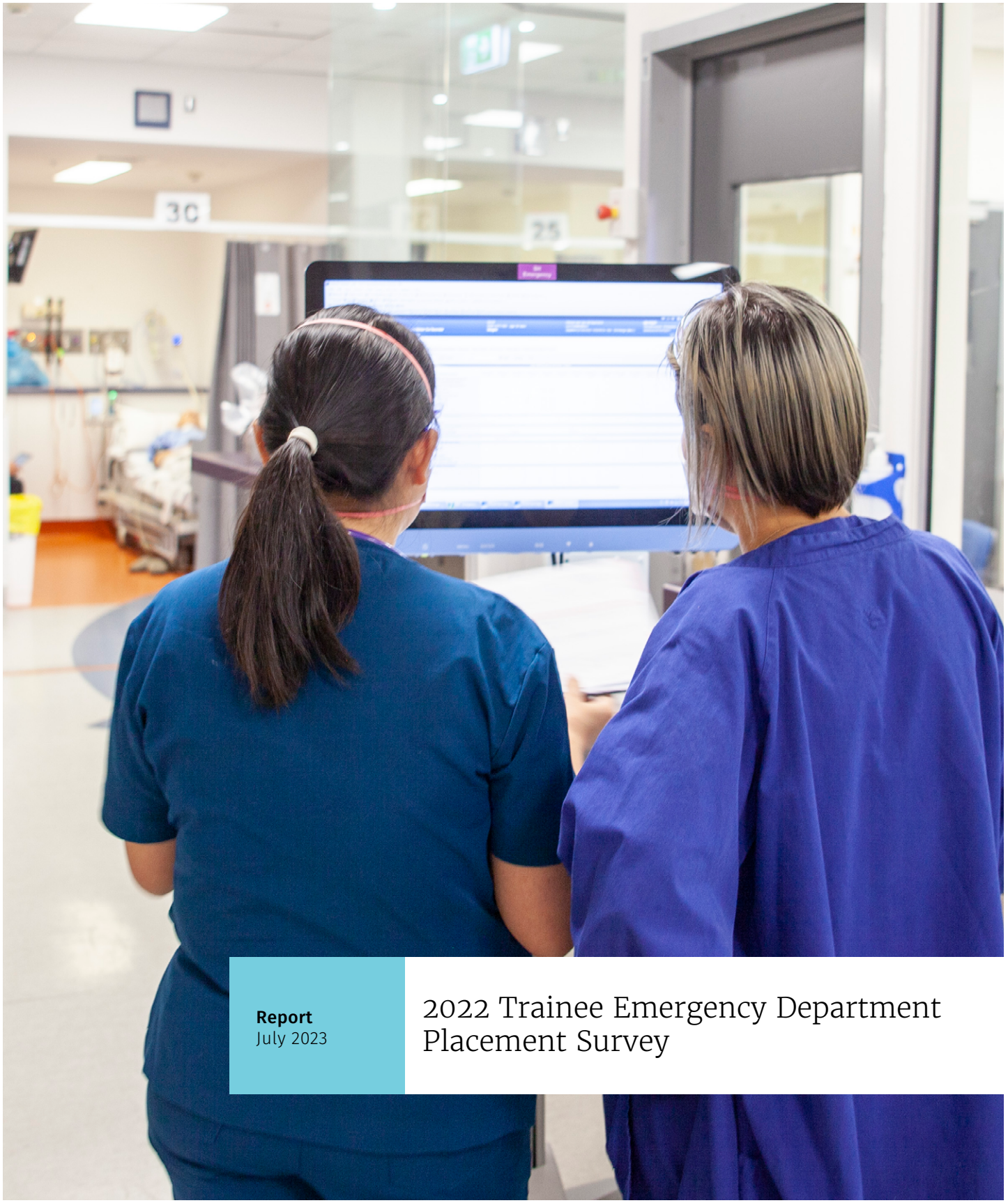
Australasian College
for Emergency Medicine

acem.org.au



**Report**
July 2023

# 2022 Trainee Emergency Department Placement Survey

Australasian College
for Emergency Medicine

# 2022 Trainee ED Placement Survey

## Key findings

This is an annual survey that captures site-specific data to ensure that sites provide training and a training environment which are appropriate, safe, and supportive of FACEM trainees. The survey is mandatory and 1543 trainees responded to the 2022 survey.

**93%**

of trainees agreed their training needs were being met at their emergency department placement

## Supervision

**91%** of trainees were satisfied with the quality of DEMT support

**89%** agreed that the clinical supervision received from FACEMs met their needs

## Education

**82%** of trainees agreed that the structured education program at their placement met their needs

**81%** agreed that rostering enabled them to attend the education sessions

## Welfare

**89%** agreed their placement provided a safe and supportive workplace

## Placement highlights

- Supportive senior staff
- Supportive DEMTs
- Casemix
- Supportive team environment
- Location and ED setting

## Areas for improvement

- Rostering
- Staffing and workload
- Teaching and education
- Clinical and procedural training
- WBA support

**For the full survey findings, please refer to:**
Australasian College for Emergency Medicine (2023), *2022 Trainee Placement Survey - ED Placement.* ACEM Report.

## Executive Summary


The Trainee Placement Survey is an annual survey that captures site-specific data to ensure that sites provide training and a training environment which are appropriate, safe, and supportive of FACEM trainees. Findings from the 2022 survey that included feedback from all eligible trainees (n= 1543) undertaking an ED placement are summarised below:

### Health, Welfare and Interests of Trainees

- Nearly all (93%) trainees agreed that their training needs were being met at their ED placement.
- 78% of trainees were satisfied overall with the rostering at their placement, with the highest proportion agreeing that the rosters supported the service needs of the site (85%) and ensured safe working hours (86%).
- 94% reported knowing where to go for assistance if they had difficulty meeting training requirements, with a smaller proportion (89%) reporting knowing where to go for assistance if they had a grievance.
- 89% agreed that their placement provided a safe and supportive workplace overall, however a smaller proportion agreed that their placement sustained their wellbeing (75%), provided a comprehensive orientation at commencement (76%), or provided support processes other than mentoring (78%).
- 30% reported experiencing discrimination, bullying, sexual harassment, or harassment (DBSH) or other unreasonable behaviour from a patient/ carer, whilst 11% reported experiencing DBSH or other unreasonable behaviour exhibited by ED or hospital staff, with in-patient medical staff and FACEMs being the most frequently reported staff category.
- Over half (60%) agreed that they could participate in decision-making regarding governance, while 73% agreed that they could participate in quality improvement activities at their ED placement.

### *Supervision and Training Experience*

- 91% of trainees were satisfied with the quality of DEMT support, and a similar proportion (89%) were satisfied with the supervision received overall.
- 89% agreed that the clinical supervision received from FACEMs met their needs, however only 78% agreed that they received regular informal feedback on their performance.
- Over three-quarters of advanced and training stage 1 trainees were satisfied with the level of support received from their Local WBA Coordinator (77%) and FACEMs (79%) to complete Workplace-based Assessments (WBAs).
- Trainees agreed that the ED casemix at their placement was appropriate with respect to the number (96%), breadth (89%), acuity (86%), and complexity (91%) of cases.

### *Education and Training Opportunities*

- 79% agreed that the clinical teaching at their placement optimised learning opportunities.
- 82% of trainees agreed that the structured education program at their placement met their needs, with 81% agreeing that rostering enabled them to attend the education sessions.
- 70% agreed that they had access to formal ultrasound training.
- Similar proportions reported having access to (either onsite or offsite) written exam revision programs and clinical exam preparation programs at their ED placement (95%, respectively).

### *Further Perspectives on ED Placement*

- The most nominated highlights of their placement were supportive senior staff/ DEMT/ colleagues and ED casemix. In contrast, rostering, staffing and workload arrangements were the identified areas for improvement.

### *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, with a smaller proportion (75%) agreeing that they are well-supported in their training by ACEM processes.

# 1. Purpose and Scope of Report

The Emergency Department (ED) Trainee Placement Survey is administered annually to FACEM trainees undertaking an ED placement in Aotearoa New Zealand and Australia during survey distribution. Survey questions focused on three key areas of the ED placement: Health, Welfare and Interests of Trainees; Supervision and Training Experience; and Education and Training Opportunities. The survey further sought trainee feedback on the support they received from ACEM and potential areas for advocacy and quality improvement for the FACEM Training Program. This report details the findings from the 2022 ED Trainee Placement Survey.

# 2. Methodology

Participation in the annual Trainee Placement Survey is mandatory (as per item G1.5 in Regulation G of the 2022 FACEM Training Program). Eligible FACEM trainees were those undertaking an ED placement in ACEM-accredited sites as of 31 October 2022, excluding trainees on an interruption to their training.

All eligible trainees must submit the online survey before paying their annual training fees through the ACEM member portal. The survey was made active on Monday, 21 November 2022. An email was sent to all eligible trainees about the online fee payment process and the requirement to complete the annual Trainee Placement Survey.

All collected trainee feedback was handled in confidence, with anonymity ensured in reporting. Survey findings were 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. Training level primarily compared advanced and provisional trainees, with the term 'provisional' consistently used to report combined findings for provisional and training stage 1 (TS1) trainees.

# 3. Results

A total of 1543 completed surveys were received from a pool of 1546 eligible FACEM trainees undertaking an ED placement as of 31 October 2022. The three non-responding trainees became inactive during the survey period and therefore were no longer eligible for the survey. There was a 100% response rate, excluding inactive trainees and those on training interruptions.

Six trainees were undertaking part-time ED placements at two hospitals and completed a survey for each placement. All survey findings were reported based on the total responses, except for the demographic information (Section 3.1), which was presented for the 1537 individual trainees.

## 3.1 Demographic Characteristics of Respondents

Of the 1537 FACEM trainees, 92% were undertaking an ED placement in Australia and the remainder (8%) were undertaking a placement in Aotearoa New Zealand. Half (n= 763) of the trainees were female, with the gender composition remaining the same (50%) as reported in the 2021 Trainee Placement Survey.

Three quarters (75%, n= 1159) of trainees were in the advanced stage of training (Table 1). Provisional trainees, including TS1 trainees (n= 378) had an average age of 34 years, compared with 36 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 (n= 1159) | % Provisional (n= 378) |
|---|---|---|---|---|---|---|---|
| | n | n | n* | % | | | |
| **Australia** | **694** | **713** | **1407** | **91.6%** | **49.3%** | **75.8%** | **24.2%** |
| ACT | 14 | 10 | 24 | 1.6% | 58.3% | 62.5% | 37.5% |
| NSW | 212 | 201 | 413 | 26.9% | 51.3% | 76.5% | 23.5% |
| NT | 25 | 10 | 35 | 2.3% | 71.4% | 88.6% | 11.4% |
| QLD | 189 | 211 | 400 | 26.0% | 47.3% | 75.5% | 24.5% |
| SA | 28 | 46 | 74 | 4.8% | 37.8% | 71.6% | 28.4% |
| TAS | 8 | 11 | 19 | 1.2% | 42.1% | 94.7% | 5.3% |
| VIC | 157 | 162 | 319 | 20.8% | 49.2% | 74.0% | 26.0% |
| WA | 61 | 62 | 123 | 8.0% | 49.6% | 78.0% | 22.0% |
| **Aotearoa** | **69** | **60** | **129** | **8.4%** | **53.5%** | **70.8%** | **29.2%** |
| **Total no. of trainees** | **763** | **773** | **1536*** | **100%** | **49.7%** | **75.4%** | **24.6%** |

***Total excludes one trainee who did not specify their gender.***

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% compared to 1%) were undertaking an ED placement in a paediatric ED. Nearly three-quarters (73%) of the responding trainees were undertaking their placement at EDs accredited for 36 months, while less than 10% undertook placements at 12-month accredited sites.

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

| Type of ED | Provisional | | Advanced | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Adult/ Mixed | 375 | 99.2% | 1034 | 88.8% | 1409 | 91.3% |
| Paediatric | 3 | 0.8% | 131 | 11.2% | 134 | 8.7.% |
| **ED accreditation level** | **n** | **%** | **n** | **%** | **n** | **%** |
| 12 months* | 8 | 2.1% | 122 | 10.5% | 130 | 8.4% |
| 24 months | 103 | 27.2% | 179 | 15.4% | 282 | 18.3% |
| 36 months | 267 | 70.6% | 864 | 74.2% | 1131 | 73.3% |
| **Total no. of responses** | **378** | **100%** | **1165** | **100%** | **1543** | **100%** |

*Note: Six advanced trainees completed the survey for two placement sites.*
***12-month accredited sites included previously six-month linked sites, specialist hospitals, and private hospitals***

## 3.2 Health, Welfare and Interests of Trainees

This section 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 feedback on their experiences of discrimination, bullying, harassment, and sexual harassment (DBSH) at their ED placement is also included in this section.

### 3.2.1 Overall trainee needs

Nearly all (93%, n= 1434) trainees strongly agreed or agreed that their training needs were being met at their ED placement, with 2% (n= 28) disagreeing that their needs were being met and 5% (n= 81) being neutral. Comparable proportions of provisional and advanced trainees (92% and 93%, respectively) agreed that their training needs were met.

*93% of FACEM Trainees agreed their training needs were being met.*

Trainees (n= 109) who did not agree that their training needs were being met at their placement were asked to comment on their response, with 106 of them providing feedback. Key reasons outlined by trainees concerning their needs not being met at their placement included:

- Limited on-the-floor teaching, including lacking procedural opportunities (42%)
- Unsafe rostering or workplace (mainly due to understaffing, frequent night shifts, or ED overcrowding (31%)
- Unsatisfactory senior supervision and/or feedback (17%)
- Difficulty in completing Workplace-based Assessments (WBAs, 15%)
- A lack of education and support opportunities for exam preparation (14%)
- Inadequate ED casemix, particularly higher acuity patients (12%)
- No protected teaching time (6%)
- Difficulty in obtaining required rotation (2%)

Trainee feedback often contained more than one reason, with these reasons interrelated. Some examples of trainee comments included:

> *Department is so busy there are limited teaching opportunities. Consultants have tried to improve this with an extra teaching consultant on Thursdays, but we are too rushed to take time off seeing patients.*
>
> *Limited opportunities for practical skills experience/procedural skills despite this issue being raised multiple times at In-Training Assessments. Procedures are limited and senior staff often prefer to maintain their own skills rather than teach.*
>
> *There is also a paucity of on the floor teaching from consultants and not as nearly as many offers for WBAs - the consultant rostered to perform this duty during the week does not often make themselves known to registrars on the floor. Access to procedures can sometimes be difficult.*
>
> *Poorly structured teaching sessions, often inadequate for preparing for Fellowship exam.*
>
> *Limited paediatric or obstetric exposure. Most trauma is managed by trauma team. Supervision on paediatric medical feels unenthusiastic and either dominated or overlooked by consultants rather than supported.*

### 3.2.2 Mentoring program

Eighty-one per cent (n= 1245) of trainees reported having an ACEM Mentoring Program Coordinator at their ED placement, and 1% reported that there wasn't one. A further 18% of trainees reported that they were unaware of this position at their placement. Trainees undertaking a placement at sites accredited for 36 months (82%) and 24 months (80%) were significantly more likely to report the availability of an ACEM Mentoring Coordinator than trainees undertaking a placement at sites accredited for 12 months (69%).

The majority (84%, n= 1289) of trainees reported that there was a formal mentoring program available at their ED placement, with 3% (n= 45) reporting that there was not one available and 14% (n= 209) of trainees reporting not knowing whether a formal mentoring program was available. Of the trainees who reported having a formal mentoring program, around two-thirds (63%, n= 816) had utilised the program. Among those who utilised the program, there was a higher proportion of provisional (72%, n= 232) than advanced trainees (61%, n= 584) reporting so.

*Almost two-thirds (63%) of FACEM Trainees who reported their placement had a formal mentoring program used the program.*

For the remaining trainees (n= 473) who reported not utilising the formal mentoring program at their placement despite this program being available, 40% reported that they had a mentor already, while another 25% 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 5% reported that it was difficult to access the mentoring program at their placement.

Other reasons (18%) provided for not utilising the formal mentoring program were mainly because of time constraints (n= 21), for example, prioritising exam preparation, or difficulties in finding time to meet with mentor; 14 others commented that they did not need a mentor. Trainees also mentioned other reasons for not utilising the formal mentoring program, such as they had not found a suitable person (n= 9), a preference for informal mentorship (n= 8), or they were still waiting for a mentor to be allocated (n= 6). Five trainees mentioned that it was difficult to access formal mentorship during a short-term placement and three indicated they were not ready to meet with their mentor.

### 3.2.3 Rostering

Over three-quarters (78%) of trainees were in agreeance that they were satisfied overall with the rostering at their site, with similar proportions of advanced (78%) and provisional (77%) trainees reporting being satisfied. Relatively comparable proportions of advanced trainees (ranged 74%-86%) and provisional trainees (ranged 75%-85%) were in agreeance with each of the rostering statements (1-3% difference).

*Over three-quarters (78%) of FACEM Trainees reported being satisfied overall with rostering at their placement.*

Table 3 shows the proportion of trainees who agreed with the rostering statements by region. The highest proportions of trainees agreed that rosters ensured safe working hours (86%), supported the service needs of the site (85%), and took into account leave requests (85%). On the contrary, the smallest proportions of trainees agreed that rosters were provided in a timely manner (75%) and their rostering gave them equitable exposure to day/ evening/ night shifts (77%). Trainees who were undertaking a placement in the Northern Territory (NT) were more likely to agree with most of the rostering statements compared with trainees from other regions. Whereas trainees undertaking ED placements in Aotearoa EDs were less likely to agree with most of the rostering statements.

*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 or agreed (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ | Total |
| Overall, I am satisfied with rostering at my site | 87.5% | 79.0% | 88.6% | 80.0% | 79.5% | 73.7% | 77.7% | 78.0% | 63.9% | 77.9% |
| Rosters are provided in a timely manner | 83.3% | 67.2% | 91.2% | 78.7% | 79.7% | 84.2% | 71.6% | 74.8% | 81.7% | 74.5% |
| Rosters give equitable exposure to day/ evening/ night shifts | 66.7% | 77.4% | 88.6% | 79.9% | 83.6% | 84.2% | 74.9% | 79.7% | 67.2% | 77.3% |
| Rosters give equitable shifts to all areas of the ED | 75.0% | 77.3% | 77.1% | 84.7% | 64.9% | 94.7% | 76.8% | 82.1% | 84.0% | 79.7% |
| Rosters consider workload as a trainee | 79.2% | 81.9% | 97.1% | 77.7% | 86.3% | 73.7% | 87.8% | 84.6% | 72.7% | 81.9% |
| Rosters support the service needs of the site | 95.8% | 86.8% | 82.9% | 85.9% | 77.0% | 84.2% | 86.5% | 87.8% | 76.9% | 85.3% |
| Rosters ensure safe working hours | 91.3% | 85.8% | 94.3% | 89.9% | 84.9% | 94.7% | 87.8% | 83.7% | 71.8% | 86.1% |
| Rosters take into account leave requests | 95.8% | 87.2% | 85.7% | 85.7% | 81.1% | 89.5% | 88.7% | 85.2% | 67.7% | 85.2% |
| Rosters take into account the skill mix required | 79.2% | 82.3% | 88.6% | 79.0% | 81.1% | 68.4% | 80.3% | 84.6% | 69.2% | 79.9% |
| **Total no. of responses** | **24** | **416** | **35** | **400** | **74** | **19** | **319** | **123** | **133** | **1543** |

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

Trainees undertaking a placement in EDs accredited for 36 months were generally more likely to agree with being satisfied with rostering at their placement than 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 or agreed (%) | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| Overall, I am satisfied with rostering at my site | **68.5%** | 75.8% | 79.6% |
| Rosters are provided in a timely manner | 75.4% | **72.0%** | 75.1% |
| Rosters give equitable exposure to day/ evening/ night shifts | 77.5% | 82.9% | **72.1%** |
| Rosters give equitable shifts to all areas of ED | **77.7%** | 81.9% | 79.3% |
| Rosters consider workload as a trainee | **77.5%** | 82.9% | 82.1% |
| Rosters support the service needs of the site | 87.7% | **81.1%** | 86.1% |
| Rosters ensure safe working hours | **81.4%** | 81.7% | 87.8% |
| Rosters take into account leave requests | 80.6% | **79.0%** | 87.2% |
| Rosters take into account the skill mix required | 81.5% | **75.3%** | 80.9% |
| **Total no. of responses** | **130** | **282** | **1131** |

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= 397) and some example comments. Comments that reflected negatively on rostering (n= 270, 68%) significantly outnumbered the positive feedback about rostering (n= 51, 13%). A wide range of rostering issues were raised, with understaffing being regularly stated as a factor that further complicated rostering at sites.

A further 5% of comments reflected mixed feedback, and 6% 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= 270)<br>- Understaffed, particularly for senior registrars<br>- Excessive evening/night shifts<br>- Late issuing of roster<br>- Rigid rostering and difficulty accessing leave (incl. study leave)<br>- Unsafe staffing level and skills mix, especially overnight and over weekends<br>- Insufficient breaks between shifts<br>- Insufficient exposure to specific clinical areas<br>- Poor teaching roster/ limited clinical teaching time | *The rostering at this site is extremely challenging. Multiple long shifts stretch without proper days off. Long stretches of night shifts. Multiple sets of nights per month. Practices such as rostering registrars to "extra night shifts" to cover staff shortages. This produces high levels of fatigue.*<br>*Finalised rostering releasing less than four weeks prior to term commencement. Handover timing, usually 30 minutes before shift ends, means most shifts particularly evening and night shifts result in late finish.*<br>*Large amount of sick leave cover required from registrars, often registrars down on late/ night shifts due to lack of cover.*<br>*My primary exam is in February, and I have been given two weeks of night shifts in last two weeks of January. I wish my exam was considered before assigning me to those night shifts.*<br>*Due to the way rostering works- missing approx. 20-40% of education session per month.*<br>*Less exposure to resuscitations than all other areas. Rostering and leave requests are done through a consultant which at times feels like a conflict of interest/bias.* |
| Positive (n= 51)<br>- Fair and equitable shifts<br>- Accommodating annual/ study leave requests and individual needs<br>- Good rostering system in place | *Very supportive of my requests as a trainee and a mother of two young children. Roster writer has taken account of the difficulty in juggling between work and being a present mom and to roster the days around childcare availability.*<br>*The utmost is done by our roster coordinator to accommodate leave requests, plus family and life commitments. She is very organised and responsive.*<br>*Easy to access roster and submit roster requests via online, easy to organise swaps with a dedicated roster email, very reasonable common-sense approach to swaps, really try to accommodate rostering request.* |
| Mixed positive and negative (n= 19)<br>- Fair rostering but extreme workload leading to fatigue | *Rostering is, on the whole, excellent. However, as a junior level trainee the roster is primarily evenings, with a small sprinkling of days and required nights, which can be incredibly fatiguing.*<br>*Access to leave is excellent. Access to teaching is adequate but could be better.*<br>*Overall equitable rostering. Released well ahead of time which is helpful. Skill mix has been difficult to manage with a high ratio of junior staff and junior trainees.* |
| Suggestions for improvement (n= 22) | *More teaching opportunities should be provided in roster for ACEM trainees.*<br>*There should probably be 2 registrars on overnight. Staff sick leave is frequently not covered, and turnaround is frequently not staffed with doctors for considerable periods of time, particularly in the morning.*<br>*Need for live online roster, and ability to view what shifts colleagues are working over the entire rotation for ease of shift swapping.*<br>*It would make a lot of difference if we could have the rosters at least 2 months in advance since we have a 6-month roster plan.* |

### 3.2.4 Assistance for trainees

Almost all trainees (94%) reported knowing where to go for assistance if they were having difficulty meeting the training requirements, with comparable proportions of advanced and provisional trainees reporting so (Table 6). There were also no differences observed among responses between male and female trainees. Just over three-quarters (77%) of trainees agreed that their ED placement has adequate processes in place to identify and assist trainees encountering difficulty in progressing through the FACEM Training Program.

*Nearly all (94%) FACEM Trainees reported knowing where to go for assistance regarding training requirements, while three in four reported adequate processes were in place to identify and assist trainees facing difficulties meeting training requirements.*

In relation to handling trainee grievances, 89% of trainees reported knowing where to go for assistance if they had a grievance about their training, with a further 7% neither agreeing nor disagreeing and 3% disagreeing with this. Similarly, a much smaller proportion of trainees (73%) agreed that their placement had adequate processes to manage trainee grievances, with 11% 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 or agreed (%) | | |
|---|---|---|---|
| | Provisional | Advanced | Total |
| Know where to go for assistance if have difficulty meeting the training requirements | 93.9% | 94.2% | **94.1%** |
| ED placement has adequate processes in place to identify and assist trainees having difficulty in progressing through their training | 79.0% | 76.6% | **77.2%** |
| Know where to go for assistance if have a grievance about training | 89.9% | 89.2% | **89.4%** |
| ED placement has adequate processes in place to manage grievances | 71.7% | 72.9% | **72.6%** |
| Total no. of responses | 378 | 1165 | 1543 |

Table 7 shows that trainees undertaking a placement in Tasmanian (TAS) EDs were least likely to agree with all the statements related to the trainee assistance, compared to trainees undertaking a placement in other jurisdictions.

*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 or agreed (%) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ |
| Know where to go for assistance if have difficulty meeting the training requirements | 100% | 93.0% | 100% | 95.0% | 93.2% | 89.5% | 94.0% | 92.7% | 94.7% |
| ED placement has adequate processes in place to identify and assist trainees in difficulty | 70.8% | 77.3% | 74.3% | 78.9% | 78.1% | 63.2% | 77.2% | 78.0% | 74.0% |
| Know where to go for assistance if have a grievance about training | 91.3% | 87.5% | 94.3% | 90.9% | 94.5% | 78.9% | 88.1% | 87.7% | 92.4% |
| ED placement has adequate processes in place to manage grievances | 66.7% | 71.1% | 60.0% | 75.4% | 78.4% | 47.4% | 73.9% | 71.5% | 72.1% |
| Total no. of responses | 24 | 416 | 35 | 400 | 74 | 19 | 319 | 123 | 133 |

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

Trainees undertaking a placement at sites accredited for 36 months were most likely to agree with statements regarding assistance for training, in comparison to those at 12- and 24-month accredited sites (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 assistance for trainees | Strongly agreed or agreed (%) | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| Know where to go for assistance if have difficulty meeting the training requirements | **90.8%** | 92.6% | 94.9% |
| ED placement has adequate processes in place to identify and assist trainees in difficulty | 77.3% | **75.9%** | 77.5% |
| Know where to go for assistance if have a grievance about training | **86.8%** | 89.0% | 89.8% |
| ED placement has adequate processes in place to manage grievances | 70.9% | **70.7%** | 73.3% |
| Total no. of responses | 130 | 282 | 1131 |

The survey further sought feedback about the assistance or processes available at their ED placement for trainees in difficulty or with respect to handling grievances, with 76 responses received. Slightly more positive (n= 41, 54%) comments were received than negative (n= 35, 46%) comments. Most positive comments referred to supportive and approachable senior staff available for trainee assistance. On the other hand, negative comments generally referred limited processes or poor management of grievances. Some examples of these negative comments are provided in the following:

> *I have raised grievance about the rostering system, and its effect on my training (I am unable to get WBAs done because I am rarely working supervised shifts).*
>
> *I am wanting to sit Fellowship exam soon and sat a practice exam in August. I still haven't been given an opportunity to sit down and go through the whole exam and don't have my mark for the practice exam. My meeting has been deferred until after Christmas (no date set). I don't think that's good enough. There needs to be a better process to support trainees sitting Fellowship. At this stage there is no dedicated teaching time for trainees at my level, and no strong level of support for exam practice at my placement.*
>
> *I know where to go, but definitely feel like the processes don't actually work.*

### 3.2.5 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. Most trainees (89%) 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 provided a safe and supportive environment for personal safety (86%), cultural safety practices (85%), clinical protocols (87%) and supervision arrangements (87%). The other aspects, such as support processes other than mentoring (78%) and the provision of a comprehensive orientation program at commencement (76%) received less agreement from trainees, with the lowest level of agreement received for the statement that their placement provided a safe and supportive workplace for sustaining trainee wellbeing (75%).

*FACEM Trainees were least likely to report their ED placement provides a workplace which sustains their wellbeing.*

Comparable proportions of provisional and advanced trainees agreed their placement provides a safe and supportive workplace overall and for each of the statements, except advanced trainees were slightly less likely than provisional trainees (86% compared to 90%) to agree that their placement provided a supportive workplace with respect to the clinical protocols.

*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 or agreed (%) | | |
|---|---|---|---|
| | Provisional | Advanced | Total |
| Overall safety and support | 89.9% | 88.6% | **88.9%** |
| Personal safety (e.g., aggression directed by patients and/ or carers) | 85.9% | 85.9% | **85.9%** |
| Sustaining my wellbeing | 76.4% | 74.6% | **75.0%** |
| Support processes (other than mentoring) | 76.7% | 78.4% | **77.7%** |
| Clinical protocols | 90.2 % | 86.4% | **87.3%** |
| Supervision arrangements | 88.6% | 87.0% | **87.4%** |
| Cultural safety practices (cater for culturally diverse patients and EM workforce) | 86.4% | 84.4% | **84.9%** |
| Comprehensive orientation program at commencement | 78.8% | 75.3% | **76.2%** |
| **Total no. of responses** | **378** | **1165** | **1543** |

Trainees who did not agree they had a comprehensive orientation at commencement in the ED were given the opportunity to describe what was missing, with 66 providing comments. Most commonly, trainees stated there was no orientation program at their placement commencement (n= 35). A further 21 trainees described that although an orientation (formal or informal) was given, it was brief and not comprehensive, or it was a hospital-wide orientation, and they did not receive an orientation specific to the ED setting. Three mentioned they were only provided a manual or booklet for orientation purposes without in-person orientation. Seven trainees indicated they were not given an orientation as they had previously worked in the same hospital, but each expressed a length of time had lapsed and required an updated orientation of the ED.

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 TAS, South Australia (SA) and Western Australia (WA) were among those who reported the lowest agreement level for more than one aspect of a safe and supportive workplace, compared 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 or agreed (%) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ |
| Overall safety & support | 95.8% | 88.9% | 85.7% | 90.8% | 84.7% | 84.2% | 88.1% | 88.6% | 88.0% |
| Personal safety | 79.2% | 85.0% | 65.7% | 89.5% | 80.6% | 84.2% | 89.3% | 81.3% | 83.3% |
| Sustaining my wellbeing | 83.3% | 73.6% | 85.3% | 76.8% | 72.2% | 78.9% | 78.1% | 68.3% | 70.2% |
| Support processes (other than mentoring) | 79.2% | 78.5% | 74.3% | 79.6% | 72.6% | 78.9% | 81.2% | 69.4% | 74.8% |
| Clinical protocols | 75.0% | 88.2% | 91.4% | 88.0% | 78.1% | 73.7% | 90.6% | 82.9% | 87.1% |
| Supervision arrangements | 87.5% | 86.5% | 94.3% | 89.9% | 87.5% | 84.2% | 84.9% | 85.1% | 89.4% |
| Cultural safety practices (cater for culturally diverse patients and EM workforce) | 70.8% | 83.8% | 91.4% | 88.2% | 70.8% | 84.2% | 83.7% | 82.1% | 84.8% |
| Comprehensive orientation | 66.7% | 76.4% | 74.3% | 74.8% | 59.5% | 42.1% | 81.0% | 84.6% | 75.9% |
| **Total no. of responses** | **24** | **416** | **35** | **400** | **74** | **19** | **319** | **123** | **133** |

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

Trainees who were undertaking a placement in a 12-month accredited sites were slightly more likely to agree that their placement provided a safe and supportive workplace for the majority of aspects, including overall safety and support (92%), support processes (80%), clinical protocols (88%) and providing comprehensive orientation at training commencement (86%) (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 or agreed (%) | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| Overall safety & support | 91.5% | **88.3%** | 88.8% |
| Personal safety | 88.5% | 89.0% | **84.8%** |
| Sustaining my wellbeing | 75.0% | 76.5% | **74.7%** |
| Support processes (other than mentoring) | 79.8% | **76.9%** | 78.0% |
| Clinical protocols | 88.4% | **83.3%** | 88.2% |
| Supervision arrangements | 86.7% | **86.1%** | 87.8% |
| Cultural safety practices (cater for culturally diverse patients and EM workforce) | 83.8% | 85.1% | **83.6%** |
| Comprehensive orientation | 86.2% | **70.6%** | 76.4% |
| **Total no. of responses** | **130** | **282** | **1131** |

Trainees who disagreed their ED placement provided a safe and supportive workplace were asked to provide a reason(s) for their response, with 176 trainees providing feedback (Table 12). More than half of the comments were about a lack of focus on trainee wellbeing (40%) and personal safety (20%).

*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= 70)<br>*Unsupportive rostering, increasing workload, burnout, lack of wellbeing initiatives, not feeling supported at their placement* | *Rostering is the main thing. Also, we were tricked into agreeing to an on-call roster, and now on our days off are expected to be on call until 10pm for a 10:30pm shift, so that's just another day taken away from my life and family.*<br>*The workload at this hospital is far above what the hospital can cope with. Bed block is a massive problem, and there are daily occurrences of poor care to patients due to lack of access to staff/beds/scans etc. Seeing, and being involved in, this poor patient care due to factors outside of my control causes a moral distress which is incompatible with sustaining my wellbeing.*<br>*Chronic understaffing. Rates of turnover of nursing staff also make shifts quite difficult in providing safe care.*<br>*Trainee wellbeing does not seem to be a focus for this Department.* |
| Personal safety (n= 35)<br>*Inefficient security, increasing violent alcohol/drug-related or mental health patients, ineffective zero violence policy* | *Increasingly aggressive patient population, both verbally and physically. I have had threats and physical aggression directed toward me despite all safety measures in place.*<br>*As with most EDs, our department talks about 'no tolerance' for verbal and physical abuse from patients/families; however, this is not at all followed.*<br>*Security staff generally slow and reactive rather than being proactive.* |
| Clinical supervision and senior support (n= 29)<br>*Especially during night shifts, service-oriented with limited on-floor teaching* | *Increasing demands in registrars in terms of short staffing and bed block. Less and less time to learn new skill or be supervised on shifts due to reduced staff and demands to admit or discharge people.*<br>*Trainees frequently made to be in charge of a base without adequate supervision on day/evening shift. Majority of shifts done without direct consultant supervision.*<br>*Can struggle to get supervision for shifts and WBA allocation/availability can be challenging, particularly on evening shifts.* |
| Clinical protocols (n= 17)<br>*Limited, unorganised* | *The clinical protocols are not easy to locate and have not been openly shared or discussed during my time at this rotation.*<br>*Overall, I actually think there are too many protocols which hamper clinical decision making as people are quick to become overly reliant on the protocol/guidelines (particularly nursing staff who try to impose them on trainees without necessarily understanding why a guideline may not apply to that particular patient).*<br>*Lack of accessibility to clinical protocols* |
| Patient safety and quality of care (n= 14)<br>*Access block, understaffing especially at night shift* | *Patient safety is a major issue currently due to inadequate nursing and medical staffing.*<br>*Doctors are allocated patients after they have been triaged, with no regard to acuity or triage status, results in un-necessary time pressures. Felt unsafe to work when we were being rostered for around 18–20-night shifts, feeling run down with potential fear that this may affect our clinical judgement.* |
| Cultural safety (n= 14)<br>*Limited availability of Aboriginal Liaison Officer, interpreter services unavailable, lack of cultural awareness* | *Despite our FACEMs best efforts our ED, the lack of access to interpreters and the pressures on our ED, especially the lack of time and space, including the insane practice double-bunking, means we are not providing culturally safe healthcare to our local population, especially our local Aboriginal patients.*<br>*Regarding cultural safety - no bilingual signs, patients of all ethnicities largely managed the same and went through the same processes. Kaitiaki is available each day now which is new but not overnight. Very few Māori staff members. Try to obtain translators where appropriate.*<br>*I am not aware of any Aboriginal or Torres Strait Islander support within the department and I have not met an Aboriginal Liaison Officer during my time at this location.* |

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

### 3.2.6 Discrimination, Bullying, Sexual Harassment, Harassment (DBSH) and other unreasonable behaviour

Trainees were asked if they had experienced DBSH or other unreasonable behaviour in their placement, with detailed definitions provided for each aspect of DBSH. Just under one-third (30%, n= 456) of the 1543 trainees in an ED placement reported experiencing at least one aspect of DBSH and/or unreasonable behaviour from a patient or carer at their placement, of which 39% (n= 179) reported experiencing two or more aspects of DBSH behaviour. Of the 142 placement sites, three-quarters (n= 107) had at least one trainee reported experiencing DBSH from a patient or carer.

*Almost one in every three FACEM Trainees reported experiencing Discrimination, Bulling, Sexual Harassment, Harassment or other unreasonable behaviour from a patient or carer.*

Trainees were more likely to report experiencing harassment (14%), discrimination (12%), or other unreasonable behaviour (not classified as DBSH, 12%) than bullying (4%) or sexual harassment (4%), from a patient or carer (Table 13). Female trainees were more likely than males to report experiencing discrimination, harassment and sexual harassment from a patient or carer, except for bullying. DBSH incidents by patients or carers were also slightly more likely to be reported by provisional than advanced trainees (33% compared to 28%).

*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= 1543 | Gender | | Level of training | |
|---|---|---|---|---|---|
| | | Female n= 776 | Male n= 777 | Provisional trainees n= 378 | Advanced trainees n= 1165 |
| Discrimination | 177 (11.5%) | 108 (13.9%) | 69 (8.8%) | 56 (14.8%) | 121 (10.4%) |
| Bullying | 65 (4.2%) | 34 (4.4%) | 31 (4.0%) | 19 (5.0%) | 46 (4.0%) |
| Sexual Harassment | 67 (4.3%) | 58 (7.5%) | 9 (1.2%) | 24 (6.3%) | 43 (3.7%) |
| Harassment | 220 (14.3%) | 127 (16.4%) | 93 (12.0%) | 59 (15.6%) | 161 (13.8%) |
| *Other unreasonable behaviour | 192 (12.4%) | 108 (13.9%) | 84 (10.8%) | 52 (13.8%) | 140 (12.0%) |
| **Overall** | **456 (29.6%)** | **267 (34.4%)** | **189 (24.3%)** | **125 (33.1%)** | **331 (28.4%)** |

*Note: Overall is the total number of trainees who reported at least one aspect of DBSH. Each trainee may report more than one aspect of DBSH or other unreasonable behaviour.*

**A separate option (other unreasonable behaviour) was added to the 2022 survey for trainees to report other incidents not appropriately classified as D, B, S, or H. For instance, 'bullying', which refers to a type of unreasonable behaviour that is repeated over time or occurs as a pattern of behaviour that creates a risk to health and safety. One incident may not be appropriately classified as bullying, and thus may be raised as other unreasonable behaviour.*

Of the trainees (n= 456) who reported experiencing DBSH from patients/ carers, 232 (51%) trainees indicated having experienced DBSH or other unreasonable behaviour from patients, 17 (4%) from carers, and 207 (45%) from both patients and carers.

The trainees who reported having experienced DBSH from a patient or carer were asked to provide further information about their experience if they were comfortable doing so, with 170 trainees responding. Common themes identified included female trainees experiencing a lack of trust in their clinical knowledge and skills because of their gender; verbal aggression often associated with patient anger due to excessive wait time; alcohol/ drug-related and mental health-related presentations were frequent contributors to physical and verbal abuse incidents; and harassment and discrimination due to their ethnicity or from a non-English speaking background.

Some example comments related to DBSH from a patient or carer are presented below:

*Generally sexist stuff, for example, being patronized or opinion dismissed because I am female. Patients and relatives will often address the male medical student, refer to me as a nurse or complain at the end of their ED time that they haven't seen a doctor.*

*Both verbally aggressive, uncontrolled anger and disrespect towards all staff. Not able to articulate what they wanted, just directed anger and aggression toward staff instead.*

*Screaming at me, threatening to follow me home, spitting at me, threatening other physical violence. This occurs on a daily-to-weekly basis from violent patients to me and ED colleagues, most often from those intoxicated with methamphetamine.*

Trainees were also asked if they had experienced any DBSH from ED or hospital staff while working in their placement. A total of 162 (11%) of 1543 trainees in an ED placement reported experiencing at least one aspect of DBSH or unreasonable behaviour exhibited by ED and/ or hospital staff, of which 39 (24%) reported experiencing two or more aspects of DBSH behaviour. Eighty-one (57%) of 142 placement sites had at least one trainee reported having experienced DBSH by ED or hospital staff.

*One in every ten FACEM Trainees reported experiencing Discrimination, Bulling, Sexual Harassment, Harassment or other unreasonable behaviour from an ED or hospital staff.*

Findings from this survey were consistent with the findings from the 2021 Trainee Placement Survey, where overall, 10% of trainees reported experiencing DBSH behaviour from ED or hospital staff. The main difference was a decrease in the proportion of trainees who reported experiencing bullying (4% compared to 8% in the 2021 survey), noting 'Other unreasonable behaviour' being added as an additional option (Table 14).

Female trainees were generally more likely than male trainees to report experiencing discrimination, bullying, or other unreasonable behaviour by ED or hospital staff. Comparable proportions of provisional and advanced trainees reported experiencing DBSH behaviour from an ED or hospital staff member, except for discrimination (5% of provisional trainees compared to 2% of advanced trainees).

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

| Experienced DBSH from a hospital or ED staff | Total trainees n= 1543 | Gender | | Level of training | |
|---|---|---|---|---|---|
| | | Female n= 766 | Male n= 777 | Provisional trainees n= 378 | Advanced trainees n= 1165 |
| Discrimination | 44 (2.9%) | 37 (4.8%) | 7 (1.0%) | 17 (4.5%) | 27 (2.3%) |
| Bullying | 68 (4.4%) | 41 (5.4%) | 27 (3.5%) | 15 (4.0%) | 53 (4.6%) |
| Sexual Harassment | 3 (0.2%) | 2 (0.3%) | 1 (0.1%) | 1 (0.3%) | 2 (0.2%) |
| Harassment | 30 (1.9%) | 17 (2.2%) | 13 (1.7%) | 7 (1.9%) | 23 (2.0%) |
| *Other unreasonable behaviour | 71 (4.6%) | 48 (6.3%) | 23 (3.0%) | 15 (4.0%) | 56 (4.8%) |
| **Overall** | **162 (10.5%)** | **110 (14.4%)** | **52 (6.7%)** | **40 (10.6%)** | **122 (10.5%)** |

***Note: Overall is the total number of trainees who reported at least one aspect of DBSH. Each trainee may report more than one aspect of DBSH or other unreasonable behaviour.***
****A separate option (other unreasonable behaviour) was added to the 2022 survey for trainees to report other incidents not appropriately classified as D, B, S, or H.***

Trainees who reported experiencing DBSH from ED or hospital staff were further asked which person(s) displayed the DBSH behaviour toward them. Consistent with the 2021 survey findings, in-patient medical staff, FACEMs and ED nursing staff were the most frequently reported staff categories (Table 15).

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

| ED or hospital staff | Discrimination n= 44 | Bullying n= 68 | Sexual Harassment n= 3 | Harassment n= 30 | Other unreasonable behaviour n= 71 |
|---|---|---|---|---|---|
| FACEM | 21 | 23 | - | 9 | 21 |
| DEM/ Deputy DEM | <4 | <4 | - | <4 | - |
| DEMT | 6 | 6 | - | <4 | <4 |
| ED nursing staff | 20 | 17 | <4 | 10 | 17 |
| Other ED doctor | 9 | 5 | <4 | 4 | 5 |
| Other ED staff (e.g., clerical, orderly, allied health) | <4 | <4 | - | <4 | <4 |
| In-patient medical staff | 10 | 28 | - | 14 | 33 |
| In-patient non-medical staff | <4 | 4 | - | <4 | <4 |
| Other staff | 4 | 4 | - | <4 | 6 |
| Prefer not to say | 8 | 5 | <4 | <4 | 9 |

*Note: Trainees could select more than one staff category.*

Table 16 presents by region, the percentage of trainees who reported experiencing DBSH from a patient or carer, from ED or hospital staff, and specifically from FACEMs. Over one-third of the trainees in WA (42%), the Australian Capital Territory (ACT, 38%) and TAS (37%) reported having experienced DBSH from a patient or carer while working at their placement. Trainees from TAS (26%) and WA (15%) were also more likely to report experiencing DBSH from ED or hospital staff, whilst the highest rates of DBSH from FACEMs were reported by trainees in the NT (9%) and Queensland (QLD, 7%).

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

| | Reported experiencing DBSH (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ | Total |
| Experienced any DBSH from a patient/ carer? | 37.5% | 29.8% | 31.4% | 26.8% | 25.7% | 36.8% | 26.3% | **41.5%** | 33.1% | 29.6% |
| Experienced any DBSH from ED or hospital staff? | 4.2% | 12.5% | 11.4 % | 7.8% | 8.1% | **26.3%** | 9.7% | 14.6% | 10.5% | 10.5% |
| Experienced DBSH by FACEMs? | 0% | 2.9% | **8.6%** | 6.8% | 5.4% | 0% | 4.7% | 5.7% | 4.5% | 4.8% |
| **Total no. of responses** | **24** | **416** | **35** | **400** | **74** | **19** | **319** | **123** | **133** | **1543** |

Fifty-six trainees provided further information on their DBSH experiences from staff, with key themes including:

- Trainees most frequently reported experiencing discrimination based on gender (less favourable treatment to females), age (being new or junior in the team), or ethnicity (fewer opportunities for those with non-English speaking backgrounds).
- Some trainees also mentioned being discriminated against due to their part-time employment status or having other competing personal priorities such as family commitments.
- A culture of bullying and harassment of trainees by nursing staff was frequently reported, and some trainees commented that this had become the norm in the ED environment.
- For the trainees who reported experiencing bullying or harassment by ED consultants, their experiences included being repeatedly shouted at or openly criticised as inefficient or slow in their progress, with some trainees reporting being pressured to meet unrealistic expectations.
- Incidents of bullying and harassment exhibited by in-patient medical staff were often reported, with complaints about frequently encountering unfair criticism from the in-patient team during patient referrals.

- Several incidents of unreasonable behaviour were recounted, such as uncivil behaviour and disruptive attitudes (e.g., being intentionally ignored or refusing to provide assistance), from other staff members.

### 3.2.7 Opportunities to participate

Sixty per cent of 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 26% neither agreed nor disagreed, 8% disagreed, and 6% reported not knowing. A higher proportion of male trainees than female trainees (64% compared to 56%) were in agreeance with this, with no differences observed between advanced and provisional trainees (60%, respectively).

A larger proportion (73%) of trainees strongly agreed or agreed that they were able to participate in quality improvement activities at their placement, 19% neither agreed nor disagreed, and 4% disagreed. A higher proportion of male trainees compared with female trainees (77% compared to 69%) agreed they could participate in quality improvement activities, and no differences were observed by training level (74% of advanced trainees compared to 73% of provisional trainees).

*FACEM Trainees were more likely to agree that they could participate in quality improvement activities than in decision-making regarding governance (73% vs. 60%).*

Table 17 and Table 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.

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

| Opportunities to participate | Strongly agreed or agreed (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ | Total |
| Able to participate in decision making regarding governance (e.g., workplace committees) | 41.7% | 63.3% | 54.3% | 61.2% | 56.8% | 63.2% | 60.2% | 58.5% | 53.8% | 60.0% |
| Able to participate in quality improvement activities | 66.7% | 72.5% | 62.7% | 78.9% | 64.9% | 63.2% | 70.4 | 74.0% | 72.7% | 73.1% |
| Total no. of responses | 24 | 416 | 35 | 400 | 74 | 19 | 319 | 123 | 133 | 1543 |

*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 24 months and 36 months were more likely to agree that they had opportunities to participate in both the governance and quality improvement activities, compared to sites accredited for 12 months (Table 18).

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

| Opportunities to participate | Strongly agreed or agreed (%) | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| Able to participate in decision making regarding governance (e.g., workplace committees) | 50.8% | 59.1% | 61.3% |
| Able to participate in quality improvement activities | 66.2% | 72.0% | 74.2% |
| Total no. of responses | 130 | 282 | 1131 |

## 3.3 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.

### 3.3.1 Supervision and feedback

Trainees were asked about supervision, support and feedback provided by DEMTs and senior staff at their ED placement. Most (89%) were satisfied with the supervision they received at their placement overall, and nearly all (95%) trainees agreed that their DEMT had discussed what was expected of them at their stage and phase of training.

*Nine out of ten (89%) FACEM Trainees were satisfied overall with the supervision received but they were less likely to agree they received regular, informal feedback on their performance and progress.*

Only a slight difference was observed by training level (provisional trainees, 89% compared to advanced trainees, 90%) in their overall satisfaction with the supervision received. Likewise, similar proportions of provisional and advanced trainees agreed with the other statements on supervision, support and feedback provided at their placement. On the other hand, more noticeable differences were seen in comparison by gender, with male trainees consistently reporting higher agreement levels to all of the statements, compared with female trainees (Table 19).

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

| Statements about supervision, support and feedback | Strongly agreed or agreed (%) | | |
|---|---|---|---|
| | Female | Male | Total |
| Overall, satisfied with the supervision received | 88.4% | 90.4% | 89.4 % |
| Satisfied with quality of DEMT support | 89.9% | 91.7% | 90.8% |
| Availability of DEMT for guidance and supervision meets needs | 91.1% | 92.4% | 91.7% |
| Clinical supervision received from FACEMs meets needs | 87.6% | 89.9% | 88.7% |
| DEMT had discussed what is expected of trainee at their stage of training | 94.6% | 95.6% | 95.1% |
| Receive regular, *informal feedback on performance and progress | 76.4% | 79.5% | 78.0% |
| Total no. of responses | 766 | 777 | 1543 |

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

The proportion of trainees agreeing with statements relating to supervision, support and feedback provided at their ED placement is presented by region (Table 20) and accreditation level (Table 21). Compared to trainees in other regions, trainees from TAS were less likely to agree with most of the statements. In contrast, trainees from the NT and ACT generally reported a higher level of satisfaction with each aspect relating to supervision, support and feedback received at their placement.

*Table 20. 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 or agreed (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ | Total |
| Overall, satisfied with the supervision received | 82.6% | 90.1% | 94.3% | 91.8% | 86.5% | 83.3% | 87.7% | 87.8% | 88.0% | 89.4% |
| Satisfied with quality of DEMT support | 95.7% | 90.8% | 94.3% | 89.7% | 89.0% | 83.3% | 90.9% | 91.9% | 93.2% | 90.8% |
| Availability of DEMT for guidance and supervision meets needs | 100% | 91.7% | 100% | 90.9% | 95.9% | 88.2% | 89.9% | 91.8% | 93.2% | 91.8% |
| Clinical supervision received from FACEMs meets needs | 87.0% | 90.3% | 94.1% | 90.2% | 82.4% | 72.2% | 88.1% | 83.7% | 90.2% | 88.7% |
| DEMT had discussed what is expected of trainee at their stage of training | 100% | 94.4% | 100% | 95.5% | 94.6% | 100% | 93.7% | 95.9% | 96.2% | 95.1% |
| Receive regular, *informal feedback on performance and progress | 73.9% | 77.9% | 82.9% | 80.4% | 77.0% | 55.6% | 78.0% | 74.0% | 78.2% | 78.0% |
| Total no. of responses | 24 | 416 | 35 | 400 | 74 | 19 | 319 | 123 | 133 | 1543 |

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

Comparable proportions of trainees reported agreeing with statements about supervision, support and feedback across all accredited levels (Table 21).

*Table 21. 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 or agreed (%) | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| Overall, satisfied with the supervision received | 93.1% | **89.0%** | 89.1% |
| Satisfied with quality of DEMT support | 91.5% | **89.6%** | 91.0% |
| Availability of DEMT for guidance/ supervision meets needs | **89.1%** | 91.4% | 92.1% |
| Clinical supervision received from FACEMs meets needs | **88.4%** | 89.4% | 88.6% |
| DEMT had discussed what is expected of trainee at their stage of training | **93.1%** | 93.6% | 95.7% |
| Receive regular, *informal feedback on performance and progress | **75.0%** | 79.1% | 78.1% |
| Total no. of responses | 130 | 282 | 1131 |

*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.*

### 3.3.2 Workplace-based Assessments

Advanced and TS1 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 and TS1 trainees were satisfied with the level of support they received from their Local WBA Coordinator to complete their EM-WBA requirements, with 15% neither agreeing nor disagreeing and 7% disagreeing. A slightly larger proportion (79%) were satisfied with the level of support they received from FACEMs. A much larger proportion of advanced and TS1 trainees (87%) were in agreeance that WBA assessors/ FACEMs provided useful WBA feedback to guide their training.

*Over three-quarters of FACEM Trainees were satisfied with the support they received from their Local WBA Coordinator (77%) and FACEMs (79%) in completing their EM-WBAs.*

The proportion of advanced and TS1 trainees who agreed that they were satisfied with the support from their Local WBA Coordinator, FACEMs and WBA assessors is provided in Table 22 by region, and in Table 23 by ED accreditation level. Trainees undertaking a placement in SA EDs were generally less satisfied with the support and feedback received for WBAs, with just over two-thirds of trainees from SA satisfied with the level of support received from FACEMs to complete their EM-WBA requirements.

*Table 22. Proportion of advanced and TS1 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 or agreed (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ | Total |
| Satisfied with the level of support from Local WBA Coordinator | 72.2% | 75.6% | 83.3% | 77.5% | 75.8% | 88.9% | 81.8% | 74.1% | 73.0% | 77.3% |
| Satisfied with the level of support from FACEMs | 72.2% | 79.9% | 83.3% | 77.3% | 69.7% | 88.9% | 83.5% | 82.8% | 70.3% | 79.0% |
| WBA assessors/ FACEMs provide useful feedback | 83.3% | 87.1% | 83.3% | 85.6% | 80.0% | 88.9% | 87.5% | 89.5% | 87.3% | 86.7% |
| Total no. of responses | 18 | 361 | 12 | 377 | 66 | 18 | 291 | 116 | 111 | 1370 |

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

Trainees undertaking a placement in an ED accredited for 24 months and 36 months were generally less likely to agree with most aspects of support and feedback for EM-WBAs (Table 23).

*Table 23. Proportion of advanced and TS1 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 or agreed (%) | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| Satisfied with the level of support from Local WBA Coordinator | 85.2% | 76.5% | 76.5% |
| Satisfied with the level of support from FACEMs | 86.8% | 77.7% | 78.3% |
| WBA assessors/ FACEMs provide useful feedback | 88.4% | 87.4% | 86.3% |
| Total no. of responses | 122 | 234 | 1370 |

Advanced and TS1 trainees were further surveyed about how WBAs were organised at their site (Table 24), with the majority reporting that it was the trainee's responsibility (70%), rather than the DEMT or WBA Coordinator to schedule WBAs (29%). They were also more likely to report that the WBAs were conducted on an ad hoc basis (37%), or organised through a rostered WBA Consultant (23%) but less frequently through rostered WBA session (9%).

*Table 24. How WBAs are organised at sites for advanced and TS1 trainees*

| How are WBAs organised at your site? | n | % |
|---|---|---|
| It is the trainee's responsibility | 954 | 70.3% |
| On an ad hoc basis | 498 | 36.7% |
| They are scheduled by DEMT or WBA Coordinator | 395 | 29.1% |
| Through rostered WBA Consultant | 305 | 22.5% |
| Through rostered WBA session | 121 | 8.9% |
| Other (e.g., a mixture of the above, only rostered for a specific type(s) of WBA etc.) | 22 | 1.6% |
| Total no. of respondents | 1357 | |

*Note: Respondents may select more than one way WBAs were organised at their site, with 586 (50.3%) trainees doing so.*

### 3.3.3 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 concerning the number (96%), breadth (89%), acuity (86%), and complexity of cases (91%) (Table 25). Similar levels of agreement were seen between advanced and provisional trainees for each aspect relating to casemix.

Trainees with an ED placement in the NT were less likely to report satisfaction with their placement in providing an appropriate training experience when considering different aspects of casemix, compared with trainees in other regions (Table 25).

*Table 25. 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% | 96.8% | 91.7% | 94.7% | 93.2% | 94.7% | 94.6% | 97.6% | 96.2% | 95.6% |
| Breadth of cases | 91.7% | 90.8% | 82.9% | 88.9% | 90.5% | 84.2% | 88.6% | 87.8% | 88.7% | 89.2% |
| Acuity of cases | 87.5% | 88.0% | 77.1% | 84.9% | 90.4% | 89.5% | 85.4% | 87.0% | 87.2% | 86.4% |
| Complexity of cases | 91.7% | 91.2% | 82.9% | 89.4% | 93.2% | 89.5% | 90.5% | 88.6% | 93.2% | 90.5% |
| Total no. of responses | 24 | 416 | 35 | 400 | 74 | 19 | 319 | 123 | 133 | 1543 |

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

Trainees undertaking placements in EDs accredited for 24 months and 36 months were more likely than trainees in 12-month accredited EDs to agree that the ED casemix at their placement was appropriate with respect to the number, breadth, acuity, and complexity of cases (Table 26).

*Table 26. Proportion of trainees who agreed that their current placement provided an appropriate training experience when considering aspects of casemix, by accreditation level.*

| Aspects of casemix | % Strongly agreed / agreed | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| Number of cases | 93.0% | 94.0% | 96.4% |
| Breadth of cases | 79.7% | 83.3% | 91.7% |
| Acuity of cases | 67.2% | 77.3% | 90.9% |
| Complexity of cases | 78.0% | 84.7% | 93.3% |
| Total no. of responses | 130 | 282 | 1131 |

### 3.3.4 Further comments on supervision and training experience

There were 86 comments provided by trainees relating to supervision or the training experience at their placement. Almost half (47%, n= 40) of the comments reflected on various aspects of the casemix available at their placement, including lack of high acuity patients or factors impacting casemix (e.g., demographics of the population, close to major-referral hospital, not a trauma centre). A further 21 (24%) comments were positive feedback about supportive and approachable senior staff, well-structured training and support, good support in organising their WBAs or diverse casemix for learning and training.

There were 39 (45%) negative comments that largely reflected on the difficulty in completing WBAs, lack of supervision or training opportunity, and limited quality feedback (Table 27). There were 22 (26%) other suggestions for improving support for WBAs, supervision, and/or feedback on performance.

*Table 27. Negative perspectives and suggestions for improvement regarding the supervision and training experience at ED placements, themes with example comments.*

| Theme | Example comments |
|---|---|
| **Negative comments** | |
| Casemix (n= 15)<br>*Lack of complexity or acuity to maintain skills*<br>*Service provision is priority, rather than teaching on complex cases* | *The large volume of subacute geriatric patients takes up the majority of time, making it difficult to keep procedural skills fresh.*<br>*We don't often get chance to see acuity because it's quicker for senior medical officers to see them themselves.*<br>*Senior house officers in training/junior registrars and provisional trainees need to be actively helped to seek more complex and high acuity cases, as at this stage they often go to more senior staff.* |
| Lack of senior supervision or training opportunity (n= 15)<br>*Not supported or allocated high acuity cases; lack of learning opportunities in the busy department* | *Formal primary teaching program was somewhat lacking and very self-directed.*<br>*Huge workload and marked bed-block which limits opportunity for on the floor learning and ability to study at home.*<br>*The FACEMs & department are excellent, the problem is the time pressures & under resourcing which leads to reduced supervision.* |
| Difficulty completing WBAs (n= 5)<br>*High workload and time constraint; WBA sessions not rostered* | *There is a good case mix but just lack of time and high workload of department that makes WBAs most of the time difficult to complete.* |
| Limited quality feedback (n= 5)<br>*No feedback was given; limited formal or informal feedback* | *Would be nice to get more informal/constructive feedback day to day - has been difficulty lately with combo of increasing patient numbers and understaffing issues, meaning less time able to be spent on this.* |
| **Suggestions for improvement** | |
| Better support for WBAs | *My biggest issue with WBA is not being able to arrange them in the time required. I have lost multiple fantastic cases due to the shift work and not being able to arrange a meeting within the 28 days of seeing the case. I would suggest even lengthening it to 6 weeks would be super helpful.*<br>*Would be great to have a consultant rostered on specifically for WBAs (often it is so busy for the clinical staff that it is difficult to pull them away from their work for a supervised procedure / Clinical Evaluation Exercise).* |
| More supervision and/ or feedback | *Consistent supervision for certain procedural skills would be greatly appreciated.*<br>*Senior house officers in training/junior registrars and provisional trainees need to be actively helped to seek more complex and high acuity cases, as at this stage, they often go to more senior staff.* |

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

## 3.4 Education and Training Opportunities

This section covers clinical teaching, the structured education program, access to educational and examination resources, simulation learning experiences, and leadership and research opportunities.

### 3.4.1 Clinical teaching and the structured education program

Over three-quarters of trainees strongly agreed or agreed that the clinical teaching at their placement optimised their learning opportunities (79%), with a larger proportion of trainees agreeing that they received training for, and were provided with opportunities to use relevant clinical equipment (89%). However, just over two-thirds (70%) of trainees were in agreeance that they had access to formal ultrasound teaching, with the proportion of trainees who agreed with having access to formal ultrasound teaching increasing as site accreditation limits increased (12 months, 48%; 24 months, 65%; and 36 months, 74%).

More comparable proportions of trainees 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 (82% and 85%, respectively). There were also no differences between advanced and provisional trainees in their agreement about the structured education program.

Trainees were asked whether the structured education sessions were provided for, on average, a minimum of four hours per week at their placement, with 89% agreeing. However, a smaller proportion of trainees (81%) were in agreeance that the rostering at their placement enabled them to attend the structured education sessions.

*Comparable proportions of FACEM Trainees agreed that the structured education program at their placement met their needs (82%) and rostering enabled trainees to attend education sessions (81%).*

Trainees undertaking a placement in TAS were least likely to agree with most of the statements in Table 28 consistent with the findings from the 2021 Trainee Placement Survey.

*Table 28. Proportion of trainees who strongly agreed or agreed with statements about the clinical teaching and structured education program at their ED placement, by region.*

| Statement on teaching and education | Strongly agreed or agreed (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ | Total |
| My current placement provides clinical teaching that optimises learning opportunities (including bedside and on-floor teaching) | 79.2% | 80.0% | 85.7% | 77.2% | 70.3% | 57.9% | 84.9% | 80.5% | 75.2% | 79.3% |
| I have access to the educational resources that I need to meet the requirements of the FACEM Training Program | 79.2% | 86.2% | 91.2% | 86.9% | 82.4% | 89.4% | 90.0% | 90.2% | 91.0% | 87.8% |
| I receive training for, and am provided with, opportunities to use relevant clinical equipment | 83.3% | 88.1% | 94.1% | 90.2% | 81.1% | 73.7% | 92.4% | 82.9% | 89.3% | 88.8% |
| The structured education program meets needs | 91.7% | 83.0% | 88.6% | 81.8% | 79.7% | 63.2% | 83.9% | 78.0% | 75.0% | 81.6% |
| Structured education sessions are provided for a minimum of four hours per week | 100% | 88.6% | 100% | 87.0% | 87.8% | 73.7% | 93.1% | 85.1% | 84.2% | 88.6% |
| The structured education program aligns to the content and learning outcomes of the ACEM Curriculum Framework | 95.7% | 85.4% | 85.7% | 83.6% | 79.7% | 68.4% | 89.0% | 80.7% | 80.3% | 84.6% |
| Rostering enables trainees to attend structured education sessions | 75.0% | 80.0% | 91.7% | 75.4% | 85.1% | 84.2% | 92.1% | 81.7% | 71.2% | 81.3% |
| **Total no. of responses** | **24** | **416** | **35** | **400** | **74** | **19** | **319** | **123** | **133** | **1543** |

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

In general, a smaller proportion of trainees undertaking a placement in 12-month or 24-month accredited sites were in agreeance with the statements relating to clinical teaching and the structured education program at their placement, compared with trainees in 36-month accredited EDs (Table 29).

*Table 29. Proportion of trainees who strongly agreed or agreed with statements about the clinical teaching and structured education program at their ED placement, by accreditation level.*

| Statement on teaching and education | Strongly agreed or agreed (%) | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| My current placement provides clinical teaching that optimises learning opportunities (including bedside and on-floor teaching) | 78.5% | **78.3%** | 79.6% |
| I have access to the educational resources that I need to meet the requirements of the FACEM Training Program | **84.6%** | 86.8% | 88.4% |
| I receive training for, and am provided with, opportunities to use relevant clinical equipment | 86.2% | **86.0%** | 89.8% |
| The structured education program meets needs | **79.2%** | 80.9% | 82.1% |
| Structured education sessions are provided for a minimum of four hours per week | **86.2%** | 87.5% | 89.2% |
| The structured education program aligns to the content and learning outcomes of the ACEM Curriculum Framework | **81.5%** | 83.9% | 85.1% |
| Rostering enables trainees to attend structured education sessions | **74.4%** | 80.0% | 82.4% |
| **Total no. of responses** | **130** | **282** | **1131** |

### 3.4.2 Access to examination resources

Trainees were asked if they have access to exam preparation resources either onsite at their placement or at another site (linked or networked ED). Similar proportions of trainees reported having access to written exam revision programs (95%) and clinical exam preparation programs (95%), either onsite or offsite (Table 30).

Of those who reported they had access to written exam revision programs (n= 1,459), the majority (84%) agreed that they had sufficient access to the program. Whereas for trainees who reported having access to clinical exam preparation programs (n= 1,469), a similar proportion (83%) agreed they had sufficient access to the program.

Table 30 shows the proportion of trainees who reported having access to written and clinical exam preparation programs either onsite at their placement or at an external (linked/ networked) site, by region. Trainees undertaking an ED placement in Aotearoa were the least likely to report having access to onsite written exam revision programs, compared with trainees in other regions. Whereas TAS and New South Wales (NSW) were least likely to report having access to onsite clinical exam preparation programs.

*Table 30. Proportion of trainees who reported having access to written and clinical exam preparation programs onsite or offsite at another linked/ networked site, by region.*

| I have access to: | Reported yes (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | NZ | Total |
| **Written exam revision program** | | | | | | | | | | |
| Onsite | 95.8% | 85.3% | 97.1% | 89.0% | 89.2% | 89.5% | 89.7% | 88.6% | **82.0%** | 87.8% |
| Offsite (linked/ networked ED) | 4.2% | 8.9% | 2.9% | 5.5% | 4.1% | 5.3% | 3.8% | 8.9% | 12.0% | 6.7% |
| **Clinical exam preparation program** | | | | | | | | | | |
| Onsite | 95.8% | 84.9% | 97.1% | 92.0% | 91.9% | **84.2%** | 92.2% | 88.6% | 86.5% | 89.4% |
| Offsite (linked/ networked ED) | 0% | 9.4% | 2.9% | 4.5% | 4.1% | 5.3% | 1.9% | 8.1% | 8.3% | 5.8% |
| **Total no. of responses** | **24** | **416** | **35** | **400** | **74** | **19** | **319** | **123** | **133** | **1543** |

Trainees undertaking a placement at EDs accredited for 24 months and 36 months were most likely to report having access to both written and clinical exam preparation programs, compared with trainees at sites accredited for 12 months (Table 31).

*Table 31. Proportion of trainees who reported having access to written and clinical exam preparation programs onsite or offsite at another linked/ networked site, by accreditation level.*

| I have access to: | Reported yes (%) | | |
|---|---|---|---|
| | 12 months | 24 months | 36 months |
| **Written exam revision program** | | | |
| Onsite | **55.4%** | 79.1% | 93.7% |
| Offsite (linked/ networked ED) | 33.9% | 10.6% | 2.7% |
| **Clinical exam preparation program** | | | |
| Onsite | **58.5%** | 83.3% | 94.5% |
| Offsite (linked/ networked ED) | 31.5% | 9.2% | 1.9% |
| **Total no. of responses** | **130** | **282** | **1131** |

Trainees who disagreed with any statements relating to educational and training opportunities available at their placement were asked to comment on the reason(s) for their response.
Table 32 provides the key themes and subthemes from 235 responses, which were primarily focused on the unsupportive rostering and a lack of protected teaching time (40%), the absence of formal ultrasound teaching onsite (32%), and a poorly structured education program (24%). Compared to the

2021 Trainee Placement Survey, relatively few trainees reported the COVID-19 pandemic impacted education and training opportunities in their ED placement (n= 14 in the 2021 survey compared to n= 2 in the 2022 survey).

*Table 32. Themes and subthemes of trainee comments regarding the educational and training opportunities at their ED placement.*

| Key themes and sub-themes |
|---|
| Rostering unsupportive of education program (n= 95)<br>• *Teaching schedule not accessible on evening or night shift roster*<br>• *Not rostered on for teaching*<br>• *Rostered clinical shift during teaching sessions*<br>• *Teaching rostered as overtime* |
| Limited or no formal ultrasound teaching (n= 75)<br>• *Informal or ad hoc teaching and supervision*<br>• *Difficult to access (not rostered or on-site)*<br>• *Site unprepared for ultrasound teaching*<br>• *Formal ultrasound teaching provided only to trainees on the ultrasound rotation (Ultrasound Fellows) or for specific level or number of trainees* |
| Poorly structured education program (n= 56)<br>• *Generic education program, not tailored to the level of training*<br>• *Not aligned to ACEM curriculum or examination content*<br>• *Does not apply directly to clinical practice*<br>• *Lack of quality, relevance, repetitive in content* |
| Minimal clinical/ on-floor teaching (n= 43)<br>• *Patient load and access block cause limited clinical on-floor teaching*<br>• *On-floor teaching not supported or rostered by department*<br>• *Provided by very few senior staff* |
| Less than 4 hours education program per week (n= 33)<br>• *Not achieving 4 hours/week of formal education*<br>• *Scheduling other commitments over teaching (meetings, forums)* |
| Lack of exam preparation support or resources (n= 9)<br>• *No exam-specific teaching available*<br>• *Inadequate/no formal primary exam teaching* |

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

### 3.4.3 Simulated learning experiences

The majority (92%) of trainees reported that simulation learning experiences were utilised at their ED placement, with 3% unsure and 5% reporting simulation was unavailable at their placement. Trainees undertaking a placement in EDs accredited for 36 months (94%) were more likely than those in EDs accredited for 12 months or 24 months (86.2%, respectively) to report that simulation learning experiences were utilised.

Of trainees who reported the availability of simulation learning experiences (n= 1418), 95% reported participating in simulation learning experiences at their placement (n= 1352). A larger proportion of provisional trainees than advanced trainees (98% compared to 95%) reported participating in simulation learning at their placement.

*92% of FACEM Trainees reported the availability of simulation learning experiences at their placement, with nearly all of them participating.*

The trainees (n= 66) who did not participate in simulation learning at their placement were asked to provide reason(s), with 51 trainees doing so. The main reason for not participating was that they were not rostered on when simulation sessions were conducted (n= 28, 55%). Other reasons included a limited schedule or no scheduled simulation sessions at their placement (n= 8, 16%), have not attended either by choice, being on leave, or on non-ED rotations (n= 8, 16%), prioritising exam preparation (n= 3, 6%), attending other teaching sessions instead (n= 3, 6%), or simulation not being available to registrars (n= 2, 4%).

Among the trainees who reported participating in simulation learning at their placement, over three-quarters (81%, n= 1094) reported that they had participated in multidisciplinary team-based simulation training, with a slightly larger proportion of advanced (81%) compared to provisional (79%) trainees reporting so. Advanced trainees reported similar agreement levels with provisional trainees relating to the benefits of participation in multidisciplinary team-based simulation training (Table 33).

*Table 33. Proportion of trainees who strongly agreed or agreed with statements regarding participation in multidisciplinary team-based simulation training, by training level.*

| Participation in multidisciplinary team-based simulation training at this placement: | % Strongly agreed / agreed | | |
|---|---|---|---|
| | Provisional | Advanced | Total |
| Has improved my effectiveness in ED team-based practice | 92.5% | 93.1% | **93.0%** |
| Has contributed to my leadership development | 91.3% | 91.3% | **92.7%** |
| Has enhanced my learning and team-based practice | 92.7% | 92.5% | **92.5%** |
| Total no. of responses | 266 | 815 | 1081 |

Of those who disagreed with any of the above statements relating to multidisciplinary team-based simulation training, 21 trainees provided an explanation. Most comments were related to the limited quality, overly generic, or lack of relevance of the simulation content (n= 9, 43%), or that they were only able to observe the simulation (n= 4, 19%). Five trainees commented that they were not rostered for simulation sessions. Four other trainees commented that they did not find the team-based simulation training useful, whilst one found it stressful.

### 3.4.4 Leadership opportunities

A slightly higher percentage of trainees strongly agreed or agreed that they were provided with opportunities to teach and supervise junior trainees (93%), compared with opportunities for leadership and management appropriate to their stage and phase of training (90%). The advanced trainees were only slightly more likely than the provisional trainees to agree that they were provided with opportunities to teach and supervise junior medical staff (93% compared to 92%), as well as having leadership and management opportunities (90% compared to 88%).

### 3.4.5 Research opportunities

Just under two-thirds (64%) of trainees reported being able to participate in research opportunities at their placement. Trainees at sites accredited for 36 months (68%) were more likely to report having research opportunities than trainees at sites accredited for 12 months (57%) and 24 months (55%).

Table 34 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 accreditation level. Trainees undertaking their ED placement in hospitals accredited for 36 months (45%) were much more likely to report there was a designated staff member to advise on the research component, compared to trainees at 12-month and 24-month accredited sites (29% and 26%, respectively). It is important to note that, one-third (34%) 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 consistent across EDs with different accreditation levels.

*Table 34. Availability of a staff member to provide advice about the research component of the FACEM Training Program, by accreditation level.*

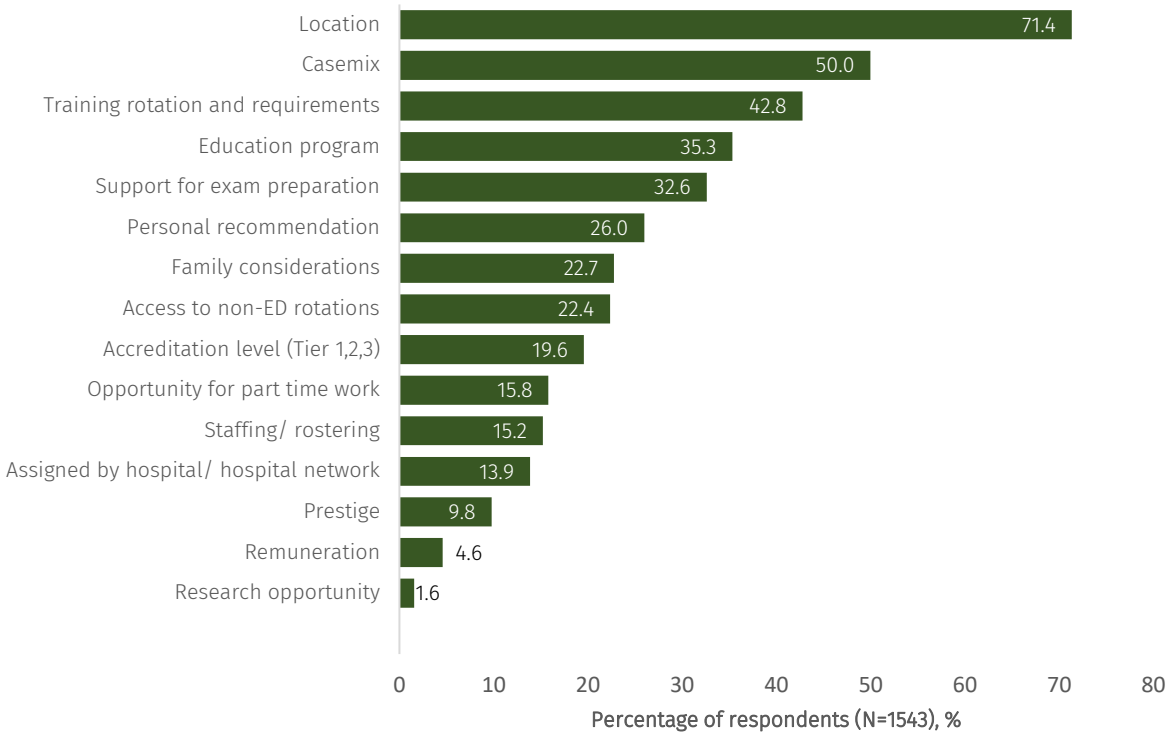
| Staff member available | 12 months | 24 months | 36 months | Total |
|---|---|---|---|---|
| Yes | 28.5% | 25.9% | 44.9% | **40.1%** |
| No | 7.7% | 6.4% | 3.1% | **4.1%** |
| Don't know | 34.6% | 40.1% | 32.5% | **34.1%** |
| *Not applicable | 29.2% | 27.7% | 19.5% | **21.8%** |
| Total no. of responses | 130 | 282 | 1131 | 1543 |

*Note: *Not applicable includes trainees who have previously completed or have not yet started the research component.*

## 3.5 Further Perspectives on Placement

From a list of potential factors, trainees were asked to select up to five key factors they considered in arranging their training placement (Figure 1). The nominated key factors were consistent with those identified in previous survey iterations, where ED location was the most considered factor when trainees arranged their placement, followed by casemix. On the contrary, remuneration and research opportunities were least considered by trainees.

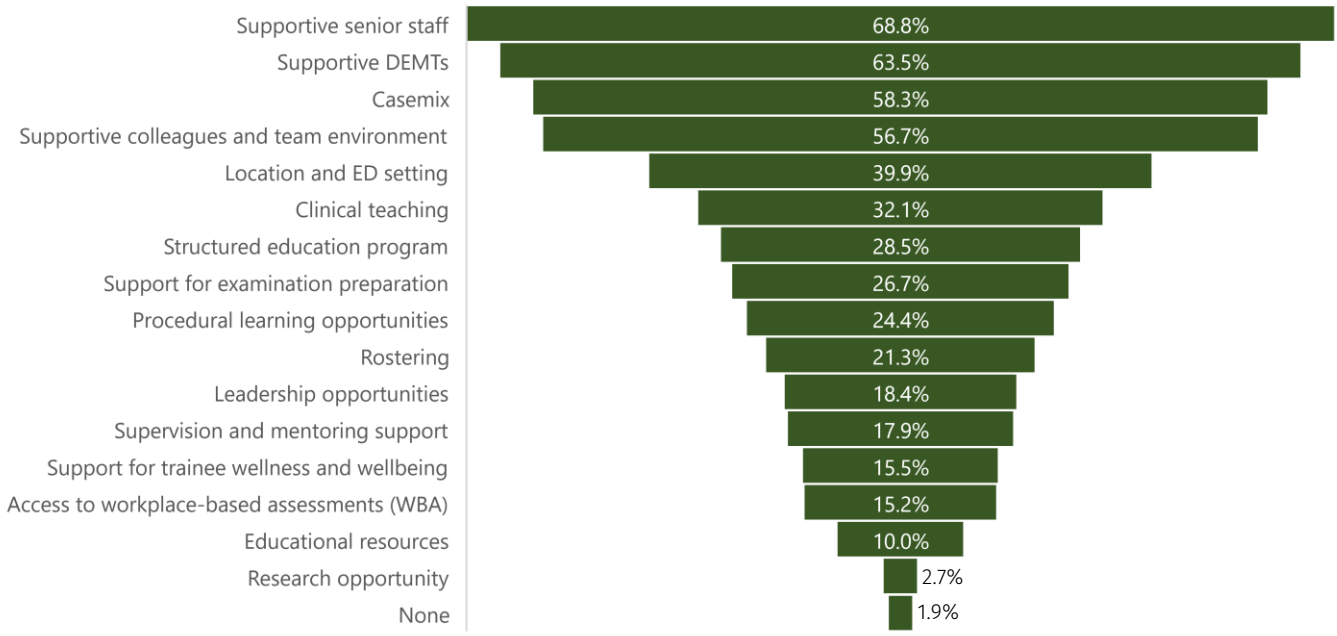
*Figure 1. Factors for consideration in arranging training placement, ranked from the most important to the least important.*




*Note: Trainees 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, which were consistent with the 2021 survey findings (Figure 2). Clinical teaching was selected as a highlight by nearly one-third of trainees, with a smaller proportion selecting structured education program (29%) or support for exam preparation (27%). Access to WBAs, educational resources, and research opportunities, on the other hand, were the least selected highlights.

*Figure 2. ED placement highlights ranked from most common to least common, n=1543*




*Note: Respondents could select more than one highlight for their placement.*
*'None' refers to no highlight in their placement, whilst no trainee selected 'Other' as an option.*

Trainees were provided with the opportunity to outline key areas for improvement that could be made at their placement, with 186 trainees providing feedback (Table 35). Consistent with the findings from previous survey iterations, improvements to rostering (n= 65, 35%) and staffing and workload arrangements (n= 63, 34%) were two most commonly raised areas for improvement. This was followed by teaching/ education program (n= 55, 30%), and clinical and procedural training (n= 37, 20%).

*Table 35. Themes and subthemes for areas for improvement.*

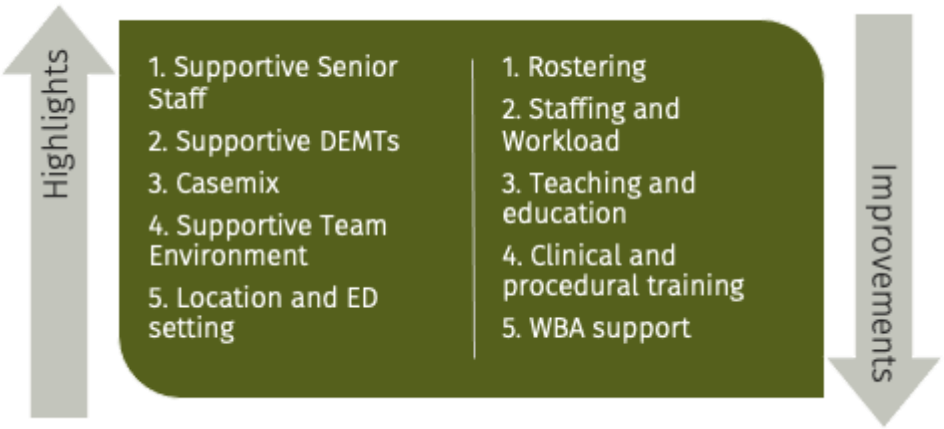
| Key themes and sub-themes |
|---|
| Rostering (n= 65)<br>• *Reduced frequency of night shifts*<br>• *Better access to leave (including study leave)*<br>• *Timely provision of roster*<br>• *More equitable roster (turnaround between night and day shift)*<br>• *Rostered WBAs, protected teaching time*<br>• *Specific rostering to resuscitation and trauma* |
| Staffing and workload arrangements (n= 63)<br>• *Increase recruitment of nursing and medical staff to meet department demand*<br>• *Increase range in staff skill levels, particularly on night shift*<br>• *More medical staff to allow for supervision, education and on-floor teaching*<br>• *Increase staff recruitment to reduce workload, burnout, work-related stress and fatigue*<br>• *Allow part-time work for exam preparation*<br>• *More sustainable staffing and workplace expectations* |
| Teaching/ education program (n= 55)<br>• *Structured, examination-specific education and teaching program*<br>• *Education more aligned with the FACEM curriculum*<br>• *Targeted teaching for training level*<br>• *Better access to training sessions*<br>• *Integration of simulation into teaching sessions* |
| Clinical and procedural training (n= 37)<br>• *Improve support for bedside and on-floor teaching*<br>• *Increase procedural learning opportunities*<br>• *Formal training of clinical skills, particularly for those not completing anaesthetics rotations*<br>• *On-floor ultrasound training*<br>• *More resuscitation and trauma opportunities* |

| |
|---|
| Structured and better support for WBAs (n= 24)<br>• *Better access to WBAs through staffing and roster*<br>• *Formalised WBAs, including rostered and structured assessment*<br>• *Introduce WBA Coordinator and allocated WBA consultant* |
| Senior supervision and feedback (n= 22)<br>• *More formal and informal feedback*<br>• *Structured and ongoing feedback (incorporate positive and negative feedback)*<br>• *Better support from senior staff and leadership*<br>• *Increase supervised practice*<br>• *Structured supervision to correlate with increasing responsibility* |
| Trainee welfare and wellbeing (n= 20)<br>• *Improve culture of department and team collegiality*<br>• *More support to reduce burnout*<br>• *Support for trainee wellness and wellbeing*<br>• *Encourage social events* |
| Improve ED resources (n= 20)<br>• *Improve ED space and bed availability to cope with access block*<br>• *Increase security staff*<br>• *Dedicated study rooms*<br>• *Improve IT access and infrastructure* |
| Casemix (n= 6)<br>• *More equitable access to higher acuity and paediatric cases*<br>• *Increase casemix of simulations* |
| Leadership and junior teaching opportunities (n= 5)<br>• *Opportunities to supervise junior doctors*<br>• *Opportunities for leadership and better defined team-leading roles* |
| Other (n= 6)<br>• *Overall, placement requires improvement*<br>• *Increase availability of anaesthetic rotation positions*<br>• *Equitable remuneration*<br>• *Provide an orientation program*<br>• *Encourage and support research projects and publications* |

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

Placement highlights were compared with the areas for improvement identified (Figure 3), with apparent differences observed. The key areas for improvement were staffing arrangements and rostering, contrasted with supportive senior staff, team environment and casemix as key highlights. Although supportive senior staff and supportive DEMTs were nominated as placement highlights, other trainees commonly reported teaching (both exam preparation and clinical teaching), and better support for WBAs as areas requiring improvement.

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



## 3.6 Overall Perspectives on the FACEM Training Program and Support from ACEM

### 3.6.1 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. Female (89%, compared with male, 87%) and provisional trainees (88%, compared with advanced trainees, 87%) were slightly more likely to agree with this statement.

*88% of FACEM Trainees agreed that the FACEM Training Program is facilitating their preparation for independent practice as EM specialists.*

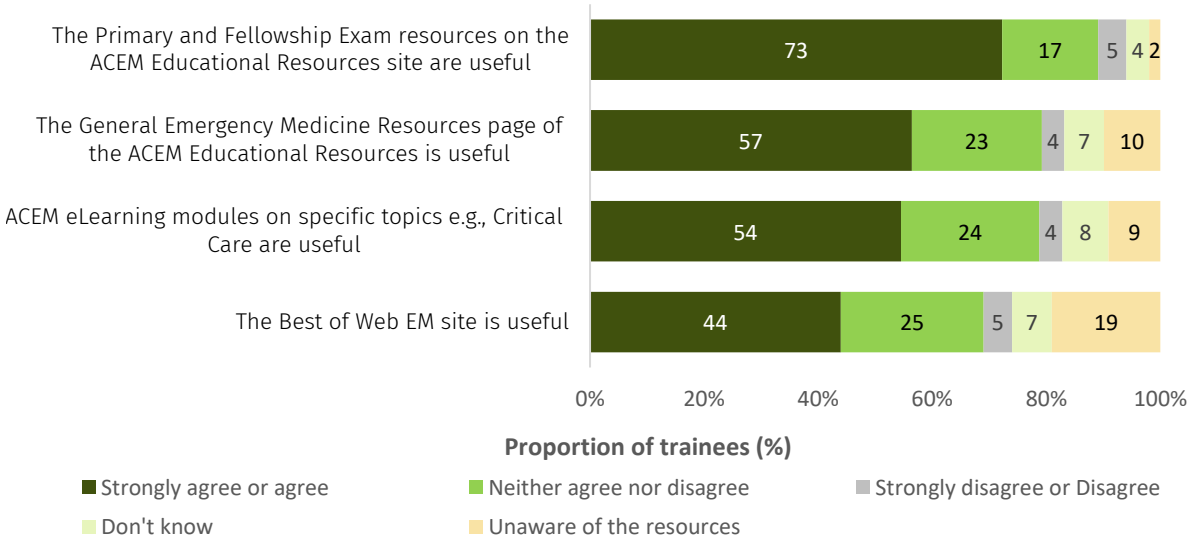
A smaller proportion (75%) of trainees agreed that they were well supported in their training by ACEM processes, with 18% neutral and 4% disagreeing. A higher proportion of provisional trainees (79%, compared with advanced trainees, 74%) and male trainees (77%, compared with female, 74%) were in agreeance with this.

Trainees who disagreed that they were well-supported in their training by ACEM processes were given the opportunity to provide further details, with 58 trainees doing so. The majority of comments (n= 24) were regarding areas for improvement in the FACEM training program, including ACEM's involvement and oversight, program structure or curriculum, and greater flexibility in the training requirements. Trainees also expressed there should be an increase in support and guidance through the training program and requirements (n= 21). Other comments were regarding examinations (n= 16) including better support and resources for preparation, improve relevance of content, increase number of allowed attempts, better support for trainees who failed. Several others commented on increasing wider support and representation of FACEM trainees (n= 7) and improving the process of WBAs (n= 3).

### 3.6.2 Online resources available for FACEM trainees

Trainees were asked to state their level of agreement with statements relating to the usefulness of the listed resources that ACEM provides to support FACEM trainees. (Figure 4). Consistent with the 2021 Trainee Placement Survey findings, more trainees found the Primary and Fellowship exam resources to be useful (73%), compared with other online resources (ranged between 44% and 57%). Some improvements were seen, with an increase in the proportion of trainees finding ACEM eLearning modules (54%, up from 46% in the 2021 Trainee Placement Survey) and the General Emergency Medicine Resource page (57%, up from 52%) useful.

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



### 3.6.3 Support and resources – areas of need and interest

Trainees were asked to nominate resources and support as an area of need and/ or interest and their preferred delivery mode(s) for each selected area (Table 36), 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. Nearly a quarter of trainees nominated the FACEM Training Program structure/administration and clinical governance resources (22%, respectively) as an area of need.

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 generally the most preferred mode for the other resources and areas for support.

*Table 36. 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 | % | % | % | % | % | % |
| College updates | 88 | 5.7% | 15.9% | **47.7%** | 39.8% | **47.7%** | 23.9% |
| FACEM Training Program structure and administration | 344 | 22.3% | 40.4% | **51.2%** | 35.5% | 24.7% | 36.6% |
| Learning Development Plan | 130 | 8.4% | 42.3% | **56.9%** | 34.6% | 16.9% | 38.5% |
| In-Training Assessments (ITAs) | 176 | 11.4% | **55.7%** | 40.3% | 23.3% | 15.9% | 20.5% |
| EM-WBAs | 300 | 19.4% | **60.0%** | 40.7% | 23.0% | 10.0% | 25.3% |
| Primary Exam – Written | 207 | 43.9%* | 43.0% | **55.1%** | 34.8% | 34.3% | 34.8% |
| Primary Exam – Viva | 208 | 45.2%* | **55.8%** | 49.0% | 41.8% | 34.1% | 32.2% |
| Fellowship Exam – Written | 790 | 51.2% | 58.7% | **69.7%** | 46.5% | 41.3% | 33.2% |
| Fellowship Exam – OSCE | 789 | 51.1% | **73.9%** | 63.5% | 47.8% | 37.9% | 32.2% |
| Communication skills | 243 | 15.7% | **69.1%** | 60.1% | 45.3% | 21.8% | 17.3% |
| Leadership and management skills | 554 | 35.9% | **69.3%** | 57.4% | 39.9% | 25.8% | 17.1% |
| Clinical skills | 449 | 29.1% | **79.1%** | 57.2% | 48.8% | 31.0% | 27.2% |
| Clinical governance (HR, rostering, dealing with patient complaints) | 336 | 21.8% | 47.9% | **65.5%** | 37.8% | 27.7% | 30.1% |
| Research | 134 | 8.7% | 46.3% | **59.0%** | 38.1% | 43.3% | 32.1% |

*Note: Respondents may select more than one type of preferred delivery mode for each nominated resource/support.*
*Trainees were able to select 'None', with no nomination of any resources/ support from the list (n= 171, 11.1%).*
*For 'Primary exam' resources (Written and Viva), responses from only provisional trainees were included. The percentages reflect the proportion of 378 provisional trainees.*

Trainees were asked if they had any suggestions for improvement to the current online resources provided by ACEM, with 56 providing feedback. The main theme was to improve resources for exam preparation, including more and updated resources, more past examination examples, providing example answers for past exams, resources to practice the style of examinations (n= 30). Others suggested improvements to the ACEM website including updating the user interface and reorganising the structure for easy access to online resources (n= 22). Several trainees suggested focusing on improving the ACEM Portal (n= 4) and more tailored communications from ACEM (n= 2).

## 3.7 Potential Areas for Advocacy/ Quality Improvement

This is the final section of the report, which presents the findings on three key areas of interest to inform the FACEM Training Program experience, which include access to critical care rotations, telehealth for supervision and education purposes, and support for the research requirement.

### 3.7.1 Access to critical care rotations

Less than three-quarters (72%, n= 1112) of trainees reported that they had previously undertaken a critical care (intensive care or anaesthetics) rotation, with more than half reporting having undertaken the rotation at the hospital where they were currently undertaking their ED placement (52%), and the remaining 48% reporting that they had undertaken a critical care rotation at another hospital. Not surprisingly, a much larger proportion of advanced trainees (85%) than provisional trainees (35%) reported having undertaken a critical care rotation.

Of those who reported having undertaken critical care rotation(s), just under half (49%) reported no wait or less than six months wait to obtain a critical care rotation. However, over one-third (35%) reported waiting for 6-12 months, and a further 16% stated they waited for more than 12 months to get a critical care rotation. For trainees who indicated that they waited six months or more to obtain a critical care rotation at a single hospital (n= 567), 444 (78%) were at sites accredited for 36 months, followed by 75 (13%) at sites accredited for 24 months, and 48 (9%) at sites accredited for 12 months.

*Half of FACEM Trainees who reported previous access to a critical care rotation indicated having to wait six months or more to obtain the rotation.*

### 3.7.2 Telehealth for supervision and education purposes

Trainees were asked if telehealth had been used at any point of their FACEM training for remote supervision while they were working on the floor, with only 9% of trainees (n= 143) reporting so. Comparable proportions of provisional trainees (10%) and advanced trainees (9%) reported telehealth had been used for remote supervision.

A significantly higher proportion (38%, n= 584) of trainees reported that telehealth had been used during their FACEM training for education purposes (for example, undertaking case-based discussions). Advanced trainees (n= 485, 42%) were significantly more likely than provisional trainees (n= 99, 26%) to report that telehealth had been used for education purposes during their FACEM training.

*FACEM trainees were more likely to report telehealth had been used during their FACEM training for education purposes (38%) than for remote supervision (9%).*

Feedback was provided by 121 trainees on their experiences of telehealth for supervision and/or education purposes. Overall, trainees considered their experiences of using telehealth to be positive (n= 83). The positive feedback focused on the convenience and flexibility (e.g., less travel required, didn't miss out on education sessions even during their day-off) of using telehealth, especially for trainees with family commitments. Seventeen trainees reflected on negative experiences using telehealth, which were mainly related to technological issues, or that it was less interactive/engaging, and they preferred face-to-face meetings.

Fifty-four trainees also shared the areas for which telehealth had been used, with half (n= 27) of them stating it has been particularly useful for case-based discussions, followed by WBAs (n= 8) and ITAs (n= 7). Telehealth was also frequently used for teaching and education days. Four trainees commented on using telehealth for remote supervision, either contacting an on-call consultant during night shifts to seek advice or using telehealth for stroke patients.

Several examples of positive comments are presented in the following:

> *Great for reducing risk in a covid-rich environment. Enabling access for staff to education while not on-site.*

*Effective, time-saving, easier to schedule the case-based discussions when able to use teleconferencing.*

*Zoom. Works well, means can do WBAs outside of clinical shop floor time and still have your "off days" without going to work - better for work/life balance.*

### 3.7.3 Support for the research requirement

A fifth (20%, n= 311) of 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 (41%) reporting that they had completed the research requirement, either by coursework (n= 539) or by recognition of previous research and/ or publications (n= 84). A further 603 (39%) trainees indicated they had yet to commence the research requirement.

*FACEM Trainees were less likely to report undertaking research requirements by research project (20%) than by research coursework (35%).*

A small proportion (9%, n= 29) of those who had undertaken or were undertaking the research project indicated they encountered barriers to commencing or completing their research project, with 20 providing further details. The main barriers encountered were financial barriers to undertaking research-related training (n= 10) and time constraints (e.g., workload or limited non-clinical time, n= 9). Other barriers raised included limited guidance for research support, including recognition of prior research experience (n= 4), university-specific training information (course content or structure, n= 2), and difficulty with ethics approval (n= 1).

A further 11 commented on resources ACEM could have provided that would better support trainees in their research projects. Six trainees suggested increasing support and information such as a list of accepted research courses, a video explaining research requirements, and dedicated ACEM staff to advise on the research requirement. Other trainees suggested ACEM develop research modules (n= 3), financial support from ACEM to complete research training (n= 2), and increase the scope of recognition for prior research experience (n= 2).

# 4. Conclusion and Implications

Nearly all trainees agreed that their training needs were being met at their ED placement, consistent with the findings of previous survey iterations. Most trainees reported knowing where to seek help if they experienced difficulties meeting FACEM training requirements or experienced grievances; however, they were less likely to report that assistance mechanisms were adequate. Overall, trainees agreed that their placement provided a safe and supportive training environment, although were less likely to agree that their placement sustains their wellbeing. Trainees were more likely to agree that the rosters at their placement ensured safe working hours and supported the departmental service needs, but were less likely to agree that the rosters were issued on time, provided equitable shifts, or considered required skill mix.

Almost one-third of trainees reported experiencing DBSH from a patient or carer at their ED placement, an increase from 27% in the 2021 Trainee Placement Survey findings. A smaller proportion of trainees (11%) reported experiencing DBSH or other unreasonable behaviour exhibited by ED and/or hospital staff, which was comparable to the findings from the past three years (2021, 10%; 2020, 11%; 2019, 10%). Also consistent with the previous survey findings, in-patient medical staff, ED nursing staff and FACEMs were most frequently reported as the perpetrators of the DBSH behaviours. Monitoring of trainee feedback on DBSH behaviour exhibited by ED staff will continue, and concerns of potential negative workplace culture will be raised with relevant placement sites.

With respect to the supervision and the training experiences at ED placements, most trainees reported they were satisfied with the supervision received from DEMTs and FACEMs. Nearly all trainees agreed that their DEMT had discussed their expectations of the trainee at their stage of training. Consistent with the findings from the previous surveys, areas of training experience that were rated lower than others were the level of informal feedback received and the support for workplace-based assessments.

The majority of trainees (80% and above) reflected positively on the structured education program available at their placement. However, there was a decrease in the proportion of trainees reporting their ED placement provided clinical teaching that optimises learning opportunities (79%, down from 87% in the 2021 Trainee Placement Survey). Nearly all trainees reported participating in simulation learning experiences, and there were also increases in the proportion of trainees who reported the availability of leadership and research opportunities at their placement, compared to the 2021 Trainee Placement Survey.

Trainees expressed that location, casemix and training requirements were the top considerations when choosing an ED placement. The most nominated highlights were supportive senior staff, DEMT and colleagues, and ED casemix. On the contrary, rostering, staffing and workload were areas most commonly described as needing improvement.

Consistent with the previous years, noticeable differences in trainee feedback were identified based on gender. Female trainees were less likely than male trainees to agree 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 adequate supervision and feedback on their performance.

Also remaining consistent, female trainees were more likely than male trainees to report experiencing discrimination, bullying, harassment, sexual harassment and other unreasonable behaviour from patients/carers and from ED or hospital staff. This highlights conscious or unconscious gender bias among some patients, carers and staff. Research investigating gender equity issues at ACEM-accredited EDs and the potential impact on trainee progression and performance will be considered.

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

## 5. Suggest Citation

Australasian College for Emergency Medicine. (2023). *2022 Trainee Placement Survey Report – ED Placement.* ACEM Report: Melbourne.

## 6. Contact for Further Information

Jolene Lim
Manager, Research
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