Australasian College
for Emergency Medicine

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Report
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2022 DEMT Survey

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for Emergency Medicine

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Key findings

The Director of Emergency Medicine Training (DEMT) Survey is a biennial survey which aims to identify areas where ACEM can better support DEMTs in their role and to seek their perspectives on how their site provides an appropriate and safe training environment. Findings from the 2022 DEMT Survey for the 259 responding DEMTs (representing 140 of 147 ACEM-accredited emergency departments in 2022) are summarised in the following:

91%

agreed that their
DEMT role was rewarding

Support for DEMTs

80% agreed that their ED had a **governance structure** in place that supported their role

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

Time with trainees

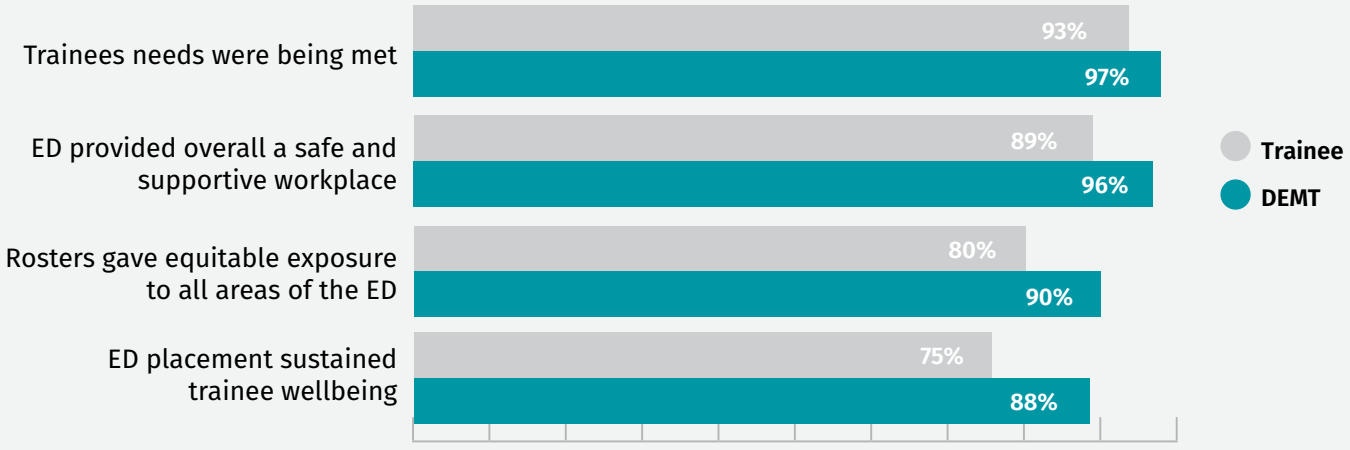
82% agreed that they were routinely rostered on **clinical shifts** with trainees

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

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

DEMT vs. trainee responses

2022 DEMT Survey responses compared with the 2022 Trainee ED Placement Survey on major parameters of the FACEM trainee experiences.



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

Contents

1. Executive Summary

The Director of Emergency Medicine Training (DEMT) Survey is a biennial survey that aims to identify areas where ACEM can better support DEMTs in their role and to seek their perspectives on how their site provides an appropriate and safe training environment. Findings from the 2022 DEMT Survey for the 259 responding DEMTs (representing 140 of 147 ACEM-accredited emergency departments (EDs) in 2022) 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 (91%, respectively).
- 79% agreed their ED roster ensured sufficient time for them to complete the clinical requirements of their DEMT role.
- 80% agreed that their ED had a governance structure supporting their role.
- A significantly larger proportion (91%) agreed that their DEM(s) worked cooperatively with them in their role when compared with the Hospital Executive (51%) and hospital human resources and administration (53%).
- A similar proportion of DEMTs were in agreeance that they were well-supported in managing trainees in difficulty by the ACEM processes (78%) and ACEM Regional Censors (79%).
- Resources and support related to supporting trainees in difficulty (54%), the FACEM Training Program structure/ administration (53%), and College processes (49%) were the three most nominated areas of need/ interest by DEMTs.

Supervision and Trainee Educational Opportunities

- 82% of DEMTs agreed that they were routinely rostered on clinical shifts with trainees (twice per week), compared with 70% agreeing that they had regular non-clinical shifts with trainees (once per week).
- 90% agreed that their ED provided educational and learning resources that met the needs of trainees at all stages and phases of their training.
- 82% 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 (99%).
- Most DEMTs were in agreeance that casemix at their site provided an appropriate training experience with regard to the number (99%), breadth (97%), acuity (97%), and complexity (99%) of cases.
- 77% of DEMTs who reported the availability of critical care rotations at their hospital/ hospital network indicated that trainees had to wait six months or more to obtain a rotation.

Health, Welfare and Interests of Trainees

- Almost all DEMTs (97%) agreed that trainee needs were being met according to their stage or 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 (92%), clinical protocols (95%), supervision arrangements (97%), and cultural safety practices (91%).
- The majority of DEMTs agreed that there were adequate processes in place for identifying and assisting trainees experiencing difficulties in meeting training requirements and managing trainee grievances at their ED (96%, respectively).
- The largest proportion of DEMTs agreed that rosters at their ED considered trainee workload and ensured safe working hours (92%, respectively); however, they were less likely to agree that rosters took into account the skill mix required for the department (82%), provided equitable day/evening/night shifts (84%), and were provided in a timely manner (84%).
- 80% of DEMTs agreed that trainees could participate in quality improvement activities at their ED, whereas 70% 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 to seek feedback on the experiences of DEMTs in their role at emergency epartments (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 the 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 2022 DEMT Survey.

3. Methodology

The DEMT Survey was distributed to all 343 DEMTs across 147 ACEM-accredited EDs at the time of the survey. DEMTs in Aotearoa New Zealand and Australian EDs were invited via email at the end of February 2023 to participate in the online survey hosted in Jotform. The survey was promoted on the DEMT discussion forum, and two reminder emails were sent to DEMTs who had not responded, encouraging them to participate before the survey closed on 9 April 2023.

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 ED delineation or accreditation level. ED delineation includes major referral EDs, non-major referral EDs, private EDs, specialist and non-specialist children's EDs. ED accreditation level includes EDs accredited for 12 months, 24 months, and 36 months.

4. Results

There were 259 completed DEMT surveys received from a pool of 343 surveys, a response rate of 76%. Nine responding DEMTs (3%) were working in the role at two EDs and completed the survey for each ED. Twenty-five (10%) of the 259 respondents were Paediatric DEMTs.

A total of 140 (95%) of the 147 ACEM-accredited EDs at the time of the survey were represented by the 259 survey responses. Of all survey responses, 56% (n= 146) were from DEMTs at non-major referral hospitals, whilst 31% (n= 80) were from DEMTs at major referral hospitals, 9% (n=25) were from children's hospitals (5% from specialist children's vs. 4% from non-specialist children's) and 3% (n=8) from Private EDs. The EDs were largely accredited for 36 months (53%), followed by 24 months (29%) and 12 months (18%).

4.1 DEMT Role and Engagement

Nearly three-quarters (71%, n= 184) of the DEMTs reported working at their current ED for over five years, with 39% (n= 102) working in their ED for over ten years. One quarter (25%, n= 64) of DEMTs reported working at their current ED for two and five years and 4% (n= 11) for less than two years. When asked how long they had been in the DEMT role for, a higher proportion (39%, n= 100) reported being in the role for less than two years, compared with 34% (n= 87) working in the role for two to five years and 28% (n= 72) who reported being in the position for more than five years.

DEMTs were asked to provide their employment type, with over half reporting they were employed part-time basis (n=133, 51%), followed by 48% (n=125) who reported full-time employment. Only one DEMT reported sessional employment.

Most respondents (60%, n=155) reported they held no other roles in addition to their role as DEMT. Of the 104 who reported having additional roles, half (n= 55) reported being Supervisor of the Emergency Medicine Certificate/ Diploma. Other roles commonly reported were DEM or Deputy DEM (n= 10), followed by Local Workplace-Based Assessments (WBA) Coordinator (n= 4), Mentoring Coordinator (n= 2), and Supervisor of Diploma of Pre-hospital and Retrieval Medicine (n= 2). The remaining roles included clinical lead in ultrasound, simulation, education or teaching supervisor, disaster coordinator, and trauma director.

4.1.1 Sharing of DEMT role

Sharing the DEMT role was common, with 87% (n= 226) of respondents reporting that they were a co-DEMT in their ED. Different models were employed for responsibility delegation among co-DEMTs, where trainees were more likely to be a shared responsibility than allocated to individual co-DEMTs for supervision (79% compared to 21%) and teaching (94% compared to 6%). In contrast, trainee allocation to different co-DEMTs (73%) was a more common model for the completion of in-training assessments (ITAs) than co-DEMTs sharing this responsibility (27%). Almost one quarter (23%) of co-DEMTs reported other models for teaching, supervision, or ITAs completion responsibilities; for instance, responsibilities were divided by type of exam preparation (Primary vs. Fellowship) or by subjects, or structured education program was the responsibility of one designated DEMT, or that teaching was not solely the DEMT's responsibility but shared among all senior medical staff.

4.1.2 Collaborations among networked DEMTs

Half of the DEMTs reported their ED was in a network of accredited EDs (50%, n=130), with the majority (94%) of these DEMTs reporting they worked collaboratively with other DEMTs in the network. Nearly all DEMTs reported sharing information and resources (96%) with other DEMTs in their network, and over three-quarters reported collaborating with other DEMTs in their network to support trainees (78%). DEMTs (n=26) also described other forms of collaboration, including regular meetings with network DEMTs, rotation of trainees across networked EDs, and coordinated teaching sessions for trainees across their network.

4.1.3 DEMT workshops

DEMTs were asked when they last attended a DEMT workshop, with over two-thirds (68%) reporting having attended a DEMT workshop within the last one to two years, whilst 20% reported last attending a workshop more than two years ago. Notably, 12% reported never attending a DEMT workshop, a considerable decrease from 35% in the 2020 DEMT survey.

When asked to provide a reason for not attending a DEMT workshop, 12 DEMTs reported that they were still new to the role and planning to attend the workshop in the near future. Four others no longer new to the DEMT role also indicated their plans to participate in future workshops. Two other DEMTs explained the COVID-19 pandemic impacted their attendance and were waiting for face-to-face workshops to recommence.

DEMTs were asked to suggest topics they would like to see covered in future workshops, with 104 providing a response. The proposed topics included:

- FACEM Training Program, including new program, transitioning trainees from old to the revised program, revised curriculum/ requirements, critical care and paediatric rotations, special skills (n= 38)
- Managing trainees in difficulty (n= 26)
- Providing effective trainee feedback (n= 15)
- Preparing trainees for exams (exam format updates, exam processes, more guided resources, etc.) (n= 13)
- Assessment, including ITAs and WBAs (requirements, marking calibration, constructive reporting, etc.) (n= 12)
- Management and leadership (performance reviews, motivating trainees, mentorship training, clinical management etc.) (n= 12)
- Teaching and education programs (set-up tips, consistency across networked sites) (n= 9)
- ACEM resources including teaching resources, networks, wellbeing resources, navigation of ACEM website (n= 9)
- Requirements and expectations of DEMT role, including task delegation (n= 6)
- Site accreditation (n= 2)
- Managing trainees on Specialist International Medical Graduate (SIMG) pathway (n= 1)

4.2 Support for Role as a DEMT

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

4.2.1 Requirements of the DEMT role

Overall, almost all (91%, n= 235) responding DEMTs strongly agreed or agreed that their role as a DEMT was rewarding. However, a smaller proportion (79%) of DEMTs were in agreeance that their ED roster ensured them sufficient time to complete the clinical support requirements of the role, with 12% being neutral and 9% disagreeing with this.

Ninety-one per cent of respondents agreed that they were able to complete all requirements of their DEMT role. Six per cent neither agreed nor disagreed, while 3% disagreed that they could meet ACEM's requirements for the DEMT role. DEMTs who reported they were unable to meet requirements of their role were given an opportunity to provide a reason, with 17 commenting. Most DEMTs commented that the non-clinical time allocated was inadequate and having to complete the requirements using their personal time (n= 13). Other comments focused on staffing and resource issues, including unsupportive executives and colleagues, lack of education space, no administrative support, no training to guide education delivery, and service provision taking precedence in the understaffed department (n= 7). One DEMT expressed that the changes, although necessary, to the College's requirements are challenging to keep up with. Some example responses provided by DEMTs included:

> *The clinical support time allocated to DEMTs does not allow sufficient time to complete all trainees' pastoral care as well as administrative work.*
>
> *We have lost a number of experienced staff specialists and the hospital has been slow to replace them. The general non-clinical load from other vital work e.g. results checking, and patient follow-up, as well as teaching and supervision, falls to a smaller group of staff specialists.*
>
> *Until very recently, I did not have adequate time to complete my DEMT duties. Much of my DEMT work was done in my own time to not disadvantage the trainees or inequitably a heavier load fell on my Co-DEMT. This has now been remediated by removing the Resident Medical Officer (RMO) roster portfolio from my allocated workload, and ensuring I am rostered adequate clinical support time to complete my DEMT role.*

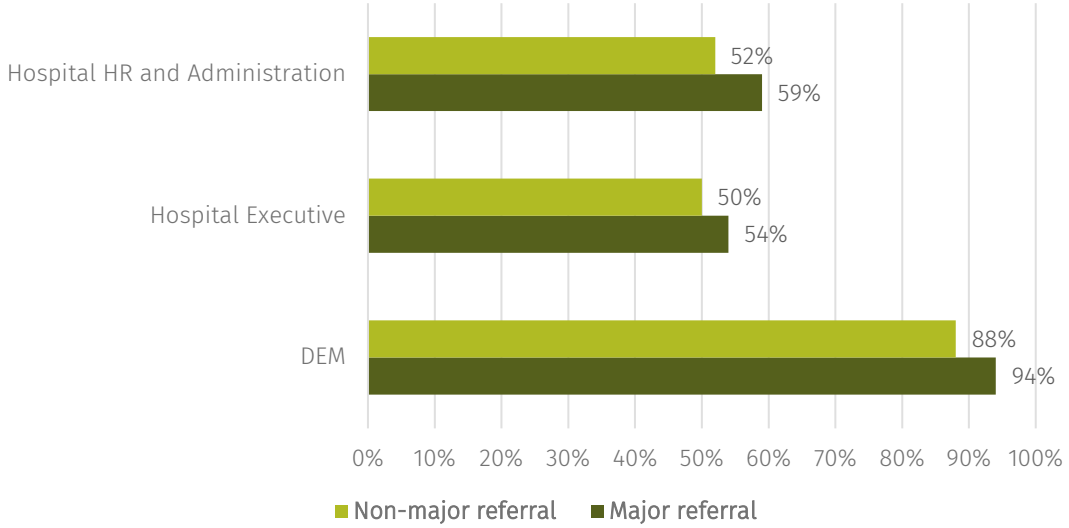
4.2.2 Governance structures and support from the hospital

Eighty 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 5% 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 much larger proportion of DEMTs strongly agreed or agreed that the DEM worked cooperatively with them in their role (91%) when compared with the Hospital Executive (51%) and hospital HR and administration (53%). Comparable proportions of DEMTs across the ED accreditation levels (12/24/36 months) agreed they were supported by their DEM (range between 89% and 91%), Hospital Executive (range between 49% and 54%), and hospital HR and administration (range between 50% and 54%).

Consistently, higher proportions of DEMTs working in major referral hospitals agreed they were supported by the DEMs, Hospital Executive, and hospital HR/administration, compared with those in non-major referral hospitals (Figure 1).

Figure 1. Proportion of DEMTs in agreeance that DEMs, Hospital Executive, and hospital HR/ administration worked 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 an opportunity to provide their reason(s). A total of 62 DEMTs provided feedback that primarily focused on minimal or no support from DEM, Hospital Executive or hospital HR (n= 40), a priority of service provision over education (n= 13), limited understanding, awareness, or recognition of the DEMT role (n= 11). Other DEMTs commented on the limited allocation of clinical support time (n= 7), or a lack of governance structure (n= 3), while four others mentioned they had not needed support from their hospital governance yet.

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

> *I do not think that the Hospital Executive understand the DEMT role and certainly do not prioritise education opportunities and space. There is no clear governance or support structure for departments to access institutional resources.*
>
> *Unfortunately, there is very poor understanding and minimal channels of useful communication between Hospital Executive and DEMTs. I would be unsurprised if Executive even partially understood the role and purpose.*
>
> *Don't feel/not aware that there is any direct interest or support from the executive level in us providing optimal training environment and education for our ACEM trainees, outside of accreditation requirements.*
>
> *Registrar education is often seen as a lower priority than other work. Room allocations can be withdrawn at the last minute for workshops that have been planned for months. Executive meetings/Head of Department updates are sprung upon us during registrar education.*

4.2.3 Support from ACEM Regional Censors and ACEM processes

Over three-quarters (79%) of DEMTs strongly agreed or agreed that they were well-supported in managing trainees in difficulty through ACEM Regional Censors, with 10% neither agreeing nor disagreeing. While 1% of DEMTs disagreed with this, a further 10% of DEMTs reported they did not know if they were well-supported by their Regional Censor. Of the 24 comments provided by the DEMTs who did not agree that they were well-supported by their ACEM Regional Censor, most (n= 16) commented that they had not needed to engage with or seek help from their Regional Censor. Three DEMTs commented that they required more support than they received from their Regional Censor, three commented about accessibility issues (either challenging to access or unsure how to access), and two mentioned they were only contacted by Regional Censor when a trainee was placed in additional training time.

A similar proportion (78%) of DEMTs were in agreeance that they were well-supported by ACEM processes in managing trainees in difficulty. A further 11% indicated neutrality, 1% disagreed, and 10% reported not knowing. The two DEMTs who disagreed that they were well-supported by ACEM processes provided reasons for this, which included difficulty contacting the College regarding tasks pertaining to their role as a DEMT on various occasions and a lack of clarity in the definition of 'a trainee in difficulty' in the guidelines.

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 1), to inform the future development of appropriate resources and support offered by the College. Consistent with previous survey iterations, resources and support nominated as areas of need and interest by the largest proportion of DEMTs were supporting trainees in difficulty (54%) and College processes such as remediation, appeals and special consideration (49%). It is noteworthy that more than half (53%) of DEMTs also nominated the need for resources related to FACEM Training Program structure and administration, considering the revised training program introduced in 2022. The previous DEMT Survey in 2020 saw a shift in DEMT preferences with respect to the resource delivery mode, from online delivery to face-to-face training for most of the resources. Interestingly, the trend has reversed again, with most DEMTs selecting resources and support to be delivered through either online module or online workshop. The only exception was for resources regarding DEMT role orientation which DEMTs nominated face-to-face training as their preferred delivery mode.

Table 1. DEMT (n= 259) 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	Online module	Video podcast	Web-link	Online DEMT Network	How-to guide	Online Workshop	College email
Resources & Support	n	%	%	%	%	%	%	%	%	%
College updates	89	34.4%	25.8%	20.2%	14.6%	6.7%	33.7%	20.2%	33.7%	**56.2%**
Curriculum Framework	91	35.1%	26.4%	**42.9%**	27.5%	11.0%	24.2%	29.7%	39.6%	23.1%
FACEM Training Program structure and administration	138	53.3%	39.9%	41.3%	24.6%	10.9%	21.0%	28.3%	**54.3%**	23.9%
Learning Needs Analysis/ Learning Development Plan	47	18.1%	23.4%	**61.7%**	36.2%	10.6%	10.6%	34.0%	38.3%	12.8%
In-Training Assessment	59	22.8%	45.8%	**50.8%**	42.4%	10.2%	25.4%	35.6%	42.4%	13.6%
EM-Workplace-Based Assessment	37	14.3%	32.4%	**64.9%**	32.4%	8.1%	29.7%	32.4%	45.9%	18.9%
DEMT role orientation	72	27.8%	**52.8%**	43.1%	27.8%	5.6%	29.2%	30.6%	50.0%	15.3%
Role delineation between DEMTs, and other roles	46	17.8%	28.3%	32.6%	19.6%	2.2%	10.9%	**39.1%**	34.8%	15.2%
Primary Exam	64	24.7%	32.8%	29.7%	28.1%	32.8%	34.4%	18.8%	**51.6%**	26.6%
Fellowship Exam	93	35.9%	38.7%	38.7%	22.6%	31.2%	32.3%	18.3%	**45.2%**	30.1%
College processes (remediation/ appeals/ special consideration)	127	49.0%	42.5%	35.4%	18.9%	11.0%	26.0%	33.9%	**49.6%**	21.3%
Supporting trainees in difficulty	140	54.1%	59.3%	42.9%	25.7%	17.1%	26.4%	29.3%	**60.7%**	12.1%
Research	13	5.0%	7.7%	**61.5%**	23.1%	0.0%	15.4%	23.1%	23.1%	23.1%

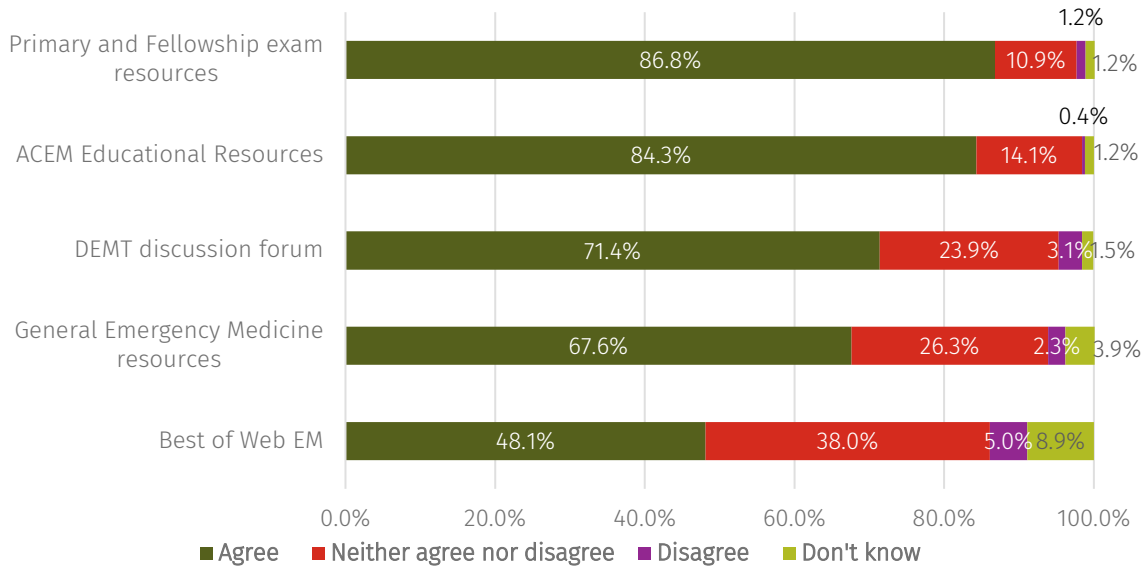
Note: Respondents may select more than one type of preferred delivery mode for each nominated resource/support.
Ten (3.9%) DEMTs selected 'None', with no nomination of any resources or support from the list.
The most selected delivery mode for each resource or support is in bold.

DEMTs were asked to comment on any additional support, resources or training ACEM could provide to assist them in their DEMT role, with 23 providing feedback. Suggestions primarily focused on workshops (n= 13), including running workshops more frequently, requesting face-to-face workshops, and covering topics such as various training stages of FACEM trainees, trainees in difficulty, and the Specialist International Medical Graduate (SIMG) pathway. Four DEMTs commented on the usefulness of DEMT networks or mentorship meetings. Others requested updates on changes to Curriculum Framework and training requirements (n= 4), examination resources and support (n= 3), improved support for rural-based DEMTs and training (n= 2), advocacy for DEMT role (n= 2), and administrative support (n= 2).

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 2). Similar to the previous survey findings, the Primary and Fellowship exam resources and the ACEM Educational Resources site were found to be valuable by most of the responding DEMTs, and less than half deemed the Best of Web Emergency Medicine site useful for their DEMT role.

Figure 2. 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 the ACEM's online resources, with 51 choosing to provide their suggestions. The majority of suggestions were about the search and navigation functionality of ACEM's Educational Resources website for improved ease of access to resources (n= 23), increasing resources in the exam repository, including past examinations (n= 7), and revising the structure of the DEMT forum (n= 3). Other comments included increasing other online resources and subscriptions, recording DEMT workshops, collating research updates, and improving the Best of Web EM. Nine stated no improvements were required, with the resources provided being adequate.

4.3 Supervision and Trainee Educational Opportunities

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

4.3.1 DEMT supervision, learning and education opportunities

Most DEMTs (82%) agreed they were routinely rostered on clinical shifts with trainees (twice per week). However, fewer (70%) agreed they had regular (once per week) non-clinical shifts with trainees. A similar proportion of DEMTs working at major referral EDs (81%) and non-major referral EDs (82%) 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 (81%) than DEMTs at non-major referral EDs (66%). A greater proportion of DEMTs at EDs accredited for 24 months (86%) and 36 months (81%) agreed that they were regularly rostered for clinical shifts with trainees compared to DEMTs at EDs accredited for 12 months (76%). Whereas DEMTs who worked at EDs accredited for 36 months (77%) were more likely to agree they had regular non-clinical shifts with trainees than those at EDs accredited for 24 months (67%) or 12 months (56%).

Most DEMTs (90%) were in agreeance their ED provided educational and learning resources that met the needs of trainees at all stages and phases of their training, with a higher proportion of DEMTs at major referral EDs (95%) than at non-major referral EDs (87%) reporting so. DEMTs at EDs accredited for 36 months (94%) were more likely to agree the ED provided stage and phase-appropriate educational and learning resources compared to sites accredited for shorter training periods (24 months: 87%, 12 months: 80%).

The majority of DEMTs (83%) agreed their ED had processes in place that facilitated clinical teaching by supervisors to maximise trainee learning opportunities both on and off the floor; however, a smaller proportion reported that trainees at their site had access to formal ultrasound teaching (78%). DEMTs at major referral EDs 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% compared to 75%). Likewise, DEMTs at EDs accredited for 36 months (93%) were significantly more likely to agree that their trainees had access to formal ultrasound training compared with EDs accredited for 24 months (64%) and 12 months (54%).

4.3.2 Workplace-based Assessments

Eighty-two per cent of DEMTs were satisfied with the support they have received from their Local WBA Coordinator to monitor EM-WBAs at their site. DEMTs at major referral EDs (79%) were less likely to agree they were satisfied with the support they received from their Local WBA Coordinator, compared with DEMTs at non-major referral EDs (82%). DEMTs working at EDs accredited for 12 months (89%) were more likely to agree they were satisfied with their Local WBA Coordinator's support, compared with sites accredited for 24 months (75%) and 36 months (84%).

Consistent with the 2020 DEMT survey, the majority (74%) of DEMTs reported that WBAs were the trainee's responsibility (Table 2). WBAs were more likely to be scheduled by the Local WBA Coordinator (48%) than by DEMTs (5%) 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 2. How WBAs were organised for trainees at sites.

How are WBAs organised at your site?	Number of Respondents	%
It is the trainee's responsibility	192	74.1%
Scheduled by Local WBA Coordinator	125	48.3%
On an ad hoc basis	104	40.2%
Through rostered WBA Consultant	77	29.7%
Through rostered WBA session	32	12.4%
Scheduled collaboratively by DEMT and Local WBA Coordinator	23	8.9%
Scheduled by DEMT	12	4.6%
Other (e.g. mix of the above, regular reminder to trainees, varies according to the type of WBA, etc.)	19	7.3%
Total no. of respondents	259	

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 (99%). A smaller proportion (87%) agreed that the structured education program at their site was regularly evaluated. The proportion of DEMTs agreeing with a minimum of 4 hours per week of structured education sessions for trainees was consistent between those working at major referral (100%) and non-major referral EDs (99%). The proportion agreeing with this statement differed slightly by ED site accreditation level, varying from 95% of DEMTs at 12-month, 99% at 24-month, to 100% at 36-month accredited EDs.

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 95%, respectively), compared to Primary written and viva exam resources (92% and 94%, respectively). The proportion of DEMTs who agreed with trainees having adequate access to exam resources by site accreditation level is in Table 3.

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

Trainees had adequate access to exam revision and preparation programs or courses	Accreditation level			Total
	12 months	24 months	36 months	% (n)*
Provisional and TS1 trainees				
Primary written exam	**83.3%**	91.7%	94.8%	92.4% (219 of 237)
Primary viva exam	**80.0%**	93.1%	97.0%	93.7% (222 of 237)
Advanced trainees				
Fellowship written exam	91.1%	**89.3%**	97.8%	94.1% (241 of 256)
Fellowship OSCE exam	95.6%	**88.0%**	99.3%	95.3% (244 of 256)

Note: The smallest proportions are in bold. *Total in bracket excluded responses selected '*Not applicable*.'

4.3.4 Casemix

DEMTs were asked to reflect on their site's ability to provide an appropriate trianing experience with respect to casemix. Overall, nearly all DEMTs were in agreeance that the number (99%), breadth (97%), acuity (97%), and complexity of cases (99%) in their ED provided an appropriate training experience (Table 4). Consistently, a smaller percentage of DEMTs working at sites accredited for 12 months agreed that their ED provides an appropriate training experience when considering aspects of casemix, compared with DEMTs at EDs accredited for a longer period of advanced training.

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

Aspects of casemix	Accreditation level			Total
	12 months	24 months	36 months	% (n)*
Number of cases	**97.8%**	98.7%	99.3%	98.8% (255 of 258)
Breadth of cases	**95.7%**	97.3%	97.8%	97.3% (250 of 257)
Acuity of cases	**93.5%**	96.1%	99.3%	97.3% (251 of 258)
Complexity of cases	**95.6%**	98.7%	100.0%	98.8% (250 of 253)

Note: The smallest proportions are in bold. *Total in bracket excluded responses selected '*Not applicable*.'

4.3.5 Access to critical care rotations

The majority (90%, n= 232) of DEMTs reported having a critical care (ICU/ anaesthetics) rotation available at their hospital or within their hospital network, with the proportion of DEMTs reporting the availability of critical care rotations increasing as site accreditation limit increased (78% at 12-month accredited sites, 82% at 24-month sites and 98% at 36-month sites). All DEMTs at major referral hospitals (100%) reported access to critical care rotations while those at non-major referral hospitals were less likely to report having access (84%).

Of the DEMTs who reported having a critical care rotation at their hospital/ network, only 14 (6%) reported that the rotation was difficult to fill. Consistent with previous survey findings, DEMTs described location-based challenges as the key reason for the difficulty in filling the critical care rotation, either due to insufficient critical care rotations to meet trainee demand at major referral hospitals or the difficulty in recruiting to fill the rotations in regional and rural hospitals. Other challenges raised included sites were no longer accredited for critical care training, leave restrictions for critical care rotations, and paediatric critical care rotations being difficult to fill due to limited interest (i.e., only useful for paediatric emergency medicine).

DEMTs who reported the availability of critical care rotations at their hospital/ network were further asked how long the trainees had to wait to obtain a critical care rotation on average. Just over half reported that trainees had to wait 6-12 months (51%), and 26% reported more than 12 months wait to obtain a critical care rotation. A further 13% reported trainees waited for less than six months and 10% reported there was no waiting time. DEMTs at major referral EDs (77%) were slightly more likely than those at non-major (74%) referral hospitals to report that trainees had to wait six months or more before obtaining a critical care rotation. Contrary to the findings from the previous survey, DEMTs working at 12-month accredited sites (82%) were more likely to report that trainees waited greater than six months to obtain a critical care rotation, compared with DEMTs at sites accredited for longer duration (70% at 24 months and 79% at 36 months, respectively).

4.4 Health, Welfare and Interests of Trainees

This section details the perspectives of DEMTs regarding whether their ED meets the health, welfare and interests of trainees, and includes the following areas: ability of the ED environment to meet trainee needs; mentoring program; workplace safety and support; trainee assistance; rostering; and opportunities for trainees to participate. Some of the areas covered in this survey were also asked in the 2022 Trainee Placement Survey, with comparisons being made between the two surveys.

4.4.1 Meeting trainee needs

Almost all (97%, n= 251) of the DEMTs were in agreeance that trainee needs were being met according to their stage and phase of training at their ED. Eight DEMTs did not agree with this, with the reasons provided being their department was understaffing and prioritising service provision, which resulting in poor quality teaching or limited clinical teaching and supervision. A smaller proportion of FACEM trainees (93%) agreed their needs were being met at their ED placement in the 2022 Trainee Placement Survey, with several trainees who did not agree expressing similar reasons, including limited teaching and supervision.

4.4.2 Mentoring program

The majority (95%) of DEMTs reported a formal mentoring program available for trainees at their ED, compared with a slightly smaller proportion (92%) who reported the availability of an ACEM Mentoring Program Coordinator. Of those (n= 13) reporting not having a formal mentoring program, the majority of DEMTs were at sites accredited for 12 months (n= 7) and 24 months (n= 5). DEMTs were more likely than FACEM trainees (per the 2022 Trainee Placement Survey) to report there was a formal mentoring program (84%) and ACEM Mentoring Program Coordinator (81%) at their ED.

Of the 246 DEMTs who reported having a formal mentoring program at their ED, just over one-third (35%) reported DEMTs at their site were involved in the formal mentoring of trainees. Ninety-one per cent of DEMTs reported that trainees used the formal mentoring program at their ED. On the contrary, a significantly smaller proportion (63%) of FACEM trainees (as reflected in the 2022 Trainee Placement Survey) reported having utilised the formal mentoring program at their placement. DEMTs at sites accredited for 12 months (88%) and 24 months (86%) were less likely to agree that trainees utilised the formal mentoring program, compared to DEMTs at sites accredited for 36 months (94%).

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 all 246 responding to this question. DEMTs could select multiple options for how the mentoring program was structured, with most reporting that trainees nominated their preferred mentor (70%, n= 172) rather than mentors being allocated to trainees (34%, n= 84). An opt-in model (58%, n= 142) was also more commonly reported than an opt-out model (11%, n= 27), and over half (57%) reported a combination of the formats.

4.4.3 Workplace safety and support

Nearly all (96%) DEMTs strongly agreed or agreed that, overall, their ED provided a safe and supportive workplace. Over 90% of DEMTs were in agreeance that their ED provided a safe and supportive workplace with respect to support processes (92%), clinical protocols (95%), supervision arrangements (97%), and cultural safety practices (91%). Whereas a smaller proportion of them agreed that their ED provided a safe and supportive workplace when considering personal safety (88%) and sustaining trainee wellbeing (88%). DEMTs at 24-month accredited EDs were generally more likely than DEMTs at other sites to agree with the statements regarding workplace safety and support (Table 5). The exception being DEMTs at 36-month accredited sites were more likely to agree that a comprehensive orientation program was available for FACEM trainees.

Compared with the 2022 Trainee Placement Survey, a smaller proportion of FACEM trainees (89% vs. 96% of DEMTs) agreed their ED placement provided a safe and supportive workplace overall. Consistently, FACEM trainees were less likely to agree their ED placement provided a safe and supportive workplace for each safety and support area. The greatest discrepancy was seen in their

reflection on the availability of an orientation program, with 93% of DEMTs vs. 76% of FACEM trainees agreeing that a comprehensive orientation program was provided at the training commencement.

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

Safety and support areas	Accreditation Level			Total
	12 months	24 months	36 months	% (n)
Overall safety and support	**91.3%**	98.7%	96.4%	96.1% (249)
Personal safety	89.1%	96.1%	**83.9%**	88.4% (229)
Sustaining trainee wellbeing	91.3%	93.4%	**84.7%**	88.4% (229)
Support processes (other than mentoring)	**89.1%**	94.7%	91.9%	92.2% (237)
Clinical protocols	95.7%	**94.7%**	94.9%	95.0% (246)
Supervision arrangements	97.8%	97.4%	**95.6%**	96.5% (250)
Cultural safety practices	**89.1%**	93.4%	90.4%	91.1% (234)
Comprehensive orientation program at the commencement of training	93.5%	**86.8%**	96.4%	93.1% (241)

Note: The smallest proportions are in bold.

4.4.4 Governance structures and trainee assistance

Eighty per cent 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. However, a larger proportion (92%) of DEMTs agreed their ED had a governance structure in place that supports trainees in completing the requirements of the FACEM Training Program.

The same proportion of DEMTs agreed that adequate processes were in place for identifying and assisting trainees experiencing difficulties meeting the training requirements at their ED and managing trainee grievances (96%, respectively). Likewise, the reflection provided by FACEM trainees in the 2022 Trainee Placement Survey was relatively less positive, where 77% agreed their placement has adequate processes to identify and assist trainees having difficulty, and 73% agreed that adequate processes were in place to manage trainee grievances.

4.4.5 Rostering

Just over three-quarters of DEMTs (78%) agreed they were satisfied with rostering at their ED overall. The largest proportions of DEMTs were in agreeance that rosters at their ED considered trainee workload and ensured safe working hours (92%, respectively). DEMTs were less likely to agree that their rosters took into account the skill mix required for the department (82%), or that the rosters were provided to trainees in a timely manner (84%). Compared to the responses of the 2022 Trainee Placement Survey, trainees were consistently less likely than DEMTs to agree with all the rostering statements..

The proportions of DEMTs who were in agreeance with each of the rostering statements are presented in Table 6, by accreditation level. DEMTs working at sites accredited for 36 months were generally less satisfied with the individual rostering statements, compared with sites accredited for shorter duration.

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

Rostering statements	Accreditation level			Total
	12 months	24 months	36 months	% (n)
Overall, I am satisfied with rostering at my site	80.4%	76.3%	**77.4%**	77.6% (201)
Rosters are provided in a timely manner for trainees	91.1%	84.0%	**81.0%**	83.7% (215)
Rosters give equitable exposure to day/ evening/ night shifts	**78.3%**	81.3%	88.2%	84.4% (217)
Rosters give equitable shifts to all areas of the ED	91.3%	93.4%	**88.1%**	90.3% (232)
Rosters consider trainee workload, including attendance at education sessions	95.7%	**90.8%**	91.9%	92.2% (238)
Rosters support the service needs of the site	93.5%	90.8%	**89.7%**	90.7% (234)
Rosters ensure safe working hours	93.5%	92.0%	**91.9%**	92.2% (237)
Rosters take into account staff leave requests	**89.1%**	90.8%	95.6%	93.0% (239)
Rosters take into account the skill mix required for the department	84.8%	**78.9%**	83.1%	82.2% (212)

Note: The smallest proportions are in bold.

DEMTs were asked to comment on the rostering at their ED, with 71 providing feedback. Consistent with the 2020 DEMT Survey, over two-thirds (70%, n= 50) of comments were negative, describing poor rostering primarily due to understaffing (n= 39). The remaining comments were positive, mentioning the improvements to rostering. Table 7 details the rostering themes and sub-themes described by DEMTs.

Table 7. DEMT responses regarding rostering, themes and subthemes.

Key themes and sub-themes
Poor rostering (n=50) • *Understaffing causing rostering issues* • *Lack of senior staffing for adequate supervision of trainees* • *Did not consider the skill mix required* • *Inequitable rostering of evening/ night/ weekend shifts* • *Inequitable exposure to specific clinical areas* • *Difficulty accessing leave* • *Late issuing of rosters* • *Limited administration support of rostering*
Positive or improvements being made to rostering (n= 21) • *Equitable rostering of clinical areas or day/ night shifts* • *Fair access to leave* • *Considered skill mix required* • *Trainees involved in rostering arrangements or were allowed to nominate preferred clinical areas*

DEMTs were asked to describe how equitable access to protected teaching for trainees was ensured at their ED, with 135 responding. The majority of comments focused on the teaching at their site was protected by rostering (n= 90); for example, rostering all trainees for teaching sessions, and pro rata protected teaching was provided for part-time trainees. Other DEMTs described paid teaching time (n= 32), including over-time allowance for trainees if not rostered for teaching sessions or if they were rostered for evening or night shifts after teaching sessions. Online access or a hybrid model for teaching and education was another common initiative to ensure equitable access (n=25). Twenty-two DEMTs explained that extra medical staff were rostered on-floor to cover trainees during their teaching sessions. Twelve commented that there were additional teaching opportunities, such as

training stage or phase-specific sessions and multiple sessions of the same content per week to accommodate ED rostering needs. Nine DEMTs mentioned part-time trainees were encouraged to attend teaching sessions which they were not rostered for, six described a pro-rata payment scheme for part-time trainees, and one stated that trainees who were job-sharing were expected to share rostered teaching shifts equally. Seven DEMTs also described initiatives to encourage attendance to education sessions at their ED, such as auditing attendance, providing assistance to trainees who could not attend, and encouraging trainees to come forward if they were not receiving rostered teaching that met their needs.

4.4.6 Opportunities for trainees to participate

While most DEMTs (80%) were in agreeance that trainees were able to participate in quality improvement activities at their ED, fewer (70%) agreed that trainees were able to participate in decision-making regarding governance (for example, workplace committees). Nearly all (98%) DEMTs agreed that trainees were able to actively participate as a presenter in formal teaching. A few DEMTs further commented on opportunities for trainees, consistently detailing that although opportunities were available, trainee engagement was often limited due to a lack of allocated clinical support time, or that trainees focussing on examination preparation or prioritising their health and wellbeing.

4.5 Final Comments

DEMTs were provided an opportunity to leave final comments regarding their role as a DEMT, with 38 responding (Table 8). Fifteen comments highlighted areas of support they needed from ACEM. Fourteen outlined the challenges DEMTs were facing in their role. Twelve DEMTs reflected on the rewarding aspects of the role, and eight DEMTs described positive experiences and support.

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

Key themes and sub-themes
Areas of support from ACEM (n= 15) • *Increase resources, online modules and teaching materials* • *Guidance on DEMT role requirements (e.g. clinical support time per trainee supervised)* • *Advocacy for increased clinical support time and the recognition of DEMT role by hospital management* • *Better support for rural EDs (staffing, trainee recruitment)* • *Support and resources for trainee exam preparation and feedback*
Challenges as a DEMT (n= 14) • *Understaffing, prioritising service provision over training, health system pressures* • *Time constraints, unable to provide desired support or supervision for trainees* • *Unsupportive DEM, or hospital executives* • *Difficult to meet College requirements, particularly ITAs*
Role as DEMT – rewarding (n= 12) • *Satisfying, enjoyable, rewarding role* • *Enjoy guiding and mentoring trainees progress through the training program* • *See the role of DEMT as a privilege* • *Being able to influence the next generation of emergency physicians*
Positive experience (n= 9) • *Having a co-DEMT is beneficial and supportive* • *Great support from their department and/or ACEM*

5. Conclusion

Almost all responding DEMTs agreed their role as a DEMT was rewarding and reported being able to complete all requirements of the DEMT role. However, they were less likely to agree that their ED rostering ensured sufficient time to meet the clinical support requirements of their role. Over three-quarters of DEMTs were in agreeance that their ED had governance structures that supported their role in managing the FACEM Training Program. Most DEMTs agreed that their DEM worked cooperatively with them in their role, but significantly less likely to agree that their Hospital Executive and hospital HR/ administration worked cooperatively with them. Over three-quarters agreed they were well supported in managing trainees in difficulty through ACEM Regional Censors or ACEM processes; an improvement was seen in both aspects compared with the previous survey iteration.

All but eight DEMTs agreed that trainee needs were being met at their ED. Consistent with the previous survey findings, DEMTs were more likely to agree that they were routinely rostered on clinical shifts with trainees instead of having regular non-clinical shifts. Similar proportions of DEMTs at major and non-major referral hospitals reported being rostered for clinical shifts; however, DEMTs at non-major referral hospitals were less likely to agree they had regular non-clinical shifts with trainees. Nearly all DEMTs agreed the structured education program was aligned with the content and learning outcomes of the ACEM Curriculum Framework. Importantly, all except three DEMTs agreed that structured education sessions at their site were provided for a minimum of 4 hours per week on average for trainees, fulfilling ACEM accreditation requirements.

Most DEMTs also agreed that their ED provided education and learning resources that met the needs of trainees, including having adequate access to both Primary and Fellowship exam revision/ preparation programs. Some differences were observed by the ED accreditation level, where DEMTs were more likely to report greater opportunities available for learning as the accreditation level increased, for example, the presence of formal ultrasound teaching, access to exam preparation programs, and the availability of critical care rotations.

When DEMT responses were compared to FACEM trainee responses for the same questions asked in the 2022 Trainee Placement Survey, a number of interesting differences were observed. DEMTs consistently responded more positively than FACEM trainees in all aspects of whether their ED provided a safe and supportive training environment or considered the rostering at their ED. With respect to rostering, the most noticeable difference in agreement level between DEMTs and FACEM trainees was observed for whether rosters gave equitable shifts to all areas of the ED (90% DEMTs vs. 80% of trainees), or that rosters considered trainee workload (92% DEMTs vs. 82% of trainees).

Considering the survey respondents represented 140 of the 147 ACEM-accredited EDs, the DEMT survey findings are helpful in informing the College on areas of need to provide continuing support for those undertaking the DEMT role and ensuring ACEM-accredited EDs continue to provide a safe and supportive training environment for FACEM trainees.

6. Suggested Citation

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7. Contact for Further Information

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