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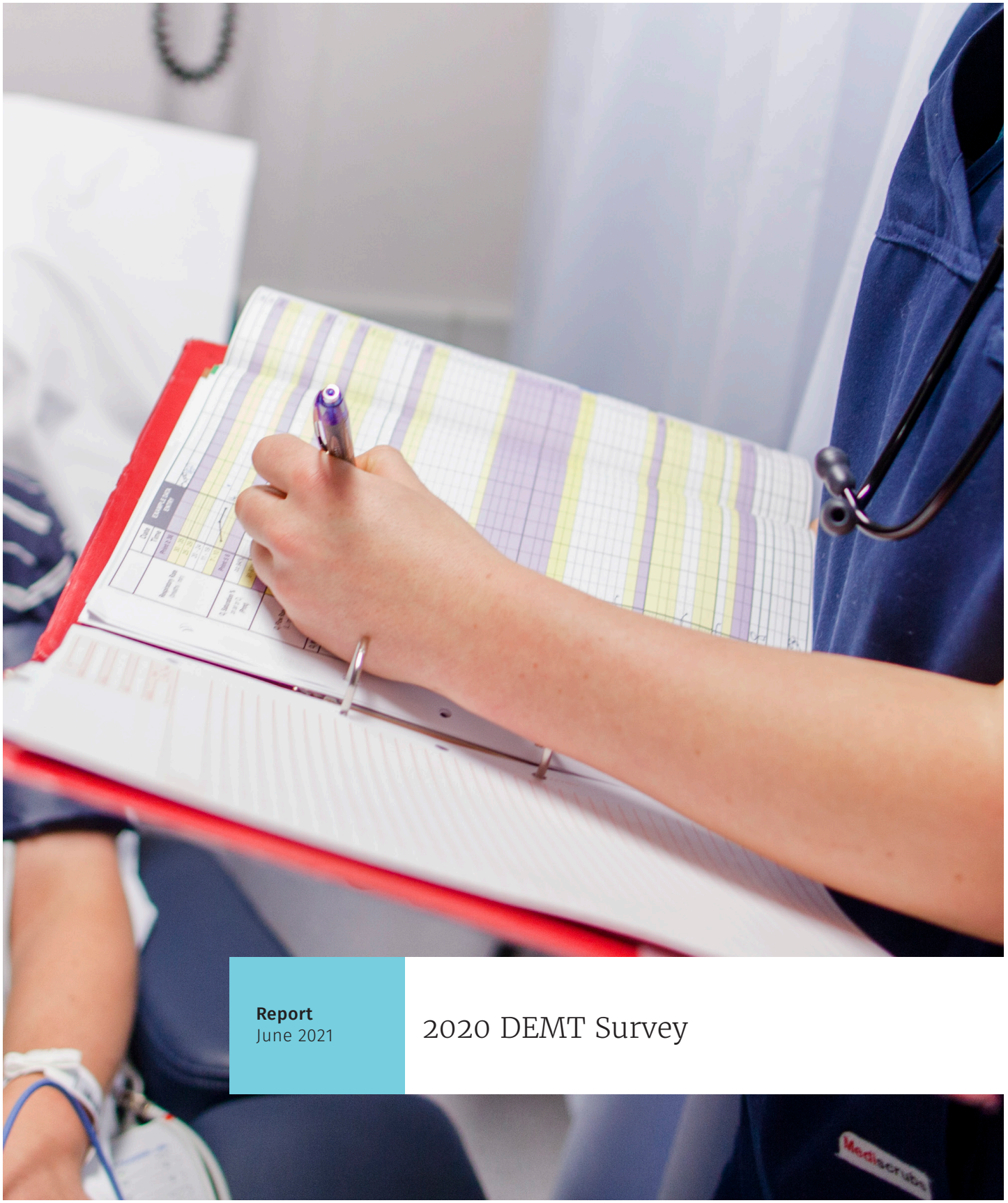


Report
June 2021

2020 DEMT Survey

Australasian College
for Emergency Medicine

2020 DEMT Survey

Key findings

The annual Director of Emergency Medicine Training (DEMT) Survey identifies areas where ACEM can better support DEMTs in their role and seeks their perspectives on how their site provides a safe and supportive training environment. There were 223 respondents, a response rate of 70%. 134 (90%) of 149 ACEM-accredited EDs are represented in the sample.

94% agreed that their **DEMT role was rewarding**

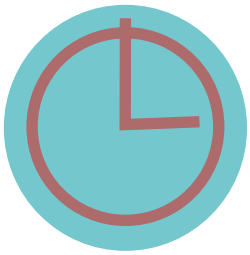
Support for DEMTs

75% agreed that their ED had a **governance structure** in place that supported their role

69% agreed that they were well supported by **ACEM processes** to manage trainees in difficulty

Time with trainees

82% agreed that they were routinely rostered on **clinical shifts** with trainees



71% agreed that they had regular **non-clinical shifts** with trainees

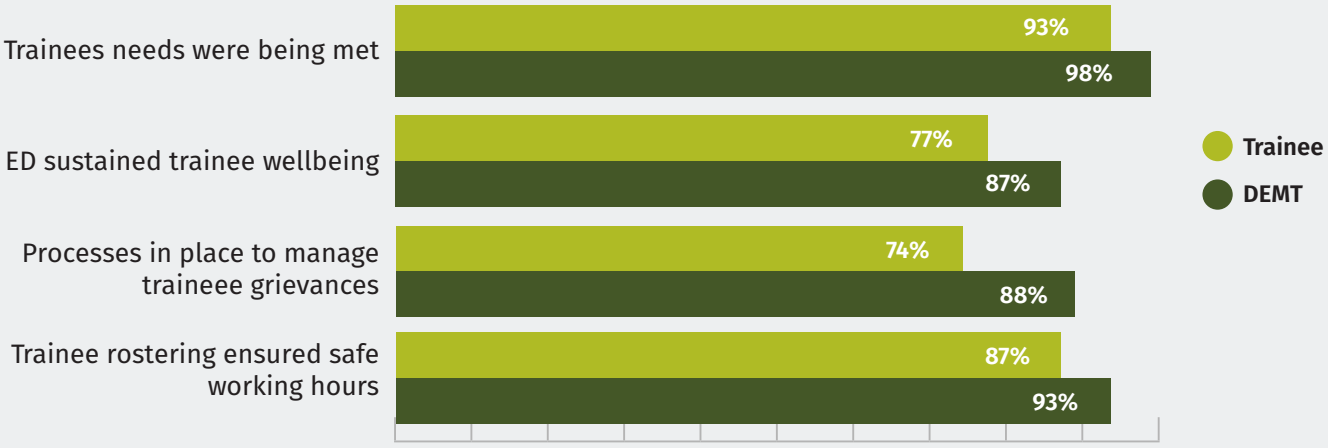
99% agreed that a **structured education program** was provided for a minimum of 4 hours per week on average

83% satisfied with the **trainee rostering** at their site overall

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

DEMT vs. trainee responses

2020 DEMT Survey responses compared with the 2020 Trainee ED Placement Survey on major parameters of the FACEM trainee experiences.



Contents

1. Executive Summary

The Director of Emergency Medicine Training (DEMT) Survey is an annual survey which aims to identify areas where ACEM can better support DEMTs in their role and to seek their perspectives on how their site provides an appropriate and safe training environment. Findings from the 2020 DEMT Survey for the 223 responding DEMTs (representing 134 of 149 ACEM accredited emergency departments) are summarised in the following:

Support for Role as a DEMT

- 94% of DEMTs agreed that the role is rewarding, with a smaller proportion (90%) reporting that they were able to complete all requirements of their DEMT role.
- Whilst 75% agreed that their ED had a governance structure in place that supported their role, a significantly larger proportion (90%) agreed that their DEM(s) worked cooperatively with them in their role (90%) when compared with the Hospital Executive (40%) and hospital HR/ administration (46%).
- A smaller proportion of DEMTs were in agreeance that they were well-supported in managing trainees in difficulty by ACEM processes (69%), compared with support from ACEM Regional Censors (74%).
- Resources and support related to supporting trainees in difficulty (57%) and College processes (52%) were the most nominated areas of need/ interest by DEMTs.

Supervision and Trainee Educational Opportunities

- 82% of DEMTs agreed that they were routinely rostered on clinical shifts with trainees (twice per week), compared with 71% who were in agreeance that they had regular non-clinical shifts with trainees (once per week).
- 91% agreed that their ED provided educational and learning resources that met the needs of trainees.
- 77% agreed that they were satisfied with the support they received from their Local WBA Coordinator.
- Nearly all DEMTs agreed that the structured education program at their site was aligned with the content and learning outcomes of the ACEM Curriculum Framework (95%) and was provided for a minimum of 4 hours/ week on average (99%).
- Most DEMTs were in agreeance that the number (99%), breadth (98%), acuity (95%), and complexity of cases (99%) in their ED provided an appropriate training experience.
- 77% of DEMTs whose hospital/ hospital network had critical care rotations available, reported that trainees had to wait six months or more to obtain a rotation.

Health, Welfare and Interests of Trainees

- All but four of the DEMTs agreed that trainee needs were being met at their ED.
- Over 90% of DEMTs were in agreeance that their ED provided a safe and supportive workplace with respect to personal safety (95%), clinical protocols (93%), and supervision arrangements (97%).
- The majority of DEMTs agreed that there were adequate processes in place for identifying and assisting trainees experiencing difficulties (92%), and to manage trainee grievances (88%) at their ED.
- The largest proportions of DEMTs agreed that the rosters at their ED supported the service needs of the site and considered trainee workload (94%, respectively), however they were less likely to agree that rosters were provided in a timely manner (81%) or considered the skill mix required for the ED (83%).
- 87% of DEMTs agreed that trainees could participate in quality improvement activities at their ED, whereas 66% agreed that trainees were able to participate in decision making regarding governance.

2. Purpose and Scope of Report

The DEMT Survey is an annual survey to seek feedback on the experiences of DEMTs in their role at ACEM's accredited EDs, with the key purpose to understand how supported the DEMTs are at their hospital, and to identify areas of support and resources they need from the College. The survey also seeks DEMT perspectives on how their ED supports Fellowship of the Australasian College for Emergency Medicine (FACEM) trainees, with a focus on supervision and educational opportunities and various aspects related to trainee health, welfare and interests. This report details the findings from the 2020 DEMT Survey.

3. Methodology

The DEMT Survey was distributed to all DEMTs in ACEM's accredited EDs at the end of February 2021 (328 DEMTs across 149 EDs at the time of the survey). DEMTs in Aotearoa New Zealand and Australian EDs were invited via email to participate in the online survey hosted in Jotform. The survey was promoted on the DEMT discussion forum, and two reminder emails were sent to DEMTs who had not responded, encouraging them to participate prior to the survey closing date on the 29th of March 2021.

Participation in the DEMT survey was voluntary, and completion of the survey was considered as implied consent. All information collected was treated confidentially, with data reported only in the aggregate as a percentage of total responses, or by ED delineation or accreditation level.

4. Results

There were 228 completed DEMT surveys received from a pool of 328 surveys, a response rate of 70%. Five responding DEMTs were working in the role at two EDs and completed a survey for each ED. Twenty-one (9%) of the 228 respondents were Paediatric DEMTs.

A total of 134 (90%) of the 149 ACEM accredited EDs at the time of the survey were represented by the 228 survey responses. Of all survey responses, 39% (n=88) were from DEMTs at urban district hospitals, whilst a quarter (n=58) were from DEMTs at rural/regional-based hospitals and 36% (n=82) were from DEMTs at major referral hospitals. These hospital EDs were largely accredited for 24 months (42%) and 12 months (29%) of advanced training, followed by 18 months (15%), six months, and six months linked (7%, respectively).

4.1 DEMT Role and Other Roles

Over half (58%, n=132) of the DEMTs reported working at their current ED for over five years, with one-third (n=76) working in their ED for between two and five years and 9% (n=20) working in their ED for less than two years. When asked how long they had been in the DEMT role for, a larger proportion (44%) reported being in the role for less than two years, compared with 31% working in the role for two to five years and 25% who reported being in the role for more than five years.

Sharing of the DEMT role was common, with 90% (n=204) of respondents reporting that they were a co-DEMT in their ED. Different models were employed for responsibility delegation among co-DEMTs, where trainees were more likely to be a shared responsibility rather than being allocated to individual co-DEMTs for supervision (78% vs 22%, respectively) and teaching (81% vs. 5%, respectively). In contrast, trainee allocation to different co-DEMTs (68%) was a more common model for completion of in-training assessments (ITAs) than co-DEMTs sharing this responsibility (29%). A further 14% of co-DEMTs reported other models for teaching responsibilities, for instance, responsibilities were divided by type of exam preparation (Primary vs. Fellowship) or by subjects, or that teaching was not solely the DEMT's responsibility but shared among all senior medical staff.

DEMTs were asked when they last attended a DEMT workshop, with a quarter reporting having attended a DEMT workshop within the last one to two years, whilst 41% reported last attending a workshop more than two years ago. Importantly, over one-third (35%, n=79) reported that they had never attended a DEMT workshop. The main reasons provided for having not attended a DEMT workshop were a lack of availability (n=45), or the workshop was cancelled due to COVID-19 restrictions (n=22), rather than due to rostering (time/frequency) of the workshop (n=4). A further eight reported that they were still new to the role and were planning to attend the workshop in the near future.

Feedback was sought about the topics DEMTs would like to see covered in future workshops, with 116 DEMTs providing a response. The key topics highlighted included the following:

- Managing trainees in difficulty (n=42)
- Changes to the FACEM Training Program, including curriculum, requirements etc. (n=31)
- Assessment, particularly for In-Training Assessments (requirements, marking calibration exercises, constructive reporting, etc.) (n=20)
- Providing effective trainee feedback, especially negative feedback (n=18)
- Preparing trainees for exams (exam format updates, exam processes, more guided resources, etc.) (n=14)
- Teaching and education programs (set-up tips, consistency across networked sites, etc.) (n=10)
- Requirements and expectation of DEMT role, including task delegation between co-DEMTs (n=10)
- Changes to site accreditation (n=6)
- Navigation of ACEM website and online resources (n=6)
- Emergency medicine workforce planning (n=3)

Of the 228 respondents, half (n=115) reported holding other ACEM roles in addition to their DEMT role at their ED. Other roles most commonly reported were Supervisor of the Emergency Medicine Certificate/ Diploma (n=65), followed by Local Workplace-Based Assessments (WBA) Coordinator (n=13), Mentoring Coordinator (n=10), and DEM or Deputy DEM (n=9). A small number of DEMTs reported also holding the position ACEM Director of Research (n=4) and EMET lead (n=4).

4.2 Support for Role as a DEMT

This section presents the perspectives of DEMTs on their role, including how supported they feel and further resources that are required to support them in their role. It covers the following areas: the ability to meet the requirements of the role; governance structures and support from their hospital; support from ACEM processes; and areas of need for ACEM resources and support.

4.2.1 Requirements of the DEMT role

Overall, almost all (94%, n=214) responding DEMTs strongly agreed or agreed that their role as a DEMT was rewarding. However, a smaller proportion (80%) of DEMTs were in agreeance that their ED roster ensured them sufficient time to complete the clinical support requirements of the role, with 11% being neutral and 8% disagreeing with this.

Ninety percent of respondents were in agreeance that they were able to complete all requirements of their DEMT role. Eight percent neither agreed nor disagreed, whilst 3% disagreed that they were able to meet ACEM's requirements for the DEMT role, with 21 providing a reason(s) for not being able to meet the requirements. Feedback was largely focused on insufficient non-clinical time allocated and having to complete the requirements using personal time (n=10), or the challenge of meeting the requirements of the DEMT role within the context of service provision (n=6). Three other DEMTs felt that they would like to do more but lacked time, and two DEMTs commented on the lack of protected teaching time for trainees. Some example responses provided by DEMTs included:

Insufficient clinical support time provided. This leads to having to do stuff in own personal time. Some of the ACEM requirements of DEMTs should ideally be removed from the DEMTs role expectations.

In any teaching role there is probably always the potential to do more - I do a good amount of teaching but could always do more if I had more time!!

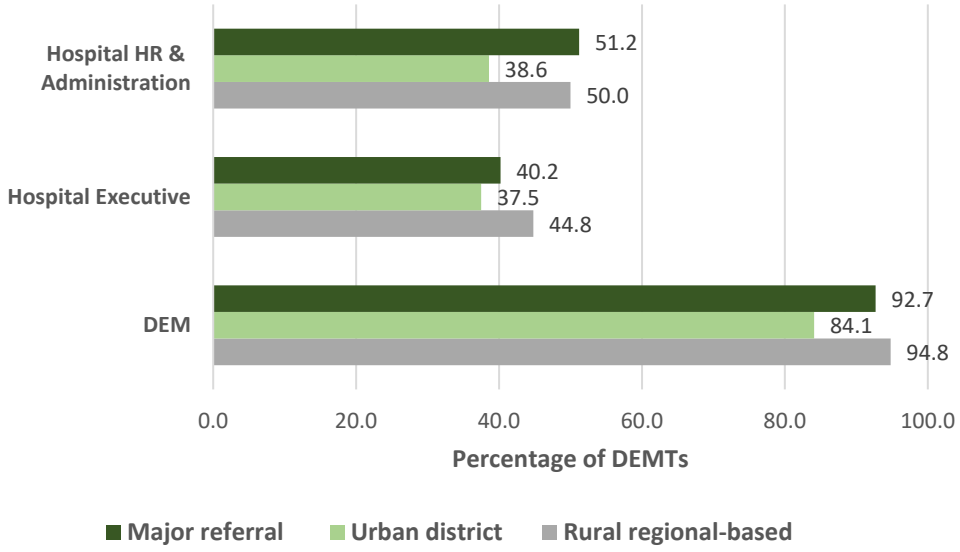
I am still struggling to get the trainees rostered off on teaching days and to get paid protected teaching time.

4.2.2 Governance structures and support from the hospital

Three-quarters of responding DEMTs were in agreeance that their ED had a governance structure (for example, administration processes, committees, etc.) in place that supported their role in managing the FACEM Training Program, 16% neither agreed nor disagreed, while 9% disagreed.

DEMTs were asked whether the Director of Emergency Medicine (DEM), Hospital Executive (i.e. governance level above DEM), and hospital human resources (HR) and administration worked cooperatively with them in their DEMT role. Consistent with findings from the previous survey iterations, a much larger proportion of DEMTs strongly agreed or agreed that the DEM worked cooperatively with them in their role (90%) when compared with the Hospital Executive (40%) and hospital HR and administration (46%). Interestingly, DEMTs working in an urban-district ED were generally less likely to agree with this (Figure 1).

Figure 1. Proportion of DEMTs in agreeance that DEMs, Hospital Executive and hospital HR/ administration work cooperatively with them in their role (N=228), by ED delineation



DEMTs who did not agree with any of the statements regarding their DEM, Hospital Executive or hospital HR/ administration working cooperatively with them, were given an opportunity to provide their reason(s). From the feedback provided by 62 DEMTs, there were consistent comments about minimal or no support/ interaction with Hospital Executive or hospital HR (n=27), or that there was no interest or recognition of the DEMT role at all (n=15). Other comments included unsupportive rostering or limited allocation of non-clinical time (n=9), an emphasis on service provision over trainee education (n=6), and that FACEM training issues were dealt solely by the DEM and/ or DEMTs (n=5).

The following provides some example responses from the DEMTs regarding the lack of cooperation or understanding provided by the hospital Executive, administration and HR:

> *Executive and HR/admin do not seem to be involved (or even aware) of the DEMT role and appear to be oriented primarily towards service provision rather than education.*
>
> *My hospital executives do not value DEMT roles as the managerial allowance for DEMT was removed/cancelled.*
>
> *Hospital executive is currently actively trying to reduce all clinical support time to 20%. Difficult for a small hospital to provide teaching for primary exam, fellowship exam and weekly clinical teaching without more support from hospital executive.*
>
> *Executive have recently begun arbitrarily cancelling education/training due to hospital capacity issues.*

4.2.3 Support from ACEM Regional Censors and ACEM processes

Three-quarters (74%) of DEMTs strongly agreed or agreed that they were well-supported in managing trainees in difficulty through ACEM Regional Censors, with 14% neither agreeing nor disagreeing. While 2% of DEMTs disagreed with this, a further 10% of them reported they did not know if they were well-supported by their Regional Censor. Of the 30 comments provided by the DEMTs who did not agree that they were well-supported by their ACEM Regional Censor, most (n=24) commented that they had yet to engage with or seek help from their Regional Censor. Four DEMTs commented that they did not receive useful guidance or assistance from their Regional Censor when they needed it, whereas two DEMTs did not know whom their Regional Censor was.

A smaller proportion (69%) of DEMTs were in agreeance that they were well-supported by ACEM processes in managing trainees in difficulty. A further 18% indicated being neutral, 2% disagreed and 11% reported that they did not know. Four DEMTs who disagreed that they were well-supported by ACEM processes provided reasons for this, which focused on their need for greater support for trainees experiencing difficulties, as well as requiring more constructive feedback for trainees who fail the Primary or Fellowship exams, and increased transparency in the decision-making process of the trainee review panel.

4.2.4 Support and resources – areas of need and interest

DEMTs 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 1), to inform the future development of appropriate resources and support offered by the College. Resources and support nominated as areas of need/ interest by the largest proportion of DEMTs were supporting trainees in difficulty (57%), and College processes such as remediation, appeals and special consideration (52%), which are consistent with those identified in the previous survey iteration. However, there has been a shift in DEMT preferences with respect to the resource delivery mode, from online delivery to face-to-face training for most of the resources. Except for DEMTs who nominated Learning Needs Analysis, College Processes, Primary Exam and Fellowship Exam as areas of need/ interest, their preference was for online delivery (either provided through online learning modules or an online DEMT Network).

Table 1. DEMT (N=228) response rates to resources and support nominated as areas of need and/or interest and the preferred delivery mode(s)

Resources & Support	DEMTs who nominated as an area of need/interest		*PREFERRED DELIVERY MODE						
			Face-to-face training	Online learning modules	Video podcasts	Web-links	Online DEMT Network	How-to-guide	College email
	No.	% of N=228	%	%	%	%	%	%	%
College updates	72	31.6%	36.1%	8.3%	15.3%	9.7%	30.6%	18.1%	**61.1%**
Curriculum Framework	84	36.8%	**40.5%**	36.9%	25.0%	17.9%	22.6%	33.3%	29.8%
Learning Needs Analysis/ Learning Development Plan	91	39.9%	35.2%	**50.5%**	33.0%	9.9%	19.8%	47.3%	22.0%
In-Training Assessment (ITAs)	94	41.2%	**54.3%**	43.6%	28.7%	3.2%	22.3%	38.3%	24.5%
EM-Workplace-Based Assessment (EM-WBAs)	38	16.7%	**55.3%**	52.6%	34.2%	2.6%	21.1%	34.2%	28.9%
DEMT role orientation: scope/responsibilities	99	43.4%	**59.6%**	44.4%	21.2%	11.1%	22.2%	34.3%	22.2%
Role delineation between DEMTs, WBA Coordinators and Mentors etc.	51	22.4%	**49.0%**	39.2%	19.6%	5.9%	21.6%	41.2%	19.6%
Primary Exam	64	28.1%	28.1%	35.9%	23.4%	35.9%	**37.5%**	29.7%	23.4%
Fellowship Exam	98	43.0%	37.8%	**40.8%**	26.5%	31.6%	37.8%	28.6%	25.5%
College processes (remediation/ appeals/ special consideration)	119	52.2%	43.7%	**47.9%**	23.5%	13.4%	28.6%	39.5%	31.9%
Supporting trainees in difficulty	130	57.0%	**72.3%**	43.1%	31.5%	17.7%	25.4%	29.2%	19.2%
Research	16	7.0%	18.8%	50.0%	25.0%	43.8%	43.8%	**62.5%**	37.5%

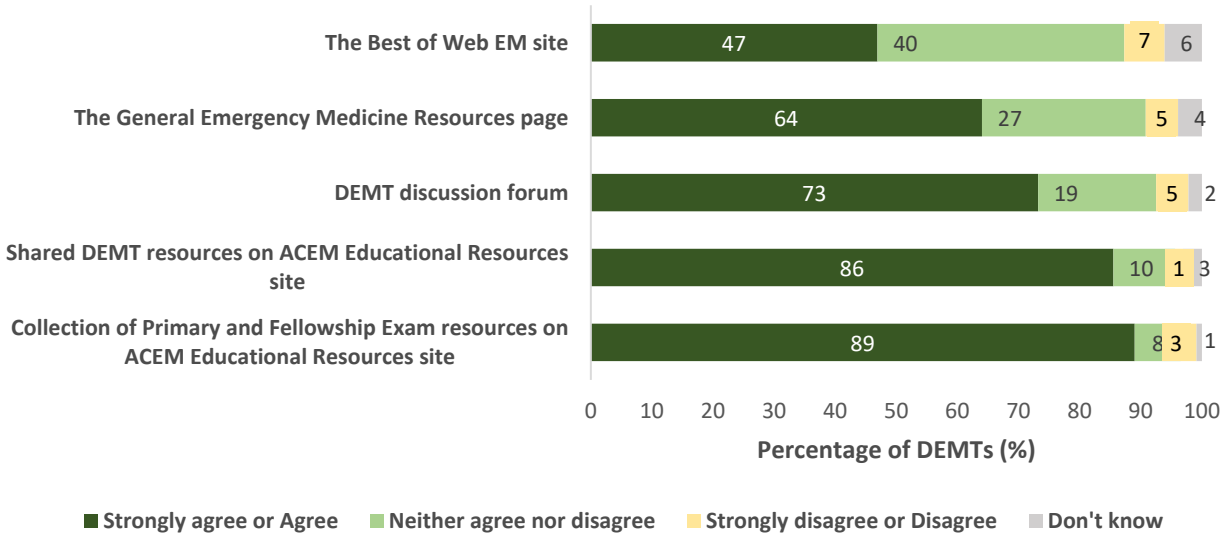
*Note: *Respondents may select more than one type of preferred delivery mode for each nominated resource/support. Eleven (5%) DEMTs selected 'None', with no nomination of any resources/ support from the list.*

DEMTs were asked to comment on any additional support, resources or training ACEM could provide to assist them in their DEMT role, with 28 providing feedback. Key areas DEMTs outlined that ACEM could provide to assist them in their role were a DEMT workshop (preferably face-to-face training) (n=7), DEMT network or mentorship meetings (n=6), resources and support for examinations (n=4), 'how to' guide for new DEMTs (n=4), improvement of ITA processes (n=3), updates about changes to the Curriculum Framework or training requirements (n=2), and better support for rural-based DEMTs (n=2).

4.2.5 Available online resources for DEMTs

ACEM currently provides a range of resources to support Fellows, with DEMTs asked to provide their level of agreement on the usefulness of each of these resources in supporting their role as a DEMT (Figure 2). The collection of exam resources and shared DEMT resources on the ACEM Educational Resources site were found to be useful by most of the responding DEMTs, whilst slightly less than half of them found the Best of Web Emergency Medicine site useful for their DEMT role.

Figure 2. Level of agreement of respondents (N = 228) with statements relating to usefulness of a range of resources to support their DEMT role



Feedback regarding the current online resources was sought from DEMTs, with 34 choosing to provide suggestions for improvement. The suggestions were mostly about improving the search functionality and organisation of resources on ACEM's website (n=18), increasing resources in the exam repository (n=9), and revising the structure of the DEMT forum (n=6). There were a few other comments relating to the need for more online resources for new DEMTs or paediatric DEMTs.

4.3 Supervision and Trainee Educational Opportunities

This section presents responses to the survey items regarding supervision, clinical teaching and educational opportunities for FACEM trainees. It covers rostering of DEMTs with trainees; clinical teaching for trainees; support for EM-WBAs; the structured education program; access to critical care rotations; and the ability of the ED to provide an appropriate training experience when considering casemix.

4.3.1 DEMT supervision, learning and education opportunities

While the majority (82%) of DEMTs strongly agreed or agreed that they were routinely rostered on clinical shifts with trainees (twice per week), a smaller proportion (71%) were in agreeance that they had regular (once per week) non-clinical shifts with trainees. DEMTs working at major referral EDs were generally more likely to agree that they had regular clinical (85% vs. urban district EDs, 77%; rural regional EDs, 83%) and non-clinical (76% vs. urban district EDs, 71%; rural regional EDs, 66%) shifts with trainees. Similarly, DEMTs who worked at EDs accredited for 18- and 24-months of advanced training were more likely to agree that they were routinely rostered on clinical (85% vs. 82% at 6/12 months vs. 56% at 6-month linked) and non-clinical (79% vs. 62% at 6/12 months vs. 56% at 6-month linked) shifts with trainees.

Ninety-one percent of the DEMTs were in agreeance that their ED provided educational and learning resources that met the needs of trainees at all stages and phases of their training. A smaller proportion of DEMTs agreed that their ED had processes in place that facilitated clinical teaching by supervisors to maximise trainee learning opportunities both on and off the floor (79%), and that trainees at their site had access to formal ultrasound teaching (72%). A significantly larger proportion of DEMTs working at major referral EDs (83%) agreed that trainees at their site had access to formal ultrasound teaching than those working at urban district (71%) or rural regional-based (60%) EDs. Similarly, a larger proportion (82%) of DEMTs at EDs accredited for 24-months of training were in agreeance that trainees had access to formal ultrasound teaching, compared with sites accredited for shorter training periods (56%-59%).

4.3.2 Workplace-based Assessments

Slightly over three-quarters (77%) of DEMTs were satisfied with the support they have received from their Local WBA Coordinator to monitor EM-WBAs at their site, with a further 19% being neutral and 4% dissatisfied. DEMTs working at rural regional-based EDs (69%) were significantly less likely to agree that they were satisfied with the support they received from their Local WBA Coordinator, compared with DEMTs at major referral (83%) and urban district (76%) EDs. Those working at EDs accredited for 18- or 24-months (86%) were more likely to be satisfied with the support received from their Local WBA Coordinator support, compared with sites accredited for shorter training periods (65% & 63% respectively for 6/12 month and 6-month linked sites).

When asked about how WBAs were organised at their site, the majority (77%) of DEMTs reported that WBAs were the trainee's responsibility (Table 2). WBAs were more likely to be scheduled by the Local WBA Coordinator, than by DEMTs or collaboratively by the DEMT and WBA Coordinator. DEMTs were also more likely to report that WBAs were conducted on an ad hoc basis, instead of being organised through a rostered WBA Consultant or rostered WBA session.

Table 2. How WBAs are organised for trainees at sites.

How are WBAs organised at your site?	Number of Respondents*	%
It is the trainee's responsibility	176	77.2%
On an ad hoc basis	101	44.3%
Scheduled by Local WBA Coordinator	99	43.4%
Through rostered WBA Consultant	47	20.6%
Through rostered WBA session	33	14.5%
Scheduled collaboratively by DEMT and Local WBA Coordinator	21	9.2%
Scheduled by DEMT	15	6.6%
Other (e.g. mix of the above, regular reminder to trainees, varies according to the type of WBA, etc.)	12	5.3%
Total no. of respondents	228	

Note: *Respondents may select more than one way of how WBAs were organised at their site.; only 29% (65) selected a single method of how WBAs were organised.

4.3.3 Structured education sessions and examination resources

When surveyed about the structured education program, the majority of DEMTs were in agreeance that the program at their ED was aligned to the content and learning outcomes of the ACEM Curriculum Framework (95%), and that it was regularly evaluated (88%).

Nearly all (99%) of the DEMTs strongly agreed or agreed that the structured education sessions at their site were provided for, on average, a minimum of 4 hours per week for trainees. The proportion of DEMTs agreeing with this statement on the frequency of structured education sessions was quite consistent when compared by ED site accreditation level, ranging from 94% (at 6-month linked sites), 97% (at ED accredited for 18 months) to 100% (at EDs accredited for 6-,12- and 24-months). Similarly, little variation was seen across ED delineations, with 100% of DEMTs from major referral EDs and 98% of DEMTs from both rural regional-based EDs and urban district EDs agreeing with this.

Higher proportions of DEMTs were in agreeance that trainees at their site had adequate access to Fellowship written and clinical exam resources (94% and 93%, respectively), than had access to Primary written and clinical exam resources (89% and 90%, respectively). The proportion of DEMTs who agreed with trainees having adequate access to exam resources increased as site accreditation limits increased (Table 3).

Table 3. Proportion of DEMTs who strongly agreed or agreed that trainees at their ED had adequate access to Primary and Fellowship exam revision and preparation programs/ courses, by accreditation level (N=228)

Trainees had adequate access to exam revision and preparation programs or courses	Accreditation level			
	6-month linked	6 & 12 months	18 & 24 months	Total % (n)
Provisional trainees				
Primary written exam	56.3%	87.7%	93.1%*	88.5% (201)
Primary clinical exam	62.5%	90.1%	93.8%*	90.3% (205)
Advanced trainees				
Fellowship written exam	87.5%	90.1%	96.9%	93.9% (214)
Fellowship clinical exam	75.0%	92.6%	95.4%	93.0% (212)
Total no. of responses	16	81	131	228

Note: *One DEMT was excluded from the analysis given that there were no provisional trainees at their site

4.3.4 Casemix

DEMTs were asked to reflect on their site's ability to provide an appropriate training experience with respect to casemix. Overall, the majority of DEMTs were in agreeance that the number (99%), breadth (98%), acuity (95%), and complexity of cases (99%) in their ED provided an appropriate training experience (Table 4). A smaller percentage of DEMTs working at 6-month linked sites agreed that their ED provides an appropriate training experience when considering most aspects of casemix, compared with EDs accredited for a longer period of advanced training.

Table 4. Proportion of DEMTs who strongly agreed or agreed that their ED was able to provide an appropriate training experience when considering various aspects of casemix, by accreditation level (N=228)

Aspects of casemix	Accreditation level			Total
	6-month linked	6 & 12 months	18 & 24 months	% (n)
Number of cases	**93.8%**	100%	99.2%	99.1% (226)
Breadth of cases	**87.5%**	98.8%	99.2%	98.2% (224)
Acuity of cases	**87.5%**	96.3%	94.7%	94.7% (216)
Complexity of cases	100%	98.8%	**98.5%**	98.7% (225)

4.3.5 Access to critical care rotations

The majority (92%, n=209) of DEMTs reported having a critical care (ICU/ anaesthetics) rotation available at their hospital or within their hospital network, with the proportion of DEMTs reporting the availability of critical care rotations increasing as site accreditation limits increased (69% at 6-month accredited sites, 85% at 6- and 12-month sites and 99% at 18- and 24-month sites). Of the DEMTs who reported having a critical care rotation at their hospital/ network, only 10 (5%) reported that the rotation was difficult to fill. The reasons provided for this were insufficient critical care rotations available to meet trainee demand particularly in major referral hospitals (n=5) and in contrast, difficulty in recruiting sufficient trainees to rural regional-based hospitals to fill the rotations (n=4).

DEMTs who reported the availability of critical care rotations at their hospital/ network were further asked about how long on average the trainees had to wait to obtain a critical care rotation. Most of them reported that trainees had to wait for 6-12 months (46%) or more than twelve months (31%) to obtain a critical care rotation. A further 15% reported trainees waited for less than 6 months on average and 8% reported there was no waiting time. As expected, DEMTs at major referral hospitals (84%) were more likely to report that trainees had to wait for 6-months or more before obtaining a critical care rotation, compared with DEMTs at urban district (79%) or rural regional-based (65%) hospitals. Similarly, DEMTs working at 18- and 24-month accredited sites (83%) were more likely to report that trainees waited 6 months or more to obtain a critical care rotation, compared with DEMTs at sites accredited for shorter durations (68% and 73% for DEMTs at 6/12 month and 6-month linked sites, respectively).

4.4 Health, Welfare and Interests of Trainees

This section details the perspectives of DEMTs regarding whether their ED meets the health, welfare and interests of trainees, and includes the following areas: ability of the ED environment to meet trainee needs; mentoring program; workplace safety and support; trainee assistance; rostering; and opportunities for trainees to participate.

4.4.1 Meeting trainee needs

Almost all (98%, n=224) of the DEMTs were in agreeance that trainee needs were being met according to their stage and phase of training at their ED. Four DEMTs did not agree with this, with the reasons provided being understaffing and rostering issues, which negatively impact the training experience or contribute to trainee burnout.

4.4.2 Mentoring program

The majority (91%) of DEMTs reported that there was a formal mentoring program available for trainees at their ED, with a slightly smaller proportion (89%) reporting the availability of an ACEM Mentoring Program Coordinator. Of those reporting not having a formal mentoring program, the majority of sites were 6- and 12-month accredited sites, with a small number of 18- and 24-month accredited sites included.

Of the 208 DEMTs who reported having a formal mentoring program at their ED, just over one-third (37%) reported that DEMTs at their site were involved in the formal mentoring of trainees. A larger proportion (94%) of DEMTs reported that trainees utilised the formal mentoring program at their ED. However, DEMTs at 6-month linked sites (77%) were less likely to agree that trainees utilise the formal mentoring program, than DEMTs at EDs accredited for 6, 12, 18 and 24 months (93%-96%).

DEMTs who reported that a formal mentoring program was available for trainees at their site were further surveyed about how the mentoring program was structured, with all 208 responding. DEMTs were able to select multiple options for how the mentoring program was structured, with most reporting that trainees nominated their preferred mentor (75%, n=154) rather than mentors being allocated to trainees (36%, n=75). An opt-in model (51%, n=107) was also more commonly reported than an opt-out model (18%, n=38) and nearly two-thirds (63%) reported a combination of the aforementioned formats, where trainees nominated several mentors of their choice, with mentors being allocated based on trainee preferences.

4.4.3 Workplace safety and support

Nearly all (96%) DEMTs strongly agreed or agreed that overall, their ED provided a safe and supportive workplace. Over 90% of DEMTs were in agreeance that their ED provided a safe and supportive workplace with respect to personal safety (95%), clinical protocols (93%), and supervision arrangements (97%). Whereas a smaller proportion of them agreed that their ED provided a safe and supportive workplace when considering sustaining trainee wellbeing (87%), workplace safety and support processes other than mentoring (90%, respectively). DEMTs at 6- and 12-month accredited EDs were generally more likely than DEMTs at other sites to agree with all of the statements regarding workplace safety and support (Table 5).

Table 5. Proportion of DEMTs who strongly agreed or agreed that their ED provides a safe and supportive workplace in relation to specific areas, by accreditation level (N=228)

Safety/support areas	Accreditation Level			Total
	6-month linked	6 & 12 months	18 & 24 months	% (n)
Overall safety and support	**93.8%**	98.8%	**93.9%**	95.6% (218)
Personal safety	**87.5%**	100%	92.4%	94.7% (216)
Workplace safety	87.5%	95.1%	**86.3%**	89.5% (204)
Sustaining trainee wellbeing	87.5%	92.6%	**83.2%**	86.8% (198)
Support processes (other than mentoring)	**81.3%**	96.3%	87.0%	89.9% (205)
Clinical protocols	**87.5%**	90.1%	94.7%	92.5% (211)
Supervision arrangements	**93.8%**	98.8%	96.9%	97.4% (222)

4.4.4 Governance structures and trainee assistance

While 75% of DEMTs reported that their ED had a governance structure that supports them in their role as a DEMT, a much larger proportion (90%) strongly agreed or agreed that there was a governance structure in place that supports trainees in completing the requirements of the FACEM Training Program.

Whilst most DEMTs (92%) were in agreeance that there were adequate processes in place for identifying and assisting trainees experiencing difficulties meeting the training requirements at their ED, a smaller proportion (88%) agreed that there were adequate processes in place to manage trainee grievances.

4.4.5 Rostering

The majority of DEMTs (83%) strongly agreed or agreed with the statement 'Overall, I am satisfied with rostering at my site'. The largest proportions of DEMTs were in agreeance that the rosters at their ED supported the service needs of the site and considered trainee workload (94%, respectively). DEMTs were less likely to agree that rosters were provided in a timely manner (81%), and that their rostering took into account the skill mix required for the department (83%).

The proportions of DEMTs who were in agreeance with each of the rostering statements are presented in Table 6, by accreditation level. DEMTs working in EDs accredited for 18- and 24-months were generally less likely to agree with most of the statements regarding rostering, compared with DEMTs working at other EDs.

Table 6. Proportion of DEMTs who strongly agreed or agreed with statements regarding rostering at their ED, by accreditation level (N=228)

Statements re. rostering	Accreditation level			Total
	6-month linked	6 & 12 months	18 & 24 months	% (n)
Overall, I am satisfied with rostering at my site	81.3%	85.2%	**80.9%**	82.5% (188)
Rosters are provided in a timely manner for trainees	81.3%	86.4%	**77.9%**	81.1% (185)
Rosters give equitable exposure to day/evening/night shifts	**87.5%**	88.9%	87.8%	88.2% (201)
Rosters give equitable shifts to all areas of the ED	93.8%	92.6%	**88.5%**	90.4% (206)
Rosters consider trainee workload, including attendance at education sessions	93.8%	93.8%	93.9%	93.9% (214)
Rosters support the service needs of the site	93.8%	95.1%	**93.1%**	93.9% (214)
Rosters ensure safe working hours	100%	**90.1%**	93.1%	92.5% (211)
Rosters take into account staff leave requests	100%	92.6%	**87.0%**	89.9% (205)
Rosters take into account the skill mix required for the department	87.5%	**80.2%**	83.2%	82.5% (188)

DEMTs were asked to comment on the rostering at their ED, with 60 providing feedback. Over two-thirds of the comments were negative, detailing poor rostering which was primarily due to understaffing. The remaining comments were positive, including that rostering accommodated trainee needs, and detailed various initiatives implemented to improve the rostering at their ED. Table 7 presents the key themes and subthemes for DEMT comments regarding rostering at their ED.

Table 7. DEMT responses regarding rostering, themes and subthemes

Key themes and sub-themes
Poor rostering (n=41) • *Understaffing causing burnout* • *Impacted by COVID-19 pandemic* • *Disproportionate amount of evening/ night/ weekend shifts* • *Inequitable exposure to specific clinical areas* • *Difficulty accessing leave* • *Late issuing of rosters* • *Limited protected teaching*
Flexible and accommodating rosters (n=8) • *Fair allocations* • *Priority given to leave requests* • *Considered the skill mix required*
Improvement on the rostering (n=11) • *Input from senior registrar to help with rostering* • *Roster arrangements were monitored by FACEMs* • *New rostering software* • *Roster rule guides*

4.4.6 Orientation and opportunities for trainees to participate

With respect to orientation at their ED, 91% of DEMTs strongly agreed or agreed that trainees were provided with a comprehensive orientation program when they commenced training, while 8% neither agreed nor disagreed and 1% disagreed with this.

While 87% of DEMTs were in agreeance that trainees were able to participate in quality improvement activities at their ED, around two-thirds (66%) agreed that trainees were able to participate in decision making regarding governance (for example, workplace committees). A small number of comments (n=17) were provided with respect to opportunities for trainees to participate in quality improvement activities or in decision making regarding governance, with responses mixed. Eight DEMTs commented that opportunities were there but there was low uptake from trainees either due to limited non-clinical time allocated for this purpose or that trainees were focused on exam preparation instead. Other comments included that there were limited opportunities for trainees to participate (n=3), and that the DEMTs were exploring new ways to better engage trainees in quality improvement and/or departmental decision-making activities (n=6).

4.5 Final Comments

DEMTs were given an opportunity to provide any final comments on their role as a DEMT, with 35 providing a response (Table 8). Twelve comments highlighted areas of support they needed from ACEM. While eight DEMTs reflected on the DEMT role as being rewarding, seven others commented on the challenges of their role. Six DEMTs mentioned that they were still new to the DEMT role, and five others provided suggestions to improve trainee experiences.

Table 8. Areas DEMTs provided final comment on, themes and subthemes

Key themes and sub-themes
Areas of support from ACEM (n=12) • *More frequent DEMT training/ workshops* • *Guidance on DEMT role requirements (smaller vs larger EDs)* • *Regular meetings with ACEM regional censors* • *Advocacy on clinical support time and safe staffing levels* • *Better support for rural EDs (e.g. more regular informal discussion, trainee recruitment)* • *Support for trainee exam preparation*
Role as DEMT – rewarding (n=8) • *Enjoy seeing trainees progress through the training program* • *See the role of DEMT as a privilege* • *An ongoing learning journey*
Challenges as a DEMT (n=7) • *To advocate for trainee safety and quality training/ education* • *Risk of being accused of bullying/ harassment* • *Excessive ratio of trainees to one DEMT* • *Time consuming to meet College requirements, particularly ITAs*
New to the DEMT role (n=6) • *Greater support from ACEM to assist with the transition* • *Feel supported by regional censors or other colleagues/ DEMTs*
Suggestions to improve trainee experience (n=5) • *Useful to have a networked model* • *Involve trainees in junior medical staff teaching* • *Provide regular clinical support time to advanced trainees* • *Encourage trainee rotations from major referral centres to rural/ smaller hospitals*

5. Conclusion

Overall, nearly all of the responding DEMTs agreed that their role as a DEMT was rewarding. However, they were less likely to agree that their ED roster ensured them sufficient time to meet the clinical support requirements of their role, or that they were able to complete all requirements of their DEMT role. Most DEMTs agreed that their DEM worked cooperatively with them in their role, but less than half agreed that their Hospital Executive and hospital HR/ administration worked cooperatively with them. Three-quarters of DEMTs were in agreeance that their ED had governance structures that supported their role in managing the FACEM Training Program, with comparable proportions agreeing that they were well supported in managing trainees in difficulty through ACEM regional censors or by ACEM processes.

All except four DEMTs agreed that trainee needs were being met at their ED. With respect to supervision and trainee educational opportunities, DEMTs were more likely to agree that they were routinely rostered on clinical shifts with trainees, as opposed to non-clinical shifts. Over three-quarters of DEMTs agreed that they were satisfied with the support they received from their Local WBA Coordinator, but less than half reported that WBAs at their site were scheduled by the WBA Coordinator. Importantly, nearly all of the DEMTs agreed that structured education sessions at their site were provided for a minimum of 4 hours per week on average for trainees, fulfilling ACEM accreditation requirements. Most DEMTs also agreed that their ED provided education and learning resources that met the needs of trainees, including having adequate access to both Primary and Fellowship exam revision/ preparation programs. Some notable differences were observed by ED accreditation level, where DEMTs at 18- and 24-month accredited sites were more likely than those at other sites to report that they were rostered on both clinical and non-clinical shifts with trainees and they were also more likely to report greater opportunities available for learning (for example, formal ultrasound teaching and access to exam preparation programs).

When DEMT responses were compared to trainee responses for the same questions asked in the 2020 Trainee Placement Survey, a number of interesting differences were observed. DEMTs consistently viewed more positively than trainees all aspects of whether their ED provided a safe and supportive training environment and all aspects of rostering. With respect to rostering, the biggest differences in agreement level between DEMTs and trainees were observed for whether rosters give equitable exposure to day/ evening/ night shifts, whether rosters give equitable shifts to all areas of the ED, and whether rosters consider trainee workload. Importantly however, aspects such as rostering timeliness, equitability and consideration of skill mix were consistently identified as areas for improvement by both DEMTs and trainees.

Considering that survey respondents represented 134 of the 149 ACEM accredited EDs, the DEMT survey findings will be useful to assist the College in providing continuing support for those undertaking the DEMT role and ensuring ACEM-accredited EDs continue to provide a safe and supportive training environment.

6. Suggested Citation

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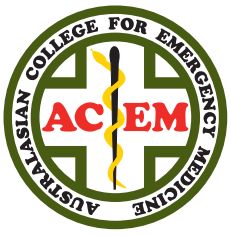
7. Contact for Further Information

Ms. Katie Moore
Research Manager
ACEM Research Unit, Department of Policy, Research and Partnerships
Australasian College for Emergency Medicine (ACEM)
34 Jeffcott Street, West Melbourne VIC 3003, Australia
Telephone +61 3 9320 0444



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

acem.org.au