your ED

AOTEAROA NEW ZEALAND
Vaccine Campaign

WORKPLACE-BASED ASSESSORS
The Unsung Heroes of the ED

ED MUSOS
The Virtual Ensemble

TWO STEPS FORWARD, ONE STEP BACK
Minimising Alcohol-Related Harm

GLOBAL EMERGENCY CARE
A Guide to Responsible and Safe Volunteering

Cover: People walking on Takapuna beach in the morning with Pohutukawa flowers in full bloom
iStock.com/Janice Chen

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 Enquiries
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

Inga Vennell

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

Message from the Editor

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

This issue we hear from Dr Elspeth Frascatore about the grassroots open letter in support of vaccination against COVID-19 in Aotearoa New Zealand and the movement that followed.

We look at the roadmap for tobacco in both Australia and Aotearoa New Zealand, we feature a study on alcohol-related harm and how to minimise this, and we take a look at the ACEM Core Values featuring the first of the four values, respect.

Dr Helen Willcock shares her story of the ultimate multitasking – sitting the Fellowship Clinical Examination (OSCE) with a newborn, we hear about ED Musos and their virtual ensemble, and Liverpool Hospital Emergency Department share their views on wellness and how to maintain it.

This issue also features an in-depth look at Workplace-Based Assessments (WBAs) that improve clinical skills, clinical reasoning and decision making, and have become an integral part of the FACEM Training Program.

Our Global Emergency Care stories this issue focus on ACEM's launch of the Global Emergency Care Community of Practice and we hear from Dr Megan Cox and Dr Jenny Jamieson about responsible and safe volunteering.

We hope you enjoy these perspectives on emergency medicine. In these unpredictable times, please take care of yourselves – and each other.

ACEM in the Media

In **November**, ACEM released a media statement welcoming Dr Clare Skinner as President.

Dr Skinner said, 'I feel deeply honoured to have been chosen to lead the College in its vital work and I will do my best to represent each of our 6000 members and trainees for the next two years'.

In **November**, Dr Skinner told the ABC that the AMA's Public Hospital Report Card 2021 highlighted the dire state of Australia's public health system.

'We have consistent evidence that the system has been under too much pressure for years and years. And as we start to open up, we're all very concerned about how that pressure will play out'.

Dr Skinner said the report also showed that when governments prioritised certain elements, those areas showed improvement. She said, 'If governments put structures into addressing emergency departments' flow and performance – it works'.

In **November**, the College issued a press release responding to the outbreak of COVID-19 in the Northern Territory, urging residents to stay safe by following government directives, and to seek emergency care if needed.

In **November**, the College released a statement acknowledging the release of the *Report of the Independent Inquiry into Perth Children's Hospital*, following the tragic death of Aishwarya Aswath.

The College stated that it will be seeking to work with the Western Australia Department of Health and the Board of the Child and Adolescent Health Service to support the implementation of the 30 recommendations raised by the Report, to ensure similar tragic events are avoided in future.

In **November**, the College released a statement raising concerns following reports of ambulance ramping at the Women's and Children's Hospital in Adelaide. The College urged the South Australian Government to take immediate steps to make sure women and children in need of acute medical care do not have to experience dangerous waits.

In **November**, ACEM released a joint statement with the College of Emergency Nursing Australasia (CENA), the peak professional association representing emergency nurses across Australia, offering condolences on the death of Melbourne emergency nurse, Ms Gillian Dempsey, from COVID-19.

The College told *The Australian*, 'The death of Ms Dempsey demonstrates the continuing impact of the COVID-19 pandemic on our communities'.

In **December**, Immediate Past President, Dr John Bonning told *The Courier Mail* that Queensland emergency departments (EDs) struggle to treat people experiencing mental health issues due to the lack of inpatient beds in the state's hospitals.

Dr Bonning said, 'A patient in mental health crisis has as much right to be in emergency department for their acute health needs as somebody with trauma or a medical issue'.

The College subsequently issued a statement, published by *The Courier Mail*, responding to comments attributed to the Royal Australian and New Zealand College of Psychiatrists Queensland Branch President, Professor Brett Emmerson.

'ACEM would like to make it unequivocally clear that emergency healthcare workers care deeply about people experiencing mental distress or trauma that seek help in emergency departments, and their carers' and delays were an 'indicator of widespread healthcare system failure.'

In **December**, the College made a statement welcoming the parliamentary inquiry into ambulance ramping in South Australia.

In **December**, Dr Juan Carlos Ascencio-Lane, Chair of the ACEM Tasmania Faculty, spoke to the ABC about the preparedness of the Tasmanian health system for a surge in COVID-19 cases. Dr Ascencio-Lane said staff had concerns about access block and overcrowding but had been working to ensure the ED was safe even once borders open and encouraged people to seek care if they needed it.

'We are the right place for those people that do need emergency care and we will do our utmost to ensure that we deliver a high level of care for them', he said.

In **December**, the College issued a joint statement with other colleges across Australia and Aotearoa New Zealand calling on the federal government to commit to stronger 2030 targets and come up with a plan to protect Australians and the healthcare system from the impacts of climate change.

In **December**, Dr Bonning told the *Waikato Herald* that alcohol-related ED presentations must be avoided. He said, 'The healthcare system is under pressure as it is, now we are in the middle of a pandemic'.

'It's not just about yourself. Think about it … visualise the overworked nurses that care for you when you are incontinent and vomit everywhere. It's not fun. Your actions don't just affect you.'

In **December**, ACEM Queensland Faculty Deputy Chair, Dr Shantha Raghwan told the *Herald Sun* Queensland had learnt from other responses to COVID-19 but the anticipated surge of cases when the border opened would be 'really tough' on the health system.

'We've been working hard to try and keep EDs safe for people who need emergency care after our borders open but it is going to be very hard, especially on exhausted healthcare workers', she said.

‘Staff are weary, and morale is low – we will manage but we are at breaking point.’

In **December**, the College released a statement offering condolences to the families, carers, friends and teachers of the children who were injured or lost their lives in the tragic jumping castle incident in Devonport, and acknowledging the efforts of first responders.

Dr Ascencio-Lane told the ABC, ‘I fear that this event will take its toll mentally on so many of those within our [healthcare] family. We do train for these events … but never, ever do you expect to have to face an event like this’.

In **December**, Dr Peter Allely, Chair of the ACEM Western Australia Faculty, spoke to Channel 7 about the preparedness of the Western Australian health system for an influx in COVID-19. Dr Allely said, ‘There is a lot of work going on all over health, with preparations going on for months. We are as ready as we can be, but we are nervous’.

‘Staff are exhausted already, and next year is going to be the toughest of our professional career’, he said. ‘The best thing you can do to stop the burning out is to get vaccinated.’

In **December**, ACEM released a statement welcoming the Australian Institute of Health and Welfare (AIHW) emergency department care report 2020-21, stating that it verified that the healthcare system in Australia is no longer fit for purpose.

Dr Skinner told the ABC, ‘There’s a COVID impact, but there’s also a steadily increasing trajectory of presentations that we’re seeing all of which are resulting in very heavy pressures on our emergency departments’.

In **December**, ACEM Northern Territory Faculty Chair, Dr Stephen Gourley told the ABC that the Northern Territory health system was ‘as ready as we’re going to be’ for a surge of COVID-19 cases.

‘Although we’re a little bit nervous about it all, we’ve been planning for this for well over 18 months, and we’re ready to go. Nervous but ready’, he said.

In **December**, the College released joint statements with the College of Emergency Nursing New Zealand CENNZ – NZNO and CENA urging Kiwis and Australians to have fun, but play it safe over the festive season and help prevent avoidable trips to busy EDs.

Dr Bonning told 1News, ‘When people are off on holiday, the rest of us will be fully togged up in PPE, wearing N95 masks, protecting ourselves, protecting our patients…’

Dr Bonning said people are always seen in order of urgency. ‘Please do be patient – we’re working our hardest, doing our best. There can be times where there’s 30, 50 patients waiting to be seen – some patients have to wait 6, 10, twelve hours to be seen’, he said.

In **December**, the College issued a statement regarding the Omicron variant of COVID-19.

Dr Skinner told *The Guardian* there is a nervousness among health experts as numbers continue to rise. She said, ‘It is too early to tell how Omicron will play out for the hospital system. We’re nervous, and we are treating the situation with caution’.

‘We’re concerned about potential overload on already overcrowded emergency departments, and we welcome conversations with health decision makers on how to create the best systems for optimal patient care.’

In **December**, Dr Michael Edmonds, Chair of the ACEM South Australia Faculty, told *InDaily* that FACEMs were concerned at a lack of planning for a surge in COVID-19 in the healthcare system.

‘Emergency physicians are very frustrated and quite concerned about how things are going to pan out in the next few weeks. We feel we’re not being listened to by the Government. They’re not asking us what our opinions are and when we’re offering our concerns and solutions we’re not being listened to.’

In **January**, ACEM Victoria Faculty Chair, Dr Mya Cubitt spoke to *The Age* about the pressures EDs were under due to the twofold blow of a surge in people requiring urgent care over the traditionally busy summer period as well as rising numbers of COVID-positive patients, including ‘significant numbers’ of people with COVID-19 who require medical attention but do not need admission.

Dr Cubitt said, ‘It is very important that this significant cohort of patients, and the resources required to provide appropriate care, are factored into ongoing healthcare system planning and responses to COVID-19’.

In **January**, the College released a statement acknowledging that EDs and staff were facing extreme pressures due to providing ‘business-as-usual’ urgent care over the busy summer period, as well as managing increasing COVID-19 presentations, exacerbated by workforce shortages. The College encouraged policymakers to communicate with the public about testing for, and managing, COVID-19.

Dr Skinner featured on the ABC encouraging the public to seek health at EDs if they needed acute help and calling for the government to educate the public.

‘If you have life-threatening emergency symptoms – if you’ve got chest pain, dizziness, feeling short of breath – we do want you to seek care. We are there for you, and the system is there to look after you.’

‘There are a lot of elections coming up in the next year, and this is a vital opportunity to make sure that our politicians know that the public health system is important. It’s not good enough to be in an overcrowded emergency department with not enough workforce. It’s not good enough that we don’t have a coordinated strategy this far into the pandemic. And we need to make sure that we make some noise about that.’

In **January**, Dr Bonning spoke to media in Aotearoa New Zealand about the further pressures Omicron cases will add to EDs over the busy summer period and encouraged people to try keep safe to prevent avoidable presentations. He said, 'Unfortunately, at the moment people are experiencing extremely long waits to get emergency care'.

In relation to Omicron, he said, 'If you have chronic illness, comorbidities, immune compromise – older patients they need to seek care. Call Healthline, try to see your GP if you're not particularly unwell and only come to the emergency department if you're really unwell'.

In **January**, Dr Skinner told *The Age* that while Omicron was the dominant strain of COVID-19, EDs were seeing 'the full gamut of coronavirus presentations'.

'We're seeing people present very, very unwell with low oxygen saturation, to the usual viral type symptoms – sore throat, runny nose, fever, vomiting, and diarrhoea, abdominal pain – and we're seeing everything in between: the person with a fractured wrist or appendicitis, who just happens to have coronavirus that we pick up incidentally, or those gastrointestinal symptoms, like abdominal pain and diarrhoea, who may not realise they have the virus.'

In **January**, Dr Bonning told media across Aotearoa New Zealand that a surge of Omicron cases would be 'really, really difficult' for the health system to manage. Although many cases would be mild, it was the 'sheer volume that is going to get us', he said.

In **January**, Dr Allely spoke to WA Today about the health system's preparedness for a surge of COVID-19 cases when the border opens.

'The older hospitals are struggling and are having to almost make it up as we go along', he said.

'We're expecting that first [half] of the year to be pretty painful for our staff and we're predicting a lot of waits for patients. We're … hoping there aren't any bad outcomes but fear that it's almost inevitable'.

'We're all a bit nervous and scared.'

In **January**, the College released a statement, and featured in *The Age*, welcoming the Pandemic Code Brown called across the Victorian health system.

ACEM stated that it would allow hospitals to access a range of critical levers for meeting the unprecedented challenges of the next month, including the movement of healthcare workers across the healthcare network, support from the Australian Defence Force and the release of federal funding.

The College reassured the public that people experiencing medical emergencies would be prioritised and would still receive care.

In **January**, Dr Skinner spoke to the 7.30 Report about the ongoing pressures on the Australian health system. The hospital system has been fragmented and difficult to navigate for years.

'This is just not a COVID phenomenon – this has been building for years, with increasing out-of-pocket costs.'

'What we need to do is make sure that we remember how it feels right now. We're seeing the fault lines exposed through COVID.'

'Care is difficult to access, but it's particularly difficult to access for the most vulnerable in our community – those with complex and chronic disease, those with low levels of education or income, and those who are marginalised for other reasons.'

'So I encourage everybody, remember how it feels now, and then as we emerge from this wave, we need to make sure that a health reform is on the political agenda, because we need to make sure we design a health system that is safe and fair and accessible for all Australians.'

In **January**, Dr Skinner told the *Brisbane Times* that the shift for emergency departments in Queensland had been swift and challenging from their prior largely virus-free status, exacerbated by workforce issues.

'There are simply not enough community care pathways for the sheer amount of people being infected', Dr Skinner said.

'Emergency departments are sometimes the only option for people to turn to when they need care, or health advice on managing COVID-19.'

In **January**, ACEM released a statement responding with 'mixed feelings' to the announcement that the Western Australia border would remain closed.

Dr Allely said, 'We are, in part, relieved, as we were nervous about the ability of the already overloaded health system to cope with an Omicron surge. Opening the border when the rest of the world is hitting the Omicron peak was always going to be challenging, as high numbers of infection would mean a very rapid incursion of COVID into WA'.

'The benefits of a delay of a few more weeks will allow us to make our processes for managing COVID-19 in emergency departments (EDs) more robust.'

In **January**, Dr Allely told the 7.30 Report that the Western Australian health system was as ready as it could be for an influx of COVID-19 and he was concerned that the border closures would make staff shortages even worse. Western Australia was very dependent on overseas doctors, particularly from the UK, he said, and that they had been working towards the planned date of 5 February 2022.

'Now they are left in limbo', he said. 'We need to give them some certainty, otherwise they're going to work somewhere else, I'd imagine. Why would they want to come and work in Western Australia when they can go to any other part of Australia and not have to hotel quarantine for seven or 14 days?'

ICEM 2022

14–19 JUNE

BETTER CARE FOR A BETTER WORLD

Hybrid Conference
Melbourne Convention and Exhibition Centre

Join us at the 21st International Conference on Emergency Medicine (ICEM) for clinicians, physicians, nurses, aid workers and disaster experts from developing and developed countries across the world.

STANDARD REGISTRATION

Register on or before 13 June 2022 and save up to **AUD$200** per person

icem2022.com

A GENEROUS GLOBAL PROGRAM WITH PLENARY & CONCURRENT SESSIONS FOR ALL

- 6 program days
- 100+ speakers, facilitators and panelists from 37+ countries
- 2 Marketplaces
- 9 plenary sessions plus live panel discussions and 40+ concurrent sessions
- 5+ specific clinical and literature update concurrent sessions
- 15+ pre-conference workshops to choose from

ENQUIRIES Email:**info@icem2022.com** Tel:**+61 7 3858 5400**

PRESIDENT'S WELCOME

Welcome to the first *Your ED* for 2022.

Like the last two years, we have begun this year with uncertainty in a world that keeps evolving in new and exhausting ways.

While there is varying data on whether Omicron is less severe, or more virulent, than other strains of COVID-19, its impact on our workforce has been devastating. Across Australia, 20 per cent of us are typically furloughed at any one time due to infection or exposure, and those left standing are exhausted.

So what do we hold onto when everything feels as if it's unstable? We hold on to each other, our own sense of ethics, and our collective core values.

Core values are explicit, governing principles that guide us. They help us make sense of the world, and how we choose to move through it. In a world that requires constant decision-making, our core values help hone our choices, and help us determine what is right and wrong.

The core values of a group help the people within it make choices, and act individually and together, in a coherent and concerted way.

Several years ago, following member and staff consultation, ACEM identified four Core Values: respect, integrity, collaboration and equity.

I have been asked to articulate what the first value – respect – means to me.

To me, respect is simple. It means that we treat every single person we encounter with dignity, without judgement, and appreciate and acknowledge the experiences that have shaped them. It's following the rule we all learn in early childhood – d*o unto others as you would have them do unto you*.

We recognise that the people who interact with us are doing their very best with what they have in the present moment. We recognise their inherent humanity, we consider their feelings, and we treat them in a way that allows for the support of their autonomy and agency.

This can be difficult; I know it. These are extremely challenging times and our exhaustion and frustration can be hard to manage. To be asked – on top of everything else we're being asked to do – to be nice? But respect isn't about niceness. It's about honesty and courage. It's about humanity. And treating people with respect is as much for ourselves as it is for other people. Sometimes, especially when faced with discrimination or bias, being nice is the least respectful way forward.

We are all in this together and it will take every one of us supporting each other to get through it. And when I mean all of us, I don't just mean FACEMs and trainees. I mean everyone involved in healthcare: doctors, nurses, allied health, ward clerks, cleaners, hospital executives, and government.

At the heart of it, we all have the same goals – to serve people in need of care. I get that many areas of medicine are a loyal bunch, us included. But this isn't a time for tribalism, it's a time for collaboration. A time for forming relationships and building bridges.

Please enjoy these stories from our world of emergency medicine. And thank you for all that you do.

Dr Clare Skinner

ACEM President

CEO's Welcome

Dr Peter White

Two years ago, my column referred to welcome rains along the east coast of Australia, following catastrophic bush fires. It also discussed the arrival of COVID-19 and the early days of ACEM staff working from home, as the initial effects of the pandemic began to take hold in this region of the world.

Now, as I write, there are floods devastating two Australian states along the eastern seaboard of the country. We are, apparently, 'learning to live' with the virus, and, in the opposite hemisphere of the globe, events that remind us of the fragility of peace are unfolding by the day.

It would be a courageous individual who would speculate on developments by the time this goes to print.

At a college level, we once again look to the future with the hope of being able to resume activities that once were commonplace on the college calendar.

ACEM staff have again returned to the Jeffcott Street office following another period of working from home in early 2022. It is hoped that the resumption of some college face-to-face activity will be progressed before the end of the financial year.

However, while some government mandated restrictions are being loosened, local considerations relating to service delivery as a result of the effects of COVID-19 on staffing numbers means that resuming meetings and other face-to-face activities involving members cannot be the quick process that some might prefer.

The wellbeing of all ACEM members, staff and others involved, and the desire to maintain the best possible delivery of healthcare across all jurisdictions, dictates that a cautious approach to this will remain the preferred approach for the near future.

Many of you will be aware of the excellent outcome of the College's accreditation assessment. It was conducted by the Australian Medical Council (AMC) as scheduled during the second half of last year. The final report and decision of the Medical Board of Australia (MBA) confirmed accreditation of the College's FACEM Training Program, CPD program, process of assessment of Specialist International Medical Graduates (SIMGs) and recognition of the FACEM for eligibility for recognition as a specialist physician in emergency medicine until 31 March 2026. This accreditation is subject to meeting three conditions during that time, and the usual ongoing monitoring processes of the AMC.

This is an extremely positive outcome for the College. It is also a strong vindication of the direction that it has taken in recent times and the work that is done by all involved in college activities.

ACEM is currently conducting a final consultation in relation to its strategic plan for the period 2022 -2024. The document is due to be finalised at the meeting of the College Board scheduled for April, following consideration of feedback received.

Once again, an associated Business Plan will be developed to support the delivery of activities to meet the priorities described in the strategic plan. The breadth of activity now undertaken by the College points to a full and productive period ahead.

In closing, I thank all involved in the work of the College. It is your work that enables ACEM to deliver what it does as an organisation – particularly during trying times, such as those that we have experienced over the past two years.

The College plays an important role in the delivery of emergency care in Australia and Aotearoa New Zealand, as well as more widely. A small sample of that is again captured in this edition of *Your Ed*.

College Embarks on New Reforms

Over the last two years you would all be aware of the significant work the College has undertaken to consult with members and external partners to explore the solutions needed to address the workforce issues facing emergency medicine (EM).

ACEM has more trainees and Fellows than ever but continued geographic maldistribution of the specialist emergency medicine workforce persists, impacting communities and ED staff. For patients, issues of health inequity remain, increasing morbidity and mortality and negatively effecting numerous other health outcomes. For ACEM members and trainees, staffing shortages, coupled with continued access block and the stressors of a once-in-a-century pandemic have meant the overall sustainability of a long-term EM specialist career has never been under more pressure.

The College is now pleased to launch its *Workforce Planning Strategy*. This *Strategy* is acknowledgement of ACEM's commitment to continuous improvement of its training programs and improving health equity – the College must be a leading contributor to positive change.

ACEM will use the coming decade to focus on working with service partners to alleviate the workforce maldistribution in regional and rural areas, continuing to build on a multidisciplinary workforce with FACEMs leading the way, and support programs that deliver the highest possible standards of education and training. This includes:

1. Establish accredited training networks.
2. Each network to provide a balance of metropolitan, outer urban, regional and rural experiences, and all future trainees will be required to complete a mandatory 6-month rural-rotation.
3. Through a pilot program, explore the feasibility of blended supervision for FACEM trainees i.e. on-site + remote clinical supervision.
4. Develop detailed guidelines for health services outlining medical workforce models and appropriate use of non-FACEM senior decision makers (SDMs).

Accredited training networks and expanding rural training opportunities

Fundamental to this Strategy has been consideration of how the ACEM training pipeline can improve and broaden the trainee experience for emergency medicine training and also improve the access and equity to quality care across emergency departments.

Through the establishment of accredited training networks, trainees will have greater certainty regarding their training placements and their employment. They will also be guaranteed a breadth of experience, as each network will be required to offer a variety of hospital (and other) training sites across a range of geographical and case-mix experiences.

The College acknowledges the introduction of a mandatory six-month rural training term will be challenging. However, the College is committed to seeing more trainees in rural and regional settings, and contributing to the development of a critical mass of EM specialists in all regions.

Exploring remote supervision

Further expanding the College's commitment to improving rural and regional training options, ACEM will explore the feasibility of remote clinical supervision models for some aspects of training. The College recognises this a significant piece of work, and that there are currently differing views amongst the membership as to the merits of remote clinical supervision.

Like telemedicine, remote supervision may work well for some aspects of training. For particular trainees and/or stages of training, it could provide unique clinical opportunities in a safe environment as part of broader networked arrangements. The College needs to lead the testing and development of this area to determine if and how these experiences can be safely delivered whilst enhancing the training experience and improving community access to care.

Constructing the ED workforce

The current ED 24/7 model of care relies heavily on recruiting FACEM trainees, with some trainees encouraged towards speciality training, despite EM not necessarily being their preferred choice. It was clear throughout stakeholder consultation over the last two years that members want to see the College develop and promote standards for who can work on an ED-middle grade roster, and assessment processes to determine this.

ACEM has committed to undertaking this work and formalising guidance on non-FACEM SDMs, and the different models of care that utilise these personnel across a range of settings and locations. A dedicated middle-grade workforce will contribute to addressing the significant increase in patient presentations and subsequent service requirements, and in practice this will lead to an improvement in the quality of patient care, whilst maintaining the integrity of the FACEM Training Program.

Conclusion

These are the most significant reforms the College will undergo in the next decade, and it has been wonderful to see members and trainees engaged in the conversation during the past two years of development. NowACEM moves forward to the next stage of implementation and ACEM moves forward to forward to bringing members and trainees on this journey.

Author: Fatima Mehmedbegovic, Manager, Workforce Planning and Inclusion

---

i More information

For regular updates visit acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Sustaining-our-workforce/Workforce-sustainability

ICEM 2022

Dr Simon Judkins, ICEM 2022 Convenor

'I think we should go with "Better Care for a Better World" as the theme for the conference.'

I looked around the room at the faces of my emergency medicine friends. We had just pulled together the first meeting of the local organising committee for the International Conference on Emergency Medicine (ICEM) to be held in June of 2022. Our first meeting was pre-COVID-19, pre-lock downs and pre-everything Zoom. It was, from my recollection, the only meeting we had with many of us in the same room.

We had an agreement, we all want better care, and we all want a better world, so that was decided.

Since then, there has been a lot more meeting, planning and decision making, and not all of it has been plain sailing. Moving though the uncertainties of lockdown, a possible virtual conference, a hybrid conference, more lockdowns, and Omicron, we are now here, three months out, with venues booked, a program solidified and momentum building to at ICEM2022 in my hometown, Melbourne.

The meeting is, of course, the Annual Scientific Meeting for the International Federation on Emergency Medicine. The host organisation is your College, ACEM, and I have the privilege of being the Conference Convenor, with a fantastic team of FACEM and trainees working hard to put this event together.

This will be the 21st ICEM and the first on-site conference in three years. Last year the conference was hosted by the Emirates Society for Emergency Medicine as a virtual event, a first for ICEM and a great success with thousands of delegates globally. The year before in 2020, ICEM was to be hosted in Buenos Aires and in the lead up, amid all the buzz and excitement, it was regrettably cancelled due to COVID-19.

We are therefore thrilled to be able to host so many of you in person at this hybrid event.

With both on-site and virtual attendees ACEM has worked diligently to create an event that features an incredible social program, with links to live stream panels and plenaries, as well as a series of purely virtual sessions, adding extra clinical content to the meeting for all to view.

I have attended ICEM in Mexico City, in Hong Kong, Seoul, Dublin and, in 2004 in Cairns, back when I was a newbie FACEM. I will never forget that conference Gala Dinner and its "Underwater" theme. There is something so extraordinary and unforgettable about ICEM, and we are sure, that being the first where we can all get together for some time, this will be truly memorable.

What makes these meetings so important is the community of clinicians who come from all corners of the globe, to discuss, learn, support, and solve some of the great challenges in the delivery of emergency care. Particularly now, after the last two years of hardship, these conversations have never been more significant. Never, at least in my lifetime, has the role of emergency medicine and those who are on the frontline, the doctors, nurses, paramedics, and

ICEM 2022 will cover topics from emergency medicine leadership, health equity, the impacts of the pandemic, disaster responses and, of course, the latest updates in trauma, infectious diseases, neurology, and cardiology.

others; have we had such a vital role, an important impact and as big a challenge as we have all faced throughout this pandemic. For me, joining with colleagues for the first time in over two years will be a moment of celebration, of joy and reflection, but a moment we have all been waiting for and very much deserve.

The program starts with two days of pre-conference workshops followed by four days each with their own curated theme, Global Health, Health Equity, Planetary Health, and Innovation and Technology on the final day. We have presenters from the UK, Canada, Kenya, Vietnam, Hong Kong, Nepal, India, Mexico, the US just to name a few.

ICEM 2022 will cover topics from emergency medicine leadership, health equity, the impacts of the pandemic, disaster responses and, of course, the latest updates in trauma, infectious diseases, neurology, and cardiology. We have over 300 abstracts from over 30 countries in total culminating an excellent and varied program to share with all of our delegates.

Through the work of the ACEM Foundation and the Global Emergency Care Committee (GECCo), International Scholarships will bring clinicians from LMIC (Low-and Middle-Income Countries) to Melbourne. And, joining forces with the Foundation, DFAT and you (when you register and donate to our sponsorship program), we are supporting the virtual attendance of 250 delegates for LMIC's across the globe.

This is a not to be missed event. I am so excited about the program, the venue, the chance to see friends and colleagues in Melbourne, connect with people, and show you what we, the organising committee, with support of IFEM, have put together.

You will want to be part of delivering "Better Care for a Better World" …. we all do.

ICEM 2022 Organising Committee

Dr Simon Judkins
Convenor

A/Prof Paul Middleton
Deputy Convenor

Dr John Bonning
Oversight Committee Representative

Dr Peter White
ACEM Chief Executive Officer

Dr Elyssia Bourke

Dr Simon Craig

Dr Lai Heng Foong

Dr Jessica Forbes

Dr Jenny Jamieson

A/Prof Tony Joseph

Dr Rob Mitchell

Dr Georgina Phillips

Dr Viet Tran

Dr Gina Watkins

REGISTER NOW icem2022.com

iStock.com/Mlenny

COVID-19 Vaccination Campaign in Aotearoa New Zealand

Dr Elspeth Frascatore

In September 2021, you may have heard of a grassroots open letter in support of vaccination against COVID-19 in Aotearoa New Zealand. You may even have signed it! Herein follows the story around that letter and the campaign that followed. It's hard to summarise the experience of creating New Zealand Doctors Stand Up For Vaccination (NZDRSUV), but I learned that with successful advocacy, you might not be ready for your outcome. Did I bite off more than I can chew, or is this what successful advocacy feels like?

In February 2021, Aotearoa New Zealand's COVID-19 vaccination campaign started – beginning with those most at risk and rolling out to the general population – and, as doctors, we breathed a sigh of relief. However, over the ensuing months, this elation soon began to wane as we became aware of a new problem: vaccine mis- (or even dis-) information and the resulting vaccine hesitancy. Social media was alight with joyous selfies of the newly vaccinated, but equally a different sentiment was heard in other corners of social media, telling of a myriad perceived horrors regarding the vaccine.

As doctors, it was difficult to see patients decline vaccination for reasons we knew were categorically untrue. It caused a sense of helplessness that no other clinical scenario had ever provoked. Unless someone is physically in front of me as my patient, how do I help them? As doctors, we collectively wrestled with these emotions and began to talk to each other in social forums, over coffee, and at work. The same questions came up: What can we do? How can we make our voice heard? What would be a powerful statement?

As an emergency physician on the frontline of the pandemic response, I wanted to make a difference for patients AND doctors. The idea came up to do an open letter from the doctors of Aotearoa New Zealand to the people of Aotearoa New Zealand.

Easy, right? … Right?

A journey into advocacy began, which I'm not entirely sure I was ready for. My enormous thanks goes to the core NZDRSUV team, my husband, the Association of Salaried Medical Specialists (ASMS), ACEM, and many others without whom I would never have succeeded.

As we all know from our training, the first step is to 'assemble stakeholders', although in medicine it is less dramatic than in the Marvel Universe, and has an awful lot more Zoom meetings. I assembled a very small central cohort of doctors, including Dr John Bonning (then ACEM President) and two other doctors. It was our core group of four that would bear the brunt of the work. It would be fair to say this was significantly more work than any of us anticipated.

First, we agreed upon our goal. From the outset, our wish was to show the general public the overwhelming support of the vast majority of doctors for vaccination against COVID-19. We wanted our patients to see and feel our confidence, and to ensure that we were a positive counterpoint to the small but vocal anti-vax minority so heavily depicted in the media at that time. We did not want to enter arguments or be pulled into political discussions; we just wanted to concentrate on what we knew well – evidence-based medicine.

We carefully composed the letter with that in mind and, despite this being a complex space, it turned out to be one of the easier parts of the process. More complicated was the creation of a Frequently Asked Questions (FAQ) document regarding the COVID-19 vaccine – countless hours of revisions of a fully comprehensive document, created with the assistance of the International Medical Assistance Corporation (IMAC) – that has subsequently been shared nationwide.

We began thinking about how we would collect signatures. How do you reach the inbox of every doctor in Aotearoa New Zealand? We contacted every specialist college, rapidly becoming familiar with their acronyms – ACEM, ANZCA, ASID, CICM, PHA, RACS, RANZCGP, RANZCOG, RCPA, RNZCUC, and many more. We liaised with Te Ora and the Pasifika Medical Association, the New Zealand Medical Association (NZMA), ASMS, and Specialty Trainees of New Zealand (STONZ).

From the outset, our wish was to show the general public the overwhelming support of the vast majority of doctors for vaccination against COVID-19.

Hours and hours of phone conversations and emails ensued. Every entity was enormously supportive from the outset and we came to understand how COVID-19 would affect all aspects of medicine, from radiologists to ophthalmologists, to rural physicians. Each entity had to navigate internal processes to formally endorse our unprecedented grassroots cause, and, over a course of weeks, 51 medical colleges and entities formally endorsed us and contacted their membership to encourage members to sign. To my knowledge, this has never been done before, and I thank those entities for their support. I made a website to promote our cause and host our material, set up a Twitter and Facebook group, and we were ready to go.

Next came the issue of how to collect signatures. We set up a survey on SurveyMonkey to collect each practitioner's medical council number, name and specialty. The survey went live on 1 September 2021. In 48 hours, we had received over 2,000 signatures. By 5 September we had more than 3,600 signatures, by 9 September we had more than 4,500 signatures, and by the end of the month we had reached over 5,000 signatures. Our small grassroots initiative had become far bigger than I had ever anticipated. I was thrilled but intimidated.

I hadn't realised the enormous appetite among the doctors of Aotearoa New Zealand to advocate for the COVID-19 vaccine. Every doctor had encountered vaccine hesitancy, either in a patient, a whānau member, or friend. And most were feeling the same helplessness I had experienced. We were all in that same boat and we all wanted to help. At the time of writing, 6,781 doctors have signed the letter.

SurveyMonkey created what seemed to be the world's longest Excel spreadsheet of names – the visual of that many doctors who had come together to support the cause was humbling. We wanted every name to be checked against the medical register, which is available to the public on the Medical Council of New Zealand (MCNZ) website, and there was no way to automate this process. Myself and an emergency medicine trainee manually checked every single name against that register. Double ups were removed, along with a surprising number of humorous fake names. It was tiring work, often running into the early hours of the morning.

By the time we had collated our final list, we were certain of its integrity and just in time for a deadline that had appeared halfway through our collection process: Super Saturday. Herein followed a new conundrum: we have our letter; we have our signatures. Now what do we do with them?

We needed the media to promote our cause, but until that point in time, my only dealing with the media had been as a consumer. I had no media training and was new to the concepts of news cycles or 'new angles'. We made contact with Stuff, one of the most popular news websites in Aotearoa New Zealand, and worked closely with a senior journalist and graphic design team to create interactive content that allowed the letter to be read and every single name scrolled through, grouped by specialty. Scrolling through nearly 7,000 names takes a LONG time. The visual was impressive and launched the morning of Super Saturday. Finally, we had achieved everything I had hoped for – we had reached the public and supported the vaccine program at the time it needed it most.

I was proud and exhausted, but soon realised it wasn't over. We were inundated by press enquiries and hits on our website soared, along with hate mail to our inbox. I assembled a diverse group of doctors willing to fulfil media requests, from different ages, cultures and specialties. It was vital we showed that all doctors support vaccinations, not just the usual 'talking heads'. I'm extremely grateful to the doctors who volunteered to talk for our cause.

Until this point, I had tried to stay mostly behind the scenes, not willing to jeopardise my own cause with my lack of media experience. However, the further the cause travelled, the more I felt myself being pushed to put my head above the parapet. This analogy sounds strange, but that was how it felt. Vaccination is a hot topic, and, at times, social media backlash can be deeply soaked in vitriol. I was receiving daily hate mail and being discovered by strangers on Facebook – outcomes I had never considered a few months prior.

I finally joined the group doing the media rounds – morning TV shows, news interviews, writing op-eds (opinion pieces). I was completely new to this and terrified to make a mistake, but the need was there. I had created this group to promote a cause, and had an obligation to see it through. After the first few media appearances, it got easier, but I don't believe I will ever be comfortable with seeing my own face on TV.

From the outset, I said that we would never know if our initiative had worked. Aotearoa New Zealand currently has some of the highest vaccination rates in the world, so I hope we did manage to make a difference. To this day, NZDRSUV has been a useful counterpoint for the media – whenever talking about the minority of antivax doctors, they will always compare to our, now vocal, vast majority.

We gave the doctors a voice and for that I will always be proud. Along the way, I've made many new friends, doubled my phone contact list, and developed a new set of skills, but, most importantly, I proved to myself that a pipeline dream can come true if you're willing to see it through. If you can say you've made a positive difference in the world, no matter how small, you've left your mark. I hope I've achieved that and that's all I could ever have wanted. Stay safe, Aotearoa.

Dr Charlotte Durand

Dr Durand is an ACEM/PEM trainee in Darwin, Australia, with interests in team performance, FOAMed and endurance sport.

Why emergency medicine?

On one hand it feels as though it took me a long time to decide on a specialty, but perhaps growing up as the child of two paramedics I was always going to wind up in emergency… At the crux of my "why" is the desire to be ready for anything at any time and to have skills that make me useful in a range of settings. I also love the hustle and bustle, the hectic department and being right where the action is.

What do you consider the most challenging / enjoyable part of the job?

I love the social science aspect of emergency. So much of what I do is not medicine at all, but the process of connecting with other human beings. Hearing their stories, understanding their needs and helping to choreograph a team to achieve a common goal. I care deeply for my patients and my colleagues (including those from other departments), which can be both a significant challenge and an enormously rewarding experience.

What do you do to maintain wellness/wellbeing?

I am a massive extrovert, so I recharge through time spent in the company of friends. I can usually be found deep in conversation somewhere in reach of a good coffee. My other outlet is through my sport, which typically involves some combination of swimming, cycling, mountain-biking, or running. I fully acknowledge how shamelessly I perpetuate the lycra-clad ED reg stereotype. Even worse, I am known for turning my colleagues into triathletes eventually!

What do you consider your greatest achievement?

This is a tough question! I think probably the hardest thing about medical training is how easy it is to lose yourself in a never-ending list of check boxes and forget to look up at life going by. I feel like I have been able to (so far, and because of great privilege) allow myself the space to find joy in my life outside of my work. To me, that feels like something big.

What do you see as the most eminent accomplishment in your career?

The network of fantastic clinicians, mentors, and friends that I have worked to establish so far. It's taken a lot of guts to approach senior people I admire for advice and connection, but I get so much from these relationships and am newly inspired by them each time we cross paths.

On the same level is my work in recording and publishing a podcast for ACEM Primary Examination candidates, called Primary Cast. It has been a steep learning curve and a lot of hard work, but I have been rewarded in messages from grateful trainees and the knowledge that I have created some useful FOAMed for the wider team.

What inspires you to continue working in this field?

I work with some of the most tenacious, compassionate and clever people for whom no task is too big and nothing is ever tackled alone. This bond and sense of camaraderie and shared experience is something I treasure deeply, and it lifts me up on days where the job gets a bit overwhelming.

Tell us a piece of advice that you would have liked to receive as a trainee or early on in your career.

I have been lucky to receive a lot of great advice. One that sticks with me went something like this:

"The rules of the universe mean that it is inevitable that sometimes you will miss something. One day, you will miss a diagnosis and something bad will happen. It will feel like the end of the world. You need to know that happens to everyone. The day this happens to you, pick up the phone and call me."

More information

Visit acemprimarypodcast.com

Two Steps Forward, One Step Back: Minimising Alcohol-Related Harm

The history of Australia since colonisation is one of a challenging relationship with alcohol, with one of the most famous and formative events of the newly established colony of New South Wales being the Rum Rebellion of 1808. This problematic history continues to this day, with 25 per cent of people reporting drinking at risky levels and nearly 17 per cent reporting exceeding the lifetime risk guidelines in the 2019 National Drug Strategy Household Survey.[1]

Alcohol-related harm is one of the largest preventable public health issues facing communities in Australia and Aotearoa New Zealand. This has clear and direct flow-on effects to presentations at emergency departments (EDs). Alcohol-related presentations impact on the volume of patients who present to the ED, particularly during peak public alcohol consumption hours. Such patients are commonly resource and time intensive. One in 12 (8.3 per cent) presentations to Australasian EDs are alcohol-related. Snapshot surveys conducted by ACEM at peak times (Friday and Saturday nights) show that alcohol-related presentations account for one in seven patients. However, Aotearoa New Zealand EDs have a higher prevalence of alcohol-related presentations compared to Australian EDs (17 per cent and 13 per cent respectively).[2]

Across Australian jurisdictions, there is an important move towards harm minimisation approaches by state governments. Unfortunately, we are not seeing the commensurate investment into health-led responses or adequate regulation of the alcohol industry. Access to alcohol is regulated at national and state levels, with additional responsibilities at local government levels. Nationally, Australian law covers the legal drinking age, drink driving, advertising and labelling. Where you can drink and who is licensed to drink is governed by state-based laws,[3] with retail and hospitality venues required to be licensed and staff to be trained in identifying and managing intoxication.

Nevertheless, generally speaking, it's quick, easy and affordable to access alcohol, with tens of thousands of liquor licenses available across both countries. Alcohol is easily accessible from supermarkets in Aotearoa New Zealand, and this has also become commonplace in Australia through the use of co-located, supermarket-owned stores.

A number of broader trends are having an impact on the way that alcohol is bought and sold, particularly through the rise in online shopping, which has been turbocharged by the pandemic.

Rapid delivery of alcohol

Even prior to the pandemic, online shopping and delivery services had been gaining significant ground on traditional brick and mortar retail. Large food retailers and alcohol delivery services were starting to respond to a market opportunity in delivering alcohol to people's homes.

During the pandemic in Victoria, retail alcohol had record sales with hospitality-based alcohol impacted by lockdowns in relevant jurisdictions.[4] On average, sales were $15 million a week higher during the pandemic.

More concerning than the general delivery of alcohol is the way some services have been set up, or have evolved, to provide rapid delivery of alcohol, typically within two hours and sometimes within 30 minutes in some areas.[5]

From a consumer focus, or the point of view of those companies, this may seem like a wonderful innovation, however, given the limited regulation of these services, the potential risks are significant:[6]

- It facilitates excessive consumption of alcohol by people who are already intoxicated, with minimal checks on welfare (responsible service of alcohol).
- Vulnerable people are regularly using these services and placing other people in the home at risk of violence.
- It creates new opportunities for people under 18 years of age to access alcohol, including being the recipient of the delivery.

There have been some attempts to regulate these services. Following extensive advocacy by a coalition of concerned organisations (including ACEM), the NSW Parliament revised regulation of alcohol delivery, requiring online age verification and for delivery drivers to be accredited in responsible service of alcohol (rapid deliveries are still allowed). Victoria currently has a bill before Parliament to update liquor licensing but many health organisations feel it's a missed opportunity to address the challenges posed by this new form of access.

Prior to the pandemic, there had been a reduction in the proportion of young people drinking at risky levels since the introduction of the National Health and Medical Research Council (NHMRC) guidelines in 2019. These new delivery services may appeal to younger people in attempt to increase drinking rates in this cohort.

In the meantime, EDs will continue to bear the brunt of acute alcohol-related illness and the occupational violence that is too often associated with this.

ACEM is working with partners to propose achievable changes to the regulation of these services that maintain public health.

The Foundation for Alcohol Research and Education (FARE) has proposed the following measures to reduce the harms associated with online sale and delivery of alcohol[7]:

- No alcohol deliveries between 10 pm and 10 am, to reduce the known risks of alcohol-related family violence and suicide, which peak late at night in the home.
- Introduce a delay of two hours between order and delivery, to stop rapid supply of alcohol to people who may be intoxicated or dealing with alcohol dependence.

iStock.com/Astarot

- Require online age verification through digital ID checks, to ensure alcohol is not sold to children.
- Require ID checks on delivery and ban unattended delivery, to ensure alcohol is not supplied to children or people who are intoxicated.
- Prevent alcohol companies from predatory targeting and marketing towards vulnerable people, to protect people's health and privacy.

ACEM is working as part of Alcohol Change Vic to influence the Victorian Government in introducing these types of measures through amendments to the current review of the Liquor Control Reform Amendment Bill 2021.

ACEM will continue to work with other organisations across Australia and Aotearoa New Zealand to ensure that changes in alcohol supply don't come at the expense of the safety of the community and ED staff.

Public drunkenness

On the flip side to supply in the home, there is the issue of being intoxicated by alcohol while in a public place. Public drunkenness is a behaviour that has had significant attention throughout the histories of Australia and Aotearoa New Zealand since colonisation.

Historically, being drunk in public was associated with being undesirable or less worthy, including Indigenous peoples, homeless people and working class people. It has long been argued that these laws have been applied inconsistently and certain sub-populations are overly impacted.

These laws have largely been repealed in Australia and Aotearoa New Zealand over several decades, with Queensland the last remaining jurisdiction to retain these laws. ACEM has welcomed this shift towards a health-oriented, harm-minimisation approach.

In the Australian context, the Royal Commission into Aboriginal Deaths in Custody was a significant driver of the repeal of these laws.[8] This Royal Commission, the final report of which was released in 1991, demonstrated there was limited appreciation of, nor dedication to, the duty of care owed to First Nations people while in custody, with close to half of all public drunkenness cases involving First Nations people.

The most recent repeal of these laws occurred in Victoria. This repeal was prompted, more than 20 years after the Royal Commission, by the death of Ms Tanya Day, a Yorta Yorta woman, in 2017.[9] Ms Day was asleep on a regional train when arrested for being drunk, and then subsequently died in a holding cell.

Based on the advice of an Expert Reference Group,[10] the repeal occurred in February 2021 and will take effect on 7 November 2022. The repeal[11] includes the offences of:

- Persons found drunk
- Persons found drunk and disorderly
- Drunkards behaving in a riotous or disorderly manner.

It's important to note there are other laws still in effect that allow police officers to respond to behaviour that is threatening or violent.

The intent of the laws is promising. At an individual level, substance use is primarily a health issue and should be responded to as such. If someone is seriously unwell due to high levels of intoxication, a health response is superior to a policing response. It's clear that there are some people who should have been in hospital, but instead died in a holding cell.

As with many reforms, the intent must be backed up with appropriate infrastructure to avoid unintended consequences. The Victorian Government is exploring the development of dedicated sobering up centres that would support intoxicated people without the need for a police response, and with the intent of avoiding unnecessary trips to the ED.

However, as sobering up services have not operated in Victoria before, there will be risks for patients and for the health system. There will be complex decision-making processes involved in determining whether a transfer to the sobering up facility is appropriate, as well as for staff at those facilities. Some of the key issues include:

- awareness of physical health conditions that masquerade as intoxication but require urgent medical attention
- in the context of 'intoxication', ensuring decision-makers have the skills to make a patient-centred decision on the risk to that patient's health and the interventions required
- who accepts the risks in making that determination on behalf of that patient.

Sobering up services will need to be staffed appropriately to ensure the wellbeing of people in their care. There should be protocols and support for addressing abusive and violent people. The service must operate at times that meet the needs of the community. The police and ambulance services will need confidence in their ability to take on the appropriate duty of care. There will also need to be escalation procedures for transferring patients to the ED when the situation warrants it.

Due to these risks, there is real concern that shifting the decision-making out of the ED will not work as intended, and that the diversion process may fail to achieve the intended outcomes. This may result in the majority of these patients being transferred to the ED immediately, anyway, as a risk mitigation strategy or, conversely, community members experiencing significant harm at the sobering up facility and ending up in the ED in a worse state than if they had been transferred immediately.

These risks are more likely if changes are implemented without the input of emergency physicians, and with no support to those being asked to take on these complex triage decisions.

ACEM will seek to work with the Department of Health, police, paramedics and the new alcohol services being developed, to ensure that intoxicated people get the appropriate care related to their substance use.

Broader than these services, there is also a question about access to appropriate alcohol and other drug (AOD) services. ACEM has long called for improved access to integrated and multidisciplinary services, which comprehensively address AOD use as well as other co-morbid physical and psychiatric conditions. The limited availability of acute treatment services, and the lack of service integration and community assistance, means that people requiring support for AOD use often seek support from EDs in crisis. There may also be significant delays between ED referral to outpatient community rehabilitation services.[12]

Ultimately, the removal of these laws is important for the rights, health and wellbeing of some of the most disadvantaged in our communities. In the Victorian context, and likely in Queensland in the future, we will need to work with our partners to ensure these types of legal changes are enacted well, so that community members get the care they require, and ED staff work in a safe environment.

Where to from here?

The changes discussed here should form part of a broader discussion about how to address problematic drug and alcohol use in communities.

More information

For more information about FARE, go to fare.org.au
For more information about Alcohol Change Vic, go to alcoholchangevic.org.au

With thanks to Dr Mya Cubitt for sharing her insights
Author: James Gray, Manager, Policy and Advocacy

References

1. Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW.
2. Australasian College for Emergency Medicine. 2018 alcohol and other drug harm snapshot survey. Melbourne: ACEM; 2019. Available at: https://acem.org.au/getmedia/3e940b76-3215-4b6f-a6ae-97b4d30d1d95/2019- Alcohol-and-methamphetamine-snapshot-survey_R2
3. https://www.health.gov.au/health-topics/alcohol/about-alcohol/alcohol-laws-in-australia
4. Foundation for Alcohol Research and Education 2021. Alcohol Retail in Victoria. Available at: https://fare.org.au/wp-content/uploads/Alcohol-retail-in-Victoria.pdf
5. Alcohol Change Vic 2020. Online sale and home delivery of alcohol: measures to prevent harm in Victorian communities. Available at: https://www.alcoholchangevic.org.au/downloads/position-statements/online-alcohol-sales-and-delivery-position-statement.pdf
6. Ibid
7. https://fare.org.au/policy/online-sales-delivery/
8. A Wright. (2021) Summary Offences Amendment (Decriminalisation of Public Drunkenness) Bill 2020, Parliamentary Library and Information Service, Melbourne, Parliament of Victoria. Available at: https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/13982-summary-offences-amendment-decriminalisation-of-public-drunkenness-bill-2020
9. Ibid
10. Expert Reference Group (2020) Seeing the Clear Light of Day: Expert Reference Group on Decriminalising Public Drunkenness. Available at: https://www.justice.vic.gov.au/public-drunkenness
11. Summary Offences Amendment (Decriminalisation of Public Drunkenness) Bill 2020. Available at: https://www.legislation.vic.gov.au/bills/summary-offences-amendment-decriminalisation-public-drunkenness-bill-2020
12. Australasian College for Emergency Medicine. 2018 alcohol and other drug harm snapshot survey. Melbourne: ACEM; 2019. Available at: https://acem.org.au/getmedia/3e940b76-3215-4b6f-a6ae-97b4d30d1d95/2019- Alcohol-and-methamphetamine-snapshot-survey_R2

Dr Shantha Raghwan

Dr Raghwan is a FACEM based in Brisbane, Queensland working at Logan Hospital and with My Emergency Doctor.

She is Fiji-Indian and grew up in Australia and Thailand before attending medical school in the UK where she worked for two years before returning to Australia and commencing FACEM training as an international medical graduate (IMG).

Shantha is a passionate advocate for intersectional equity in medicine and for developing training and work systems that place wellbeing and resilience at the forefront.

She is a core member of NoWEM and is involved in ACEM in many ways including the AWE Executive, the ACEM Inclusion Committee, TPR Panel, CAPP and is the deputy chair of the QLD Faculty.

What do you consider the most challenging / enjoyable part of the job?

This is two sides of the same coin! Providing a high standard of holistic care with limited resources (but no limit to the number or complexity of patients) requires flexible thinking, collaboration, empathy, and bravery. It's our biggest challenge, but my goodness does it feel amazing to find solutions amongst the chaos!

What do you consider your greatest achievement?

Being visible.

When I was a medical student, I didn't see many Brown women in professorships, lecturing or in senior roles in the hospital. During FACEM training, some of my biggest influences were women I looked up to – who looked and spoke like me. They showed me what I could achieve. And now I'm paying it forward, so our trainees can see people that look like them sitting on ACEM committees, on expert panels, in positions of authority. So that our committees look like our community, and we can build the pipelines that will ensure diversity and inclusion is embedded at every level.

What inspires you to continue working in this field?

My patients, my trainees, and my colleagues.

The community that Logan Hospital services is incredibly diverse and includes a significant population of Fijian Indians and Pacific Islanders. These are my people, and it makes me incredibly proud to offer them care with cultural understanding and insight. Being able to offer that to all my patients, whatever their background, keeps me motivated to grow and learn.

My colleagues and my trainees also inspire, motivate, and uplift me – every day we share stories, laughs, moments of connection. I love seeing my trainees develop and grow. And I love the comfort and power of working in a team.
This applies even with My Emergency Doctor, which is FACEM led telehealth. The connection to patients and to my colleagues is a powerful motivator, even remotely.

Tell us a piece of advice that you would have liked to receive as a trainee or early on in your career.

Work hard, play harder.

By this, I mean you must have balance between work and home, but always put home and your own health first. I cannot name a single colleague who hasn't traversed the spectrum of burnout at least once in their careers. It isn't about resilience alone. We are incredibly resilient by definition – think of medical school and our junior doctor years. But you need more than that to maintain your wellbeing. Just like all skills we develop; you need practice and a game plan.

I use Professor Martin Seligman's PERMAH framework as my game plan. It theorises that happiness in life depends on 6 pillars – Positive Emotions, Engagement, Relationships, Meaning, Accomplishment and Health – I check in on a regular basis and try to create balance amongst the pillars. I also use the Recovery Rocket framework to ensure I'm practising good self-care habits.

For me, the frameworks take the *je ne sais quoi* of wellbeing and resilience and makes them tangible and achievable.

I wish someone had told me this early in my career so now, I teach these to my juniors.

If you're interested in knowing more look up the Permah Survey or watch Professor Seligman's TED talk, and Andrew May has a great summary of the Recovery Rocket online.

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

There is so much to look forward to! We are in an era of innovation. With the growth of telehealth, we are developing ways to support remote communities, to provide more timely care in collaboration with our paramedic and RACF colleagues and finding ways to maintain career longevity.

I am also excited about the changes we are seeing in the equity and wellbeing spaces. We are becoming more engaged and holistic, more flexible, and we are embracing the benefits of equity and diversity.

We are also becoming more vocal – and I couldn't be prouder of ACEM for this. We are leading the charge and advocating on issues that affect our patients and members- things like climate change, mental health reform, access block and wellbeing.

It's an exciting time, and I encourage everyone to get involved – we need to hear all our members' voices on our committees and in decision making. There are always opportunities to get involved advertised on the ACEM site and in the newsletter. Come be a part of the change!

Sarah Goddard's Journey from Tennant Creek and Back Again

Dr Sarah Goddard is a proud Kaytetye woman of the Barkly Region of the Northern Territory and the second female Aboriginal Fellow of the Australian College of Rural and Remote Medicine. She is also the first Aboriginal Rural Generalist at Tennant Creek General Practice and its hospital. ACEM now has an opportunity to welcome Sarah and gain an insight into what life is like working as an emergency doctor in a town where you grew up and ask the question, "why emergency medicine?".

One glance at where Tennant Creek sits on a map of Australia, and it's easy to see why Sarah felt compelled to train in emergency medicine. It makes logistical sense when you consider that Tennant Creek is 500 kilometres to the nearest city, Alice Springs, and the fifth largest town in the Northern Territory. The hospital services a population of nearly four thousand people and that number doesn't include, backpackers, tourists and the grey nomads who travel along the Stuart Highway on a regular basis.

When Sarah is asked, "why emergency medicine?" she puts it in practical terms and states frankly, 'Well it just makes sense'. Then after a small pause she adds, 'And I love it. I love the work I do in emergency. I was always most comfortable in an ED. I knew I was going to be the one here to team lead and I obviously needed to study. I thrive in emergencies'.

Sarah divides her time between general practice, the wards, the emergency department and with her family. Now

also taking on the role of aunty, helping to bring up her niece and nephew, Tracker and Iraya. It seems like a lot to take on, but it's clear Sarah wouldn't have it any other way.

Sarah says that she knew that she was going to be a doctor at a very young age and there is the evidence to back it up, 'There are photos of me at three years old with a stethoscope around my neck'. Sarah's attributes her late mother Denise Goddard, for the determination required to persevere and to achieve a career in medicine.

'My mum was a copper for over 20 years.' Sarah lets out a big sigh, 'She was a very strong-willed woman, who has had a lot of medical challenges and against all odds would just keep going. So, I guess I have her to thank for the stubbornness and determination. She was told back before I was born that she would never have kids, well there's me and my brother to answer to that, we're talking about that kind of determination. My grandmother was a health worker and I have mum to thank for exposing me to the health profession, as she had kidney disease since I was a kid'. After a moment Sarah continues, 'In 1988 she was first diagnosed, so I was two, I've grown up in the hospital seeing professors and her renal physicians who I idolised'.

Sarah's mother Denise served in the Northern Territory Police Force for more than 20 years, despite serious health problems that began in her twenties triggered by a rare auto immune disease that resulted in kidney failure.

'Growing up in Tennant, seeing the rural lifestyle, disadvantage, Indigenous health firsthand it was set from an early age what kind of doctor I would be.'

'So, once I decided to go to uni there was no directional change, I wasn't going to go anywhere else. I knew I was going to be a doctor and the doctor I was going to be, was a generalist in Tennant Creek.'

'It's a place where you see real-life medicine, that some would only see in textbooks. I am seeing patients with acute medical problems in the emergency department, but also spending time in general practice. Tennant Creek is what rural and remote medicine is all about.'

It's not an easy road, but nothing was going to deter Sarah as she states, 'I just kept going, I was that determined that's what I was going to do. If I got a roadblock, well, I would just change my course and go around it, go to the next one. I had lots of setbacks, in getting through med school let alone family complications, failing three times, it would be enough for anyone to say, no maybe I shouldn't be doing this, but I just kept going'.

Sarah shares all this without a hint of complaint or resignation however when pressed she can acknowledge that the tough times had an impact on her. 'Don't get me wrong it hits you in the guts and crashes your world down, when you get that exam result that says, you've been unsuccessful. That's how Dad got me through boarding school, I'd be cracking it and wanting to quit and come home and he'd be saying, "try one more week darl and see how you go", and then the next week was fantastic, and I'd be loving life and I wanted to stay at school. So, after a failure or a setback you give yourself time to get through that little bit and then pick yourself up and march along again.'

Even when Sarah was forced to come home to be with her mother, she still managed to work through the grit to make it all happen. 'Things changed – family happened, my mum got (seriously) sick and I pulled out and came home. Then I decided – no I was still going to be a doctor, so I went to Newcastle University and did an Indigenous enabling program. I worked hard and got into medicine.'

Predominantly, encouragement was something Sarah received from her home. She laughs when she mentions the conversations, she had with her career advisor telling them she wanted to be a doctor, 'They thought it was hysterical, obviously I wasn't the A grade academic along the way, I would much prefer to be outdoors, playing sport but I did like to sit in the biology lab. Just, don't tell me no and don't tell me I can't do something because I will get around it'.

Without the support of her now husband, and her father, Sarah doesn't think she would have got through medical school. 'I've got a pretty good family. Mum and Dad let us kids be who we wanted to be. And they supported us along the way. No matter how outright impossible the dream was, they still supported us. I'm the first one on my mum's side to go to university. That's the Indigenous side, so I didn't have an academic to follow. My dad's sister had been to uni, but both my parents hadn't been. My dad did everything possible to keep us afloat when mum was sick and when I got older, they both worked together to get me to boarding school in year eight. I then left Tennant Creek again to complete medical school.'

It was 2008 when Sarah got to University in Newcastle. She made sure she came back for birthdays, sometimes rodeos, venturing home most weekends. This would entail travel from Newcastle to Sydney to Alice Springs and then drive to Tennant Creek – then she would do it all again on the way back. It's clear this is what kept Sarah grounded, but she makes it clear that it's more than being a homebody, it's embedded in more meaning and is sometimes difficult to describe its true meaning. 'It's coming home to recharge, coming home to family and being back to be where you want to be. No matter how far away you go or what you do, home is always home where you make it, and no one can stop that pull to bring you back. I can't explain it, and I can't put it into words, I know that I'm me and I'm happiest when I'm home and with my family.'

After a long pause Sarah adds, 'It's also my cultural side as well you know. We're all born to the land. This is where all my mob are and for them to see me have one little impact as a doctor in my home community makes it all worthwhile'.

'I've got plenty of friends and colleagues who are very passionate and love Indigenous health and rural medicine. But all the patients in the waiting room line up for me, it's got nothing to do with skill base and I can't explain that either.'

Sarah is straight forward when addressing questions on how she managed the change and contrast from Tennant Creek to study in Newcastle, 'I was just a little Black girl going to the big smoke and it was confronting'. On the other hand Sarah explains that her dad did take them to the east coast for Christmas, this was when her mother Denise was sick and they spent time in Sydney and she adds, 'So it wasn't a complete little Black kid out of the creek and into the big wide world'. When asked about her first day at Newcastle University she remembers driving up, parking the car and thinking, 'What am I doing here?' Sarah waits a moment before continuing.

'I'm in a four wheel drive that's got red dirt all over it and I'm parking next to BMW's and Audis at university where I'm thinking I really shouldn't be here and I've got NT number plates on the car and I'm jumping out in a pair of wranglers and a t-shirt. I walked into the Indigenous Health Unit and all these other kids there were looking as scared as I was. Little did I know that my best friend would be someone who was the complete opposite of me. She grew up in Newcastle and she was a goth, that was confronting except we're still the best of mates. We laugh about it all the time, the fact that I get out in my cowboy attire, and she gets out in black clothing with black lipstick and dog collar on.'

Sarah explains there were lots of opportunities to study Indigenous health and med school did give people the opportunity to work in remote areas, but as Sarah explains, 'Not all Indigenous health is the same. There are different groups and languages, chronic health issues that affect different people. University does give a foundation but it's something that you need to build in, when you do the practical work in those places'.

Part of the reason that Sarah loves working in Tennant Creek is as she says, 'It's a place where you see real-life medicine, that some would only see in textbooks. I am seeing patients with acute medical problems in the emergency department, but also spending time in general practice. Tennant Creek is what rural and remote medicine is all about'.

In the hospital Sarah is the only Indigenous doctor and she adds, 'I'm also the crazy one that lives here permanently. I'm working with doctors that I've seen when I was growing up (caring for her mother) and they keep coming back here to service the community. They're all passionate about remote medicine, Indigenous Health, and emergency'.

It doesn't stop there, Sarah says, 'There are now other trainee's coming on board. People come up here from Melbourne, New South Wales and Queensland, and want to be here and experience the situations they're put in. They want to do their training here and now we're at a point where we're turning people away. We've built an empire. We have so many people applying. They want the practical hands-on experience that you get in emergency in a small hometown.'

I ask Sarah what she thinks the interest for students might be? 'Med students that come here, it blows their mind. They have no idea until they get here how different it is. We get a lot of people that were originally going to do their internship in Canberra or Melbourne and then they find themselves applying to the Northern Territory. They're coming back to do their training in the Northern Territory and putting their hands up to do their intern terms in Tennant Creek. They get to experience, not just medicine, they get to go out with the Aboriginal Liaison Officer, social workers, hang out with the practice nurse, but they also get to do their acute medicine, they get clinical skills.'

'This year is our first year, since I've been here, that we're getting registrars and I think it's about place and the community. They get the welcome with open arms experience when they walk through the door. Here it's everything. It's surgical, it's paediatrics, it's anti-natal, it's end of life care. It's all areas of medicine. You have to manage it because high speciality areas are 500ks away.'

I ask about being the only Indigenous doctor and how the other staff respond and this is when Sarah laughs through her answer saying 'One of my closest friends calls me the oracle and that everything she doesn't know medical wise or Tennant Creek wise, she knows where to get it from. We get new junior doctors coming through and I get the response oh so you're Sarah Goddard'.

'I don't think we practice medicine differently. I just have a bit more to add being a community member or childhood friend. I have the addition of being the checkout chick who served them as a teenager or someone who they competed against in a Rodeo, I'm the one who has run water on the footy field, I'm someone who they ride horses with or go fishing with. I have the community engagement side.'

I ask Sarah what a day in ED looks like? 'Well, first I have to get the kids off to school. Then into the ED to find out what's happened the night before.' I ask Sarah what happens if it's someone she knows? And she replies, 'It happens every day, I'm more shocked when I walk into the department, and I don't know someone. I am the only Indigenous doctor working in ED and sometimes I feel like the Aboriginal Liaison Officer. I gently remind some of the other doctors to be careful when they're talking about the patients, because it's most likely that the cleaner who works here, will have a connection to that patient and their family group.'

When it comes to specific health challenges, relating to the Indigenous community in ED, Sarah is once again straight forward with her response, 'Emergency is emergency. You don't know what's going to walk through the door. You don't know the number of presentations or the population that you're dealing with. Some areas might be an older population, whereas here you can have young people with cardiac disease that have intensive hospital experience and numerous presentations that are not even 30.'

'And of course, it's not just the locals', as Sarah reminds me, 'It's people coming down the Stuart Highway, we get people pulling in sometimes who I think, they really shouldn't be doing this trip with their cardiac or respiratory condition, we just don't know what's going to come through that door, ever. It's not just the community we've got a 500k radius of other hospitals and a lot of desert in between.'

In order to balance her private and professional life, Sarah tells me what she does to maintain boundaries in her hometown. 'It's not easy, especially when these people have had my phone number since I was a kid. I avoid the supermarket.' Sarah let's out a laugh and continues, 'They'll ask me if their results have come back, I say, "I'm going to call you at 2.00am and ask you what the price of milk is". They know me, they've known me a long time so I can get away with stuff like that'. After a moment Sarah adds, 'Also shutting the gate, even then there's still a demand, sometimes they call me the Sarah App. Dad will get a message with a photo of a stubbed toe from one of the relatives and he'll ask me to take a look at it. Then I go fishing'.

Sarah has the support of other services such as telehealth and the Aboriginal Medical Service. 'They did a great job and luckily the community was also quick to act with COVID. They received their first case in December, up until then immunisation was lacking, but now they have a vaccination rate of 80%. They went out on a drive through centre over Christmas and New Year. Omicron is well and truly here, but it seems they're doing okay.'

Some people may just do their job, but it's when they have a sense of purpose attached that it makes a difference and is evident in the work they do. Sarah is both passionate about improving Indigenous health outcomes, and proud to be an advocate for providing medical services in remote areas.

Sarah is both passionate about improving Indigenous health outcomes, and proud to be an advocate for providing medical services in remote areas.

'I hope that I can have that influence on someone, that no matter how hard it is, how homesick you are, no matter what roadblock you're faced with, you pick yourself up and you go again. Don't give up there are other means and ways to get around to do something.'

And the advice that she would share with doctors wanting to work in Tennant Creek and other rural areas? 'Give it your all. Have a go. Come prepared and know where you're going and what communities and areas you're dealing with, make sure you take every opportunity you can get to be exposed, or involved in a team. We're all a pretty good friendly bunch here and we work.'

The future for Sarah is in Tennant Creek as she says, 'I see me working Tennant Creek until I retire. Which is bizarre to some, but it's home. I can't fix everything but I can do one thing a day to help someone, and that makes a real difference even if it's to hold their hand while they take their last breath.'

Author: Maha Sidaoui, Media and Publications Advisor

ED Musos

Dr Clare Skinner

Music can help us to find a way forward. When the social fabric of society begins to shred, music can act as a social glue and bring people together.

In 2019, when Notre Dame Cathedral, 'Our Lady of Paris', burned, onlookers lined the banks of the Seine River and gazed on in disbelief at the inferno. Many stood in silence, shedding tears, but then, as the flames continued to incinerate the famous world heritage site, Parisians began to sing.

Less than 12 months later, at the end of January 2020, on the other side of the world, singers, songwriters, musicians and composers united to pay tribute to all of those working on the frontline after bushfires burnt through 46 million acres of south-east Australia.

And just two months later, in March, the first COVID-19 death was reported in Australia, days before the World Health Organization (WHO) declared a pandemic. As we watched ominous graphs indicating a daily and seemingly irreversible rise in numbers, Australians were forced into lockdown. They were restricted to their state borders, and sometimes even metropolitan/regional borders, and emergency doctors across Australia prepared for the inevitable challenges ahead.

Soon after, Dr Clare Skinner, now President of ACEM, took to social media with a video of fingers playing the piano and asked, 'Can anyone write some new lyrics for this song?' The song was Billy Joel's New York State of Mind swiftly transformed with new lyrics to Stay at Home State of Mind.

It turns out, Clare has been a musician longer than she has been an emergency doctor, so responding creatively to the unprecedented COVID-19 pandemic was second nature to her. 'I picked this song because I grew up playing the works of Elton John and Billy Joel.'

With that one tweet, Clare began the process of creating the first emergency care virtual ensemble and, in the coming months, she collected multiple recordings of the song, with the aim of editing them into a single recording. She originally thought that a handful of friends might respond, not really knowing who they would be. The response was quick and the support heart-warming.

The first person to reply was Dr Amanda Stephens, emergency doctor from Sydney, and her husband began writing lyrics on Twitter", says Clare. Dr Carolyn Hullick from Newcastle was next to join, and her sister, Jane Hart became the group's first musical director.

'Lockdown was isolating and I thought making a music video would be a fun and positive thing to do. Even being at work was quite a lonely experience because we had to wear PPE and take meal breaks alone. We were also feeling homesick and separated from people. We were desperate to see our loved ones and colleagues in other places.'

The group quickly became the ED Musos and it effortlessly crossed borders and oceans around the world, soon comprising healthcare workers from emergency departments in Australia, Aotearoa New Zealand, the United Kingdom, Ireland, and the United States. The talent pool of over 400 expanded beyond emergency clinicians, as staff members from ACEM joined, along with family and friends.

ED Musos now encompasses singers, instrumentalists and dancers. Some are experienced performers with impressive music qualifications and experience, while others are beginners who are singing with a group for the first time.

Clare is one of those with impressive qualifications: at the age of three she was selected to join music classes at the Sydney Conservatorium, and has always understood the connection between happiness and music. 'Many people find their wellbeing getting out in nature or practising yoga — I get mine from playing the piano.'

Another member, Dr Ayanthi Perera, who works at the Prince of Wales Hospital – a busy tertiary emergency department (ED) in Sydney, New South Wales – expressed a similar sentiment about the importance of singing and music in her life.

'I believe ED Musos helped me connect to all those elements related to mental health, especially in terms of spiritual wellbeing. For me, spirituality is about my ability to be in the present moment and just be. My experience is that music – like nothing else – enables me to really concentrate and be in that present moment.'

Ayanthi really missed singing in person during lockdown, so it was no surprise that she decided to join ED Musos. 'I was on maternity leave during the start of the pandemic and initially did not know that ED Musos existed. One day, I happened to see the video of their *Stay at Home State of Mind* and was intrigued. As I used to be actively involved in choral music and acapella groups until about 10 years ago, the idea of being part of a virtual choir really appealed to me, so I contacted Clare to say I was interested in joining.'

An Honorary Fellow at the Melbourne Conservatorium of Music at the University of Melbourne, Dr Joseph Jordania strongly believes that music is the answer when it comes to conquering separation and enhancing wellbeing. He says, 'It is exactly the way to cure the problem of isolation. It's very rewarding to see choir members on Zoom, then hear yourself on the final recorded track'.

Being a member of ED Musos also helped Dr Laura Brown to bond with others. An emergency physician at Westmead Hospital in Sydney, New South Wales, she says she was honoured to be a member of ED Musos and felt a strong connection to others in the ensemble. 'It was lovely to feel part of a bigger group of like-minded people. Although we recorded individually, seeing the videos come together has been really heart-warming and fulfilling. Even recording the videos as an individual was fun, and it's the closest thing to performing I have done in a long time.'

But ED Musos didn't stop with *Stay At Home State of Mind*. After the first production came *Te Aroha*, which a Māori elder taught the crowd to sing at the ACEM Winter Symposium in 2019. It didn't take much to get the ball rolling because of the joy experienced when different components come together organically.

As Clare says, 'This one happened really quickly and almost by mistake. In passing, I mentioned to Dr Ruth Large (an emergency physician working at Thames and Waikato hospitals) that *Te Aroha* had stayed on my mind after the conference. It has lovely complex harmonies and is very intimate. Before I knew it, Ruth had spoken to Dr Kim Yates, Director of Emergency Medicine Research at Waitemata District Health Board, to see if it was culturally okay for us to perform the song. Kim then lined up Dr Kathryn Clark, a paediatric emergency physician at Waitemata and Starship Children's hospitals, along with Dr Claire Manning, an emergency physician at Wairau Hospital, who were already keen.

'I thought "We can't turn back now" because Ruth had already arranged for nearly half of the North Islanders Aotearoa to be involved. With so many of New Zealand's FACEMs on board, we'd better just do this.'

Clare also understood that there are challenges when working with music with strong cultural significance that reflects tradition and folklore of a particular society. 'We were very lucky to receive permission to sing a waiata, and we made sure that we set it up properly and got it right.'

When watching all five ED Musos videos, it becomes clear that ED Musos are a diverse bunch, made up of extraordinary people. As not only the producer of the ensemble, but also the caretaker of the group, this is something that is not lost on Clare. 'I felt I had to be the custodian of a psychological safe place. This is about all of us. We wanted ED Musos to include doctors, nurses, ward clerks, paramedics – everyone. We have a range of cultures, ages, professions and many women involved.'

There was one criterion that had to be adhered to, says Clare. 'From the outset, it was really important to me that no one should feel embarrassed to be in one of those videos. We're going to change the lyrics a little bit, but nothing can be rude, nothing can be tribal or critical of another group. Everyone has to be really comfortable.'

This meant that when ED Musos were asked to sing at the Sydney Opera House as part of the Australia Day ceremonies, Clare had to decline. 'The events manager offered us Australia Day and I knew it would be really problematic. They even offered Nigel Westlake (one of Australia's finest composers) to write us a piece, but we couldn't do it. We believe in cultural diversity. We have Indigenous members in this choir and this group cannot perform on the 26 January. It didn't fit with our mission.'

Behind the scenes, other hard decisions were made too, and if you happen to catch up with Clare at a conference, she may tell you some stories – off the record of course – about interacting with management for some world-renowned musicians, and

the angst of trying to play by the rules and adhere to copyright regulations. So, when it came to arranging the next song – the cover of *A Whole New World* from the movie Aladdin – you could easily be forgiven for thinking a large conglomerate like Disney might play hard ball when asked to borrow their music, but as it turns out, it was just the opposite.

Clare was delighted when she heard back from Disney. 'Once Disney saw one of our videos, they got back to me and said, that sounds wonderful, go for it. They said, you don't need to have a contract or rights and please know that if we see it, we will not challenge you. We really want to support this.'

ED Musos quickly decided that the video needed a Disney theme. Having fun with costumes, toys and props, they created a colourful background to the gorgeous sounds of the cello in the opening sequence, effortlessly setting the mood for the warm and mellow vocals.

Judging by the videos, the fun and themes continued, with ED Musos singing traditional Christmas songs. And the added bonus? No copyright issues. The group reworked the lines of many traditional favourites, and it's difficult not to crack a smile when you listen to the new lyrics sung to the tune of *Jingle Bells*, including '*Oh what joy it is to work, in ED Christmas Day*'. Perhaps a tad tongue-in-cheek, and certainly not as direct as their revamped lyrics of Joy to the World: *'Joy to the world, the next shift comes. Let hand over begin*'.

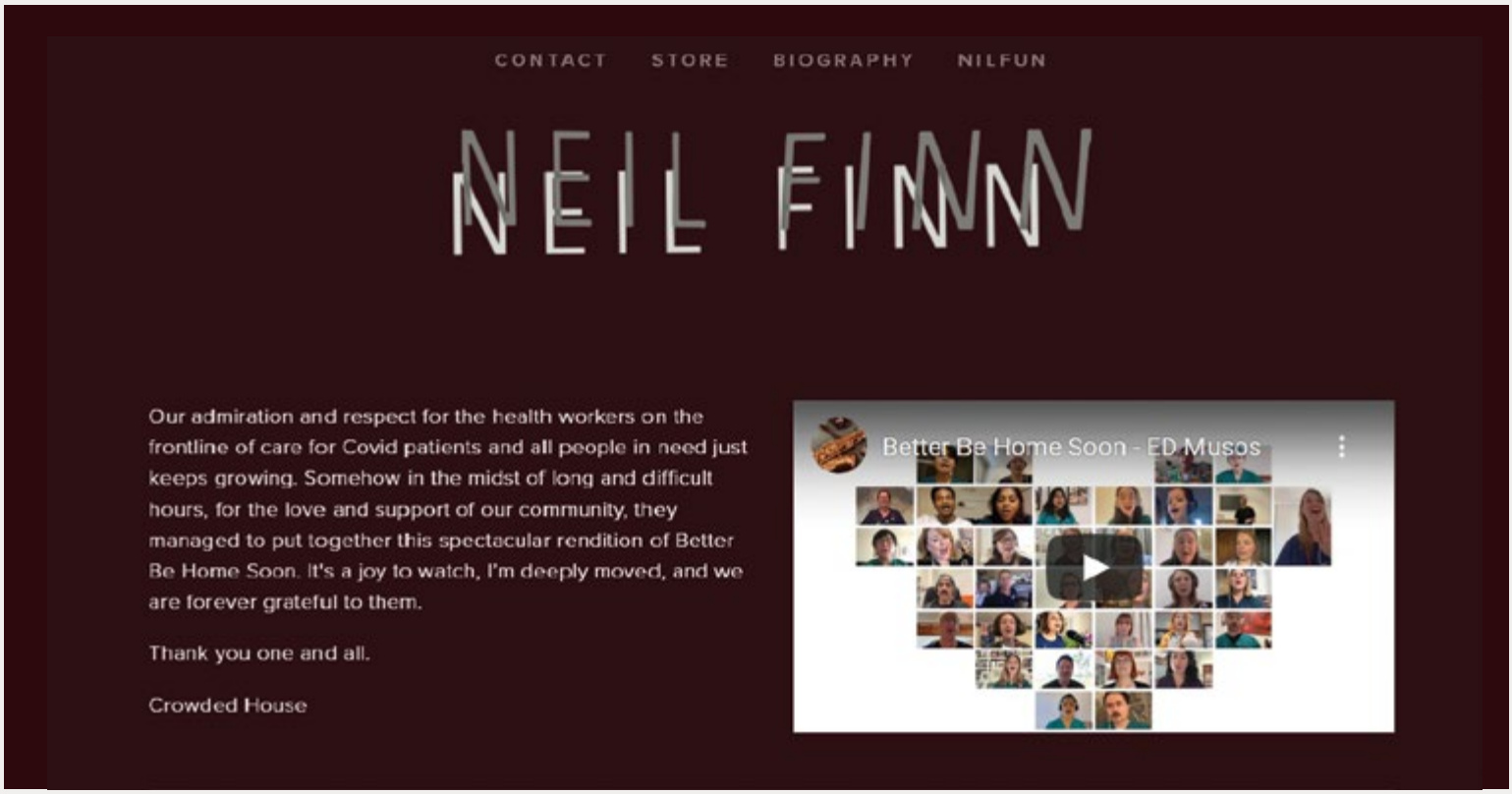
As the credits roll on each video, we are reminded that 'healthcare workers rehearsed and performed this song in their own time'. With rolling lockdowns occurring across the country, by Christmas, many health workers were understandably suffering from fatigue. Finding time and space to be part of ED Musos became increasingly difficult, especially when the direct message from State and Federal Governments was that emergency clinicians would continue to play a crucial role and remain on the frontline to support responses to the pandemic.

While we saw lethargy set in around the world, we also witnessed people in other countries attempting to mend communities and come together again, despite having to remain isolated. In Italy, citizens played instruments and sang from their balconies to help create a sense of belonging and participation. In Wuhan, people shouted from their windows 'Keep it up' as an antidote to the growing sense of alienation and isolation. And in Australia, ED Musos helped to lift community spirits and reminded us to look after not just ourselves, but each other.

Few people or organisations can motivate an entire workplace, let alone inspire an entire workforce sector across the world, so why was ED Musos so popular and how did it grow so quickly? Professor Kate Curtis, a nurse at Wollongong in New South Wales and member of ED Musos, has been an ED nurse since 1994, and attributes the inclusiveness of ED Musos to the group's success. She says, 'It felt like we were all one team. I'm not surprised by how quickly ED Musos has grown, or by the media attention, because it was never about that. It was about inclusivity. It wasn't done to create attention: it was done to build spirits and highlight the plight of emergency departments … and it happened to be fun'.

Clare further explains that ED staff are a diverse bunch and quite creative, which could also contribute to the large-scale uptake and participation. 'Working in the emergency department is a real-life version of theatre sports. For example, I'll be sitting at my desk, be called to resus, then walk into someone's worst moment of their life and take care of them. We are flexible, creative people and we like to think on our feet.'

A virtual ensemble performance is not something that can be easily thrown together at the last minute. It requires resources, time and plenty of patience, as well as technical audio and video engineering skill, which were contributed by Christopher Wiseman, who has previously worked as part



of the ACEM Communications Team. Clare had thought that the Christmas-themed video would be the group's last one … until she began receiving messages from group members just a few weeks later, asking her what the next song would be. 'Everyone really missed it, so we decided we would do one more and it would be the finale.'

However, no one anticipated the ripple effect this would have on the group.

Clare explained that when ED Musos members decided on the last song, they wanted to find one that made sense to both Aussies and Kiwis. 'Crowded House was the obvious choice for the band, and we conducted a poll to choose the song.' Better Be Home Soon won the poll and was the perfect follow-up song, as it conveyed feelings that everyone felt at the time. Many people would agree with Clare's sentiments about this song: 'It has a sense of longing. I think we nailed the song choice.'

The number of views of the ED Musos videos is more than a hundred thousand. The fact that Neil Finn retweeted the YouTube video of the group performing Better Be Home Soon may have contributed to audience growth and it's easy to see why his heartfelt thanks to the group also inspired ED Musos.

Although media attention was never an objective, it certainly helped to lift the profile of EDs across Australia and Aotearoa New Zealand. It was, after all, a positive news story about emergency clinicians doing encouraging and inspiring things. Ayanthi puts it best, 'I believe the media attention has helped portray emergency departments and emergency healthcare workers in a positive manner, and possibly helped the communities we serve. It helps when others can empathise with the challenges EDs have faced, especially during this pandemic. It also gave a lot of emergency healthcare workers a platform to connect with each other from a creative perspective, especially at a time when everyone was isolated.'

While *Better Be Home Soon* was still in production, the ED Musos were invited to perform at the NSW Australian of the Year ceremony at Luna Park in Sydney in November 2021, which was to be live-streamed on ABC iView. As COVID-19 restrictions hampered arrangements, Clare was able to choose only four members of the group to participate: Ayanthi Perera, Kate Curtis, Laura Brown and Johann de Alwis. They met each other in person for the first time just before going on stage that day.

Laura says, 'It was lovely to rehearse and perform together, and an honour to sing the Australian National Anthem. I'm from Ireland and I've never even been asked to sing the Irish National Anthem. It was truly humbling'.

Ayanthi recalls, 'A limitation of being in a virtual choir is that you don't get to hear anyone else sing until everything is finally audio-mixed, so it was wonderful that we got the opportunity to perform together. Hearing everyone's voices come together in real time during rehearsals and the actual performance was amazing. It was also great to experience that very special feeling of team spirit and comradeship, combined with the rush of adrenaline before going on stage to sing together. I'm sure anyone in a band or team sport knows what I mean'.

Kate, who learned the flute in high school, saw it as a good excuse to get out her old instrument and have another go at playing it. She joined after seeing ED Musos on social media and said, 'Being on stage was absolutely nerve-wracking, but then I felt we were all part of one team. Mind you, I'm not giving up my day job … I love it too much'.

ED Musos might pretend they are retiring from performing, but over the break, NSW Health shared the ED Musos version of *Jingle Bells* on their social media channels on Christmas Day 2021, which introduced the group to an even broader audience and, with Crowded House touring Australia in 2022, there are already wheels in motion to get them on stage at Sidney Myer Music Bowl in Melbourne – watch this space.

Author: Maha Sidaoui, Media and Publications Advisor

Wellness Program at Liverpool Hospital

'It brought positivity because there was something else to talk about on the floor other than COVID-19 – there was something to look forward to.'

In 2021, as healthcare workers struggled with the impacts of COVID-19 on their workplaces, communities and lives, wellbeing became an important issue for many emergency departments (EDs). We spoke to Liverpool Hospital Emergency Department about their wellbeing initiative, Liv ED Wellness.

Liverpool Hospital ED is one of the busiest in Australia. Located in Sydney's south-west suburbs, it serves a diverse population with a high proportion of essential workers. During the 2021 Delta outbreak in New South Wales, it saw some of the highest concentrations of COVID-19 cases.

Over the past two years, the hard-working ED staff have had to adapt to a lot of changes.

FACEM Dr Joe Marie 'Jom' Jardiolin said, 'With the pandemic, we just changed the way we do things. Now everyone has to wear full PPE and our whole emergency department had to be reconfigured to see more COVID patients, so it was quite confronting'.

The ED COVID-19 rearrangements included two new areas: the RICA (Respiratory Illness Cohort Area) for assessment of patients with respiratory symptoms; and CPOW (COVID Positive Overflow Ward) for those that tested positive for COVID-19. During this time of change, staff often felt like the department was in disarray.

When COVID-19 hit, Nurse Unit Manager Dragana Martinez returned early from maternity leave to assist her department. She found that having to regularly enforce changes and readjust daily to new information was creating a sense of uncertainty and fear in the team. She said, 'That was another reason why we had noticed, for a lot of us, that morale had dropped and why an initiative needed to be started in our department. The impetus was just everyone was overwhelmed – I could see that in their faces'.

When the lockdown protests began in Sydney, she noticed a lot of negativity in her colleagues. 'I remember coming to night shift the day of the protests and a lot of people were really emotional, thinking "Why are we doing this?"'

It was then that she decided to do something about morale.

FACEM Training Program trainee Dr Georgie Torlot moved to Sydney from the UK just before the pandemic. The difficulty of being away from family, while also in lockdown, and knowing that many of her colleagues were in the same position, was a driving force for her to start something positive.

Jom, Dragana and Georgie met for a brainstorming session and Liv ED Wellness was born.

Launched on R U OK Day 2021, Liv ED Wellness offered weekly wellbeing events online, giving the whole department the opportunity to get together and participate in some feel-good activities.

To establish the Liv ED Wellness brand, the team created a logo, website, social media accounts and fundraising initiatives. It was a whole team effort, using all available means – including Dragana's graphic designer husband who helped create the logo for social media. Social media gives people the opportunity to engage and share photos and ideas, and the website ensures content is accessible outside of work emails and provides information on upcoming events.

The team have seen many benefits since starting Liv ED Wellness, including getting to know their colleagues better outside of work – and seeing them without PPE on!

The games and prizes have unleashed people's competitive nature and brought a much-needed morale boost to the department. Dragana said, 'It brought positivity because there was something else to talk about on the floor other than COVID-19 – there was something to look forward to'.

While offering a welcome distraction from COVID-19, Liv ED Wellness has had the added benefit of increasing staff awareness

of workplace wellness. Georgie says it has brought wellbeing to the forefront of people's minds. 'We've had good feedback and I've noticed that it's made people more aware of their own wellbeing. I've noticed a lot of people checking in on each other, too. And that's not nurses to nurses and doctors to doctors, it's everyone really looking out for each other.'

Jom and Dragana agree that there has been a greater sense of unity and people felt less isolated. Dragana said, 'There was still a little family that you had outside of work; it wasn't just on the floor'.

Each member of the organising team brought their own hobbies and contacts to organise weekly events. They also sought input from across the department and were pleased to see other staff members offer to contribute and host events. Offerings included a personal trainer session, yoga, martial arts, and tips from an award-winning dog breeder – one of the ED administration staff. The online quiz, which included the coveted first prize of a paid day off – proved so popular that they ran it twice.

Now, with restrictions currently eased in Sydney, and enthusiasm for online events waning, the Liv ED Wellness team are excited about running face-to-face events.

This year they have already seen ED registrars come together for a well-attended teaching and wellbeing day on Cockatoo Island in Sydney Harbour.

Georgie said, 'It's exciting to have the freedom to do some of the ideas we had originally thought of. We have a line-up of activities for the next three months, such as a beach family fun day, a sports day, dog play dates for dog owners, and paintball war games, which will continue to build up teamwork and strengthen staff camaraderie'.

Due to the unpredictability of COVID-19, the team will remain flexible. Jom said, 'We're still having to adjust. Face-to-face activities may need to be postponed until we see stability'.

But, with plans ahead for more wellbeing sessions for all ED staff, Jom said, 'We are more energised than ever to keep this going and bolster our staff morale'.

Jom tells me that he's motivated by the inspiring work of registrar Dr Sam Bulford, who started The Awesome and Amazing Project, which encouraged staff to highlight the great work of their fellow colleagues. It's clear that inspiration goes a long way in improving team wellness and, with more face-to-face activities coming up, the Liv ED Wellness program is proving to be a brilliant way to kick off the year in 2022.

Author: Maha Sidaoui, Media and Publications Advisor

Workplace-Based Assessors – the Unsung Heroes of the ED

ACEM introduced Emergency Medicine Workplace-Based Assessments (WBAs – including CbD, DOPS, Mini-CEX and Shift Reports) in 2015. WBAs help assessors provide structured feedback to trainees and detailed information to Directors of Emergency Medicine Training (DEMTs) and Trainee Progression Review Panels about the development of clinical skills, clinical reasoning and decision-making. WBAs have become an integral part of the FACEM Training Program, with almost 120,000 being completed up to December 2021. FACEMs Dr Ali Al Joboory, Dr Courtney Pennuto and Dr Matthew Feain sat with us to discuss their individual experiences in WBA.

Dr Ali Al Joboory

Dr Joboory, originally from Iraq, is an emergency medicine consultant at Royal Melbourne Hospital in Melbourne, Victoria.

I chose emergency medicine because it's an active specialty, delivering a wide variety of medical cases. We treat patients of all ages with a large spectrum of physical and mental disorders. It's a stimulating and rewarding specialty requiring a particular set of skills. You must be able to think quickly on your feet, have a passion for procedures, and be unshakeably comfortable with potentially difficult traumas.

The people I work with at the Royal Melbourne Hospital are very inspiring. I feel like we are in a race, with continuous learning and development of skills, and the new faces we meet and friends we make every day. This keeps pushing me forward.

I've been part of the WBA program since I started working as an emergency physician in 2015. WBAs are a part of our daily work and practice. Crucially, the program is a great tool to measure our registrars' performance, support them, and have close one-to-one communication. For me, it has also been a great way to socially interact with junior colleagues.

WBAs assess a trainee's professional skills and attitude and should provide evidence of appropriate clinical competencies. They assess actual workplace performance, which is incredibly valuable. WBAs also help identify trainees who are struggling and require extra support. This creates a supportive environment for trainees in difficulty.

WBAs essentially achieve two things: a summative purpose, to encourage decisions on the learner's achievement; and a constructive purpose, to guide learning and monitor personal development.

The most valuable part of the assessment is the narrative, where feedback is given, strengths and weaknesses discussed, and an action plan formulated. Interactive and direct feedback is vital to help doctors improve and develop professionally.

WBAs give a considerably better review of competence compared to other types of assessment. As in Miller's Pyramid of Assessment, where performance and action are at the top of the pyramid, WBAs assess performance in everyday practice rather than in an exam situation.

Yes, it can be challenging. Giving feedback is not always easy. WBAs are not about writing good comments about the trainees. Instead, the reflective learning can prepare trainees to develop into competent FACEMs, both through their excellent performance and adversity. I might ask the trainees to do it again or represent the case, and we have another discussion about it. The goals of a WBA must be addressed at the beginning of the session to give the trainee a sense of the 'pass/fail' criteria.

WBAs can have a significant impact on a registrar's performance with a particular skill. For example, direct observation of procedural skills (DOPS) is considered a valuable learning opportunity for trainees to enhance performance in a skill. With constructive feedback and discussion, the performance of the trainees gets better and safer.

The most satisfying part of WBAs revolves around the discussion and feedback process. In addition to educational value, it's a great opportunity to establish social interaction with the registrars. The main difficulties with WBAs are around lack of time in busy emergency departments and finding a suitable case or scenario.

The WBA is one of the tools for measuring a trainee's performance, not the only one. It can be limited by lack of access to suitable cases or lack of time. More resources are needed in this field, such as dedicated FACEMs, more time allocations, and ongoing research into this kind of assessment. WBAs are, however, one of my favourite tasks in daily practice. To me, it's a mutual learning experience, where I can also learn from the registrars and interact with them in the discussion.

iStock.com/Charday Penn

Dr Courtney Pennuto

Dr Pennuto is a FACEM based at Queen Elizabeth II Jubilee Hospital, Brisbane, Queensland.

I love emergency medicine and the varied spectrum of pathologies and people that you encounter – patients, families and staff alike. You never know who or what is coming through the door next. It allows me to keep up my knowledge and skills in a wide variety of areas. I felt quite unfulfilled on my ward rotations, like I was rapidly deskilling in many areas when not in an ED environment. I love feeling that I'm part of a bigger family when I walk into the ED and greet everyone.

I've always felt that most patients would prefer not to be in the ED and it has taken a lot of courage for them to be there. For some patients, it may be the only time they ever access medical care, and if I can acknowledge their concerns and reassure them or help find answers to their symptoms, or even tell them what they don't have, then I have hopefully given them a somewhat positive experience.

I've been involved with WBAs since their inception. I commenced training prior to the existence of WBAs and, after time off to start a family, returned to training as they were being introduced. I'm fairly proactive in trying to get trainees engaged in the WBA process as I found it so incredibly helpful to my own development as a clinician. I participated in as many WBAs as possible as a trainee, with as many different FACEMs as I could find, and I encourage others to do the same.

I found that exposing myself as a trainee to the perceived stress and pressure of 'performing' in front of my seniors and peers put me in good stead for the stress of preparing for the OSCE exam, and dealing with imposter syndrome on my first, second and even third time on call as a FACEM – and even today still!

In completing WBAs and opting to be assessed by a variety of different clinicians, I was exposed to many different approaches to clinical problems. I could then pick and choose the best 'bits' of each clinician that suited my 'style' and integrate them into my own approach. I was lucky to train in amazing departments with incredibly supportive FACEMs, who just wanted to see me succeed.

It's always challenging giving feedback to ensure the trainee can take some learning point from the process – especially if you would not necessarily change anything and their approach was great. Sometimes it's just about asking the trainee how they might approach things differently if their method had not been so successful.

I continue to learn from watching trainees perform WBAs, as I often pick up tips and tricks they've learned from my peers, who I often don't get to see in action.

WBAs have definitely been a positive addition to the FACEM Training Program and I have not personally found them to be onerous or troublesome to complete, despite working in an extremely busy and often poorly resourced department. I try to offer procedures and challenging cases to trainees as much as possible to help support their learning and the WBA process.

My advice to trainees is to embrace the WBA process, do as many as you can, and take every opportunity that can be turned into a WBA – not just the bare minimum allocated. This will ensure that you easily fulfil the College requirements while gaining important exposure to a wide variety of feedback.

Dr Matthew Feain

Dr Feain is an ED Staff Specialist at St George Hospital, Sydney, New South Wales.

Emergency was definitely not my forte as a junior medical officer (JMO) and I never suspected I would end up where I am now. Nonetheless my interest in emergency medicine began while working in rural general practice, covering occasional night shifts in the ED to give the locum a rest.

Although it made for long hours doing General Practice all day and emergency overnight, I found the emergency work increasingly interesting and started looking forward to the ED shifts.

After completing the GP fellowship, I thought it would be great to do the ACEM Emergency Medicine Certificate with a view to combining general practice and emergency medicine, but I found myself addicted to the teamwork, the unpredictability, and the dynamic nature of emergency and never looked back! I love the camaraderie amongst the people I work with, from the fantastic nurses and registrars through to the dedicated group of consultants.

It's a privilege to be able to look after patients with such varied acute and chronic conditions, often when people are at their sickest and really need our help. I'm inspired by the challenge of not only diagnosing and managing multiple patients at once, but helping to teach JMOs along the way.

Emergency is such a dynamic area of medicine where we get the opportunity to apply the best evolving evidence in caring for patients, as has been demonstrated over the course of the pandemic.

I have been one of the WBA coordinators at St George Hospital for a year now, having started almost by accident when Simone Moore & Ryan Snaith, the two other fantastic coordinators at St George both took a well deserved block of long service leave across the same time in 2021. I was a newer FACEM in the department and so it seemed a good opportunity to fill the temporary void for overseeing WBAs.

I have to admit, having been remediated during my training as I lost track of my own WBAs, I was especially motivated to help make WBAs as easy as possible for registrars to complete, both for the sake of teaching, but also avoid other trainees being remediated also.

WBAs are an integral part of the FACEM Training Program, as they help to promote and formalise teaching on the floor. They are also a chance for FACEMs to pause and concentrate on how a trainee is performing in a specific area or skill. We are often unaware of where we could improve our abilities without someone more experienced or knowledgeable there to provide valuable feedback. By reflecting on specific and structured advice, physicians have the chance to make adjustments in skills or techniques to enhance performance.

It's uncommon for trainees to perform brilliantly across every facet of emergency medicine. I like to remind registrars that WBA feedback is neither a judgment of their overall performance nor their value as a doctor. It's simply a chance to provide constructive advice on how something related to that particular WBA could be improved next time. Great learning opportunities often come from experiences where things didn't go as smoothly as planned, so there's always an upside to a suboptimal assessment.

I'm forever grateful for the very honest feedback I received midway through advanced training from a respected FACEM in a particular case-based discussion (CbD) during which I was absolutely dismal! I thought I was cruising towards Fellowship at the time, so it was a much-needed wake-up call for what would be required later on, especially as I prepared for the OSCE exam.

I am forever grateful for the very honest feedback I received during advanced training from a respected FACEM on a CBD in which I was absolutely dismal!

Ultimately, WBAs are part of the process for assisting trainees to reach the standard required for both exam success and independent emergency medicine practice as a FACEM. WBAs make a difference in day-to-day work. Mostly, they remind us of the importance of teaching on the floor, even when things are busy. Additionally, they help to give trainees and consultants confidence that a trainee is either fine with a similar scenario or procedure for next time, or whether some extra support and supervision is needed.

It can be difficult at times to pause for a WBA when the department is heaving, particularly over the last year when COVID threw in all sorts of unexpected challenges. Nonetheless, it's really encouraging and satisfying to watch trainees improving throughout their WBAs. In future, I think we can strive as a specialty to be creative in how we complete WBAs, in particular, while working on the ED floor. Perhaps an ACEM WBA app with voice recognition would help facilitate getting them done more easily in real time?

One of the benefits of doing many WBAs is the chance I get to learn things myself or even discover new techniques that registrars have learnt from experience in other specialties. It's rare for every procedure or doctor-patient interaction to be the same, so they all offer an opportunity to learn something new.

Author: Inga Vennell, Editor

ACEM Core Values

The ACEM Core Values of *Respect, Integrity, Collaboration* and *Equity* are at the foundation of who we are: how we conduct ourselves, work with each other, and build upon our service and commitment. These values define the organisation's guiding principles and underpin the way ACEM works in order to meet its vision and mission of ensuring the highest standards are maintained in the training of emergency physicians, and in the provision of emergency care to the communities of Australia and Aotearoa New Zealand.

In this issue of *Your ED*, we sat down with FACEMs Dr Mark Sagrin and Dr Minnie Seward to discuss the first of the four core values.

Respect

We work for one another, for patients and for other health professionals. We practise in ways that defer to the inherent humanity of others, that give space and opportunity to the thoughts and minds of the people we work with, and that give regard to their position of strength or vulnerability.

Dr Mark Sagarin

Dr Sagarin from Oakura, Aotearoa New Zealand, is based at Taranaki Base Hospital and has a particular interest in wellness.

I chose emergency medicine because I had broad interests within medicine and felt I would never get bored even after 20 or 30 years, and this has remained true. One of my mentors told me this is the greatest job in the world and he truly meant it. I have contemplated that statement for many years.

What do you consider the most enjoyable part of working in emergency medicine?

The day-to-day practice of looking after patients remains my favourite part of my current role – meeting new people and assessing their various issues is still, after 25+ years, interesting to me. I like to use the concept of the human family tree, in which we are all closely related members of the human family tree: it helps me think of each patient, even the most belligerent or difficult, as essentially a member of my family.

I recently organised a conference called Humanity: a Taranaki Emergency Medicine Conference, which was held in New Plymouth in February 2021. I found this work quite enjoyable and rejuvenating.

What does work / life balance mean for you?

I seek to never feel like my work is a burden. I'm fortunate to be in a field that engages me and makes me feel I'm helping people at their moments of greatest need, while also having sufficient time off to exercise, eat well, sleep, spend time with friends and family, and carry on a hobby or two.

Why do you feel that respect is an integral part of emergency medicine?

We must recognise that our training in modern medicine is a gift to be shared and utilised for the benefit of anyone who comes through our door. We must respect each other as members of the human family tree. This is easy when it's an adorable child or gentle elderly person, but how can we find the empathy to respect the belligerent gang member who comes in high on methamphetamines with nazi tattoos? It's not our role to make a judgement on each individual.

We know that in day-to-day life respect is an important part of your work. Is there a memorable time that you demonstrated respect at work?

Once I was looking after a middle-aged, homeless, alcoholic man early in my career in Boston, USA. He came into our ED about three times every week, mostly looking for a meal or a bed to sleep in, sometimes deeply intoxicated and, other times, in severe alcohol withdrawal. On this occasion, however, the nurses told me his heart rate was 160 and he was sober. It turned out he was in supraventricular tachycardia and he had poor quality veins after years of intravenous drug abuse. I'd never spoken with him much in the past because he usually presented with an altered mental state, but in this case he shocked me by saying, 'Hey doc, you might want to look for an external jugular vein, and when you get a line, give me some adenosine IV'. (This was in the era before ultrasound-guided IV lines.) I got his external jugular line and he reverted to normal sinus after one dose of adenosine.

I asked him how he knew all the medical terminology – and after a chat I discovered he had been in medical training at the University of California San Francisco, one of the top US medical schools, when he got involved in the 1960s counterculture movement and, sadly, became addicted. This person must have been highly intelligent and a top student before his decline to a less productive member of society. This is just one example of why we should keep our initial judgements to ourselves and treat every patient with the same high level of dignity.

How do you foster a respectful work environment?

Years ago in the USA, there was occasional shaming and negative comments about overweight people, substance abusing patients, transgender patients, and other vulnerable populations. I even caught the tail end of the 'GOMER' ('get out of my ER') era as described in the 1978 book *The House of God* by Samuel Shem. While funny in parts, this book denigrates elderly patients with multiple comorbidities, calling them GOMERS. I trained at the hospital in that book and some of the things described still existed in the 1990s.

We can no longer allow disparagement of our patients, and I will not tolerate it as it inevitably leads to worse medical care. It's also essential to treat respectfully and try to learn the names of cleaners, ED clerks, healthcare aides, nurses, and everyone else with whom we work. Without our team working together respectfully, we can't get much done.

Throughout your years of training and education, was there an important moment where respect was shown?

One time, in my third year of medical school, on my first hospital rotation on the Surgery service, I thought I would stay up all night and try not to go to sleep. I'm someone who absolutely requires a minimum of six hours a night, if not eight. After four days with minimal sleep, my brain was fried and I was emotionally unstable and unable to carry on at all. I left the hospital and rang my family. I decided in my sleep-deprived delirium that I was going to quit medicine and choose another field, such as teaching. I thought that if this is what being a doctor is like, I don't want to do it.

Two of my mentors took an hour after class to talk honestly with me and discuss my plans. They encouraged me to take a few days off, catch up on sleep and then speak with the surgeon in charge of the surgery rotation. By that point, I had recognised that my grade in the surgery rotation was not worth endangering my own health. Since that time, over 25 years ago, sleep hygiene is an absolutely essential component of my personal health regimen – more than anything, for mental health. I greatly appreciated the respect these physicians gave me by spending an extra hour with me after class, as they recognised I was having a personal mental health crisis. Fortunately, one of them was a psychiatrist and the other, a very empathetic GP!

I have recently been trying to practise Manaaki Mana values with our Māori patients and I have found that simply saying 'kia ora' and trying my best to properly pronounce their names can open the door to a more productive consultation.

How has ACEM implementing Core Values highlighted the importance of Respect, Integrity, Collaboration and Equity for you?

I think this is an excellent initiative by the College. One of my biggest issues with the American healthcare system is that, over the past decade or so, the emphasis has increasingly revolved around money and payments. Virtually all of our consultant group meetings at my former employer in New Mexico revolved primarily around different 'metrics' and the importance of optimising reimbursements for the hospital from the various insurers. I'm not sure all New Zealand physicians recognise how lucky we are to work in a single payor, government-run healthcare system. This emphasis on Core Values is very refreshing for someone who previously worked in the US. It helps us stay in touch with the reasons why we went into medicine in the first place.

Dr Minnie Seward

Dr Seward is an Emergency Physician working in Geelong and Ballarat, Victoria, with an interest in staff wellbeing, education and wilderness medicine.

What do you consider the most enjoyable part of your role?

I love working in such a diverse and dynamic team environment. Every day is different, rarely boring, and provides great work satisfaction with the connections I make with patients and colleagues.

What does work/life balance mean for you?

Being able to switch off and leave work at work. Enjoying my free time; spending it outdoors or with friends and family. The thrill of the occasional midweek coffee or catch up with friends while everyone else is at their 9-5 weekday job.

Why do you feel that respect is an integral part of emergency medicine?

Patients may come to the ED on the worst day of their lives. They are often in pain, scared or at risk. Respecting a patient's vulnerabilities and equal rights to emergency care provides us with a remarkable opportunity to advocate for them.

The ED is a unique environment where a variety of staff, who may never have worked together before, congregate to care for patients. Collaboration and professional respect is vital to ensure we can all work together with the mutual goal of optimal patient care.

How do you foster a respectful work environment?

Be willing to lead by example in your workplace – where no task is beneath you over someone else. It may be as simple as changing a bed, finding a bedpan, or offering to make a cup of tea or a sandwich. Respect each other's skills, knowledge and limitations – we can create a positive work environment and optimal shared outcomes.

Considering there are so many moving cogs within a hospital, can you think of a time when respect has held departments together?

The COVID-19 pandemic has brought emergency staff closer together than ever before. Respect for each other could not be more celebrated. From the patience and kindness of our administrative and patient services staff to the cleaners making our work spaces safe between caring for COVID-19 patients, to our skilled and hardworking healthcare staff. The collaboration and teamwork to carry on and remain so positive in such challenging times is what helps me to keep working and continue to love emergency medicine.

A respectful relationship with a patient is key in emergency medicine. Is there a time where this was reinforced for you?

Taking the time to have curiosity about your patients can bring so much more to your working relationship and overall job satisfaction. It's the jokes, the laughter and the stories that help remind you of the person lying in the bed, and separate the person from their diagnosis.

Sitting the OSCE with a Newborn – the Ultimate in Multitasking

Dr Helen Willcock
Dr Willcock is an ACEM advanced trainee in Sydney, lecturer at UNSW and University Notre Dame Australia, and has a strong interest in medical education

February 2020. Ten months until the Fellowship Written Examination and the Fellowship Clinical Examination (OSCE) is twinkling on the horizon. Sitting at base camp and admiring my new desk, I contemplate the long hike to examination summit. And then, in what might be the greatest example of procrastination, I think 'maybe this is a good time to have a baby!' Assuming it would take six to twelve months, if we were lucky, I tell my husband maybe I'll be pregnant by the time I finish my examinations, and wouldn't that be efficient? Having never been pregnant or attempted the Fellowship examinations before, I had absolutely no idea what I was talking about.

Three months later and my lockdown-enhanced study is in full swing. And then – a positive pregnancy test! Shocked and delighted, I calculated the dates. I'll be 25 weeks at the Written Examination … that's fine. Imagining I'd be about to pop just after OSCE and wouldn't that be 'fun', my maths then tells me the baby will be born a MONTH before. That can't be right. But it is. My obstetrics still being a bit rusty, I scanned my brain for ways to keep the baby inside until 44 weeks until I realised there wasn't one.

With such a huge motivator, I developed a new laser focus, determined to get through. November and the Written Examination arrived, followed by an interminable nine-week wait for results, and with extreme relief I passed. Now I had to think about the OSCE for real. I knew it was my ticket to freedom and I was never going to have as much medical expertise as I did at this point, so it felt like this was my best chance to pass. Luckily, I had a very supportive study group (one of whom was also pregnant) as well as supervisors who genuinely believed I could do it.

There may be no perfect time to have a baby and this is compounded by the complexities and demands of specialty training. Perhaps there are better times, for example, between the Primary and Fellowship examinations, or once you have finished training and have the safety net of a staffie position. Peri-examination is definitely not one of those times. However, real life often takes over and we don't do our training in a vacuum. As the number of female senior trainees increases, as well as a shift to post-graduate medical degrees producing older trainees, many more women will find themselves balancing pregnancy and birth (as well as miscarriages or fertility treatment) with examinations. It's not really anyone's first choice but pregnancy can rarely be timed perfectly and COVID-19 examination cancellations have meant many candidates face disrupted plans and sit an examination when other life events are happening.

How many of us are out there?

Nobody really knows. While I knew of several people who sat their examination while pregnant, I didn't know of anyone who had done it with a newborn. I was flying blind in terms of how to approach the OSCE or knowing what support the College offers. Even though I knew that I couldn't be the only one out there, I couldn't find any numbers and ACEM doesn't hold specific data on candidates who are pregnant or postpartum. Seeking some anecdata, I reached out to an Australasian-wide Facebook group for doctors who also happen to be mothers. I received many messages with eye-popping stories of women, from all different specialties, who had attempted to balance babies and examinations. A common theme was the degree of support offered by the different colleges, ranging from the Dark Ages to refreshingly comprehensive. What became clear is that ACEM is one of the better colleges, with a dedicated policy for candidates in this position.

What support does ACEM offer?

The College actually offers a lot of support to pregnant and postpartum candidates, but unless you've been made aware of the policy (or come across it during your revision), it's not easy to find.

What is the policy?

The *Pregnant Examination Candidates and Candidates Nursing an Infant* Guidelines outline modifications that can be made to accommodate candidates, for example, taking food into the examination, bringing a cushion to sit on or being seated close to the bathroom. For breastfeeding candidates, it covers modifications such as appropriate breaks, space to express milk, being exempt from lengthy post-OSCE quarantine, or being allocated a morning or afternoon circuit as necessary. Using this policy, I was seated close to the bathroom for the Written and was exempt from quarantine for the OSCE. Specific questions can be directed to Primary.exam@acem.org.au or Fellowship.exam@acem.org.au

How much does it cost?

NOTHING! Fees for applications for special circumstances in the case of pregnancy or birth are waived.

What if I need to withdraw after the census date?

That's ok. There is no financial penalty for withdrawal post-census date for reasons related to pregnancy or birth, regardless of whether or not there are any medical complications.

Where can I find the policy?

It can be found on the ACEM website under Policies and Regulations — policy number TA657. It will soon be available on the examination resources homepage along with an explanatory video.

Deciding to sit the examination

The decision to go ahead with the examination is a personal one. Every trainee's circumstances are unique and it's not a one-size-fits-all approach. You need to be academically and psychologically ready. Academic readiness is easier to gauge based on performance in trial examinations and past papers. I would strongly recommend you get the objective opinion of a supervisor who you trust to give an honest answer about your performance and readiness to sit the examination. Psychological readiness is something only you can know but is just as important. The additional challenge of being postpartum will inevitably make it harder to pass. The postpartum period is one of heightened emotional vulnerability so you need to have a 'performance buffer' to protect you, particularly for the OSCE. My decision to go ahead was partly based on the fact that I felt (and was given similar feedback) that I was ready to be a FACEM and I knew having a baby wouldn't fundamentally change that. Nevertheless, I had to acknowledge there was a significant chance I might not get through. Failing an examination can be a huge psychological knock, even in normal circumstances, and for those for whom it would be an absolutely crushing blow, it might be better to wait for the following or subsequent sittings.

Examination day – the reality

Turning up to an examination with a newborn at home was really hard. Sleep deprivation combined with postpartum hormones meant some stations (for example, paediatric resuscitation and mandatory reporting) were emotionally draining. There was also the guilt that I'd turned up to an examination when I 'should' have been at home with my baby. I still had dressings on my c-section wound and it was only the second time I'd left the house. I remember sitting in the holding room thinking I must be crazy or a bad mother, or both, and I was absolutely exhausted at the end, but I had to do my best not to get distracted by these thoughts and keep my eye on the prize – freedom.

Was it worth it?

For me, it was the right decision, particularly as the subsequent sitting was cancelled. My baby girl was four weeks old and knew nothing of what I was doing and I felt ready to sit the examination. It was liberating attempting something many considered to be ridiculous and the joy of having a little baby at home put the examination into context. Yes, it's important, expensive and something we've worked towards for years, but it's still just an examination and, whichever way it worked out, I already had the real prize at home.

With thanks to my study buddies Aruna and Ruella and all the bosses who supported me. Thanks also to Dr Kate Field, Deputy Censor-in-Chief, ACEM.

Some pearls if you've decided to sit the examination

Recalibrate your expectations around examination performance

If you are postpartum it is inevitable that you will be sleep deprived and your ability (and desire) to study will be reduced. Your examination performance will be affected to some extent and for high-achieving type As this is a very uncomfortable feeling. While you won't perform as well as you might have done without a newborn, if you are ready to sit the examination, you can still perform well enough to pass.

Quality over quantity

With all these competing interests you don't want to waste any time. Make every study session count and be selective about which seniors you practise with. My study buddy arranged daily OSCE practice with consultant examiners at our local hospitals, so we had high quality sessions with people who were familiar with the structure and requirements of the examination (including COVID-19 modifications) and could give us accurate feedback on our performance. Register for every trial examination but be flexible as medical appointments or an early birth might mean you end up missing some.

Make use of technology

One positive to come from the pandemic is Zoom. Pre-pandemic it would have been extremely difficult to do any practice with consultants without physically being present. Traipsing around hospitals with a tiny baby would have been virtually impossible. Zoom allowed me to do several sessions from home while the baby was sleeping or feeding. It meant I could continue to benefit from practising with my colleagues and record the sessions for later review. My supervisors also did one-to-one sessions with me when I was not able to join the group and I got to stay in my pyjamas!

Do as much as you can before the baby is born

Despite my intentions, I probably only did around 20 hours of reading/practice between the birth and OSCE. However much practice you think you'll do once the baby is born, quarter it and that's more realistic. Once you factor in caring for the baby, plus the sleep deprivation, topics that you'd previously go over in about an hour will now take close to four! Anything you can get done prior to the birth is therefore money in the bank.

Be kind to yourself

You're attempting something physically, emotionally and psychologically demanding on top of the standard examination requirements. Have realistic expectations about what you can do each day. You and your baby's wellbeing have to come first. When the baby arrives, your perspective changes immeasurably and you may well decide that the absolute last thing you want to do is an examination. That's ok – remember you have the option to withdraw without penalty.

The Roadmap for Tobacco in Australia and Aotearoa New Zealand

Smoking is a public health issue that has undergone a massive shift in public perception over the last 30 years. While once it was commonplace to smoke in cars, schools and restaurants, with children by your side, and to see cigarette advertisements on billboards and TV, the slow yet strong implementation of a range of regulations has led to significant behavioural changes in our communities.

This is evident in smoking rates in the general Australian populace, which has dropped from 43 per cent for males and 33 per cent for females in 1976, to 14 per cent and 12 per cent respectively in 2019.[1] Aotearoa New Zealand has also seen significant shifts with 13.4 per cent of adults smoking in 2019/2020, down from 16.6 per cent in 2014-2015.[2] Despite pushback from tobacco companies, large legislative changes continue to be passed to deter the public from starting smoking, to support them in quitting, and to reduce the harms of tobacco seen within our healthcare system.[3]

ACEM members and trainees see first-hand the effects of tobacco on the populace, whether it be from active or passive smoking. The New Zealand Government's recent announcement of the Smokefree Aotearoa 2025 Action Plan, which launched in late 2021, aims to work towards a smokefree future through targeting smoking-related inequities among Māori, Pacific peoples and disadvantaged communities.[2] Through the collaborative work of FACEMs and partnering organisations, ACEM will seek to actively aid this transition, not only to create a difference in the lives of New Zealanders, but to set an example for Australia and its future tobacco-related harm prevention.

ACEM's position

In 2021, tobacco smoking was still the largest single preventable risk factor for death and disease in Australia and Aotearoa New Zealand.

ACEM has identified the need for more regulation around e-cigarettes and tobacco use, and has detailed our position on this through S42: *Statement on Tobacco Smoking and E-Cigarettes.*

This statement, developed under the leadership of ACEM's Public Health and Disaster Committee, highlights the numerous key periods where encouraging smoking cessation for e-cigarettes and other tobacco products is particularly relevant, including pregnancy, adolescence, and middle-age and later years. The Statement also outlines specific approaches that involve strengthening regulatory systems, making products less available and affordable, and supporting current users to stop smoking, to ensure we can transition society to one that is smoke and e-cigarette free.

ACEM supports all jurisdictions moving to ban smoking, e-cigarettes, and smokeless tobacco products. The College urges the adoption of evidence-based approaches to reduce tobacco and e-cigarette use from a health perspective.

A short history of smoking reform

Aotearoa New Zealand

Aotearoa New Zealand started its public health response to the issue of tobacco consumption far earlier than Australia, or indeed any other country. From 1963, cigarette advertising was banned on TV and radio, and health warnings were displayed on packs from 1974. In 1984, Aotearoa New Zealand's first tobacco control program began with smokefree policies, taxation measures, health education, support to quit, health warnings, smokefree environments, regulation of tar content, and a ban on tobacco event sponsorship. As a result, between 1985 and 1990, Aotearoa New Zealand had the most rapid reduction in smoking among OECD countries. Tobacco taxation was introduced in the 1990s and stricter marketing regulations were brought in. Recently, in 2006, 2014 and 2019, the Smoking Not Our Future, Stop Before You Start and QuitStrong campaigns were launched to target vulnerable teenagers and ensure education is utilised as a preventative measure against tobacco use.[2,4]

In Aotearoa New Zealand, the Māori population has been identified as vulnerable to smoking and its effects. This is especially evident as Māori smoking rates are higher than those for the overall population, with Māori women having the highest smoking rates in any population, at 32 per cent and Māori men at 25 per cent. Comparatively, the smoking rate is 13.4 per cent for the general population, meaning smoking within the Māori community is three times and two times respectively higher than the national average.[2]

iStock.com/Bowonpat Sakaew

Australia

The Tobacco Advertising Prohibition Act 1992 was introduced in Australia to ban advertisements that encourage people to smoke or use tobacco products. This also led to the introduction of laws that restrict sponsorships and retail displays of tobacco products by states and territories. This strong stance against smoking was a key moment in tobacco legislation, with multiple reforms being introduced in states and territories after this period. In 2011, the Tobacco Plain Packaging Act 2011 was established to ensure that all packaging was a certain colour and did not display brand images, promotional text or logos. Within the same year, the Competition and Consumer (Tobacco) Information Standard 2011 stated that all tobacco products must display graphic health warnings to make consumers aware of the long-term effects of the product.[3] Concurrently, the introduction of a tobacco tax, which led to a 25 per cent increase in tobacco excise, reduced the affordability of products like cigarettes. The tax, which was initially increased by 25 per cent in 2010, has since been increasing annually by 12.5 per cent based on average weekly ordinary-time earnings, to ensure that tobacco products become less affordable over time. [5]

Through these active changes, in less than 40 years, the everyday consumption of tobacco has changed from being a normal part of life, to one that removes the use of it in shared spaces such as public transport, schools and airports. [3]

Indigenous Australians have a higher smoking rate than non-Indigenous Australians, with rates being almost three times higher at 43.4 per cent in comparison to 15.1 per cent in 2018.[6]

New challenges and reforms

The rise of vaping and the challenges it poses for reducing harm

While targeted ads have been produced to highlight the physical impacts of active and passive smoking, the recent prevalent use of e-cigarettes, colloquially known as vaping, has increased in popularity.

E-cigarettes, when first introduced, were marketed as the miracle cure for smokers, as they were thought to be less harmful than tobacco smoking and aided smoking cessation.[7,8] However, neither of these assertions have been proven. Conversely, information has been released that suggests this method does not reduce one's dependency on cigarettes but is actually a gateway to smoking, with previously statistically unlikely groups, such as young people, taking up e-cigarette use.[9]

The introduction of this form of tobacco consumption has caused concerns there will be a rise in health issues that we previously saw decline over the ages. Beyond the direct health impacts of being dependent on nicotine, there are other risks as demonstrated by data from the US Centre for Disease Control, which, in 2019, was notified of over 2,600 cases of e-cigarette or vaping product use-associated lung injury (EVALI), with the median age of those affected being 24 years old.[10] This new issue has little to no longitudinal studies covering its long-term effects, and regulation is only now starting to catch up, as is healthcare, with legislation being introduced in 2021 for mandatory prescriptions for vaping product purchases, and public awareness slowly increasing around the effects of its use within Australia and Aotearoa New Zealand.[11]

iStock.com/Yaroslav Litun

Smokefree 2025: Zero smoking target and the smokefree generation

In order for Aotearoa New Zealand to reach its zero smoking target by 2025, ACEM recognises there is a need to implement the regulatory measures of reducing availability, targeting vulnerable demographics, having a smokefree generation policy, and reducing nicotine in smoking products. The implementation of these reforms will lead to the end goal: a smokefree generation that will not suffer the effects of tobacco-related harm and declining smoking rates in our society.

The Smokefree Aotearoa 2025 Action Plan has established that the key to ensuring smoking rates continue to decrease is to identify the smoking inequities that exist, and the groups that are disproportionately affected by tobacco-related disease. In addition, minimising availability of tobacco and reducing nicotine in smoking products are integral means of reaching the target. A smokefree generation policy, which prohibits the sale and supply in public places of tobacco products and e-cigarettes to new cohorts under the age of 18, at the time legislation commences, is also a key step forward.

While the public health response to the issue of smoking has been successful in recent years, evident in the declining smoking rates in Australia and Aotearoa New Zealand, the rise of e-cigarettes risks changing this trend. Responding to misinformation around new tobacco products such as vaping is key to ensuring that instances of tobacco-related diseases do not continue to rise within our communities. Investing in our campaigns and regulations today will keep us all healthy and keep our future communities free of tobacco-related disease.

Author: Arshdeep Cheema, Policy Officer

References

1. Greenhalgh EM, Bayly M, Winstanley MH. Trends in the prevalence of smoking [Internet]. Tobacco in Australia: Facts and Issues. Tobacco in Australia; 1970 [accessed 1st February 2022]. Available from: https://www.tobaccoinaustralia.org.au/chapter-1-prevalence
2. Smokefree Aotearoa 2025 Action Plan [Internet]. Ministry of Health NZ. [accessed 1st February 2022]. Available from: https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/smokefree-aotearoa-2025-action-plan
3. Australian Government Department of Health. Smoking and tobacco laws in Australia [Internet]. Australian Government Department of Health. Australian Government Department of Health; 2021 [accessed 1st February 2022]. Available from: https://www.health.gov.au/health-topics/smoking-and-tobacco/about-smoking-and-tobacco/smoking-and-tobacco-laws-in-australia
4. History of tobacco control [Internet]. History of Tobacco Control | Health Promotion Agency Smokefree. [cited 1st February 2022]. Available from: https://www.smokefree.org.nz/history-of-tobacco-control
5. Tobacco excise [Internet]. Department of Health. [accessed 1st February 2022]. Available from: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/tobacco-control-toc~excise
6. Alcohol, Tobacco & Other Drugs in Australia, Aboriginal and Torres Strait Islander People [Internet]. Australian Institute of Health and Welfare. [accessed 1st February 2022]. Available from: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-people
7. National Academies of Sciences, Engineering, and Medicine. Public Health Consequences of E-Cigarettes [online]. The National Academies Press: Washington, DC, 2018 [accessed 25th January 2022]. Available at: https://www.nap.edu/catalog/24952/public-health-consequences-of-e-cigarettes
8. Australian Government Department of Health. About e-cigarettes. Department of Health: Canberra, 2021 [accessed 25th January 2022]. Available at: https://www.health.gov.au/health-topics/smoking-and-tobacco/about-smoking-and-tobacco/about-e-cigarettes
9. Lucas N, Gurram N, Thimasarn-Anwar T. Smoking and vaping behaviours among 14 and 15-year-olds: Results from the 2018 Youth Insights Survey. Health Promotion Agency/Te Hiringa Hauora Research and Evaluation Unit, Wellington: 2020 [accessed 25th January 2022]. Available at: https://www.hpa.org.nz/sites/default/files/Smoking%20and%20vaping%20behaviours%20among%2014%20and%2015-year-olds%20report2.pdf
10. King BA, Jones CM, Baldwin GT, Briss PA. The EVALI and youth vaping epidemics—implications for public health. New England Journal of Medicine. 2020 Feb 20;382(8):689-91.
11. Australian Government Department of Health. Therapeutic Goods Administration. Nicotine vaping laws are changing [Internet]. Therapeutic Goods Administration (TGA). Australian Government Department of Health; 2021 [accessed 1st February 2022]. Available from: https://www.tga.gov.au/blogs/tga-topics/nicotine-vaping-laws-are-changing

A Guide to Responsible and Safe Volunteering

Dr Megan Cox and Dr Jenny Jamieson

Planning work or volunteering in Global Emergency Care (GEC) well in advance gives you the best chance of a supported, safe and successful experience. There are many possible global EM work environments and ACEM's GEC Desk is always happy to be contacted for advice and guidance. Some of this planning may be logistical, other parts may be preparing to "cultivate an ethical sensibility." Cultivating an ethical sensibility is not about taking the fun out of what we do, but about ensuring that above all we do no harm to ourselves, to other individuals and to the communities within which we work.

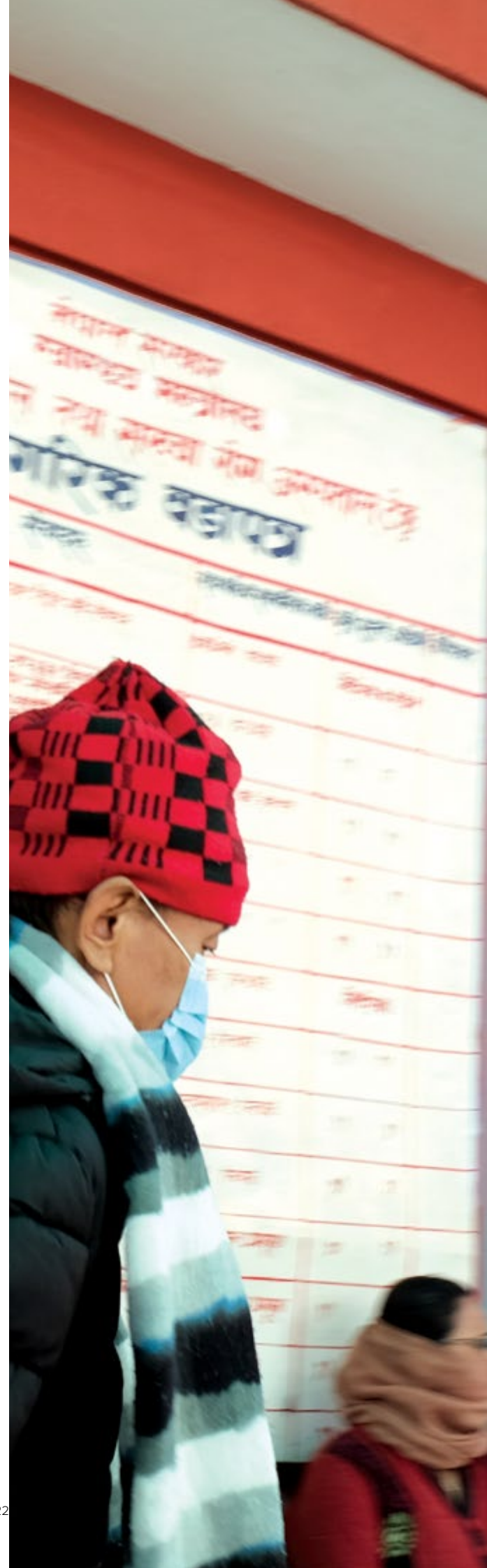
Term supervisors should be experienced in the ACEM special skills term requirements and have worked in global health settings themselves. Considering you will be working out of Australia; you will need to arrange a local ACEM and a host country supervisor for the term. Both these supervisors should be easily accessible, agree to be available to mentor you for the time frame and help you establish some achievable objectives for your time away. Best practice would be to meet/contact supervisors BEFORE you actually have definite plans, reducing the urgency in discussions and any potential ACEM training issues can be identified early. Discuss mentoring expectations before you go, when you are there and when you return. Host country supervisors should be contacted regarding logistics issues such as bringing donations, possible research projects and teaching expectations. There will be unexpected delays, problems and issues and discussing with them openly upfront will help prepare you for the unexpected.

More information

The GECCo team are all very approachable and enthusiastic, feel free to contact them via GECNetwork@acem.org.au

References

1. Thurtle N, Phillips G, Keage J, Wallis A, Mitchell R, Jamieson J. Perspectives on working and training in global health and international emergency medicine. Emerg Med Australas. 2014;26(6):635-8.
2. Sistenich V. International emergency medicine: how to train for it. Emerg Med Australas. 2012;24(4):435-41.
3. Sawe HR, Murray B, Jamieson J. Compassion fatigue in emergency providers: Experiences from Sub-Saharan Africa. Emerg Med Australas. 2016;28(1):109-11.



Take-Home Messages:

1. Early Investigation

- Consider possible work or volunteer opportunities and contact local supervisors and mentors.
- Review the Australian Council For International Development (ACFID) Practice Note for Responsible International Volunteering for Development as a guide for selecting a reputable organisation to volunteer/deploy with
- Email the GEC desk – GECNetwork@acem.org.au

2. Logistics and Documentation

- Review the ACEM GEC website
  Think about where you would like to work, in what capacity and document some objectives for the term
- Ensure you have appropriate in-country safety and security support including access to psychological support for the duration of your placement. The experience of COVID-19 for many working overseas is a testament to the importance of this.
- Ensure you have the appropriate insurance and registrations with the local medical board if intending to provide clinical care.

3. PREPARE before you leave

- Vaccinations and Health check. Visit your GP and discuss any health-related concerns. If you are working in a public hospital, arrange to see your vaccination clinic to check your Hep B, Tetanus and other immunisations (e.g. pertussis, measles status)
- There will be unexpected delays and problems. Even though you cannot predict these – discuss with family, friends and supervisor about your expectations and what could happen if there's a problem…breakdown in communication, personal or family member sickness, financial issues etc. This will be especially relevant if you are contemplating a remote, emergency or potentially dangerous mission.

4. DURING your time working or volunteering

- Remember that patient rights are universal
- Put the interests of the hospital and local community first and give local practitioners and trainees priority. Building relationships are key!
- Consider the broader implications of your presence in-country
- Think long-term sustainability
- Emphasise education
- Know your limits – it's easy to feel overwhelmed and that you "should" be doing as much as possible, but this is a fast-track to burnout.

5. PREPARE for you return

- Consider your own mental health- anxiety and depression are common (especially in emergency missions). Reverse culture shock is a real phenomenon and you should have realistic objectives for your return to work once your GEC term is over. Contact with psychologists or counsellors are recommended on your return. ACEM trainees and members can access ACEM Assist upon return to Australia or Aotearoa New Zealand.

In conclusion, be flexible, adaptable and as prepared as possible. There will be changes, difficulties and unforeseen issues; but you will learn a lot about yourself, your view of medicine and the world.

istock.com/mpalis

ACEM Launches the Global Emergency Care Community of Practice

The ACEM Global Emergency Care Committee (GECCo) is all set to launch the Global Emergency Care Community of Practice (GECCoP) early this year. Its aim is to bring together like-minded individuals to share ideas, innovations and opportunities, and facilitate effective communication and partnership between individuals and organisations engaged in global emergency care (GEC) capacity development across the Indo-Pacific region.

The multi-disciplinary GECCoP will form an important link between GECCo and the ACEM GEC Network. It will bring together the ACEM GEC special interest group, FACEM and trainee members, other individual ACEM-linked practitioners interested in GEC, ACEM's existing GEC partners and other GEC key stakeholders across the Indo-Pacific region. The GECCoP will meet virtually at least twice per year providing a forum for resource sharing, networking, and mutual learning among the GEC community. To promote multi-disciplinary engagement, GECCoP will be co-chaired by a FACEM as well as a non-medical GEC practitioner from within or beyond Australia and Aotearoa New Zealand. The term dates for co-chairs will coincide with the term of office of the ACEM Council of Advocacy, Practice and Partnerships.

Excitingly, following the expression of interest process conducted from December 2021, GECCo warmly welcomes the inaugural GECCoP Co-Chairs Dr Rob Mitchell (FACEM Chair) and Ms Sarah Bornstein (Non-medical Chair).

Dr Rob Mitchell

Rob is an Emergency Physician based at the Alfred Hospital Emergency and Trauma Centre in Melbourne, Victoria who has been a key advocate for the establishment of the GECCoP. He has been a member of the ACEM GECCo since 2018 and is the current Deputy Chair.

Through his PhD and ACEM GEC activities, Rob is currently involved in a number of emergency care projects in the Pacific, including Papua New Guinea (PNG), Solomon Islands and Vanuatu, focussing on emergency care systems, triage implementation and data registries. In addition, Rob contributes to the ACEM GEC COVID-19 online support forums for emergency care clinicians in the Indo-Pacific and the resultant research activities. He also is actively involved in the organisation of other key GEC events, including the annual GEC Conference and this year's ICEM 2022.

Ms Sarah Bornstein

Sarah is an emergency nurse from Sydney, New South Wales who has been working in emergency departments (EDs) around Australia and Papua New Guinea for the past 10 years.

Since 2020, Sarah has been working as Project Lead of the Emergency Care Capacity Development Support Model Project in PNG through ACEM. Sarah has supported the implementation of a new triage system in four PNG ED's, as well as provided support to emergency care teams during the COVID-19 pandemic. Sarah also actively contributes to GEC emergency nursing research, education and forums across the region.

Sarah completed a Bachelor of Arts and Master of Nursing at the University of Sydney in 2010, then completed a Master of Clinical Nursing with emergency specialisation in 2015 at the University of Tasmania. She is currently completing a Master of Global Health at the University of Sydney.

Participation in GECCoP is free of cost. There are two categories of membership: organisational and individual. The latter is for clinicians and development practitioners with an interest in GEC. Whilst the organisational membership is for those stakeholders involved in GEC capacity development, including those that have a direct engagement and established working relationship and those interested in learning more about partnering with ACEM.

More information

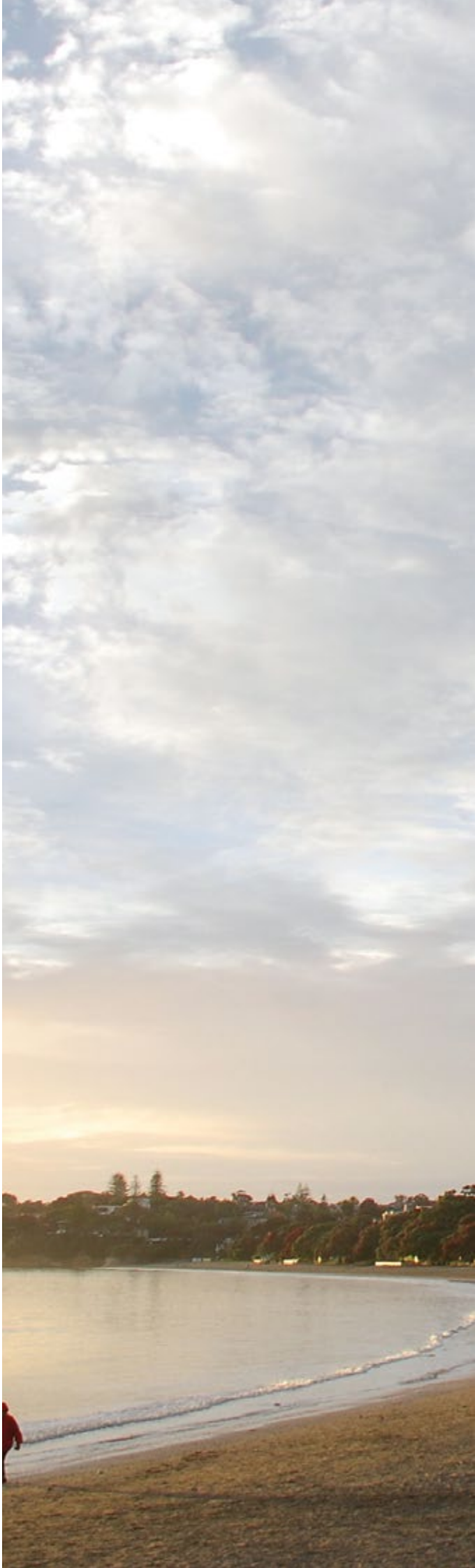
Further details about joining GECCoP and the inaugural meeting will be disseminated through the ACEM GEC Network and to GEC partners in the very near future. If you wish to receive any upcoming information, please contact the ACEM GEC Desk at: gecnetwork@acem.org.au.

Assistance program

ACEM Assist

ACEM Assist offers members and trainees free and confidential counselling, complemented by professional coaching and advice for both personal and work-related issues.

Australia: 1300 687 327
Aotearoa New Zealand: 0800 666 367



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