Australasian College
for Emergency Medicine

Supervision of junior medical staff in the emergency department

Policy P53

v3.0 December 2019
acem.org.au

Document review

Timeframe for review:	Every three years, or earlier if required.
Document authorisation:	Council of Advocacy, Practice and Partnerships
Document implementation:	Council of Advocacy, Practice and Partnerships
Document maintenance:	Department of Policy and Strategic Partnerships

Revision history

Version	Date	Pages revised / Brief explanation of revision
1.0	Nov 2008	First version
2.0	Nov 2013	Second version
3.0	Dec 2019	Minor modification and new template adopted

1. Purpose and scope

This policy relates to the supervision requirements for junior medical staff in the Emergency Department (ED).

The policy is applicable to emergency departments in Australia and New Zealand.

2. Definition

Junior Medical Officer (JMO)

For the purposes of this Policy, and in recognition of the different terminology used across jurisdictions, a junior medical officer (JMO) is defined as a registered medical practitioner who is in their first or second postgraduate year. This stage of the medical education continuum is referred to as prevocational training. The term 'intern' applies exclusively to doctors in postgraduate year one.

3. Position

The prevocational years represent an important transition period from basic to specialist medical education. To ensure adequate experience in generalist medicine, junior doctors must be exposed to a wide spectrum of acute and undifferentiated illness. This is best obtained by a period of training in emergency medicine (EM).

The complex nature of emergency medical care means that junior doctors need extensive support and oversight to function safely and efficiently in the ED. This includes comprehensive orientation, structured teaching and effective supervision. These components are also essential for a robust educational experience.

Demand for JMO ED terms has increased significantly as a result of the substantial rise in medical graduate numbers. The availability of senior decision makers[1] to provide effective supervision represents a major constraint in expanding capacity. Support and training for ED supervisors is therefore critical to growing both the EM and broader medical workforce.

The parallel objectives of high quality care and training mean that EDs must be adequately resourced to provide effective supervision. Staffing arrangements should be sufficient to allow early senior decision maker involvement in the assessment and management of patients by JMOs.

In the case of interns, the roster profile should ensure that a senior decision maker with experience in EM is available to provide direct supervision, on a case-by-case basis, at all hours of the day. There should be capacity for oversight of procedures, interpretation of tests (including x-rays) and clinical decision-making (in relation to both treatment and disposition). Interns should be considered supernumerary for staffing purposes.

In the case of JMOs in their second postgraduate year, a graduated approach to supervision is encouraged. The depth and proximity of oversight should be tailored to individual skills, knowledge and experience, thereby allowing junior doctors to safely and progressively increase their responsibility for providing timely and effective patient care.

In order to ensure safe, high-quality and efficient emergency care, it is essential that EDs are equipped to provide appropriate supervision for all junior medical staff. This is also in the in the interests of a positive training experience for JMOs, and the development of a highly skilled medical workforce. Where there is a conflict between these two goals, patient care should take precedence.

1. As defined by G23 *Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce*. ACEM, Melbourne.

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