your ED

Australasian College
for Emergency Medicine

Editor	Inga Vennell
Design	Studio Elevenses
Printing	Printgraphics Printgreen
Mailing	D&D Mailing Services

Your ED

34 Jeffcott Street, West Melbourne, VIC 3003, AUSTRALIA
t +61 3 9320 0444 | f +61 3 9320 0400 | admin@acem.org.au

Submissions and Advertising Inquiries
We welcome the submission of letters and other materials. Please contact Inga Vennell, Publications Specialist (e: inga.vennell@acem.org.au).

The Australasian College for Emergency Medicine (ACEM) acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia. In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

Contents

Your ED | Spring 2020

Inga Vennell

inga.vennell@acem.org.au
+61 3 8679 8855

Message from the Editor

Welcome to the seventh issue of *Your ED*. ACEM is again proud to showcase stories of emergency medicine from across Australia, New Zealand and the globe.

What a year 2020 has been. From March onwards all ACEM staff have been working from home and I write to you from a makeshift home-office. It has been a challenging year, however, hearing stories of those who have persevered through adversity and come out then other side stronger, and more resilient, has been inspiring.

In this issue we celebrate the life of one of ACEM's founding fathers, Dr Tom Hamilton, and thank Dr Simon Judkins for his tireless efforts as our former President as we welcome in President-Elect, Dr Clare Skinner.

We share stories of LifeFlight and the great works done in the field of pre-hospital and retrieval medicine (PHRM) as well as focusing on gender equity in medicine and how we can strive to improve this.

Our *Nowhere Else to Go* feature shines a light on failures in our system for those in mental health crisis and the feature Physical Restraint in the ED examines the perils of containment.

The Global Emergency Care stories in this issue highlight the story of Volunteering in Vanuatu during COVID-19, a family's journey in Papua New Guinea and the Emergency Medicine Certificate pathway in the Pacific.

We hope you enjoy these perspectives on emergency medicine and take care of yourselves.

ACEM in the Media

In **August**, the Chair of ACEM's Public Health and Disaster Committee, Dr Lai Heng Foong, featured on ABC Radio in Queensland to discuss an open letter to the Australian Prime Minister signed by leading medical groups, and coordinated by Doctors for the Environment Australia, calling for a climate-focused COVID-19 recovery.

'We have an opportunity now to reimagine our lives and the way our economy works. If we could put health at the centre of this economic recovery program, then we could ensure the sustainability of our planet and also ensure that communities are kept healthy and able to live out their dreams, and not having to worry about their future and their children's future', said Dr Foong.

In **August**, ACEM's call for better cooperation between the Victorian and Commonwealth Governments, as well as the communication of a long-term strategy for the treatment and ongoing care of aged care patients during the COVID-19 pandemic, received significant media coverage.

In a statement, the College raised concerns that systemic and inter-governmental issues were contributing to situations in some Melbourne hospitals where aged care patients who had presented for assessment and treatment, were prevented from returning to their homes or other environments for ongoing treatment or care.

'The emergency departments are getting dangerously overcrowded and we need a strategy, a plan shared with those at the frontline, around what we're going to do about these numbers of vulnerable elderly people', ACEM President Dr John Bonning told ABC News.

In **August**, ACEM's Victoria Faculty Chair Dr Mya Cubitt featured in a Radio New Zealand report on the experiences of expat New Zealanders working on the response to COVID-19 in Victoria.

'This is hard. It's a long haul', said Dr Cubitt. 'We don't want to be where we are and we're just getting on and getting the job done, but to know others are thinking of us and supporting us has been really wonderful.'

In **August**, ACEM issued a joint statement with the Royal New Zealand College of General Practitioners and the Royal New Zealand College of Urgent Care, welcoming swift government action following confirmation of New Zealand's first positive cases of COVID-19 community transmission on 11 August. The statement highlighted the importance of continuing to implement best practices, and learning the lessons from New Zealand's first wave of COVID-19, as well as from other countries experiencing resurgences.

'While New Zealand had done very well in its suppression of COVID-19, the identification of community transmission is concerning and it is important we keep doing everything we can to limit its spread and additional burdens on our healthcare system', said Dr Bonning.

In **September**, the College issued a statement confirming the election of FACEM Dr Clare Skinner as the College's next President-Elect, following an election in which more than 1,200 Fellows voted.

With Dr Skinner due to assume the role for a year from the date of the College's Annual General Meeting on 21 October, before becoming President in late 2021, Dr Bonning offered congratulations on behalf of ACEM.

'Clare has been a wonderful advocate for our specialty and the many communities involved in and served by that specialty. Her support by her peers reflects her strong relationships across Australia and Aotearoa New Zealand, and the respect and esteem with which she is held', said Dr Bonning.

Dr Bonning also thanked the other candidates for the role, Dr Kim Hansen and Associate Professor Didier Palmer.

'Didier and Kim were both equally outstanding candidates. We thank them for putting themselves forward and for their exceptional passion and advocacy for emergency medicine.'

In **September**, ACEM expressed concerns about the temporary cancellation of elective surgeries at Adelaide hospitals being used to address dangerous access block and ambulance ramping issues.

'This is the latest escalation of a dangerous situation for patients and staff', said ACEM's South Australia Faculty Chair Dr Mark Morphett. 'In the current climate, where the risk of COVID-19 is still so prevalent, it is unethical to allow issues such as emergency department (ED) crowding – where patients and staff may be forced to wait or gather in dangerously close quarters – to occur.'

In **September**, an opinion piece by Dr Cubitt, outlining her experiences in quarantine and being separated from her family after testing positive to COVID-19, was published by the ABC.

'My intention isn't to minimise the experience of those who have suffered more physically than me, lost loved ones, nor the incomprehensible complexity of the decisions faced by those tasked with navigating our path', said Dr Cubitt.

'But in my abrupt isolation, my own illness, I was suddenly scared in a way I wasn't while caught up in the constant fight to save others' lives. Not because I feared I would not survive COVID-19, but because I am petrified that in the success of our fight, we may well lose the very essence of our reason to live.'

During **September**, commentary from the College about significant issues experienced Australia-wide in relation to long and dangerous ED waits for patients seeking mental health support featured prominently in media coverage. The common theme of the coverage was that the

COVID-19 pandemic continues to exacerbate pre-existing issues and present new, complex challenges.

College Immediate Past President Dr Simon Judkins featured on ABC's *The Drum* program to discuss a multitude of current issues. Dr Bonning featured in *The Advertiser* (Adelaide), responding to a disturbing account from a patient about being restrained after arriving at the Royal Adelaide Hospital while experiencing a mental health crisis.

'Unfortunately, similar stories are still too common, and major systemic improvements are urgently needed to properly care for some of our communities' most vulnerable patients', said Dr Bonning. 'It is still routine for mental health patients to wait days in EDs for a bed in hospital, in an environment designed for a maximum stay of four hours.'

Meanwhile, ACEM's Western Australia Faculty Chair Dr Peter Allely, spoke to *The West Australian* about systemic inadequacies in the unacceptably long waits facing patients needing mental healthcare support.

'Emergency doctors are dedicated to getting people on the road to recovery, so we find it abhorrent that we're having to sedate and occasionally physically restrain these people simply because there's nowhere for them to go', said Dr Allely.

In Victoria, Dr Cubitt spoke to *The Age* about the increasing numbers of mental health presentations and dangerously long waits for beds in Victorian hospitals, with the COVID-19 pandemic having exacerbated a pre-existing crisis.

'The pandemic has further reduced the system's capacity to manage these issues', said Dr Cubitt. 'We need some urgent solutions, to provide help to those who need care now.'

Later in the month, ACEM issued a joint statement with the Royal Australian and New Zealand College of Psychiatrists in South Australia, calling for additional mental health beds to help alleviate the ongoing crisis.

Maintaining a strong focus on mental health, in **September**, the College launched the *Nowhere else to go report*, examining why patients seeking mental health support continue to become 'stuck' in EDs. Prepared for ACEM by the Mitchell Institute, the report contains a comprehensive set of recommendations aimed at improving Australia's fragmented and under-resourced mental healthcare systems, by improving alternative community care and health system options, as well as ED resourcing and set up.

The launch was covered in *The Sydney Morning Herald*, *The Age* and on the ABC, while an opinion piece by Dr Judkins coinciding with the launch was published by *Croakey*.

'More political will and leadership is still needed, but the challenges will no doubt be exacerbated by the financial strains and recession brought on by the COVID-19 pandemic', said Dr Judkins.

'But we can't accept the ongoing neglect and lack of care for some of the most vulnerable people in our communities which continues.'

In **September**, the College offered its support to staff at Launceston General Hospital following media reports outlining additional pressures and disquiet stemming from ongoing workload, bed block and staffing issues.

'These are very challenging times and we are eager to see systemic solutions quickly, which address the long-standing issues and improve the situation for patients and staff', ACEM Tasmania Faculty Chair Dr Juan Ascencio-Lane told *The Examiner.*

In **October**, the College responded to the Australian Federal Budget, acknowledging a strong investment in healthcare, but noting a lack of long-term reform initiatives, particularly in relation to mental healthcare.

'The College appreciates the significant financial burden and disruption the COVID-19 pandemic has presented for governments, but the pandemic's impacts are also precisely why it is all the more urgent to find structural and systemic solutions, particularly where mental healthcare is concerned', said Dr Bonning.

In **October**, ACEM featured prominently in the Tasmanian media, responding to the release of a feasibility report by the state government suggesting urgent care centres (UCCs) in the community may help address significant issues of ED crowding and hospital bed block.

The College noted that, while access to UCCs (which aim to provide patients with immediate, non-life-threatening health issues with alternatives to visiting EDs) would be welcomed in communities where it has been difficult to access urgent GP appointments, the centres would not solve the current significant issues facing the state's hospitals.

'These issues are overwhelmingly caused by system and capacity shortcomings, leading to an inability to admit seriously ill or injured patients to hospital inpatient beds, and system-wide solutions are required', said Dr Ascencio-Lane.

Dr Bonning said: 'It is a popular but misguided public narrative that "GP-type" patients are the main cause of crowding and therefore access block in EDs'.

'Patients with relatively minor ailments who present to EDs generally do not require beds or admission to hospital, and attributing the dangerous crowding and access block which occurs in EDs to such patients risks distracting from the systemic and deep-rooted causes of such issues.'

In **October**, Dr Bonning featured on Radio New Zealand discussing the need to step up community testing for COVID-19 in order to identify and stay on top of any future outbreaks.

'We need to keep our eye on the ball here. It was very rapid, how we dropped the ball on testing in June, became complacent, and then of course after 102 days of no community transmission, we suddenly had an outbreak. So we are encouraging numbers more like 4,000 to 5,000 (tests) a day to continue on', said Dr Bonning.

PRESIDENT'S WELCOME

Welcome to the final issue of *Your ED* for 2020 – what a year it has been.

Despite so many challenges, I hope there is some room for optimism moving into 2021 as we reflect on what has been achieved thus far during the COVID-19 pandemic.

Compared to much of the world, Australia and Aotearoa New Zealand are in very fortunate positions.

Our thoughts remain with those who have been impacted by the disease locally and perhaps lost loved ones, as well as our colleagues contending with surging case numbers internationally.

Case numbers in Victoria clearly came under control at the end of October and we send our gratitude to the Victorian community, and our truly excellent emergency medicine workforce, for their immense sacrifices and extraordinary work.

While threats remain, we hope to enter a more manageable phase, acknowledging successes and continuing to seek genuine and lasting health system improvements.

Throughout the pandemic we have maintained focus on seeking long-term change, through our important work, consultation and advocacy on access measures, (Access measures and TBTs are used interchangeably by Policy) access block, mental healthcare reform, workforce, and the staging of our virtual ASM and, of course, remaining College examinations.

This is just a snapshot of our regular work carried out in a far from regular year.

In making this possible, all of our members and trainees have had roles to play – not only as emergency clinicians on the frontline of a pandemic, but also as advocates for our specialty, colleagues and patients.

Speaking of strong advocates, I am pleased to welcome Dr Clare Skinner to the position of ACEM President-Elect, following the College's Annual General Meeting (AGM) in October.

Clare is well known to us and will bring an excellent level of experience, insight and enthusiasm to the role.

In welcoming Clare, I also acknowledge and thank the other President-Elect nominees, Dr Kim Hansen and Associate Professor Didier Palmer.

The AGM also marked a number of other changes to the composition of the College Board, with the election or appointment of three other new members, and the stepping down of several serving members following the conclusion of terms.

In that context, I welcome to the Board Dr Shannon Townsend, as Trainee Member; as well as Non-FACEM Members Ms Libby Pallot (Legal) and Mr Craig Hodges (Finance). While it is no longer a position on the ACEM Board, I also welcome Dr Kate Field as our new Deputy Censor-in-Chief.

ACEM members and trainees should feel reassured at such a depth of talent and expertise in these leadership positions, which stands us in excellent stead for the future.

My sincere thanks go to outgoing Deputy Censor-in-Chief Associate Professor Gabriel Lau, Trainee Member Dr Swaroop Valluri, as well as Non-FACEM Members Mr Tony Evans and Mr Michael Gorton, both of whom have left the Board following the conclusion of the maximum period that they are able to serve. All have assisted immensely in the advancement of our College and specialty.

My thanks go also to ACEM's Former President, Dr Simon Judkins, who has stepped down from the College Board having served his term, for his tireless, tremendous contribution over many years.

While there is much work to forge ahead with into 2021, and of course many of you will be occupied in your very busy EDs, I do hope you will find some quite time to enjoy not only the stories in this magazine, but also a summer period with some opportunities for relaxation, reflection and time reconnecting with those dearest to you, be it virtually or in person.

Thank you all for your extraordinary efforts this year, and don't forget the compassion, for your colleagues, your patients, and for yourselves.

Dr John Bonning
ACEM President

CEO's Welcome

Dr Peter White

And so, December comes and the promises of another year start to beckon. This is not the first time these thoughts have embedded themselves in the consciousness, or sub-consciousness, of me or others at this time of the year. Perhaps, though, it is one of the few times in mainstream living memory that they have been so eagerly welcomed and the end of the year that is almost over been so eagerly anticipated. We all know there is no magic about one period labelled '2020' changing over to another with a label of '2021', but there is an expectation about the symbolism and hope associated with this transition that is probably without parallel in the time I have been alive.

As the College President says in his message welcoming readers to the final issue of *Your ED* for 2020; "… what a year it has been". Not only a year that has been 'unprecedented', and where, 'You're on mute' has become a familiar catch-cry, but also a year in which we have had reinforced the idea that things are not always predictable, let alone certain, that sometimes decisions need to be made that will not satisfy everyone, and that things do not always 'go to plan'. Thankfully, though, we have also been reminded that solid systems, reasonable resourcing, good planning and sound decision-making will stand us in better stead than fragile systems, insufficient resourcing, resting on the laurels of past achievements and making populist decisions. If any of us needed to learn that about healthcare or the sector in which our College operates, the lessons have been delivered with clarity.

We are all aware of the difficulties that the COVID-19 pandemic, along with other events, has brought with it over the past twelve months. The positives, though, are not insignificant, and as a profession and the organisation with significant responsibility for that profession, we have much to be thankful for. Not least in this regard is the recognition that that those associated with the practice of emergency medicine and the education and training of practitioners in the specialty can rise to challenges and find ways to navigate through them.

In just over twelve months we have dealt with the Whakaari / White Island tragedy in New Zealand, the summer bushfire crisis in Australia and the COVID-19 pandemic. As individuals and groups, the profession has responded to community needs, and as an organisation, ACEM has responded to the needs of the profession. Indeed, to this end, I will reiterate what I said in the previous issue of *Your ED*; that is, that the College has played a significant role in supporting and advocating for members and trainees and has shown itself in difficult times to be an effective engagement and advocacy body, focused on enabling the delivery of high-quality, safe emergency care.

It has also shown itself to be an effective body in what are its core activities; that is, the training, assessment and ongoing education of medical practitioners in the specialty of emergency medicine. The last twelve months have also reinforced the importance of what I think is one of the central requirements to a successful organisation such as ACEM, and that is the 'partnership' that operates between College members and trainees, College staff and others members, trainees, College staff and others who contribute to College activities. Indeed, for those involved in planning a course of action and making decisions to progress the College through the range of issues dealt with through this year, I have nothing but admiration.

I have had the privilege of seeing people work together to solve a range of issues that involve multiple, sometimes conflicting factors, fully aware that someone will likely want to criticise the final decision. The most obvious example is, of course, decisions relating to examinations in the FACEM Training Program, which have been complex and made in the context of frequently changing environments, whose rules and requirements have been totally out of the hands of the College. Nevertheless, the core desire has been to enable trainees to progress through training in a fair and reasonable manner that is clearly and promptly communicated, with decision making that is based on the best information available at the time. Along with other matters, it has been a tremendous effort by all concerned and has involved significant work by the College's members, trainees and staff that were involved.

The President has summarised the recent changes to the ACEM Board and thanked those who have left positions having given valuable service for which the College is grateful. I echo his thanks and welcome those new to positions. In particular, having been involved in navigating ACEM through the year, and at the risk of not giving deserved public thanks to others, I do wish to acknowledge the leadership of the College President, Dr John Bonning, throughout this time. John is a dedicated servant of ACEM whose commitment to the College, the specialty and the wider profession of medicine is unquestionable. I am fortunate to have the opportunity to work with him. As the CEO of ACEM I am also fortunate to lead a dedicated and professional team of staff whose commitment to the College and its stakeholders cannot be questioned. All members and trainees of ACEM are fortunate that this is the case.

Toward the end of a year that has tested us all, there seems to be a desire to leave 2020 behind us and make the symbolic transition to 2021. The College is in good hands and the coming year will be a busy one that will see significant developments through the implementation or final planning stages of initiatives such as the launch of revised Emergency Medicine Certificate and Diploma programs and the new Advanced Diploma program, the formal launch of the Diploma in Pre-Hospital and Retrieval Medicine and preparations for the launch from the beginning of the 2022 training year of the revised FACEM Training Program.

Clearly, pandemic or no pandemic, ACEM has been a productive entity in 2020 and will continue to be so in the coming year, regardless of the circumstances that we are presented with. I wish to thank all ACEM members, trainees and staff for their contributions to the community and the College throughout 2020 and wish all readers and their families a safe and happy Festive Season.

On Whose Shoulders We Stand – Dr Tom Hamilton

It is with great sadness this year that we learned of the passing of the inaugural ACEM President Dr Tom Hamilton AM. As we close out the year, we want to pay tribute to his enduring legacy for ACEM and for medical healthcare in Australia and New Zealand.

Tom is remembered as a man of wit, charm and intelligence, a gentle soul with a warm disposition and a renowned sense of humour. He was a straight shooter who always displayed absolute dedication to his work, his family and friends.

He is a giant of the College – a Foundation Fellow, inaugural President, and the epitome of the values ACEM was founded on and continues to live by.

Tom obtained his bachelor's degree from the University of Edinburgh, and – apart from his Fellowship of ACEM – was a Fellow of the Royal College of Surgeons Edinburgh and the Royal Australasian College of Surgeons.

Tom came to prominence as the director of the emergency department at Sir Charles Gairdner Hospital, in Western Australia (WA), in 1977. It was from here he began agitating for recognition of emergency medicine. He joined a group of doctors discussing local issues and sharing clinical information, and ultimately they formed the Western Australian Society for Emergency Medicine. The Society was established to improve standards of practice, training and research in WA. The first national organisation – the Australian Society for Emergency Medicine – formed four years later – in 1981 – and voted overwhelmingly for the establishment of a College. From ACEM's inception in 1983, Tom was appointed its inaugural President.

He remained active in College activities right throughout his life attending the ACEM Annual Scientific Meeting (ASM) in Perth in 2018, where he received his President's Medal, together with the other of the first 10 ACEM presidents. His legacy is celebrated each year at that event through the Tom Hamilton Oration, this year presented by FACEM Professor Daniel Fatovich on 'Clinical Research, Evidence and Emergency Medicine'.

Daniel paid tribute to Tom during his oration, saying, 'Nothing great in the world has been accomplished without passion', a quote from philosopher Georg Wilhelm Friedrich Hegel.

In addition to his service to emergency medicine and his work as the College's inaugural President, Tom was acknowledged as a Member of the Order of Australia (AM) in 1992, awarded the ACEM Medal in 1999, and bestowed the Centenary Medal in 2001 for his more than 50 years' service to St John Ambulance in Australia and the UK.

Following his passing, the College was inundated with messages of condolences and kindness, celebrating Tom's life and contribution to emergency medicine. These messages remain available to view – and contribute to – on the ACEM website.

Tom Hamilton was a mentor and inspiration to many. ACEM is committed to honouring and building on his vision and legacy.

Tom is survived by his three children – Vivien, David and Doug.

Vale Dr Tom Hamilton.

Message from President John Bonning

'Tom you were a paragon of a man, a giant on whose shoulders we now stand.

Energy, passion, resilience, vision, persistence, so many values we all aspire to. A founding father of our College, you started the journey on which we continue.

It was Douglas Adams who coined the phrase, "I may not have gone where I intended to go, but I think I have ended up where I needed to be."

Emergency medicine has evolved significantly since the birth of our College in 1982, with you at the helm, accepted as a stand-alone, independent specialty in 1993, with 67 founding Fellows, having been once labelled "a Holden speciality, not a Rolls Royce", by a plastic surgeon. One might discuss what vehicle analogy might be made now; something fast, adaptable, still rapidly developing, - perhaps the Tesla of Medicine, not perfect, but cool, innovative and looking to save the planet.

Thanks for your contributions, your leadership.

Our thoughts and condolences are with your family who will now be celebrating your wonderful life.'

Reflections from a Former President

Dr Simon Judkins
Dr Judkins is continuing in his longstanding role at Austin Health, Victoria but has recently commenced work at Echuca Hospital, Victoria, where he is hoping to make an impact on the ED workforce.

After finishing his term on the ACEM Board – and at the tail end of a surreal four years – FACEM Simon Judkins is reflecting on what it's meant to be ACEM President.

'It's hard to think how we managed to fit so much in', Simon says.

For the past four years, he's been right in the thick of it.

'I look back and think about what I wanted to try and do. I really wanted to try and engage more people in the College, and use the vehicle of the College and the role of President to elevate and escalate issues on a much wider forum about equity in healthcare and social justice, and the issues we have in emergency departments about access, overcrowding and mental health.

'I think we've managed to achieve a lot of that, but it's an ongoing battle.'

It's not what he had imagined for himself when he started out.

'The first job interview I had, I told the director (Professor George Braitberg) that I just wanted to do clinical work.

'I view myself as just a very normal dad of three kids, focused on the simple things in life. But I think I've gotten to this point by wanting to change things for the better; by having a desire to make a difference.'

After first being encouraged to pursue the role of President by Dr Jo Dalgleish – 'the puppet master in all this' – Simon remembers being called by then President Professor Anthony Lawler in the spring of 2016 to congratulate him on his election.

'Initially I thought, oh yeah, that's interesting that I got elected. I wasn't really expecting it.

'It took a few months [to appreciate the magnitude].'

He thinks – hopes – he made the most of it.

'My attitude when I had the opportunities present is you only get one chance. You've got to make the most of it. I think I did. I feel like I did – certainly, my family feel like I did. I hope others feel that way.

'I suppose it will be over the next few years I'll look back and think about what an amazing ride it's all been. At the moment, it still does all seem a bit surreal.

'I look at all the people I work with and all the opportunities I've had and I've always thought "Gees, they're bloody good at what they do". You know, amazing people I've worked with or bumped into. And I look at myself sitting watching the footy on a Saturday afternoon, reflecting on how lucky my path has been.'

For the record, he's a long-suffering Dees (Melbourne Demons) fan.

Simon forged his pathway to leadership away from medicine.

'I attended a community leadership program. It wasn't actually about medical leadership; it was just about leadership development.

'I was just inspired by the impact leadership can have across the all different areas of community, but especially at the coalface.'

It was here he began to better grasp the inequities in healthcare and his opportunities to make a difference.

'I realised I could make a greater change to healthcare delivery by advocating for system change.'

Twenty years on, he thinks of himself as doing the same thing, if not on a slightly grander scale. Through his presidency, he hopes to have given others the licence to be engaged and get involved.

He says the role has changed his own understanding of what it is to be an Emergency Physician.

'It is an incredibly privileged position to be in. You have the ability to change and impact individual lives, but also take on other challenges. It gives you the foundation to do a whole lot of other things.

'I was quite encouraged [over the past four years] to see others say, "I wish our College would do what ACEM is doing."'

He still loves being an Emergency Physician.

'When I was really in the heat of being President, I found the floor a pleasant escape. I could say, "No, I'm doing a clinical shift." It was almost a way of getting away from other stressors.

'It was quite interesting that I found it a good place to go; essentially, back where it all started.'

Simon is looking forward to a new chapter where he can dedicate more time to some of his particular passions – workforce and mental health among them. He's as much full of admiration for those following him as those who came before.

'The combination of Bonning and Skinner will be fantastic for the College. John has been incredible this year – he's so engaged and engaging – and Clare is a force to be reckoned with.

'I don't see myself in the same category as others who have been in the role. It's my impostor syndrome coming out. I can't imagine my photo up in that hallway in the College because I look at all of them and think about how amazing and brilliant they are. I'm just an average bloke who worked really hard to try and do a good job.'

Author: Natasha Batten, Communications Advisor

President-Elect

Dr Clare Skinner
Dr Skinner is Senior Staff Specialist and Director of Emergency Medicine at Hornsby Ku-ring-gai Hospital in New South Wales. She is President-Elect of ACEM.

When ACEM President-Elect Clare Skinner was told that an article about her will feature alongside outgoing President Simon Judkins and the inaugural President Tom Hamilton, she said her impostor syndrome started kicking in. 'I feel like a minnow in that line up!'

Clare has been making an impact in the New South Wales (NSW) health system recently. She was the Clinical Lead for Emergency Medicine in the NSW COVID-19 Response and Chair of the NSW Emergency Department Community of Practice. Stepping down from those roles recently, she is now returning to her usual job as Director of Emergency Medicine at Hornsby Ku-ring-gai Hospital.

Clare's path to becoming a leader in emergency medicine wasn't straightforward. She describes herself as an all-rounder, interested in the arts and humanities, as well as science and health policy.

'I went to the comprehensive government high school in my local area and the reality is that no one gets into medicine. It wasn't even on my horizon.'

After completing her medical degree, Clare didn't go into FACEM training straight away, but positive experiences in the emergency department (ED) during her intern years and some inspiring mentors eventually convinced her that emergency medicine was where she belonged.

'In the ED, there are a lot of stories and humanity, and I like that. It's like playing medical theatre sports, you're waiting then it's 'Thank god you're here', and you have to just make the most out of whatever you get. I love the improvisational nature of ED.'

Clare has been involved in the College across a number of committees and entities. 'If you're doing things that you're interested in and care about, then it doesn't feel like work. I do all this because I can't help it. It actually energises me and makes me feel better about the stuff I can't easily change in my workplace.'

She also puts a high value on working collaboratively to get things done. 'The way you make leadership sustainable is you build a network of people around you that feed you and you support them back. So, it's a joint effort.'

Even with the best teamwork and collaboration, sometimes the constraints of resources and systems can make things difficult. 'The hardest thing is knowing that you'd like to do something differently, but you don't have the financial, physical or human resources to do it.'

As a natural communicator, Clare has found a passion for the educational aspects of her work, particularly supporting and mentoring junior doctors. 'I love that. Getting to know people, hearing their stories, helping them with career decisions. And it's not just people wanting to get into emergency medicine. I like helping people find their niche.'

For Clare's presidency, she thinks emergency medicine has some work to do on its specialist identity. She wants to raise awareness of FACEMs and ensure their competence and capabilities are known to the general public and to other clinical groups. As a passionate member of the ACEM Diversity and Inclusion Steering Group, she says this area will be a major focus of her work. 'I would hope that something I can achieve is to improve diversity in College entities and leadership in emergency medicine. Hopefully, through role modelling, mentoring and setting targets. That's really important to me.'

Her advice to others hoping to make big changes in their workplace is to consider a gentle, step-by-step approach. 'You need to work on relationships and trust before you can make change. Just walking up to someone you don't know and saying "you must do this" doesn't work. You need to somehow get to the table and build trust. Do things slowly and be strategic. That doesn't mean you're a pushover and it doesn't mean that you don't do what you want, but you need to think about how to break it up into steps that are achievable.'

Encouraged by her recent experience in statewide roles, and the increase in online communications that COVID-19 has brought, Clare is looking forward to collaborating across emergency medicine in Australasia.

'I had an extraordinary year, because I got to be the lead for the ED Community of Practice in NSW. And the learning from that was, if we collaborate and share and we're open with each other, there is a lot we can achieve. And that inspired my decision to run. It built my confidence. I'm very collaborative in my style. And if I can manage this collaboration and engagement work in the NSW context, it would be really lovely to be doing that at a bi-national level. Opening things up, getting people engaged, communicating more openly.'

Author: Katie Lee, Campaign Assistant

ACEM Faculties and ACEM Foundation

2020 has been a very busy year for ACEM's faculties, with Faculty Boards, supported by the ACEM faculties team, undertaking significant advocacy and support for members during COVID-19. In an average year, each faculty would hold four meetings, totalling about 36 meetings across Australia and New Zealand. In 2020, ACEM hosted more than twice that.

The use of video conferencing has been welcomed by all faculties, with members reporting an increased ability to attend meetings and engage with each other. It has been amazing to see how we can adapt and thrive with the use of technology when it's forced upon us. Faculties will continue to use video conferences and hybrid meetings in the future, making it easier for members from across each region to connect.

It has been amazing to see how we can adapt and thrive with the use of technology when it's forced upon us.

Faculty Chairs, assisted by members of the relevant Faculty Board, have been an incredible source of support to members and trainees, not only in chairing the significant number of meetings (in some cases weekly), but, more importantly, in being available to offer guidance and highlight issues that require advocacy. The President and Faculty Chairs regularly contacted relevant departments and government to highlight the support members needed during very challenging times. With thanks to their hard work and dedication, while also coping with their own jobs, ACEM's advocacy efforts helped influence some significant policy changes. These have included:

- The Australian Border Force Commission confirming that registrar-level staff would be eligible for visa exemptions to enter Australia, opening the door for recruitment of overseas-trained doctors
- Influencing personal protective equipment (PPE) guidelines across jurisdictions to ensure guidelines were reviewed and reflective of safety, not availability
- Standing up for Victorian Communities of Practice to bring together ACEM, the College of Emergency Nursing Australasia (CENA), Ambulance Victoria, Safer Care Victoria and the Department of Health and Human Services (DHHS) to facilitate the sharing of information, issues and solutions during Victoria's challenging second wave of COVID-19
- Providing support for Tasmania's North West region during periods of significant pressure in the pandemic.

ACEM gives thanks for the tireless work of our Faculty Chairs, Faculty Boards and all our members in supporting the College, each other, and our communities during 2020.

ACEM Foundation

Life has not been business as usual for the ACEM Foundation in 2020. To use the latest buzz word, the Foundation had to 'pivot' the awards program as the year progressed, and it was clear that many of the activities the Foundation typically supports would not be possible.

The Foundation would usually sponsor a number of important conferences relevant to its pillars of Indigenous Health, Research and Global Emergency Care, which, unsurprisingly in 2020, did not go ahead. However, the Foundation has committed to sponsoring events in 2021 or providing support in other ways, for example, confirming a formal partnership arrangement with Te ORA in Aotearoa New Zealand.

The ACEM Foundation was pleased to support our Indigenous members and international partnerships by providing registration to the ACEM 2020 Annual Scientific Meeting (ASM). The Foundation offered registration to all Indigenous trainees and International Affilaite members of the College, as well as to ten international organisations with which ACEM has a formal partnership (predominantly universities and hospitals). Additionally, a further 30 tickets were made available for international emergency care staff via an expression of interest process. In total, the Foundation offered 92 registrations to the event, with 43 taking advantage of the opportunity.

Feedback from all of the Foundation's ASM attendees was very positive, with our colleagues internationally particularly excited to be able to join in thanks to the virtual nature of the event, for many their first medical conference. We understand the WhatsApp chats were running with ideas and sharing throughout the four days.

ACEM gives thanks for the tireless work of our Faculty Chairs, Faculty Boards and all our members in supporting the College, each other, and our communities during 2020.

One of the highlights of the ASM program was the fantastic Foundation Lecture, presented by John Whaanga, Deputy Director of Māori Health at the New Zealand Ministry of Health. John shared the journey towards equity that New Zealand is on and provided insights relevant to us all, regardless of where we are working currently. John was joined by a panel including Dr Max Raos, Ms Jacqui Gibson-Roos and Dr John Bonning, who engaged a great discussion considering questions such as the value of a treaty in the Australian context, how to be an ally for Indigenous peoples and what steps we can all take to support the journey towards equity in healthcare for Māori and Aboriginal and Torres Strait Islander peoples.

A number of other awards and grants have continued to run as usual, with some currently being finalised. Successful applicants will receive their award or grant at the ACEM Winter Symposium in 2021. We encourage everyone to apply for the range of awards, grants and scholarships offered by the ACEM Foundation. Information is available on the ACEM website.

Ordinary People Doing Extraordinary Things

LifeFlight Retrieval Medicine

Dr Katherine Gridley and Dr Akmez Latona
Dr Gridley and Dr Latona are both final-year FACEM Training Program trainees and are currently working as retrieval registrars with RACQ LifeFlight Rescue.

For the uninitiated, a retrieval team may just seem like adrenaline junkie emergency registrars racing off into the wilderness, ready to dangle themselves precariously out of a helicopter in a daring rescue. While this absurd imagery makes for action-packed cinema, in reality, the doctor is only one tiny cog in the powerful retrieval machine. It takes an army of ordinary people doing extraordinary things, to achieve the remarkable.

In Queensland, from the first 000 call to the arrival of a helicopter, a number of highly skilled individuals are working feverishly to ensure efficiency and the safety of everyone involved. When a task is coordinated through the central hub of Retrieval Services Queensland (RSQ), an enormous number of factors need to be taken into account – whether it's a hospital transfer or a primary trauma scene, the patient condition and complexity, the required crew members and their level of fatigue, the available aircraft, the suitable service and, most importantly, the weather and flying conditions.

Royal Automobile Club of Queensland (RACQ) LifeFlight Rescue critical care doctors are on board most of the aeromedical helicopters throughout Queensland, as well as some jets. When an RACQ LifeFlight Rescue aircraft is tasked on a mission, only after the pilots determine it's safe to fly do the medical team receive any information about the patient. This is an important exercise in separating emotions and logistics.

RACQ LifeFlight Rescue crews are a mix of team members, working out of a variety of aircraft. Depending on the base and type of mission, medical teams on the helicopters usually consist of a flight nurse or paramedic with a doctor, who could range from a late phase registrar to emergency consultant, anaesthesia, intensive care, or rural and remote medicine. For longer missions, in the jets, there can be an army of medical professionals, sometimes including extra neonatal, paediatric or ECMO-trained intensive care teams.

These retrieval teams are supported by the staff at RSQ, who work 'behind the scenes' liaising with hospitals across the state to ensure patients receive the most appropriate care, at the most appropriate site. When 20 requests for assistance are occurring simultaneously, the amount of collective problem-solving it can take boggles even the brightest of minds.

Retrieval medicine is a truly fascinating discipline and one that critical care health professionals are in a prime position to experience and enjoy.

These are the stories of some of our LifeFlight crew.

Dr Claire Bertenshaw: post-Fellowship FACEM Training Program Advanced Trainee, RACQ LifeFlight Rescue Critical Care Doctor – Mackay, Brisbane and Toowoomba

What attracted you to retrieval medicine as a subspecialty?

I have been exposed to many different leadership styles throughout my emergency department (ED) training and the specialists who inspired me most had completed some training time in retrievals. In addition to the transferrable skills I can develop, what could be better than working with like-minded, highly-skilled paramedics, nurses, pilots and rescue crew officers in small teams, with the patient at the forefront of all decisions, while working in some of the most spectacular places in Queensland?

As a female trainee, did you have any preconceived ideas about retrieval medicine?

My only preconceptions came from seeing women thriving in the role. I knew nurses and doctors — both male and female — with children, who were working for the RACQ LifeFlight Rescue base where I was to spend my term, and I met other registrar parents during our training week. I found that working in retrieval medicine is no different to any roster-based emergency medicine job, where balancing work and family commitments is a constant juggle – just like it is for any working family.

Friends and family had the perception that aeromedical retrieval is a 'dangerous' field. While I can understand those initial concerns, I'm completely reassured by the aviation processes and coordination of medical tasking processes, which are carefully planned and executed. The crew empower everyone to speak up if they feel unsafe.

What have been your biggest challenges working as a trainee in retrieval medicine?

Translating my ED skills into unfamiliar environments has shown me how unaware I was as to how much a change in environment could impact my ability to make decisions and work effectively. This has been made easier by the support of a highly skilled crew with amazing situational awareness and scene control abilities.

I also needed to trust myself more in order to make quick decisions with comparatively limited information, while maintaining diagnostic flexibility.

What have you enjoyed the most about working in retrieval medicine?

The patients I have had the privilege to care for, the places I have been, and the friends for life I have made from these retrieval teams. I now know people across the state, understand the capabilities of their medical facilities, and also where to find the best bakeries! I have a greater understanding of the coordination aspect of retrievals and have developed some highly transferable skills to take with me for my entire medical career.

Dr John Kao: FACEM, Medical Coordinator and Retrieval Consultant, RACQ LifeFlight Rescue Critical Care Doctor – Brisbane

What attracted you to retrieval medicine?

I was drawn to retrieval medicine for the challenge of applying my emergency medicine skills outside an ED, in addition to a clinical variety that I thought would benefit me with professional longevity. Aside from the fact that it's just flat out cool to be able to fly in an 'air ambulance'!

How did you first become involved in coordinating retrievals?

Shortly after I obtained my Fellowship, I was credentialed as a retrieval consultant and took up clinical coordination in addition to my flight shifts. It was initially a scary and uncomfortable experience to hold clinical oversight over patients requiring aeromedical retrieval across an entire state as large as Queensland. However, over time, I noticed a significant overlap between the reasoning skills that I used in the ED and in coordination. The two jobs have been mutually beneficial ever since.

What challenges do you find in coordination that are different from those faced as an ED-based FACEM?

The cognitive load during a coordination shift is very different from working in an ED. The lack of visual cues means we rely on exceptional verbal communication skills to make some relatively big decisions based on very little clinical information. You also have to be realistic about the limitations to how much definitive care you can provide in the pre-hospital and retrieval setting.

What things do you enjoy about coordination that are different to what you experience working in ED?

I enjoy seeing a different side to our healthcare system and how it can impact a patient's clinical journey. No matter how remote a patient is, the system always seems to find a way to get to that patient and provide them with world class healthcare. The chance to work with and learn from my experienced colleagues in the retrieval setting has helped my growth as a clinician, which is something that I can also contribute to my own ED.

Dr Sujith Kumarasinghe: UK emergency trainee, RACQ LifeFlight Rescue Critical Care Doctor – Sunshine Coast and Brisbane

What attracted you to working in retrieval medicine in Australia?

I had a background interest in trauma but really thought it was a job only for anaesthetists or anaesthesia trainees. I then worked with ED consultants in the UK who did it and was fascinated by their experiences. After discovering that an ED consultant had completed her retrieval term at a similar stage in her specialist training to where I was, I googled LifeFlight and applied for a position.

As an international medical graduate, did you have preconceived ideas about the job?

I was tasked on fewer winch jobs than I had expected, however, there were a lot more trauma cases than anticipated. In fact, they make up about half of our caseload, which is great experience.

I always thought that pre-hospital medicine in Australia would be far more enjoyable compared to in the UK — especially the weather and the amazing scenery! And it sure has lived up to my expectations.

What have been your biggest challenges of the job?

What has challenged me most has been stepping up my game from being an ED registrar with a good support network within the confines of a hospital, to being a more independent practitioner, in a resource-limited setting with sicker patients. Unlike being directly supervised in ED, the coordinator is relying on your clinical judgement over the phone rather than seeing the patient with you. I learnt not to doubt my skills and to remind myself that everyone is chosen for the job because they are willing and capable (and have survived training week!).

I was lucky that I had some baseline understanding about how the Australian healthcare system functions after working in an ED in rural Victoria. However, the medicine aspect between the UK and Australia is more or less the same.

What have you enjoyed most about it?

Everything! The challenge of critically ill patients, the problem-solving, thinking on your feet outside of the hospital, and working with a small team. The flying is simply amazing – it gives you an opportunity to see a lot of Australia and enjoy the much nicer weather!

Dr Caroline Venner: FACEM Training Program Advanced Trainee, RACQ LifeFlight Rescue Critical Care Doctor – Toowoomba

What attracted you to retrieval medicine?

I'd always had my heart set on being a trauma surgeon, but over time I've realised that people working in the pre-hospital field really have the best job in the world! I was extremely fortunate to have experienced major trauma in the Midlands while doing the anaesthetic and critical care components of the UK emergency medicine training program. I also grew up in the Royal Air Force and trained to be a gliding instructor, as well as doing some powered flying, so being a 'flying medic' is the combination of two lifelong dreams.

What have you enjoyed most about the job?

Spending time on base with the aircrew and the paramedics is amazing, as they all have extensive experience and the best stories. I love the autonomy and the shared mental model of working in a small team with limited resources in a multitude of unpredictable environments. Unlike in ED, we mostly get to focus on a single patient at a time, often providing a level of intensive care that they might not otherwise receive for several hours or even days. The extensive research occurring in pre-hospital and retrieval medicine at the moment is exciting and satisfying, proving that what we do can make a significant difference to a patient's outcome.

What challenges were you expecting with juggling work and study? How have you been able to fit both in?

I'm currently studying for the ACEM Fellowship examination and I would recommend this placement to anyone else doing the same. There is just enough downtime between interesting and relevant jobs to squeeze in some study, which you just won't get in any hospital-based placements. The teaching sessions and standard operating procedures are very relevant to the ACEM Curriculum and the actual cases provide ample opportunity to be the team leader for extended periods of time. While I would wholeheartedly recommend this job, I wouldn't recommend planning a wedding during COVID-19 at the same time!

David Bourke: rural-based LifeFlight Critical Care Paramedic – Roma base

What attracted you to the aeromedical industry and working with helicopters instead of on the road?

Prior to commencing with LifeFlight, l had been working within the aeromedical industry for 15 years, on and off, with extensive overseas experience. I always had an interest in it and steered my career towards it with additional courses and experience. Moving into aeromedical work was just a natural extension of my intensive care skill set (road-based), applied to an austere environment.

What do you enjoy the most about retrieval care?

No two days are the same. Your work environment constantly changes. The retrieval environment is very team-based and communication is key. We problem-solve as individuals, as a team and as a crew. We train extensively, clinically through scenario training and educationally through zone audits, always learning from others and improving. Basically, we just try to eliminate error in everything we do and adapt when plans go 'south'. Additionally, as a flight paramedic, we maintain a rescue crew skill set that includes general airmanship, hoisting skills and emergency drills. It makes a work environment like no other and it's this uniqueness that attracts dedicated people.

What is it like working at a rural base?

As with most bases, our work is divided between pre-hospital retrieval and inter-hospital transfers to Brisbane or Toowoomba. In our rural location, we also respond to oil and gas sites. The team spends a lot of time together, so we know each other pretty well, which translates to excellent crew resource management, both on the ground and in the air. We debrief over coffee frequently and integrate when we can with local emergency services and the community.

What are some of the challenges of working in rural areas?

People who live in the country are very resilient, so whatever you do is always appreciated. The challenges are similar to what any rural healthcare provider would face. Sometimes we are saturated with resources and sometimes we aren't – flat tray utes are the perfect work platform in the middle of nowhere! We work in the dark, wet, dust and more dust. On average, a job (a case) can take up to 10 hours or more, so the shifts can be long but rewarding.

Natalie White: RACQ LifeFlight Rescue helicopter co-pilot – Brisbane

What was your background before you started with LifeFlight?

After school, I undertook pilot training with the Royal Australian Navy. I was military-based for 13 years, which included deployment to Afghanistan, and I have also undertaken humanitarian work in the south west Pacific. I was fortunate to join LifeFlight in November 2019.

What attracted you to work for emergency medical services (EMS)?

Helicopter pilots often choose to go into EMS or offshore work. I feel that EMS has intrinsic value in being able to help people and give back to the community, which is something I value highly. I really enjoy the dynamic environment and the fact that you work with a small team of highly skilled specialists, with the common goal of providing the best patient care possible.

What were some of the challenges you expected before starting work with LifeFlight?

I was interested to see how I would be able to transfer my aviation skill set from military to civilian due to the different rules and nature of work. I was also unsure how I would fit in as a young woman in this traditionally male-dominated environment. I had never even met another female EMS pilot until recently.

The actual challenges I faced were not as expected, aside from the fact that it was a slow but calculated process to learn how to fly a new type of aircraft. It's interesting learning the medical aspect of retrievals and appreciating the situation as a whole, rather than viewing my job as being solely to 'drive the bus'.

What have you enjoyed about the job?

I love the dynamic environment and the short-notice nature of our work. The medical side has been fascinating and the sense of helping the community is unparalleled.

Flying for an organisation with such a mature and self-actualised culture, it's refreshing to see an absence of the male–female divide and, instead, to just see a group of specialists – highly trained and hard-working in their own right – working towards a common goal. Nobody just 'ends up' working in EMS. Everyone has chosen to do so with purpose and this makes for a very inclusive workplace environment.

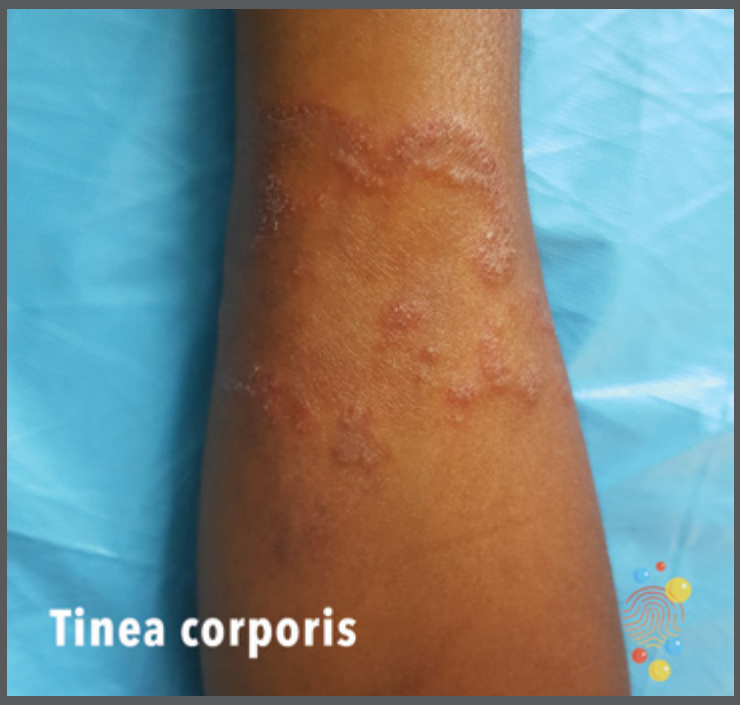
The captains at the Brisbane RACQ LifeFlight Rescue base are passionate and forward-thinking. Having such an enthusiastic and outcome-focused crew really shows what you can achieve using the right people, with the right attitude and the right experience.

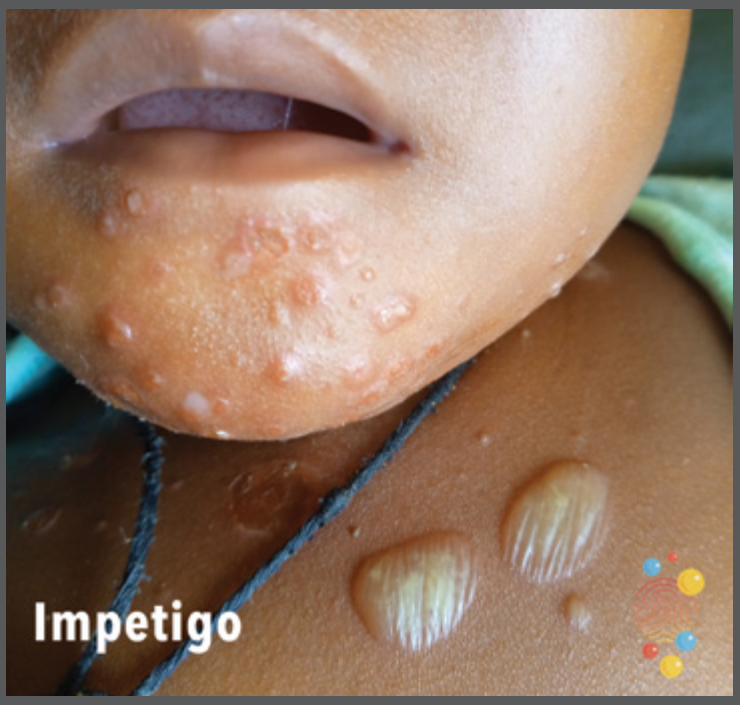
Retrieval medicine, much like emergency medicine, is true to its nature in being a 'generalist specialty': it takes all types. It is a wonderful melting pot of critical care capability and pre-hospital proficiency, blended together with medical and aviation crew, with a diverse range of experience, personality types and leadership styles, all striving towards the common goal of saving lives in the most dire of circumstances. One could argue that emergency and retrieval medicine are one and the same; but it's only when you find yourself in a time or treatment-critical situation in a resource-deplete environment, with only yourself and your fellow crew to help you that you realise how vastly challenging the pre-hospital world can be.

It takes a certain strength of character to become a retrievalist, but with it comes one of the most diverse and exciting career experiences of a lifetime.

i More information

Interested in working with LifeFlight? Contact LifeFlight Retrieval Medicine's Senior Recruitment Officer Monique O'Reilly: recruitment@lifeflight.org.au or log on to the website for further information: Becoming a Retrieval Registrar.





Skin Deep

A Don't Forget The Bubbles project to catalogue the appearance of paediatric skin conditions on non-white skin hopes to improve medical education and, consequently, medical care.

Dr Alyah Seif
Dr Seif is a paediatric registrar working in paediatric emergency medicine and is the DFTB Skin Deep Australia Lead.

Dr Alyah Seif is a paediatric registrar with a keen interest in emergency medicine. She's also the Australian lead for a new project from the team at Don't Forget The Bubbles (DFTB).

'DFTB Skin Deep is a project aiming to improve the diversity of paediatric medical images', Alyah says.

'Patients deserve to have doctors who have learned how skin conditions look on all skin colours so they can get the best care.

'When patients don't see themselves reflected in medical literature – it can feel like they are excluded or "othered".'

Alyah first got involved with DFTB when she worked with the project's co-founder FACEM Dr Andy Tagg at Sunshine Hospital Paediatric Emergency.

Together they and the Director of Paediatric Emergency Medicine at Sunshine Hospital, Associate Professor David Krieser, realised the dearth in diversity of images of paediatric skin conditions and the potential impact of this on medical care.

'Every day in the emergency department, we make time-critical decisions about a rash or skin condition – whether a patient needs to be isolated because a rash is contagious; how quickly to be worried about a purpuric rash; is this cyanosis or jaundice?' says Alyah.

'If we have less experience from our medical education with identifying these signs in diverse skin, we compromise the quality of care we are giving.'

They decided to launch a project to catalogue that diverse imagery – and DFTB Skin Deep was born.

'We launched at the end of June 2020 and now have more than 200 images online.'

The project is led by DFTB in collaboration with Sunshine Hospital and The Royal London Hospital in the UK.

'The aim for Skin Deep is to be a global collaboration. There are already a number of international hospitals and organisations involved as collaborators and supporters', Alyah says.

Collaborators include hospitals, organisations such as the Eczema Association of Australasia, countries such as Sierra Leone, Peru and India, and medical schools and medical students.

'Skin Deep has evolved and grown so rapidly in such a short space of time. It quickly required its own website, separate to the original DFTB site.

'We now have a research project and we are collaborating with organisations for genetic conditions, medical schools, and our nursing colleagues. Skin Deep images will also be featured in the *Illustrated Textbook of Paediatrics 6th edition.*'

Alyah says, when parents go looking online, the default search result is often for paler skin types – and this same unconscious bias exists throughout medical education.

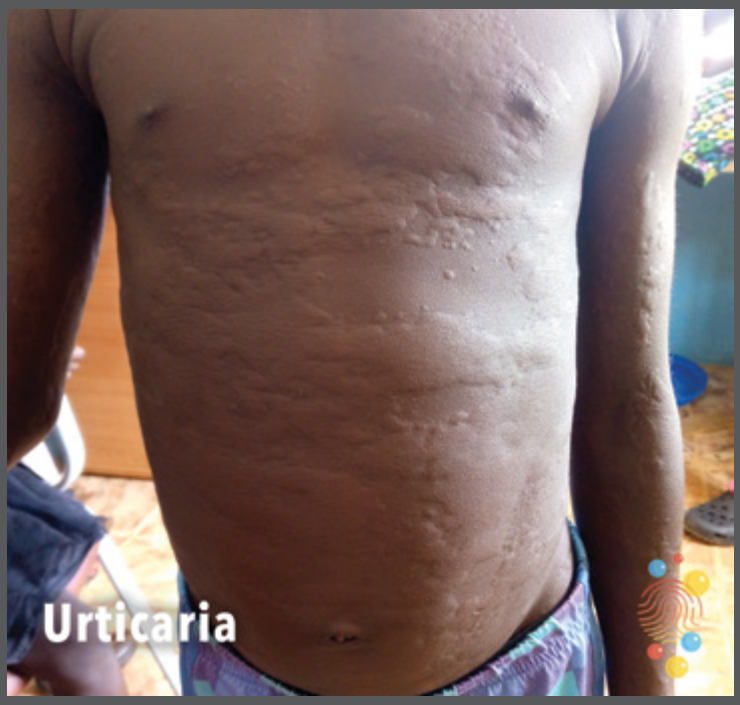
'I personally have searched for images online multiple times to try and work out what the rashes on my children are.

'I always need to add further descriptors to my search – "fungal rash" has to be rewritten as "fungal rash dark skin".

'As medical professionals, we are also constantly using online resources to help with our decision-making and diagnosis.

'If the images we see do not reflect the diverse population we treat, this can lead to misdiagnoses, or missed diagnoses. These diagnoses have potentially life-threatening implications.'

'The response to Skin Deep has been amazing,' Alyah says.



Photos: DFTB Skin Deep

'Patients are keen to be involved. They are happy to get more representation and jump at the chance to be involved in a positive change in medical education.

We have also had a great response from various organisations and individuals who feel the same.'

One of the challenges and core requirements in setting up Skin Deep was to ensure appropriate access to and consent for the use of the images obtained.

'We put together a streamlined process at each site to ensure appropriate consent, confidentiality and medical photography. This all differs based on whether photographs are coming from individuals, GP practices, clinics, or hospitals in different states.'

Each image is anonymised, including removal of case details and information about the child. Submissions are open to individuals and organisations via the DFTB Skin Deep website, where guidance on consent requirements can also be found.

'We ensure all images received are reviewed by a dermatologist and paediatrician before they are published on the site.'

Adult skin images are not within the current remit of the project.

'We may look to collaborate in the future on adult skin images and we have recently agreed to extend the project to include images of skin conditions in adults, but these conditions must still also affect children.'

The key, for now, is for others to engage and get involved by contributing images.

'We want to have the largest repository in the world of diverse paediatric images and to encourage wide, free sharing and use of those images.'

Author: Natasha Batten, Communications Advisor

Goals

- Have the largest repository in the world of diverse paediatric images
- Encourage wide and free sharing and usage
- Build a global collaboration where the paediatric healthcare community can all contribute images
- Engage with external organisations to improve training and education to include diversity
- Engage in research to demonstrate the impact of the project
- Be leaders in diversity

Collaborators

- Organisations (e.g. African Federation for Emergency Medicine, Eczema Association of Australasia, British Skin Foundation)
- Hospitals in Australia: Sunshine Hospital, Sydney Children's Hospital, Royal Darwin Hospital, Perth Children's Hospital, and others
- Hospitals in the UK: The Royal London Hospital, Nottingham Children's Hospital, Kings College Hospital
- Countries (e.g. Sierra Leone, Kenya, South Africa, Ireland, Italy, Peru, India, and US)
- Nursing colleagues in the UK
- Medical students/schools

More information

@dftbskindeep
https://dftbskindeep.com
aushospitals@dftbskindeep.com

Dr Jonathan Lee

Dr Lee is a FACEM Training Program Advanced trainee in Melbourne, Victoria.

Why Emergency medicine:

I'd always thought I'd become a surgeon – having wanted to do OBGYN and then orthopaedics. But I realised that there was too much of medicine I would have to give up.

Emergency medicine allowed me to practice both the surgery, the medicine, and more.

Above all that, emergency medicine provided the greatest exhilaration with a time-critical element.

What do you think is the most challenging part of the job?

Emergency medicine presents many different kinds of challenges; I like to think they come in three main parts. The first being the breadth of knowledge required. You go from a croupy kid, to an elderly patient with end stage heart failure, to a pregnant woman with hyperemesis gravidarum. You then have to muster up the courage to start team leading time critical resuscitations. Lastly, which I think most trainees won't understand until they get there: is the managerial skills required as a FACEM at the end of training.

You are going to start working at Echuca ED next year. What was the decision behind that?

I truly believe that all emergency physicians love critical care/acute medicine. We love to be hands-on i.e. resuscitation, procedures etc. Those experiences, however, come by far less in the metropolitan hospitals due to the support we have from the specialties present. Whereas in a rural setting, that luxury isn't there and many times we have to make do with what is available. We have to make the harder decisions with less support when it comes to patient care.

What inspires you to continue working in this field?

All junior doctors have to work in the ED at some point in their career. The ED can be very daunting and overwhelming. For most, this is their first experience having direct responsibility of patients that they care for. The ability to guide and groom these doctors bring me a lot of joy, particularly when they begin to understand and enjoy the thrill of working here.

What do you do to maintain wellbeing?

I freedive. I get in the water as often as I can – Victoria in the summer, Queensland or Southeast Asia in the winter months. There's a sense of peace and understanding of your own body – not necessarily to push your boundaries; more to be in tune with yourself. It's a great way to meditate. Fun fact: I tried holding my breath over four minutes at work and my SpO2 never once dropped below 100 per cent.

One good advice that you have been given in your career?

I was given one piece of advice during my time as a medical officer in Singapore. When your consultant advises you on something, there can only be three replies:

"Yes sir." "Sorry sir." "do that again sir." That, of course, is different from the Australian culture, but my biggest gain from that is the ability to be teachable. There is so much we can learn from one another if we are willing. Someone wise once said, "when you stop learning, you stop growing".

I truly believe that all emergency physicians love critical care/acute medicine.

Supervision of Senior Trainees – 'Feel Free to Cope'

Dr Annemarie Newth is a FACEM Training Program Advanced trainee and Senior Registrar in Victoria. She completed medical school in New Zealand and has trained all over Australia (four out of seven states), both in metropolitan and regional/rural EDs. Annemarie's other interests include research, electronic medical records (EMR) development, hyperbaric and diving medicine, and working as a trekking guide/expedition doctor for Peak Learning Adventures. Since progressing to Advanced Training, Annemarie has been a member of the FACEM Training Program Accredited Site Review Working Group, the Global Emergency Care Special Interest Group and is a trainee representative on the Accreditation Inspection Panel.

I have been fortunate to work (as a trainee) all over Australia, and while I do not have experience in the New Zealand training system, I have been privy to the feedback and surveys pertaining to both countries. My recent experience on an ACEM working group and a difficult site accreditation visit has prompted me to contribute to the discussion about training culture.

As FACEM trainees in the final stages of training, what we expect and what we get can be quite different things. Comments from the annual training surveys highlight this mismatch between trainee expectations and the reality they often face in their final phase of FACEM training: references to being 'chucked in the deep end' and a sink or swim mentality highlight the need for change in culture.

This article aims to highlight what being a Late Phase Advanced trainee means, the challenges faced by these trainees and their training sites, and hopefully provides some guidance for a way to be a part of a change in training culture. The onus rests on both consultants and trainees to create a training environment that produces excellent consultants, who are knowledgeable, skilled and highly respected.

Trainee perspective: what do trainees need and what is the reality?
Dr Annemarie Newth, Advanced Trainee

What does being a trainee mean? What do we need to become gold standard consultants?

Emergency medicine is, in many respects, the ultimate apprenticeship. It is on-the-job training with the see one, do one, teach one model often employed. While this model of learning does work for some activities and procedures, it is not always what we, as trainees near the end of FACEM training, need. This method alone does not produce excellent specialist emergency physicians; it makes consultants who can manage and get the job done.

Shouldn't being a trainee be an opportunity to become fantastic (gold standard) through guidance, mentorship and experience in all domains? Shouldn't it mean being given the time and supervision to learn well and practice. To then feel safe and confident in what you are doing and why, versus knowing that you can get it done because you have to? The difference can be subtle, but it's there and the toll for coping (rather than thriving with confidence) may be higher than we realise. To become the best consultants we can be, What all trainees need is a positive, supportive and collegiate training culture that includes meaningful feedback and supervision.

We know what we as trainees expect, but for some trainees, the reality that is reported via trainee surveys and discussions with registrars is somewhat different.

The table below contrasts the expectations with what is sometimes the reality.

FACEM perspective: what do we expect of trainees?
Associate Professor Melinda Truesdale, FACEM

Associate Professor Melinda Truesdale is Director of the Royal Women's Hospital ED and previous ED Director and current interim Divisional Director at the Royal Melbourne Hospital. Melinda joined the ACEM Board in 2019 after significant involvement with the College that commenced in 2002. Her roles have included Chair of the Accreditation Subcommittee and the ED Ultrasound Subcommittee, Supervisor of Special Skills Placement trainees, membership of the Specialist Training and Assessment Committee, International Medical Graduate Review and Credentialing Panel, Quality and Patient Safety Committee, Governance and National Program Steering Committees, the Pre-hospital and Retrieval Section, and the Standards and Endorsement Committee. Melinda is an Accreditation Inspector and a member of the FACEM Training Program Review and Accredited Site Review Working Groups, the Victorian Faculty Board, and the Advancing Women in Emergency Medicine and Trauma Emergency Medicine Sections.

For many emergency physicians, the inspiration for our work often includes a feeling of wonder about our specialty. The ability to help a patient or family member who is likely to be having one of the worst days of their life is a privilege; we have the chance to make their journey a little easier. This feeling of wonder can be reignited when working with our trainees. It gives us pleasure to see the challenge and excitement; to know you have helped to make a difference in their knowledge, technique or understanding of a patient's care, and then to help guide and mentor the trainee's progress as their skills continue to develop.

	Trainee expectations		Reality
Supervision	Time to learn and practice with supervision	>	Expectation to just know it and get on with it
	Opportunity to discuss cases to hone skills for demonstration of consultant-level thinking for the OSCE and for being a FACEM	>	Lack of opportunity to discuss cases (in realtime) with time pressures. Lack of bedside teaching and supervision
Time	Time to study and maintain mental health and wellbeing while achieving Fellowship examination success	>	Longer training pathways as often unable to get the rotations needed and time to study and be successful in the examination
	Having non-clinical time – for progression in training (examinations, skill acquisition) and for mental wellbeing	>	No non-clinical time for senior trainees
Workforce	To be recognised as more than simply the workforce of the ED	>	Feel used as work horses, pure service providers
	Opportunity to run the show and (let's be honest, in your own minds and in group discussions) show everyone how it's really meant to be done	>	Managing other trainees who are not coping or have been put into senior positions too early (due to workforce issues)
	Respect for the specialty and understanding of the role	>	Lack of respect for our specialty
	To feel part of the hospital team	>	ED being siloed off from the main hospital and departments
Leadership and guidance	Leadership (modern and effective) on the floor, in our departments and from the College	>	Lack of strong leadership and work ethic from some FACEMs
	Guidance to develop a portfolio that will help us in the job market (it's tough out there)	>	Good ideas from the College (mentoring, ultrasound teaching, research) that don't always correlate to the reality of the workplace (not done/provided, need to be done in own time) and therefore often just not done

One of the pivotal points in a trainee's journey is the transition from senior trainee to junior consultant. In the final phases of training, trainees develop a greater understanding and appreciation for the overall clinical floor; the busyness, the flow, the access challenges, the support that junior staff need, and the importance of collegiality with nursing staff and peers.

To successfully make the transition from senior trainee to junior consultant, trainees need to self-direct their learning and development, and constructively contribute to their EDs across a range of important areas.

During clinical time, trainees should:

- Formulate discussions with peers
- Seek out colleagues to discuss cases
- Keep an open mind
- Reflect and follow up.

To consolidate learning:

- Reflect on what they need to develop – self-direct and enquire
- Discuss with a mentor
- Seek people out for advice.

To improve leadership and management skills:

- Step up and run the floor
- Take responsibility and be accountable – outline what they are going to do and how
- Volunteer for additional leadership positions (suggest and conduct small audits or case reviews, lead journal article critique)
- Support junior staff.

Study should predominantly be self-directed, self-motivated and satisfying. With knowledge comes greater understanding and the ongoing education process becomes entrenched. Gone is the didactic teacher-pupil relationship. Life-long learning becomes a natural and desired focus.

The next group of inspiring leaders for our specialty is emerging and hopefully this will include engagement with the College, as we all work together to encourage a new group of doctors to discover the wonders of emergency medicine.

What all trainees need is a positive, supportive and collegiate training culture that includes meaningful feedback and supervision.

A way forward: clinical supervision redefined – How can we do better?
Dr James Collier, FACEM

Dr Collier is the Director of Emergency Medicine at Princess Alexandra Hospital in Brisbane, a Senior Examiner at ACEM and member of the Accredited Site System Review Working Group. James' involvement in Education and Training at ACEM began in 2007 and has since included roles as Director of Emergency Medicine Training, Regional Censor, Chair of the Accreditation Subcommittee, Accreditation Inspector and membership of numerous groups including the Council of Education, Workplace-based Assessments Panel, Curriculum Revision Project and the Accreditation System Review and Accreditation Requirements Working Groups. James' significant commitment to EM teaching and ACEM has been recognised through the ACEM Teaching Excellence Award (2007) and the ACEM Distinguished Service Award (2019).

There are many aspects of the FACEM Training Program that speak to the partnership required between training sites, trainees, Fellows and the College to ensure a quality training experience.

It is arguable that, historically, there has not been sufficient emphasis within the accreditation requirements on the aspect that accounts for 90 per cent of a trainee's time at work each week – their delivery of clinical care.

Traditionally, Fellow clinical coverage (Fellow hours per week on the floor or number of Fellows at any one time on the floor) has been perceived to hold primacy with respect to trainee clinical supervision, when, in fact, it simply mandates a minimum standard of Fellow presence from which clinical supervision has the opportunity to occur.

So, what is the clinical supervision that trainees should expect and that Fellows should be expected to provide?

Firstly, what is it not? For Fellows, it's not simply a physical presence on the floor; it's not just an interaction at the start and end of a shift; and it's not simply an awareness of what trainees are doing and the care they are delivering, irrespective of its quality. For trainees, it's not attending to numerous patients and never having to ask for help, irrespective of how well this is being accomplished; and it's not perceiving that enquiry of your practice is criticism or a lack of trust.

What is it? Clinical supervision is multidimensional – it's an interactive educative process; it occurs at the point-of-care to ensure safety and quality of care; it does consider, and is appropriate to, the trainee's stage of training and the learning outcomes attached to it with respect to their clinical responsibilities; it does consider the acuity and complexity of the casemix; it involves enquiry into trainee clinical reasoning; it seeks justification for actions; it monitors and models behaviours; and it aims to support and nurture.

In essence, it encompasses the 'what, how and why' with respect to the application of knowledge, skills, attitudes and behaviours of trainees in their delivery of clinical care.

Understanding and alignment of expectations on each side of the clinical supervision equation will undoubtably improve not only the trainees' experience but, ultimately, the experience of the patients we all serve.

Dr Annemarie Newth, Advanced Trainee

We all have our own experiences of training. You will have had good experiences and those that have been more challenging. If you have a growth mindset, these experiences are the ones that you can learn from the most — about yourself, your own standards and your line in the sand on behaviour. Without a growth mindset, emergency training can be really hard. The reality of being a trainee in any program is tough. Emergency medicine has additional challenges that have been even more highlighted in the past months.

On a positive note, there are many good aspects of being an emergency medicine trainee and a number of rewarding reasons why most of us have chosen it as our specialty:

- Emergency medicine can be a lot of fun, with great variety and the opportunity to create your own portfolio.
- The training program is flexible from a medical and personal perspective.
- Most days bring something new.
- You meet interesting colleagues with varied backgrounds.
- ACEM keeps up with current events and makes changes to create a more diverse and culturally robust program and working environment.

Revisions to the FACEM Curriculum, Training Program and Accredited Site Classification System for 2022

Background

In late 2017, the ACEM Council of Education established working groups to undertake reviews of the ACEM Curriculum Framework and the FACEM Training Program. In 2018, an additional working group was established to review the accreditation site limits (currently six-month linked, 6/12/18/24 months) and delineation (Major Referral (MR), Urban District [UD] and Regional/Rural [RR]) of emergency departments (EDs) accredited by ACEM for FACEM training.

After multiple periods of stakeholder feedback, including focused collaboration with key ACEM entities, proposed revisions to the FACEM Curriculum, Training Program and Accreditation System were considered and approved by the ACEM Council of Education in July 2020, and by the ACEM Board in August 2020. The revised Curriculum and Training Program will apply to new trainees commencing in January 2022. The revised Accreditation System will apply to all training sites accredited for FACEM training from January 2022.

Rationale for review

The reviews were prompted by external and internal factors, including:

- the College's accreditation as a specialist medical college by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ)
- ongoing quality improvement activities guided by the ACEM Quality Improvement Framework.

As a specialist medical college, ACEM is accredited by the AMC and the MCNZ. The purpose of this accreditation is to ensure that ACEM is delivering a continuing professional development (CPD) program that produces medical specialists who can 'practice unsupervised as emergency medicine physicians, providing comprehensive, safe and high-quality medical care. As part of this process, ACEM, as the education provider, is required to undertake regular reviews of all aspects of the training and education programs and revise accordingly.

In addition, as a professional organisation, ACEM follows a Quality Improvement Framework to ensure its programs are continuously evaluated and improvements implemented accordingly. Specialist medical education is a constantly evolving field and ACEM endeavours to implement best practice initiatives that will ensure we are producing the most prepared emergency physicians possible.

In undertaking the reviews, the working groups recognised the important components of the current Curriculum, Training Program and system for accrediting and delineating EDs. For example, the working groups ensured that proposed revisions continue to accommodate the flexibility with which training and assessment requirements may be met, and the opportunities to undertake training in medical disciplines outside the ED that complement ED work and aid in the development of the well-rounded emergency physician. These principles underpin the modifications to curriculum content, as well as the revised system for accrediting EDs in which training can take place. Overall, modifications to the Curriculum, Training Program and Accreditation System endeavour to ensure that the integrity and rigour of training and assessment, as much as possible, support the learning and development of future FACEMs who are capable of dealing with the dynamic and demanding nature of contemporary emergency medicine practice in Australia and Aotearoa New Zealand.

Consultation

The reviews were informed by the ongoing monitoring and evaluation of the Training Program that has been undertaken since the program's inception in December 2014, as well as feedback procured from stakeholders as part of the activities of the working groups. Stakeholders were formally consulted in the development and evaluation of the proposed modifications, with the most recent consultation undertaken in March 2020 regarding the Accredited Site Classification System. Based on the responses received, the working groups modified their proposed revisions to ensure the many and varied perspectives and experiences of FACEM training were carefully considered and reflected in the final recommendations regarding modifications made to the Council of Education and the ACEM Board.

Table 2. Summary of consultations

Timing	Details
Early 2018	Initial survey
June 2018	First draft of suggested revisions to the FACEM Training Program circulated to all stakeholders (all ACEM entities and members, external stakeholders)
September 2018	Second draft of suggested revisions to the FACEM Training Program circulated to all stakeholders
October 2018	Council of Education survey regarding Accredited Site Classification System
September 2019	Draft of FACEM Curriculum, Training Program and Accredited Site System circulated to all stakeholders
March 2020	Revised draft of Accredited Site System circulated to all stakeholders

Implementation

Steps for the implementation of the revised FACEM Training Program will take place over the next 18 months and include the development of new regulations, policies, handbooks, assessment forms, site accreditation guidelines, and a revised My ACEM portal.

Trainees enrolled in the current FACEM Training Program will not be transitioned to the new program. The College will run two training programs simultaneously, with each one having their own set of regulations.

However, the new Site Accreditation System will apply to all training sites and be applicable to trainees in the current FACEM Training Program as well as those undertaking the revised program commencing in 2022. Over the coming months, the ACEM Training and Accreditation teams will provide further details of how trainees and sites will be transitioned to the new Site Accreditation System and guidelines. Arrangements will be based on the principle of fairness to all trainees and sites, with no disadvantage.

As the implementation progresses, details and information will be released across ACEMs bulletins and other channels, so all members and trainees are encouraged to regularly check College communications.

i More information

https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Emergency-Medicine-Standards

FACEM Training Program structure and requirements for new trainees from the 2022 training year

	Training Stage 1	Training Stage 2	Training Stage 3	Training Stage 4
Placement requirements	12 months FTE (adult/mixed ED)	12 months FTE in ED	12 months FTE in ED	6 months FTE in ED
	AND 6 months FTE in non-ED at any time during TS1-3			
				AND 6 months FTE of Elective (ED or non-ED)
		AND 6 months FTE in Critical Care (adult/mixed ICU and/or Anaesthetics) at any time during TS2-4		
Programmatic assessment requirements	ITAs (every 3 calendar months)	ITAs (every 3 calendar months)	ITAs (every 3 calendar months)	ITAs (every 3 calendar months)
	WBAs 8 x Mini-CEX 2 x Communication Skills Assessments	WBAs 4 x CbD 4 x Mini-CEX 2 x Communication Skills Assessments	WBAs 4 x CbD 3 x Mini-CEX 3 x Shift Reports	WBAs 3 x Shift Reports (in-charge) 2 x Team Lead in resus/ intubation Formal Teaching presentation
Specific training requirements	Research requirement			
	Paediatric Emergency Requirement (additional 6 x WBAs, 2 x DOPS, Logbook/Portfolio)			
			Guideline/Protocol Review or Audit M&M presentation	
	Procedural Requirement (Core DOPS x 12)			
Examinations	Primary Examination (Written)		Fellowship Examination (Written)	
	Primary Examination (VIVA)			Fellowship Examination (Clinical)
Online learning modules	• Indigenous Health & Cultural Competence • Assessing Cultural Competence • Critical Care Airway Management	• Clinical Supervision • Giving Feedback	• Clinical Leadership	

Tales from New FACEMs

The transition from trainee to fully fledged FACEM happens instantaneously following the news that you have passed the Fellowship OSCE (barring the completion of any remaining training time). Does this mean that once Fellowship is received, new Fellows hit the ground running? Data from ACEM's biannual *New FACEMs Early Career Survey* suggest it's not that straightforward, with findings that:

- Only 47 per cent of new FACEMs had a specialist position secured at Fellowship.
- 61 per cent were working across multiple workplaces.
- Although 89 per cent felt well prepared for independent practice as a FACEM, training in non-clinical skills was among the most frequently nominated area that new FACEMs felt was inadequately covered in the FACEM Training Program.
- Commonly reported challenges within the first few months post-Fellowship included: managing the feeling of impostor syndrome; adjusting to managing a department and being the final decision-maker; and building a non-clinical portfolio.

Some of our new FACEMs share their experiences and tips for trainees about to embark on this next chapter of their emergency medicine (EM) career.

Dr Angela La Macchia

The transition from registrar to consultant is a challenging and enjoyable one. Much like the transition from medical student to intern, all of a sudden, you feel the responsibility solely on you and a sense of 'this is real now'. People have told me it takes three to five years to feel comfortable as a consultant. I would say they're not wrong, but on a smaller level, with each shift comes more comfort and confidence in the position.

There are definitely perks to being a consultant; better hours, paid non-clinical time and fewer night shifts, to name a few. One of the biggest challenges for many new FACEMs is figuring out what 'non-clinical' is and how to do it properly.

Many aspects of non-clinical time are not experienced during training as a registrar. You may know about them, but most of us haven't DONE them. It may also be difficult to find a non-clinical portfolio that is available if you work in a large centre. My advice is not to stress if your first few non-clinical shifts feel confusing. Start simple and small. I started with completing the mandatory online training for my new workplace and some results checking, which wasn't a completely new activity for me.

I offered help to other consultants with their non-clinical work, such as teaching, OSCE preparation and attending meetings that the head of the department couldn't get to. Think about what you enjoy – is it education, literature, managing complaints or research? Start with these things and soon enough you'll fill all your non-clinical time and more.

The transition to becoming a Fellow would not be complete without mentioning the enormous sense of impostor syndrome. The knowledge and confidence you had immediately post-examinations seems to dissipate quickly and is replaced with doubts. When you realise you are where the buck stops, suddenly, you question your decisions a lot more.

I found it helpful to acknowledge my impostor syndrome and talk about it with friends and colleagues or a mentor. It's a universally shared experience and normalising it makes it immediately more manageable. I also found that teaching junior doctors and registrars helped immensely – you realise how far you have come and that you do know things. We often forget to look back at where we started.

What have been the highlights of my transition to Fellowship? There hasn't (yet) been one defining moment, but rather several little things that accumulate into a sense of achievement. Receiving my letters on stage is definitely a moment I will remember for the rest of my career. The first time I attended a meeting as a consultant, being asked for a job reference, and the first time I was called while on-call, were all instances where I felt proud and like I had settled into my role.

Becoming a consultant felt like I'd climbed a mountain. I was exhausted, a bit sweaty, my body ached, I felt elated, and somewhat left with a lingering sense of 'what now?'.

It reminds me of my experience climbing a mountain on the Appalachian Trail in the US a few years ago. You would ascend to the summit, relieved you'd made it, only to realise there was yet another higher, tougher peak ahead of you. Fortunately, the last peak was sign posted as such and, being 2,500m above sea level, there were no doubts. The view at the top made it all worth it. Achieving Fellowship is not dissimilar. But is becoming a consultant the last peak? Perhaps we all have more of a journey ahead of us.

Dr Elissa Pearton

Athletes have been practicing self-actualisation for years, visualising themselves achieving their desired outcome. I did just that. I pictured myself on results day reading that short but all so sweet phrase: 'We are pleased to advise that you passed the recent Fellowship OSCE'.

What I didn't realise until after is that athletes also picture themselves overcoming adversity to achieve their goal. I had not pictured myself forgetting my login to the ACEM website for the best part of the day and hoping desperately that I was not locked out of the system.

Visualise yourself overcoming adversity to achieve your goal, or, more to the point, make sure you have a memorable,

Becoming a consultant felt like I'd climbed a mountain. I was exhausted, a bit sweaty, my body ached, I felt elated, and somewhat left with a lingering sense of 'what now?'.

fail-safe password. After reading those beautiful words, taking a screen shot of the page just in case it disappeared, getting friends and family to triple check it was not some form of delirious self-actualisation, the celebrations could commence.

I thought the excitement and sheer jubilation of reaching the peak of the EM mountain would last for months. I was surprised when I felt a slight numbness, a feeling of meh, like a day-old helium-filled balloon. It was not until a much respected FACEM let me in on a secret that I started to feel OK. It turns out that many of us feel this way. I'd had one clear goal for so long and had been blessed to have achieved it, but failed to look past this achievement. What kind of FACEM did I want to be? Where can I, or should I, flex my first FACEM muscles?

I could see the pros and cons for staying at a hospital where I was a registrar and progressing to consultant, and for moving to a new hospital and starting fresh. I was supposed to complete my Fellowship, pack up my house and dog, and move to the UK to be with my partner, who is following his career dreams. I had not planned past this point. Now version 3+ of the plan has seen me take a locum consultant job in another state, while waiting for the UK plans to pan out. And while not the original plan, I have landed in a beautiful location, with a wonderfully supportive and fun department.

My first official day was spent with my dog in an Airbnb as part of 14 days of isolation post relocating from interstate. I used this time to vamp up my resume to read more like a consultant than a registrar. Being a new FACEM in a new hospital, in a state I had never worked in before, came with its own challenges. I found it hard to have credibility as a FACEM when I still had to ask where the bathroom was and learn new systems, with many new passwords (not my strong suit).

While I'm still getting used to my new title, I'm also working on the kind of FACEM I wish to be when I grow up. I'm enjoying the time I have now to decide. I'm acutely aware that the way I practice now is very much due to the mentors I had while training; a little bit from each mentor, tweaked to feel natural to me. For those junior doctors I will work with, I hope to impart some of these traits too. I am excited to see where this FACEM journey takes me, alongside marvellous mentors turned colleagues and talented trainees. I have to trust that my training will serve me to do the best for my colleagues, the College, and my patients.

Dr Nick Johnson

'We are pleased to advise that you passed the recent Fellowship OSCE.'

That moment will always stay with me, reading those words while window shopping in an attempt to distract myself. All those hours spent trying to remember the details of a Delta formula, or how to explain Sgarbossa criteria to a confused intern, had paid off. After consuming a large chocolate milkshake (I was on call), it was time to prepare for the next chapter.

Walking onto the floor for the first shift as a new consultant, I recall a great sense of pride, but also trepidation as to how the day would unfold. The job itself, I thought, wouldn't be too dissimilar from that of a registrar, having previously been in charge on nightshift, led a resuscitation, and looked after junior staff. The difference now, as I took handover from the night team, was the realisation that the buck stopped with me. I remember a feeling of unease that there was now the expectation upon me that I was responsible for these patients, their diagnoses and, ultimately, where they would end up.

The first change I noticed was my increased vigilance on the floor. There was a new sense of hyper-awareness when reviewing patients. I started to find that differentials gleaned from Dunn or Cameron popped into my mind every time a history was presented; the standard chest pain history became a grilling as to why this was not a dissection, or asking if a vertiginous patient needed a scan of their cerebellum. Relaxing into the role, I've since found that this vigilance has been balanced with a sense of confidence as I learn to recognise and trust my clinical instinct.

If there is any doubt, then go and see the patient for yourself. It sounds obvious, but in a busy environment, it can be too easy to accept the nicely presented history on constipation. 'Lay a hand' was the mantra we were all taught as students. Go prod the stomach, talk to the patient, find out what it is they are most concerned about.

In saying this, one challenge is that there is less time to see patients and you must say goodbye to the autonomy you previously had. A queue suddenly forms next to your desk, which wasn't there before, consisting of not only Head Medical Officers, but now also registrars. The phone calls are endless, as you field concerns from referring GPs, the positive D-dimer result that you weren't expecting, and anyone else who switchboard decide to put through.

Take a breath and remember that these colleagues are coming to you for help, often out of concern for their patients. You are now seen as a source of knowledge, guidance and reassurance in times of uncertainty. I remember getting used to reading 'discussed with Dr Johnson' at a somewhat alarming frequency and hoped to God I was right. It is a genuine privilege to be in such a position and I'm still amazed how grateful people are.

There is, of course, the shift towards management roles in becoming a consultant, as you transition between a clinician on the floor to a supervisor at the desk. Instead of monitoring the multi-trauma, you find yourself monitoring the waiting

times, Short Stay Unit bed status, and dissolving the Mexican standoff when no one is picking up the category 5 toenail. I've also been heard uttering phrases like 'They have to come and see the patient before ordering the scan', or 'Why has that patient not gone to the ward yet?', or my favourite, 'What made the patient present today?' It's just like *Grey's Anatomy.*

If it's possible to imagine, in the end, I think the learning curve during the transition to consultant has actually increased. It isn't without its challenges, but it's also incredibly rewarding, so enjoy it. Not only does clinical experience grow exponentially, but also your appreciation of the need to stay calm, the importance of teamwork, and knowing when to ask for help. Always remember, we in the ED are a frontline unit made up of some the most compassionate and dedicated people you will ever work with. When it's time to handover, and you walk out with a renewed sense of purpose, don't forget to thank them.

Dr Shani Raghwan

Being a Fellow is not what I thought it would be.

The transition from trainee to FACEM was so much bigger and has taken much longer than I thought it was going to. I'd imagined that, like a key, gaining Fellowship would unlock my inner consultant and, just like that, I'd be fully grown. It wasn't quite like that. It was much, much slower than that. More than 18 months later, I'm only just starting to feel comfortable in the consultant role and I certainly don't feel that I'm anywhere near mastering it.

There is a whole other world of medicine that opens up with the consultant role – non-clinical portfolios, teaching rosters and management meetings too numerous to count.

On one of my first shifts as a consultant, I attended our Mos Board meeting. It's where we pause to take a snapshot of the department every morning – how many patients are in the department, how bad is the bed block, what else has arisen that will slow down workflow and how can we mitigate it?

I had worked in this department as a registrar for almost a year prior and had never once attended the Mos Board, or even thought about how the department ran on a day-to-day basis.

We ran through the usual questions and then they turned to me. 'Any concerns from a medical staffing point of view?'

I mentioned that we had a couple of junior doctors call in sick, proud that I knew the answer to the question.

There was a pause and then, 'What have you done about it?'. I didn't have an answer. I knew that filling staffing shortages was important and had to be done by someone. I just didn't think that someone was me. While I was comfortable with my clinical skills as a FACEM, when it came to these management moments, I was looking for the 'real' leader, the 'adultier' adult – I hadn't realised that person was now me.

I've had dozens of 'aha!' moments like this and, on a daily basis, I am learning, feeling out my leadership style, and becoming better at the non-clinical side of things.

The single biggest thing I've learned is that it isn't enough to be aware of a problem. It's also not enough to make others aware of the problem. You need to come up with solutions too.

It's wonderfully empowering!

I've been a diversity advocate for a long time but since becoming a consultant, I've had the time to really step into it. The skills I have gained as a FACEM have given me the confidence to network harder, to join and speak up in important committees, and to suggest and initiate change.

There is power in being a FACEM. I didn't realise that straight away. I was too busy giving space to impostor syndrome, but as I settle into this new role, I can see it. It can also be more subtle. As a trainee, I looked to the female FACEMs, especially women of colour that I worked with. They gave me a glimpse of what my future would look like. Now I'm proud that I can do the same for my trainees. Representation matters.

There is power in being a FACEM. I didn't realise that straight away. I was too busy giving space to impostor syndrome, but as I settle into this new role, I can see it.

Not everything about being a new Fellow is positive. I'm currently employed in a temporary contract – one of many that have varied in length from several weeks to several months.

I know many new Fellows stuck in dreaded 'zero hours' contracts; their lives are beholden to the department they work in, always available to demonstrate their commitment in the hope it will open up some sort of contract for them one day. This is not empowering. But I've found that finding something new to be passionate about, whether at work or outside work, putting my hand up to get involved in the College, and looking for new opportunities (interstate, private practice, telemedicine) has helped.

Being a Fellow is not what I thought it would be because it doesn't look the same for everyone. But I'm finding my feet and making it my own and I couldn't be more excited about it!

More information

Findings from the New FACEMs Early Career Survey are reported annually, with findings from the 2019 survey available on the ACEM website: https://acem.org.au/getmedia/e03c2fbd-e633-47b2-ab64-d3cdaeba6a47/2019-New-FACEMs-Early-Career-Survey

Council of Advocacy, Practice and Partnership

Associate Professor Didier Palmer
Chair of the Council of Advocacy, Practice and Partnership (CAPP).

I believe that to create change you have to be sitting at the table. If you are not sitting at the table, then you may well be on the menu.

The role of leadership is to create positive change and I think it is often a journey of stages. When you start out, you see many things around you that need change and single-mindedly go about solving the problems you see. After time passes, you look around and see that you have accomplished quite a lot and want to protect it, silo it. As more time passes, you realise the only way you can solve bigger, systemic problems is to collaborate with others, find compromise and influence widely.

There is a stage before this and that is those who externalise problems and think everything is someone else's job. Those people, in my view, rarely progress or influence positive change. People, groups and organisations can step onto the leadership ladder at different levels. The above well describes my own personal journey and I see a similar progression in ACEM's 37-year history. We have developed into a more outward-looking organisation that actively seeks diverse opinion and partnerships to achieve the best for our patients.

In my career, these simple concepts have led me to contribute to many groups regionally: the Ministerial Advisory Group; the health service executive, the hospital executive; the Northern Territory Clinical Senate; the Northern Territory Australian Medical Association Council; the Australian Salaried Medical Officers' Federation (ASMOF) as lead Enterprise Bargaining Agreement (EBA) negotiator; and ACEM Northern Territory Faculty Chair, amongst others.

This, and the amazing contribution and leadership of my local FACEM colleagues, has helped develop emergency medicine in the Top End of the Northern Territory, from an unaccredited single-FACEM emergency department (ED) 20 years ago, into a tertiary multi-service ED, which is now a respected and influential part of the local and regional health system.

That same view of the world has led me to want to influence the development of my specialty and the wider health system. This is why I joined the ACEM Council of Advocacy, Practice and Partnerships (CAPP). I previously chaired the ACEM Standards Committee for nearly a decade. Now I am incredibly privileged to have been voted Chair of CAPP and also to sit on the ACEM Board.

This year, the pandemic has touched, in one way or another, nearly every human on the planet. It has also fundamentally changed the way we view the world because government, for the first time overtly, has had to measure the cost of human life directly against economic loss.

From my local health system and from Zooming into many regional faculty meetings across Australasia, I've seen a palpable sea change in hospital practice and, to some extent, in the way our discipline is viewed by health service management.

There has been far greater collaborative work between specialties. Emergency physicians have come to the fore for their skills in system management and leadership, and, importantly, there has been far more civility as we face a common mission. This is typical in disaster management and we have a disaster that will run into our foreseeable future. It has not been perfect and there is already entropy, but we must seize the opportunity to harness the positive to improve our health system through and beyond COVID-19.

There can be no going back. Crowded hospitals are no longer just a financial dilemma, which is what health departments have viewed them as; they are an ethical dilemma. We know crowding kills; with COVID-19 it can slaughter. We need accelerated system change.

COVID-19 has some of its most significant health system impacts on EDs. It is not the proven positive cases that at present crush us as elective surgery restarts, mental health crises increase, and patient presentations return, but the 'COVID-possible' cases. These presentations require active screening into a separate stream, space and staffing. If we get it wrong at the front door of the hospital, it is often not picked up until later with obvious consequences.

Queueing and batching (to be seen by a doctor/waiting for investigation/waiting for an inpatient team/waiting for a hospital bed/waiting for allied health) all increase risk; we need systems without queues. This will require changes to funding and staffing of EDs, changes to the way hospital inpatient departments do business and, in many jurisdictions, an increase in physical beds.

Emergency care is not only delivered in cities by FACEMs. Health systems in rural areas are incredibly fragile, especially in COVID-19 times. We need to develop functional networks, contribute to rural generalist pathways, and develop a less metrocentric outlook as a specialty.

We also need to think in parallel of fundamental changes to healthcare delivery, to decrease the rate of rise of hospital presentations by enhanced primary and chronic disease care, exemplified by the Canterbury model. We must remember that these changes take a decade or more to have effect and probably need a single funder model to achieve, which is not present in Australia. We need to work with health departments to develop enhanced and supported primary care, but if it is proposed as the only solution to capacity, then we and our patients will continue to be doomed to the misery of worsening crowding.

As Chair of CAPP, these are the challenges and opportunities I see that we face in current uncertain times. We have commenced policy and advocacy work covering nearly all of the above areas. We do, however, need to balance any change by also protecting the discipline of emergency medicine from becoming a simplistic triage service. We add value in the unscheduled diagnosis and treatment of the undifferentiated, resuscitation of the critically ill, being a safety net for the most vulnerable, education of trainees and others, system development, research, advocacy, and many other areas. We must ensure that any new system values us and gives us protection to do and develop the things that give us meaning and agency. It is not all about time.

Gender Equity – What's the Big Deal?

"No country can ever truly flourish if it stifles the potential of its women and deprives itself of the contributions of half its citizens" – Michelle Obama

Dr Jenny Jamieson, Dr Kim Hansen and Dr Shantha Raghwan on behalf of the Advancing Women in Emergency Section Executive

This year has seen the onslaught of the rapidly spreading COVID-19 pandemic, with the ensuing economic fallout and global recession. Amongst this there have been other heart-wrenching catastrophes: Beirut, natural disasters, and one of the worst bushfire seasons in Australia's history. No wonder many of us have wanted to push the reboot button for 2020.

ACEM and the Advancing Women in Emergency Medicine (AWE) Section Executive have released their long-awaited statement on gender equity after an extensive consultation with members. They have also released an impact statement highlighting the gendered impact of COVID-19.

This begs the question – in the midst of a global pandemic, why focus on gender equity?

While it's true that these events have affected all of us, it is equally true that the effects are not felt equally among us, and that COVID-19 has made existing equity gaps wider.

Why is ACEM suddenly so interested in our gender? Surely this isn't core business.

Equal Pay Day in Australia was on 28 August 2020. It marks the 59 additional days from the end of financial year that women have to work in order to earn the same amount as men.[1]

In medicine, controlling for hours worked, the annual earnings of female specialists and gender diverse physicians were 16.6 per cent less than their male counterparts.[1] This is a 2.6 per cent[1] greater wage gap than the average Australian at 14 per cent. The reality is that female emergency doctors are less likely to obtain the career progression of their male counterparts due to factors other than talent and experience.[2] These inequities also affect individuals and groups who belong to other diverse and minority groups – and that's a large portion of our community. That makes diversity and inclusion core business.

Why do we need a statement on gender equity? Doesn't ACEM already have gender parity in trainees and FACEMs?

ACEM certainly has a solid record of roughly equal numbers of men and women within the FACEM Training Program. Recently graduated FACEMs also have near equal numbers of women and men, although this appears to drop off as careers progress.

Unfortunately, equal numbers do not translate to equity. The 'leaky pipeline' and the 'glass cliff' mean that, with regards to senior emergency medicine leadership roles within the College and as heads of departments, we are still far from gender equity.

The 'leaky pipeline' occurs when some women progress through to lower level leadership positions, yet suffer a disproportionate dropout rate along the way due to various obstacles. The 'glass cliff' applies to female leaders who are more likely to be promoted into positions of power during crises, when failure is more likely. Reasons cited for both of these phenomena include reduced access to mentoring opportunities and role models, isolation, lack of managerial support, lack of recognition, and decreased access to resources such as personnel and space.

There are promising signs of improvement though. It is well known that the ACEM Board comprised 100 per cent males for a number of years until 2019. No other medical college matched this level of zero female representation. The Board now has three female members, with the election of FACEMs Dr Rebecca Day and Associate Professor Melinda Truesdale, as well as Community Representative, Ms Jacqui Gibson-Roos.

There has only been one female ACEM president in 37 years, Associate Professor Sally McCarthy, from 2008 to 2012. Pleasingly, Dr Clare Skinner is the next President-Elect for 2020-21.

While we may question why this has happened, it's clear that there have always been exceptional women in our profession. The aperture must be opened to further understand the structural impediments to gender diversity within emergency medicine.

Shouldn't women just do as Sheryl Sandberg said and 'lean in' a bit more?

Sandberg's brand of self-empowerment feminism rose to fame in 2013 with her best-selling book Lean In; an individualistic manifesto, which largely ignored many societal barriers facing women, particularly for those less privileged than Sandberg. There have been many critics since its publication, highlighting that dismantling gender inequality requires more than merely an individual approach. The structural barriers need to be broken down in conjunction with individual biases.

Surely we can all agree that a merit-based approach is the right way to recruit talent to senior leadership roles?

Wouldn't this be the silver bullet to everything!

In order to assess the suitability of this approach, we need to ask where our current ideas of 'merit' come from. Employing a meritocracy approach when hiring or promoting doctors is common, but likely outdated. The meritocracy angle is often used by senior members of departments or organisations (individuals who have had similar merits of success used against them to judge their credibility and suitability for a role). These values are embedded in a system that still reflects the values, motivations and views of a male majority. This is not done intentionally or even consciously, yet they still form a barrier.

Metrics for 'success' are similar between medical specialties: success in first part and Fellowship examinations, working full-time, ability to travel to conferences and courses, length of uninterrupted service, publications and citations, research grants, and other leadership positions.[3] These metrics are historically based within an androcentric working environment.[3] While we often appreciate extracurricular pursuits or demands, these are not often acknowledged as metrics for success in emergency medicine. Whether you're an elite athlete, a parent of three children, or the president of a not-for-profit organisation, these attributes are not often viewed through a lens of success. The traditionally feminine characteristics of communication, collaboration and empathy are now seen as the hallmarks of great leaders, yet within medicine we are not proficient in selecting for these.

Meritocracy would work best if there is an equal playing field. We must ask whether all candidates were given equal opportunities to succeed. Have they had equal amounts of support, mentoring, encouragement and leadership roles to demonstrate their qualities?

I'm a woman and this wasn't an issue when I was starting out on my journey.

Many of these issues might have been less discussed 'back then', but that doesn't make them less pertinent in today's climate. Ultimately, it's about the younger women coming through who may get snagged on these issues. While not all women are affected, a significant number are. Sadly, there is an ugly side to bias and inequity, and that is the number of females suffering discrimination, bullying and harassment, including sexual harassment, in workplaces. We should all feel compelled to address these issues.

Why are we just focusing on women? Many other groups have biases against them too.

This is where the concept of intersectionality fits in. We know that there are many types of discrimination (gender, age, race, sexuality, class, ability, etc.) and that none of them exist in a bubble. In fact, different biases can be laid upon each other and when that happens, the resulting discrimination is often amplified. This is what we call intersectionality. It has been defined as 'the complex, cumulative manner in which the effects of different forms of discrimination combine, overlap, or intersect'. ACEM recognises that intersectionality can result in a double jeopardy (or even triple or quadruple) for many women.

Luckily, there is evidence to guide us in addressing these biases, including from other industries that we should be learning from. We know that representation matters; that diversity at every level of an organisation creates diverse opinions, ingenuity and outperforms every time. We know that amplifying diverse voices leads to more nuanced and inclusive decisions. Achieving gender parity is the first, incredibly important step in achieving equity for all of us.

But what about me? Won't this naturally lead to a reverse bias against men?

The 'what-about-me' mentality can affect all of us. Employing a human framework is essential. Developing open, fair and transparent processes on recruitment, career progression, awards and other markers of success leads to a fairer workplace for all. There are already processes in which females have advantages in our society that would benefit males, such as access to adequate, paid parental leave (employer and government-funded) and the ability to work flexibly without stigma. Addressing gender inequity leads us on a path to value diversity in all its forms.

Isn't all this hashtag activism helping gender equity?

Many social movement campaigns have leveraged social media platforms in order to transcend geographic boundaries, reach a wider audience and create shared meaning. Yet the disparities and power asymmetry in hashtag activism cannot be underestimated.

One of the more prominent examples of gender equity activism was the #MeToo movement, that quickly became a global conversation about the violation of women's rights. The #NotAllMen counter-movement then attempted to block dialogue about gendered violence, discrimination and sexism.

Although #MeToo was done with the best intentions of raising awareness to widespread gendered violence, it ultimately illustrated that with a purely individual focus, the structural inequalities facilitating sexual harassment and violence cannot be addressed. While hashtag activism can draw attention to gender equity issues, it must be followed up with sustained and meaningful action in order to achieve lasting change.

So why is a gender equity statement important?

Gender equity statements value and acknowledge the importance of people's differing experiences and abilities and set the tone and actions of an organisation. By embracing gender equity, this can lead to a more inclusive and diverse workforce. This is not merely a social justice construct; we know that it is smart business management. A more inclusive workforce positively affects business performance, reputation and staff retention. We hope ACEM will continue to advocate for inclusive workforces that uphold the principle of gender equity and celebrate diversity.

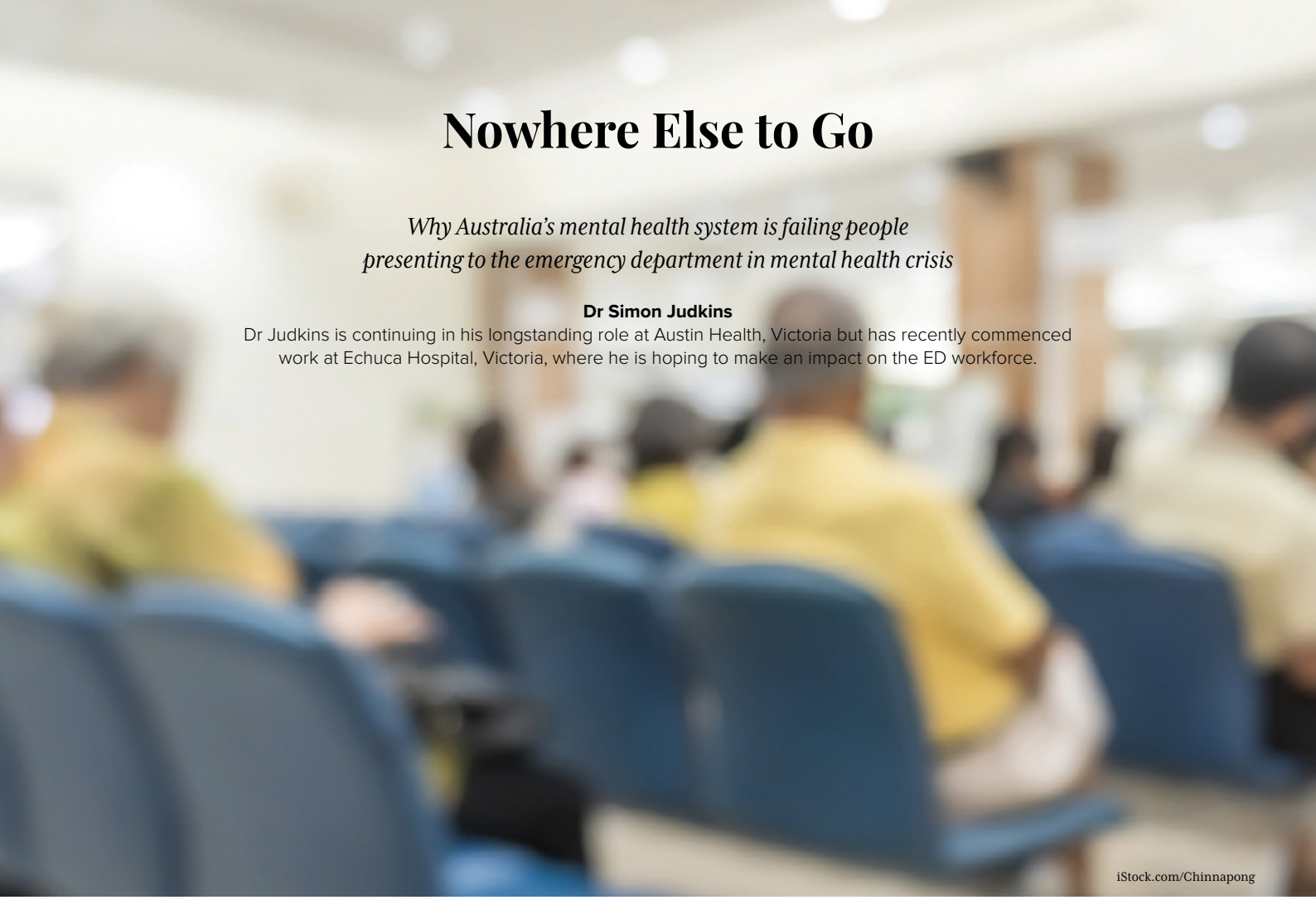
References

1. Workplace Gender Equality Agency (WGEA). Available at: https://www.wgea.gov.au/newsroom/latest-news/fifty-nine-days-later-and-its-equal-pay-day
2. Gender segregation in the workplace and its impact on women's economic equality. Submission prepared by Level Medicine.
3. Jamieson J, Tran V and Mackenzie S. Gender equality in emergency medicine: Ignorance isn't bliss. *Emergency Medicine Australasia*. 2016 Jun;28(3):341-3.

Nowhere Else to Go

Why Australia's mental health system is failing people presenting to the emergency department in mental health crisis

Dr Simon Judkins
Dr Judkins is continuing in his longstanding role at Austin Health, Victoria but has recently commenced work at Echuca Hospital, Victoria, where he is hoping to make an impact on the ED workforce.



iStock.com/Chinnapong

In 2018, ACEM, in collaboration with the Royal Australian and New Zealand College of Psychiatrists, convened the Australian Mental Health in the Emergency Department Summit. A total of 170 delegates from across the country came together to discuss the emerging crisis impacting people seeking mental healthcare from emergency departments (EDs) in Australia.

A delegate with lived experience opened the meeting, describing her experiences in trying to get the mental healthcare she needed, and ending up being brought into an ED by ambulance, with police present, in a crisis, physically restrained and sedated. We saw a graphic video account, presented by Professor Daniel Fatovich, an emergency physician working in Perth, depicting the trauma experienced by patients who, requiring mental healthcare in an inpatient unit, instead had to spend three days in a single room in an overcrowded ED with no privacy, a security guard, constant noise, and no real initiation of the mental healthcare required. We saw video footage of violent acts, staff describing the moral injury they suffer, knowing consumers deserve better and, in fact, are being harmed.

Patients arrive in EDs with mental health crises, just like they do with physical conditions. They receive initial assessment and management by ED nurses and doctors, trained to deal with all-comers with all-of-health issues. All kinds of patients can be so unwell, they need admission to an inpatient unit for further management. There can be delays to admission for any patient but delays are significantly exaggerated for mental health patients.

At the Summit, we heard from experts across many fields, including those working in health departments, policy makers and jurisdictional health ministry representatives, calling for change and promising things will change. The Victorian Government, leading up to the Summit, announced the Royal Commission into Victoria's Mental Health System and, at a Federal level, we saw the announcement of a Productivity Commission Inquiry into Mental Health. We felt positive; we felt buoyed by the engagement, the media interest and the promises that things will change.

So, what have we seen since 2018?

We have seen some new models and investment to try and fill the huge voids between our community providers, including GPs, and the hospital-based care in EDs, including the capacity of inpatient units to admit and care for people in mental health crisis who can't be cared for and supported outside of the hospital environment.

In Victoria, we are seeing the implementation of crisis hubs across six EDs in the metro area to provide a therapeutic environment with multidisciplinary care on the front-line. We are seeing community mental health supports boosted by recent COVID-19 support funding, including plans for 15 new mental health clinics across Victoria, and the state-wide rollout of the Hospital Outreach Post-Suicidal Engagement (HOPE) program.

We are seeing the national development of adult mental health centres in the community, to provide crisis care outside of the ED environment, with extended opening hours and the capacity to provide immediate care. Funding

has been allocated for eight trial sites (one in each state and territory), with the hope that the impact of these centres will be assessed and, if proven to be positive, introduced into other areas across Australia.

We are seeing drop-in centres, such as that developed in the Safe Haven Café at St Vincent's Hospital in Melbourne, being developed in Queensland sites. Following the encouraging trial results of Beyond Blue's The Way Back Support Service, we have seen funding committed for up to 30 more sites across Australia, providing critical personal connection and links to community services following an ED visit.

We have also seen many collaborations developed between groups representing the spectrum of mental healthcare, working together to build links, to understand where investments are needed and how investment in community care impacts the need for and utilisation of inpatient bed capacity. We all work in one system and what happens in one part of that system will no doubt impact other areas.

However, there is so much more we need to do.

On 22 September 2020, ACEM released a new report, prepared for the College by the Mitchell Institute, entitled *Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments.* This report explores the systemic problems that have seen our mental health systems fail those who need it the most. Those who need care that is accessible and caring, and doesn't have to cut corners, or make you wait weeks for an appointment. A system that treats patients with medical, surgical and mental health issues equally well. A system which has enough capacity, so you don't have to be discharged from hospital before you are ready because there is someone more acutely unwell who has been waiting in an ED for three days, or in fact a system which doesn't discharge you from the ED after 48 hours because there are no beds, despite the pleas of your family.

Unfortunately, since the 2018 Summit, the data, my experience and the experience of my physician and nursing colleagues AND, most importantly, our patients, is that not much has changed. In fact, there are signs of further deterioration, worsened by a surge in mental health distress during the COVID-19 pandemic.

We are seeing an increase in ED presentations. In Tasmania, patients still wait for days in EDs. In South Australia, it's the same. In regional Victoria, it seems the only groups of patients who spend more than 24 hours 'stuck' in an ED waiting for a bed are those requiring mental healthcare. In metro Victoria, we are seeing the number of patients stuck in EDs for over 24 hours increasing. Similar reports are coming from across the country, in both urban and rural EDs.

Concerningly, this situation will probably worsen further before it gets better. COVID-19 has slammed a wedge into those system gaps and widened the chasms. The rise in mental health needs for younger Australians is expected to increase dramatically over the next 18 months. COVID-19 has made all the promises and recommendations from the afore-mentioned commissioned reports seem like the first paragraph in the first chapter in the book of mental healthcare reform; there is much more to do as this story unfolds.

From where I sit, as an emergency physician and a father of three, who usually has an optimistic outlook, my view is clouded, unfocused and somewhat pessimistic. Not because I don't have a vision; the *Nowhere else to go* report informs my vision and, with the inputs of other experts in the field, including those with lived experience and their families, we can surely align our views and drive forward to a common destination. More political will and leadership is still needed, but the challenges will no doubt be exacerbated by the financial strains and recession brought on by the COVID-19 pandemic.

However, with a crisis comes opportunity. Like many parts of our healthcare systems, COVID-19 has permitted us to innovate, create, cut through previous barriers and implement new models of care. We must focus on what our communities need, what those with lived experience can tell us is required, what works, what we need to throw on the scrap heap. We need to introduce change and be brave with change, but we also need to have the courage to leave behind 'the way we do things around here'.

It's hard to have an all-encompassing view of success and what it looks like. For me, it will be when a person who needs care has accessible options and doesn't have to come to the ED because there is nowhere else to go. It will be when a person who does need to come to the ED for crisis care has a multidisciplinary team available; either in person or via well-developed telehealth supports, so the needs of the individual can be assessed and a plan developed to ensure they have somewhere to go. I want patients to be seen in a timely fashion, especially out of 'office hours'. And, if that patient requires admission, I want there to be a bed ready and waiting … from 'nowhere to go' to 'somewhere to go'.

Until I see that we don't have patients waiting for days in EDs, until I see patients being treated in a suitable therapeutic environment through design changes and collaborative staffing models, until I see an ED or a GP being able to refer to a community service that can see the patient when they need to be seen; until then, in my view, we will not have succeeded in achieving our goal … and people will still be arriving in EDs and saying, 'I need your help. I've tried everything, but I had nowhere else to go'.

---

i More information

This article was originally published on Croakey.
Read the *Nowhere Else to Go* report here: acem.org.au/nowhere-else-to-go

The Perils and Pitfalls of Physical Restraint in the ED

Associate Professor Anna Holdgate
Associate Professor Anna Holdgate is an emergency physician working in Sydney, with experience in coronial and medicolegal matters in addition to her clinical practice.

The video of the death of George Floyd in the United States, graphically disseminated through the media, provides a hideous insight into the potential impact of physical restraint. Although the actions that led to Mr Floyd's death are potentially criminal – the officer has been charged with murder – it is a salient reminder to all emergency physicians of the risks around the use of physical restraint.

As an emergency physician in clinical practice for more than 30 years, I have been involved in the containment of many severely agitated patients who were a threat to themselves and those around them. In the latter phase of my career, I've also undertaken medicolegal and coronial work, including the review of patients who have died while being restrained. Before discussing the clinical aspects of restraint in the ED, I must first acknowledge the devastating effects that such deaths have, not only on the family and friends of those who die, but also on the healthcare staff involved, who, in my experience, have used restraint as the safest option in very challenging circumstances.

Restraint of any kind should always be viewed as a last resort when less restrictive measures have failed. This article is focused on physical rather than mechanical restraint, as all of the deaths I have reviewed have been in the context of physical restraint. I have almost no personal experience of mechanical restraint and never use it in my own practice.

In the ED, restraint is generally reserved for patients who pose an immediate risk to themselves and others, and cannot be de-escalated by other means. Many of these patients are suffering from acute mental illness and/or acute intoxication, which limits their ability to engage with healthcare staff. Legal frameworks for using restraint in patients vary from state to state and are beyond the scope of this discussion. Nevertheless, the fundamental principles are the same in most jurisdictions.

While death during physical restraint is rare, there are some factors that can increase the risk of death. Prone positioning is often cited as significant risk but the evidence to support this is soft. Chan et al showed that, in healthy, non-obese adult men, the prone position produces a restrictive lung function picture with reduction in FEV1, FVC and maximal voluntary ventilation when compared with the sitting position. However, there was no difference in oxygen saturation or pCO2 (partial pressure of carbon dioxide) between the two groups.

Many patients requiring restraint have other factors that may increase oxygen consumption and reduce their respiratory reserve. Many of the reported deaths during restraint have occurred in patients who had a prolonged period of agitation prior to restraint. Patients who require physical restraint are commonly intoxicated with stimulant drugs and/or alcohol. All of these factors may mean that the patient is already acidotic, tachycardic, hyperthermic and dehydrated prior to any physical restraint. A small degree of additional hypoxia during restraint, in addition to these pre-existing derangements, may well be the trigger for progression to worsening acidosis, cardiac dysrhythmias and death.

Other elements that have been identified as increasing the risk of harm during restraint are patient factors such as obesity and underlying chronic disease, the duration of restraint, and lack of training for the staff applying the restraint.

Clinical staff managing highly agitated patients, who present an immediate threat to themselves and those around them, are faced with the dilemma of controlling the situation as quickly as possible while minimising the risk of harm to the patient and themselves. This can be one of the most challenging clinical scenarios and is, by definition, always fraught with risk.

So what can we do to minimise the risk of harm when physical restraint is required?

Firstly, training. Regular mock scenarios with all staff likely to be involved in physical restraint is crucial – this includes doctors, nurses, security officers, police, and any other relevant staff. Understanding and practising the techniques to safely physically hold a patient without applying excessive force to the trunk and without obstructing the airway is essential. In the heat of the moment, when staff are frightened for their own safety, and overly enthusiastic non-clinical staff may perceive the protection of staff as more important than patient safety, poorly trained restrainers may apply excessive force. At times, the only safe method may be a period of prone restraint, but this should be as short as possible.

Secondly, planning. Once it is identified that a patient will need physical restraint, this should be a planned and coordinated action. Risk factors specific to the patient should be identified such as obesity, chronic disease and prolonged agitation. There must be a clear endpoint to maintain control once the patient has been physically restrained. This usually involves the using of parenteral sedation with or without the application of mechanical restraints. Prior to approaching the patient, the team leader should clearly identify the role of each staff member and articulate the plan to initiate restraint and then maintain control. Drugs must be drawn up in advance and doses should be agreed upon. Monitoring must be immediately available as soon as the patient is contained.

iStock.com/SDI Productions

The team leader has a critical role in hands-off supervision of the process. They must ensure that there is no inadvertent compression of the trunk or neck and that, if prone positioning is required, it is applied for the absolute minimum time and for no more than one to two minutes.

While there are many similarities to team leading in other resuscitative situations, there are some unique challenges in leading the containment of a severely agitated patient. The staff involved in physical restraint are often non-clinical and may not understand the risks. Security staff, and more so police, are generally used to being in control of physical containment and may not immediately recognise the authority of the medical team leader. It is particularly important to establish your role as the leader and ensure in advance that the whole team will respond to your direction. If the process of maintaining control does not go to plan, for example, difficulty obtaining venous access or failure of administered medications to rapidly achieve sedation, it's often safer for everyone to step away and let the patient rage in a contained environment rather than persist with prolonged physical restraint while establishing control. Similar to a failed airway in medical resuscitation, there must be a willingness to step back, ensure safety and reconsider the options before trying again.

Another key challenge is that the clinical areas where physical restraint occurs are often not equipped with standard equipment such as oxygen, suction and monitoring. It is generally impossible to establish monitoring until the patient has been restrained and contained. Therefore, the team leader must ensure that monitoring and resuscitative equipment is immediately available and that there is a plan to rapidly establish monitoring, particularly oxygen saturation, as soon as the patient is contained.

As emergency physicians we continuously reinforce our resuscitative skills for paediatrics, cardiac arrest, trauma and other common emergencies, with in-situ multidisciplinary simulation training.

Given the high risks associated with physical restraint in acutely agitated patients, this should be considered an additional core area for ongoing training, with an emphasis on patient and staff safety, and the importance of good planning and preparation.

References

1. Knott J, et al. Restrictive interventions in Victorian emergency departments: a study of current clinical practice. EMA. 2020 Jun;32(3):393-400.
2. Chan TC, et al. Restrain position and positional asphyxia. Annals of Emergency Medicine. 1997 Nov;30(5):578-586.
3. Stratton SS, et al. Factors associated with sudden death of individuals requiring restraint for excited delirium. American Journal of Emergency Medicine. 2001 May;19(3):187-191.
4. Hick JL, et al. Metabolic acidosis in restraint-associated cardiac arrest: a case series. Academic Emergency Medicine. 1999 Mar;6(3):239–243.
5. Parkes J. A review of the literature on positional asphyxia as a possible cause of sudden death during restraint. British Journal of Forensic Practice. 2002 Feb;4(1):24–30.

Smith Family Robinson

A family of five adventure on board a medical ship in Papua New Guinea

Dr Zafar Smith

Is it possible to combine a career in emergency medicine with raising three children and travelling to remote parts of the planet? Before emergency physician Dr Zafar Smith met the team from Youth With A Mission (YWAM) Medical Ships, he never would have dreamed it possible.

Some may remember the adventure story of *The Swiss Family Robinson*. A family of five from Switzerland travel on a ship from Europe and get attacked by pirates, leaving them stranded on a remote Pacific island off the shores of New Guinea. The Smith family of five also love an adventure and Zafar shares his story of travelling the seas with his family, without the pirates, helping deliver healthcare to coastal villages of Papua New Guinea (PNG).

Why PNG?

When I was a teenager growing up in PNG, I had this vision of becoming a doctor and travelling in a dugout canoe, paddling from village to village, delivering healthcare to people in the bush. This was based on the inspiration of Dr Sirus Naraqi, a Baha'i family friend and mentor, who spent nearly two decades working in PNG training doctors and delivering healthcare to villages.

So I studied hard, got into medical school in New Zealand, and was well on the way to making my life vision of 'canoe medicine' come true. Then I got married, had three kids, completed seven years of emergency specialist training, and

Zafar doing a presentation on mosquitoes.

YWAM staff returning from a village clinic.

Zafar and his two sons, Zorion and Zavian.

Cora playing the mosquito net game with village children.

life rolled on. My dream of working in a dugout canoe was slowly drifting away, literally.

When I shared my fading dream with my wife, her response was unsurprising. 'You're dreaming! It's too dangerous. If we took the kids and the canoe tipped over in the middle of the ocean, no one would know where we were.' Before I could interrupt, she went on to wisely explain, 'I'm not taking my kids into malaria-infested villages in the middle of nowhere. If we got sick, no one would be able to help us'. And that is where my 'family-canoe-medicine dream' ended … until I came across YWAM Medical Ships.

What is YWAM Medical Ships?

It was established in 1960 by American missionaries Loren and Darlene Cunningham. YWAM Medical Ships Australia (YWAM MSA) is a branch that has headquarters in Townsville, Queensland. YWAM MSA first engaged with PNG in 2009, although YWAM's presence through land-based teams in PNG began in 1969. The focus of YWAM MSA's work in PNG is primary healthcare, particularly women and children, health promotion and preventative medicine. YWAM MSA uses a large cruising vessel called the YWAM PNG to provide primary healthcare to people in remote parts of coastal PNG. The vessel is co-owned by YWAM MSA and the PNG Government, with key direction provided by the PNG Department of Health.

84 per cent of the people in PNG live in rural and remote village settings, particularly along the coast. The ship can access remote populations along the coast and inland river regions. The ship's health team and crew work together with local health workers to provide services to the village people.

How did you convince your wife and three kids to come?

Our kids were two, five and seven years old on our first trip on the ship. We had always wanted to show our kids what life is like for other kids living in a village setting. The main fears of travelling to a developing country with a young family are the risk of disease, crime and injury. YWAM PNG provided a safe place to sleep each night away from snakes, mosquitos and crime. It was also comfortable having hot water and air conditioning, which was important for our young children. It was reassuring knowing that, although we were doing medical work on land, at any time during the day, if the kids were getting too hot or miserable or the toddler needed her nap, we could jump back on board the ship and recharge.

PNG paediatrician Dr Fiona Kupe practises CPR during the APLS course on board YWAM MSA in PNG.

A YWAM nurse being evacuated by stretcher after being bitten by a snake.

Chelsea doing a presentation on handwashing.

Tulua Smith, Zafar's mother doing a presentation on nutrition.

This sounds a bit like 'voluntourism'. What do you think?

I think these positions differ greatly from I think these positions differ greatly from voluntourism activities. YWAM Medical Ships are a member of Australian Council for International Development (ACFID) and a signatory to the ACFID Code of Conduct, which is a commitment to adhering to best practice in responsible and ethical Volunteering for International Development.

Another strength of the program is that it's focused on education and training of local health workers, through upskilling, mentoring and support. PNG medical and nursing students are encouraged to join the ship in its outreaches to gain insights of how healthcare is delivered in rural settings. I certainly enjoyed working with a PNG third-year medical student during our last outreach. I was also involved in running the first Advanced Paediatric Life Support (APLS) course in PNG, with 12 local doctors and nurses completing the three-day training program on board the ship. I remember one of the senior YWAM staff members saying, 'Our aim is to make ourselves redundant and have the entire ship staffed and run by local Papua New Guineans'.

What did your family do on the ship with no medical training?

My wife has a degree in communications and women's studies, while my children have skills in persuasion and adult behaviour modification. Although they had no medical background, there were many ways that they could use these 'skills' to help in the villages.

My family joined the community engagement team that primarily built friendships and delivered health promotion material to the village people. My three kids developed a drama about the pathogenesis of malaria, its prevention and treatment. Each day they would perform the skit in front of all the village people, with the children acting as different characters, including a pesky mosquito, a health worker and a local village boy. The rest of the village children were involved in the skit by creating a mosquito net through holding hands in a circle.

There were action songs about the importance of handwashing along with immunisation colouring sheet activities. My kids also helped in the mass eradication of parasitic worms by systematically hand-delivering albendazole tablets to every village child. These worms cause intestinal diseases and the debilitating condition filariasis or 'elephantiasis'.

What was a typical day like?

During the mornings, we were in the villages doing health-related skits, songs and craft activities with the village children. In the afternoon, my wife and kids would return to the ship while I stayed on and joined the medical clinics. This way, we served the community with my family in the morning, then focused on medical care delivery in the afternoon.

What cases did you see as an emergency physician on board the ship?

On our first day, we saw a patient who had been bitten by a snake. We arranged for a pressure immobilisation bandage and leg splint. Kids in villages like to climb trees. We saw a five-year-old boy who had a fractured hip and another boy with a nasty head laceration, both from climbing coconut trees. A girl had her elbow chopped off by a machete during a domestic violence incident, requiring wound management and transfer to the tertiary hospital. Another woman was brought from a remote village after giving birth to twins a few hours prior. She had persistent bleeding due to a retained placenta and required intravenous treatment and urgent helicopter transfer to the provincial hospital for surgery. There were a lot of skin wound infections, chest infections, malaria cases, tuberculosis and muscular injuries.

What would you do differently if you go again?

I would love to learn more about traditional PNG plant medicines. Nearly every clinic we went to had run out of medications and some of the health workers were using traditional knowledge of plants to treat people.

What are your plans for the future?

To get back on board the ship again with my family as soon as COVID-19 has settled down. I would love to encourage more medical colleagues and their families to get on board. 'If not us, then who? If not now, then when?' – John Lewis.

More information

Reference for Sirus Naraqi
https://www.mja.com.au/journal/2004/181/11/sirus-naraqi-cbe-md-facp-fracp

A Lovely Bridge

Stakeholder Perspectives of the ACEM Emergency Medicine Certificate in the Pacific

You may not be familiar with the Bridge to Nowhere. It's the largest and most intact structure relating to the former Mangapurua Valley Soldiers Settlement near Whanganui, New Zealand. Presumably, due diligence was done before work was started in the 1930s to replace the older, creaky swing bridge. However, despite the impressive engineering and solid construction, by the time the bridge was completed, these areas of the Valley were deserted, the bridge rarely used, and construction of the road to the Whanganui River abandoned.[1] It's hard to argue that the exercise was worthwhile. Lovely bridge, though.

While the Emergency Medicine Certificate (EMC) path taken in Tonga to replace the prior 'creaky' approach made sense at the time, has excellent foundations, appears well constructed, and is well-intentioned, where does the EMC lead? Have our Pacific emergency medicine (EM) colleagues been enthused along a wasted path? Are there now better alternatives?

It has been 20 years since the first FACEM was invited to present EM topics at the Tonga Medical Association Conference.[1] Since then, there has been recognition of the need for a formal EM training program and career path in Tonga.[2] Consequently, the EMC program began.[3] It includes a requisite four-week emergency department (ED) attachment to be undertaken in either New Zealand or Australia.[4] The first five EMC candidates based in Tonga enrolled in 2012. The first Cook Island and two Vanuatu candidates enrolled in 2020. Then in 2018, at their 76th annual conference extended the invitation to EM specialists to present at their annual conference, where the latest recommendations for emergency care standards and priorities in the Pacific were partly formulated.[5,6]

What is EMC?

The EMC is a foundation-level course created and provided by ACEM for those medical practitioners who have some experience in EM. The EMC Curriculum is delivered in a series of online modules, introducing important EM concepts. Self-directed online content is supplemented by visits from overseas EM doctors and nurses, and weekly online training. All EMC candidates continue to work in their own ED.

Candidates are required to complete a series of face-to-face and written assessments throughout the course. Examples include mini-clinical examinations, a procedures list and case reflections. This multimodal approach enables supervisors to make a broad assessment of the candidates, who are eligible for the final MCQ examination once all other requirements have been met. A minimum of six months and up to 24 months are available to complete the EMC.

Why EMC?

EM in Tonga had no recognised career pathway prior to the start of the EMC Program; potential trainees were not encouraged to pursue EM as a career because EM was not recognised as a discipline. At the time, the EMC was the only training
option for EM doctors in Tonga. There was no formal training pathway for EM in the Pacific, except in Papua New Guinea.

Stakeholder perspectives

Access to alternative training in EM, e.g. at Fiji National University (FNU), is now an option for some. For many Tongan doctors, the EMC is the only post-graduate qualification available. They have described EMC as a high-quality course in terms of content, delivery and means of assessment. It is regularly reviewed by ACEM, thus ensuring the medical team in Tonga can be confident they have the knowledge and skills comparable to other candidates throughout Australasia. EMC helps prepare them for the many undifferentiated patients they will see in the ED, assisting them with evidence-based decision-making.

The structure of the EMC allows for a balance between in-country and Australasian practice, with regular visits from supervisors. Frequent Zoom calls provide support for other issues, which has strengthened the mentoring relationships with candidates.

Upon commencing the EMC, many stakeholders felt that it led to improved EM practice straight away, without any loss of remuneration. Recognition of the course has resulted in hugely increased local interest in EM as a specialty path.

A junior Tongan doctor who participated in the program commented that, 'The EMC is a great foundation for anyone wishing for a career in EM. It builds the core foundations of an emergency physician and motivates the intern doctors to want to work in the ED.'

Supervisors often reflect on the many barriers that EM trainees overcome to achieve success in the EMC. They are motivated and engaged, and the case-based discussions allow for insights into the challenges health professionals in the ED face on a day-to-day basis.

However, as with any training course, challenges are encountered. There is no dedicated continued medical education (CME) time in which to complete the course, resulting in many of the doctors studying in addition to fulltime work. The online modules rely on adequate internet for streaming videos. COVID-19 has meant loss of face-to-face teaching time and postponement of the compulsory placement in Australia and New Zealand, resulting in missed opportunities to consolidate knowledge and skills.

The relevance of EMC to the local setting must also be considered. Some of the logbook requirements are for procedures that other countries may not have the infrastructure to provide. Within resource-constrained environments, some ED teams are often not able to provide clinical care to the same level that is reflected in the EMC content.

Summary

The EMC (and Emergency Medicine Diploma (EMD)) are potentially useful courses for EM trainees in the Pacific. Benefits include training and retention of EM staff in-country, accessibility, the high quality of content and delivery, and up-to-date and comprehensive methods of assessment. There are downsides, and alternatives.

Rather than going offshore, the EMC and EMD could help some doctors continue their work and training in underserved local EDs. For others, it may become a bridge to nowhere, especially if this qualification remains unrecognised around the Pacific, except by ACEM.

When things are tough, others who have navigated similar challenges can provide perspective:

'The journey has many roadblocks. Some can be overcome alone, some need help to overcome, some need others to overcome for you, some can be circumnavigated, some can be waited out, while others - a few - are insurmountable and one simply has to go back to base camp and take an entirely different route.'[7]

References

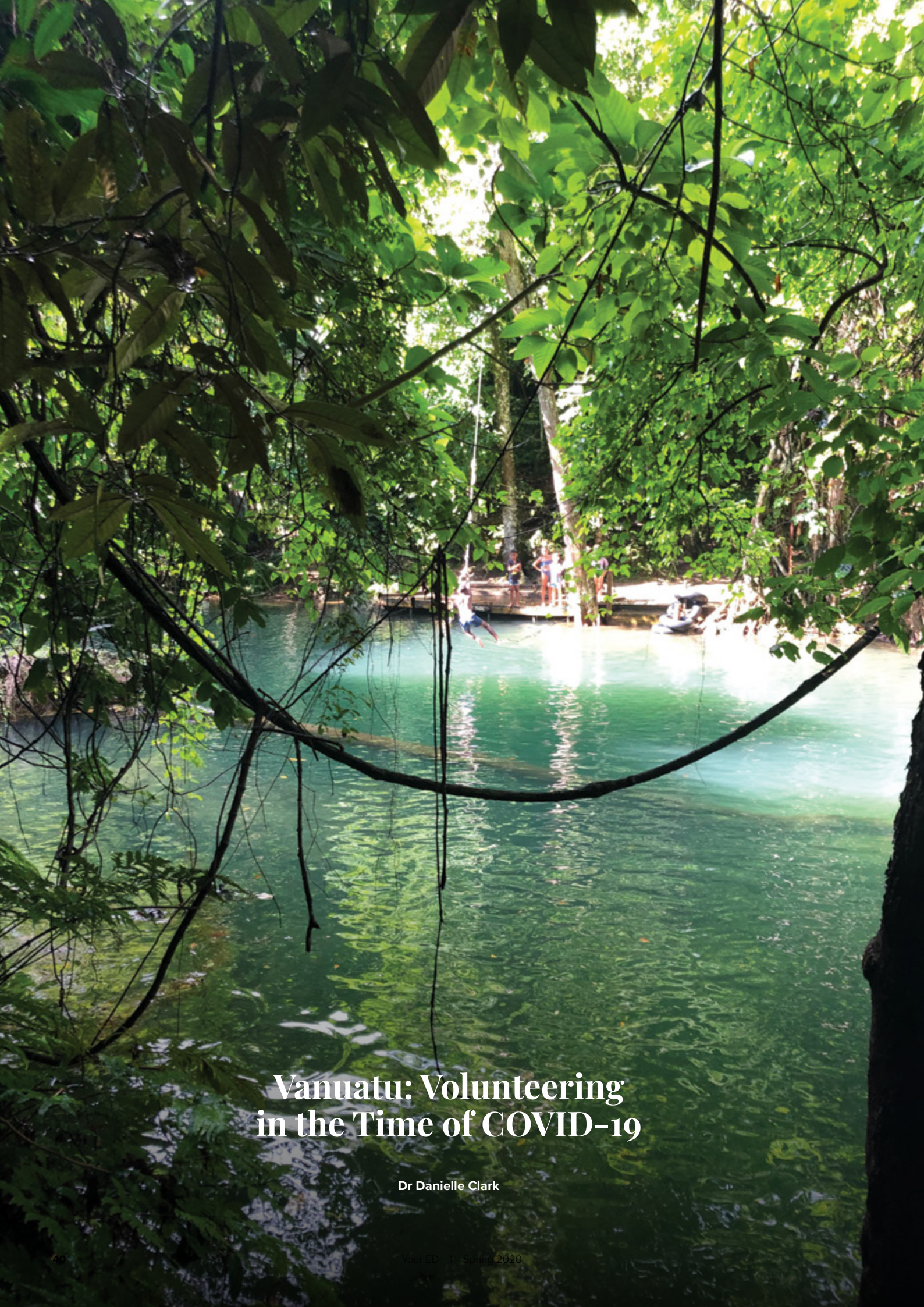
1. Peddinti B. Developing Emergency Medicine in Tonga. *IEMSIG Newsletter.* 2006;2(3).
2. Tupou M. Emergency Medicine in Tonga: an emerging discipline. *IEMSIG Newsletter*. 2011;7(2).
3. Doran O. Tonga. Making Progress with the ACEM Emergency Medicine Certificate. *IEMNet Newsletter*. 2015;1(1).
4. Tangitau P, Nicholls GM. Pafi's Perspective. *IEMNet Newsletter*. 2017;Nov (2):23-5.
5. Phillips G, Creaton A, Airdhill-Enosa P, Toito'ona P, et al. Emergency care status, priorities and standards for the Pacific region: A multiphase survey and consensus process across 17 different Pacific Island countries and territories. *The Lancet Regional Health – Western Pacific*. July 2020. DOI: 10.1016/j.lanwpc.2020.100002
6. Phillips G, Creaton A, Toito'ona P, Airdhill-Enosa P. Pacific Regional Emergency Care: Priorities and Standards for Development. 2019.
7. Curry C. A perspective on developing emergency medicine as a specialty. *International Journal of Emergency Medicine*. 2008;1(3):163-7.
8 https://www.doc.govt.nz/parks-and-recreation/places-to-go/manawatu-whanganui/places/whanganui-national-park/things-to-do/tracks/bridge-to-nowhere-walk/

Contributors

Dr Jono Henry (Australia/Vanuatu)
Dr Kaloafu Tavo (Tonga)
Dr Ko Ko Lwin (Cook Islands)
Dr Leanne Cameron (New Zealand/Vanuatu)
Dr Matamoana Tupou (Tonga)
Dr Mike Nicholls (New Zealand, Tonga)
Dr Owen Doran (New Zealand)
Dr Pafilio Tangitau (Tonga)
Dr Penisimani Poloniati (Tonga)

Editors: Mike Nicholls, Matamoana Tupou

iStock.com/Uwe Moser



Vanuatu: Volunteering in the Time of COVID-19

Dr Danielle Clark

Emergency medicine is always unexpected, never knowing who or what presentation will come through the door. Emergency medicine in Vanuatu during a pandemic is, as expected, even more unpredictable. My family and I came for a six-month position with the Visiting Emergency Medicine Registrar Program, supported by the Australian Volunteers Program (AVP) and ACEM. We've always loved to travel.

Prior to and during medical school, I did plenty of stints volunteering in different low and middle-income countries (LMICs) and my husband and I were married in Vanuatu. This position was the ideal experience, starting just after I'd sat (and passed!) part one of the Fellowship examination.

Six months in and we are still here, having experienced not only the pandemic and preparing a LMIC for it, but also the ongoing effects of a category five cyclone and an emergency landing in a plane, as well as the joys of a nine-day public holiday celebrating 40 years of Vanuatu's independence, intermingled with the plain old everyday life that is usually far from plain.

The Emergency Department in Vila Central Hospital, the primary referral hospital in Vanuatu, is relatively new. Up until two years ago, it was run by nurses alone. A scoping visit by Dr Leanne Cameron (New Zealand FACEM) and charge nurse Nicky Headifen-Murden identified ways to build the capacity of the Department. This resulted in Dr Vincent Atua, a locum from Papua New Guinea (PNG), being placed here. My work initially consisted of learning things: learning the language; learning what medications were routinely available versus donated; learning what inpatient teams and treatments are available; and what equipment we have. I have been so impressed with what they can do with so little resources.

Two weeks in, at the time when COVID-19 was escalating in Italy, AVP (like most agencies) were calling everyone home, but we wanted to stay. I felt that, even as an EM registrar, I could be much more useful in Vanuatu as the needs and gaps were so large compared to at home. At the last hour, I was permitted to stay and the following day thrown directly into that deep gap: I was asked to join the Ministry of Health meetings to help plan the national COVID-19 response.

Prior to this, Vanuatu had done exceptionally well keeping COVID-19 out (as much as we can clinically and statistically ascertain, as there was no testing back then) despite cruise ships and tourists still arriving.

Those initial months after the border lockdown were a whirlwind. We encountered many challenges while setting up an ED isolation ward and a COVID-19 ward, and making decisions around who to test and when (swabs were initially sent to New Caledonia for testing, with an added logistic and cost component). I was also working in the ED as a supervisor and mentor to the junior registrars and interns, but mainly as the sole doctor, since many of the local doctors have periods where they have no contracts and therefore don't work.

Then the cyclone came. It was a week of angst about what to expect. We boarded up the house, bought extra food, packed bags with electronics wrapped in plastic, carried a satellite phone and beacon, and ensured there were staff to work in the ED. In the end, it was merely a bad storm for us in Port Vila, but the northern islands were flattened by Harold, a category five cyclone. With limited medical staff in the entire country, most of the ED doctors were deployed to that area in the weeks that followed, often leaving me as the only ED doctor at Vila Central Hospital, while also preparing for COVID-19.

Once big decisions were made, such as the ethical and medical indications of treatment for COVID-19 patients (with only a single ventilator available for use) and where they will be cared for within the country, and after emergency management of the cyclone was implemented, things calmed down.

Presentations to our ED are as varied as they are elsewhere. However, we have limited equipment, drug and treatment options, so some decisions are easily made due to lack of choice. Despite impending disasters, the Ni-Vans (as the local Vanuatu people are called) seem to have remarkable resilience.

For example, a woman 38 weeks pregnant presented with ongoing massive haematemesis. She was tachycardic, pale and dropping in blood pressure, while the blood continued to flow. I gave her the one and only medication I had for this scenario: metoclopramide (Maxolon).

I started collecting equipment to intubate, explaining the steps to ED staff who know nothing about intubating, let alone difficult airways, and called the one doctor who can scope, as well as O&G and anaesthetics. All while her family had their blood type identified to donate to her.

'Just send her down to the ward.' This sounds dangerous but, previously, all intubations and resuscitations were done on the wards, as that's where the doctors were based. She had a brief reprieve in vomiting, so we took her down and handed her over. I saw her that afternoon walking around the grounds of the hospital. One blood transfusion, no scope, still pregnant.

The ED nurses are fabulous, with a diverse range of skills and knowledge gained through experience and using whatever equipment they have. They can suture anything, cannulate newborns with ease, and treat non-communicable diseases (NCDs) without blinking, but they don't quite appreciate vital signs, and have only limited experience with advanced cardiac life support (ACLS).

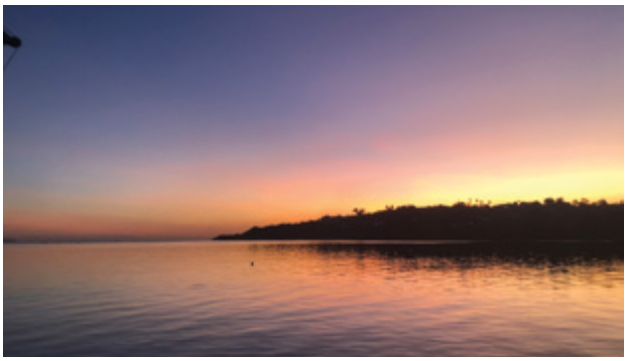
My current project is to rectify this, not just for the ED, but for the whole hospital. I have rolled out an Adult Deterioration Detection (ADD) chart in the medical ward; a change that has effectively increased how often staff check vital signs for a patient meeting the criteria. My aim is to roll this out in the surgical ward, then the maternity ward; ideally supported by a couple of studies I'm assisting local doctors to write.

A triage system was due to be initiated for our ED prior to the border lockdown. Hopefully, remote triage learning can take place to help improve the flow of patients. In addition to the ED ADD chart, I'm also creating an ACLS course. This was previously delivered by visiting teams at irregular times and is a perfect example of how regular training can affect resuscitations.

These projects may seem enormous, but none of this is out of my league. While I may be less familiar with the complexities of policymaking and workforce planning, and I don't have formal qualifications to train others, this is a country with a

small population, a small number of healthcare workers, and where the system is still at a basic, developing level compared to home. I may be 'just' an EM registrar, but I've trained within a brilliantly organised healthcare and hospital system, so I have experience and understanding of what is required for the next steps in building capacity.

My wonderfully supportive remote supervisor, Dr Leanne Cameron, always says there is so much low-hanging fruit here. It is so true. Being in Vanuatu as a volunteer, you can make a great deal of difference to not only the staff and ED, but also gain so much personally as well.



The Visiting Emergency Medicine Registrar Program (VEMRP) is an ACEM and AVP Partnership. The Australian Volunteers Program is an Australian Government initiative that is managed by AVI in a consortium with Cardno and the Whitelum Group and provides key safety, security and pastoral support to VEMRP volunteers. For further information please visit:https://www.australianvolunteers.com/ and https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Global-Emergency-Care-(1)/Where-we-Work/ACEM-Supported-Projects-and-Activities

Dr Kathryn Maltby

Why emergency medicine?

I did a short job in ED as a house officer in the UK early in my medical career, which I really enjoyed. I then spent the next few years trying out various other specialties, including oncology, research and paediatrics, trying to convince myself that ED wasn't for me as I didn't want a lifetime of shiftwork and antisocial hours. Despite my best efforts I kept gravitating back to jobs in ED. Moving to New Zealand and starting work in Christchurch sealed the deal and I finally committed to EM training. I love that every day is different, and that things can go from mundane to exciting in minutes. I enjoy the diagnostics of seeing the patient 'fresh' without prior work-up or investigations, and the variety of presentations – from medical to psychological and social, and usually a combination of them all. Most of all I have found that ED attracts a team of motivated individuals that work closely together and support each other.

What is the the most challenging / enjoyable part of the job?

I'm writing this at 3am from the ED while watching a drunk patient vomiting on the floor while wearing the vomit bowl on his head and swearing at my colleagues – I think this highlights some of the challenges of ED work. We have to make life work around shifts, and get things done when work allows. We encounter people from all walks of life, and while we sometimes get to share their joy, we do often see them at their worst. Most of us have experienced violence and aggression at some point in our careers. Thankfully, these challenges are being recognised more and more, and systems are being put in place for staff safety and support, but I do think this will always be part of the job. However, these aspects do have their positives. I've learned to love shift work – having time off when the 'normal people' are working, and regularly having longer than the standard two-day weekend allows for much more freedom to enjoy life outside of the office. And while nobody wants to be vomited on, through our work we gain an insight into all aspects of society and behaviours, and this has taught me lots.

What do you do to maintain wellness/wellbeing?

One of the aspects of ED that I love is that at the end of the day we hand over our patients and go home. We don't bring our work home with us. For me, this makes it much easier to switch off between shifts and relax. Most of my time off is spent in the Christchurch Hills, usually on my road or mountain bike or the running trails. I'm lucky enough to have a great group of friends, many of them from ED, to spend those midweek days off with. We've had a couple of great adventures including cycling 100km in matching lycra for fish and chips, and more recently attempting our 'summer goal' of riding a new gap jump at the bike park.

What do you consider your greatest achievement?

I'm not sure I have a single 'greatest achievement', but there's lots of things that I'm proud of along the way. I spent six months working in Kolkata, India, carrying out research into paediatric malnutrition. We managed to secure funding and resources for a feeding program which is still going. Every few months I get an update with some photos of the children, and this always makes me smile. While working at a New Zealand ski field for the winter, managing to coordinate the resuscitation and retrieval of an unstable trauma patient in a blizzard felt like a great achievement. And I still remember my first terrifying ED nightshift as the 'senior registrar' – three triage 1 patients arrived within five minutes of each other and as an ED team we successfully managed them all. Definitely a team effort!

What inspires you to continue working in this field?

Every day I've worked in ED I've learned something new. We work in such a quickly evolving environment that constantly challenges us and forces us to keep up to date, and for me this is what keeps the job interesting and exciting.

What advice would have liked to receive as a trainee or early on in your career?

I think the best advice I've been given is that training is about gaining knowledge and experience along the way, and there's no rush to get to the 'end'. Take your time and enjoy it! I've spent years working in various jobs and working out where my career in medicine is taking me, and I'm still not entirely sure where it's going to end up. So far it has taken me across the world, to various specialties, to meet lots of great people, and with some time out of medicine focusing on family and friends.

What do you most look forward to in the future of emergency medicine?

I really hope that the importance of emergency medicine is recognised on a wider level than just the medical world. Having left the NHS partly because the political climate, funding cuts and ED waiting time targets made it more and more difficult to feel like you're giving patients the best care, I really hope that New Zealand bucks this trend. We need increased funding for nursing, allied health and medical staffing, better mental health services, and further integration of community and inpatient services. Regardless of peoples political views, I think that we all need to advocate for our specialty.

Heatwaves – The Silent Killer

Heatwaves are a significant cause of morbidity and mortality, and have caused more deaths in Australia in the past 200 years than any other natural event, including bushfires, storms, cyclones and floods.[1] With the chill of winter behind us and long, hot summer days fast approaching, now is the time for emergency departments (EDs) to ensure they are prepared for heatwave events and increasing presentations due to heat-related illnesses.

Courtesy of the efforts of ACEM's Public Health and Disaster Committee, the College will shortly be releasing updated versions of the *Heat Health Resource for Emergency Departments and the P59 Policy on Heatwave and Heat Health*. These documents highlight that EDs are well placed to assist in pre-heatwave preparedness by identifying at-risk patients and providing education and interventions as appropriate. EDs also play an important role in the emergency medicine system response to heatwave-induced surge demand.

Key procedures and actions covered in these documents include:

Preparedness/Planning

- Hospitals should have a heatwave response plan that is integrated with existing emergency and disaster response plans. It is therefore recommended that an emergency physician be assigned heatwave planning either as a specific portfolio duty, or as part of responsibility for overall disaster planning. The emergency physician who has responsibility for heat health should ensure that they:
  - Know how the ED will be notified of a heatwave or heat health alert from central authorities or the Bureau of Meteorology (BoM)
  - Know how a heatwave notification will be disseminated to ED clinicians
  - Have a stockpile of public information material available for ED staff, including posters and pamphlets, regarding maintaining health during heatwave conditions.
- The ED should be stocked with appropriate equipment for the treatment of heat illness, including ice, fans, water spray bottles and cooling blankets.
- ED staff should be provided with training and understand: the extensive direct and indirect health effects of heatwave; heat illness thermoregulation/physiology; risk factors and at-risk groups; presentation and management; and adverse effects of medications in hot weather.
- Emergency physicians should be involved in public health planning for heatwave and work collaboratively with other stakeholders such as government services, community healthcare providers, pre-hospital services and GPs. Planning should incorporate educational public health interventions, as well as action plans for demand surge responses during heatwave.

iStock.com/danefromspain

Response

- Hospitals should have a heatwave response plan that reflects the increased capacity requirements, as well as the multidisciplinary and multi-agency service response requirements that occur during a heatwave. This plan should be integrated with existing emergency and all-hazard disaster response planning arrangements and treated as a whole of health service emergency.
- Disaster planning should include consideration of appropriate triggers for an external disaster response, for example, when an extreme heat warning or alert is issued, or when the demand for patient care exceeds hospital capacity.
- EDs should play a central role in the clinical and systems response to a demand surge for acute medical care as a result of a heatwave.
- The majority of excess presentations will be triggered by dehydration, causing decompensation and aggravation of chronic disease.
- Emergency physicians should use clinical opportunities during care delivery or at discharge from the ED to educate patients and their carers about mitigation of adverse health effects from heatwave, including advice about medication alteration and storage, fluid intake, and maintaining a cool and safe environment. Safety netting procedures should be emphasised.
- Emergency physicians should identify vulnerable patients (for example, the elderly, infants, socially isolated [including CALD communities] and disadvantaged people, outdoor workers, and those with comorbidities) and consider the effects of heat stress when planning disposition from the ED during a heatwave.
- As heatwaves can affect multiple EDs (whole cities/regions/states), emergency physicians should take a pivotal role in communication with other EDs and hospitals, and with central coordinating bodies, to provide information on activity, demand, capacity and resource requirements, in order to ensure a functional system-wide response.

Author – Emily O'Connell, Policy Officer ACEM

More information

Read more about ACEM resources developed to support EDs in preparing, managing and planning for surges in demand: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Climate-Change-and-Emergency-Medicine/Resources

Reference

1. Coates L, Haynes K, O'Brien J, McAneney J, Dimer de Oliveir F. Exploring 167 years of vulnerability: an examination of extreme heat events in Australia 1844–2010. Environ Sci Policy. Oct 2014;42:33-34.

Events

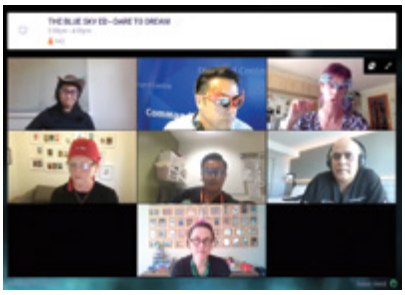
ACEM Virtual Annual Scientific Meeting 2020

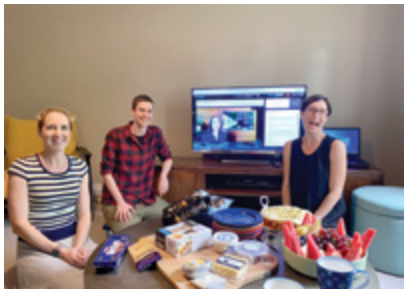
24-27 November, Online

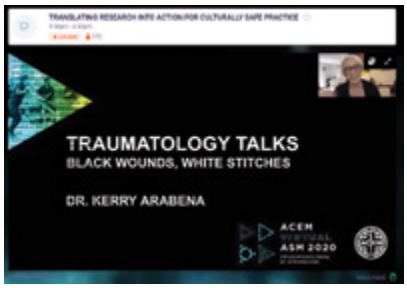
2020 ushered in a brand new way for ACEM to deliver an Annual Scientific Meeting (ASM). Given the ongoing risks and restrictions around travel and gatherings due to COVID-19, the 37th ACEM took place virtually for the first time ever, with over 780 attendees from 25 countries logging on to take part in a highly interactive program. Featuring engaging keynote presentations, panel discussions, live Q&A sessions, and interactive workshops; the online delivery and access to on-demand content during and after the event was extremely well received.

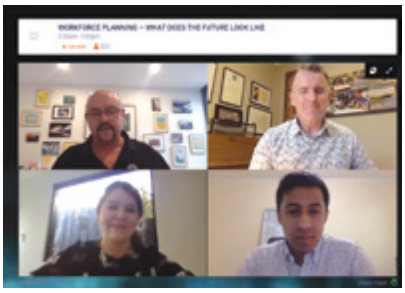
Scientific Program and Workshops

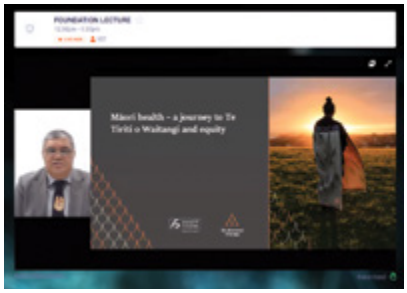
The theme of the ACEM Virtual ASM was 'No Going Back – an opportunity to redefine the role of emergency departments'. 'No Going Back' was about redesigning our acute health system based on necessities and learnings from the pandemic. The scientific topics of the program included *The Future of Technology in Healthcare, Applying Lessons from COVID-19 to Tackling the Climate Crisis, Careers in Emergency Research,* and *Innovative Thinking in Emergency Medicine*. Although attendees were not able to participate in person at workshops, a range of stimulating and thought-provoking workshops were delivered virtually on topics such as *Workforce Wellbeing, Leadership Essentials, Workforce Planning* and *Equity in the Emergency Department.*

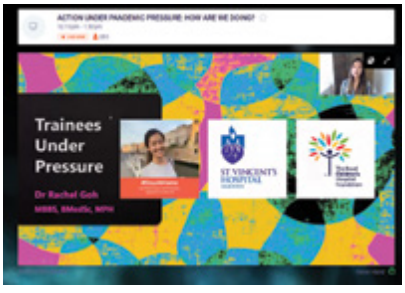












Social Networking

While traditional social interactions were not available, there were opportunities for delegates to connect via speed networking sessions and a networking hub on the technology platform. Virtual Trivia and Virtual Wine Tasting activities provided attendees with a fun, relaxed environment to connect with new and old friends.

Wellbeing

To help attendees balance the ASM against their work and home lives, several wellbeing initiatives were introduced. Virtual yoga, meditation and pilates enabled moments of disconnect that allowed everyone to refresh their bodies and minds.

Special thanks must go to the ASM Working Group comprising Dr John Bonning, Dr Clare Skinner, Associate Professor Didier, Dr Shani Raghwan, Dr Aline Archambeau and Nicola Ballenden. They stepped up to help put the program together at short notice and played a major part in facilitating the event over the four days. Thanks must also be given to Professor Daniel Fatovich for delivering the Tom Hamilton Oration, and John Whaanga for presenting the ACEM Foundation Lecture.

As we take learnings from what has been achieved at this year's ACEM Virtual ASM, we now look forward to delivering the 38th ACEM ASM on 7-11 November 2021 in Christchurch as a hybrid event. The College looks forward to welcoming you to the ASM in 2021 in person or online.

ACEM WINTER SYMPOSIUM 2021

27-30 JULY | Cairns Convention Centre, Queensland

SHATTERING ILLUSIONS: EMBRACING THE IMPACT

2020: Never in our lifetime has our sense of stability been so challenged. The global pandemic and other events have unveiled harsh realities and inequities we can no longer choose not to see. How do we continue to connect with our humanity, even in a crisis?

Emergency medicine specialists don't deal in routine. We are trained to embrace uncertainty. What can we learn from extreme events that will help us prepare for the future?

We want you to BE. HERE. NOW. We want to move you out of your comfort zone as we explore how ethics, evidence and experience will support and nourish us in an illuminated new normal.

The Winter Symposium will be a hybrid event. Gimuy, the beautiful city of Cairns will host the face-to-face Symposium, coupled with an online program so that if you can't come to Cairns, Cairns can come to you. By offering a hybrid model we can be more inclusive and welcoming to a larger community.

Keynote Speakers

Professor Sir Michael G. Marmot
Director, Institute of Health Equity, UCL
Department of Epidemiology and Public Health, UK

Dr Lai Heng Foong
Emergency Staff Specialist, Bankstown Hospital
Chair, NSW ED CoP COVID-19 Response
VMO Royal Prince Alfred Hospital, Sexual Assault (Forensic) and Emergency, Gosford Hospital
Chair, ACEM Public Health and Disaster Committee
Conjoint Lecturer, University of NSW, University of Western Sydney
Senior Clinical Research Fellow, South Western Emergency Research Institute

Dr Mark Little
Emergency Physician, Emergency Department, Cairns Base Hospital

Key Dates:
Call for abstracts closes 19 Feb 2021
Early bird registration closes 16 Apr 2021

For more information:
WS2021@encanta.com.au
+61 3 9863 7608

REGISTER NOW
www.acemws2021.com
#acemws21

My First Day on the Job

Dr Mohamed Elwakil

Almost two years now since my first working day in Australia.

The 1st few weeks of hitting the shop floor were a bit of frustration, depression, and fear.

For me, every little setback in those first weeks made me feel like a failure. I came as SIMG and it was a huge leap going from Egypt to Australia.

In an ideal world, you'd have a transition period of a month or so to shake that look of being a deer in headlights, I did not.

Nothing can really prepare you for it. In an ideal world, you'd have a transition period of a month or so to shake that look of being a deer in headlights, I did not.

However, I never felt alone, with the support of my lovely wife and kindness FACEMs in Lyell McEwin hospital, I was able to pass these times of exhaustion and misery.

A few months later, I passed the written examination then I have become a night TL. I remember the first night as a team leader when I had to manage a very busy department with a couple of critical patients including a two-year-old baby with accidental GHB overdose, lucky me!!.

Now, it is only a few steps left to be a FACEM, I remember these years of hard work it had taken to reach this point.

Dr Ruth Large

I have two distinctly different memories of working in an ED for the first time.

When I was a student and about to go off to my first ED placement at Auckland's North Shore Hospital I called my Mum, who had worked there as a first year House Officer about two decades before. She told me that she had been sole charge of this now very large tertiary ED in her first year as a House Officer, and boy did she have some stories to tell. Needless to say she scared the pants off me! Thus the first shift was more of a relief than anything else, although I do recall thinking that it was not a job for me, little did I know I would go on to get my FACEM.

"now you have survived your first week at Middlemore you can survive anything"

When I went into my first Registrar job it was at Middlemore Hospital. I remember the relief of being on a roster with two more senior Registrars who were just amazing, we did all of our nights together and formed a close bond. I still feel an incredible sense of gratitude to Grant and Werner for supporting me through some really tough times when Meningococcus was rife, and we had just started thrombolysing AMIs. After about the first week one of the FACEMS said to me "now you have survived your first week at Middlemore you can survive anything". I have often reflected back on those words and been strangely comforted by them.

Dr Kim Hansen

My first day working in an emergency department was as a young, enthusiastic and naive intern in 1999 at the Gold Coast Hospital. I'd gone through medical school loving every speciality, and then went through four other intern rotations, ruling them all out as long term options.

The late, great ED Consultant Leo Maneros was on the floor imparting wisdom with kindness and I was so inspired.

I learnt so much from my patients that day. I looked after a complex, medical patient and was warned by colleagues that the medical registrar would yell and call me names if my referral was not complete - and so I learnt about bullying. An elderly gentleman commented on my appearance, asked me about my relationships and proposed to me - and so I learnt about sexual harassment. A lady with neck pain left me baffled, and my junior colleagues talked me through an approach - and I learnt about teamwork and decision-making.

The late, great ED Consultant Leo Maneros was on the floor imparting wisdom with kindness and I was so inspired. From that first day, I loved connecting with people in their time of trouble, working with a dynamic team and the challenge of managing undifferentiated patients, and I knew this would be my medical home forever.

"There is no such thing as work-life balance – it is all life. The balance has to be within you."

–Sadhguru

Need tips for managing competing demands?

Speak in total confidence to a Converge International consultant.
Australia 1300 our eap (1300 687 327) New Zealand 0800 666 367
convergeinternational.com.au

Converge international

Australasian College
for Emergency Medicine

34 Jeffcott Street
West Melbourne VIC 3003
Australia

t +61 3 9320 0444
f +61 3 9320 0400

acem.org.au