EMTA Survey 2020: Results

July 2021

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Executive Summary

The survey was completed by 367 trainees with demographics broadly representative of the wider trainee body. It contains 59 questions and was available to all UK EM trainees to complete from March 8th to April 13th 2020.

A deliberate decision was taken to continue to run the EMTA survey despite the challenges of the COVID-19 pandemic. The survey still allows us to capture longitudinal data and comment on trends in the state of Emergency Medicine Training in the UK, and it was felt may even help to highlight where differences exist as a result of the pandemic.

Key Findings

1. Around three-quarters of trainees plan on taking a locum or substantive consultant job after completing training, only 28.1% plan on working full time as a consultant.
2. Most trainees felt that their educational supervisor **was effective** and added value to their training.
3. Over one-third of trainees report having **no access** to SPA time, despite RCEM recommendations.
4. The frequency of regional teaching found to correlate with the highest attendance is monthly. The frequency of local teaching found to correlate with the highest attendance is weekly.
5. Nearly 1 in 5 trainees felt unable to drive home safely from work yet the vast majority had **no access** to somewhere to sleep after a night shift.
6. The majority of trainees completing training in emergency medicine do not feel competent to manage **paediatric emergencies**.
7. **Bullying, harassment** and undermining are described as ‘endemic’ and ‘widespread and accepted practice’ in UK emergency medicine. The data across the past three EMTA surveys and the free-text responses do not make for pleasant reading.

Introduction and Purpose

EMTA has conducted surveys of all UK emergency medicine trainees, in various guises, since the first which was conducted in July 2013 and published in December 2014 [1]. This first iteration was led by the College of Emergency Medicine in conjunction with EMTA and focused on 'the attractiveness of a career in emergency medicine'. The report contained many useful findings, but it also highlighted that a focused effort in gathering the views of trainees about training had real value. Following on from this EMTA has collected data on training and the trainee experience in July 2015 [2], November to December 2016 [3] and November 2017 to January 2018 [4]. Each has been a phenomenal amount of work by the subsequent survey teams and the data contained in each report has allowed EMTA to represent trainees' views at the College and to other stakeholders. Many aspects of training have improved and when taken as a body of work it is clear that each survey has played an important role in providing the data that has helped drive this improvement.

This iteration marks an ending and a new beginning. Training in emergency medicine is shortly to benefit from a new curriculum. We are also facing an uncertain road as the specialty, along with the rest of the world, attempts to recover from the impact of COVID. As such EMTA has decided that now is the right time to develop a new survey. We recognise that trainees are repeatedly asked for their thoughts and opinion and survey fatigue is a real risk. Activities such as the annual GMC trainees survey are an excellent resource for advocating for training and trainees but we are mindful not to duplicate such work.

We hope that the findings in this report are of use and I want to take the opportunity to thank all the trainees who have taken their time to complete any of the surveys going back to 2013. Without this input, the surveys would not succeed and EMTA's job of trying to make training better would be much harder.

Survey results

Demographics

367 trainees completed the survey. 2390 were invited to participate, giving a response rate of 15.4%. Of the respondents, 9.3% were DRE-EM trainees, 46.9% were female, 49.9% male with 12 respondents choosing not to disclose their gender

Grade	Number	%
CT/ST1	58	15.8%
CT/ST2	44	12.0%
CT/ST3	63	17.2%
ST4	67	18.3%
ST5	72	19.6%
ST6	53	14.4%
ST7+	10	2.7%
Total	367	100%

Table 1. Survey respondents by current grade.

LETB	Number	%
Defence	8	2.2%
Scotland	23	6.3%
Wales	15	4.1%
Northern Ireland	7	1.9%
East Midlands	27	7.4%
East of England	47	12.8%
Thames Valley	13	3.5%
Kent Surrey and Sussex	12	3.3%
London	58	15.8%
North east and north Cumbria	13	3.5%
North west	30	8.2%
Peninsula	8	2.9%
Severn	12	3.3%
West Midlands	37	10.1%
Wessex	14	3.8%
Yorkshire and Humber	43	11.7%
Total	367	100%

Table 2. Survey respondents by training region or board.

Figure 1. Demographics of respondents

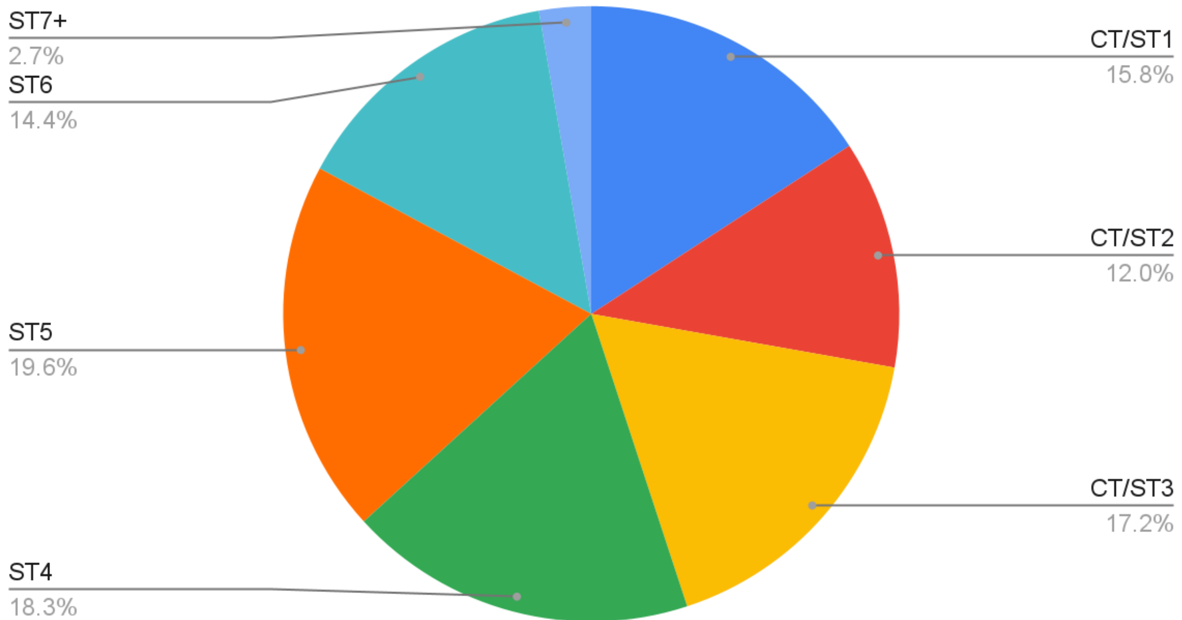
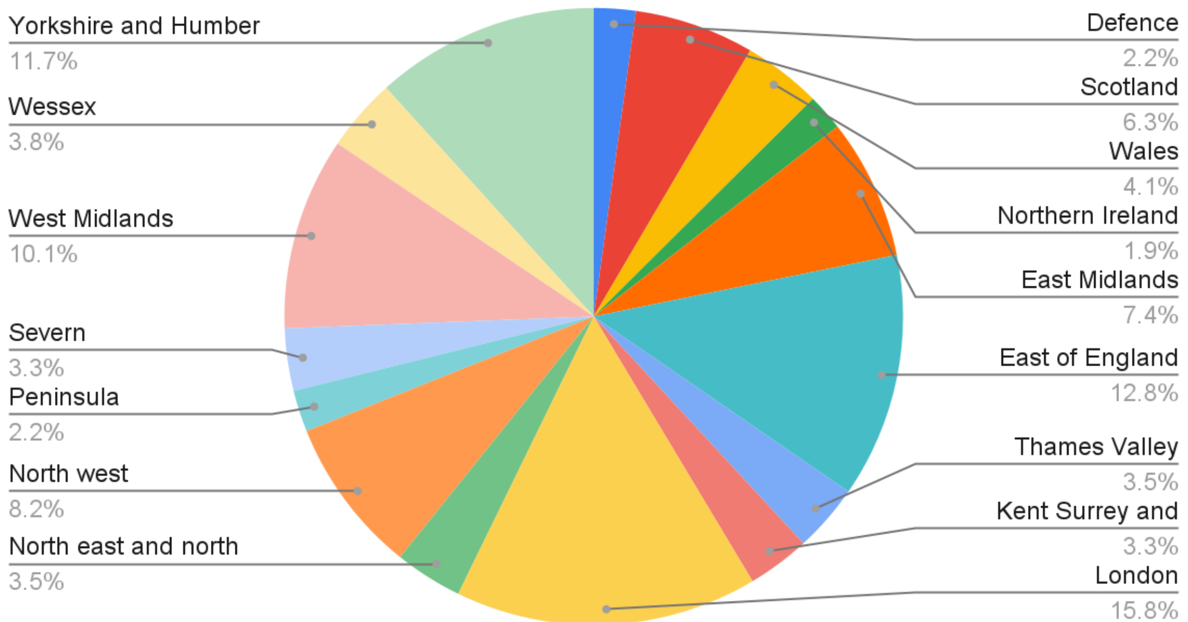


Figure 2. LETB of Respondents



Less than full time training

Trainees are currently eligible to enter Less Than Full Time Training (LTFT) under 3 categories. Category 1 – caring responsibilities or health needs, Category 2 – work, other opportunities or commitments that do not qualify for Category 1, and Category 3 where, since 2017, trainees have been able to apply for LTFT without the requirement to give a reason. Trainees have previously reported that this results in less burnout, the ability to provide better care, to achieve better educational outcomes, and to improve their work-life balance.

The majority of trainees, 286 of 367 (77.9%) were full time; 51 (13.9%) were less than full time for health or caring responsibilities, 13 (3.5%) for unique personal or professional development reasons, and 17 (4.6%) were LTFT through personal choice.

Perhaps more significantly, 114 (28.9%) are considering going LTFT under category 3 in the future, whilst a further 119 (32.4%) anticipate going LTFT under categories 1 or 2. Only 106 (28.9%) do not foresee working LTFT in the future. Of 276 respondents, 97 (35.14%) indicated that they wanted to work LTFT, but could not afford the pay cut.

After training

Of 367 respondents, 199 (54.2%) anticipated their first post being as a substantive EM consultant in the UK, whilst 88 (24.0%) anticipated working as locum consultants in the UK; 53 (14.4%) anticipate undertaking further training, most commonly in PHEM, PEM and ultrasound.

It should also be noted that only 103 (28.1%) are anticipating working full time as a consultant, with 166 (45.2%) actively planning to work LTFT and the remaining 98 (26.7%) undecided.

Placement choice

Of 367 respondents: 125 (34.1%) chose their current hospital, 116 (31.6%) had their current hospital on their preference list, and 103 (28.1%) were happy with their allocation even though they didn't choose it. Only 23 (6.27%) were unhappy with their allocation.

SPA Time

At the time of the survey the Royal College of Emergency Medicine recommended that CT3/ST3 trainees were allocated 2 hours per week SPA time and higher specialist trainees (HSTs) allocated 4 hours per week SPA time, or WTE.

Overall, from 367 respondents, 130 (35.4%) report having no access to SPA time, 140 (38.2%) have less than 4 hours per week on average and 97 (26.4%) have 4 hours per week or more. For those 165 respondents at grades CT1-3, 104 (63.0%) report having no SPA time, 45 (27.3%) have less than 4 hours per week on average, and 16 (9.7%) have 4 hours per week or more.

It should be noted that with EMTA representation through the Curriculum and Training Standards Committee it has been agreed that SPA time will be re-named Educational Development Time, to avoid confusion with how this term is used to describe Consultant work schedules, and that the recommendation be changed to a minimum of:

- ACCS – 3 hours per week or 60 hours during their 6-month EM block
- ST3 – 4 hours per week or 160 hours per annum
- HST – 8 hours per week or 320 hours per annum, (pro-rata for LTFT)

Fatigue and facilities

Of 367 respondents, 244 (66.5%) had not received formal guidance or training on fatigue; 63 (17.2%) had received training at regional induction, and 81 (22.1%) had received training at local (trust or department) induction.

Fatigue Statements	Total	%
I have felt fatigued after night shifts	300	87.2%
I have felt fatigued after daytime or evening shifts	221	64.2%
I have felt my ability to drive home was impaired by fatigue (after day/ evening shift)	84	24.4%
I have felt my ability to drive home was impaired by fatigue (after twilight/ night shift)	178	51.7%
I have felt unable to drive home safely	68	19.8%
Fatigue affected my performance at work	137	39.8%
Fatigue has affected my ability to participate in a training event	126	36.6%
Fatigue has negatively affected my family or personal life	219	63.7%

Table 3. Number and percentage of trainees agreeing with statements related to fatigue. (344 respondents)

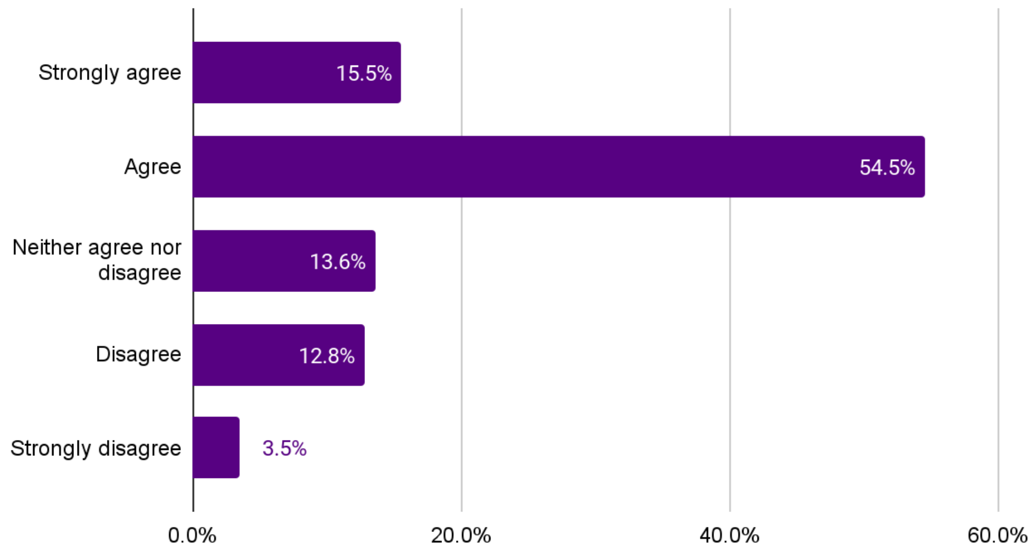
Hospital Facilities	Number	%
Canteen selling hot food 24/7	42	11.9%
Somewhere to sleep after a night shift (free of charge)	101	28.5%
Somewhere to sleep after a night shift (at cost)	55	15.5%
A locked room or secure locker in which to store belongings while working	184	52.0%
Child care facilities	35	9.9%
Access to a library open 24/7	129	36.4%
Facilities to shower and change before and after shifts	222	62.7%
Recycling bins in clinical areas	110	31.1%
Social club	28	7.9%
Gym	50	14.1%

Table 4. Number and percentage of respondents stating that this facility was available to them. (354 respondents)

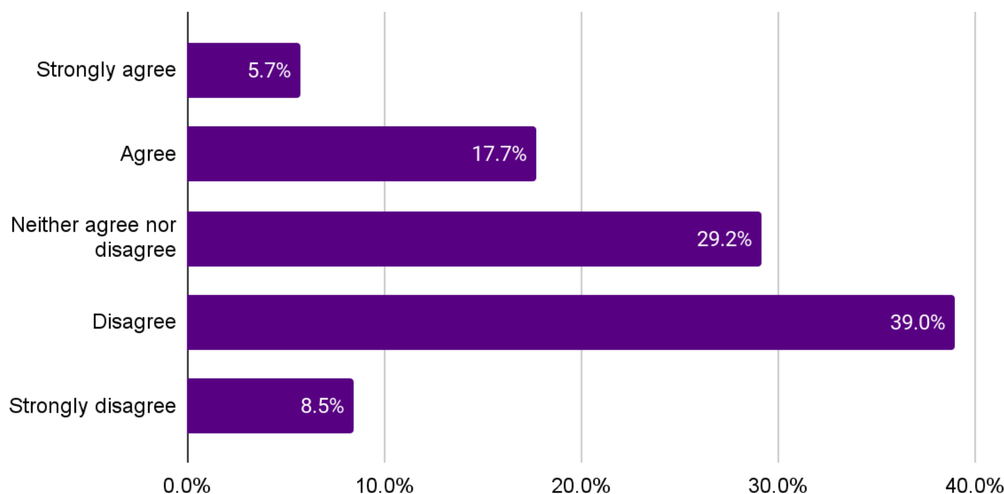
Tables 3 and 4 include a number of concerning findings. Nearly 1 in 5 trainees felt unable to drive home safely from work yet the vast majority had no access to somewhere to sleep after a night shift. Nearly 2 in 5 felt that fatigue had impacted their performance at work and greater than 3 in 5 that it had negatively impacted their family or personal life. Similar findings in previous years in part drove the development of the EMTA Rest and Rota Charter, published in July 2020 [1]. Departments can add their signature to the charter here.

Training

Most trainees thought that their current post met their training needs as shown in figure 3 below.



Difficult referrals are one aspect of working in emergency medicine that a significant minority of trainees state may impact the sustainability of the career — see figure 4 below.



Supervision

Of 367 respondents, 108 (29.4%) reported that doctors in foundation or core training in their current workplace were occasionally or frequently supervised by non-medically trained clinicians, e.g. ACP/ANPs, whilst 179 (48.8%) stated that this never occurred. This is potentially

problematic as RCEM guidance [2] places both these groups of staff in the same tier, and highlights inconsistencies with lines of responsibility that have been raised to EMTA via other means.

Of 367 respondents, 90 (24.5%) reported that CT3/ST3 doctors worked as the most senior doctor present in the emergency department either occasionally or frequently. Of these respondents, 32 (8.7%) reported that this happened frequently.

This is again problematic, as RCEM states ‘the critical difference between [tier 3 and tier 4] is that tier 4 doctors may be expected to be in charge of a department without a consultant being on-site.’ [2] Trainees at grades below ST4 but who are deemed by local evaluation to be capable of operating at ST4 and who agree to undertake the additional responsibility of the ST4 role should be formally recognised as competent to do so and recommended for advancement at ARCP in line with competency-based training. Where they are not deemed competent or do not feel ready for the responsibility, they should not find themselves in charge of a department unsupervised. This presents a danger to patients.

From 165 respondents at ST1-3 level, 60 (36.4%) felt they were supervised by a more senior doctor who is not operating at the level expected for their grade. This compares with 56 (27.7%) from 202 respondents at ST4+ level. Nearly three-quarters of trainees felt that their educational supervisor was effective — see figure 5 below. Trainees were split about whether they would be happy to have a staff grade or associate specialist doctor as their education supervisor — see figure 6 below.

Figure 5. My educational supervisor is effective and adds value to my training.

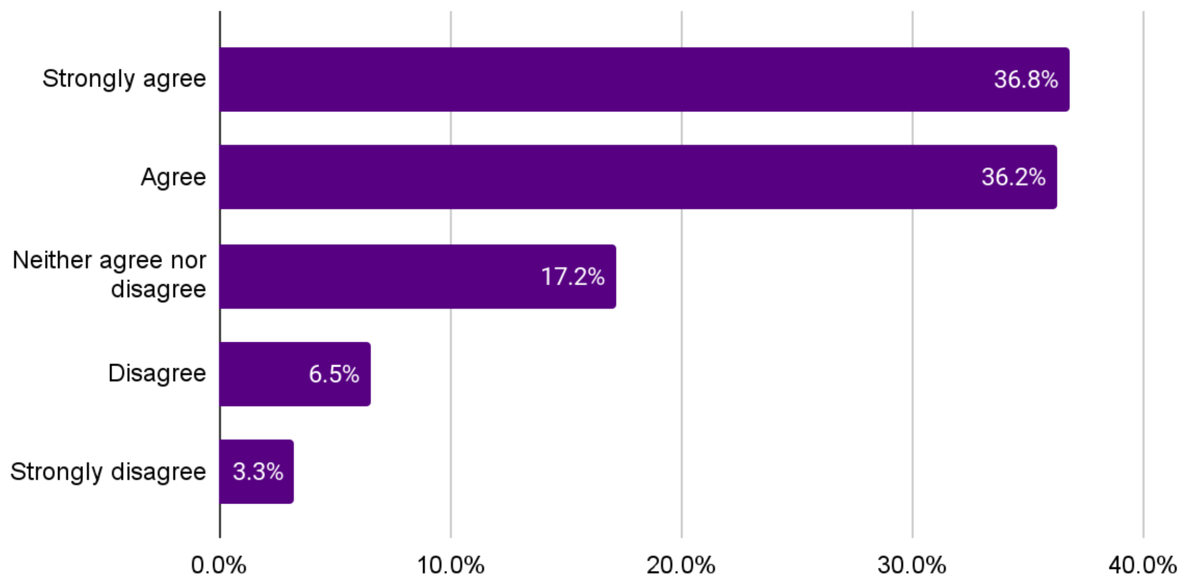
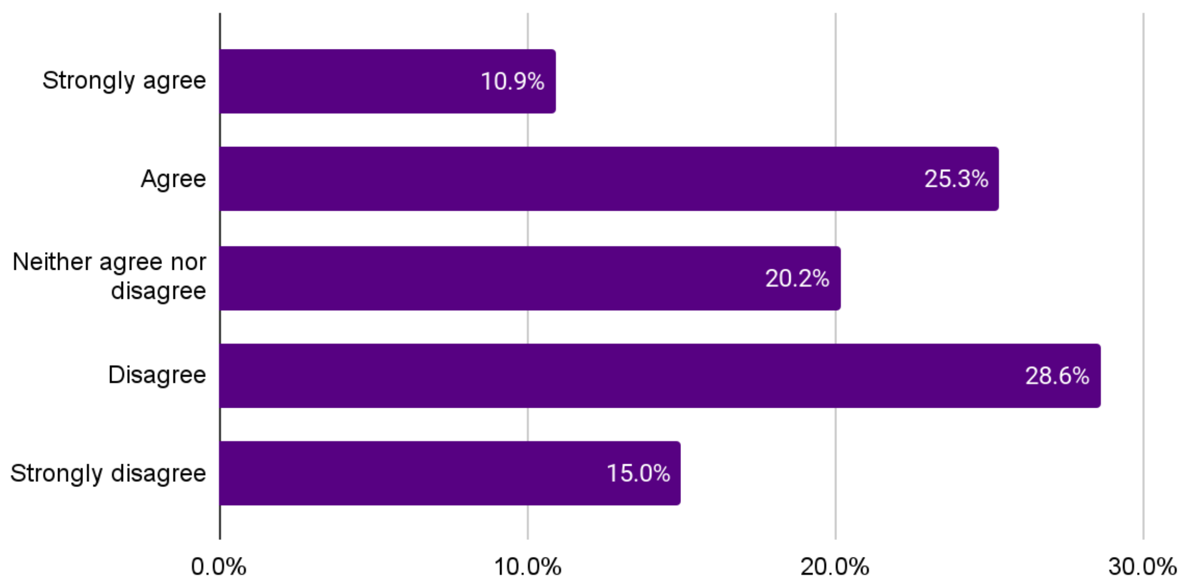


Figure 6. I would be happy to have a staff grade or associate specialist doctor as my educational supervisor.



Teaching

From 367 respondents, regional teaching is most commonly held monthly for 297 (80.9%) of respondents. For those replying that regional teaching was held monthly, 93.9% reported that they were able to attend monthly; for those replying that regional teaching was held fortnightly, only 50% reported that they were able to attend with the same frequency.

Local teaching is most commonly held weekly for 188 (51.2%) of respondents, and 82.9% of those reported that they were able to attend with the same frequency. This was greater than reported attendance for either twice weekly, fortnightly or monthly teaching.

As in previous surveys, monthly regional teaching and weekly local teaching have the highest reported attendance.

Nearly half of trainees reported rarely or never receiving shop floor teaching from a more senior doctor (see figure 7), though in general trainees found regional, local and shop-floor teaching valuable (see figure 8).

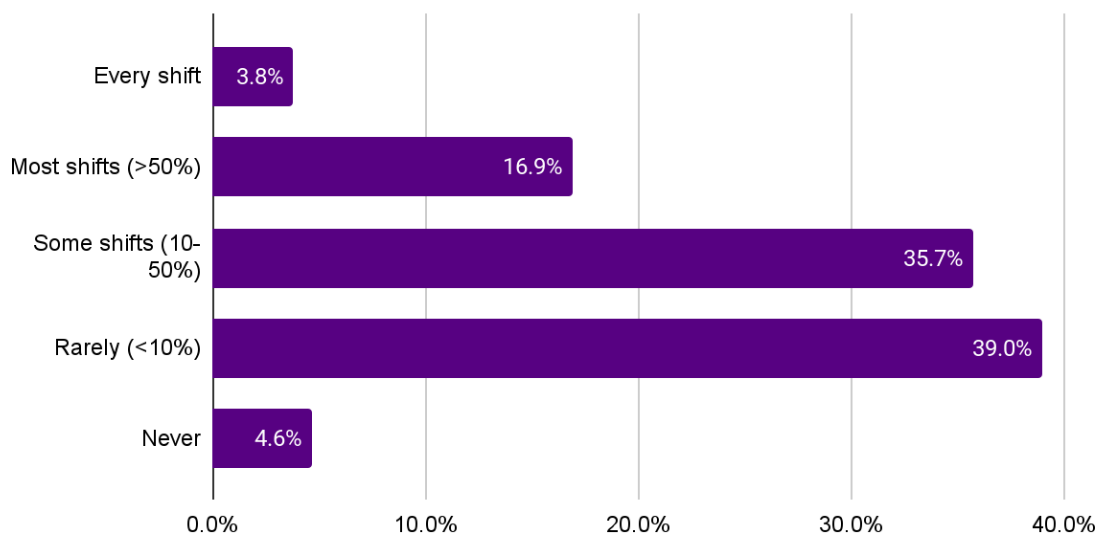
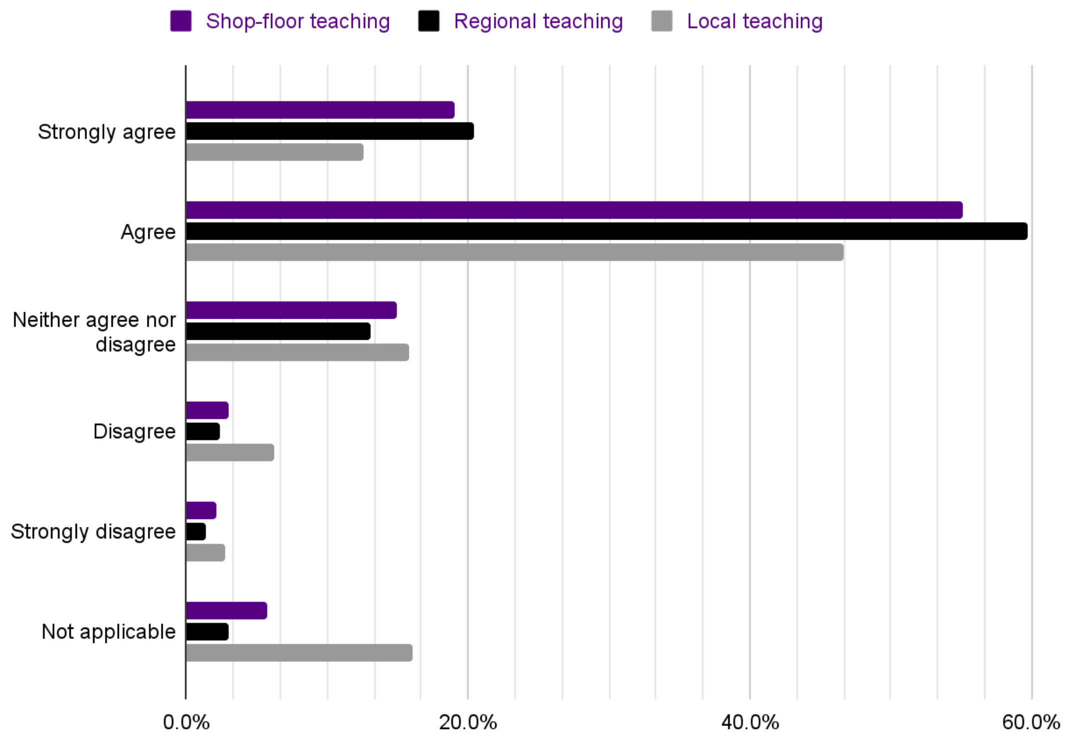


Figure 8. The teaching I receive is valuable to my training and development?



Workplace-based assessments (WBPAs)

Trainees tended to report finding WPBAs useful, though not overwhelmingly so; answering the question 'how useful do you find the following WBPAs?' trainees rated the following good or very good versus poor or very poor:
miniCEX (52% vs 17%)
CBD (60% vs 13%)
DOPS (58% vs 13%)
ACAT (40% vs 11%)
ESLE (59% vs 4%)

Many trainees found them problematic to arrange; answering the question 'how easy do you find it to arrange WBPAs in your current post?' trainees rated the following good or very good versus poor or very poor:
miniCEX (30% vs 63%)
CBD (43% vs 26%)
DOPS (34% vs 33%)
ACAT (19% vs 39%)
ESLE (27% vs 37%)

For more detail, free text comments and a breakdown for ST4+ trainees, refer to appendix 1.
miniCEX = mini clinical evaluation exercise
CBD = case-based discussion
DOPS = direct observation of procedural skills
ACAT = acute care assessment tool
ESLE = extended structured learning event

Faculty governance statement

46.9% felt they were useful, 56.4% accurate, 59.4% fair. 11.7% had concerns reported in their faculty governance statements not previously raised with them by their educational supervisor. 44.4% had been able to discuss the statement prior to ARCP. 4.1% had their training time extended due to the statement.

Annual review of competence progression (ARCP)

Of 367 respondents, 249 (67.9%) discussed their anticipated ARCP outcome with their educational supervisor, 71 (19.4%) had an unexpected ARCP outcome, and 10 (2.7%) had appealed their ARCP outcome.

Paediatric EM ST3

Of 259 respondents, 166 (64.1%) felt their PEM ST3 placement was adequate to provide them with the skills needed to manage and advise on a range of paediatric emergencies as a senior decision-maker in their HST years.

Trainees completed their PEM ST3 year in a range of locations (see table 5) and had access to a range of opportunities (see table 6.)

Where did you do your Paediatric EM ST3?	Number	%
Dedicated children's hospital	66	25.3%
Major Trauma Centre	67	25.7%
Trauma Unit	105	40.2%
ED without MTC/TU status	23	8.8%

Table 5. Where trainees completed their ST3 PEM placement. (261 respondents)

During your PEM ST3 placement, did you spend time in the following?	Number	%
Paediatric ED	247	96.1%
PAU/Children's ward	59	23.0%
Paediatric Clinics	30	11.7%
SCBU	7	2.7%
NICU	12	4.7%
PICU	9	3.5%

Table 6. Opportunities available during ST3 PEM placement. (257 respondents)

Of 255 respondents, 119 (44.9%) felt they spent enough time gaining experience in PEM during their HST years. Of 257 respondents, 160 (60.4%) felt they have supervision by PEM subspecialty consultants (RCEM or Paediatric) during HST.

Of 256 respondents, only 119 (44.9%) felt their continuing training in PEM during your HST was sufficient to feel competent in managing a range of paediatric emergencies as a consultant without the need for formal PEM sub-specialty training.

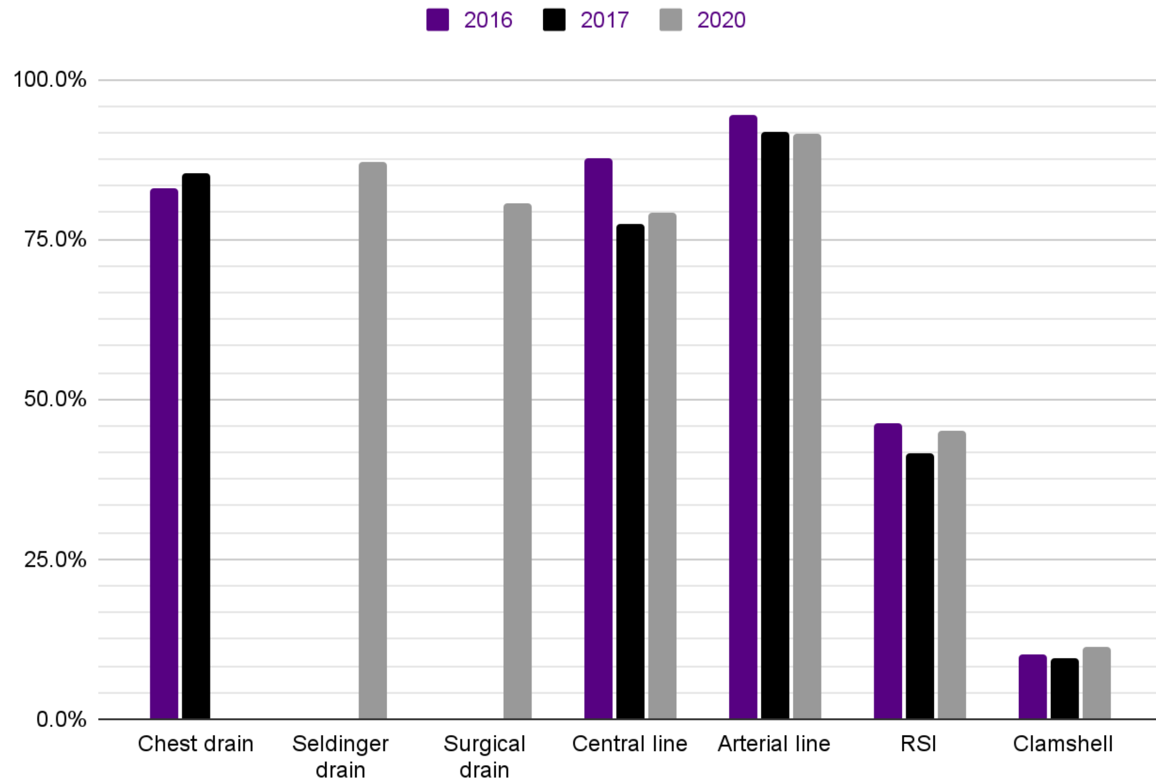
These findings imply that the majority of trainees completing training in emergency medicine do not feel competent to manage paediatric emergencies.

Procedural competence

Trainees reported varying degrees of confidence in their ability to perform unsupervised or teach a range of procedural skills (see figure 9). A significant proportion of ST6+ respondents were not confident to teach rapid sequence induction and clamshell thoracotomy (see figure 8).

Trainees also reported that different specialties would be responsible for different procedures performed in the ED. In many instances, a newly qualified consultant would be expected to be able to perform a procedure (see table 7 and 8) which ST6+ doctors did not report confidence with (see figure 10).

Figure 9. Proportion of ST4+ confident to perform unsupervised or teach each procedural skill.



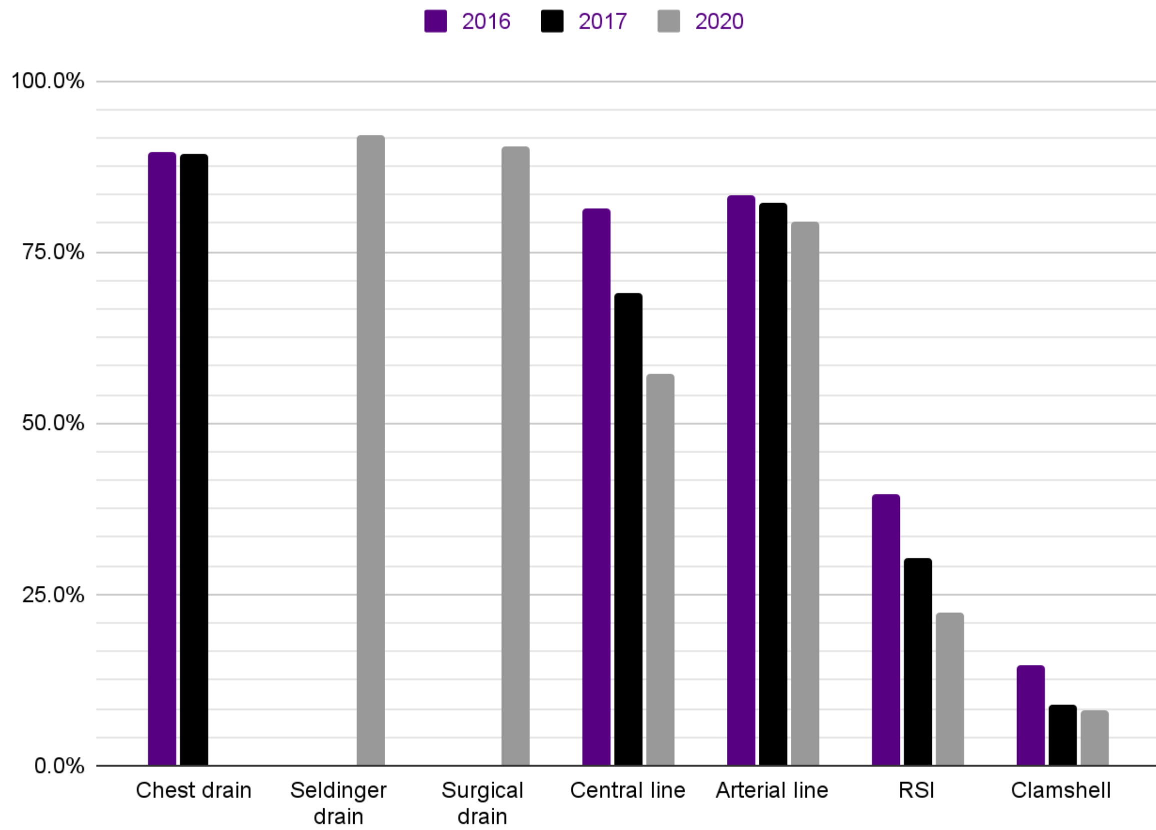


Figure 10. Proportion of ST6+ confident to teach each procedural skill.
2016
2017
2020
100.0%
75.0%
50.0%
25.0%
0.0%
Chest drain
Seldinger drain
Surgical drain
Central line
Arterial line
RSI
Clamshell

	Emergency medicine	Intensive care/ anaesthetics	Orthopaedics	General/ acute medicine	Not applicable
Lead non-traumatic cardiac arrest	96.2%	9.3%	0%	16.9%	1.1%
Lead traumatic cardiac arrest	94.3%	7.4%	1.1%	1.1%	5.7%
Adult procedural sedation	93.7%	27.3%	0.5%	0.5%	2.5%
Paediatric procedural sedation	58.9%	36.0%	0.5%	0%	23.4%
Arterial line	58.9%	85.0%	0%	4.1%	2.5%
Central line	45.0%	90.2%	0%	3.8%	3.3%
Manipulation of ankle fracture-dislocation	91.3%	1.4%	54.5%	0%	1.4%
Rapid sequence induction	40.1%	93.2%	0%	0.3%	1.9%
Start NIV	90.7%	37.6%	0%	46.3%	1.9%

Table 7. In your current emergency department which specialty would perform the following procedures? (367 respondents) NIV = non-invasive ventilation

	Emergency medicine	Intensive care/ anaesthetics	Orthopaedics	General/ acute medicine	Not applicable
Lead non-traumatic cardiac arrest	98.9%	6.5%	0.5%	10.1%	0.5%
Lead traumatic cardiac arrest	99.2%	5.2%	1.4%	0.3%	0.8%
Adult procedural sedation	98.4%	22.9%	0.8%	0.5%	0.5%
Paediatric procedural sedation	86.9%	39.0%	0.5%	0.3%	3.5%
Arterial line	83.4%	61.3%	0%	7.6%	0.5%
Central line	75.5%	69.2%	0%	7.4%	0.5%
Manipulation of ankle fracture-dislocation	96.3%	1.6%	48.2%	0%	0.5%
Rapid sequence induction	71.7%	75.2%	0%	0.5%	0.5%
Start NIV	97.6%	33.8%	0.5%	40.1%	0.5%

Table 8. In your first job after CCT which specialty would you expect to do the following? (367 respondents) NIV = non-invasive ventilation

Ultrasound

94.3% have access to a suitable machine. 7.4% had no access to supervision with >6months experience of independently practicing level 1 emergency ultrasound. 85.8% did not have a system for routine review of images. These findings, expanded in figures 11, 12 and 13, suggest that despite emergency ultrasound becoming integrated into the curriculum a significant minority of trainees do not have access to the required equipment or expertise to meet the curricular requirements.

Figure 12. Do you have access to supervision for point of care ultrasound within your department? (By a clinician with >6/12 experience of independently practicing level 1 emergency medicine ultrasound)

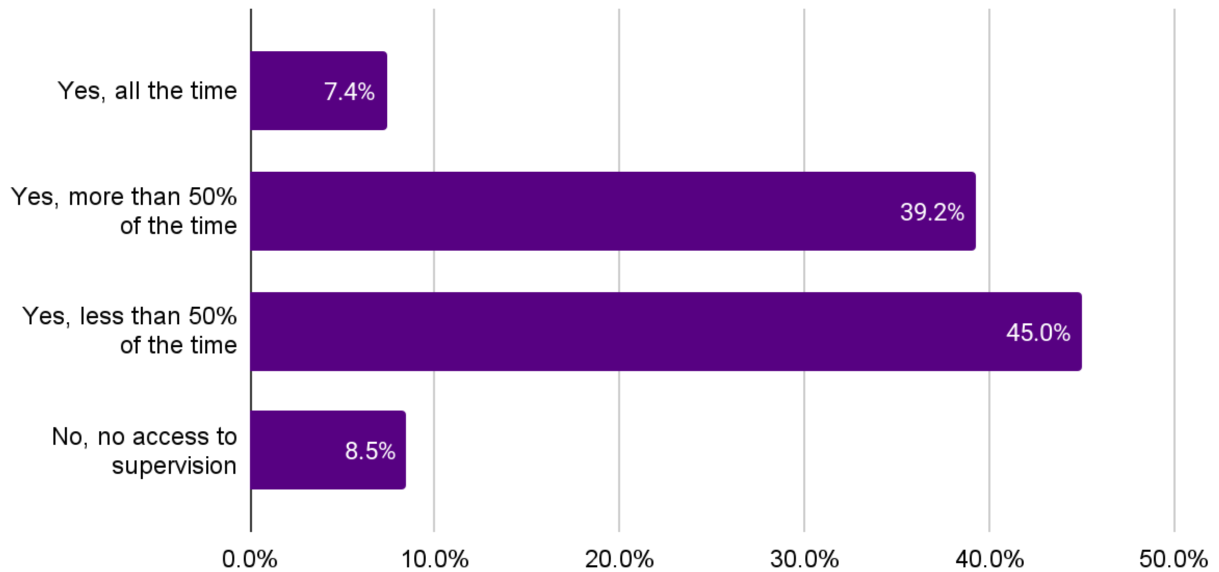
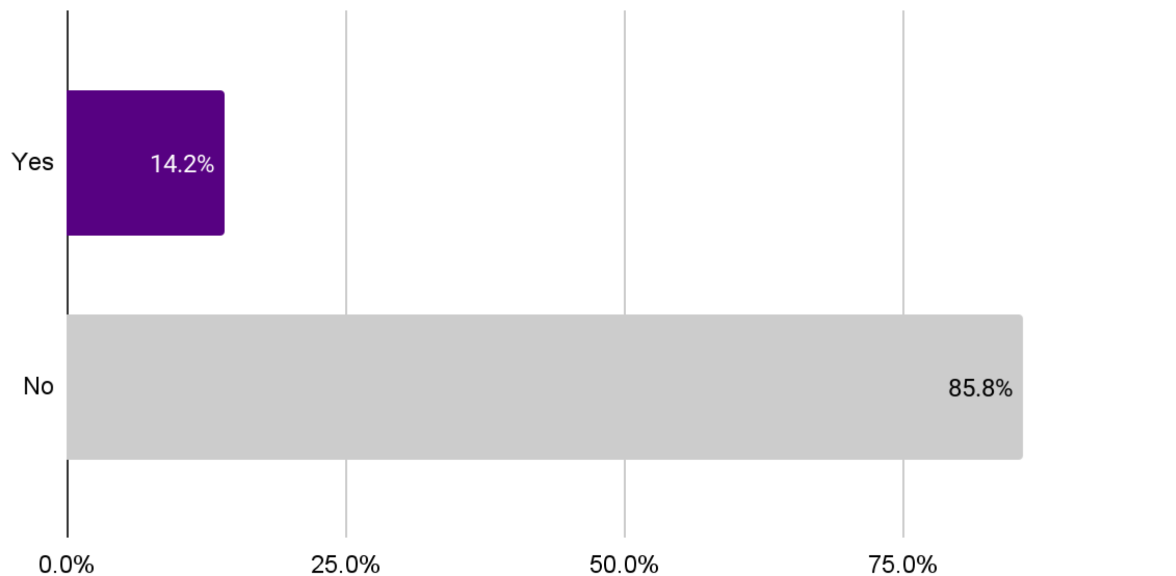


Figure 13. Does your current department have a system for routine review of POCUS imaging?



Bullying and harassment

From 367 respondents, in the last four weeks:

- 99 (27.0%) felt undermined at work
- 24 (6.5%) had been harassed at work
- 37 (10.1%) felt bullied at work
- 71 (19.4%) witnessed a colleague being undermined
- 30 (8.2%) witnessed a colleague being harassed
- 40 (10.9%) witnessed a colleague being bullied

From 367 respondents, for those who witnessed undermining, harassment or bullying, they reported the victim as:

- 119 (32.4%) medical staff
- 45 (12.3%) nursing staff
- 15 (4.1%) other healthcare staff
- 4 (1.1%) management staff

From 367 respondents, for those who witnessed undermining, harassment or bullying, they reported the aggressor as:

- 105 (28.6%) medical staff
- 63 (17.2%) nursing staff
- 18 (4.9%) other healthcare staff
- 31 (8.5%) management staff

In comparison, the 2017 EMTA survey [3], which was the first to assess this, found that “in the last 4 weeks” 19.9% felt bullied at work, 53.5% felt undermined and 20.8% had witnessed a colleague being harassed. This was compared to the British Orthopaedic Trainees Association 2016 census where 7% of trainees reported being bullied but 70% had witnessed a colleague being undermined [4]. The following year’s EMTA survey showed slightly higher levels [5]. This most recent survey has shown a reduction with 27% reporting having felt undermined, 6.5% harassed, 10% bullied in the last four weeks. Similar numbers had witnessed a colleague being undermined (19.4%), harassed (8.2%) or bullied (10.9%).

Anonymised free-text responses on the topic of bullying, harassment and undermining can be found in Appendix 2.

Global health

From 363 respondents, 173 (47.7%) either agreed or strongly agreed that they would be interested in a global health OOPE/OOPT/fellowship during training. Amongst ST4+ trainees, 85 of 201 (42.3%) expressed this sentiment.

Of 363 respondents, 38 (10.5%) stated they are involved in local global emergency medicine networks, whilst 241 (66.4%) stated they would be interested in joining one.

85.9% thought that 'a structured programme when deployed overseas' is either important or very important. 87.9% thought that funding was important or very important 'for deployment overseas.' 89.3% thought that 'recognition of time spent out of training' is important or very important. 86.8% thought that 'duration of the deployment overseas' is important or very important. 90.1% thought that 'pre-deployment training on important aspects of global health; is either very important or important. More detail around these questions is available in appendix 3.

Free text responses to the question 'what would be the most important motivations, considerations and barriers for you when considering an OOPE/OOPT/fellowship in global emergency medicine?' can be found in appendix 3.

EM Research

Around 1 in 5 trainees have completed research activity while in a training post, with over 2 in 5 stating that they had not but would like to. The vast majority had heard of TERN and around half held a GCP certificate (see figures 14, 15 and 16).

Figure 14. Whilst in an EM training post have you done any research activities?

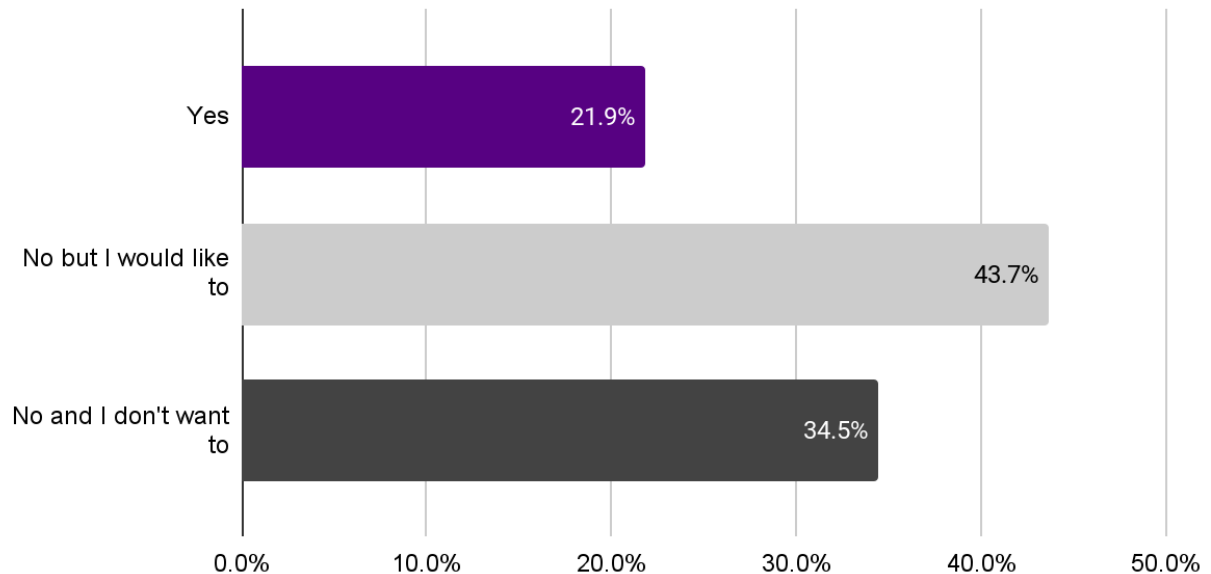


Figure 15. Have you heard about the trainee emergency research network (TERN)?

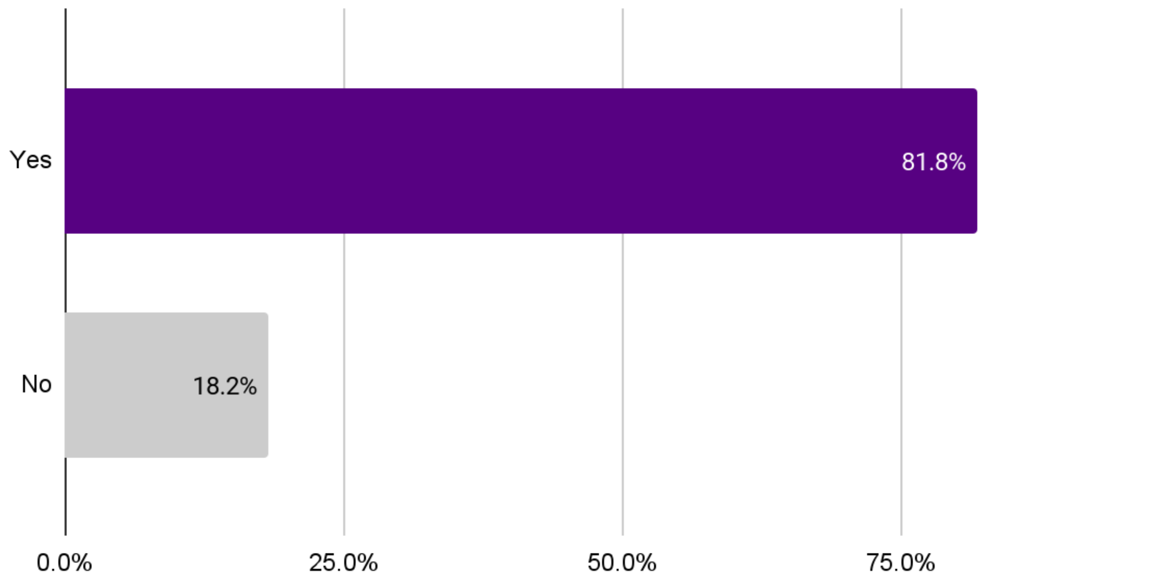
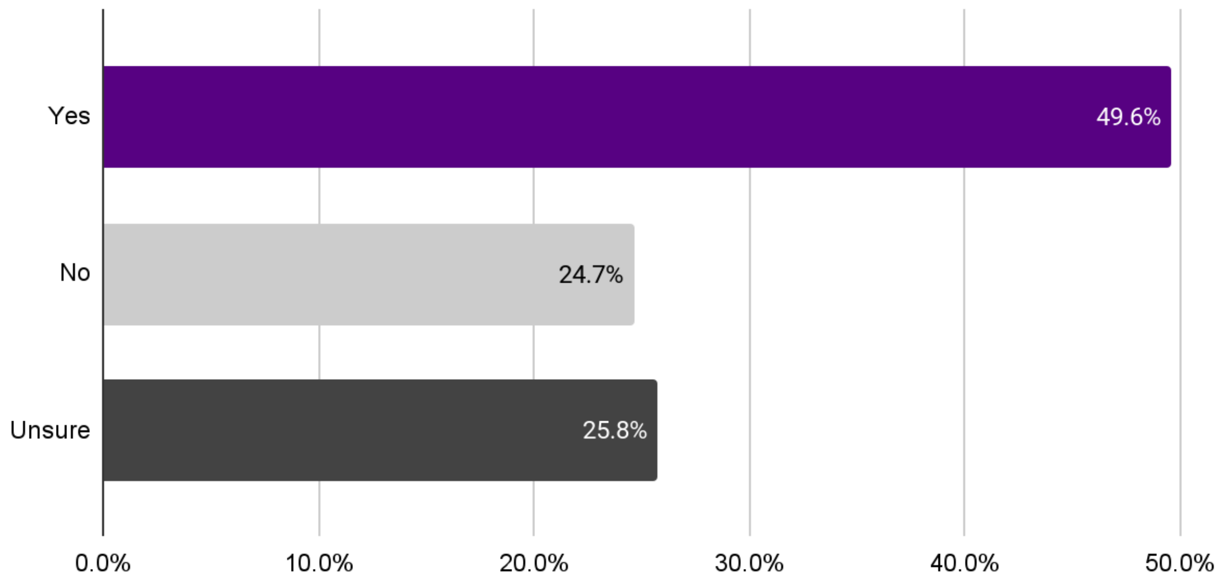


Figure 16. Do you hold a Good Clinical Practice (GCP) certificate?



From 357 respondents:

- 104 (29.1%) have been on a delegate log to recruit patients into a research trial
    - 77 of 199 (38.7%) ST4+
- 110 (30.8%) have recruited patients into a research trial
    - 85 of 199 (42.7%) ST4+
- 33 (9.2%) have been PI for a research trial
    - 24 of 199 (12.2%) ST4+
- 6 (1.7%) have been CI for a research trial
    - 5 of 199 (2.5%) ST4+
- 42 (11.8%) have submitted an abstract to RCEM ASC
    - 31 of 199 (15.6%) ST4+
- 100 (28.0%) have submitted an abstract to any other conference
    - 71 of 199 (35.7%) ST4+
- 73 (20.5%) have given an oral presentation at a conference
    - 55 of 199 (27.6%) ST4+
- 52 (14.6%) have submitted a paper for publication
    - 39 of 199 (19.6%) ST4+
- 52 (14.6%) have had a paper published in a journal
    - 41 of 199 (20.6%) ST4+
- 19 (5.3%) have ever held an academic post
    - 10 of 199 (5.0%) ST4+

In response to the question ‘What do you currently feel are barriers to you becoming involved in EM research?’, 163 of 260 (77.6%) cited a lack of time to do so, alluding both to absolute time poverty and distribution of antisocial clinical hours compared to research meetings and planning in normal working hours.

Emergency Medicine Journal (EMJ)

Respondents read the EMJ always (6.4%), usually (27.5%), sometimes (39.5%), rarely (22.7%) or never (3.9%). Around half preferred to read the paper version of the EMJ.

27.5% reported having a departmental journal club. It would be worth noting that the RCEM Curriculum 2021 outlines a requirement in SLO 10 for all trainees to be acquiring and demonstrating skills in critical appraisal of literature and its application to clinical practice, through each training year. Many of the skills relating to this SLO are expected to be demonstrated in local journal clubs where trainees receive feedback and guidance on their participation and presentation.

Figure 17. Do you read the Emergency Medicine Journal?

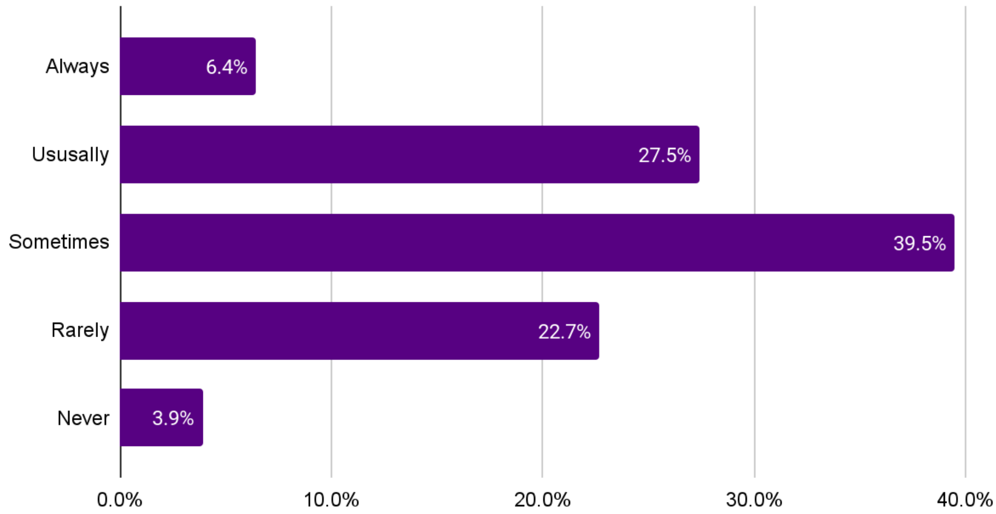
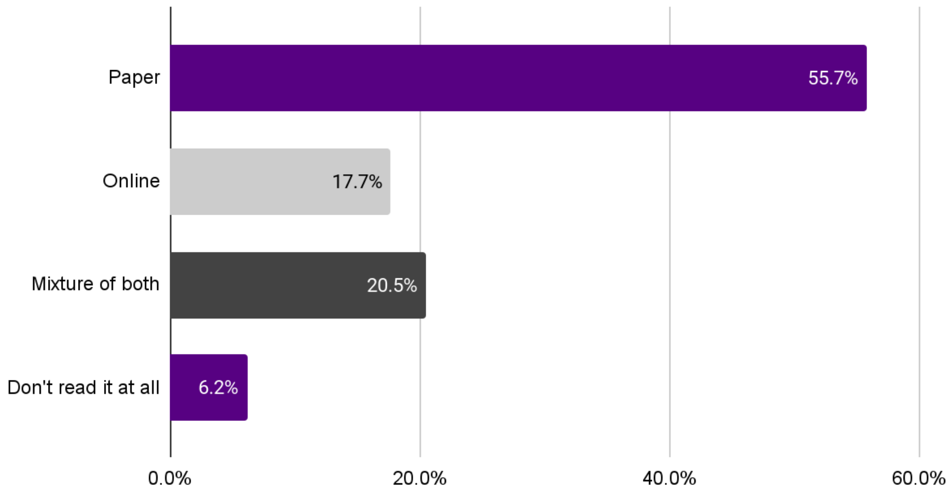


Figure 18. What is your preferred reading method for the EMJ?



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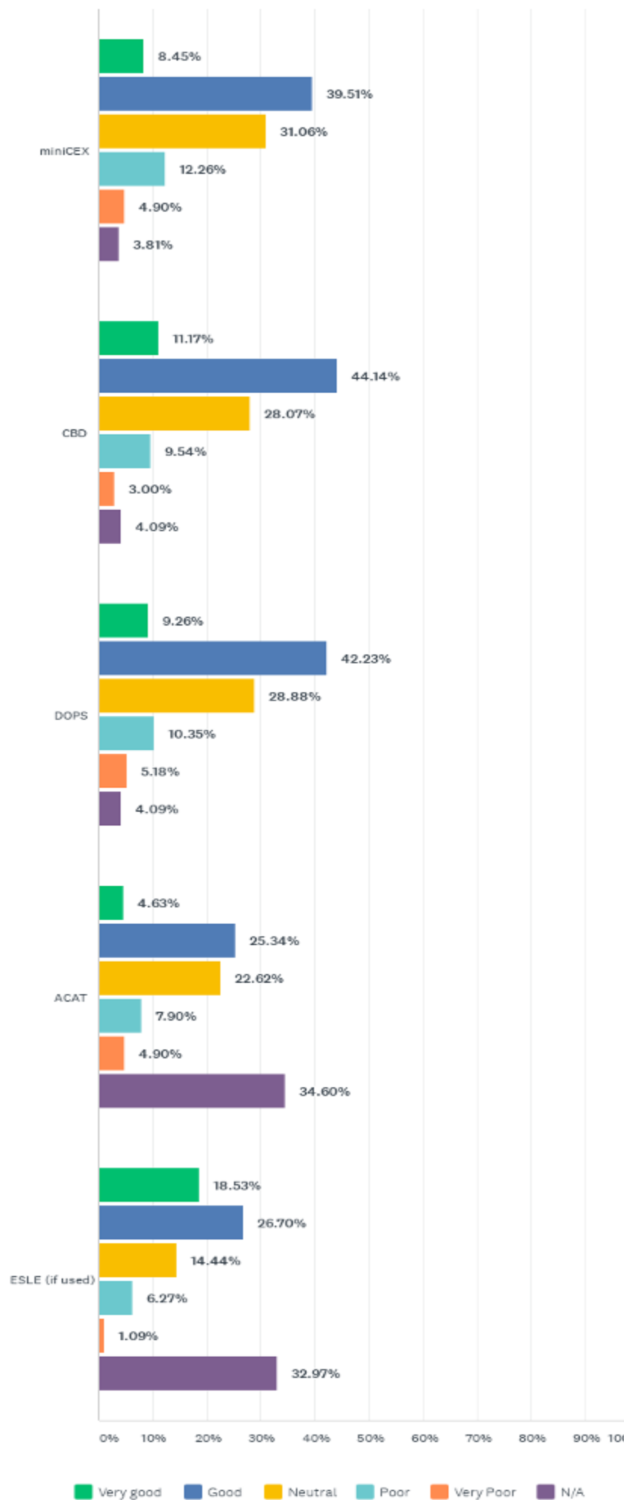
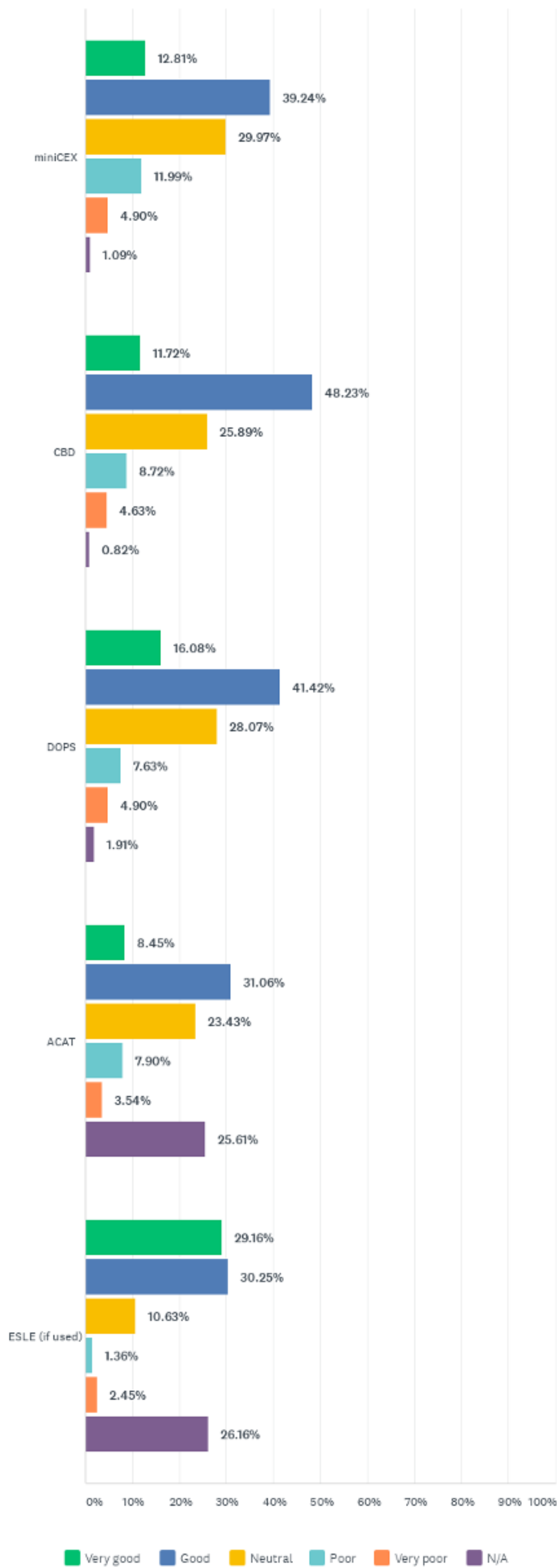
Appendix 1. Extended WBPA data

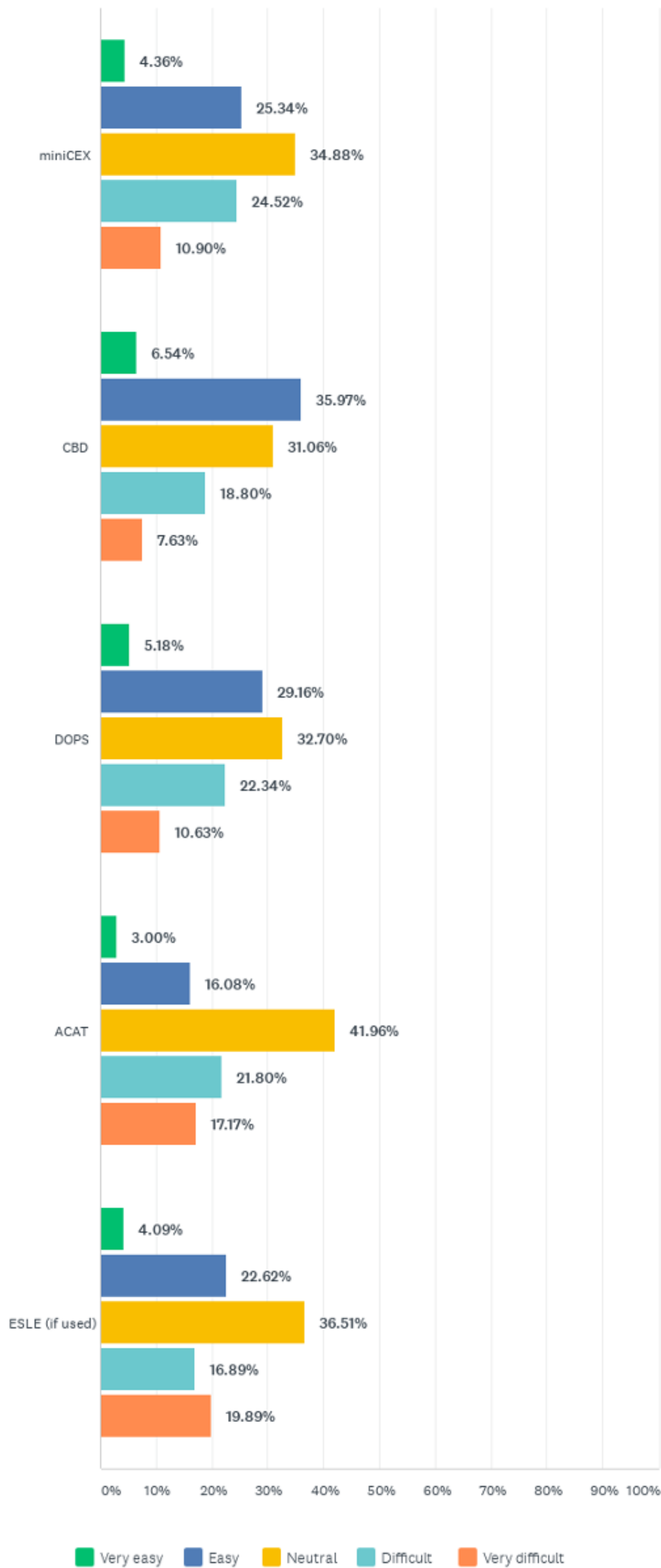
How does your experience of WBPAs in your current post compare to the RCEM 2015 curriculum guidance?



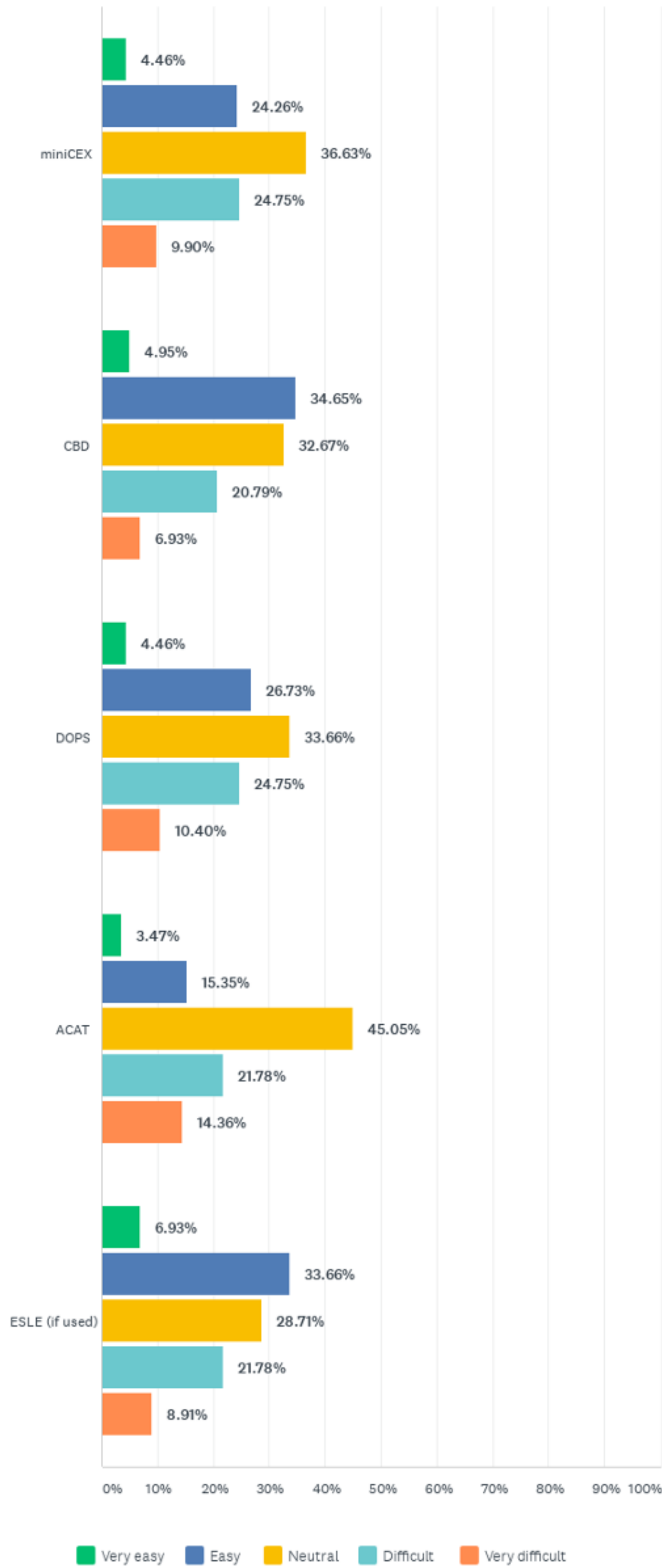
For your development, how useful do you find the following WBPAs?



How easy do you find it to arrange WBPAs in your current post?



How easy do you find it to arrange WPBAs in your current post (ST4+ only)



General WBPA comments

Positive

- Supervisors are helpful and feedback is valuable
- Great tool for learning
- Great

Mixed

- Sometimes difficult when busy. Supervisors are helpful and feedback is more valuable
- Difficult for it to be spontaneous when the opportunity arises
- This only as useful as the person filling it and their motives. It’s only as easy to get done as much as you are willing to pester / chase, again person dependent. These methods of assessment should be modernised.
- V difficult to do during COVID
- Extremely useful depending on the Consultant and the feedback given
- Useful if done with the correct consultant
- Currently difficult due to covid
- Difficult to allocate time due to current covid pandemic
- Consultants are not approachable

Negative

- After a few it becomes a routine tickbox exercise
- Waste of time
- THIS IS NOT A FORM OF TRAINING
- All of the SLEs are not good learning opportunities but rather a tick box exercise to hit the amount you need it whatever particular skill or presentation.
- Difficult to get the assessments filled out
- Overall quality of assessments is just incredibly poor often only filled in months later after repeated resending adding no value at all.
- Difficult to obtain in ED rotation
- Frowned upon
- Easy in arrange anaesth/ITU/AM, but not EM
- Often seen by consultants as a waste of time and therefore not given the time it deserves.
- The amount of effort required to complete the requirements of eportfolio are out of proportion with its utility in enabling development as a clinician.
- Still mostly a pointless box-ticking exercise.

Suggestions

- Make forms shorter and concise with one line reflection of learning point on ticket from trainee, consultants are busy and don't have much time for each trainee and ACP
- Consultants must be offering to do these for juniors with more regularity
- Would be better if trainees could fill in the form for consultants to add/amend/sign as is the norm for most other portfolios now.
- Needs consultant to provide support like anaesthetic training.
- Should have compulsory session which can be booked easily

MiniCEX comments

'Only useful if done properly, in all my years of training rarely done properly'

- No one keen to directly observe when at HST level
- Never properly supervised
- Easy to get signed off, difficult to actually get observed for any period of time
- Only 3 consultants can competently assess HSTs + CT3
- Difficult to get as needs to be a consultant
- Could be useful if done with direct supervision
- Rarely done and difficult to obtain
- Many consultants are not trained to do minicex
- Often told to just send the form without any proper supervision and feedback
- As a senior trainee (St6) you aren't really watched do your job so these are less helpful than CBDs
- Good, thorough and highlight the essentials
- Usually not done as a formal mini CEX but instead as a resus case (in current job M-F 0800-2300 there is usually one reg and one cons in resus) — either one that both of you have been directly involved in or that you have had supervision of while the cons is also dealing with the rest of resus. As with all WPBA except ESLE variable return rate when tickets requested.
- Difficult for registrars as consultant is the only body who can supervise
- The electronic form is not designed in a useful format. It is too binary in its approach
- Great tool poorly used
- Sometimes useful for opportunistic cases otherwise a bit forced/pointless.
- Consultants/ seniors have no time to spare to do a min-CEX with a trainee
- Difficult to get on busy shift and dependent on who you are working with
- Terrible — very rarely done properly
- Hard to get a consultant to supervise practice due to lots of competing demands on their time

CBD comments

'They've set up a rota for CBDs being done in teaching — gives you the opportunity to discuss a case and others to learn from it — this is a point of good practice.'

- Hardly discuss
- Difficult to arrange
- Difficult to get formal CBDs and time away from shop floor in ED rotation
- Only 3 consultants can competently assess HSTs+CT3
- Consultants happy to do at later date with notes brought up on screen
- This feels more like a tick mark exercise often with duplication/writing up of unnecessary details without real benefit
- Get told can do then. But then no time to ever sit down and complete discussion.
- CBD ARE extremely hard to get for anyone to sit and take time to talk.
- Would be better done as planned sit down pre-prepared meeting
- Good for unusual cases
- Most are from resus. They've set up a rota for CBDs being done in teaching — gives you the opportunity to discuss a case and others to learn from it — this is a point of good practice. As with all WPBA except ESLE variable return rate when tickets requested
- Great when done well with reflection and surrounding reading
- Occasionally useful but massively depends on the clinician.
- Good, specially for interesting cases or cases overnight when no consultant present at time, to aid reflection and learning after events.
- difficult to get on busy shift and dependent on who you are working with
- Most of my HST assessments, but largely useless from a learning point of view and mainly a tick box exercise. Should be scrapped
- Dedicated time
- Still mostly a pointless box-ticking exercise.
- Can ICM/anaes dept provide CBD clinic amd dedicated DOPs clinic

DOPS comments

'Difficult to obtain on skills you already have — attitude of we're too busy today so another time — except there is never another time.'

- No one keen to directly watch when at HST level
- Hardly supervised just seen a complete procedure
- Poor practical skills among consultants
- Very hard in the ER given the reluctance to upskill SHOs in procedural skills
- Supervisors seem to be happy to stay for a 'procedural' skill for longer than a 'clinical' skill
- Easiest to get done in ED

- No time for consultants to supervise
- Only 3 consultants can competently assess HSTs+CT3
- Very useful. However, in Acute Medicine is very difficult to do them under SpR supervision
- Not particularly useful as a routine thing but can be useful as a sign off of competence
- Very difficult. All Dops done on nights when no senior available to watch.
- Easy in arrange Anaesth/ITU, but not AM/EM
- Could be useful if done with direct supervision
- As ST6, most procedures now competent therefore not watched
- Always requested after the fact. Most skills it's assumed you can just do them. As with all WPBA except ESLE variable return rate when tickets requested
- Majority night shifts do not allow these to be done easily
- Useful. Bit limited regarding the actual curriculum. Rarely use them in ST6.
- difficult to get on busy shift and dependent on who you are working with
- Confusion re: number of total DOPS needed by end of CT2 — ARCP form & eportfolio don't match up
- Ask at beginning of shift and give chance to trainee if one arrive
- Still mostly a pointless box-ticking exercise.
- Can ICM/anaes dept provide CBD clinic amd dedicated DOPs clinic
- Only useful for new skills
- Plentiful dops opportunities

ACAT comments

'Great for ward rounds' and 'feels useful to discuss a cluster of cases together' however 'difficult to arrange, and seem a bit pointless' as 'they are mini-CEXs/CBD but more difficult to achieve without any gain in learning'

- Alongside CBD's, most useful exercise
- Rarely used
- Can be quite useful but would be better if split into 2 types of ACAT - management or clinical
- Easy in EM/AM/ITU
- ACAT are impossible to get even when I have noted down each patient and stated and discussed each one in emergency medicine. Okay in acute medicine by one consultant. An acute medical consultant actively told me how I managed two emergencies very well but to not send any assessments because he will not fill it. He worked with me daily.
- Difficult to organise in view of obstructive staff and other colleagues who feel it takes time and doctors from seeing more patients
- Difficult in the ed, except CDU
- Stocking filler. Useless but signs off 5 cases.
- Difficult to get on busy shift and dependent on who you are working with

- I am unsure these are useful in any stage of my training, especially ED or Acute med. They are mini-cexs/CBD but more difficult to achieve without any gain in learning. A tick-box.
- Still mostly a pointless box-ticking exercise.

ESLE comments

‘Incredibly useful but difficult to arrange’

- Useful to have a consultant supervising you
- Bit difficult because I was told I need to book it ahead of time with my supervisor. But I am looking forward to do it. Bit difficult now due to COVID status
- Feedback needs to be delivered formally - some require training on this
- In recent years ESLE has been the predominant WPBA that I have used
- Very dependant on assessor
- I don't know what ESLE is
- The entire training period should be an 'ESLE' not just 1-2 hrs of consultant following you around like a CCTV camera. This puts unnecessary stress on the trainee and makes him either underperform or overdo things instead of doing things naturally. A consultant working with a trainee for months should be able to assess and feedback without doing this 1hr exercise
- Needs at least 30 minutes planned debrief time
- The most useful feedback you can get
- I have been waiting over 3 months for my consultant to actually complete the form for this
- Very difficult to arrange as we only have 4.5 WTE consultants in our department and 7 trainees!!
- Fantastic, real reflection
- Difficult to organise as you need to have access to the full consultant rota and know if/when within that they are free. Have had them cancelled last minute due to the state of the dept/higher management visiting the dept.
- Most useful particularly at ST6 level
- Often a burden and poorly used tool
- Very helpful. Get a good insight into the soft elements of my care that I might be unaware of.
- These are amazing and if done properly are exceptionally useful
- Useful for HST and cover range of presentations and non clinical skills. Reduces the need for minicex type of examinations
- This is the only assessment I find useful as a senior trainee
- Most useful assessment to gauge performance
- Actually really useful — the only WBPA where you get some feedback
- Difficult
- Possibly the most useful assessment, especially the sit down proper debrief

Appendix 2. Bullying and harassment free-text responses

Below are anonymised free-text responses around bullying and harassment, undermining, aggressors, actions and suggestions, and COVID.

'Difficult interactions with colleagues is common in the emergency department. Junior doctors and nursing staff or staff new to the department are particularly vulnerable to undermining or unnecessary comments but the attitude of senior staff within the ED is excellent and this behaviour is never tolerated. As junior staff we always feel supported following these incidents.'

General

- It's endemic in my current trust.
- It's endemic in the region.
- Nothing gets done about it- there's been complaints for years.
- Should be section on racism.
- The management turns a blind eye…
- No point in raising anyway.
- Bullying, harassment and undermining occurred to me in a previous department hence reason for redeployment on occupational health grounds. First time anything like this has occurred in 10 years of Emergency Medicine.
- Have seen it as a trainee and have experienced it.
- We do not have support as we are been blackmailed to do not complaint.
- Seems to be inherent in the system, despite good mechanisms in place to check them.
- Standard for the course. Always has been at this trust, it is an unfriendly place to work.
- As a female, I had a male patient be physically inappropriate with me following, when I told the clinician in charge (also male) he laughed. So I just left it at that, I wasn't really sure how to take that any further.
- Widespread and accepted practice.
- Seen in the past. Not on current post.

Bullying and harassment

- I was bullied by a consultant during a previous rotation. This was recognised and accepted by the department's management who stated that this consultant was notorious for behaving this way with specific trainees each year. When this was raised formally, this consultant took sick leave for stress to avoid any repercussions.
- I personally had to take two sick days off work because of how bad the bullying was by an A&E manager who no one has any confidence in. Matrons and managers on site verbally abuse medical registrars and emergency care registrars in front of anyone

with conflicting advice from one site person to another on a different day. Worse place I have ever worked and would consider quitting the training program because of it.

- Sometimes people pick on others.

Undermining

- It is endemic in some senior non-ED doctors. Their trainees learn their behaviour from them. And very little is done about it. Even when everyone knows they are recurrently undermining ED staff.
- Its hard being a junior doctor , people automatically assume that you are no good.
- I think there is often undermining of junior medical staff occurring in the [redacted] ED prior to COVID. There was low morale amongst junior EM trainees due to this.
- Undermined by emboldened HCA staff who seem to go unpoliced in certain EDs.
- In dept I worked in there was an undermining atmosphere and very low morale. If I had worked in this department as my first EM job I would never have applied to EM training. I have fed back and complained about specific problems but unsure if anything will change.
- Undermining of EM referrals by other specialties is still an issue.
- Specialist registrars can undermine junior ED staff
- I have had raised issue of belittling with my education supervisor and it was buried with words and no actions in my generic EM post at [redacted]. I feel the current scenario is just service provision when it comes to training in EM department. Rest of the rotation in AM, ITU, Anaesthesia, Paediatrics is amazing.
- Some time people do undermining not even realising when under stress . Managing stress on shop floor is skill esp when under staffed.

Aggressor

- One member of staff, everyone knows about him, no one does anything, they are all just hoping he retires soon.
- It was from a senior Medical SpR.
- I have not directly witnessed bullying, harassment or undermining but have had a couple of junior doctors (FY2) come to me to say this is how they have felt, or they have been shouted at. The aggressors have been consultants.
- In my experience — bullying/aggressive tends to be directed by other specialities towards ED, rather than being within the department. Time and time again, specialty colleagues have used verbal aggression to force their own agenda eg not accepting a patient, and I find this unacceptable. I have experienced it myself and witnessed it numerous times. In my experience, I have come across this much more from general and orthopaedic surgeons than other specialities. And because it seems to occur from consultant down to SHO, I am forced to conclude that a particular attitude, say, of contempt to other specialties, within a department, fostered by senior doctors, trickles down and affects how that whole department interacts with other

departments. I am lucky that within my current hospital, I have always had the support of my ED seniors to hold people accountable for their incivility - but it does make the job more unpleasant than it needs to be.

- Unfortunately I experience constant bullying, undermining almost daily from management, senior nurses and occasionally specialities.
- One particular locum consultant does but the rest of team are fantastic.
- I have seen a lot of it at my previous post, sisters and nurses bullying staff grade and oversea doctors, and sometimes UK doctors.
- Senior trainees doing it to more junior members of the team and apparently still being praised by your consultants makes it hard to escalate.
- My supervisor has taken a dislike to me and picks up on every minor flaw/mistake, not in a way that is either constructive or overt bullying that I could ever report, but still makes me feel on edge whenever I am working with her. Eternal problem that I doubt there's a solution to though...
- The consultants are not supportive with rota and as usual nursing staff do bully junior doctors and its a shame.

Actions and suggestions

- Consultants and nurses should have annual MSF to make equal to trainees in anonymous assessments.
- I think it would be useful to have a training session on how to approach these sensitive issues and escalate them without fear of the repercussions.
- Formal letter to management done collectively.
- Discussed with supervisor in dealing with these issues..
- Fed back to appropriate parties and datix/feedback undergoing.
- Currently undergoing formal procedure with support of current ES

COVID

- This is letting doctors work in very unsafe environment without any protective gear.
- I have to work in area with extreme viral load with no safe barrier between hot resus and Hot majors.
- Very poor support from management during the pandemic, particularly with regards to appropriate PPE/guidelines, and supporting those in emergency rotas, and their welfare.
- I felt undermined when I called in ‘sick’ as my partner (also a doctor) fell in with Coronavirus so OH told me to not work for 14 days. Management staff made an unhelpful comment saying “it always happens on nights”. I am yet to bring this up with the person in question.
- Often registrar to registrar especially in Covid times. Everyone thinks they are an expert.
- Has increased in some areas with the additional stress of Covid.

Appendix 3. Global health free-text responses

	Very important	Important	Neither important nor unimportant	Unimportant	Very unimportant
A structured programme when deployed overseas	36.9%	49.0%	11.9%	1.1%	1.1%
Funding for deployment overseas	43.8%	44.1%	10.5%	0.6%	1.1%
Recognition of time spent out of training	52.6%	36.6%	9.6%	0.6%	0.6%
Duration of the deployment overseas	38.8%	47.9%	11.3%	0.8%	1.1%
Pre-deployment training on important aspects of global health	47.4%	42.7%	8.5%	0.3%	1.1%

Table 9. How important are the following elements of a global EM training or deployment programme? (363 respondents)

The following comments are in response to the question 'what would be the most important motivations, considerations and barriers for you when considering an OOPE/OOPT/fellowship in global emergency medicine?'

'I have done several humanitarian relief OOPEs in my HST, with 6 different deployments. I have been fully supported by HENE for all of these and have found that very beneficial to my UK clinical work and further development. I would recommend these to any interested trainee'

Motivations

Word cloud from free-text responses related to 'motivations' to global EM part of the 2020 EMTA survey. (wordart.com)

- Interest in public health, working to help develop health care systems on low to middle income countries.
- Having worked in a rural environment, doing a global em job would be exciting and challenging.
- Interest in developing portfolio career in future. Developing specialist interests.
- Prior experience of seeing the benefit to myself and others of working in resource poor environment, desire to use my skills to help others in future, desire to improve access in EM in resource poor countries.
- To use my knowledge, skills for to help deprived pts.
- Ability to do fellowship within the UK would be strong motivator with potential to do masters in international public health / global health
- Interest in global EM
- Break and time away from training.
- The most important motivational factor would be to be able to treat patients with resources that are fewer than I am used to. This would improve clinical skill rather than dependence on investigations and imaging.
- Extra training benefit for specialist areas or areas of interest not offered locally.

- I would like to do a global health OOPE to gain perspective and improve my clinical practice.
- I strongly consider it to be very helpful and will improve my clinical practice
- Interest and opportunities to work outside the NHS.
- Coming from Pakistan, I would like to take my experience from UK and RCEM guidelines to help developing countries establish a sustainable Emergency Department systems.
- Previous experience, enthusiasm for work in low-resource settings, learning skills to bring back to UK.
- The opportunity to challenge myself in a completely different environment and the opportunity to learn something new and different would be a motivation.
- Would love to contribute to the development of health systems across the world.
- It has always interested me and I have a background in languages.
- Gain more experience, augment knowledge gained from my diploma in tropical medicine and hygiene.
- Experience of EM in a resource limited setting, and in a setting where there is no 4-hour target limiting the utility of EM skills.
- It's my intention to work long term in global health in addition to my work in the NHS.
- Work in different environment with some people need me.
- To get a different perspective and understanding of working of these departments and their setup and to inculcate best practices from them.
- 1.Have previously worked in under funded hospitals/regions outside UK, prior to my training, would like to see how my training will make a difference if I were rejoin their workforce now. 2.Would like to use my skills and knowledge to help the underprivileged and under resourced. 3.Have seen EM training in UK, always open to new ideas and thoughts, would now like to see what global EM fellowship has to offer and how I can use that to develop myself professionally & personally.
- Broader skill set and knowledge.
- Working in more enhanced and deprived departments to test my skills.
- Changes applied to practicing medicine due to different culture, beliefs and language.
- Motivation is to practise humanitarian medicine.
- Experience and skills obtained.
- Interest, gaining more experience and extending training as it is very short.
- Learning, new environment, outside of comfort zone, exploring future career prospects, self development.
- Getting a broader experience.
- Working in different environments.
- Motivated by interest, previous deployments and teaching abroad and the widening of my career horizons. Would consider extensions to CCT.
- Experience prior to CCT, gaining some control over life/rota.
- Interest in the topic.
- Fellowship in trauma.
- Learn different systems.

- Valuable experience both clinically and will improve management skills.
- Experience of variety and expanding my knowledge and skillset.

Considerations

Word cloud from free-text responses related to 'considerations' to global EM part of the 2020 EMTA survey. (wordart.com)

- How it would affect career progress and daily life.
- Any contribution to training.

- Reputation of place going to work.
- Allowance for OOP.
- How difficult will it be to relocate my family to another country for a period of time.
- Could consider working beyond borders/MSF/UN.
- Whether it would add anything extra or additional procedural skills.
- emergency medicine experience in areas with limited resources.
- Topic, location, if my partner could come with me.
- Place of travel, funding, length of stay.
- For it to be at a time that suits my personal circumstances.
- For it to provide skills that will benefit my career.
- It would depend on where it was and how much time it took up.
- Assurance that it would meet my expectations in terms of being able to offer a positive contribution and have adequate supervision in place.
- Useful programme to be associated with, with potential for long term connections following CCT.
- Ease of application. Not just smoke and mirrors and just doing service provision.
- Funding.
- I think it sounds great but I have two young children so foreign travel not an option at present.
- Location, ease of arranging, formal qualification gained, fits in with personal life, pay.
- Location of OOPE/OOPT.
- Access to clinical work to maintain skills developed.
- Ethics of global health - has to be a proper partnership.
- Ability to travel with my family.
- Extending training.
- Finding the right project.
- Travel would be wanted.
- Ease of return to training.
- Pure EM work and provision of adequate financial support.
- Location of placement and duration.
- Service provision in post.
- Funding , affect on my department, logistics, how it fits in with wider training.
- Time counting towards training.
- Costs, approval for training, smoothness of paperwork, not being disincentivised by need for trainees to fill rota gaps.
- Supervision by in country clinicians for advice/guidance.

Barriers

Word cloud from free-text responses related to 'barriers' to global EM part of the 2020 EMTA survey. (wordart.com)

- Salary. Accommodation. Local expenses.
- Finances — ability to keep paying my mortgage etc.
- Getting permission for time out of training.
- Main barrier is my age and how close I am to CCT — can't be bothered to faff anymore.
- Mainly financial barrier — I think, never really heard of this opportunity before.
- Pay drop.
- Time taken to complete it.

- Extending training time.
- Family.
- I can't work outside the UK for family reasons.
- Cost — it would likely be self funded, lack of a formal pathway currently, unclear if it would be formally recognised by RCEM, lack of support from current supervisor "how will that help you get a consultant post?"
- The barrier would be that my department would not let me go out of programme as they feel they cannot spare staff.
- Family commitment is my barrier.
- Most imp barrier will be caring of my own family.
- Don't know much about it.
- I don't know much about it.
- Family commitments would be barrier to work overseas.
- Extra time in training. Also how applicable in further EM career?
- Financial implications.
- Fitting within my other career plans.
- ARCP outcome.
- Caring responsibilities.
- Family life.
- Work life balance... Family needs both barriers.
- Application process, content, qualifications achieved.
- Reaction to taking time out.
- Length of training.
- Pay.
- I'm hearing impaired. This would be a significant barrier to work globally and in a noisy environment.
- I had an opportunity but lost it because my Tier 2 visa regulations as I cannot spend about a year outside UK as this will affect my ILR application in the future.
- If required to travel/move the financial and family implications.
- The cost of the course itself.
- Family. Pay.
- I don't know much about it.
- Extension of training time.
- Need to live away from home (inc costs).
- Barrier would be relocation for period.
- Financing time for OOPE and getting time authorised for OOP.
- Time away from home, pay, duration of programme — 1 year positive, longer would depend on level of interest. Still applicable for mat/pat leave and other employee benefits?
- Personal life, I have a young family whom I cannot move easily.
- Will the trust allow this? Will I get sponsored?
- length of time of the fellowship.
- Current family commitment.

- CCT date.
- I am getting on a bit and probably should CCT some time soon. Would have interested me earlier in my training.
- Time to organise it.
- Visa.
- Difficulty/ease returning to training, financial.
- A barrier would be distance from country of origin and duration of placement above 6 months.
- Some of the barriers would be arranging formal leaves for the stints and family commitments to my local deanery.
- Application.
- Added CCT time with no clear alteration/benefit to immediate consultant working.
- Ability to fit this in with family life — leaving a relationship for an extended period to work overseas when trying to have children, or potentially with a young family.
- Family wouldn't be able to come abroad with me due to work priorities. Wouldn't want to be away from family for long periods.
- Would need to be paid the same to cover mortgage.
- I have limited interest and knowledge of this area. It does not strike me as being useful to my anticipated career in EM in the UK, so I have no current plans to pursue this route.
- Location.
- Family life.
- Also interested in PHEM and deanery would not allow both.
- Visa requirements.
- Travelling alone.
- Family commitments mean I wouldn't be able to travel.
- Completed training now. After going LTFT for childcare, OOPE doesn't really feel possible in addition.
- Biggest barrier is it not being supported by my employer (military).
- Family life — other commitments.
- Financial.
- Family and cost.
- Not appealing to my area of interests. Would not want to travel away from partner and home.
- Ease of organisation and approval from military Chain of Command are main potential barriers.
- Flexibility of training, funding/salary.
- No interest as I feel current exposure too much! Those currently doing it seem to be a little overbearing at present with their views on CoVID19.
- Time, money, opportunity.
- The pandemic we are in.
- Barrier is being military, so limited chance to extend training due to requirement for 'finished product' of consultant.

- Taking a year out would be an issue.
- TIME and salary.
- Visa issues, salary, family care.
- Permission from deanery.
- Family circumstances.
- Trust support.
- Covid.
- Expenses/finances and family that I leave behind.
- Other interests for OOPE and finite allowance with defence for delayed CCT.
- Family.
- Disrupting training/rotations and further prolonging cct.
- Family commitments.
- Barrier may be in arranging OOPE/T but hope that this would be possible.
- Family and location — childcare and partners job not being able to move
- cost, amount of time off.
- Stress.
- My life plans at the time.
- Family.
- Knowing where to start in organising it.
- Already taken lots of time out.
- Family life.
- Family commitments.
- Limited by military employment.
- Access back to training and implications of time out of training.
- Family and moving around my life.
- Family life and finances.
- Family commitments.
- I am dual training in ICM/EM so my training programme is very long anyway.
- Poor quality of most global health placements. Lack of recognition within the EM curriculum (none of it would count towards any training).
- Extended training time.
- Time and financial constraints.
- Time, money.

Other comments

- Integrated with training, ideally paid.
- They don't exist so currently hard to do. Should be an official sub-specialty.
- Funding, access, opportunity, sustainable projects, links to in country partnerships and not UK-centric.
- I would want it to be easy to access, for approximately 6 months.
- Options to work in Europe for example Greek refugee camps after Brexit.
- I did an F3 in South Africa, I would love to go again — but with adequate supervision and not be expected to deliver care for which I am not trained.
- There seems to be limited RCEM endorsed options.
- Staying in my deanery but with some time abroad.
- I do not see this as a particular core aspect of Emergency Medicine training.
- No interest following over exposure in Covid.
- I am not sure, never considered it.
- Not sure what it would involve and how readily it would translate into useful skills for future career.
- Attractive career option, but only few training posts available.
- To be included in training, not to be considered time out of training.
- Extension of training, quality of placements.
- Future work possibilities. Less clinical time.
- A way for it to contribute to training.
- I wouldn't like to prolong my training any further but would love to have a global fellowship experience.
- I used to be interested this idea, but my family now take priority so I am not going to go abroad for an extended period of time, or disrupt their lives by taking home with me for a short time.
- The world comes to us. We should probably go to it to learn.

Appendix 4. Responses to questions related to FOAMEd

To follow at a later date.