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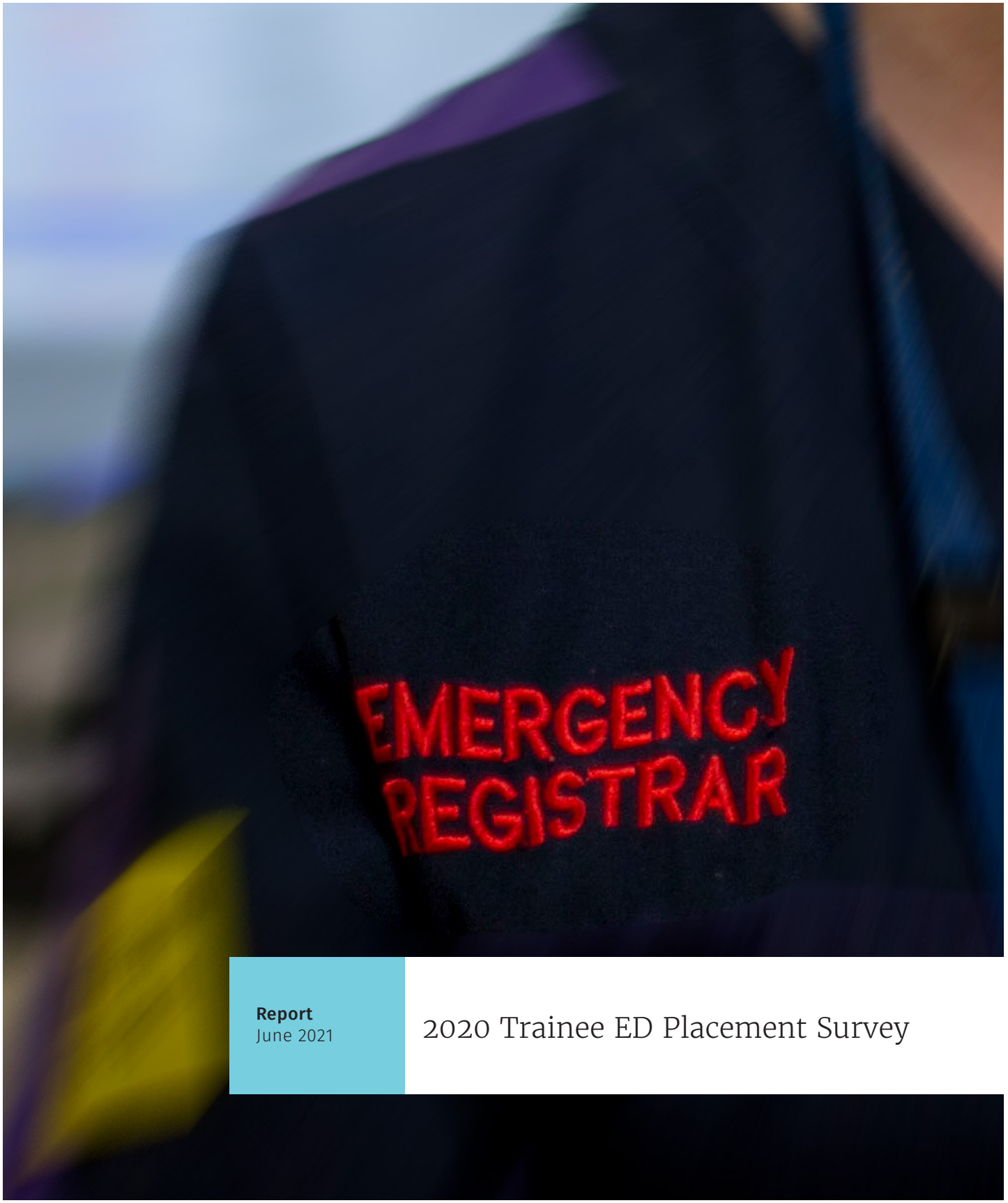


Report
June 2021

2020 Trainee ED Placement Survey

Australasian College for Emergency Medicine

2020 Trainee ED Placement Survey

Key findings

This is an annual survey that captures training site data to ensure ACEM-accredited sites are providing a safe and supportive environment for FACEM trainees. It is a mandatory survey and 1662 trainees responded to the 2020 survey.

93%

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

Supervision

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

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

Welfare

92% agreed that their placement provided a **safe and supportive workplace** overall

95% reported knowing whom to **get assistance** from if falling into difficulty meeting training requirements

Education

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

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

Placement highlights

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

Areas for improvement

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

For the full survey findings, please refer to:
Australasian College for Emergency Medicine (2021), *2020 Trainee Placement Survey - ED Placement* ACEM Report, Melbourne.

Contents

1. Executive Summary

The Trainee Placement Survey is distributed annually at the end of the training year to trainees enrolled in the FACEM Training Program. The survey captures site specific data to ensure that sites are providing training and a training environment, which are appropriate, safe and supportive of FACEM trainees. Findings from the 2020 survey for all eligible trainees (N=1662) undertaking an ED placement are summarised as below:

Health, Welfare and Interests of Trainees

- Nearly all (93%) trainees agreed that their training needs were being met at their placement.
- Overall, rostering was viewed positively by 77% of trainees, with the highest proportion agreeing that the rosters at their placement supported the service needs of the site (86%) and ensured safe working hours (87%).
- 95% reported knowing whom to get assistance from if they experienced difficulty meeting training requirements, compared with 88% who reported knowing whom to get assistance from if they had a grievance.
- 92% agreed that their placement provides a safe and supportive workplace overall, however a smaller proportion agreed that their placement sustained their wellbeing (77%), provided a comprehensive orientation at commencement (78%), and provided support processes other than mentoring (80%).
- Nearly one-third (32%) reported experiencing discrimination, bullying, sexual harassment, or harassment (DBSH) behaviour from a patient/ carer, whilst 11% reported experiencing DBSH behaviour exhibited by ED or hospital staff, with FACEMs being the most reported staff category.
- Just over half (57%) agreed that they could participate in decision making regarding governance at their ED placement, while 74% agreed that they could participate in quality improvement activities.

Supervision and Training Experience

- Over 90% of trainees were satisfied with the quality and availability of DEMT support.
- 90% agreed that the clinical supervision received from FACEMs met their needs, however only 78% agreed that they received regular informal feedback on their performance.
- Just over three-quarters of advanced trainees were satisfied with the level of support received from their Local WBA Coordinator (77%) and FACEMs (78%) to complete WBAs.
- Trainees agreed that the ED casemix at their placement was appropriate with respect to the number (95%), breadth (88%), acuity (84%), and complexity (89%) of cases.

Education and Training Opportunities

- 87% agreed that the clinical teaching at their placement optimised learning opportunities. However only 65% agreed that they had access to formal ultrasound training.
- 84% of trainees agreed that the structured education program at their placement met their needs, with 82% agreeing that rostering enabled them to attend the education sessions.
- Comparable proportions agreed that they had access to written exam revision programs (86%) and clinical exam preparation programs (87%) at their placement.

Further Perspective on ED Placement

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

Perspectives on the FACEM Training Program and Support from ACEM

- 88% agreed that the FACEM Training Program is facilitating their preparation for independent practice as an emergency medicine specialist, but a smaller proportion (79%) agreed that they were well-supported in their training by ACEM processes.

2. Purpose and Scope of Report

The Emergency Department (ED) Trainee Placement Survey is administered annually to advanced and provisional FACEM trainees who were undertaking an ED placement in New Zealand and Australia at the time of survey distribution. Survey questions focused on three key areas, namely Health, Welfare and Interests of Trainees; Supervision and Training Experience; and Education and Training Opportunities. The survey further sought trainee feedback on support they receive from ACEM, and potential areas for advocacy and quality improvement for the FACEM Training Program. This report details the findings from the 2020 ED Trainee Placement Survey.

3. Methodology

Participation in the Trainee Placement Survey was mandatory (as per item B1.5 in Regulation B of the FACEM Training Program), and all eligible trainees were required to submit the online survey prior to paying their annual training fee through the ACEM member portal. Eligible trainees were those who were undertaking an ED placement in ACEM-accredited sites as of October 31st 2020, excluding trainees on an interruption to their training at the time.

The survey was made active on November 5th 2020, with an email being sent to all eligible trainees notifying them about the online fee payment process, including the requirement to complete the Trainee Placement Survey. The survey was promoted as being mandatory, and the information was communicated as part of news items in the ACEM Bulletin, DEMT Forum and in the Trainee Newsletter. The survey was closed on February 28th 2021.

All collected information was handled in confidence, with anonymity ensured in reporting and feedback provided to Accreditation staff and inspectors. Survey findings are reported only in the aggregate as a percentage of total responses, or by training level, gender of trainee, region or accreditation level of the ED.

4. Results

A total of 1,669 completed surveys were received from a pool of 1,670 eligible trainees who were undertaking an ED placement as of the 31st of October, a response rate of 99.9%. One trainee was not able to complete the online survey due to technical issues.

Seven trainees were undertaking part-time ED placements at two different hospitals and completed a survey for each placement. As such, all survey findings are reported based on the total survey responses (N=1669), except for the demographic information (section 4.1) which are presented for the 1662 responding trainees.

4.1 Demographic Characteristics of Respondents

Of the 1662 responding trainees, 90% were undertaking an ED placement in Australia and the remainder (10%) were undertaking a placement in New Zealand (NZ). Slightly less than half (48%, n=796) of trainees were female, and two-thirds (n=1108) were in the stage of advanced training (Table 1). Provisional trainees had an average age of 32 years, compared with an average of 35 years for advanced trainees.

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

Region	Female	Male	Total		% Female	% Advanced trainees (n=1,108)	% Provisional trainees (n=554)
	N	N	*N	%			
Australia	**716**	**785**	**1,501**	**90.4%**	**47.7%**	**67.2%**	**32.8%**
ACT	10	14	24	1.4%	41.7%	62.5%	37.5%
NSW	241	227	468	28.2%	51.5%	66.9%	33.1%
NT	27	14	41	2.5%	65.9%	61.0%	39.0%
QLD	162	231	393	23.7%	41.2%	65.2%	34.8%
SA	34	36	70	4.2%	48.6%	65.7%	34.3%
TAS	17	13	31	1.8%	56.7%	50.0%	50.0%
VIC	154	177	331	19.9%	46.5%	71.3%	28.7%
WA	71	73	144	8.7%	49.3%	70.8%	29.2%
New Zealand	**80**	**80**	**160**	**9.6%**	**50.0%**	**61.9%**	**38.1%**
Total no. of trainees	**796**	**865**	**1,661**	**100%**	**47.9%**	**66.7%**	**33.3%**

*Note: *Excludes one trainee with no gender specified*

Table 2 presents the proportion of provisional and advanced trainees undertaking an ED placement, by type and accreditation level of ED. A higher proportion of advanced trainees than provisional trainees (11% vs. 2%) were undertaking an ED placement in a paediatric ED. Around two-thirds (62%) of the responding trainees were undertaking their placement at EDs accredited for 24 months of training, while only 2% each were undertaking placements at 6 month and 6-month linked sites.

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

	Provisional		Advanced		Total	
Type of ED	**N**	**%**	**N**	**%**	**N**	**%**
Adult/ Mixed	541	97.7%	986	89.0%	1,527	91.9%
Paediatric	13	2.3%	122	11.0%	135	8.1%
ED accreditation level	**N**	**%**	**N**	**%**	**N**	**%**
6-month linked*	4	0.7%	25	2.3%	29	1.7%
6 months	12	2.2%	26	2.3%	38	2.3%
12 months	136	24.5%	180	16.2%	316	19.0%
18 months	73	13.2%	183	16.5%	256	15.4%
24 months	329	59.4%	694	62.6%	1,023	61.6%
Total no. of responses	**554**	**100%**	**1159**	**100%**	**1,662**	**100%**

Note: Two provisional trainees and five advanced trainees completed the survey for two placement sites

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

4.2 Health, Welfare and Interests of Trainees

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

4.2.1 Overall trainee needs

Nearly all (93%, n=1,547) trainees strongly agreed or agreed that their training needs were being met at their ED placement, with 3% (n=42) disagreeing that their needs were being met and 5% (n=80) being neutral. Provisional trainees (95%) were slightly more likely than advanced trainees (92%) to agree that their training needs were met, while the same proportion (93%) of female and male trainees reported so.

Those (n=122) who did not agree that their training needs were being met, were provided with the opportunity to comment on the reason(s) for their response, with 118 of them providing feedback. Key reasons trainees provided with respect to their needs not being met at their placement were:

- A lack of education and support for exams (20%)
- Inadequate casemix, particularly higher acuity patients (18%)
- No protected teaching time or clinical teaching (17%)
- Unsatisfactory senior supervision and/or feedback (16%)
- Difficulty in completing Workplace-based Assessments (WBAs, 15%)
- Unsafe rostering or workplace (mainly due to understaffing or overcrowding that leads to trainee burnout, 15%)
- Limited procedural opportunities (12%)
- Difficulty in obtaining required rotation (8%)

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

> *Teaching program needs improvement. Often pitched at wrong level, poorly organised, cancelled, not catering to various levels of training/examinations.*
>
> *Rarely any bedside teaching or formal teaching. Cannot remember the last time a consultant did formal face to face teaching. Any face-to-face teaching is done by other registrars or video link from other training sites.*
>
> *Insufficient casemix to fulfill WBA requirement, teaching quality dramatically deteriorated since COVID despite close to zero COVID presentation in this hospital site.*
>
> *Limited opportunities for supervised procedures, limited bedside teaching, criticism from consultants for asking for a bedside review to help my own learning and clinical judgement develop, having to learn everything by trial and error yourself…*
>
> *Consultant supervision and availability is extremely limited during evening shifts. The clinical environment is chaotic and multiple patient safety issues are occurring on a daily basis. The culture of senior medical staff is somewhat toxic, and the pressure of bed block within the health network continues to affect the morale of trainees.*

4.2.2 Mentoring program

Eighty percent (n=1,334) of trainees reported that there was an ACEM Mentoring Program Coordinator at their ED placement, and 2% reported that there wasn't one. A further 18% of trainees reported that they were not aware of this position at their placement. Trainees undertaking a placement at sites accredited for 18- and 24-months (84% and 83%, respectively) were more likely to report the availability of an ACEM Mentoring Coordinator, compared with sites accredited for 12 months (69%), 6 months (68%) or 6-months linked (55%).

The majority (83%, n=1,392) of trainees reported that there was a formal mentoring program available at their ED placement, with 4% (n=60) reporting that there was not one available and 13% (n=217) reporting that they did not know whether a formal mentoring program was available. Of the trainees who reported there was a formal mentoring program in place, two-thirds (66%, n=917) had utilised the program, with a higher proportion of provisional trainees (72%, n=335) than advanced trainees (63%, n=582) reporting so.

For the remaining trainees (n=475) who reported not utilising the formal mentoring program at their placement despite this program being available, 35% of them reported that they had a mentor already, while another 21% reported they were not required to participate in a mentoring program at their placement. A further 11% reported that the mentoring program did not meet their needs, and 6% reported that it was difficult to access the mentoring program at their placement.

Other reasons (26%) provided for not utilising the formal mentoring program were mainly because of time constraints (for example, prioritised study/ exam preparation, too busy to initiate the process or find times to meet with mentor) (n=27), and that they preferred informal mentorship (n=16) or did not find formal mentorship beneficial (n=12). Several other reasons included that they found it difficult to seek a suitable mentor (n=11), they could not access formal mentorship during a short-term placement (n=11), there was a lack of engagement from their allocated mentor (n=9), they were still waiting for a mentor to be allocated (n=5), or they were unsure about the process (n=3). Three trainees indicated that the mentoring program was affected due to COVID-19 restrictions, and three others indicated that they would utilise the mentoring program soon.

Some of the example responses are presented below:

> *I have yet to pursue the mentoring program due to other professional & personal commitments. I have had access to informal mentoring from a variety of sources.*
>
> *It didn't seem relevant to have it formalised as there are multiple approachable FACEMs for mentor-like advice at this particular site that I feel comfortable talking to.*
>
> *There isn't a person within the list of mentors that I have a strong enough connection to in order to nominate as a mentor.*
>
> *I was in this placement for a short period of time and could not access it during my rotation.*
>
> *Despite a formal mentoring programme being available, it feels inaccessible and lacks engagement from the senior medical staff.*

4.2.3 Rostering

Trainees were asked to state their level of agreement with statements regarding rostering at their placement. Over three-quarters (77%) of trainees were in agreeance that they were satisfied overall with the rostering at their site (78% among advanced trainees vs. 76% of provisional trainees). A higher proportion of advanced trainees (ranged 77%-87%) than provisional trainees (ranged 74%-83%) were in agreeance with most of the rostering statements, except there was similar agreement with respect to rosters giving equitable shifts to all areas of the ED, and that rosters ensure safe working hours.

Table 3 shows the proportion of trainees who were in agreeance with statements relating to rostering, by region. The highest proportions of trainees were in agreeance that the rosters at their placement ensured safe working hours (87%), and that rosters supported the service needs of the site (86%). On the contrary, the smallest proportions of trainees agreed that rosters were provided in a timely manner (76%) and their rostering gave them equitable exposure to day/evening/night shifts (77%). Trainees who were undertaking a placement in NZ and Tasmania (TAS) were less likely to agree with most of the rostering statements, in comparison to trainees from other regions (Table 3).

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

Statements regarding rostering	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Overall, I am satisfied with rostering at my site	79.2%	75.7%	82.9%	79.5%	70.0%	86.7%	78.2%	81.3%	66.3%	76.9%
Rosters are provided in a timely manner	87.5%	70.7%	85.4%	80.8%	42.9%	90.0%	77.0%	88.2%	76.9%	76.2%
Rosters give equitable exposure to day/ evening/ night shifts	87.5%	75.1%	82.9%	82.8%	82.9%	70.0%	73.4%	78.5%	71.3%	77.1%
Rosters give equitable shifts to all areas of the ED	70.8%	77.8%	85.4%	84.8%	80.0%	66.7%	76.4%	84.7%	76.9%	79.7%
Rosters consider workload as a trainee	87.5%	80.8%	87.8%	81.5%	85.7%	60.0%	91.5%	85.4%	74.4%	83.0%
Rosters support the service needs of the site	83.3%	84.0%	87.8%	88.4%	91.4%	76.7%	87.0%	93.1%	78.8%	86.2%
Rosters ensure safe working hours	87.5%	84.4%	92.7%	90.1%	81.4%	90.0%	87.9%	91.7%	80.6%	86.9%
Rosters take into account leave requests	95.8%	84.2%	87.8%	84.3%	78.6%	93.3%	85.5%	81.3%	59.4%	82.0%
Rosters take into account the skill mix required	79.2%	81.6%	80.5%	82.0%	85.7%	83.3%	78.2%	88.9%	75.6%	81.2%
Total no. of responses	**24**	**474**	**41**	**395**	**70**	**30**	**331**	**144**	**160**	**1669**

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

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

Table 4. Proportion of trainees who strongly agreed or agreed with statements regarding rostering at their ED placement, by ED accreditation level.

Statements regarding rostering	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Overall, I am satisfied with rostering at my site	90.9%	77.1%	**76.4%**
Rosters are provided in a timely manner	93.9%	**73.4%**	76.5%
Rosters give equitable exposure to day/ evening/ night shifts	87.9%	**75.7%**	77.2%
Rosters give equitable shifts to all areas of ED	93.9%	82.8%	**78.5%**
Rosters consider workload as a trainee	97.0%	84.7%	**82.1%**
Rosters support the service needs of the site	90.9%	**84.5%**	86.5%
Rosters ensure safe working hours	97.0%	**84.7%**	87.3%
Rosters take into account leave requests	97.0%	**80.5%**	82.1%
Rosters take into account the skill mix required	90.9%	**78.5%**	81.7%
Total no. of responses	33	354	1,282

Trainees were given the opportunity to comment on the rostering available at their placement, with Table 5 presenting the major themes and subthemes from the trainee responses (n=414) and some example comments. Comments that reflected negatively on rostering (n=295, 71%) significantly outnumbered the positive feedback about rostering (17%). There were a wide range of rostering issues being raised, with the COVID-19 pandemic being stated as a factor that further complicated rostering at sites. A further 8% of comments were mixed feedback and 3% of comments were related to suggestions for improving the rostering at their placement.

Table 5. Themes of trainee feedback regarding rostering at their placement, with example comments.

Theme	Example comments
Negative (n=295) - Unsafe staffing level/ lack of senior coverage at night - Understaffing (COVID-related/ sick leave/ resignations) - Disproportionate amount of evening/ night/ weekend shifts - Insufficient break between shifts - Rigid rostering and difficulty accessing leave (incl. study leave) - Late issuing of roster or short notice changes - Limited protected teaching/ non-clinical shifts - Inequitable rotation or limited exposure to specific clinical areas - Issues with leave coordinator - Unpaid over-time - Excessively rostered on-call	*Difficulties with trainee numbers, especially considering COVID affecting staff available to work in the department. As a result, staff numbers were low and remaining staff needed to increase shifts, have more frequent night shifts and unequal day to late shift ratio.* *Can be called up to 7pm for a nightshift at 10.30pm, unsafe, increase staff burnout, consecutive shifts (including 60 hours in a week). Trainees sometimes asked to attend teaching on days off, including morning of finishing a night.* *Absolutely terrible. Late rosters, not balanced, ignore requests. Significant anguish to the entire registrar group. Many people deterred from emergency medicine due to rosters. Some trainees do 50% nights!* *Annual leave requests are required to be provided well in advance, a year and a half before requested dates. Very difficult to get study leave approved for ACEM approved courses. Not getting paid for rostered overtime.* *Roster is provided at legal minimum requirement with respect to time. I spend nearly every shift in the acute monitored area with zero exposure to fast track and minimal resus exposure.*
Positive (n=72) - Accommodating rostering - Fair and equitable allocation - Improving	*The roster was provided well in advance to all trainees which was very very helpful and appreciative.* *Trainees are given the opportunity to participate in creation of the roster, supervised by FACEMs*

Mixed positive and negative (n=33)	*It has been a difficult term to roster with COVID, exams, sick leave etc. I think ordinarily this site has a very good and balanced roster.* *Often get put on more evening/night shifts given seniority BUT given that also have been given adequate time off for fellowship learning/exam needs.*
Suggestions for improvement (n=13)	*Our rostering has recently shifted to being done centrally (ie by admin staff outside the ED) and it has been plagued with issues. I strongly believe it should be done in-house to meet the complexities and nuances that are only understood if you work there.* *Introduction of online rostering timely and so useful- some tweaks needed to be more user friendly but great to finally have open disclosure for SMO roster as well as live updates on RMO roster.* *Needs a sick roster in the current climate. Sick calls put a burden on the system and the recent frequency can have an overall impact on health.* *Would prefer that at least one overnight registrar has done anaesthetics/airway training.*

4.2.4 Assistance for trainees

Nearly all trainees (95%) reported knowing whom to get assistance from at their placement if they experienced difficulty in meeting the requirements of training, with the same proportion of advanced trainees and provisional trainees reporting so (Table 6). However, a smaller percentage (80%) were in agreeance that their ED placement has adequate processes in place to identify and assist trainees encountering difficulty in progressing through the FACEM Training Program. There were no differences observed among responses between male and female trainees.

In relation to handling trainee grievances, 88% of trainees reported knowing whom to get assistance from if they had a grievance at their ED placement, with a further 7% neither agreeing nor disagreeing and 3% disagreeing with this. Similarly, a much smaller proportion of trainees (74%) agreed that their placement had adequate processes in place to manage trainee grievances, with 10% reporting that they did not know if there were processes in place.

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

Statements on assistance for trainees	% Strongly agreed / agreed		
	Provisional Trainees	Advanced Trainees	Total
Know who to get assistance from if falling into difficulty meeting training requirements	95.1%	94.5%	**94.7%**
ED placement has adequate processes in place to identify and assist trainees in difficulty	81.8%	78.8%	**79.8%**
Know who to get assistance from if experiencing a grievance at ED placement	89.6%	87.5%	**88.2%**
ED placement has adequate processes in place to manage grievances	75.7%	72.3%	**73.5%**
Total no. of responses	**556**	**1113**	**1550**

Table 7 presents the proportion of trainees who were in agreeance with statements in relation to trainee assistance, by region. Trainees who were undertaking a placement in the Northern Territory (NT) were less likely to agree with most of these statements, in comparison to trainees from other regions.

Table 7. Proportion of trainees who strongly agreed or agreed with statements regarding assistance for trainees in the ED, by region.

Statements on assistance for trainees	% Strongly agreed / agreed								
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ
Know who to get assistance from if falling into difficulty meeting training requirements	100%	93.5%	90.2%	95.9%	97.1%	93.3%	95.2%	95.8%	93.1%
ED placement has adequate processes in place to identify and assist trainees in difficulty	87.5%	76.8%	75.6%	81.0%	85.7%	73.3%	81.6%	85.4%	75.6%
Know who to get assistance from if experiencing a grievance at ED placement	100%	87.1%	80.5%	89.9%	88.6%	86.7%	90.6%	85.4%	85.0%
ED placement has adequate processes in place to manage grievances	83.3%	71.5%	53.7%	77.2%	72.9%	76.7%	77.6%	76.4%	61.9%
Total no. of responses	24	474	41	395	70	30	331	144	160

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

When this was compared by ED accreditation level, trainees who were undertaking a placement in an ED accredited for 6, 12, 18 and 24-months generally reported quite consistent agreement levels with each of the statements, except with respect to whether adequate processes were in place to manage trainee grievances, with trainees at 6-month linked sites least likely to agree with this (Table 8).

Table 8. Proportion of trainees who strongly agreed or agreed with statements regarding assistance for trainees in the ED, by ED accreditation level.

Statements regarding rostering	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Know who to get assistance from if falling into difficulty meeting training requirements	97.0%	95.2%	94.5%
ED placement has adequate processes in place to identify and assist trainees in difficulty	81.8%	79.7%	79.8%
Know who to get assistance from if experiencing a grievance at ED placement	87.9%	90.4%	87.6%
ED placement has adequate processes in place to manage grievances	66.7%	73.7%	73.6%
Total no. of responses	33	354	1,282

The survey further sought trainees' feedback about the assistance or processes available at their ED placement for trainees in difficulty or with respect to handling grievances, with 94 responses received. Nearly half (n=45) were positive comments regarding supportive and approachable senior staff, and a further 16 trainees commented that they either did not need any assistances or were unsure whom to get assistance from for grievances.

The remainder were negative comments (n=27), which mainly focused on workplace culture that discouraged the raising of grievances or difficulties, where they were afraid of repercussions or being targeted, or their issues/ complaints were ignored or not handled professionally. Some examples of these negative comments are provided in the following:

> *I have personally been on receiving end of bullying behaviour by senior staff specialist. I am fearful of making any complaints as this may impact on my ITAs [in-training assessments] and progress in training.*

Even when elevated to the director of department, concerns may not be escalated and sometimes ignored. General lack of leadership that has led to malaise on reporting issues as we know nothing will get done anyway.

Culture of "don't speak up, or you may find yourself without a job the following year". Any trainee that might be having difficulty, even from a mental health perspective, avoids voicing concerns due to previous experiences of other trainees in the department that have since been "invited to move to a different health care network".

4.2.5 Safe and supportive workplace

Trainees were asked to state their level of agreement that their placement provided a safe and supportive workplace with respect to various aspects as shown in Table 9. The majority of trainees (92%) strongly agreed or agreed that their placement provided a safe and supportive workplace overall. A higher proportion of trainees were in agreeance that their placement workplace provided a safe and supportive environment with respect to personal safety (89%), clinical protocols (90%) and supervision arrangements (89%), compared with other aspects such as sustaining their wellbeing (77%), support processes other than mentoring (80%), and in the provision of a comprehensive orientation program at commencement (78%).

Provisional trainees were slightly more likely than advanced trainees to agree that their placement provided a safe and supportive workplace overall (Table 9). However, there were comparable proportions of both provisional and advanced trainees who were in agreeance with the individual aspects relating to a safe and supportive workplace.

Table 9. Proportion of trainees who strongly agreed or agreed that specific aspects relating to a safe and supportive workplace were provided in their ED placement, by training level.

Placement provides a safe and supportive workplace with respect to:	% Strongly agreed / agreed		
	Provisional Trainees	Advanced Trainees	Total
Overall safety and support	94.1%	91.3%	92.2%
Personal safety (e.g. aggression directed by patients and/ or carers)	89.0%	88.8%	88.9%
Sustaining my wellbeing	78.8%	76.1%	77.0%
Support processes (other than mentoring)	79.0%	79.9%	79.6%
Clinical protocols	90.6%	89.5%	89.9%
Supervision arrangements	90.1%	88.1%	88.7%
Comprehensive orientation program at commencement	78.6%	77.4%	77.8%
Total no. of responses	391	1159	1550

Female trainees were less likely than male trainees to agree that their ED placement provided a safe and supportive workplace with respect to sustaining their wellbeing (75% vs. 79%), supervision arrangements (87% vs. 91%) and in the provision of support processes other than mentoring (77% vs. 82%).

The proportion of trainees who strongly agreed or agreed that various aspects of a safe and supportive workplace were provided in their ED placement, are shown in Table 10 by region and Table 11 by ED accreditation level. Trainees undertaking a placement in South Australia (SA) and NZ were among those who reported the lowest agreement level for more than one aspect of a safe and supportive workplace, in comparison to trainees in other regions.

Table 10. Proportion of trainees who strongly agreed or agreed that specific aspects relating to a safe and supportive workplace were provided in their ED placement, by region.

Placement provides a safe & supportive workplace with respect to:	% Strongly agreed / agreed								
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ
Overall safety & support	95.8%	90.3%	95.1%	95.9%	87.1%	86.7%	93.4%	95.1%	85.6%
Personal safety	75.0%	84.2%	90.2%	94.9%	88.6%	90.0%	93.1%	88.2%	81.3%
Sustaining my wellbeing	87.5%	74.7%	80.5%	81.8%	65.7%	83.3%	78.9%	79.2%	67.5%
Support processes (other than mentoring)	91.7%	77.6%	85.4%	85.3%	77.1%	73.3%	79.5%	79.2%	70.6%
Clinical protocols	83.3%	89.5%	90.2%	92.2%	91.4%	86.7%	91.5%	90.3%	82.5%
Supervision arrangements	95.8%	86.7%	97.6%	92.9%	82.9%	80.0%	88.5%	92.4%	82.5%
Comprehensive orientation	83.3%	74.1%	70.7%	82.5%	61.4%	70.0%	81.3%	86.1%	71.9%
Total no. of responses	**24**	**474**	**41**	**395**	**70**	**30**	**331**	**144**	**160**

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

Trainees who were undertaking a placement in a 6-month linked site were more likely to agree that their placement provided a safe and supportive workplace for all aspects, where those at sites accredited for 18- and 24 months were the least likely to agree that their placement provided personal safety and sustained their wellbeing (Table 11).

Table 11. Proportion of trainees who strongly agreed or agreed that specific aspects relating to a safe and supportive workplace were provided in their ED placement, by accreditation level.

Placement provides a safe & supportive workplace with respect to:	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Overall safety & support	97.0%	92.7%	**92.0%**
Personal safety	90.9%	90.4%	**88.4%**
Sustaining my wellbeing	87.9%	79.4%	**76.1%**
Support processes (other than mentoring)	90.9%	79.1%	79.4%
Clinical protocols	93.9%	**85.6%**	91.0%
Supervision arrangements	93.9%	**87.0%**	89.1%
Comprehensive orientation	87.9%	**73.2%**	78.8%
Total no. of responses	**33**	**354**	**1,282**

Trainees who disagreed that their ED placement provided a safe and supportive workplace were asked to provide a reason(s) for their response, with 169 trainees providing feedback (Table 12). Trainee's feedback was largely focused on their wellbeing and personal safety not being protected due to unsupportive rostering and/or understaffing to cope.

Table 12. Themes of trainee responses relating to their placement not meeting aspects of a safe and supportive workplace, with example comments.

Theme	Example comments
Trainee wellbeing (n=51) *Unsupportive rostering, burnout*	*Number of night shifts is exhausting, incredibly stressful, physically draining and means we all struggle to maintain a semblance of work-life balance. Managers fight us for absolutely everything including leave, course funding, breaching our contract regarding limits to hours and number of night shifts etc. It's exhausting, stressful and demoralising.* *It's not safe to not have a break when you're working in ED. It's not reasonable to expect people to work without any training. It's very hard to keep turning up knowing that there probably won't be enough staff, but still getting hassled about meeting targets as usual.* *Well-being program is a bit superficial. Doesn't really address actual concerns and seems to be more about placating trainees.*
Personal safety (n=35) *Insufficient security, increasing violent alcohol/drug-related and/or mental health patients*	*Constantly threatened verbally by a few regular patients some with criminal history and I felt sometimes very unsafe attending to those patients as a female doctor and that I don't have much support from the consultants.* *Many staff including myself have been assaulted by patients this year.* *As highlighted in the media, there have been multiple aggressive incidents with staff seriously injured. There remains a paucity of security personal for the size of department*
Orientation (n=35) *Minimal or no orientation at commencement, interrupted due to COVID-19*	*I never received orientation for this run. I was put straight onto night shifts from day one.* *Orientation was mainly several hours of online modules completed in own unpaid time.* *COVID [pandemic] caused significant interruption to orientation to a new department.*
Supervision and mentoring support (n=27) *Especially during night shifts, unsupportive DEMT*	*Supervision on the floor and bedside teaching arrangements are very poor/limited. Staff specialists allocated to the daily workplace-based assessment role are not readily identified or available.* *Poor trainee support and supervision with a distinct lack of response to multiple concerns raised by the trainee cohort. Increasing and unsafe expectations of trainees in regard to clinical shifts. High degrees of responsibility with poor supervision.* *Have a mentor who has never been rostered on with me nor reached out.*
Clinical protocols (n=15) *Outdated, lack of accessibility*	*Lack of up-to-date clinical protocols e.g. no chest pain pathway!* *Very few clinical protocols and difficult to find or not known about if they do exist.*
Service provision overrode training needs (n=13)	*The combination of heavy workload, increased requirement to provide a supervisory role and rostering meant that wellness and wellbeing was felt to be a very low priority. I felt I was there primarily for service provision and not for training purposes.* *Trainees are constantly monitored via how many patients they see on a shift which adds significantly to trainee anxiety and encourages too brief assessments.*
Patient safety and quality of care (n=11) *Access block, understaffing esp. at night shift*	*Unsafe work environment with level of patients, especially overnight, limited support from senior staff as they go home.* *Poor staffing levels compromises patient care. Perpetual access block. Regional trauma centre but no on site med registrar, no afterhours surgical registrar, no imaging on site.*

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

4.2.6 Discrimination, Bullying, Sexual Harassment, Harassment (DBSH)

Trainees were asked if they had experienced DBSH in their placement, with detailed definitions provided for each aspect of DBSH. There were 530 (32%) of the 1669 trainees in an ED placement who reported experiencing at least one aspect of DBSH behaviour from a patient or carer at their placement, with nearly half (n=256, 48%) of them reporting experiencing two or more aspects of DBSH behaviour.

Trainees were more likely to report experiencing harassment (23%) and discrimination (15%) than bullying (9%) or sexual Harassment (7%), from a patient or carer (Table 13). Female trainees were more likely than males to report experiencing all aspects of DBSH. DBSH incidents by patients or carers were also more likely to be reported by provisional trainees, compared with advanced trainees.

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

Experienced DBSH from a patient or carer	Total trainees N=1669	Gender		Level of training	
		Female N=798	Male N=870	Provisional trainees N=556	Advanced trainees N=1113
Discrimination	251 (15%)	152 (19%)	99 (11%)	97 (17%)	154 (14%)
Bullying	157 (9%)	79 (10%)	78 (9%)	66 (12%)	91 (8%)
Sexual Harassment	112 (7%)	97 (12%)	15 (2%)	48 (9%)	64 (6%)
Harassment	378 (23%)	213 (27%)	165 (19%)	145 (26%)	233 (21%)
Overall	**530 (32%)**	**303 (38%)**	**227 (26%)**	**200 (36%)**	**330 (30%)**

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

Of the 142 ACEM-accredited EDs, 109 (76.8%) sites had at least one trainee reported experiencing DBSH from a patient or carer. Some example comments from trainees on their experiences of DBSH from a patient or carer are provided below:

> *Abuse from patients will probably always be part of working in an inner-city hospital that sees a lot of drug and alcohol related presentations.*
>
> *Often receive comments from patients such as "you look too young to be a doctor "and I feel like there disbelieve that I am a doctor because I am a woman.*
>
> *Sexual harassment from patient - the "innocuous" question of "do you have a husband" or "are you married" or "what are you doing after work tonight"....*
>
> *Unfortunately due to the COVID-19 pandemic, several patients have pointed out that I am of Asian descent and have made unpleasant comments or requested that I identify "exactly where [I] am from" before interacting with them.*

Subsequently, trainees were asked if they had experienced any DBSH from ED or hospital staff while working in their placement. A total of 190 (11%) of 1669 trainees in an ED placement reported experiencing at least one aspect of DBSH behaviour exhibited by ED and/ or hospital staff, with 43 (23%) of them reporting experiencing two or more aspects of DBSH behaviour.

Trainees were most likely to report experiencing bullying (9%) by ED/ hospital staff, with 3%, respectively reporting experiencing discrimination or harassment incidents (Table 14). Female trainees were more likely than male trainees to report experiencing all aspects of DBSH by staff, whilst there were similar proportions of advanced and provisional trainees who reported experiencing DBSH behaviour by a staff member.

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

Experienced DBSH from a hospital or ED staff	Total trainees N=1669	Gender		Level of training	
		Female N=798	Male N=870	Provisional trainees N=556	Advanced trainees N=1113
Discrimination	46 (3%)	30 (4%)	16 (2%)	22 (4%)	24 (2%)
Bullying	143 (9%)	82 (10%)	61 (7%)	51 (9%)	92 (8%)
Sexual Harassment	10 (0.6%)	6 (0.8%)	4 (0.5%)	2 (0.4%)	8 (0.7%)
Harassment	50 (3%)	213 (27%)	165 (19%)	17 (3%)	33 (3%)
Overall	**190 (11%)**	**109 (14%)**	**81 (9%)**	**69 (12%)**	**121(11%)**

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

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

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

ED or hospital staff	Discrimination N=46	Bullying N=143	Sexual Harassment N=10	Harassment N=50
FACEM	15	52	<4	14
ED nursing staff	17	37	<4	13
In-patient medical staff	9	55	<4	13
Other ED doctor	9	11	<4	9
DEMT	8	9	<4	4
In-patient non-medical staff	<4	6	<4	4
Other ED staff (e.g., clerical, orderly, allied health)	4	4	<4	-
DEM/ Deputy DEM	<4	<4	-	<4
Other staff	<4	8	<4	<4
Prefer not to say	7	12	-	<4
Overall	**109 (14%)**	**81 (9%)**	**69 (12%)**	**121(11%)**

Note: Trainees could select more than one category of staff

There were 86 (61%) of 142 placement sites that had at least one trainee report having experienced DBSH by hospital or ED staff and over half of these sites (53%, n=46) had at least one trainee report experiencing DBSH by a FACEM.

Nearly half of the trainees in Western Australia (WA, 49%) and the NT (46%) reported having experienced DBSH from a patient or carer while working at their placement (Table 16). Whereas trainees from SA and TAS reported the highest rates of DBSH from ED or hospital staff, with 10% of trainees in TAS reporting experiencing DBSH from FACEMs.

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

	% Yes or Unsure									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Experienced any DBSH from a patient/ carer?	33.3%	29.3%	**46.3%**	29.4%	40.0%	36.7%	28.7%	**49.3%**	26.9%	31.8%
Experienced any DBSH from ED or hospital staff?	12.5%	11.6%	9.8%	9.1%	**20.0%**	**16.7%**	10.0%	14.6%	11.9%	11.4%
Experienced DBSH by FACEMs	4.2%	1.9%	7.3%	3.5%	5.7%	**10.0%**	5.1%	3.5%	4.4%	3.8%
Total no. of responses	**24**	**474**	**41**	**395**	**70**	**30**	**331**	**144**	**160**	**1669**

Sixty-five trainees provided further information on their DBSH experiences, with key themes identified as the following:

- For the trainees who reported experiencing discrimination, this was largely based on their gender (female in particular), followed by ethnicity, non-English speaking background, and family commitments.
- Incidents of bullying and harassment were frequently exhibited by in-patient medical staff during phone communication and the referral process.
- Bullying behaviours exhibited by FACEMs and/ or DEMTs were mainly related to harsh criticism on trainees' performance or publicly undermining their judgement.
- Culture of bullying and harassing trainees amongst nursing staff was also frequently reported, and was routinely reported as not being appropriately addressed by the hospital management.

4.2.7 Opportunities to participate

Just over half (57%) of responding trainees strongly agreed or agreed that they were able to participate in decision making regarding governance (for example, workplace committees) at their ED placement, while a further 27% neither agreed nor disagreed, 11% disagreed or strongly disagreed, and 5% reported not knowing. A higher proportion of males (compared with females, 60% vs. 53%) and advanced trainees (compared with provisional trainees, 59% vs. 52%) were in agreeance with this.

A larger proportion (74%) of responding trainees agreed that they were able to participate in quality improvement activities at their placement, with 18% neither agreeing nor disagreeing, and 5% disagreeing. Differences were observed in the proportion of those who were in agreeance with this by gender (males, 76% vs. females, 70%), but no differences were seen by training level (advanced trainees, 74% vs. provisional trainees, 73%).

Tables 17 and 18 present the proportion of trainees who agreed with statements relating to their opportunities to participate in decision making regarding governance and in quality improvement activities, by region and by accreditation level. In comparison to trainees in other regions, trainees in NZ were less likely to agree with the statement regarding participation in decision making whilst trainees in the NT were less likely to agree with the statement regarding participation in quality improvement activities.

Table 17. Proportion of trainees who strongly agreed or agreed to statements relating to participation in quality improvement activities and in decision making regarding governance, by region.

Opportunities to participate	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Able to participate in decision making regarding governance (e.g. workplace committees)	79.2%	57.4%	53.7%	56.7%	52.9%	60.0%	56.8%	60.4%	**48.8%**	56.6%
Able to participate in quality improvement activities	87.5%	67.1%	**61.0%**	80.0%	67.1%	66.7%	73.4%	86.8%	70.6%	73.6%
Total no. of responses	24	474	41	395	70	30	331	144	160	1669

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

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

Table 18. Proportion of trainees who strongly agreed or agreed to statements relating to participation in quality improvement activities and in decision making regarding governance, by accreditation level.

Opportunities to participate	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Able to participate in decision making regarding governance (e.g. workplace committees)	54.5%	**48.9%**	58.8%
Able to participate in quality improvement activities	**63.6%**	64.4%	76.4%
Total no. of responses	33	354	1,282

4.3 Supervision and Training Experience

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

4.3.1 Supervision and feedback

Trainees were asked about supervision, support and feedback provided by senior staff at their ED placement. Most (90%) were satisfied with the supervision they received at their placement overall, with no differences observed by training level or gender. A slightly higher proportion of trainees (92%) agreed that they were satisfied with the quality of the DEMT support and that the availability of their DEMT for guidance and supervision met their needs at their stage and phase of training (Table 19).

With respect to the clinical supervision received from FACEMs at their placement, 90% of trainees strongly agreed or agreed that it met their needs at their stage and phase of training. Slight differences were observed by gender (male, 91% vs. female 88%) and by training level (provisional, 91% vs. advanced, 89%).

Nearly all (94%) trainees were in agreeance that their DEMT had discussed what is expected of them at their stage and phase of training, with a higher proportion of provisional trainees (96%) than advanced trainees (93%) reporting so. However, a much smaller proportion (78%) of trainees strongly agreed or agreed that they received regular, informal feedback on their performance and progress, with a higher proportion being seen among provisional trainees than advanced trainees (81% vs.

77%). Interestingly, male trainees were significantly more likely than female trainees (82% vs. 75%) to agree that they received regular and informal feedback on their performance/ progress.

The proportion of trainees in agreement with statements relating to supervision, support and feedback at their ED placement is presented by region (Table 19) and accreditation level (Table 20). Trainees undertaking a placement in TAS were less likely to agree that they were satisfied with the quality and availability of DEMT support, whereas trainees in NZ were less likely than trainees in other regions to agree that they received clinical supervision or informal feedback that met their needs.

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

Statements about supervision, support and feedback	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Overall, satisfied with the supervision received	100%	88.6%	97.6%	93.4%	87.1%	90.0%	89.7%	91.7%	85.0%	90.2%
Satisfied with quality of DEMT support	95.8%	90.5%	95.1%	93.7%	94.3%	83.3%	90.6%	94.4%	88.1%	91.6%
Availability of DEMT for guidance and supervision meets needs	95.8%	90.5%	92.7%	94.2%	92.9%	83.3%	92.4%	92.4%	88.1%	91.8%
Clinical supervision received from FACEMs meets needs	87.5%	89.5%	92.7%	92.4%	87.1%	90.0%	88.5%	90.3%	85.6%	89.6%
DEMT had discussed what is expected of trainee at their stage of training	95.8%	92.6%	95.1%	95.9%	94.3%	93.3%	94.3%	97.2%	90.6%	94.1%
Receive regular, *informal feedback on performance and progress	79.2%	75.3%	73.2%	81.5%	77.1%	83.3%	82.2%	80.6%	71.3%	78.4%
Total no. of responses	24	474	41	395	70	30	331	144	160	1669

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

Trainees undertaking a placement in an ED accredited for 6 and 12 months were generally less likely to agree with most aspects relating to supervision, support and feedback, in comparison to trainees in other EDs.

Table 20. Proportion of trainees who strongly agreed or agreed with statements about supervision, support and feedback provided at their placement, by accreditation level.

Statements about supervision, support and feedback	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Overall, satisfied with the supervision received	93.9%	**88.4%**	90.6%
Satisfied with quality of DEMT support	97.0%	**90.4%**	91.8%
Availability of DEMT for guidance/ supervision meets needs	97.0%	**90.4%**	92.0%
Clinical supervision received from FACEMs meets needs	97.0%	**87.9%**	89.9%
DEMT had discussed what is expected of trainee at their stage of training	97.0%	**91.2%**	94.9%
Receive regular, *informal feedback on performance and progress	78.8%	79.9%	**78.0%**
Total no. of responses	33	354	1,282

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

4.3.2 Workplace-based Assessments

Advanced trainees were asked to rate the support and feedback provided by their Local WBA Coordinators, FACEMs and WBA assessors at their ED placement, with provisional trainees not required to undertake WBAs.

Just over three-quarters (77%) of advanced trainees were satisfied with the level of support they received from their Local WBA Coordinator to complete their EM-WBA requirements, with 16% neither agreeing nor disagreeing and 7% disagreeing. A similar proportion (78%) were satisfied with the level of support they received from FACEMs. With respect to feedback, a higher proportion of advanced trainees (85%) were in agreeance that WBA assessors/ FACEMs provided useful feedback to guide their training.

The proportion of advanced trainees who agreed that they were satisfied with the support from their Local WBA Coordinator, FACEMs and WBA assessors is provided in Table 21 by region, and in Table 22 by ED accreditation level. Consistent with previous findings regarding supervision and feedback, trainees undertaking a placement at NZ and TAS EDs were generally less satisfied with the support and feedback received for WBAs. It is noteworthy that just over half of trainees in TAS were satisfied with the support from FACEMs to complete their EM-WBA requirements.

Table 21. Proportion of advanced trainees who agreed that they were satisfied with the support and feedback from their local WBA Coordinator, FACEMs, and/ or WBA assessors, by region.

Statements about support and feedback for EM-WBAs	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Satisfied with the level of support from Local WBA Coordinator	93.3%	77.6%	80.0%	79.5%	71.7%	80.0%	73.7%	75.5%	70.7%	76.5%
Satisfied with the level of support from FACEMs	86.7%	80.8%	72.0%	79.8%	78.3%	53.3%	78.0%	77.5%	71.7%	78.3%
WBA assessors/ FACEMs provide useful feedback	86.7%	86.1%	88.0%	90.7%	80.4%	86.7%	82.2%	87.3%	75.8%	85.4%
Total no. of responses	15	317	25	258	46	15	236	102	99	1113

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

Trainees undertaking a placement at 6-month linked EDs were less likely to agree that they were satisfied with the support from their Local WBA Coordinator and FACEMs (Table 22).

Table 22. Proportion of advanced trainees who agreed that they were satisfied with the support and feedback from their local WBA Coordinator, FACEMs, and/or WBA assessors, by accreditation level.

Statements about support and feedback for EM-WBAs	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Satisfied with the level of support from Local WBA Coordinator	**74.1%**	77.2%	76.4%
Satisfied with the level of support from FACEMs	**74.1%**	76.7%	78.8%
WBA assessors/ FACEMs provide useful feedback	85.2%	**83.5%**	85.8%
Total no. of responses	27	206	880

Advanced trainees were further surveyed about how WBAs were organised at their site (Table 23), with the majority reporting that it was the trainee's responsibility (73%), rather than the DEMT or WBA Coordinator to schedule WBAs (27%). They were also more likely to report that the WBAs were conducted on an ad hoc basis (36%), instead of being organised through a rostered WBA Consultant or rostered WBA session.

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

How are WBAs organised at your site?	Number of Respondents*	%
It is the trainee's responsibility	815	73.2%
On an ad hoc basis	405	36.4%
They are scheduled by DEMT or WBA Coordinator	305	27.4%
Through rostered WBA Consultant	222	19.9%
Through rostered WBA session	77	6.9%
Other (e.g. a mixture of the above, trainees were informed of assessor availability, last minute changes/ cancellation on the rostered consultant, etc.)	19	1.7%
Total no. of respondents	1113	

*Note: *Respondents may select more than one way of how the WBAs were organised at their site, with 507 (46%) advanced trainees doing so.*

4.3.3 Casemix

Trainees were asked if their ED placement provided an appropriate training experience when considering casemix. Overall, the majority of trainees agreed that the ED casemix at their placement was appropriate with respect to the number (95%), breadth (88%), acuity (84%), and complexity of cases (89%) (Table 24). Similar levels of agreement were seen between advanced and provisional trainees. Trainees with an ED placement in the Australian Capital Territory (ACT) and NT were less likely to be satisfied with their placement in providing an appropriate training experience when considering different aspects of casemix, compared with trainees in other regions (Table 24).

Table 24. Proportion of trainees who agreed that their current placement provided an appropriate training experience when considering aspects of casemix, by region.

Aspects of casemix	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Number of cases	95.8%	94.3%	92.7%	96.5%	100%	96.7%	91.5%	97.2%	94.4%	94.8%
Breadth of cases	83.3%	87.6%	78.0%	88.6%	91.4%	86.7%	86.4%	94.4%	83.8%	87.7%
Acuity of cases	79.2%	85.2%	65.9%	83.5%	91.4%	86.7%	83.1%	85.4%	81.3%	83.8%
Complexity of cases	83.3%	90.1%	85.4%	87.3%	92.9%	96.7%	89.1%	90.3%	87.5%	89.0%
Total no. of responses	24	474	41	395	70	30	331	144	160	1669

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

Not surprisingly, trainees undertaking placements in EDs accredited for 18 and 24 months were most likely to agree that the ED casemix at their placement was appropriate with respect to the number, breadth, acuity, and complexity of cases (Table 25).

Table 25. Proportion of trainees who agreed that their current placement provided an appropriate training experience when considering aspects of casemix, by accreditation level.

Placement provides a safe & supportive workplace with respect to:	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Number of cases	**84.8%**	94.1%	95.2%
Breadth of cases	**75.8%**	83.3%	89.2%
Acuity of cases	**57.6%**	76.6%	86.4%
Complexity of cases	**72.7%**	84.2%	90.8%
Total no. of responses	33	354	1,282

4.3.4 Further comments on supervision and training experience

There were 154 further comments provided by trainees relating to supervision or the training experience at their placement. Nearly half (44%, n=67) of the comments reflected on various aspects of the casemix available at their placement, with some consistent feedback being provided about COVID-19 reducing the number and acuity of ED presentations. A further 12 (8%) comments were positive feedback about having supportive senior staff and that they were well-supported to complete their WBAs.

On the contrary, there were 62 (40%) negative comments that were largely reflecting on the difficulty to complete WBAs, unsatisfactory senior supervision, and limited feedback on their progress or performance (Table 26). There were 12 other (8%) comments regarding suggestions to improve trainee feedback or assessment methods.

Table 26. Negative perspectives and suggestions for improvement regarding the supervision and training experience at ED placements, themes with example comments.

Theme	Example comments
Negative comments	
Difficulty in completing WBAs (n=36) *Limited opportunity due to workload, limited access to FACEMs or WBA Coordinator*	*The WBA process/scheduling is a bit opaque, and hard to navigate if new to the department. Also, hard to organise when you're pretty much only rostered on evenings!!* *Doing WBAs is near impossible due to lack of FACEMs with non-clinical time, alignment of shifts with the non-clinical time, limited FACEMs on the floor, and overall burden of patient numbers making it difficult to find time to do, let alone time for meaningful/quality feedback.* *It can be very hard to complete WBAs. I have been told at times that a shift is too busy or too quiet to do a shift report! It would be good if there was more incentive for consultants to complete WBAs with trainees.*
Lack of senior supervision (n=15) *High workload, insufficient number of DEMTs*	*Due to the number of presentations and the nature of the department given access block, supervision of the trainees is also virtually non-existent unfortunately.* *DEMTs appear over stretched with 10+ trainees per DEMT. Feedback can be generic and can feel like trainee's sole role is service provision and on-the-floor teaching is limited.*
Limited quality feedback (n=11)	*Feedback, or lack thereof, has always been an issue at this placement. It runs an old style 'no news is good news' system and the only feedback we get generally is at ITA time and this is of variable quality and usefulness.* *I feel I have to constantly request feedback. Sometimes I will receive constructive feedback, most times it will only be an acknowledgment and appreciation.*

Suggestions for improvement	
Feedback on performance *More regular and specific feedback, mandatory meeting with supervisor*	*Regular feedback e.g., once per week/ at end of shift/ obligatory meeting with supervisor would be useful.* *Each DEMT should have a maximum number of 8-10 trainees to look after in order to be able to give appropriate and specific feedback. I would have loved to have my DEMT working with me a shift at the beginning of the term and another shift towards the end. This will enable them to form some judgement and not only rely on the other consultants.* *Regular ITA feedback of "you are doing fine" is not feedback. It would be helpful if an SMO [senior medical officer] on the floor was dedicated to supervision/ teaching on occasion. I would really appreciate dedicated protected time where I can sit down with an SMO and talk through things.*
Trainee assessments	*Some trainees are more assertive in seeing critically unwell patients and "stepping up" to do procedures, meaning that quieter trainees miss out on the exposure and feel less comfortable. This results in a cycle of them feeling less competent. Supervisors and FACEMs should work to acknowledge this and specifically allocate tasks to these less vocal trainees.* *The allowable time period [of assessment] is much too short -- cases often expire before supervisors have a chance to sign it off.*

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

4.4 Education and Training Opportunities

This section details responses to survey items relating to the educational and training opportunities available at ED placements. It covers clinical teaching, the structured education program, access to educational and examination resources, simulation learning experiences, leadership and research opportunities.

4.4.1 Clinical teaching and the structured education program

The majority of trainees strongly agreed or agreed that the clinical teaching at their placement optimised their learning opportunities (87%), and that they received training for, and were provided with opportunities to use relevant clinical equipment (88%). However, only two-thirds (65%) of trainees were in agreeance that they had access to formal ultrasound teaching. As expected, the proportion of trainees who agreed with having access to formal ultrasound teaching increased as site accreditation limits increased (6-month linked sites, 45%; 6- and 12-month sites, 56%; and 18- and 24-month sites, 67%).

The same proportion of trainees strongly agreed or agreed that the structured education program met their needs at their stage and phase of training, and that it was aligned to the content and learning outcomes of the ACEM Curriculum Framework (84%, respectively). Advanced trainees (82%) however, were less likely than provisional trainees (87%) to agree that the structured education program at their placement met their needs.

Trainees were asked whether the structured education sessions were provided for, on average, a minimum of four hours per week at their placement, with 87% agreeing with this. However, a smaller proportion of trainees (82%) were in agreeance that the rostering at their placement enabled them to attend the structured education sessions, with a slightly higher proportion of advanced trainees (83%) than provisional trainees (80%) agreeing with this.

Trainees undertaking a placement in TAS or NZ were less likely to agree with each of the four statements related to the structured education program, compared with trainees in other regions (Table 27).

Table 27. Proportion of trainees who strongly agreed or agreed with statements about the structured education program at their ED placement, by region.

Structured Education Program	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
The structured education program meets needs	83.3%	81.0%	92.7%	82.5%	80.0%	73.3%	87.6%	92.4%	80.6%	83.8%
The structured education program aligns to the content and learning outcomes of the ACEM Curriculum Framework	83.3%	81.6%	90.2%	85.6%	85.7%	70.0%	87.6%	86.1%	80.6%	84.2%
Structured education sessions are provided for a minimum of four hours per week	100%	84.2%	92.7%	85.1%	94.3%	93.3%	94.9%	83.3%	73.8%	86.5%
Rostering enables trainees to attend structured education sessions	87.5%	80.0%	85.4%	79.7%	84.3%	50.0%	93.7%	81.9%	70.6%	81.8%
Total no. of responses	24	474	41	395	70	30	331	144	160	1669

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

A smaller proportion of trainees undertaking a placement in 6- and 12-month accredited sites were in agreeance with most statements relating to the structured education program at their placement, compared with trainees in other EDs (Table 28).

Table 28. Proportion of trainees who strongly agreed or agreed with statements about the structured education program at their ED placement, by accreditation level.

Structured Education Program	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
The structured education program meets needs	84.8%	**81.6%**	84.3%
The structured education program aligns to the content and learning outcomes of the ACEM Curriculum Framework	84.8%	**80.5%**	85.3%
Structured education sessions are provided for a minimum of four hours per week	**81.8%**	84.7%	87.1%
Rostering enables trainees to attend structured education sessions	87.9%	**79.4%**	82.3%
Total no. of responses	33	354	1,282

4.4.2 Access to educational and examination resources

Similar proportions of advanced trainees (90%) and provisional trainees (89%) were in agreeance that they had access to the educational resources that they needed to meet the requirements of the FACEM Training Program.

With respect to access to exam courses, there were comparable proportions of trainees who agreed that they had access to written exam revision programs (86%) and clinical exam preparation programs (87%) at their placement. Of those who reported that they had access to written exam revision programs at their placement (n=1,428) however, less than three-quarters (73%) agreed that they had sufficient access to the program. For trainees who reported having access to clinical exam preparation programs at their placement (n=1,445), a higher proportion (83%) of them were in agreeance that they had sufficient access to the program.

Table 29 shows the proportion of trainees who reported having access to written and clinical exam preparation programs onsite at their placement or at an external (linked/ networked) site, by region. The smallest proportion of trainees undertaking an ED placement in New South Wales (NSW) reported having access to onsite exam programs, compared with trainees in other regions.

Table 29. Proportion of trainees who reported having access to written and clinical exam preparation programs onsite or at external site, by region.

I have access to:	% Strongly agreed / agreed									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Written exam revision program										
Onsite	95.8%	**77.6%**	90.2%	90.4%	88.6%	90.0%	86.1%	93.1%	84.4%	85.6%
Offsite (linked/ networked ED)	0%	12.7%	2.4%	4.3%	5.7%	6.7%	3.0%	5.6%	8.1%	6.9%
Clinical exam preparation program										
Onsite	95.8%	**80.8%**	92.7%	88.4%	88.6%	86.7%	88.5%	93.8%	85.0%	86.6%
Offsite (linked/ networked ED)	0%	9.3%	2.4%	4.8%	6.7%	6.7%	2.1%	3.5%	6.3%	5.5%
Total no. of responses	**24**	**474**	**41**	**395**	**70**	**30**	**331**	**144**	**160**	**1669**

Not surprisingly, trainees undertaking a placement in 18- and 24-month accredited sites were most likely to report having access to both written and clinical exam preparation programs, compared with sites accredited for shorter training durations (Table 30).

Table 30. Proportion of trainees reported having access to written and clinical exam preparation programs onsite or at external site, by accreditation level.

Structured Education Program	% Strongly agreed / agreed		
	6-month linked	6 & 12 months	18 & 24 months
Written exam revision program			
Onsite	**69.7%**	71.2%	89.9%
Offsite (linked/ networked ED)	15.2%	13.3%	4.9%
Clinical exam preparation program			
Onsite	**72.7%**	**72.6%**	90.8%
Offsite (linked/ networked ED)	9.1%	16.9%	5.4%
Total no. of responses	**33**	**354**	**1,282**

Trainees who disagreed with any of the statements relating to educational and training opportunities available at their placement, were asked to comment on the reason(s) for their response. Table 31 provides the key themes and subthemes from 289 responses, which were largely focused on the absence of formal ultrasound teaching onsite (32%), unsupportive rostering and a lack of protected teaching time (30%), less than 4-hours a week of teaching (15%), and poorly conducted education program (12%).

Table 31. Themes and subthemes of trainee comments regarding the educational and training opportunities at their ED placement

Key themes and sub-themes
Limited or no formal ultrasound teaching (n=93) • *Difficult to access* • *Ad-hoc* • *Off-site*
Rostering unsupportive of teaching program (n=86) • *Teaching not protected* • *Prioritised service provision* • *Frequent night shifts (missed the teaching during the day)* • *Fatigue post night shift* • *Part timer did not have access to teaching program*
Less than 4 hours teaching per week (n=43) • *Rarely met the 4-hour per week requirement* • *Less hours of teaching for provisional trainees*
Poorly structured education program (n=36) • *Not tailored to the level of training* • *Not aligned to ACEM curriculum* • *Only available at external sites* • *Poorly structured content*
Affected by COVID-19 pandemic (29) • *Loss of face-to face teaching* • *Reduction in hours of teaching* • *Cancellation of ultrasound teaching* • *Decrease in access to simulation*
Minimal clinical/ on-floor teaching (n=16) • *Affected by clinical load* • *Limited opportunities to learn using clinical equipment* • *Lacking procedural opportunities*
Lack of exam preparation support or resources (n=14) • *Limited courses or resources* • *Inexperienced FACEMs* • *Unsupportive DEMTs*

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

4.4.3 Simulated learning experiences

The majority (89%) of trainees reported that simulation learning experiences were utilised at their ED placement, with 5% unsure and 6% reporting that these were not available at their placement. Trainees undertaking a placement in EDs accredited for 18- and 24-month placements (91%) were more likely than those in EDs accredited for shorter training durations (84%-85%) to report that simulation learning experiences were utilised.

Of trainees who reported the availability of simulation learning experiences (n=1,492), most (93%) of them reported that they had participated in simulation learning experiences at their placement. A smaller proportion of provisional trainees than advanced trainees (5% vs. 8%) reported that they had not participated in simulation learning at their placement, with 85 of them providing a reason for this. The main reason given for not participating in simulation learning was due to COVID-19 where simulation had been limited or cancelled (n=43). Other reasons included rostering constraints where they were either not rostered for the simulation session, or they were too busy to attend one (n=29), they were prioritising exam preparation instead (n=9), or had attended other teaching sessions instead (n=4).

A smaller proportion (80%, n=1,108) of trainees reported that they had participated in multidisciplinary team-based simulation training at their placement, with similar proportions of provisional trainees (80%) and advanced trainees (79%) reporting so. There were no major differences in the proportion of provisional trainees and advanced trainees who were in agreeance with statements relating to participation in team-based simulation training (Table 32).

Table 32. Proportion of trainees who strongly agreed or agreed with statements regarding participation in interprofessional team-based simulation training, by training level.

Participation in multidisciplinary team-based simulation training at this placement:	% Strongly agreed / agreed		
	Provisional Trainees	Advanced Trainees	Total
Has improved my effectiveness in ED team-based practice	94.4%	92.3%	**93.1%**
Has contributed to my leadership development	90.7%	91.4%	**91.2%**
Has enhanced my learning and team-based practice	92.9%	92.1%	**92.3%**
Total no. of responses	378	730	1,108

Of those who disagreed with any of the above statements relating to multidisciplinary team-based simulation training, 41 trainees provided an explanation. Most comments were related to reduced capacity of team-based simulation due to COVID-19 restrictions (n=12), where virtual simulation had limited its effectiveness (n=5). Another 11 trainees commented that they had limited exposure to team-based simulation due to rostering, whilst 10 others commented that they did not find it useful as it was poorly conducted (e.g., unstructured, low quality debrief, not tailored to the needs of provisional trainees etc.). Three trainees commented that team-based simulation was stressful when this involved a large group of participants.

4.4.4 Leadership opportunities

A higher percentage of trainees strongly agreed or agreed that they were provided with opportunities to teach and supervise junior trainees (91%), compared with opportunities for leadership and management appropriate to their stage and phase of training (88%). Rather comparable proportions of advanced trainees and provisional trainees were in agreeance that they were provided with opportunities to teach and supervise junior medical staff (92% vs. 90%), as well as leadership and management opportunities (88% vs. 87%).

4.4.5 Research opportunities

Table 33 shows the responses to the statement 'there is a designated staff member available to provide advice about the research component of the FACEM Training Program at my current placement', by hospital accreditation level. Trainees undertaking their ED placement in hospitals accredited for 18- and 24-months of training (42%) were significantly more likely to respond that there was a designated staff member to advise on the research component, compared with 6-month linked, six- and 12-month accredited sites (25% - 27%). However, nearly one-third (32%) of trainees did not know if there was a designated staff member available to provide advice about the research component at their current placement – and this was consistently observed across EDs with different accreditation levels.

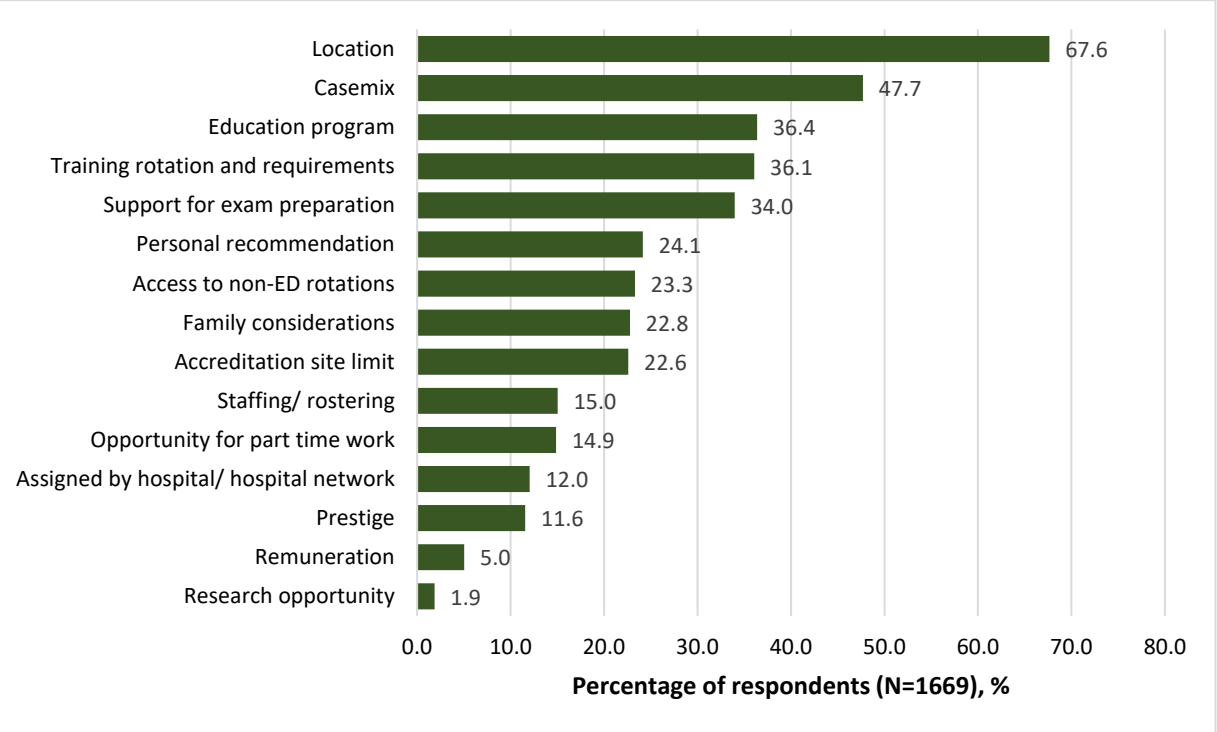
Table 33. Trainees' responses to whether there was a staff member available to provide advice about the research component, by hospital accreditation level.

Staff member available to provide advice about research component	6-month linked	6 & 12 months	18 & 24 months	Total
Yes	27.3%	24.6%	41.9%	**37.9%**
No	6.1%	8.5%	3.8%	**4.9%**
Don't know	24.2%	32.5%	31.4%	**31.5%**
Not applicable (have previously completed/ not yet started research requirement)	42.4%	34.5%	22.9%	**25.8%**
Total no. of responses	**33**	**354**	**1,282**	**1,669**

4.5 Further Perspectives on Placement

From a list of potential factors, trainees were asked to select up to five key factors that they considered in arranging their training placement (Figure 1). The list of key factors nominated is consistent with those identified in the previous survey iteration, where ED location was the most considered factor when trainees arranged their placement, followed by casemix. On the contrary, remuneration and research opportunities were factors least considered by them. It is noteworthy that the availability of an education program (36%) and support for exam preparation (34%) were factors deemed of similar importance, as was training rotation and requirements (36%).

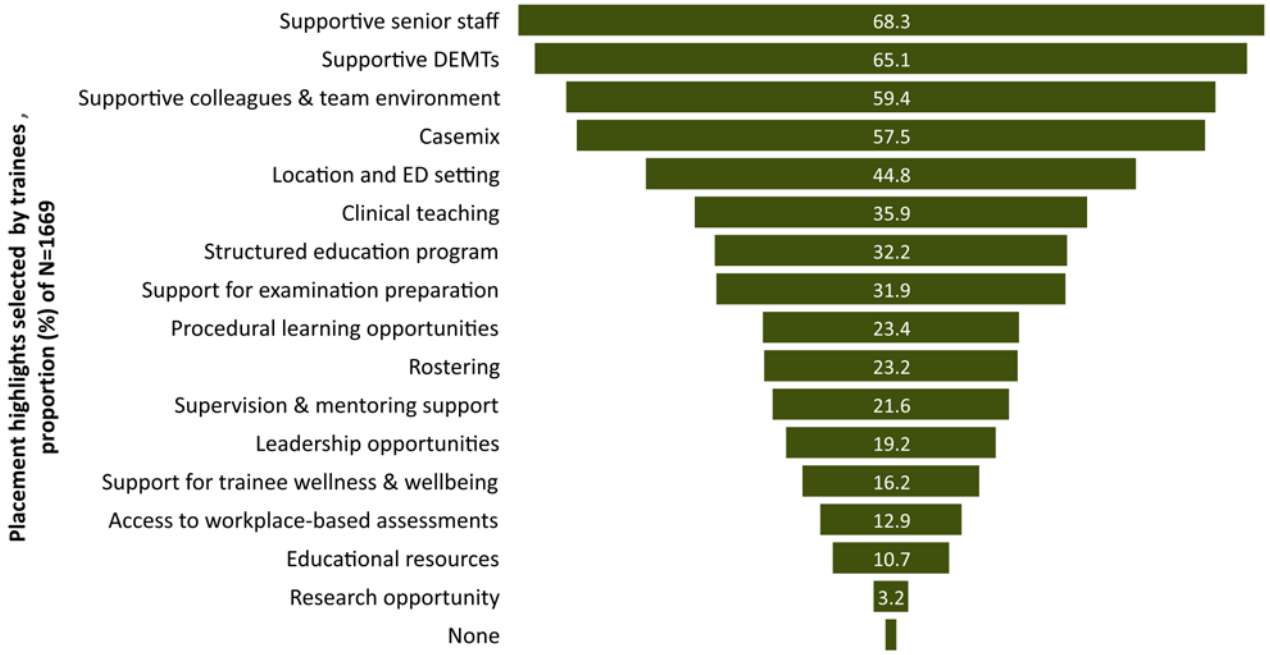
Figure 1 Factors for consideration in arranging training placement, ranked from the most important to the least important.



Note: Respondents could select up to five factors

Trainees were further asked to nominate highlights of undertaking an ED placement at their site, with trainees able to select as many highlights that applied. The most selected highlights included supportive senior staff/ DEMT/ colleagues and ED casemix (Figure 2). Clinical teaching and support for exam preparation were highlights selected by around one-third of trainees. Access to WBAs, educational resources and the research opportunity, on the other hand, were the least selected highlights.

Figure 2 ED placement highlights selected by trainees, proportion of N=1669.



Note: Respondents could select more than one highlight for their placement.
17 (1%) trainees chose 'None' (i.e. no highlight in their placement), whilst no trainee selected 'Other' as one of the options in the list.

Trainees were provided with the opportunity to outline key areas for improvement that could be made at their placement, with 214 trainees providing feedback (Table 34). Improvements to rostering (n=79, 37%), the teaching/ education program (n=61, 29%), clinical and procedural training (n=30, 14%), and staffing and workload arrangements (n=29, 14%) were among the main areas identified.

Table 34. Themes and subthemes for areas for improvement.

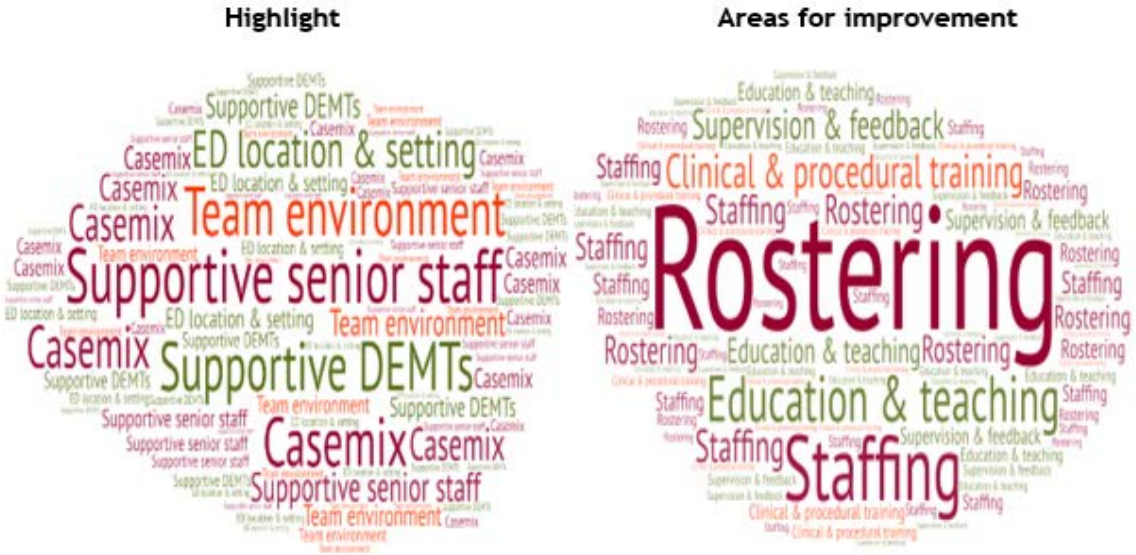
Key themes and sub-themes
Rostering (n=79) • *Reduce night shifts* • *Protected teaching time* • *Allocation of non-clinical time* • *Access to leave (including study leave)* • *Equitable shifts* • *More resuscitation shifts*
Teaching/ education program (n=61) • *Structured Fellowship teaching* • *Better support for exam preparation* • *Better simulation program* • *FACEM-led teaching* • *Consistent teaching standard across network* • *Formalise ultrasound teaching*
Clinical and procedural training (n=30) • *Improve bedside and on the floor teaching* • Increase procedural learning opportunities
Staffing and workload arrangements (n=29) • *Better senior cover for night shifts* • *Improve senior staff to trainee ratio* • *More locum support*
Senior supervision and feedback (n=24) • *More informal feedback* • *Mentoring support*

• *Better engagement with other FACEMs besides DEMTs* • *Improve night shift supervision*
Structured and better support for WBAs (n=20) • *Rostered sessions* • *More formalised process* • *Better access to WBA Coordinator*
Leadership and junior teaching opportunities (n=11) • *More opportunity for senior staff* • *More involvement in decision making*
Improve resources (n=10) • *Increase bed capacity* • *Improve ED space* • *Measures to cope with access block*
Trainee welfare and wellbeing (n=9) • *Wellness/ wellbeing program to assist trainee burnout* • *More encouragement for provisional/junior trainees* • *Process to address bullying/harassment*
Casemix- Including opportunities to manage higher acuity patients (n=7)
Improve access to non-ED rotations (n=6) • *Especially critical care rotations*
Other (n=8) • *Better access to clinical protocols* • *Better orientation program* • *Improve research support etc.*

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

Placement highlights were compared with the areas for improvement identified (Figure 3), with obvious differences observed. Rostering and staffing arrangements remained the key areas for improvement, while in contrast casemix and supportive team environment were key highlights. Improvements to the education program and clinical/ procedural training opportunities were also consistently identified as areas to be further improved. Despite supportive senior staff and supportive DEMTs being highlights, trainees commonly reported senior supervision (especially during night shift) and feedback on their progress as areas needing to be improved.

Figure 3 Highlights vs. areas for improvement of placement, five key areas.



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

4.6.1 Perspectives on the FACEM Training Program

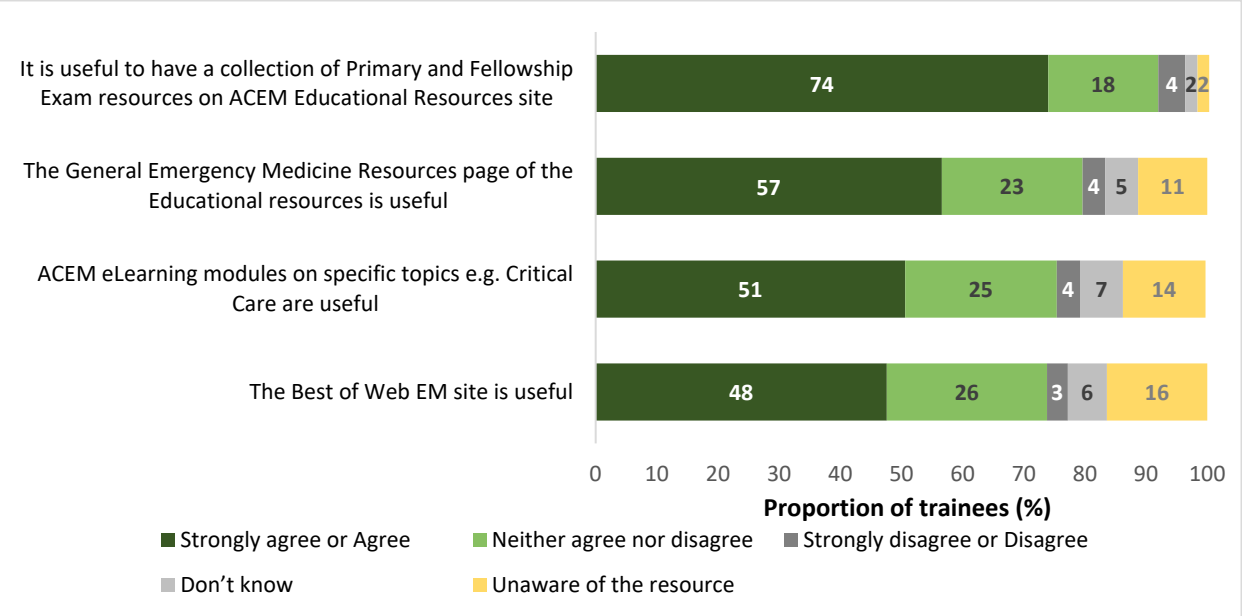
The majority (88%) of trainees strongly agreed or agreed with the statement that 'the FACEM Training Program is facilitating my preparation for independent practice as an EM specialist', with a further 9% neither agreeing nor disagreeing and 2% disagreeing with this statement. A higher proportion of advanced trainees (89%) than provisional trainees (85%) were in agreeance with this, but no differences in responses between male and female trainees were observed.

A smaller proportion (79%) of trainees agreed that they were well supported in their training by ACEM processes, with 17% being neutral and 3% disagreeing with this. There were similar responses seen by gender and by level of training. Trainees who disagreed or strongly disagreed that they were well-supported in their training by ACEM processes were given the opportunity to provide further details, with 34 trainees doing so. Half of the comments (n=18) were focused on processes relating to exam implementation or support (both Primary and Fellowship), whilst other comments were about the need for more support and guidance relating to WBAs (n=6), non-ED rotations (n=3), remediation processes and training requirements (n=4). A further three trainees commented that ACEM should undertake more proactive measures to address trainee's concerns.

4.6.2 Online resources available for FACEM trainees

ACEM currently provides a range of resources to support FACEM trainees, with trainees asked to state their level of agreement with statements relating to the usefulness of the listed resources (Figure 4). The collection of exam resources was found to be the most useful for trainees (74%), whereas slightly less than half of trainees (48%) found the Best of Web EM site useful.

Figure 4 Level of agreement of respondents with statements relating to the usefulness of a range of online resources to support FACEM trainees.



4.6.3 Support and resources – areas of need and interest

Trainees were asked to nominate resources and support in areas of need and/ or interest and their preferred delivery mode(s) for each selected area (Table 35), to inform the future development of appropriate resources and support. Resources and support nominated as areas of need/ interest by the largest number of respondents were the Fellowship Exam (both written and OSCE), followed by leadership and management skills, and clinical skills.

For all resources and areas for support that were nominated as an area of need/ interest, there was a preference for online learning modules and face-to-face training. For trainees who nominated ITAs, EM-WBAs, Fellowship exam – OSCE, communication skills, leadership and management skills, and clinical skills, the most preferred delivery mode was for face-to-face training. Whereas delivery through online learning modules was the most preferred mode for the other resources and areas for support. There was also a preference towards video podcasts for those who nominated examinations (Viva and OSCE), clinical and communication skills resources.

Table 35. Trainee response rates to resources and support nominated as an area of need and/ or interest and the preferred delivery mode(s).

	Respondents who nominated as area of need/ interest		Preferred Delivery Mode				
			Face-to-face training	ACEM online learning modules	Video podcasts	Web-links to external sources	How-to guide
Resources & Support	N	% of total	%	%	%	%	%
College updates	125	7.5%	22.4%	**45.6%**	28.0%	43.2%	12.8%
Learning Needs Analysis/ Learning Development Plan	168	10.1%	36.3%	**56.0%**	30.4%	20.2%	33.9%
In-Training Assessments (ITAs)	200	12.0%	**58.5%**	42.0%	22.5%	11.0%	19.0%
EM-WBAs	316	19.0%	**56.0%**	42.4%	27.5%	13.9%	21.8%
Primary Exam – Written	238	48.9%*	40.6%	**70.8%**	38.4%	36.9%	31.0%
Primary Exam – Viva	330	65.3%*	57.5%	**60.8%**	40.6%	33.1%	30.9%
Fellowship Exam – Written	818	49.2%	57.3%	**71.8%**	46.8%	39.4%	32.6%
Fellowship Exam – OSCE	858	51.6%	**71.3%**	63.8%	52.2%	36.9%	31.6%
Communication skills	267	16.1%	**68.2%**	56.2%	49.1%	26.2%	18.4%
Leadership and management skills	648	39.0%	**67.1%**	58.5%	43.8%	25.8%	19.9%
Clinical skills	560	33.7%	**74.8%**	59.5%	53.8%	31.4%	28.4%
Clinical governance (HR, rostering, dealing with patient complaints)	381	22.9%	48.6%	**69.8%**	42.3%	30.4%	26.2%
Research	171	10.3%	43.3%	**60.2%**	35.1%	50.9%	45.0%

Note: Respondents may select more than one type of preferred delivery mode for each nominated resource/support.
160 (10%) of trainees selected 'None', with no nomination of any resources/ support from the list.
** For primary exam resources, responses from only the provisional trainees were included. The percentages reflect the proportion of 554 provisional trainees.*

Trainees were further asked if they had any suggestions for improvement to the current online resources provided by ACEM, with 48 providing a response. Two key suggestions were observed from the responses, which were to improve resources for exam preparation (for example, more past-year examples/ question bank, better directed curriculum, updated study guide) and ACEM website to include better search functionality and/ or better orientation to the resources (n=20, 42% respectively). There were other suggestions (n=10) about reducing College correspondence, removing the focus on learning needs analysis, and developing additional resources for non-clinical training.

4.7 Potential Areas for Advocacy/ Quality Improvement

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

4.7.1 Access to critical care rotations

Nearly three-quarters (73%, n=1207) of trainees reported that they had previously undertaken a critical care (ICU/ anaesthetics) rotation, with half reporting having undertaken the rotation at the hospital they were currently undertaking their ED placement at (51%), and half reporting that they had undertaken the rotation at another hospital (49%). Not surprisingly, nearly all advanced trainees (91%) compared with just over one-third of provisional trainees (36%) reported having undertaken a critical rotation.

Of those who reported having undertaken critical care rotation(s), over half (58%) of them reported no wait or less than 6 months of wait to obtain a critical care rotation. However, over a quarter (28%) of trainees reported that they waited for 6-12 months, and a further 15% reported they waited for more than 12 months to get a critical care rotation. For trainees who indicated that they waited 6 months or more to obtain a critical care rotation at a single hospital (n=470), 390 (83%) were at sites accredited for 18- and 24-months of ED training, followed by 76 (16%) at sites accredited for 6- and 12-months, and then four at the 6-month linked sites.

4.7.2 Support for the research requirement

Only 366 (22%) trainees reported that they had undertaken or were currently undertaking the research requirement by research project since commencing their FACEM training, with a larger proportion (35%, n=577) of them reporting that they had completed the research requirement by coursework or by recognition of previous research. A further 719 (43%) trainees indicated that they had yet to commence the research requirement.

Less than ten percent (n=34) of those who indicated that they had undertaken or were undertaking the research project reported that there were barriers to commencing or completing their research project, with 30 providing further details of the barriers encountered. The main barriers encountered were the lack of non-clinical time allocated for the research project which was claimed to be very time-consuming (n=9) and financial barriers to undertaking research related courses (n=8). Other barriers included limited guidance or senior support for research (n=6), difficulty with ethics approval (n=3), progress affected due to COVID-19 (n=3), lack of statistical software (n=2) and difficulty in obtaining College recognition (n=2).

A further 14 commented on resources ACEM could have provided that would better support trainees in their research projects. Half of the comments were about having a clearer pathway or guidelines on the research requirement, while others included suggestions that ACEM develop research modules (which are currently in development) or access to statistical resources.

5. Conclusion and Implications

Consistent with 2019 Trainee Placement Survey findings, almost all trainees agreed that their training needs were being meet at their ED placement. Most of them reflected positively on the assistance available if they experienced difficulties or a grievance(s), and that their placement provided a safe and supportive workplace. With respect to rostering, trainees were most likely to agree that the rosters at their placement supported the service needs of the site and ensured safe working hours.

A total of 11% of trainees reported experiencing DBSH from ED or hospital staff at their placement, which was a slight increase on the percentage reporting this in 2019 (10%). It is concerning to know that FACEMs were most commonly reported as the perpetrators of this behaviour, followed by ED nursing staff and inpatient staff, with similar findings being observed in the previous survey. ACEM is monitoring this and will continue to raise concerns with sites that are identified as potentially having a negative workplace culture.

Regarding supervision and the training experience at their ED placement, most trainees were satisfied with the quality and availability of DEMT support, as well as with the clinical supervision received from FACEMs. However, they were less likely to agree that they received regular informal feedback on their performance. They were also less satisfied with the support received to undertake WBAs. The majority reported that it was the trainee's responsibility to organise WBAs and these were usually conducted on an ad hoc basis instead of through rostered sessions.

The majority of trainees were in agreeance that clinical teaching at their placement optimised their learning opportunities, and that they had access to the educational resources that they needed. However, a smaller proportion of trainees agreed that the structured education program met their needs, and that rostering enabled them to attend the education sessions.

Most nominated placement highlights were supportive senior staff, the positive team environment and ED casemix. In contrast, the teaching/ education program and clinical/ procedural training were identified by other trainees as areas for improvement, alongside rostering and staffing arrangements.

The majority of trainees agreed that the FACEM Training Program is facilitating their preparation for independent practice as an emergency medicine specialist, but a smaller proportion agreed that they were well-supported in their training by ACEM processes. More resources and clearer processes to support both the Primary and Fellowship exams were consistently highlighted as areas of need by trainees.

A number of interesting differences were observed based on gender, which have been observed in previous years, but have not necessarily had the focus they deserve. Although the same proportion of female and male trainees reported that their training needs were met at their placement, female trainees were consistently less likely than male trainees to agree that their ED placement provided a safe and supportive workplace; that they were able to participate in decision making regarding governance and quality improvement activities; and that they received regular and informal feedback on their performance/ progress. Additionally, female trainees were more likely to report experiencing DBSH behaviour from both patients/ carers and from ED/ hospital staff. The reasons behind these differences are unclear, although may highlight conscious or unconscious gender bias that exists among some ED staff. Currently, it is also unclear as to whether such differences impact on trainee progression.

Some notable differences were also observed by ED accreditation level. Unsurprisingly, trainees at 18- and 24-month accredited sites were more likely than those at other sites to reflect positively on the casemix, as well as opportunities for learning (for example, ultrasound and simulation learning), and with respect to opportunities to contribute in governance and quality improvement activities. Alternatively however, trainees at 6-month linked sites were more likely to report that their placement provided a safer and more supportive workplace, that rostering was equitable and safe, and that they were satisfied with supervision and support from DEMTs and FACEMs.

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

6. Suggest Citation

Australasian College for Emergency Medicine. (2021). *2020 Trainee Placement Survey Report – ED Placement.* ACEM Report: Melbourne.

7. Contact for Further Information

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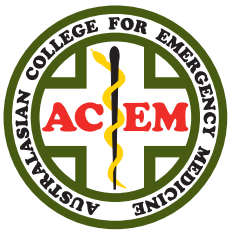

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