AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE

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June 10th 2011

To:
Expert Panel Taskforce
Hospital Policy Branch
Acute Care Division
MDP 404
GPO Box 9848
Canberra, ACT 2606

Cc:
Dr Sally McCarthy, President, Australasian College for Emergency Medicine

Via email: expertpanel@health.gov.au

Dear Expert Panel,

RE: ACEM trainee submission into the Review of the Implementation of the Elective Surgery Targets and National Access Guarantee and the Four Hour National Access Emergency Department Target

Thank you for the opportunity to provide input into the implementation of the above mentioned targets. The intent of this submission is to provide the perspective and views of junior doctors (trainees) in the training program of the Australasian College for Emergency Medicine (ACEM) on this matter. As a result the exclusive focus of this submission is on the Four Hour National Access Emergency Department Target.

This submission is provided on behalf of the Trainee Committee of ACEM. The Trainee Committee is a committee of the Council of ACEM and is composed of one representative from each state and territory of Australia and one representative from New Zealand. Our committee's purpose is to provide an identifiable forum for expression of the views of all trainees and to represent trainees in matters affecting their education in emergency medicine.

It is the Trainee Committee's view that the introduction of the Four Hour National Access Emergency Department Target will have the potential to have significant impact, both positive and negative, on the education and welfare of ACEM trainees, and indeed **all** medical students and junior doctors working in Australian Emergency Departments. We feel that the views and recommendations expressed in this submission are likely to be shared by non-ACEM trainees who spend any time training in an Emergency Department and believe it is important to acknowledge the impact of such a system change on this group. We acknowledge that junior doctors working in other areas and specialties within hospitals which have an emergency department are likely to also be significantly affected as implementation of these targets will require whole-of-hospital and indeed whole-of-system participation and contribution. We would encourage the Panel to look to other sources such as the AMA Council of Doctors in Training to consider the impact of this Four Hour National Access Emergency Department Target on the education and welfare of junior doctors training in other specialty areas who will hence also be significantly affected by this change.

In making this submission we acknowledge that our college, ACEM, has already made a submission to the Expert Panel on May 27th 2011. It is with the college's encouragement and endorsement that we write to expand on their submission in the areas relating to trainee education and welfare.

Specifically we write to expand on the following key point from the ACEM submission:

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> **"Resources must support the continued ability of the ED, hospital and community providers to fulfil clinical education, training and supervisory obligations in accordance with national professional guidelines and standards."**

In making this submission we state as requested that we also intend to address the following Terms of Reference for the Expert Panel:

> **b. the Four Hour National Access Emergency Department Target, including:**
> **i.** how clinical judgment on the appropriate length of stay should be factored into Emergency Department Targets
> **iii.** what mechanisms could be implemented to increase clinical engagement and support for the Target, and
> **iv.** what mechanisms could be implemented to drive clinical and operational change to support the Target;
>
> **c. Overarching considerations, including:**
> **i.** additional recommendations to ensure clinical safety is paramount at all times in the implementation of this Agreement,
> **ii.** additional recommendations to ensure implementation trajectories reflect a sensible path having regard to system capacity to absorb change, including workforce capacity.

Rather than addressing each ToR individually we feel that our observations and recommendations often cover a number of these ToR and so we have instead grouped our recommendations under headings related to how implementation of this target could impact on education and welfare of trainees.

Background:
Emergency Departments in Australia are a key source of training for medical students and junior doctors.

Almost all medical students will spend some period of time on a placement in an Emergency Department, and it is currently a requirement in most states and territories that all interns undertake a rotation in an Emergency Department. [1][2]

Many junior doctors who have completed their internships will spend further time training in an emergency department either as part of a general year[3] or as a requirement of their non-ACEM training program.

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1 CPMEC "Clinical Training in Prevocational Years Report" Prepared January 2009 for the Commonwealth Medical Training Review Panel – accessible at http://www.cpmec.org.au/files/CPMEC%20Clinical%20Training%20in%20Prevocational%20Years%20Report.pdf

2 At the time of writing this submission the Medical Board of Australia is yet to announce its requirements for satisfactory completion of internship and granting of full registration. Whatever the precise outcome, it is almost certain that a significant number of interns will continue to undertake emergency department rotations.

3 A general year describes a period of time, usually a year, whereby a junior doctor is not in a formal training program but is employed by a hospital and typically rotates around the hospital to various units.

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And of course a number of junior doctors will choose to specialise in the field of Emergency Medicine and hence undertake the majority of their training across a variety of Emergency Departments across Australia or New Zealand.

All of these groups share the common characteristic that the quality and quantity of the education that they receive during their time in the Emergency Department will have the potential to significantly affect the quality of care that they provide to patients (in ED and non-ED settings) both now and into the future.

ACEM Trainee Views

In April 2010 the ACEM Trainee Committee extensively discussed the section of the COAG communiqué relating to the Four Hour National Access Emergency Department Target that arose from the meeting of COAG that same month. In relation to this the committee endorsed a number of statements and principles which are summarised below:

Potential positive impacts of a timed access target for trainees:

- Reducing ED overcrowding is one of the main objectives of the Four Hour National Access Emergency Department Target. ED overcrowding has been proven to be associated with a number of significant adverse outcomes for patients[4]. Trainees feel there would be an enormous number of benefits if a reduction in ED overcrowding were achieved not only to patients but also the morale and job satisfaction of all ED staff including trainees. Such increased satisfaction would flow from such measures as being able to treat patients in a timely manner and in the appropriate environment (with a reduction in so called waiting-room medicine).
- A reduction in managing patients that have been seen and assessed by ED doctors and who are now only awaiting inpatient team review and transfer to a ward would allow trainees to spend more time on seeing new and undifferentiated patients which is our area of specialty and interest.

General principles:

- The primary aim of any system change or reform should be to improve patient outcomes. This should include consideration not only of current performance in this area but also impacts of changes on future performance in quality of patient care.
- Trainees are supportive of introduction of a time-based performance target of ED length of stay for hospitals as long as the summative result is to enhance patient care over **both** the short and longer term i.e. changes introduced should not improve current care at the detriment of future capacity.
- Education and training is a key aspect of maintaining and improving clinical excellence into the future and requires resources to be quarantined from use in achieving short term outcomes.
- Any system change should be done with adequate consultation and involvement of all groups that are affected. Emergency Medicine trainees are a key part of the hospital system with trainees providing a large proportion of doctor-patient contact in accredited Australasian Emergency Departments. With this in mind direct trainee consultation and participation in this reform process should take place. The ACEM Trainee Committee is well-placed and willing to provide such representation.
- Any reform should be properly evaluated to determine its effects. Evaluation should include the impact on ACEM and other trainees.
- Blind adherence to targets must not overrule clinical judgement and common sense and in particular not impact on patient safety.

4 Richardson DB, Mountain D. Myths versus facts in emergency department overcrowding and hospital access block. *Med J Aust* 2009; 190: 369-374

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As part of the formulation and endorsement of the above principles, significant discussion and consultation occurred with trainees. This has continued, especially with those in Western Australia and New Zealand where time-based targets have already been implemented, as well as a significant number of trainees who have emigrated from the United Kingdom and who worked in the NHS under the 4 Hour rule.

This information gathering has led to the Trainee Committee having concerns about the impact of the Four Hour National Access Target on trainees in the following 3 areas:

1. **Education, Training and Supervision**
2. **Bullying and Harassment**
3. **Future of Emergency Medicine**

We elaborate on our concerns and suggest potential solutions below:

1. Education, Training and Supervision

The greatest concern by trainees is that the implementation of a time based target will adversely affect the quality and quantity of training during their time in the Emergency Department. It is thought that time pressures may result in trainees facing such adverse effects as not being able to:

- Undertake sufficiently detailed patient histories, examinations and investigations reducing the ability to become proficient in correlation of symptoms with signs and investigations and hence overall understanding of ability to manage illness and injury.
- perform necessary procedures and hence become de-skilled in performing interventions which for some patients may be time-critical
- review patients of significant educational value that will enhance the ability of trainees to recognise and manage future similar presentations
- Receive supervision and bedside teaching sessions as a result of consultants and senior trainees focussing more on flow and meeting the access target rather than education.

Measures to eliminate these effects would need to either remove the time pressures e.g. protected teaching time, add resources or formally acknowledge the importance of teaching in relevant guidelines and definitions.

Recommendations

- Jurisdictions commit to enabling all Emergency Departments to provide regular protected teaching time accessible to all junior doctors. Regular is taken to mean at least fortnightly, and preferably weekly. Protected is used to state that the time is rostered in paid time, doesn't occur whilst on clinical duties and is not subject to being cancelled by departmental workload. Three hours is felt to be the minimum period of time for each protected teaching session although flexibility in how this is allocated e.g. 3 x 1 hour sessions over a week is felt acceptable.
- Jurisdictions support the rostering of additional consultants and/or senior registrars on shifts to act in dedicated teaching and supervisory roles which are separate and in addition to those of the senior doctors managing each shift.
- The "nationally consistent definition for ED patients for whom it is clinically appropriate to stay in an ED for over four hours" should include some allowance for those patients who would provide a significant educational benefit to the department. Examples of such cases may include a patient with classical history or examination findings being used for case-based teaching or a patient who requires a procedure to be performed (at least semi-urgently) but whose ongoing presence in the ED would result in a patient breaching the 4 hour mark.

2. Bullying and Harassment

Junior doctors are by definition lower in the hierarchy of power within a hospital than more senior doctors such as consultants. When combined with pressure to meet targets the situation exists for

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undue pressure to be placed on these junior doctors to meet the targets. Minimising the risk of this occurring requires education and training of both junior doctors and those staff involved with monitoring compliance with the targets. It also requires a system that enables reporting and follow-up of any instances of bullying or harassment.

Recommendations

- Staff designated to monitor adherence to the Four Hour target must be given clear instructions to act in a courteous and professional fashion to medical (and other) staff of all levels of seniority. Where necessary this may need to be supported through formal training.
- Trainees need to be provided with clear mechanisms through which to report any instances of perceived bullying and harassment and have the confidence that they will be treated confidentially and acted upon.
- Special consideration needs to be given to supporting those trainees who are responsible for managing EDs during those periods without Emergency Medicine consultant cover. This situation typically applies to registrars managing emergency departments overnight. Such support may include dedicated training on managing flow, supervising junior staff, assertiveness, and managing performance and conflict. This training could potentially be achieved through the development of nationally consistent and accepted educational resources delivered in a modular fashion with significant online support.

3. Future of Emergency Medicine

Shortages in the Emergency Medicine workforce are already a significant issue in most states and territories. Evidence of the lack of attractiveness of Emergency Medicine to Australian graduates can be seen through the low level of participation of Australian doctors as trainees, which in a number of states is in the order of 25%. Whilst reasons for specialty career selection are many and varied, job satisfaction is rated highly.

The introduction of a significant workplace reform such as a time-based access target has the potential for a marked impact on the job satisfaction of trainees with subsequent influence on recruitment and retention.

Individual ACEM Trainees in WA have already expressed concern to the ACEM Trainee Committee that pressure to meet the four hour target in place there means that for some patients they are unable to perform a proper assessment and hence provide proper treatment. This is especially frustrating if a delay in performing this assessment is because of external capacity constraints e.g. access to laboratory and imaging studies, or in-patient registrar advice or assessment. Some trainees have stated that they feel their role in many cases has been reduced to a triaging service rather than making a diagnosis and instituting initial treatment which they feel is an under-utilisation of the skills and abilities that they joined the ACEM training program to develop and deliver to patients.

When this has been coupled with pressure and harassment from target managers as outlined in the previous key area this can result in significantly decreased job satisfaction. It is acknowledged that significant ED overcrowding is also anecdotally associated with decreased job satisfaction and clearly a tension exists between measures that reduce overcrowding and those that reduce the ability of Emergency Medicine doctors to provide meaningful care.

Whilst it is too early from the point of time that WA has introduced its 4 hour measure to assess whether these anecdotal reports have translated into an increase in trainees leaving the ACEM training program or if there is a reduction in trainees joining the program such concerns should be evaluated if such a measure is to be introduced Australia wide.

Recommendations

- Regular evaluation should be performed of trainees assessing their levels of satisfaction with various aspects of their working environment e.g. quality and quantity of training, level of supervision, incidence of bullying and harassment, career intentions etc.
- Monitoring should be performed of the quantity, origin and timing of trainees entering and exiting the ACEM training program.

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- Trainees should be adequately consulted and involved in the implementation of the Four Hour National Access Emergency Department Target. This should include formal trainee representation on advisory panels, requests for specific trainee feedback and a communication strategy that includes trainees as a key stakeholder group. The ACEM Trainee Committee is well-placed and willing to provide such representation and advice.

In summary, the ACEM Trainee Committee believes the introduction of the Four Hour National Access Emergency Department Target will likely have significant impact, both positive and negative, on the education and welfare of all medical students and junior doctors working in Australian Emergency Departments. We have endorsed a number of principles in regard to such a target and its relationship to training. We have identified what we feel are the main potential issues, and have recommended a number of potential solutions. We offer the services of our committee as a potential source of advice and feedback and look forward to engaging constructively in the implementation phase of this target.

Regards,

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Dr Andrew Perry
Chair
Trainee Committee
Australasian College for Emergency Medicine