Australasian College
for Emergency Medicine

Constructing a sustainable emergency department medical workforce

Guidelines G23

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acem.org.au

Document review

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Revision history

Version	Date	Revisions
v1	Jul-2008	Approved by Council
v2	Nov-2015	Approved by the Council of Advocacy, Practice and Partnerships. Complete revision undertaken. Recommended staffing focuses on senior clinical decision-making availability per shift.
v2.1	Nov-2021	Application of new document style and general non-substantive updates.
v3	Nov-2023	Approved by the ACEM Board. Complete revision undertaken. Recommended staffing includes entire ED medical workforce with focus on skill mix.
v3.1	Aug-2024	Minor change to language surrounding ACEM's Associateship training programs. Addition of explanatory note regarding minimum staffing recommendations.

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Acknowledgement of Country

The Australasian College for Emergency Medicine acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our office is located. We pay our respects to ancestors and Elders, past, present, and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

1. Purpose and scope

This document provides a framework for establishing and maintaining a sustainable emergency medicine (EM) workforce for an emergency department (ED). It outlines the considerations health services must make when planning for appropriate, effective, sustainable, and comprehensive ED medical staffing.

This framework applies to all medical practitioners working in EDs in Australia and Aotearoa New Zealand.

Emergency medicine was defined by the International Federation for Emergency Medicine in 1991 as *"A field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development."*[1]

Emergency physicians are an integral part of the healthcare workforce. They provide clinical leadership and quality care for patients requiring emergency treatment, and perform essential teaching, education, research, managerial, strategic planning, and advisory roles. These activities take place in EDs, as well as other clinical and non-clinical settings, at hospital, regional, state, and national levels.

Emergency physicians are experts in emergency medical care and sit at the apex of decision-making pathways within EDs. The medical workforce in EDs also includes emergency medicine trainees, as well as a range of other specialist, non-specialist, and early career doctors.

Directors of Emergency Medicine (DEMs) and health service administrators have a duty to ensure that ED medical staffing allows for the delivery of high-quality patient care. They also have responsibility to ensure that medical practitioners working in EDs experience safe, satisfying, and sustainable careers.

Demand for emergency care is increasing. The total number of patients seeking care in EDs is steadily rising, and the acuity, severity and complexity of their clinical conditions are also escalating. At the same time, government and community expectations regarding quality and timeliness of emergency care have increased. These trends are likely to continue over time, necessitating long-term, strategic planning of the emergency medicine workforce.

ACEM recognises there is wide variation of roles, work practices and models of care between EDs and health systems. There is no single staffing formula that will suit all contexts. When determining the medical staffing profile for an ED, local and contextual factors must be considered.

These guidelines focus on three key factors:

- The level of expertise in emergency medicine that an individual medical practitioner has attained, which must be determined to design a comprehensive staffing profile with appropriate skill mix and balance.
- The minimum numbers of medical practitioners per shift, according to their level of expertise and proportionate to the number of presentations per annum to the ED.
- Contextual factors that must be considered to ensure high-quality patient experience and outcomes in EDs, and to promote wellbeing of the ED medical workforce.

1 International Federation for Emergency Medicine. Charter; Boston, October 1991.

2. Principles

Recommendations are based on two principles:

- All patients treated in an ED should have input into their assessment and management plan from a medical practitioner with high-level expertise in emergency medicine, with emergency physician input optimal.
- A 'consultant-led' ED is used as the staffing model. In a consultant-led ED, the majority of medical staff do not have high-level expertise in emergency medicine. Emergency physicians (consultants) and other medical practitioners with advanced expertise supervise and support medical staff with less training and experience, perform high-level clinical skills and directly oversee care of complex patients.

3. Medical roles in the emergency department workforce

Emergency physician

An emergency physician is a medical practitioner trained and qualified in the specialty of emergency medicine. The recognised qualification of an emergency physician in Australia and Aotearoa New Zealand is Fellowship of the Australasian College for Emergency Medicine (FACEM). Emergency physician (EP) is the preferred term to describe a medical practitioner qualified in the specialty of EM. Other acceptable terms include emergency medicine (or EM) specialist, emergency medicine (or EM) consultant and FACEM. Emergency physician and emergency specialist are titles protected by law in Australia and Aotearoa New Zealand.

Paediatric emergency physician

A paediatric emergency physician is a medical practitioner trained and qualified in the sub-speciality of paediatric emergency medicine (PEM). Recognised qualifications of a paediatric emergency physician in Australia and Aotearoa New Zealand are Fellowship of the Australasian College for Emergency Medicine (FACEM) and/or Fellowship of the Royal Australasian College of Physicians (FRACP).

Emergency medicine trainee

An emergency medicine trainee is a medical practitioner undertaking the specialist training program in emergency medicine delivered by ACEM, that, if successfully completed, leads to the qualification of FACEM and registration as an emergency physician. They are also referred to as FACEM trainees.

Other specialist medical practitioners

General practitioners, Rural Generalists, Rural Hospitalists and Urgent Care Specialists are an important part of the ED workforce, especially in regional, rural, and remote locations. They often hold high-level clinical and management roles in smaller EDs. Other medical specialists might work in EDs when their specific expertise is required, depending on locally implemented interdisciplinary models of care.

Non-specialist medical practitioners

Doctors who do not have specialist qualifications, and who do not intend to undertake specialist training, are an important part of the ED workforce. Job titles vary across health services and include Career Medical Officer and Medical Officer of Specialist Standard. They have a broad range of expertise in emergency medicine. Doctors working in registrar-level positions that are not accredited by colleges for specialist training also contribute to the ED workforce.

Junior medical officers

Junior medical officers (JMOs) are doctors in the early phase of their career (usually PGY2-3) who work under supervision from more experienced medical practitioners. They usually rotate between clinical services, including EDs. Job titles vary across health services and include Resident Medical Officer (RMO), Senior Medical Resident Officer (SRMO), and Hospital Medical Officer (HMO).

Interns

Interns are doctors in their first year of clinical practice who have conditional medical registration and must always work under direct supervision from more experienced medical practitioners. In EDs, they are considered supernumerary for staffing purposes. They are called House Officers in some health services.

For further information: G19 *Guidelines on the Role of Interns in the Emergency Department*

4. Assessing expertise in emergency medicine

Medical practitioners with a broad range of skills and experience participate in the ED workforce. ACEM recommends that skill mix is the key factor used when designing a medical staffing profile for an ED. Levels of expertise must be carefully balanced on each shift to ensure that supervision is effective and sustainable, and to achieve delivery of high-quality patient care.

For further information: P18 *Policy on Responsibility for Care in Emergency Departments*

The tables provided in this section outline four levels of expertise in emergency medicine: expert, advanced, intermediate, and basic. For each level, a range of skills are described, to allow Directors of Emergency Medicine and others involved in medical recruitment and rostering to determine the appropriate level of expertise possessed by an individual doctor, and the degree of supervision and support they will require in the ED workplace. Interns, who are yet to develop significant expertise in emergency medicine, work at introductory level in EDs and require support from more experienced doctors for all patient care activities.

Expertise should be assessed across two domains: clinical assessment and treatment skills, and communication and leadership skills. Competence across both these domains is integral to delivery of safe, effective, and person-centred emergency care.

Leadership is a critical skill that directly impacts team performance and patient care and is often challenging in the dynamic and high-pressure environment of the ED. Leadership involves setting priorities, directing the work of the multidisciplinary team within the ED, and effective communication with patients, their carers, and other healthcare teams.

Table 4.1: Clinical assessment and treatment skills

<table>
<tr><th>Level of expertise</th><th>Expert</th><th>Advanced</th><th>Intermediate</th><th>Basic</th></tr>
<tr><td>Critical illness
Resuscitation
Major Trauma</td><td rowspan="3">Can do all</td><td rowspan="2">Independent with expert support as required</td><td>With expert/advanced support</td><td>Part of team</td></tr>
<tr><td>Complex assessment/ treatment</td><td>Independent with expert/advanced support as required</td><td>With expert/advanced support</td></tr>
<tr><td>Non-complex assessment/ treatment</td><td>Can do all</td><td>Can do most</td><td>With support</td></tr>
</table>

Table 4.2: Communication and leadership skills

Level of expertise	Expert	Advanced	Intermediate	Basic
Whole of ED coordination	Can do all	Independent with expert support as required	Must not perform	Must not perform
Clinical supervision of doctors with less expertise*			With expert/advanced support	
Complex patient/carer communication		Can do all		With expert/advanced support
Consults, referrals, transfers			Can do most	With support
Non-complex patient/carer communication				

*FACEM trainees must only be supervised by FACEMs for formal training purposes

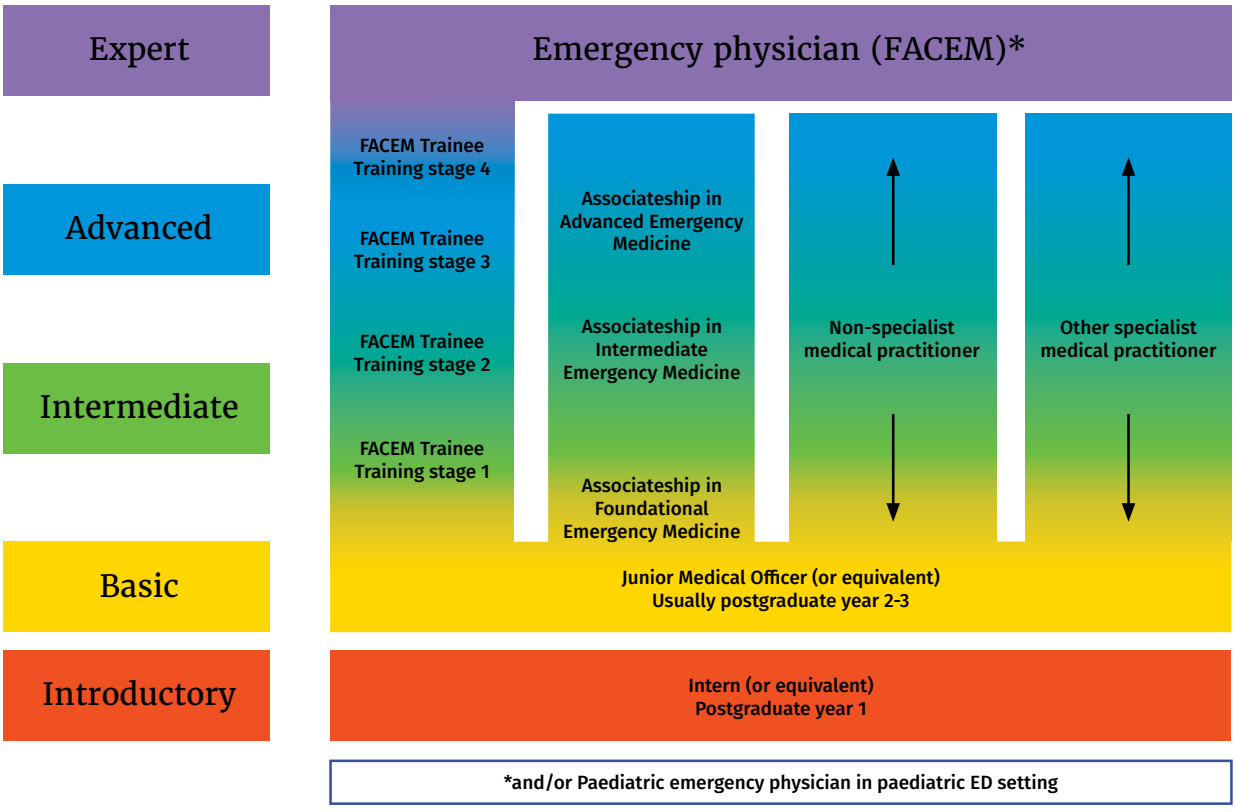
5. Progression of expertise in emergency medicine

Doctors who hold similar job titles or qualifications, or who have similar years of postgraduate clinical experience, might have quite different emergency medicine skills in practice. For this reason, it is imperative that the skills outlined in Tables 4.1 and 4.2 are used to assess the appropriate level of expertise at which an individual doctor can safely work within an ED medical team.

Figure 5.1 illustrates how expertise in emergency medicine progresses and develops according to level of training, experience and career stage across the main groups who comprise the emergency medicine workforce.

ACEM delivers non-specialist training programs that support doctors to develop their emergency medicine expertise. Three programs are available which align with stage of career progression and indicate level of competence with emergency medicine skills and practice.

Figure 5.1: Progression of expertise in emergency medicine



Explanatory note: *Associateships in Emergency Medicine were formerly known as the Advanced Diploma, Diploma and Certificate in Emergency Medicine.*

6. Medical staffing recommendations for emergency departments

These recommendations provide the minimum number of medical practitioners to be rostered for each clinical shift, according to their level of emergency medicine expertise, and proportionate to the number of presentations per annum to the ED. These recommendations apply seven days per week, including public holidays. They have been developed using modelling based on data collected from EDs accredited by ACEM for training via the Annual Site Census survey.

EDs in Australia and Aotearoa New Zealand generally operate three core clinical shifts: day, evening and night. The exact length and timing of shifts varies between hospitals and health services. The majority of patient presentations occur between 8am and midnight.[2] ACEM recommends that an emergency physician is present on day and evening shifts to align with times of greatest patient demand. When insufficient workforce is available to meet minimum numbers provided in these guidelines ACEM recommends that doctors with a higher level of expertise are recruited to cover vacancies.

These recommendations apply to EDs with presentations of 20,000 or more per annum. Because case mix, clinical models, and staffing profiles for smaller EDs are highly variable, workforce models must be locally designed to best meet community and health service needs.

Numbers provided in these tables do not include doctors who are not available to provide direct clinical care, for example because they are undertaking clinical support activities, or attending courses or meetings.

Table 6.1: Minimum medical staffing for EDs – day shift

Level of expertise	Expert (FACEM)		Advanced	Intermediate	Basic	Total
Presentations per annum	Present	On-call	Present	Present	Present	Present
Up to 20,000	1	0	1	2	1	5
20,000 – 30,000	2	0	2	2	1	7
30,000 – 40,000	2	0	2	2	2	8
40,000 – 50,000	3	0	2	3	2	10
50.000 – 65,000	4	0	3	3	3	13
65,000 – 80,000	5	0	3	4	4	16
80,000 – 95,000	6	0	4	5	4	19
95,000 – 110,000	7	0	4	5	5	21
110,000 plus	8	0	5	6	5	24

Table 6.2: Minimum medical staffing for EDs – evening shift

Level of expertise	Expert (FACEM)		Advanced	Intermediate	Basic	Total
Presentations per annum	Present	On-call	Present	Present	Present	Present
Up to 20,000	1	0	1	2	1	5
20,000 – 30,000	2	0	2	2	1	7
30,000 – 40,000	2	0	2	2	2	8
40,000 – 50,000	3	0	2	3	2	10
50.000 – 65,000	4	0	3	3	3	13
65,000 – 80,000	5	0	3	4	4	16
80,000 – 95,000	6	0	4	5	4	19
95,000 – 110,000	7	0	4	5	5	21
110,000 plus	8	0	5	6	5	24

2 Australian Institute of Health and Welfare. Emergency Department Care. Australian Government; 2023.

Table 6.3: Minimum medical staffing for EDs – night shift

Level of expertise	Expert (FACEM)		Advanced	Intermediate	Basic	Total
Presentations per annum	Present	On-call	Present	Present	Present	Present
Up to 20,000	0	0	1	2	1	4
20,000 – 30,000	0	1	1	2	1	4
30,000 – 40,000	0	1	1	2	1	4
40,000 – 50,000	0	1	2	2	1	5
50.000 – 65,000	0	1	2	2	2	6
65,000 – 80,000	0	1	3	3	2	8
80,000 – 95,000	0	1	4	3	3	10
95,000 – 110,000	0	1	4	4	4	12
110,000 plus	0	2	5	5	4	14

Explanatory note: *These tables were derived using workforce data collected in the annual site census survey of ACEM accredited EDs. Recommended numbers were based on actual staffing levels of EDs reporting within the top quartile of the 2022 ACEM training site census survey. Numbers in these tables will be revised when casemix and operating conditions in EDs across Australia and Aotearoa New Zealand are subject to significant change.*

7. Supervision, training and mentoring in emergency departments

EDs are excellent environments for clinical learning and professional development.

Emergency physicians routinely provide clinical supervision and teaching to large numbers of less experienced practitioners, including emergency medicine trainees, other doctors-in-training, junior medical officers, interns, medical students, as well as trainees and students of other health professions. When higher numbers of intermediate, basic, or introductory level doctors are rostered to each shift than specified in section 6, or when other supervisory responsibilities are required, including for medical practitioners who are impaired or have conditions on their registration, then additional emergency physicians must be rostered to ensure appropriate levels of supervision can be provided without disruption to clinical care.

For further information: P53 *Policy on the Supervision of Junior Medical Staff in the Emergency Department*

Supervision requirements are increased when EDs have modular designs with clinical teams working in physically separate 'pods.' When this is the case then additional emergency physicians are required on each shift to ensure adequate supervision is available in each clinical area.

For further information: G15 *Emergency Department Design Guidelines*

ACEM training site accreditation requirements specify minimum emergency physician staffing levels required to deliver emergency medicine training, with the ratio of trainees to FACEM to be no greater than three to one. Training site accreditation requirements differ from staffing numbers provided in these guidelines, which relate to clinical service delivery by a comprehensive emergency medicine workforce. FACEMs are the only doctors authorised to act as supervisors of FACEM trainees for formal training purposes.

For further information: AC549 *Accreditation Requirements*

Emergency physicians act as mentors to less experienced medical staff and other healthcare workers inside EDs and across the broader health system. ACEM is committed to embedding a culture of mentoring in emergency medicine and EDs.

8. Clinical support roles and activities

The emergency physician role includes both clinical and clinical support components. Emergency physicians must be allocated sufficient time to facilitate clinical support activities, including, but not limited to, self-education and professional development, teaching, mentoring, research, quality improvement, planning, policy, and representation on hospital and College committees. Clinical support activities are critical to the function of an ED but their value may be under-appreciated as the work performed is often less visible than direct clinical work.

For further information: *S17 Statement on Clinical Support Time Allocation*

Continuous improvements in quality and safety are fundamental to emergency medicine practice and require allocation of clinical support time and resources. The ACEM Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services and the associated toolkit provide detailed guidance about quality and safety criteria and activities.

For further information: *Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services*

Clinical support activities are compulsory for emergency medicine trainees in Training Stage 4 to assist their transition to specialist practice.

9. Research

Delivery of high-quality care is dependent on engagement with research. All emergency medicine practitioners should have opportunities to be involved in research activities and should be provided with adequate time and administrative support to facilitate their participation. Directors of Emergency Medicine Research should be allocated additional clinical support time to fulfil that role. Emergency physicians should contribute to research investigating clinical assessment and treatment, service delivery and health system design.

10. Emergency department short stay units

Emergency department short stay units (EDSSUs) are designed and designated for the short-term treatment, observation, assessment, and reassessment of patients following triage and assessment in ED. As operational models for EDSSUs are highly variable, specific staffing needs for EDSSUs should be considered separately from those of the main ED. Additional medical staff to the minimum numbers provided in section 6 should be rostered if the ED is supporting an EDSSU.

For further information: G554 *Guidelines on Emergency Department Short Stay Units*

11. Patient groups with special or additional needs

Staffing recommendations in these guidelines have been modelled based on the needs of a mixed and/or adult general hospital. Modifications will be required for EDs that serve high numbers of patients with special or additional needs. For example, paediatric patients tend to present at highest numbers in the afternoon and early evening. Frail, elderly patients tend to require more complex care and have longer length-of-stay in EDs. Patients experiencing psychological distress or intoxication will require higher levels of clinical oversight.

12. Support for extra services and non-emergency teams

EDs that provide support for non-ED teams, for example medical emergency calls, ward-based care or supervision of ward-based doctors, or extra services, for example telehealth or virtual care, inter-hospital transfers, hospital-in-the-home, or specialist short stay models of care such as behavioural assessment units, will need additional staffing which is specifically designed to meet the needs of those models, in addition to the recommendations made in these guidelines.

For further information: P07 *Policy on Clinical Privileges for Emergency Physicians*

13. Impacts of access block and emergency department overcrowding

Access block, which is the situation where patients who have been assessed in the ED and require admission to a hospital bed are delayed from leaving the emergency department for more than eight hours due to lack of inpatient bed capacity, is the most significant cause of overcrowding and preventable patient harm in EDs.

For further information: S57 *Statement on Emergency Department Overcrowding*

When an ED is experiencing access block, ED medical staff have extra workload from providing care to admitted patients, there are delays to seeing new patients who present to the ED due to lack of available space and staff, and processes become slow and inefficient. When access block is experienced on a regular basis, additional staff to those recommended in these guidelines must be rostered.

For further information: S127 *Statement on Access Block*

14. Sustainability of the emergency medicine workforce

The emergency physician role is changing, especially the growing expectations regarding whole-of-department coordination and management, driving patient flow, and delivering increasingly high standards of patient care. Maintaining expertise, competence and focus when practising a high standard of emergency medicine requires significant time and resources. Changing demographics in Australia and Aotearoa New Zealand, and shifting societal attitudes to work, are impacting on recruitment, retention, and sustainability of the emergency medicine workforce.

Flexibility in work is a key area of concern for most healthcare workers, including emergency physicians. ACEM predicts that significant changes to work practices will continue over coming years and notes the following trends. Emergency physicians are diversifying their careers to include portfolios such as education, research and management. Changed models of emergency care, with a shift from current consultant-led staffing profiles to increasingly consultant-run EDs, where emergency physicians and other senior decision makers comprise the majority of the medical workforce and perform primary clinical assessment of most patients with support from smaller numbers of less experienced medical staff, are also likely to occur.

ACEM is actively engaged in investigating, planning, and advocating for improved models of care and more effective work practices in emergency medicine.

15. Sustainable rostering in emergency departments

Shift work is usual in emergency medicine practice. This creates antisocial working hours and disruption to diurnal patterns and should be compensated appropriately. The impacts of fatigue on performance, as well as decreasing tolerance of shift work with age, must be considered when designing ED rosters, with adequate recovery time to be scheduled after evening and night shifts.

Total medical recruitment in EDs must allow for sustainable rostering, as well as access to adequate amounts of clinical support time, allocation of annual and personal leave, cover for unplanned leave, additional workforce needs during periods of surge demand, and continuing professional development requirements of emergency physicians, emergency medicine trainees and other doctors participating in the emergency medicine workforce.

ACEM recommends that emergency physicians work no more than:

- Twenty weekend shifts per year. This should be pro rata (per FTE) and exclude periods of annual, personal, and other leave.
- These weekend shifts may be full weekends (two shifts per weekend per month) or split weekends (one weekend shift per fortnight) depending on individual emergency physician preferences and local ED roster design.
- A maximum of one evening shift in four shifts. This should be pro rata and exclude periods of annual, personal, and other leave.

These recommendations should only be varied with explicit consent of individual emergency physicians. Emergency physicians in the later stages of their career should be supported to undertake less after-hours clinical work when that aligns with their wishes and plans.

16. Workplace wellbeing

Emergency physicians must work in equitable and supportive workplaces. Safe, clean, and appropriately equipped environments are essential for the medical workforce to function effectively, including adequate office space, places for learning and relaxation, and up-to-date information and communication technology.

Workplace wellbeing is critical to constructing a sustainable and effective emergency medicine workforce. Prioritising staff wellbeing has a profound impact on the individuals working in EDs and the quality of care they deliver to patients. Wellbeing indicators should be monitored and addressed through initiatives aimed at enhancing individual and team wellbeing, as well as system-level improvements that allow staff to experience professional satisfaction through meeting patient care needs, such as adequate recruitment, effective leadership and management, access to clinical support, education and training.

17. Cultural safety

Health outcomes for Indigenous peoples seeking and receiving emergency care are inextricably linked to cultural safety. ACEM strives to improve patient, carer, and clinician experiences in EDs for Aboriginal and Torres Strait Islander peoples and Māori through a range of initiatives to promote cultural safety in EDs, close the health gap, and grow and support the Indigenous emergency medicine workforce.

18. Diversity, inclusion and belonging

ACEM recognises that the emergency medicine workforce must reflect the communities it serves. It is important that doctors have access to ED workplaces that are psychologically safe, free of racism and discrimination, and where they are not subject to bullying or sexual harassment. Experiences of unacceptable behaviours in EDs are widespread, have negative impacts on clinical performance and patient care, and contribute to emergency physician and trainee stress, burn-out and mental ill-health. ACEM is committed to improving diversity, inclusion and belonging at the College, and in ED workplaces, as well as upholding the ACEM Core Values of respect, integrity, collaboration, and equity.

19. Casualisation of the emergency medicine workforce

Increasing casualisation of the emergency medicine workforce has occurred over the last two decades, including rising use of locums to fill long-term positions. Many emergency physicians are employed in small-fraction, casual or locum roles across multiple workplaces, not by choice, but to achieve full-time equivalence because there are no permanent or full-time positions available at their preferred primary workplace. Excessive use of casual workforce models can disrupt clinical teamwork and make it difficult for doctors to achieve a sense of belonging and inclusion in an ED workplace.

20. Improving distribution of the emergency medicine workforce

All people in Australia and Aotearoa New Zealand have the right to timely, safe, and affordable emergency care. ACEM is committed to advocating for improved service planning to improve equity in health experiences and outcomes for people living in regional, rural, and remote locations.

For further information: S27 *Statement on Rural Emergency Care*

The College is exploring strategies to address maldistribution of the specialist emergency medicine workforce.[3] ACEM supports non-FACEM practitioners who work in EDs through the Emergency Medicine Education and Training (EMET) Program, non-specialist training pathways in emergency medicine, and by participation in the ACEM continuing professional development program, courses and events.

3 Australasian College for Emergency Medicine. Workforce Planning Strategy. Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Sustaining-our-workforce/Workforce-Planning-Strategy

21. Working in collaboration with other healthcare workers

In EDs, multidisciplinary teams of healthcare professionals work closely together to deliver safe, effective, and person-centred clinical care.

The ED medical workforce must be planned in the context of broader healthcare staffing considerations, including availability and skill mix of nursing, allied health, clerical, technical and housekeeping staff. Medical practitioners working in EDs cannot fulfil their roles effectively and work to their full scope of practice unless they are appropriately complemented and supported by adequate numbers of other healthcare workers.

Extended scope practitioners are health practitioners who receive additional training to perform clinical tasks traditionally associated with another profession. In an ED setting, this may include investigation ordering, investigation interpretation, diagnosis, procedures, prescribing and patient discharge. Extended scope practitioners work with appropriate clinical autonomy within their defined and agreed scope of practice and provide essential care within the ED collaborative model of care, which is led by the in-charge emergency physician or their delegate.

For further information: P67 *Policy on Extended Role of Nursing and Allied Health Practitioners Working in Emergency Departments*

These guidelines do not apply to non-medical roles in the ED workforce, including extended scope practitioners. Non-medical healthcare workers should not be directly substituted for medical practitioners to meet medical staffing recommendations provided in these guidelines.

22. Associated documents

Internal:

All internal standards and advocacy documents can be found in the ACEM Standards and Advocacy Library.

- AC549 Accreditation Requirements
- G15 Emergency Department Design Guidelines
- G19 Guidelines on the Role of Interns in the Emergency Department
- G554 Guidelines on Emergency Department Short Stay Units
- P07 Policy on Clinical Privileges for Emergency Physicians
- P18 Policy on Responsibility for Care in Emergency Departments
- P53 Policy on the Supervision of Junior Medical Staff in the Emergency Department
- P67 Policy on Extended Role of Nursing and Allied Health Practitioners Working in Emergency Departments
- Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services
- S17 Statement on Clinical Support Time Allocation
- S27 Statement on Rural Emergency Care
- S57 Statement on Emergency Department Overcrowding
- S127 Statement on Access Block

External:

- Australian Medical Association National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors
- Australian Government – The National Medical Workforce Strategy 2021-2031
- Te Whatu Ora Health New Zealand – Health Workforce Plan 2023/24

23. Disclaimer

The *Guidelines for Constructing a Sustainable Emergency Department Medical Workforce* (G23 Guidelines) have been developed to assist Directors of Emergency Medicine and health service administrators with managing medical workforce in EDs.

The G23 Guidelines are a general document and outline a range of factors to be considered which apply at the time of their endorsement. It is the responsibility of the user to implement these guidelines with express regard to the circumstances, including variations based on locality and facility type, which apply to the ED they manage.

The Australasian College for Emergency Medicine accepts no responsibility for any inaccuracies, information perceived as misleading, or the success or failure of any process detailed. The inclusion of references to external websites does not constitute an endorsement of those organisations nor the information or services offered.

The G23 Guidelines have been prepared based on information available at the time of preparation. The user should therefore consider information, research or other material which may have become available subsequent to publication of these guidelines.

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