provide high-quality support.

- Communication protocols are established between trainees and supervisors to ensure continuous access to guidance when needed.

Further, to help address the challenges faced by trainees working in rural and remotes areas, RACGP places a strong emphasis on pastoral care for its trainees and has set up the following:

- Dedicated support officers within the Rural Generalist Training Program to provide career and wellbeing support

- Peer networks that trainees can access to connect with others working in similar environments

- Mental health resources and structured debriefing processes to help trainees manage the emotional and psychological demands of rural medical practice

Royal Australasian College of Surgeons (RACS)

RACS focuses on the accreditation of training posts which must have (*inter alia*) surgeon supervisors and surgeon trainers who provide supervisory capacity on-site. Sites that serve as training posts must meet the following criteria:

- Availability of on-site surgeon supervisors and trainers who have completed specific training in adult education principles.

- Adequate clinical caseload and operating theatre sessions, allowing trainees to perform supervised procedures.

- Ongoing mentorship and advocacy to support trainees, particularly in rural and remote locations.

To support surgical trainees in rural areas, RACS introduced the Rural Coach Program, which provides professional development, advocacy, and financial assistance for trainees pursuing rural surgical careers. While direct remote supervision models are not widely implemented, RACS continues to explore flexible training approaches that support surgeons in diverse locations.

All supervisors and trainers must themselves complete a training course which encompasses adult education principles. RACS has examined and published the detailed requirements for supervisors, covering not only the training and support for supervisors but also the nature of their professional relationships with trainees, their advocacy for trainees, and measures to maximise trainees' learning and experience. The RACS statement on supervision covers all types of surgical training sites, not only those in

regional, rural and remote settings[13].

Royal Australasian College of Physicians (RACP)

RACP currently has a requirement for on-site supervision of trainees in accredited training sites. The College acknowledges that its current accreditation criteria create challenges for regional, rural and remote training, stating that current accreditation rules make it difficult for regional, rural and remote sites to qualify (RACP, 2023).

However, RACP is taking steps to expand training access by:

- Recruiting accreditors with experience in regional, rural and remote practice to assess and support training sites.
- Introducing flexibility in supervision models within certain subspecialties, such as rheumatology, where trainees may be supervised by specialists in related disciplines (e.g., immunologists or haematologists).
- Exploring blended supervision models, although formal frameworks for remote supervision are still under development.

Royal Australasian College of Physicians. Regional, Rural and Remote Physician Strategy. RACP, Sydney, 2023; https://racp.edu.au/about/

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

RANZCOG is in the process of developing new pathways to expand obstetrics and gynaecology training in rural areas. The Fellowship Rural O&G Specialists (FROGS) program, launching in 2025, aims to prepare trainees for rural practice by offering additional skills in areas such as perinatal transport and high-risk pregnancy care[14]. However, the College has not yet published details on its supervisory arrangements for the FROGS pathway, suggesting that blended or remote supervision frameworks may still be in development.

RANZCOG also offers a Rural Training Program (RTP) for basic trainees in Dubbo and Orange to ensure trainees have structured supervision while developing skills in regional hospitals. Both sites have established supervision capacity for Fellowship of RANZCOG.

Australasian College of Dermatologists (ACD)

The ACD has recently introduced opportunities for trainees to undertake placements in RRR areas, although the supervision model remains somewhat limited. Trainees are typically placed in locations with at least one on-site consultant dermatologist providing direct supervision[15]. Trainees are likely to be based in the consultant's practice or clinic setting and involved in tele-dermatology.

However, ACD has shown some flexibility in the supervision of its trainees by allowing them to be partially supervised by Fellows of RACP in rheumatology or haematology. The College is also exploring tele-dermatology as a potential tool for remote supervision.

Australasian College of Sport and Exercise Physicians (ACSEP)

ACSEP piloted and evaluated a remote training program from 2022 to 2023 as part of the Australian Government's FATES program[16]. Key findings from the evaluation included:

---

[13] Paltridge D, Martin J, Churchill J, et al. Consensus statement: support for supervisors of surgical training in Australia and Aotearoa New Zealand. ANZ Journal of Surgery, 2024; 94: 1221-1227; DOI: 10.1111/ans.19111.

[14] Royal Australian & New Zealand College of Obstetricians and Gynaecologists. Train with Us. RANZCOG, Melbourne, 2025. Available at: www.ranzcog.edu.au/training/train-with-us/

[15] The Australasian College of Dermatologists. Dermatology in Regional Australia: A Practical Guide for Trainees. ACD, 2021. Available at: https://www.dermcoll.edu.au/

[16] Fitzgerald, Vaughan and Cheshire 2025. Australasian College of Sport and Exercise Physician's (ACSEP) Remote Supervision Program 2022-2024 Final Evaluation Report. Available at: https://www.acsep.org.au/page/members/projects/acsep-remote-clinical-supervision-model-pilot

- Feasibility and Scalability – The remote supervision model was deemed effective in supporting trainees in rural areas.

- Rural Recruitment and Retention – The program encouraged registrars to consider long-term rural practice.

- Effective Use of Multimedia Platforms – Supervisors and trainees engaged successfully through digital communication, reducing the need for frequent in-person supervision.

While the model was well-received, the evaluation recommended additional financial support for supervisor travel to further strengthen engagement and training quality.

The ACSEP currently makes use of blended and remote supervision, often in conjunction with rural generalist training. Given the small numbers of sport and exercise physicians outside metropolitan areas, the ACSEP program has flexible requirements for supervisors but specifies training coverage in some detail.

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

acem.org.au