Australasian College
for Emergency Medicine

2025 DEMT Survey
Report

August 2025

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2025 DEMT Survey

Key findings

The Director of Emergency Medicine Training (DEMT) Survey is administered biennially to gather insights into how ACEM can better support DEMTs in their roles. The survey also seeks feedback on how the training sites provide an appropriate and safe training environment for FACEM trainees. In 2025, the survey received responses from 258 DEMTs, representing 139 (93%) of 150 ACEM-accredited emergency departments. Key findings from their feedback are summarised below.

92%

agreed that their **DEMT role was rewarding**

Support for DEMTs

79% agreed that their ED had a **governance structure** supporting their DEMT role in managing the FACEM Training Program.

78% agreed their ED roster ensured them **sufficient time** to complete the clinical support requirements of the role.

78% agreed that they were well supported by **ACEM processes** to manage trainees in difficulty.

DEMT supervision and teaching

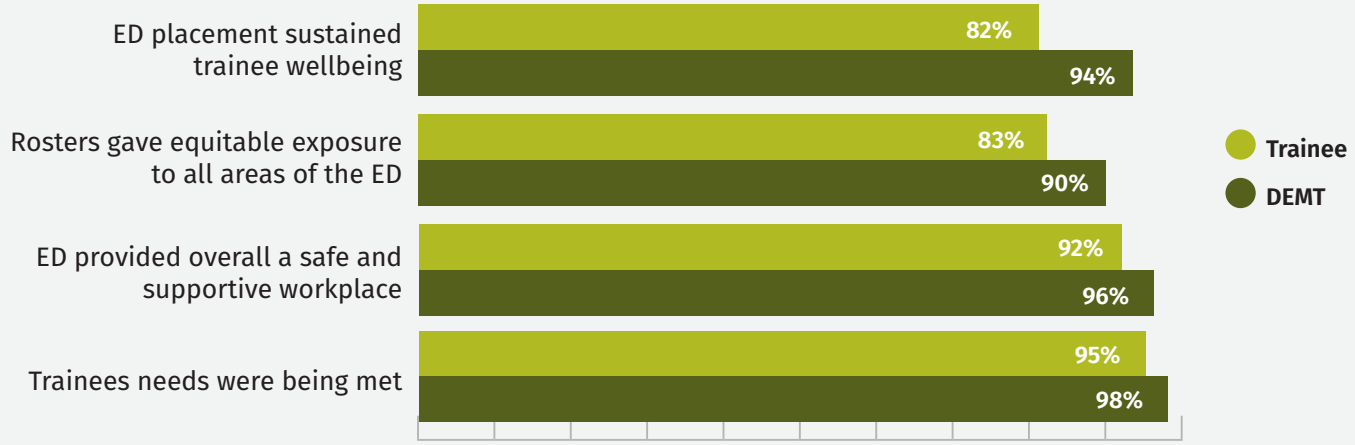
78% agreed that they were routinely rostered on **clinical shifts** with trainees.

70% agreed that they had regular **non-clinical shifts** with trainees.

93% agreed that their ED provided **educational and learning resources** that met the needs of trainees at all stages and phases of their training.

DEMT vs. FACEM trainee responses

Feedback from the DEMT Survey was compared with the Annual Trainee ED Placement 2024 Survey on key aspects of the FACEM trainee experience.



For the full survey findings, please refer to: Australasian College for Emergency Medicine (2025), *2025 DEMT Survey ACEM Report*, Melbourne.

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1. Executive Summary

The Director of Emergency Medicine Training (DEMT) Survey is a biennial survey to identify areas where ACEM can better support DEMTs in their role and to seek their perspectives on how their site provides an appropriate and safe training environment for FACEM trainees. Findings from the 2025 DEMT Survey for the 258 responding DEMTs (representing 139 of 150 ACEM-accredited emergency departments) are summarised in the following:

Support for Role as a DEMT

- Most DEMTs agreed their role was rewarding and they were able to complete all requirements of their DEMT role (92% and 90%, respectively).
- 78% agreed their ED roster ensured sufficient time for them to complete the clinical requirements of their DEMT role.
- 79% agreed that their ED had a governance structure supporting their role in managing the training program.
- A significantly larger proportion (95%) agreed that their DEM(s) worked cooperatively with them in their role when compared with the Hospital Executive (50%) and hospital human resources and administration (58%).
- Similar proportions of DEMTs were in agreeance that they were well-supported in managing trainees in difficulty by ACEM processes (78%) and ACEM Regional Censors (80%).
- Resources and support related to supporting trainees in difficulty (55%), College processes (48%), and the Fellowship Exam (40%) were the three most nominated areas of need/ interest by DEMTs.

Supervision and Trainee Educational Opportunities

- 78% of DEMTs agreed that they were routinely rostered on clinical shifts with trainees (twice per week), compared with 70% agreeing that they had regular non-clinical shifts with trainees (once per week).
- 93% agreed that their ED provided educational and learning resources that met the needs of trainees at all stages and phases of their training.
- 85% agreed they were satisfied with the support they received from their Local Workplace-Based Assessment (WBA) Coordinator.
- Nearly all DEMTs agreed that the structured education program at their site was aligned with the content and learning outcomes of the ACEM Curriculum Framework (95%), and was provided for a minimum of 4 hours per week on average (98%).
- Most DEMTs were in agreeance that the casemix at their site provided an appropriate training experience regarding the number (>99%), breadth (98%), acuity (97%), and complexity (99%) of cases.

Health, Welfare and Interests of Trainees

- Almost all DEMTs (98%) agreed that trainee needs were being met according to their respective stage and phase of training at their ED.
- DEMTs were in agreeance that their ED provided a safe and supportive workplace overall (96%), and for support processes (97%), clinical protocols (95%), supervision arrangements (97%), and cultural safety practices (95%).
- Nearly all DEMTs agreed that there were adequate processes in place for identifying and assisting trainees experiencing difficulties in progressing through their training and managing trainee grievances at their ED (97% and 95%, respectively).
- Most DEMTs agreed that rosters at their ED considered trainee workload (95%) and ensured safe working hours (98%); however, they were less likely to agree that rosters considered the skill mix required for the department (88%), provided trainees equitable shifts to all ED areas (93%), or were provided in a timely manner (90%).
- 90% of DEMTs agreed that trainees could participate in quality improvement activities at their ED, whereas 84% agreed that trainees could participate in decision-making regarding governance.

2. Purpose and Scope of Report

The Director of Emergency Medicine Training (DEMT) Survey is a biennial survey seeking feedback on the experiences of DEMTs in their role at Emergency Departments (EDs) accredited by the Australasian College for Emergency Medicine (ACEM). The key purpose of the survey is to understand how supported DEMTs are at their hospital and to identify areas of support and resources they need from the College. The survey also seeks DEMT perspectives on how their ED supports Fellowship of Australasian College for Emergency Medicine (FACEM) trainees, focusing on supervision and educational opportunities and various aspects related to trainee health, welfare and interests. This report details the findings from the 2025 DEMT Survey.

3. Methodology

The DEMT Survey was distributed to all 385 DEMTs in 150 ACEM- accredited EDs across Australia and Aotearoa New Zealand at the end of February 2025. DEMTs were invited via email to participate in the online survey hosted on Jotform. The survey was promoted on the DEMT Forum, and two reminder emails were sent to non-responding DEMTs, encouraging them to participate before the survey closed on 6 April 2025.

Participation in the DEMT survey was voluntary, and completion of the survey was considered implied consent. All information collected was treated confidentially, with data reported in aggregate as a percentage of total responses by accreditation type, which can be classified into Tier 1 (EDs accredited for 36 months), Tier 2 (EDs accredited for 24 months), Tier 3 (EDs accredited for 12 months), Paediatric EDs and Private EDs. Comparisons based on ED role delineation (Major Referral vs. Non-Major Referral) were included where relevant.

4. Results

There were 258 survey submissions received from 385 invited DEMTs, a survey response rate of 67%. Six (2%) responding DEMTs who were working in the role at two EDs completed the survey for each ED.

A total of 139 (93%) of the 150 ACEM-accredited EDs at the time of the survey were represented by the 258 survey responses. Table 1 shows the number and proportion of ACEM-accredited sites represented by responding DEMTs, by ED accreditation type and ED role delineation.

Table 1. Number and percentage of sites represented by responding DEMTs compared with total ACEM-accredited sites, by ED accreditation type and role delineation

ACEM accredited EDs	Total ACEM-accredited EDs represented by all DEMTs	Responding DEMTs	
		Number (%) of represented EDs	Number of respondents
ED accreditation type			
Tier 1	68	66 (97.1%)	134
Tier 2	44	33 (75.0%)	71
Tier 3	20	16 (80.0%)	21
Paediatric*	18	16 (88.9%)	23
Private	11	8 (72.7%)	9
ED role delineation			
Major Referral	35	34 (97.1%)	74
Non-Major Referral	97	81 (83.5%)	152
Paediatric*	18	16 (88.9%)	23
Private	11	8 (72.7%)	9

*Note: * Eleven of 18 paediatric accredited training sites were non-specialist paediatric sites that were also dual-accredited (both adults and paediatric) sites*

Of all survey respondents, 52% (n= 134) were from Tier 1 accredited sites, 28% (n= 71) from Tier 2 sites, 8% (n= 21) from Tier 3 sites, 9% (n= 23) from Paediatric sites, and 3% (n= 9) from Private sites. A significantly higher proportion of responding DEMTs were at Non-Major Referral EDs (59%, n= 152) compared with Major Referral EDs (29%, n= 74), with the remaining working in Children's and Private sites (12%, n= 32).

4.1 DEMT Role and Engagement

Over three-quarters (77%, n= 199) of responding DEMTs reported working at their current ED for over five years, with nearly half (48%, n= 95) of these DEMTs working in their ED for over ten years. A smaller proportion (18%, n= 25) reported working at their current ED between two and five years, and 5% (n= 12) reported working for less than two years.

When asked how long they had been in the DEMT role for, a slightly higher proportion (37%, n= 96) reported being in the role for less than two years, compared with 33% (n= 84) for two to five years, and 30% (n= 78) for more than five years.

DEMTs were asked to provide their full-time equivalent (FTE) allocation for the DEMT role, with the majority (87%, n= 224) reporting between 0.5 – 1.0 FTE being allocated to the role, while a smaller proportion (13%, n= 34) reported less than 0.5 FTE. Regardless, nearly all DEMTs (98%, n= 252) reported being rostered on for at least one clinical shift per week at their department.

Less than half of respondents (43%, n= 110) reported that they held other roles in addition to their role as a DEMT. Of these, the majority reported being a Supervisor of the ACEM Associateship Training Program (n= 40). Other frequently reported roles included Clinical lead in ultrasound (n= 13), DEM or Deputy DEM (n= 10), followed by Mentoring Coordinator (n= 6). Several other DEMTs also reported holding additional roles such as the Local Workplace-Based Assessment (WBA) Coordinator, clinical lead in various areas, and coordinator for education and teaching programs.

4.1.1 Sharing of DEMT role

Sharing the DEMT role was common, with 89% (n= 229) of respondents reporting that they were co-DEMTs in their ED.

Different models were employed for responsibility delegation among co-DEMTs. Trainee teaching was significantly more likely to be a shared responsibility (76%) among co-DEMTs rather than being allocated to individual co-DEMTs (24%). Other models of trainee teaching included teaching delegation based on scheduled education sessions, teaching coordinated at a network level, or a shared teaching responsibility among senior medical staff in the department rather than being solely the DEMT's role. In contrast, trainee allocation to individual co-DEMTs (66%) was a more common model for the completion of in-training assessments (ITAs) than co-DEMTs sharing this responsibility (28%), with the remainder (6%) reporting having a hybrid model.

4.1.2 DEMT workshops

Most DEMTs (86%, n= 221) reported having attended a DEMT orientation workshop, with the rest reporting they had not attended one (14%, n= 35). Of those who had not attended a workshop, 13 DEMTs indicated having registered to attend a workshop in the future. Twelve reported they had not attended a workshop due to limited availability, while six DEMTs were unable to attend due to their work rostering. Two other DEMTs reported natural disasters impacting their ability to travel for the scheduled workshop, while the remaining DEMTs cited various reasons, including location challenges, uncertainty about how to access the workshops, or having only recently been appointed to the DEMT role.

DEMTs were asked to suggest topics they would like to see covered in future workshops, with 124 providing a response. The proposed topics included:

- Managing trainees in difficulty (n= 47)
- Providing effective trainee feedback (n= 33)
- Management and leadership skills (including guidance on performance reviews, motivating trainees, mentorship training, etc.) (n= 20)
- Organising teaching and education programs (including set-up tips and ensuring consistency across networked sites) (n= 19)
- Introduction of ACEM resources (including teaching resources, wellbeing resources, navigation of ACEM website) (n= 18)
- Regular updates on changes to the FACEM Training Program, including information on revised curriculum, transitioning trainees to revised program, requirements at different training stages (n= 17)
- Guidance on ITAs and WBAs (requirements, marking calibration, constructive reporting, etc.) (n= 16)
- Preparing trainees for exams (exam format updates, exam processes, more guided resources, and tips on providing exam feedback) (n= 15)
- Supporting neurodivergent FACEM trainees (n= 9)
- Managing trainees on Specialist International Medical Graduate (SIMG) pathway (n= 3)

4.2 Support for Role as a DEMT

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

4.2.1 Requirements of the DEMT role

Overall, most (92%, n= 238) responding DEMTs strongly agreed or agreed that their role as a DEMT was rewarding. However, just over three-quarters (78%, n= 200) of DEMTs were in agreeance that their ED roster ensured them sufficient time to complete the clinical support requirements of the role, with 14% (n= 35) expressing a neutral opinion and 9%, (n= 23) disagreeing with this.

Ninety per cent (n= 232) of respondents agreed that they were able to complete all requirements of their DEMT role. Eight per cent (n= 21) neither agreed nor disagreed, while two per cent (n= 5) disagreed that they could meet ACEM's requirements of the DEMT role. DEMTs who did not agree that they were able to meet the requirements of their role were given the opportunity to provide a reason, with all 26 DEMTs providing feedback. Most of them commented that the clinical support time allocated for the role was inadequate and they had to complete the requirements of the role during their personal time (n= 19). Other DEMTs highlighted staffing and resource challenges, including managing a large number of trainees and the time-intensive nature of supporting struggling trainees without additional administrative support (n= 4). Other issues raised included time commitment challenges especially for DEMTs working part-time hours (n= 3), being allocated additional responsibilities across multiple networked sites (n= 2), and that it was challenging to keep up with the College's requirements (n= 2).

Some example responses provided by DEMTs included:

> *Getting one clinical support day each week, with 4 hours taken for teaching, it doesn't leave a lot of time for everything else.*
>
> *I struggle to get FACEM colleagues to deliver Paediatric EM teaching, so this often falls largely on me. Preparing and delivering teaching takes up the bulk of my clinical support time.*
>
> *I work 0.75 FTE, and it is difficult to meet the requirements of the DEMT role.*
>
> *I often need to use my own personal time for preparation of resources for teaching as my non-clinical time at work is often taken up by trainee administration, counselling, advocacy and career planning.*

4.2.2 Governance structures and support from the hospital

Seventy-nine per cent of DEMTs agreed that their ED had a governance structure (for example, administration processes, committees, etc.) in place that supported their role in managing the FACEM Training Program, 14% neither agreed nor disagreed, while 7% disagreed.

DEMTs were asked if their Director of Emergency Medicine (DEM), Hospital Executive (i.e. governance level above DEM), and hospital human resources (HR) and administration worked cooperatively with them in their DEMT role. Consistent with findings from the previous survey iterations, a significantly larger proportion of DEMTs strongly agreed or agreed that the DEM worked cooperatively with them in their role (95%) when compared with the Hospital Executive (50%) and hospital HR and administration (58%). DEMTs at Private-accredited sites were generally more likely to agree they were well-supported by these staff, compared to DEMTs at other types of ACEM-accredited sites (Figure 1).

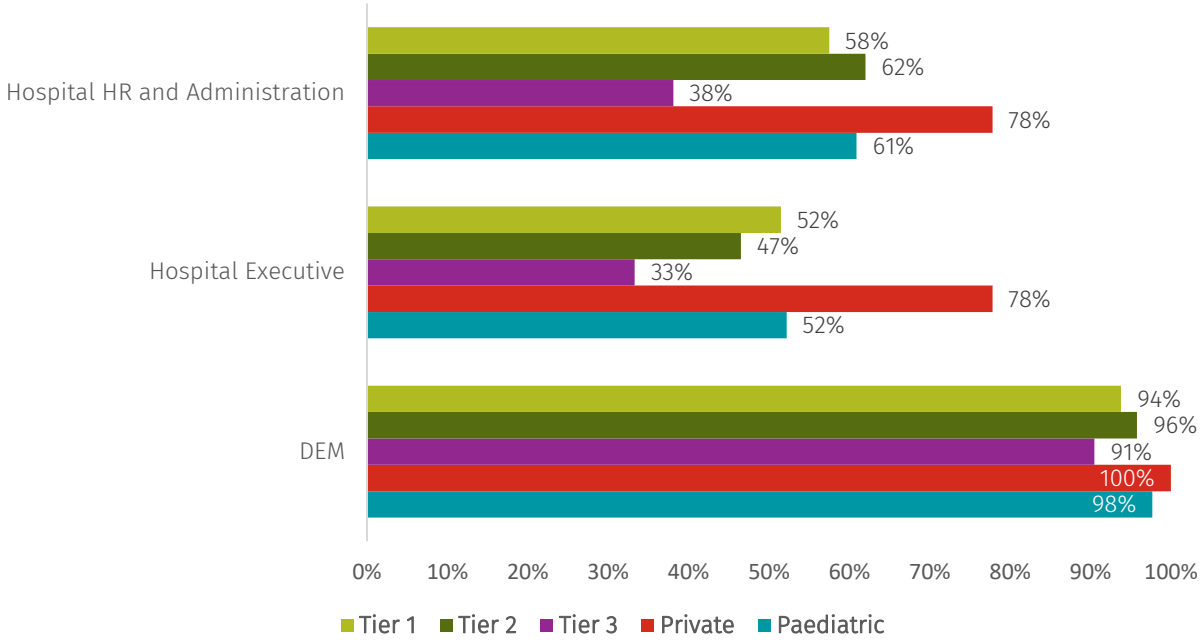


Figure 1. Proportion of DEMTs in agreeance that DEMs, Hospital Executive, and hospital HR/ administration work cooperatively with them in their role, by ED accreditation type.

A significantly higher proportion of DEMTs working in Major Referral hospitals agreed they were supported by the Hospital Executive, and hospital HR/administration, compared with those working in Non-Major Referral hospitals. The support DEMTs reported receiving from DEM(s) was relatively more comparable between Major Referral and Non-Major Referral sites (Figure 2).

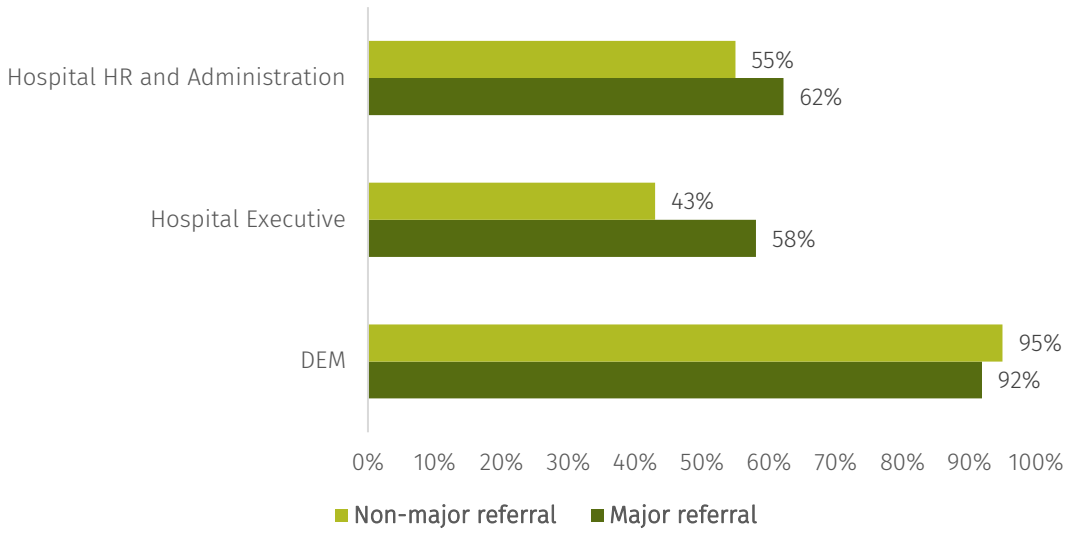


Figure 2. Proportion of DEMTs in agreeance that DEMs, Hospital Executive, and hospital HR/ administration work cooperatively with them in their role, comparing Major Referral and Non-Major Referral hospitals.

DEMTs who did not agree with any of the statements regarding their DEM, Hospital Executive or hospital HR/ administration working cooperatively with them were given the opportunity to provide their reason(s). Fifty-six DEMTs provided feedback, with the majority highlighting minimal or no support from Hospital Executive and/or hospital HR (n= 37). Other common themes included limited administrative support received (n= 11), a higher priority placed on department service provision over training opportunities (n= 8), a lack of awareness or recognition of the DEMT role (n= 8), and insufficient

allocated clinical support time for fulfilling DEMT responsibilities (n= 5). While several DEMTs mentioned they had not yet needed support from their hospital governance in their role as a DEMT (n= 7), another three mentioned that the Hospital Executive primarily engaged with the DEMs at their site, with limited direct collaboration with them.

Several example comments from the DEMTs regarding the lack of cooperation or support provided by the Hospital Executive, administration and HR are presented below:

> *I do not think that the Hospital Executive or hospital HR team have much awareness of the DEMT role or prioritise training within the department.*
>
> *The Hospital Executive at (site) does not value the training program as much as it should. Their focus is around budget and resource limitation. They should fund additional administrative staff for ED, given its complexity, rigorous training program and non-clinical demands of its consultants and educators.*
>
> *The DEMT role is protected by the DEM. But it is not supported by the Hospital Executive. The DEM has to be creative to protect the non-clinical time for DEMTs.*
>
> *The HR team do not understand the importance of [FACEM] trainees over non-trainees and, recruitment is a difficult process. Likewise trying to convince the Hospital Executive to approve external placements e.g. setting up an anaesthetic placement to encourage more trainees to work here is almost impossible. It is difficult to improve the environment for trainees with the stakeholders.*

4.2.3 Support from ACEM Regional Censors and ACEM processes

Over three-quarters (80%, n= 206) of DEMTs strongly agreed or agreed that they were well-supported in managing trainees in difficulty through ACEM Regional Censors, with 10% (n= 25) neither agreeing nor disagreeing. A further 10% (n= 25) reported they did not know whether they were well-supported, while 1% (n= 2) disagreed that they were well-supported by ACEM Regional Censors. Of those who did not agree (i.e., neither agreed nor disagreed or disagreed) that they were well-supported by their Regional Censor, 14 stated that they had not yet needed to engage with or seek assistance from their Regional Censor and seven DEMTs commented that they required more support than they received from their Regional Censor. Other feedback included they did not know how to approach their Regional Censor, or they were unsure when it was appropriate to approach them.

A comparable proportion (78%, n= 200) of DEMTs agreed that they were well-supported by ACEM processes in managing trainees in difficulty. A further 10% (n= 27) neither agreed or disagreed, while 1% (n= 2) disagreed, and 11% (n=29) reported not knowing. Twenty-four DEMTs provided the reasons why they did not agree that they were well-supported by ACEM processes. Nine DEMTs stated they had not yet needed to interact with ACEM for managing trainees in difficulty, while eight others reported a lack of clarity in the definition of 'a trainee in difficulty' in the ACEM guidelines. Seven DEMTs indicated having difficulty contacting the College on multiple occasions in relation to responsibilities associated with their DEMT role.

4.2.4 Support and resources – areas of need and interest

DEMTs were asked to nominate resources and support areas of need and/or interest and the preferred delivery mode(s) for each selected area (Table 2), to inform the future development of appropriate resources and support offered by the College. Consistent with previous survey iterations, most nominated areas of need and interest were resources in supporting trainees in difficulty (55%) and College processes such as remediation, appeals and special consideration (48%).

The preferred delivery modes nominated by the majority of DEMTs were either online learning modules or virtual workshops. The only exception was for resources regarding DEMT role orientation, where DEMTs nominated face-to-face training as their most preferred delivery mode.

Table 2. DEMT (n= 258) response rates to resources and support nominated as areas of need and/or interest and the preferred delivery mode(s).

Resources & Support	Area of need/ interest		Preferred Delivery Mode							
			Face-to-face training	ACEM Online Learning modules	Video podcast	Web-link	Online DEMT Network / Forum	How-to guide	Online Workshops	College emails
	n	%	%	%	%	%	%	%	%	%
College updates	61	23.6%	24.6%	24.6%	16.4%	6.6%	34.4%	13.1%	23.0%	**63.9%**
FACEM Curriculum document	72	27.9%	37.5%	**41.7%**	19.4%	22.2%	23.6%	27.8%	30.6%	30.6%
Learning Needs Analysis/ Learning Development Plan	52	20.2%	38.5%	**57.7%**	36.5%	15.4%	25.0%	34.6%	40.4%	13.5%
In-Training Assessment (ITAs)	72	27.9%	47.2%	**45.8%**	30.6%	8.3%	34.7%	44.4%	41.7%	20.8%
EM-Workplace-Based Assessment (EM-WBAs)	40	15.5%	**52.5%**	**52.5%**	32.5%	12.5%	32.5%	42.5%	47.5%	17.5%
DEMT role orientation: scope and responsibilities	68	26.4%	**57.4%**	51.5%	25.0%	5.9%	23.5%	36.8%	45.6%	17.6%
Role delineation between DEMTs, and other roles	52	20.2%	32.7%	28.8%	15.4%	5.8%	30.8%	**46.2%**	34.6%	19.2%
Education Program Development Support	91	35.3%	53.8%	46.2%	26.4%	28.6%	37.4%	41.8%	**54.9%**	15.4%
Primary Exam	78	30.2%	38.5%	32.1%	19.2%	25.6%	**39.7%**	26.9%	38.5%	15.4%
Fellowship Exam	104	40.3%	41.3%	34.6%	20.2%	25.0%	37.5%	32.7%	**41.3%**	13.5%
College processes (remediation/ appeals/ special consideration)	123	47.7%	43.9%	40.7%	25.2%	12.2%	28.5%	40.7%	**41.5%**	24.4%
Supporting trainees in difficulty	143	55.4%	58.0%	42.0%	28.0%	18.2%	30.1%	32.9%	**40.6%**	9.8%
Research	15	5.8%	20.0%	40.0%	20.0%	46.7%	46.7%	40.0%	**53.3%**	40.0%

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

DEMTs were asked to comment on any additional support, resources or training that ACEM could provide to assist them in their role as DEMT, with 47 providing feedback. Key suggestions included delivering more resources to support trainees in their examination preparation (n= 10), increasing opportunities for DEMT networking and access to shared resources (n= 10), more frequent DEMT workshops (n= 9), additional guides on providing effective feedback on ITAs and/ or EM-WBAs (n= 7), improvement to the ACEM website (n= 6), additional resources to support trainee wellbeing (including supporting struggling or neurodivergent trainees) (n= 6), and providing clearer guidance on trainee transition to the revised FACEM Training Program (n= 5).

4.2.5 Available online resources for DEMTs

DEMTs were asked to provide their level of agreement on the usefulness of each of ACEM's resources in supporting their role as a DEMT (Figure 3). Similar to findings of previous surveys, the Primary and Fellowship exam resources and the ACEM Educational Resources site were deemed valuable by the highest proportion of DEMTs, while a smaller proportion of DEMTs reported that General Emergency Medicine resources were helpful for them.

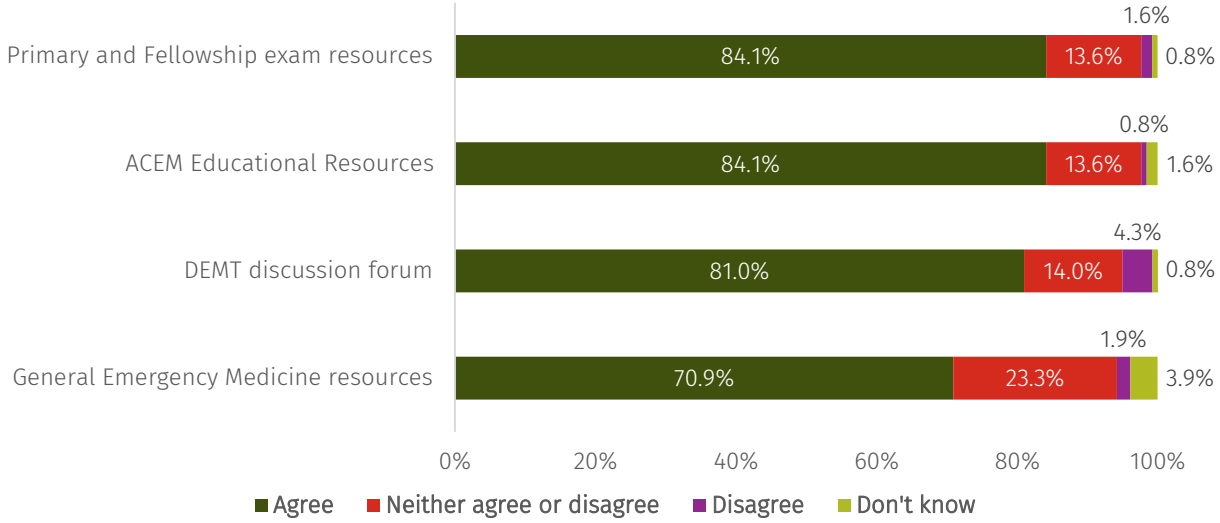


Figure 3 Respondents' level of agreement relating to the usefulness of ACEM resources in supporting their DEMT role.

DEMTs were provided the opportunity to suggest improvements to ACEM's online resources, with 50 providing feedback. Most suggestions focused on easier search and navigation functionality of ACEM's website for improved access to online resources (n= 22), or more resources in the examination repository, including previous written exam examples (n= 15). There were six comments on improving the DEMT forum functionality to ensure that new post notifications are reliably received. Other comments included allowing access to resources via cloud-based file sharing and providing clearer guidance on paediatric requirements. Seven DEMTs indicated no improvements were necessary as they found the existing resources to be adequate, while another six DEMTs stated they required more time to familiarise themselves with the available online resources.

4.3 Supervision and Trainee Educational Opportunities

This section presents the DEMT feedback on supervision and educational opportunities for FACEM trainees. It covers rostering of DEMTs with trainees; clinical teaching, educational and learning resources, and support for EM-WBAs; the structured education program in place at their site; examination resources; access to critical care rotations; and the ability of their ED to provide an appropriate training experience when considering casemix.

4.3.1 DEMT supervision, learning and education opportunities

Most DEMTs (78%) agreed they were routinely rostered on clinical shifts with trainees (twice per week). However, less (70%) agreed they had regular (once per week) non-clinical shifts with trainees. A comparable proportion of DEMTs working at Major Referral EDs (80%) and Non-Major Referral EDs (78%) agreed they were rostered on routine clinical shifts with trainees. While DEMTs at Major Referral EDs were more likely to agree they had regular non-clinical shifts with trainees (77%), than DEMTs at Non-Major Referral EDs (69%).

The proportion of DEMTs who were rostered on clinical and non-clinical shifts with trainees are presented in Table 3, by ED accreditation type. DEMTs working at Tier 1 sites were more likely to report being rostered on for both clinical and non-clinical shifts with trainees, while DEMTs at Private and Paediatric sites were less likely to report being rostered on for clinical and non-clinical shifts, respectively.

Table 3. Rostering of DEMTs on clinical and non-clinical shifts with trainees, by ED accreditation type.

	Accreditation type					
DEMTs rostered on shifts with trainees	Tier 1	Tier 2	Tier 3	Paediatric	Private	Total
Clinical shifts	82.1%	78.9%	52.4%	82.6%	**44.4%**	77.5%
Non-clinical shifts	77.6%	63.4%	61.9%	**52.2%**	77.8%	70.2%

Note: The smallest proportions are in bold.

Most DEMTs (93%) agreed their ED provided educational and learning resources that met the needs of trainees at all stages and phases of their training, with a comparable proportion of DEMTs at Major Referral EDs and Non-Major Referral EDs reporting so (93% and 92% respectively). DEMTs at Tier 1 (85%), Tier 2 (96%) and Paediatric (100%) sites were more likely to agree their ED provided stage and phase-appropriate educational and learning resources for trainees, compared to DEMTs at Tier 3 (67%) and Private (78%) sites.

The majority of DEMTs (84%) agreed their ED had processes in place that facilitated clinical teaching by supervisors to maximise trainee learning opportunities both on and off the floor. A comparable proportion reported that trainees at their site had access to formal ultrasound teaching (83%). DEMTs at Major Referral sites were more likely to agree that trainees at their ED had access to formal ultrasound training, compared with those at Non-Major Referral EDs (93% vs. 80%). DEMTs at Tier 1 sites (92%) were significantly more likely to agree that their trainees had access to formal ultrasound training compared with Paediatric (78%), Tier 2 (75%), Tier 3 (62%), and Private (56%) sites.

4.3.2 Workplace-based Assessments

Eighty-five per cent of DEMTs were satisfied with the support they received from their Local WBA Coordinator to monitor EM-WBAs at their site. DEMTs at Major Referral EDs (89%) were slightly more likely to agree they were satisfied with the support they received from their Local WBA Coordinator, compared with DEMTs at Non-Major Referral EDs (86%). DEMTs working at Tier 1 (91%) and Tier 2 (83%) sites were more likely to agree they were satisfied with their Local WBA Coordinator's support, compared with Tier 3 (76%), Paediatric (74%), and Private (44%) sites.

Over two-thirds (68%) of DEMTs reported that WBAs were the trainee's responsibility (Table 4). WBAs were more likely to be scheduled by the Local WBA Coordinator (50%) than by DEMTs (7%) or

collaboratively by the DEMT and Local WBA Coordinator (9%). DEMTs were also more likely to report that WBAs were conducted ad hoc instead of being organised through a rostered WBA Consultant or rostered WBA sessions.

Table 4. How WBAs are organised for trainees at sites.

How are WBAs organised at your site?	Number of Respondents	%
It is the trainee's responsibility	176	68.2%
Scheduled by Local WBA Coordinator	129	50.0%
On an ad hoc basis	101	39.1%
Through rostered WBA Consultant	59	22.9%
Through rostered WBA session	30	11.6%
Scheduled collaboratively by DEMT and Local WBA Coordinator	23	8.9%
Scheduled by DEMT	18	7.0%
Other (e.g. mix of the above, through rostered clinical teaching consultant, monthly email update, rostered for shift reports, etc.)	24	9.3%
Total no. of respondents	258	

Note: Respondents may select more than one method WBAs were organised.

4.3.3 Structured education sessions and examination resources

Almost all DEMTs agreed the structured education program at their ED was aligned with the content and learning outcomes of the ACEM Curriculum Framework (95%), and that the structured education sessions at their site were provided for, on average, a minimum of 4 hours per week for trainees (98%). A slightly smaller proportion (92%) agreed that the structured education program at their site was regularly evaluated.

The proportion of DEMTs agreeing that a minimum of 4 hours per week of structured education sessions were available for trainees was consistent between those working at Major Referral (100%) and Non-Major Referral EDs (98%). The proportion of DEMTs who agreed with this statement differed slightly by ED accreditation type, ranging from 100% agreement at Tier 1, Tier 2 and Paediatric sites, to 86% at Tier 3 sites and 89% at Private sites.

A comparable proportion of DEMTs were in agreeance that trainees at their site had adequate access to Fellowship written and clinical exam resources (94% and 96%, respectively), while a smaller proportion agreed that trainees had sufficient access to Primary written and viva exam resources (88% and 89%, respectively). The proportion of DEMTs who agreed with trainees having adequate access to exam resources by site accreditation type is presented in Table 5.

Table 5. Proportion of DEMTs who strongly agreed or agreed that trainees at their ED had adequate access to Primary and Fellowship exam revision and preparation courses, by ED accreditation type.

Trainees had access to exam revision and preparation programs	Accreditation type					Total
	Tier 1	Tier 2	Tier 3	Paediatric	Private	%
TS1 trainees						
Primary written exam	99.3%	87.3%	76.2%	60.9%	**33.3%**	88.4%
Primary viva exam	97.8%	91.5%	81.0%	60.9%	**33.3%**	89.1%
TS2, TS3 and TS4 trainees						
Fellowship written exam	99.3%	88.7%	**76.2%**	100%	88.9%	94.3%
Fellowship OSCE exam	100%	93.0%	**76.2%**	95.7%	100%	95.7%

Note: The smallest proportions are in bold. OSCE refers to Objective Structured Clinical Examination.

4.3.4 Casemix

DEMTs were asked to reflect on their site's ability to provide an appropriate training experience with respect to casemix. Overall, nearly all DEMTs were in agreeance that the number (99%), breadth (98%), acuity (97%), and complexity of cases (99%) in their ED provided an appropriate training experience (Table 6). A smaller percentage of DEMTs working at Tier 3 or Private sites agreed that their ED provides an appropriate training experience when considering most aspects of casemix, compared with DEMTs at EDs with other accreditation types.

Table 6. Proportion of DEMTs who strongly agreed or agreed that their ED was able to provide an appropriate training experience when considering various aspects of casemix, by ED accreditation type.

	Accreditation Type					Total
Aspects of casemix	Tier 1	Tier 2	Tier 3	Paediatric	Private	%
Number of cases	**99.3%**	100%	100%	100%	100%	99.6%
Breadth of cases	98.5%	100%	**85.7%**	100%	88.9%	97.7%
Acuity of cases	99.3%	98.6%	81.0%	100%	**77.8%**	96.9%
Complexity of cases	100%	98.6%	**90.5%**	100%	100%	98.8%

Note: The smallest proportions are in bold.

4.3.5 Access to critical care rotations

A large proportion (91%, n= 235) of DEMTs reported having a critical care (intensive care/ anaesthetics) rotation available at their hospital or within their hospital network, with DEMTs at Tier 1 (99%) and Paediatric (96%) sites being most likely to report the availability of critical care rotations, in comparison to DEMTs at Tier 2 (87%), Tier 3 (62%) and Private (56%) sites. Almost all DEMTs at Major Referral hospitals (99%) reported access to critical care rotations at their hospital or within the hospital network, compared with 89% of DEMTs at Non-Major Referral hospitals.

Of the DEMTs who reported having a critical care rotation at their hospital/ network, twenty DEMTs (9%) reported having difficulty in filling the critical care rotations with FACEM trainees. The main reasons cited included insufficient number of available trainees, particularly a lack of advanced trainees or those at the appropriate training stage to undertake the rotation; recruitment challenges in regional or rural sites, where attracting trainees can be more difficulty; a preference among trainees for intensive care rotations, making anaesthetic rotations harder to fill; and competition from trainees from other medical specialist college programs for the existing rotation spots.

DEMTs who reported the availability of critical care rotations at their hospital/ network were further asked how long, on average, the trainees had to wait to obtain a critical care rotation. The majority reported that trainees had to wait 6-12 months (47%), or greater than 12 months (23%) to obtain a critical care rotation. Less than one-third reported either trainees waited for less than six months (17%) or there was no waiting time (13%). DEMTs at Major Referral and Non-Major Referral hospitals reported comparable proportions of trainees having to wait six months or longer before obtaining a critical care rotation (64% and 73%, respectively). DEMTs working at Paediatric (78%) and Tier 1 (70%) sites were more likely to report that trainees waited greater than six months to obtain a critical care rotation, compared with DEMTs at Tier 2 (61%), Tier 3 (43%) and Private (11%) sites.

4.4 Health, Welfare and Interests of Trainees

This section details the perspectives of DEMTs regarding whether their ED meets the health, welfare and interests of trainees, and includes the following areas: ability of the ED environment to meet trainee needs; mentoring programs; workplace safety and support; trainee assistance; rostering; and opportunities for trainees to participate. Several topics covered in this survey were also included in the 2024 Trainee Placement Survey, allowing comparisons between the two surveys.

4.4.1 Meeting trainee needs

Almost all (98%, n= 253) of the DEMTs were in agreeance that trainee needs were being met according to their stage and phase of training at their ED. Two DEMTs neither agreed nor disagreed, while three disagreed that their trainees' needs were met. All five acknowledged that more could be done to support their trainees and enhance trainee wellbeing, particularly in relation to staffing and workload challenges.

In comparison, a slightly smaller proportion of FACEM trainees (95%) agreed their needs were being met at their ED placement in the 2024 Trainee Placement Survey. The main reasons cited for trainees' needs not being met were insufficient clinical teaching and limited education opportunities, largely attributed to staffing shortages and high service demands.

4.4.2 Mentoring program

Most DEMTs (97%, n= 250) reported a formal mentoring program available for trainees at their ED, with seven of the eight DEMTs who reported the absence of a formal mentoring program were from either Private or Tier 3 sites. Just over a quarter (28%, n=69) reported that DEMTs in their department were involved in the formal mentoring of trainees.

Of the EDs where a formal mentoring program was available, 90% of DEMTs reported that trainees used the formal mentoring program at their ED. DEMTs at Tier 1 and Paediatric (91% and 96%, respectively) accredited sites were more likely to agree that trainees utilised the program, when compared to DEMTs at Tier 2, Tier 3 and Private sites (89%, 71%, and 44%, respectively).

DEMTs who reported a formal mentoring program was available for trainees at their site were further surveyed about how the mentoring program was structured, with 248 providing a response and two indicating not knowing. DEMTs were able to select multiple options for how the mentoring program was structured, with most reporting that trainees nominated their preferred mentor (68%, n= 169) rather than mentors being allocated to trainees (36% n= 89). An opt-in model (59%, n= 147) was also more commonly reported than an opt-out model (15% n= 38), and nearly two-thirds (63%) reported a combination of the aforementioned formats.

4.4.3 Workplace safety and support

Nearly all (96%, n=248) DEMTs strongly agreed or agreed that, overall, their ED provided a safe and supportive workplace for trainees. Over 90% of DEMTs were in agreeance that their ED provided a safe and supportive workplace with respect to sustaining trainee wellbeing (94%), support processes (97%), clinical protocols (95%), cultural safety practices (95%), and supervision arrangements (97%). Whereas a smaller proportion of them agreed that their ED provided a safe and supportive workplace when considering personal safety (86%).

DEMTs at Paediatric and Private accredited sites were generally more likely than DEMTs at other sites to agree with most statements regarding workplace safety and support (Table 7). DEMTs at Tier 1 sites were less likely to agree their ED provided a safe and supportive environment for trainees overall, particularly considering personal safety and sustaining trainee wellbeing, whilst those in Tier 3 sites were less likely to agree their ED provided a supportive workplace with respect to availability of support processes, clinical protocols, cultural safety, and supervision arrangements.

In comparison, a smaller proportion of FACEM trainees (92%) agreed that their ED placement sites provided a safe and supportive workplace overall (according to the 2024 Trainee Placement Survey).

DEMTs generally reflected more positively than FACEM trainees in nearly all aspects of workplace safety and support areas. The greatest discrepancy in the agreement level was seen in their feedback on their EDs in sustaining trainee wellbeing (94% of DEMTs vs. 82% of FACEM trainees) and the availability of support processes (97% of DEMTs vs. 88% of FACEM trainees).

Table 7. Proportion of DEMTs who strongly agreed or agreed that their ED provides a safe and supportive workplace in relation to specific areas, by ED accreditation type.

	Accreditation Type					Total
Safety and support areas	Tier 1	Tier 2	Tier 3	Paediatric	Private	% (n)
Overall safety and support	**92.5%**	100%	100%	100%	100%	96.1% (248)
Personal safety (e.g., aggression directed by patients and/or carers)	**78.4%**	94.4%	95.2%	91.3%	100%	86.0% (222)
Sustaining trainee wellbeing	**91.0%**	98.6%	95.2%	95.7%	100%	94.2% (243)
Support processes (e.g. debriefing opportunities, collegiate environment, informal mentoring)	96.3%	97.2%	**95.2%**	100%	100%	96.9% (250)
Clinical protocols	97.0%	94.4%	**85.7%**	100%	88.9%	95.3% (246)
Cultural safety practices (cater for culturally diverse patients and EM workforce)	93.3%	95.8%	**90.5%**	100%	100%	94.6% (244)
Supervision arrangements	95.5%	100%	**95.2%**	100%	100%	97.3% (251)
Comprehensive orientation program (commencing training and/or returning from extended leave)	94.8%	97.2%	95.2%	95.7%	**88.9%**	95.3% (246)

Note: The smallest proportions are in bold.

4.4.4 Governance structures and trainee assistance

While 79% of DEMTs reported that their ED had a governance structure that supports them in their role as a DEMT to manage the FACEM training program, a larger proportion (91%) of DEMTs agreed their ED had a governance structure in place that supports trainees in completing the requirements of the FACEM Training Program.

Comparable proportions of DEMTs agreed that adequate processes were in place for identifying and assisting trainees experiencing difficulties in progressing through their training (97%) or managing trainee grievances (95%) at their ED. The feedback provided by FACEM trainees in the 2024 Trainee Placement Survey was comparatively less positive, with a smaller proportion of trainees agreeing their placement has adequate processes to identify and assist trainees having difficulty in progressing through their training (82%) or managing trainee grievances (77%).

4.4.5 Rostering

The majority of DEMTs (88%) agreed or strongly agreed that they were satisfied with rostering at their ED overall. The largest proportions of DEMTs were in agreeance that rosters at their ED ensured safe working hours (98%), considered trainee workload (95%), and supported the service needs of the site (95%). DEMTs were less likely to agree that their ED rosters considered the skill mix required for the department (88%), gave equitable shifts across all ED areas (90%), or that the rosters were provided to trainees in a timely manner (90%).

The proportions of DEMTs who were in agreeance with each of the rostering statements are presented in Table 8, by ED accreditation type. DEMTs working at Tier 3 accredited sites were generally less satisfied with the individual rostering statements, compared with those in other types of accredited sites.

Table 8. Proportion of DEMTs who strongly agreed or agreed with statements regarding rostering at their ED, by ED accreditation type.

	Accreditation Type					Total
Trainee rostering statements	Tier 1	Tier 2	Tier 3	Paediatric	Private	% (n)
Overall, I am satisfied with trainee rostering in this department	**86.6%**	87.3%	90.5%	87.0%	100%	87.6% (226)
Rosters are provided in a timely manner for trainees	90.3%	88.7%	90.5%	**87.0%**	100%	89.9% (232)
Rosters give trainees equitable exposure to day/ evening/ night shifts	94.8%	93.0%	**85.7%**	87.0%	100%	93.0% (240)
Rosters give trainees equitable shifts to all areas of the ED	88.1%	91.5%	**85.7%**	100%	100%	90.3% (233)
Rosters consider trainee workload, including attendance at education sessions	96.3%	**93.0%**	95.2%	100%	100%	95.3% (246)
Rosters support the service needs of the department	96.3%	97.2%	**81.0%**	95.7%	100%	95.3% (246)
Rosters ensure safe working hours	98.5%	**95.8%**	100%	100%	100%	98.1% (253)
Rosters take into account staff leave requests	95.5%	93.0%	**85.7%**	91.3%	100%	93.8% (242)
Rosters take into account the skill mix required for the department	88.1%	88.7%	**85.7%**	91.3%	88.9%	88.4% (228)

Note: The smallest proportions are in bold.

DEMTs were asked to comment on the rostering at their ED, with 54 providing feedback. Over two-thirds (70%, n= 38) reflected negative feedback on their rostering, primarily citing poor rostering due to staffing shortages (n= 16). The remaining comments were positive, highlighting improvements in their rostering practice (Table 9).

Table 9. DEMT responses regarding rostering, themes and subthemes.

Key themes and sub-themes
Poor rostering (n= 38) • *Understaffing causing rostering issues.* • *Unsafe skill mix, particularly during night shifts.* • *Last minute shift changes due to sickness/leave/lack of communication from HR.* • *Inequitable exposure to clinical areas.* • *Limited support from administration or management in rostering.* • *Delays in releasing rosters.* • *Difficulty accessing leave.* • *Unsafe night shift staffing.*
Positive feedback or improvements being made to rostering (n= 16) • Mixed model pairing senior decision makers with trainees to ensure effective supervision. • *Different specialty trainees were rostered on night shifts to create a better skill mix.* • *Fair access to requested leave is granted as much as possible.* • *Trainees could nominate or swap shifts to accommodate equitable access to clinical areas.*

4.4.6 Opportunities for trainees to participate

While most DEMTs (90%) were in agreeance that FACEM trainees were able to participate in quality improvement activities at their ED, a smaller proportion (84%) agreed that trainees were able to participate in decision-making regarding governance (for example, participation on workplace committees).

Consistently, FACEM trainees reflected less positively in the 2024 Trainee ED Placement Survey, compared with the DEMT feedback, with a significantly smaller proportion agreeing they were able to participate in decision-making regarding governance (65%), or that they were able to participate in quality improvement activities (79%) at their ED placement.

4.5 Final Comments

There was an opportunity to provide any final comments regarding the DEMT role and support, with 53 DEMTs providing feedback (Table 10). Twenty comments focused on the challenges faced as an DEMT, while seventeen outlined the additional support they required from the College. A further sixteen DEMTs commented about the rewarding aspects of the role, as well as the positive experiences and support received from ACEM.

Table 10. Areas DEMTs provided final comment on, themes and subthemes.

Key themes and sub-themes
Challenges as a DEMT (n= 20) • *A rewarding role but requires significant additional hours or an increased FTE to be carried out effectively.* • *Limited clinical support time for the role.* • *Trainees frequently requiring wellbeing support.* • *A lack of support from hospital administration, DEM or hospital executives.* • *Logistical challenges in supporting part-time trainees.* • *Difficult to meet College requirements, particularly for ITAs.*
Areas of support from ACEM (n= 17) • *Advocating for greater clinical support time for the DEMT role.* • *More face-to-face workshops and resources for new DEMTs to understand their role.* • *Implementing regional or rural training requirements to help fill trainee vacancies.* • *Mandating teaching logbook/Learning Development Plan.* • *Greater support and resources for trainee exam preparation and feedback.* • *Supporting trainees with paediatric emergency interests.* • *Easier access and improved awareness of educational resources.*
Positive and rewarding experience (n= 16) • *Enjoying the DEMT role; deem the role as a privilege.* • *It is rewarding being a part of the trainees' journey.* • *Appreciative of the college and DEM's support.*

5. Conclusion

The 2025 DEMT Survey achieved strong representation, with responses from DEMTs at 93% of ACEM-accredited sites, providing robust DEMT feedback to guide the College's ongoing support for DEMTs in their crucial role.

Overall, DEMTs reported a high level of role satisfaction and confidence in completing all requirements of the DEMT role. Nearly all agreed that their role was rewarding and that they were able to meet the core ACEM requirements of the role. However, they were less likely to agree that their ED rosters provided them with enough time to meet the clinical support requirements of their role. Many cited a lack of dedicated clinical support time and the time-intensive nature of supporting trainees in difficulty, compounded by limited administrative support from their department.

While collaboration with Directors of Emergency Medicine (DEMs) was viewed positively, only around half of DEMTs agreed that Hospital Executives, HR, or administrative staff worked cooperatively to support their role. In addition, there was a lower level of agreement that their ED had a governance structure that adequately supported the delivery of the FACEM Training Program. This indicates a need for stronger institutional recognition and resourcing to support the DEMT role to ensure consistent and effective support for FACEM trainees.

Comparable proportions of DEMTs reported they were well-supported in managing trainees in difficulty by both ACEM regional censors and ACEM processes. DEMTs expressed a clear need for additional resources to better support them in their role. Key areas identified included resources for managing trainees in difficulty, clearer guidance on College processes such as remediation and special consideration, and educational resources to assist with exam preparation and the provision of effective trainee feedback. Many also highlighted the value of more frequent DEMT workshops and greater opportunities for peer networking and resource sharing, to strengthen collaboration and consistency across training sites.

In terms of trainee supervision and educational opportunities, DEMTs were generally more satisfied with the quality and availability of the structured education programs provided to trainees than with opportunities for clinical supervision during rostered shifts. Disparities were noted across accreditation types of training sites. DEMTs at Tier 1 sites were more likely to report being regularly rostered on to clinical and non-clinical shifts with trainees and having access to adequate exam preparation programs, whereas those at Private and Tier 3 sites were less likely to report the same, highlighting the need to address variability in training and education opportunities across different placement sites.

Importantly, 98% of DEMTs agreed that trainee needs were being met in line with their stage of training. However, consistent discrepancies were observed when comparing DEMT responses with those of FACEM trainees from the 2024 Trainee Placement Survey. DEMTs consistently expressed more positive views regarding the training environment, including perceptions of safety, trainee assistance and support processes, and rostering practices. These differences could reflect differing experiences, expectations, or levels of awareness between DEMTs and trainees, and highlight the importance of capturing both trainee and DEMT perspectives to gain a more balanced understanding of trainee support and the training environment at accredited sites.

The 2025 DEMT Survey findings reinforce the critical role DEMTs play in the success of the FACEM Training Program. To support DEMTs more effectively and ensure a consistent, high-quality training experience across all accredited sites, the results help to identify key areas where the College can strengthen its support. This includes both advocating for strengthening support from hospital executive and administration and enhancing ACEM-provided resources to better equip DEMTs in their role.

6. Suggested Citation

Australasian College for Emergency Medicine. (2025). *2025 DEMT Survey Report.* ACEM Report: Melbourne.

7. Contact for Further Information

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