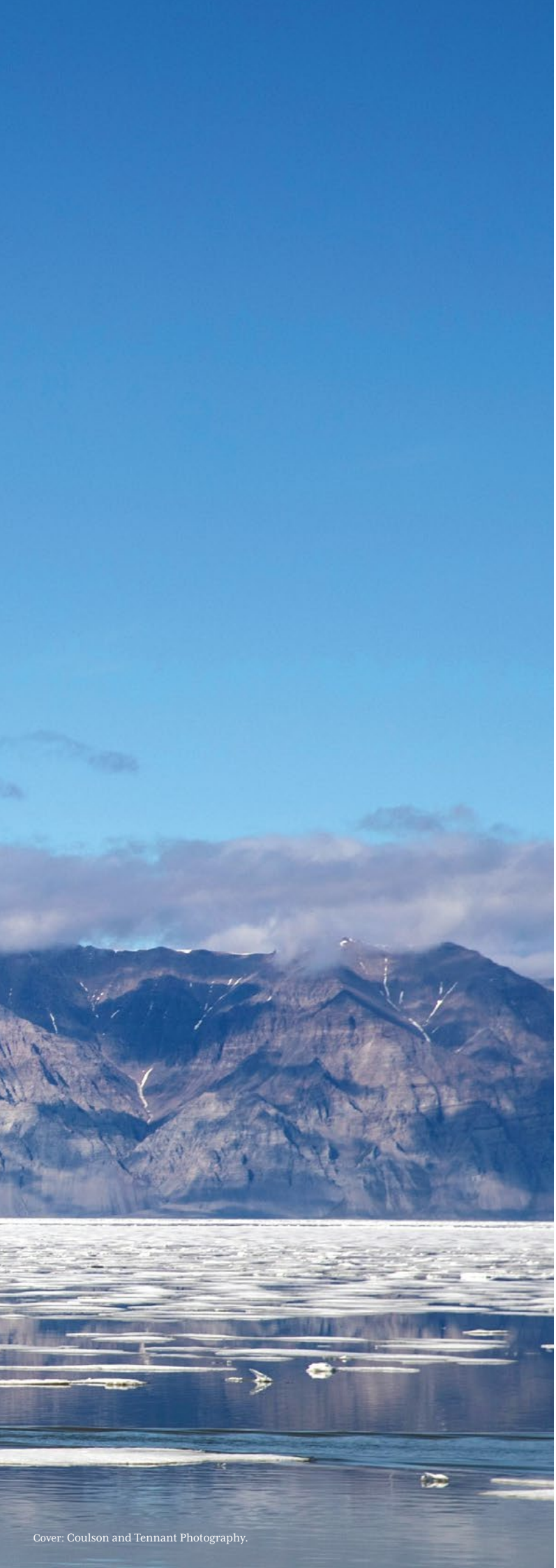
# your ED

THE OTHER SIDE OF YOU
Imposter Syndrome

WHAT IS RURAL MEDICINE?

WOMEN IN EMERGENCY MEDICINE
Around the World

GLOBAL EMERGENCY CARE
Humanitarian of the Year, Decolonising Language, and from the Polar Icecaps to Sub-Saharan Yemen



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# Australasian College for Emergency Medicine



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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*

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## Message from the Editor

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

In this issue, after focusing on Respect, Integrity and Collaboration in earlier issues, we focus on the last of the ACEM Core Values, Equity. We sat down with several College members and trainees to get their perspectives on equitable partnerships, workplaces, and healthcare for all.

We learn about the history of the College logo from ACEM Foundation Fellow Dr Bryan Walpole and the creative talents of Dr David Eddey, as well as the fascinating story behind the design elements. We hear from Dr Bec Cole with a poignant letter to her department and how to manage the emotional toll of imposter syndrome.

Our Global Emergency Care (GEC) stories for this issue come from Dr Sandy Inglis in sub-Saharan Yemen and the Polar Icecaps, IFEM Humanitarian of the Year Dr Gerard O'Reilly and his illustrious and impactful career thus far, and the GEC Desk tackles decolonising language as it evolves.

As the year draws to a close, I would like to take this opportunity to wish all members, trainees, and staff here at the College a safe and happy festive season.

We hope you enjoy these perspectives on emergency medicine. Please take care of yourselves – and each other.

# ACEM in the Media

In **August**, Aotearoa New Zealand Faculty Chair Dr Kate Allan acknowledged the difficulties faced by emergency physicians, while welcoming urgently needed government measures that aimed to improve workforce sustainability.

'No doubt it's tough out there at the moment, but this is about moving forward and about solutions,' Dr Allan told TVNZ 1.

'If the vacancies are filled, and we get the nursing staff and the doctors coming in, and we train our own as a long-term solution, then it will make a difference.

'It's a step in the right direction to get the workforce we need for our hospitals and for our communities.'

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In **August**, Victorian Faculty Chair Dr Belinda Hibble told *The Age* that quarterly health performance data from the Victorian Government illustrated more needed to be done to ensure patient risk wasn't concentrated in the emergency department (ED).

'[There are] a huge volume of patients that are spending more time in EDs than they have before,' Dr Hibble said, adding that data revealing 1,844 patients were in an ED for more than 24 hours didn't tell the whole story of what was happening.

'What you can't see is all the patients that sat for 23 hours and 22 hours waiting for a bed.'

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In **August**, ACEM President Dr Clare Skinner addressed perceptions that patients with minor medical problems were a key factor in ED waiting times.

'People who haven't had access to integrated … care in the community for months to years can develop chronic problems that get worse and they deteriorate to the stage where they need hospitalisation,' Dr Skinner told the ABC Online.

'[We need to] work out how to decompress that system and some of that is going to be adding capacity, and some of that is going to be making sure our processes are designed around the … real problems we see in clinical hospitals today.

'It's tempting to think if we just build bigger emergency departments that will solve the problem, but it doesn't, it just creates a new bottleneck.'

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In **August**, Dr Skinner explained how a struggling primary care system was resulting in further pressure on EDs and called for health system reform.

'We talk a lot about the "health system." But the truth is, we don't have a health system in Australia. We have a collection of health services that try, valiantly, to work together,' Dr Skinner said in a statement.

'Healthcare in Australia needs a fundamental re-think, and emergency doctors stand ready to work with the federal government, and other health stakeholders, to create a genuine health system that meets the needs of all Australians, now and into the future.'

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In **August**, Dr Hibble called for an increase in Victorian staffing numbers so that patients could progress through overcrowded EDs, after *The Age* reported on a patient who received treatment in an outdoor "holding area" designed to manage excess demand.

'Whenever a system is very clogged and overcrowded, all the parts within that system work less efficiently than they would usually,' Dr Hibble said, adding that patient offload areas 'risk concentrating resources at the front door'.

Dr Skinner also responded to the incident on Channel Nine's *Today*.

'Not only is this unsafe for patients and their families, but it's also very demoralising and unsafe for the staff who work in emergency departments… This is a sign that the entire health system isn't functioning as it should,' she said.

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In **August**, Western Australia Facutly Chair Dr Peter Allely explained that COVID-19 presentations are only one factor influencing the number of presentations emergency physicians are dealing with.

'COVID presentations are making up a much smaller proportion of our patients than was anticipated… The majority of patients that end up needing to be admitted have multiple other conditions and COVID is just the thing that tipped them over the edge,' Dr Allely told *The West Australian*.

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In **August**, the College announced the election of Northern Territory Faculty Chair Dr Stephen Gourley as ACEM President-Elect, a position he will formally commence in November 2022 before taking office as the President in late 2023.

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In **August**, Dr Skinner said that Australian state and territory governments have been left to deal with the consequences of a lack of federal stewardship for acute health care.

'The Commonwealth government does not run state-based health systems but it does fund them and it does allocate funding to them,' Dr Skinner told *The Saturday Paper*.

'Many of the states are really trying to do what they can with the resources they have. And the acute hospital system is overstretched because of failings in areas of federal government responsibility.'

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In **August**, ACEM stated that 25 newly announced Victorian-New South Wales Urgent Care Centres wouldn't address the larger problem of access block, with Dr Skinner telling *The Age* that only 'an increase in significant resourcing across the entire health system' would fix the problem.

'The primary driver of emergency department pressures are growing numbers of patients who are too sick, or too injured to go home,' the College elaborated in a statement.

'This issue can only be fixed by a significant increase in resourcing

across the health system, and particularly into inpatient capacity to accept patients.'

Dr Skinner also told the *Sydney Morning Herald* that the biggest issue EDs faced was patients who couldn't be sent home after their initial treatment because they required further care, a service that wouldn't be provided by an Urgent Care Centre.

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In **September**, the College advocated for a series of short- and long-term measures that would help address safety in Victoria's overcrowded EDs ahead of the state election.

The solutions included at least 1,000 fully staffed emergency department-accessible hospital beds across Victoria, appropriately trained 24/7 security guards posted at every Victorian ED and an increase in non-clinical staff such as cleaners, patient support assistants and clerical workers.

'We are seeing a perfect storm of lack of capacity, huge demand, overcrowding, and understaffing,' Dr Skinner told *The Age*.

'Healthcare workers are feeling the effects of burnout and moral injury and we need to urgently turn this around so we have a system that is fair and safe for Victorians if they need it.'

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In **September**, Immediate Past President Dr John Bonning told Radio NZ that the pressure emergency physicians and other staff were facing remained despite a drop in COVID-19 numbers.

'You work a shift in an emergency department where literally you've got patients in corridors and unable to get out of ambulances. It is really, really stressful and you go away feeling really sorry for the people impacted by that,' Dr Bonning said.

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In **September**, Dr Skinner expressed concern after quarterly health performance data from NSW Health revealed one in ten patients were leaving EDs before receiving treatment, telling the ABC's *The World Today* that it was a "major safety issue".

'We don't actually know what becomes of these patients once they leave the system. We don't know what experiences they have after they leave the ED, and we don't know what their health outcomes are,' Dr Skinner said.

'This is a marker of a system in distress.'

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In **September**, Queensland Faculty Deputy Chair Dr Shantha Raghwan told *The Courier Mail* that a nuanced, whole-of-health system approach was required to address delays in accessing ED care.

'What we need is a whole hospital and a whole system approach to improve the flow of those patients who do need to be in hospital, to get into those hospital beds, and in order to do that, we need to get those patients who are in hospital beds back into the community,' Dr Raghwan said.

'It's all a flow-on effect, and we're looking at symptoms, but the underlying cause is really an entire system that needs to be rejigged and... heavily invested in, in order to provide the resources required.'

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In **September**, ACEM called for Victorian Labor to match its pledge for expanded hospital infrastructure in the state's Northern metropolitan region with a similar level of investment and planning for the staff who will work within the new buildings.

'In implementing this pledge... it will be crucial to ensure that any investment is truly matched with commensurate investment and planning in relation to workforce,' Dr Hibble told the *Herald Sun*, explaining to *The Age* that staffing is an ongoing systemic challenge.

'Staff shortages remain a major and serious issue currently facing the system,' she said.

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In **September**, the College urged the Victorian Coalition to ensure their $325 million plan to address staffing and workforce issues would reach rural, regional, and remote areas.

'The health crisis is a bipartisan issue and Victoria's emergency doctors are pleased to see that health is firmly on the agenda, across the political spectrum, for the 2022 Victorian state election,' Dr Hibble said in a media release.

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In **October**, Dr Hibble reiterated that appropriately trained security guards were required on a 24-hour basis across Victorian EDs after raising concerns with a Victorian Liberal election pledge to trial protective services officers (PSOs) in select public hospitals.

'Instead of making emergency departments safer, the presence of PSOs could potentially decrease safety in Victoria's EDs for patients, staff, and carers,' Dr Hibble told the *Herald Sun*, explaining to ABC Melbourne's Drive why specialised guards were required.

'When you see them in action, and that the team functions really well, it's absolutely fabulous: They know when to step in, they know when to step back. They know their communities intimately and their communities have trust in them. They can read the situation so well alongside us,' she said.

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In **October**, Dr Skinner told a NSW Parliamentary Inquiry into the impact of ambulance ramping and access block on EDs that treating patients in corridors and waiting rooms had become an increasingly normal response to the difficulties of managing patient offloading.

'That means it's public, it's not dignified, and it also seriously limits your ability to perform a proper medical examination... it's just not adequate, and it's not safe,' Dr Skinner, who featured in a variety of print, broadcast and online coverage about the inquiry, explained.

'It's like working with a conveyor belt full of things you can't get to fast enough, but what's on the conveyor belt is human distress and suffering.'

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In **October**, ACEM released a commissioned report from the Sax Institute, titled *Access block: A review of potential solutions*. It analyses more than a decade of global research to ascertain four clear solutions for access block.

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# PRESIDENT'S WELCOME

Welcome to the Spring edition of *Your ED* and the last edition for 2022.

As the year draws to a close, and I sit at the kitchen bench to write this surrounded by the chatter of my family, I am reflecting on the year that's passed.

It has had some wonderful moments, with people, and communities, coming back together after two very difficult years. But with this has come more challenges. Climate change and natural disasters have devastated regions, especially across Australia and, health services around Australia and Aotearoa New Zealand have been pushed to their limits.

The ACEM Core Value for this quarter is Equity, and I have been asked to reflect on what this value means for me – both personally, and for emergency medicine and its practitioners.

Equity, put simply, is about fairness: it is to make sure that things are fair.

From the earliest age we know about this value and its importance, when we carefully eyeball every slice of birthday cake being handed out to make sure they are exactly the same size or we complain, "It's not fair!"

As we mature, however, we begin to realise that fairness is not just about equality. Sometimes, we need to give the larger portion to someone who needs it more.

Equity is about justness and considering the specific needs of those around us. It's about recognising that we do not all start from the same place, and that individuals sometimes need different environments, resources, and opportunities to flourish. A circumstance that may challenge and reward some may cause harm to others; or, to paraphrase an old Eastern European proverb, the same boiling water that softens the potato hardens the egg.

Equity shapes our professional lives constantly and informs the ways we interact with and treat patients, especially those in the most vulnerable positions. It is considerations of equity that ensure that a translator is provided for not only a patient in the emergency department (ED), but for their family as well, or that discharge plans reflect the level of access an individual may have to community resources.

Equity is something I continually see in emergency medicine and is something I believe we, as emergency physicians, are particularly good at. We FACEMs are fair to one another, to patients and to other health professionals. We work in ways that are impartial and aware. We acknowledge disparities in health outcomes across Australia and Aotearoa New Zealand, and we strive for a system and service that is better.

The College works to embody this value through various structures and systems designed to promote equity. *The Governance and Leadership Inclusion Action Plan* guides our work to promote positive culture change within ACEM and in EDs. The ACEM Inclusion Committee and Indigenous Health Committee guide equity in this space, and we work to address Aboriginal, Torres Strait Islander and Māori health inequities through our *Reconciliation Action Plan*, *Manaaki Mana Strategy*, and other College resources, scholarships and grants.

We work to attend to global equity through the ACEM Foundation, which contributes philanthropically towards three pillars: Emergency Medicine Research, Global Emergency Care, and Supporting Aboriginal, Torres Strait Islander and Māori doctors undertaking emergency medicine training. We also promote better gender equity with the Advancing Women in Emergency Network.

But there's a lot of work that needs to be done beyond the College and the various programs it has the capacity to establish and support. In our current moment, EDs are facing unprecedented challenges. We have been stretched to our limit – a case demonstrated by the recent release of *State of Emergency 2022,* produced by the College to quantitatively prove what we have all known for a long time.

The report contains data collected over the last 12 months from each state and territory across Australia. The findings are inarguable proof of the crisis EDs are currently in. There have never been more people requiring acute healthcare, people have never had such complex health needs and the system has never been so strained. It is crucial that health models and systems are redeveloped to help ease the burdens we currently face.

Equity is sometimes about recognising when we are placed in an unfair position – whether it be the position

of having to delay patient care because urgent scans aren't able to be done urgently enough, or chronically working overtime to try and help short and unsupported staff. Being able to acknowledge when something is inequitable on a personal level is something I know I have struggled with, and something I have seen my colleagues struggle with as well. We are so quick to put others before ourselves, but at a time when burnout is at an all-time high, this selfless and otherwise admirable attitude can be unsustainable.

The College is continually striving to advocate for our right to equitable working conditions. *State of Emergency 2022* is just one piece of a larger puzzle, which involves working with other colleges and organisations, as well as state and federal governments, to develop policy that will support EDs across Australia and Aotearoa New Zealand.

We must remember that it is alright to acknowledge when things are unfairly tough, and it is admirable to push for change. Please know that the College is working tirelessly to help address the problems we currently face and is using its knowledge and resources to guide and inform those who can enact real change. We are here to advocate for and support you.

But despite all of this, it is vital that we continue to appreciate and celebrate how incredible working in emergency medicine is. I feel extremely privileged to work in such a compelling and important field where our capacity to help others is so immediate. It is important to celebrate the rewards of this work as much as, if not more than, we acknowledge the challenges.

This is especially the case as we draw in to 2023 – a monumental year for the College as it marks its 40-year anniversary. I am amazed by the legacy past and founding FACEMs have left in just four short decades, and the contributions our current members and trainees are bringing into the future.

With this in mind, please enjoy the following articles and stories from the world of emergency medicine. This quarter, we are fortunate enough to share the perspectives of FACEMs working in metropolitan hubs and rurally, across our two countries and the world.

Thank you for all of the work you do, and know that we are here for you, whatever the next few months bring.

**Dr Clare Skinner**
ACEM President

# CEO's Welcome

**Emily Wooden**

As 2022 draws to a close we are well and truly in the 'new normal', coming out of lockdowns and looking to the future, with more face-to-face events and community gatherings. ACEM's Spring Symposium, held in Christchurch, Aotearoa New Zealand, heralded the last ACEM event of the year. The symposium included opportunities to reset, refocus and engage, including a Gala Dinner and various wellness activities.

It also featured a range of practical workshops, including topics such as toxicology and mentorship in the emergency department (ED), as well as lectures from medical and research leaders, addressing pertinent topics such as head injury trauma, wellness in emergency medicine and Māori and Aboriginal and Torres Strait Islander healthcare.

Across New South Wales and Victoria, we are again experiencing torrential rain and, consequently, many parts of these states have flooded. This is devastatingly not the first time many of these areas and communities have experienced rising floodwaters. The scale of the impact is unfathomable, and we hold these families, townships, health care workers and emergency personnel serving them in our thoughts during this terrible time.

This November, the Chair of the Council of Education and Censor-in-Chief of the College, Dr Barry Gunn, stepped down. I would like to offer my heartfelt thanks to Barry for all of his hard work and dedication. The College held a lunch in his honour, with all staff and colleagues celebrating his achievements. It was a privilege to listen to the stories of his efforts over the past seven years in the role. We look forward to Barry's continued involvement in the College and wish the incoming Censor-in-Chief, Dr Kate Field, all the best in picking up the baton.

I would also like to thank Dr John Bonning for his tireless efforts as President and Immediate Past President, as he stepped down from the role and his position on the ACEM Board at the 2022 Annual General Meeting (AGM) of the College. Working with John over the last six months has been a pleasure and I thank him for his dedication to ACEM, as well as his warm welcome. Ngā mihi John.

Dr Stephen Gourley took office as President-Elect following the College 2022 AGM, held on Monday, 28 November. All at ACEM are delighted to be working with Stephen as he steps into this role.

I wish everyone a joyful festive season and a safe and happy New Year, and look forward to seeing you all again in 2023.

# 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.


*We are fair to one another, to patients and to other health professionals. We work in ways that are impartial and aware. We acknowledge disparities in health outcomes across Australia and Aotearoa New Zealand, and we strive for a system and service that is better.*

**Dr Krupa Mehta**

*Dr Mehta is a FACEM Training Program trainee from Sydney, New South Wales and is based at the Royal Prince Alfred and Canterbury Hospitals. She has a particular interest in retrieval and disaster medicine.*

**Why emergency medicine?**

Is there any other speciality where you can go from removing popcorn from a toddler's nose to intubating an asthma patient? We know how to manage the first 15 minutes of most diseases yet have no idea how our day will start. And whilst there is the fair share of day-to-day cases, the extreme and exciting have a way of finding their way in at least once a week, which is more than enough to keep me going.

**Throughout your years of training and education, has there been a moment where you have recognised consideration/equity demonstrated towards yourself?**

Through my involvement in NoWEM (Network of Women in Emergency Medicine) and the Advancing Women in Emergency Network, I have seen firsthand the power of women supporting one another and building each other up. I would not have dreamed of organising events and becoming involved in developing leadership workshops had I not been given a gentle nudge. Incredible things happen when we support one another towards a common goal.

**How does equity assist in building a better/stronger emergency medicine system and service?**

Equity in the workplace allows us to come to work as our genuine selves and lets us stand in our own truth whilst we provide healthcare.

**What advice would you offer to someone in the workforce about creating an equitable environment for patients, colleagues, and departments?**

See what the gaps are, speak to the people affected and start with small tangible solutions.

An example of improving health equity in non-tertiary hospitals could be emergency dental care. It is often done poorly, is highly sought after with long wait lists and there are increased rates of tooth decay in regional and remote area patients. A way to improve this would be to work with local dentists and get in touch with tertiary maxillofacial surgeons

to provide teaching. Necessary equipment can be updated and local policies including Free Open Access Medical Education (FOAM) resources "resources" can be disseminated to staff.

**Equitable healthcare for all is one of ACEM's cornerstones, would you like to elaborate on your feelings towards this?**

I have very strong feelings about the health inequities experienced by Indigenous, migrant and refugee populations. Your postcode should not dictate the level of care received. Patients should be getting the very best care possible no matter where and when they present. This may be a very rose coloured glasses view and I realise that Australia is a large country with people needing to travel long distances to access healthcare at times. Even so, in Sydney a patient can have a very different experience attending a smaller, outer suburban hospital versus going 20 minutes up the road to a tertiary service with all the bells and whistles. The Local Government Area lockdown rules for Sydney were a clear example of outer suburbs suffering from health inequities.

I would like to improve access for all patients to these said bells and whistles and this has a lot to do with funding, but I believe we are responsible for creating change and working towards doing the very best we can with the resources available and striving for more.

**Dr Matt Bray**

*Dr Bray is a Rotuman-Australian FACEM Training Program Advanced Trainee based in Naarm, metropolitan Melbourne, Victoria, soon to complete a Masters in Public Health and Tropical Medicine. His advocacy on equity is informed by experiences working with First Nations people, asylum seekers, the Pasifika community and clinical work in Fiji.*

**Why do you feel that equity is an essential part of emergency medicine?**

We like to think that calamities like freak accidents are the great leveler and do not discriminate. But to take my recent experiences in a major trauma centre, consider for a moment the majority of road accidents involving large vehicles or workplace accidents involving heavy machinery. The demographics of people working in professions of operating heavy machinery are going to be skewed towards lower and middle income groups, migrant workers, Indigenous people and other People of Colour. It is a cross-section skewed towards existing backgrounds of disadvantage, who remain at greater risk of misadventure due to the nature of their jobs, but then whose disadvantage amplifies their suffering and their risk of having their complaints misunderstood through language, cultural barriers and racial biases. So we need to be aware of these, talk about them, critique and challenge these notions so as to be sensitive to and proportionate in our attentiveness to those greater needs.

Some people might fear that attempts to address equity in emergency departments (EDs) means special treatment for certain populations, or diverting attention from those most medically in need of our expert care. These concerns are unfounded: just as a critically ill multi-system trauma patient requires skill, time and attention, so too does an unwitting victim of circumstance, who brings with them suffering, disadvantage and risk through traumas of a different kind. We can't hope to address all the drivers of disadvantage through one episode of patient care: this would be foolish in a system already so overwrought with demand. But what we can hope to be is sensitive and attentive to the impacts of biases, ambitious and courageous in our care, and strive to ensure our patients and peers encounter the fair opportunity to give or receive care that is unencumbered by legacies of inequality or injustice.

**How do you foster an equitable working environment?**

Clinicians from diverse backgrounds are especially honed to address inequity and injustice because we live those barriers and biases and so bring a lot to the table. But it is everybody's responsibility and everyone's business.

All the cultural sensitivity training in the world cannot compete with the humanity of diverse clinicians who are, just by being themselves, better placed to relate to a diverse patient cohort, meet them where they're at, and advocate for the systemic changes needed if they feel empowered and respected to be able to do so.

Our nursing peers are excellent at this and the diversity of the emergency nursing profession is an asset to our emergency care system as a whole. The more our emergency physician cohort can mirror our community, the more holistic, efficient and satisfactory our therapeutic relationship will be for all.

**Equitable healthcare for all is one of ACEM's cornerstones, would you like to elaborate on your feelings toward this?**

I was drawn to this specialty particularly on the merits of its egalitarian nature: we see all-comers at all hours no matter the circumstances. This fosters a particular humanitarian streak among the Fellows of this College and remains one of the reasons I seek to join their ranks, but there is always more work to be done.

We need the diverse voices and experiences of our medical cohort to be representative of our patient population, and we need lots of these voices to drown out the echoes of privilege, of colonisation, of hierarchies that fail to serve our communities.

I can see the College making great strides in the equity space, in acknowledging the needs of First Nations, tangata whenua and Pasifika people, in particular, to receive fair care in our departments and enjoy better outcomes. The more we talk about this, the safer and more welcoming our departments and our specialty becomes for the next generation of emergency physicians who will see their face and their place among our Fellows, and bring their own giftedness and uniqueness to animate the mission of the College and enhance our care of patients in Australia and Aotearoa.

### Dr Suzanne Moran

*Dr Moran is an emergency physician from Tauranga, Aotearoa New Zealand, based at Rotorua Hospital, Te Whatu Ora Lakes and has a particular interest in quality improvement and system design.*

#### What is your current role and title?

Head of Department at Rotorua ED, I also work one day a week in an advisory role in our Strategy Planning and Funding office.

#### Why emergency medicine? What inspires you to keep working in this field?

I chose emergency medicine before I chose a career in medicine; I was drawn to the variety and drama (too much Casualty and ER). Once I experienced it first hand I loved that I could make a difference quickly to patients and I also enjoyed the flatter hierarchy of ED, which I think fosters a unique team atmosphere that I love working in.

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

Talking to people – staff or patients – and finding out more about them. You get to meet and work with some very interesting people.

#### What does work/life balance mean for you?

For me it means that I can enjoy my job but I can also leave it behind when I walk out at the end of the shift. Stepping into my other role as a wife and mum and being present for my family rather than answering work emails is important. I lost that balance significantly during COVID-19 and it had a detrimental effect on my energy levels and mental well being – it made me realise just how important it is to enjoy my time away from work and prioritise holidays and days off.

#### Why do you feel that equity is an essential part of emergency medicine?

If you have a system that does not provide equity for everyone in the system then no one is safe. This applies to clinical as well as non-clinical operations, and staff as well as patients.

#### How do you foster an equitable working environment?

I always try to come from a place of good intent and I'm open to critical feedback. I think it is important to foster an environment where colleagues show respect and value others, regardless of their role or position in the team. You have to include everyone when you think about the team rather than just focusing on the clinical staff. Accept that you may get it wrong sometimes and seek to understand and grow from the mistake. Be transparent in your actions and communication. I think its also important to be an ally – speak up, stand up and support others who may be feeling isolated or excluded.

#### Is there a time you have recognised something that seemed unfair/inequitable and made a change?

In a previous role I found out that all of the male specialists in the team were paid considerably more than the female specialists. Once my male colleagues realised this they were fully supportive of bringing about a change in contract. I negotiated for everyone to be on the same contract – which was better for everyone. In my current role, seconded to Strategy Planning and Funding, I'm able to get more involved in partnership with colleagues in Māori Health to develop better clinical processes and pathways that work for Māori – it is providing me with insight into the challenges that the system holds for Māori and how we can take steps to provide an equitable service for all of our patients.

#### Equitable healthcare for all is one of ACEM's cornerstones, would you like to elaborate on your feelings towards this?

Inequity in healthcare is avoidable as well as unjust and unfair. By acknowledging that it exists and taking a positive stand to change that situation, ACEM is an active advocate for equity for everyone in the healthcare system. Making it a cornerstone allows ACEM, and its members, to improve understanding of equity, gain knowledge about how to improve and challenge inequity and use the mana of the College to push against resistance to change.

**Dr Bhushan Joshi (He/Him)**

*Dr Joshi is an emergency physician in Sydney, New South Wales. He is an openly gay person of colour, and founder and chair of GLADD – The Association of LGBTQI+ Doctors and Dentists Australia. He is also a member of ACEM's Inclusion Committee.*

Like most of you, I love working in emergency medicine. I love the buzz, the moment-to-moment connection with my patients and the ever-changing environment. I love the variety, the variety of clinical medicine but also the variety of patients and staff. I think traditionally, because emergency medicine is so dynamic and frontline, it attracts a diverse range of staff and patients; this I believe is one of its key strengths.

We are all one, yet we are many. Regardless of where we are from or who we are, we all need food, shelter, safety, respect and access to the same excellent level of healthcare. That's where equity comes in. Striving to deliver health at the same standard to each of our patients, I believe, is paramount to good medical practice; and it comes from one of the core principles in medical ethics of justice.

But how does one deliver equitable healthcare when we are all different?

To me there is no conflict, and I believe it starts with us. We have to be aware of our own biases and put these aside. We also have to recognise and celebrate peoples' differences with a curious mindset. After all, what works for us, may not work for someone else. Sensitively asking questions when we don't know and being open to different models of the world will not only help individualise the care we provide to our patients, but will also improve their health outcomes.

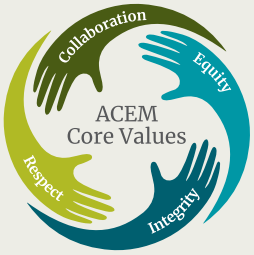
Taking a cultural history, asking pronouns, asking patients what they need and expect of us and not making assumptions about gender or sexuality are just some of the simple and effective ways we can make our patients feel comfortable and tailor the care we provide. Understandably, some questions can be uncomfortable for both us and our patients, so it's important to remember to only ask questions if the answer will affect patient care.

I, for example, as standard practice always ask whether my patients have sex with men, women or both when taking a sexual history regardless of their gender, or I always ask what the family cultural norms are when having discussions of end of life care and I, of course, don't ask about sexuality when treating hypertension.

As a department some of the things we can do to be more equitable is to acknowledge the diverse groups we serve so that we can tailor our services to them. Using interpreters, having Cultural Liaison Officers, social workers, and religious leaders are some of the ways you may have already heard of. But other more subtle ways could be the use of gender neutral toilets, name badges with pronouns and a greeting in different languages spoken by that person, patient registration that allows the use of pronouns and gender neutrality or welcoming posters in the waiting area suited to different community needs.

Education also plays a key part in providing equitable healthcare. Training staff members in what is, and what is not, culturally appropriate for different groups can be very useful. Training in cultural safety, LGBTQI+ awareness and Trauma-Informed Care can especially be useful when working in an environment with a high demographic of these patients.

One of ACEM's cornerstones is equitable and fair healthcare for all, and I am proud that we as a college embrace this value. To me it shows an openness and respect for the diverse members that represent our College, as well as the patients we serve. Equity does lead to better outcomes; less did not waits, more tailored treatments, and greater satisfaction for staff and patients, and I am confident and believe that with genuine curiosity and interest to help others we can make the emergency care we deliver more equitable and just for all.




**More information**

For more information about ACEM's Core Values, visit: acem.org.au/corevalues

# Dr Tracy Walczynski


Dr Walczynski is the current Director of Emergency Medicine Training at Albury Wodonga Health, New South Wales. Her interest in clinical education was deepened by experiences working overseas in Uganda, where emergency medicine systems are in their infancy but already making a big impact on patient care. Beyond her role in education, she has an interest in health equity, human factors and the joy of raising backyard chickens! Tracy recently learnt the expression "a squiggly career" and thinks it is probably an apt description for her journey.

### Why emergency medicine?

Like many I tried a few different options early on in my career but kept getting attracted back to emergency medicine. I enjoy working in the team environment, clinical work supported by a community. And, of course, all the cool things we get to do. The high-stakes stuff – standing at the end of the bed leading a resuscitation, performing life-saving interventions that immediately alter a patients' clinical course. The "arts and crafts" part of the day – I sometimes feel like the proud kid coming home from school with a gold star when I manage to execute a perfect fracture reduction, well applied plaster, or an impeccably sutured wound. And the little things that we say and do that make a difference along a patient's journey – the cup of tea, the kind word. Emergency medicine is predictably unpredictable – each day it is a different mix and on most days there is still some new challenge, piece of knowledge or way of doing things that keeps you on your toes.

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

Communication, communication, communication. It can be so satisfying when done right but so easily slips through your fingers if you are distracted and don't pay careful attention to cues. It is the hardest thing that we do day-in day-out, with colleagues, patients and families… especially when trying to talk about risk or uncertainty – the grey area where we spend so much time playing in the emergency department (ED). And balancing the value of a clinical pause, a moment to listen, with the impetus of disposition.

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

Having the opportunity to work with a small group of dedicated colleagues in Alice Springs to bring the vision of the Medical Retrieval and Coordination Centre into existence. It was a project to improve timely access to critical care services for remote communities and streamline retrieval referrals. We worked some crazy hours but managed to do it in an abbreviated time frame with minimal resources. This experience set me up for working with the Australian Medical Assistance Team, helping orchestrate clinical and operational requirements for the Centre for National Resilience quarantine facility at Howard Springs, during the early phase of the pandemic. The biggest reward of the project was being able to bring people home who had been stranded overseas, sometimes with no job and minimal funds, re-uniting families and keeping the community safe during a period of great uncertainty.

### What inspires you to continue working in this field?

All of the different people I work with. The trainees who bring a thirst for knowledge and enthusiasm to work each day. Australian College of Rural and Remote Medicine (ACRRM) and GP colleagues who bring a complementary set of expertise and perspectives to the regional ED, and are keen to share ideas and skills. Referring to the communication challenges above, some of the most masterful communication I have witnessed were GP colleagues navigating complex issues with patients in the ED. Nursing colleagues who are the bedrock holding the system together and the safety net for patients (and for my practice as well). Paramedics who carry patients from the uncontrolled environment of a bedroom, a roadside, a shopping centre floor, to the department – the patient lying neatly packaged on a white sheet belies the challenges faced on the transition to the hospital. Most of all, I am humbled by patient stories themselves, and the privileged position we are in when we hear them and bear witness to their lives.

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

Don't feel the need to stay still. If given the opportunity, spend some training time in a regional or remote centre. There are so many opportunities, interesting people and different ways of doing things out there. You will learn so much more about medicine and about yourself, by working in different settings and environments. Get comfortable with being a little bit uncomfortable.

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

At the interface of so many sectors of the healthcare system, the emergency medicine faculty is in a great position to consider and advocate for changes needed on a larger scale beyond our walls. Supporting our primary care and nursing colleagues for better pay and conditions, valuing a diverse workforce and speaking out for the impact that climate change is bringing to the door of our departments.

# The Medicine is the Excuse that Gets Them Through the Front Door

For Dr Louis Christie, the need to take a step back from the demands of working in a New South Wales regional emergency department (ED) was self-evident.

'None of us were particularly focused on self-care,' Dr Christie explains, looking back on his time in the ED during the 2000s.

A FACEM in the Western New South Wales Local Health District who worked out of Orange, the stresses just kept building. And building.

'I did all the dumb things. I basically got myself into a one in two on-call roster, I was working in a rural emergency department that was quite short-staffed, and I was regularly doing 70-to-80-hour weeks.'

Performing resuscitation on people that he knew socially in the town of 40,000 people had become a draining yet familiar occurrence, and he wasn't the only clinician on the verge of burnout.

The suicide of a colleague, in part influenced by the pressures of work, was a moment that forced Dr Christie to consider shifting how he managed his approach to medicine.

'I couldn't keep doing what I was doing,' Dr Christie says now.

Elsewhere, in Tamworth, a NSW regional centre similar to Orange, Dr Philip Hungerford, a FACEM in the final phase of his career in emergency medicine and intensive care, found himself reflecting on the patients presenting to the ED, specifically, the cohort dealing with an end-of-life diagnosis.

'Sometimes they had a plan for what they wanted as the end of their life approached but more often than not, they didn't,' Dr Hungerford explains, adding, 'Some sort of crisis would occur, and they would end up in the ED or the ICU having lots of tests and treatments that they didn't really need or want.'

Through "trial and error" over the years he learned how to manage and conduct the difficult conversations with patients and their families when those situations arose.

'I started to appreciate more and more the value and importance of these conversations and of the time invested in having them,' he adds.

He also began to consider the importance of palliative care medicine after helping to look after some members of his own family when they reached the end of their lives.

'We had a few deaths in the family over a number of years: Mum, Dad and a brother-in-law. We looked after them at home, and experiences like that teach you a lot about palliative care – What's needed, what works and what doesn't work,' he says.

'Seven years ago, when I turned 60 and I was tired from 25 years of being on call, some planets seemed to align in my work life. The above factors plus an opening at the hospital for a palliative care doctor that couldn't be filled, and I thought, "I could do that!"'

'As it turned out, it was a good decision for me. I found it to be really rewarding. It was a "finishing school" for both my career and for me personally.'

While Dr Christie and Dr Hungerford arrived via different pathways, working as Palliative Care Specialists has opened new ways of thinking about medicine for both FACEMs, their emergency skills and knowledge providing a sound base to work with end-of-life patients.

So what does a typical day look like for a regional Palliative Care Specialist and how do those prior emergency skills come into play?

For Dr Hungerford, a typical case load involved interactions with inpatients and their teams, visits to patients in smaller centres across the region, along with some tele-consults.

'Sometimes I'd talk to patients and their families in their homes either on the phone or on the screen, or sometimes I'd talk to a rural GP who just needed a bit of advice,' he explains.

'The experience I'd had in tele-ED meant that I was comfortable using this technology in my palliative care practice.'

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Meanwhile, for Dr Christie, a typical day will begin with a discussion about patients alongside his nursing and other colleagues in the palliative care team, following up with a lightly booked morning roster, including a ward round.

'That leaves the late morning and the afternoon to be doing home visiting and dealing with the things that come up in the community,' he explains, with visits to residential and clinical sites across the Central West of NSW a frequent feature of his work.

'The aim is to try and keep people who are best managed out of the ED, out of the ED, and out of the acute hospital setting.'

Dr Hungerford, who is now on leave as he approaches his official retirement date, found immediate use for some of his prior experiences as an emergency and intensive care specialist in his new role.

'In some ways the conversations with the patients and their families weren't that different… listening carefully, guiding them, explaining what's going on, trying to come up with some plans for them,' he says, but admits other changes were more difficult to grasp.

*'I found it to be really rewarding. It was a "finishing school" for both my career and for me personally.' Dr Philip Hungerford*

'There wasn't the scope for me to be able to do any high-end procedural work in that particular palliative care job, so the feeling of my procedural skills gradually fading away, I didn't like at all, but I've come to accept it.'

Interestingly, Dr Christie says he gets the opportunity to utilise his procedural skills, though to different ends than what he experienced during his time practicing in emergency medicine during the 2000s.

'I do quite a fair bit of ascitic drainage, quite a fair bit of pleural drainage, minor procedures, nerve blocks – familiarity with minor procedures has been really helpful, but I've always enjoyed that.'

Dr Christie commenced in palliative care in 2011, at the behest of a professional mentor, having temporarily moved into administrative hospital work, after leaving the ED due to the pressures and burn-out that he earlier experienced.

He says the shift in the sense of expectation he feels as a carer for patients is a key factor of why the work appeals to him.

'One of the big differences in 'pal care' for me, was that the burden of that contract is different because no one comes to me expecting I'm going to save their lives,' he explains.

'The contract is now, "We will look after you, we'll look after your family, we'll make sure that things are as good as they can be, and after you've died, we'll make sure that your family are okay." And that's a much easier contract to come to terms with.'

He also believes the reason his skills as a FACEM have translated so directly to palliative care have come from the broad understanding of medicine his training as a FACEM has instilled, including the ability to manage multiple dynamic and unpredictable situations.

'A lot of it [palliative care] is about undifferentiated problems that have emerged in people who are now acutely deteriorating or changed, it's about being able to develop a broad, comprehensive, clinical plan, often in the absence of detailed clinical information, and sometimes looking at referral on, or engaging other services.'

Nevertheless, if, as Dr Hungerford mentioned earlier, adapting to specific type of procedural work (or lack of it) was a challenge, Dr Christie instead found that the slower tempo

of palliative care took time to become familiar with.

'Urgent meant in the next minute and a half, and routine was something that you were going to do in the next four hours,' Dr Christie says of his time in the ED.

'But in palliative care, there are definitely a few urgent things that pop up, but even threatened spinal cord compressions and things of that ilk, the timeframe is still hours not minutes.

'Getting used to the fact that we could actually make some changes today, and then come back and see somebody in a week's time and see how that had worked was very difficult to get used to.'

However, the change of pace means that a conversation with a patient can be its own kind of treatment, as Dr Hungerford found while working with terminally ill patients considering long trips from Tamworth to a major or metropolitan health centre for treatments, tests and procedures.

'Patients who have cancer and who are getting near the end of their life, sometimes get offered a trial drug of some description,' he explains.

'For patients in Tamworth this often means they would need to travel to Sydney, which is a six-hour drive – a big deal for someone who is usually quite frail. A plane trip would be equally as taxing.

'At the same time, they or their family may be thinking, "This is a day out of my life to get there, a day out of my life to get back, three days of my life in a teaching hospital sitting around listening to doctors, having tests, getting injected with medicines that might make me feel even sicker, driving back home, feeling terrible for weeks, and all for a treatment which probably won't change what's going to happen to me".'

'They're looking for someone to say, "You know? It is a week out of your life when you haven't got that many weeks left and if you're all about quality of life and not quantity, it's okay not to have the treatment.'

'It's like you have given them back a week of their life that the medical system was trying to take away – it's a different sort of outcome and reward to successfully intubating someone and saving their life, but it's very rewarding, nevertheless.'

And if the initial change in pace was a little confronting for Dr Christie, he has come to appreciate the intrinsic acceptance of death in palliative care, and the time and space patients and their families receive so they can consider living and dying.

'When you work in emergency medicine and you find yourself in that space, we've actually got to move that conversation on in the next half-an-hour or 45 minutes. It's much simpler now, and much less distressing and brutal now than it has to be [in the ED].'

'It's a much easier and much gentler conversation to have, even with families in chaos… You're dealing with people at a point in time where they're re-evaluating all of the big questions, and what life has been about, and what its purpose is.'

Reflecting on his late-career switch, Dr Hungerford thinks that his views on the "art of medicine" and patient-centred care have changed.

'I think that when I was a young FACEM I didn't really appreciate the value to the patients and their families of the time you spend with them and of the connections you make with them,' he says

Ultimately, Dr Christie and Dr Hungerford both agree that emergency physicians are generally good at reading clinical situations and what's required, establishing rapport with patients and families and at clinical problem solving, and that these attributes also seem to be quite suited to working in palliative care medicine.

To his end, Dr Christie believes his experiences in the palliative care unit have also transformed his understanding of medicine, finding its philosophical and existential dimensions are increasingly occupying more of his mind.

*'You're dealing with people at a point in time where they're re-evaluating all of the big questions.'*
*Dr Louis Christie*

'The medicine becomes the excuse to get you through the door, and then the actual work happens often outside the narrow definitions of medicine,' he says, adding that he hopes to use these experiences in his future interactions with patients.

'You get to have some really profound discussions with people about their perspective on what life's taught them.'

He is also optimistic we'll see more emergency physicians taking an active interest in different areas of medical care, including palliative care, as the cultural expectation around career journeys and work shift, and as FACEMs find new avenues to utilise their skills.

'We're well set up to be a group of people who look at the problems around us, either systemically or at an individual patient level and come up with innovative solutions in how you go about managing that,' he says.

*Author: Ben Rodin, Media Advisor*

Dr Phil Hungerford and Dr Louis Christie

# ACEM ASM 2023

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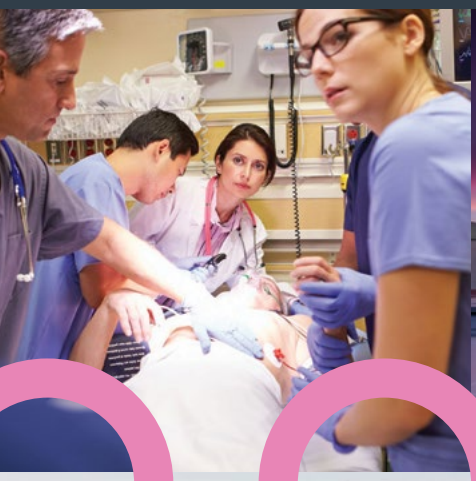

### KEY DATES

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| Early Bird Registration Opens: | **22 Mar 2023** |
| Call for Abstracts Opens: | **12 Apr 2023** |
| Call for Abstracts Closes: | **9 Aug 2023** |
| Early Bird Registration Closes: | **23 Aug 2023** |
| Standard Registration Closes: | **8 Nov 2023** |

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# How have the Cultural Capabilities of ACEM-Accredited EDs Changed Over the Years?

ACEM is committed to promoting cultural safety among emergency department (ED) staff and supporting the development of an ED environment that embeds cultural safety across all facets. Fundamentally, the College regularly monitors various aspects of the cultural capabilities of ACEM-accredited EDs through the mandatory Annual Site Census to inform areas for improvement.

Over the past five years, the proportion of Indigenous presentations to ACEM-accredited EDs has increased by 9 percent in Australia (from 5.6 percent in the 2016 Census to 6.1 percent in the 2021 Census) and by 13 percent in Aotearoa New Zealand (17.1 percent to 19.3 percent between 2016 and 2021). Consistently, Indigenous Australians and Māori are overrepresented in ED presentations, representing 3.2 percent of the Australian and 17.1 percent of the Aotearoa population, respectively[1,2,3]. Worryingly, studies have identified that Indigenous patients are significantly more likely than non-Indigenous patients to leave the ED without being seen or before care was completed, with the reasons behind this including the lack of accommodation of the culture, needs or beliefs, of First Nations people in the ED environment[4]. Accordingly, it is essential that EDs provide culturally safe emergency care to ensure the needs of Indigenous patients are met.

From the Annual Site Census, all ACEM-accredited EDs in Aotearoa consistently reported having cultural competency training available for ED staff over the past five years. This was not seen in all Australian EDs; however, the proportion of Australian EDs that reported the availability of similar training to ED staff increased from 91 percent, in 2017 to 98 percent in 2021 (Figure 1). An increasing trend was also observed for the proportion of Australian EDs that reported the availability of Indigenous Health Liaison Officers (IHLOs) or equivalent, between 2017 and 2021. It is noteworthy that all ACEM-accredited EDs in Aotearoa consistently reported having IHLOs available over the years. However, only five EDs in Australia and two EDs in Aotearoa reported having IHLOs employed directly by the ED. IHLOs are critical in providing culturally safe emergency care yet are often under-resourced and stretched across the hospital[4]. Although there is IHLO coverage across the majority of ACEM-accredited EDs, support for Indigenous patients could be improved.

Over half of EDs in Aotearoa (58 percent), reported having access to support workers (e.g., cultural liaison officers, waiting room volunteers, pastoral care) in addition to IHLOs who operate in the ED or waiting room for culturally and linguistically diverse (CALD) patients and carers. In contrast, a smaller proportion (44 percent) of Australian EDs reported having access to these support workers. The percentage of EDs with availability of support workers catering for CALD patients varied across regions in Australia; for example, approximately one-third of EDs in Tasmania and Queensland (33 percent and 35 percent, respectively), over half of South Australian EDs (57 percent), and two-thirds of EDs in the Northern Territory (67 percent) reported having additional support workers. EDs in Aotearoa often reported the "Friends of ED" volunteers supporting CALD patients and carers. Their roles included supporting patients and carers, providing refreshments, and facilitating communication between patients/carers and healthcare professionals. Common positions reported in Australian EDs included cultural liaison officers, patient experience officers, pastoral care officers, and waiting room volunteers, roles providing similar support as described in Aotearoa.

With the populations of Australia and Aotearoa continually increasing in ethnic and cultural diversity[1,5], adequate interpreter services in the EDs are critical to ensure optimal patient-healthcare provider communication. In an Australian study, only one in five CALD patients that required interpreter services in the ED were able to access the service[6]. In the 2021 Census, all Aotearoa EDs and all but three Australian EDs had interpreter services available in the ED for CALD and Indigenous patients and carers, with the majority of EDs reporting the service was available 24 hours per day. In the context of the COVID-19 pandemic, many EDs reported that face-to-face interpreter services ceased. However, accessibility remained as interpreter services were


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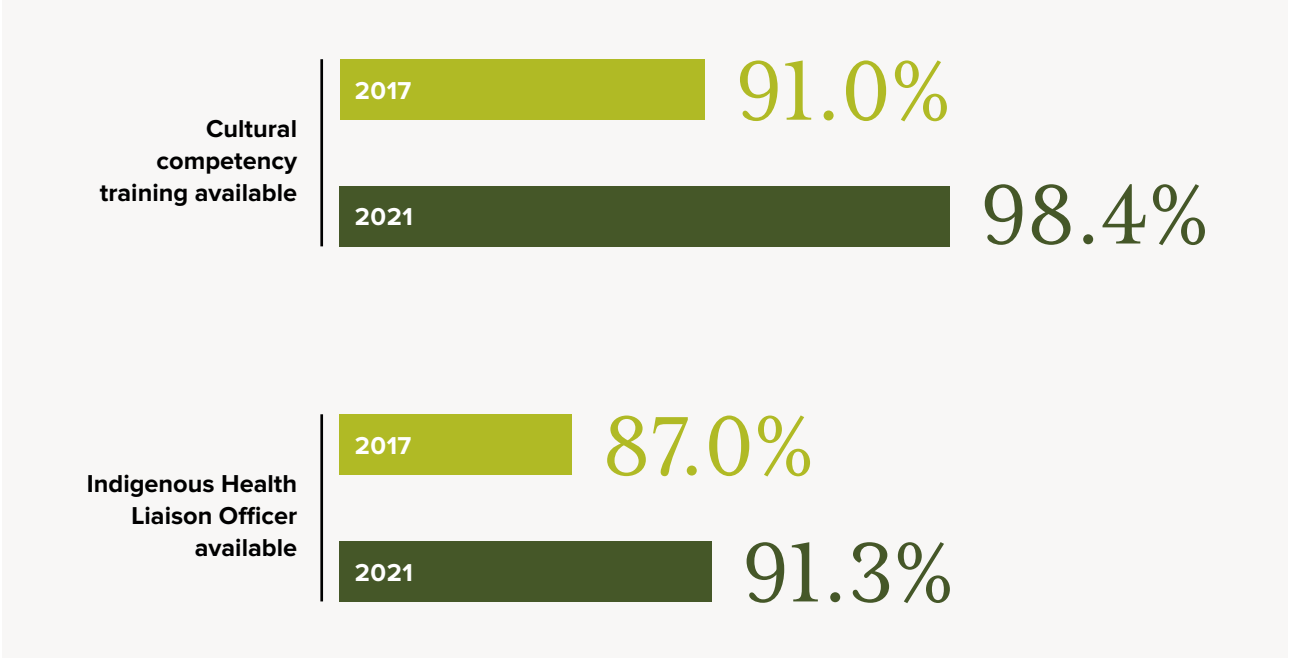
**Figure 1:** The percentage of ACEM-accredited EDs providing cultural competency training for staff and who have an Indigenous Health Liaison Officer, comparing 2017 and 2021 Census.




either exclusively provided over-the-phone or a combination of face-to-face and over-the-phone services.

Overall, ACEM-accredited EDs in Aotearoa have consistently demonstrated a commitment to providing a culturally safe environment for Māori patients and patients of other diverse backgrounds. Meanwhile, Australian EDs have made positive shifts to improve cultural safety for Indigenous patients and other CALD patients. With an increased diversity of patient presentations, EDs must evolve to support a culturally safe emergency experience for patients.

*Author: Katie Moore, General Manager, Research and Partnerships*

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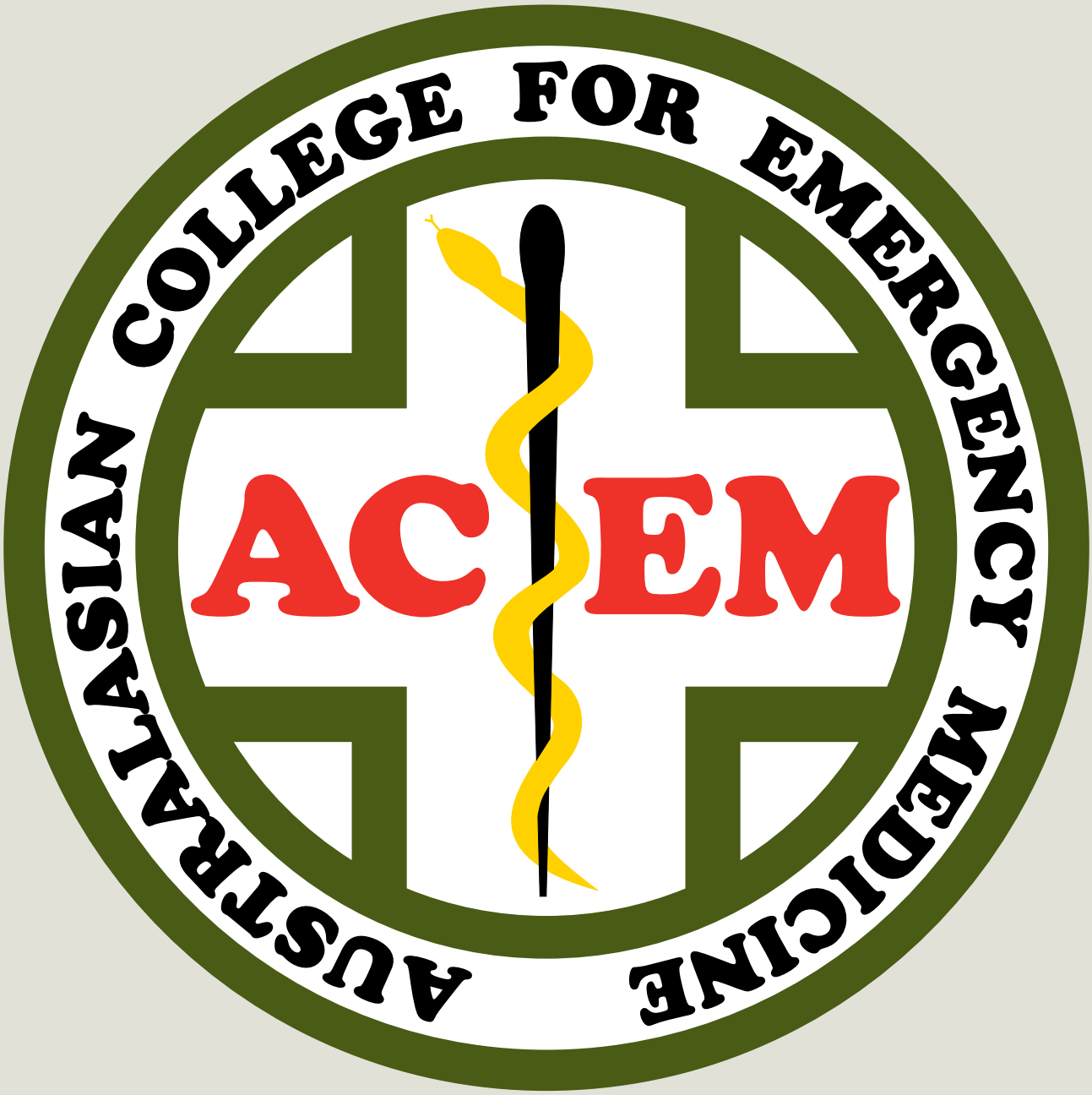


# “It Gave us an Identity”: The Story of the ACEM Logo

*The entwined snake gazes out from its staff, bold and golden against a background of forest green. It might sit on your scrubs, a letterhead, the corner of a web page or your Fellowship certificate.*

*It's easy to take it for granted, but the staff, the snake, the clashing red and green of the ACEM logo were a crucial way to legitimise an emerging field, and for nearly 40 years has situated the College and its story as part of a larger, grander and all encompassing medical history.*

*But while it's now part of College lore, the story of how the logo became entwined with ACEM's identity started with the need to officially certify the College as an organisation.*

It was 1984, a year after it was decided the College would form, and ACEM's original Council started developing official certificates. Upon doing this, they discovered that in order for ACEM to become officially certified, it would require a logo and an identity.

Dr Bryan Walpole, the Director of the Emergency Department at the Alfred Hospital in Melbourne, Victoria, and one of just six ACEM Council members at the time, volunteered. 'I'll sort it out.'

A local advertising agency quoted him between $5,000 - $10,000 – approximately $25,000 today – to design a logo. Bryan thought, 'This is absolutely ridiculous – we don't have this sort of money! It's not like we're a commercial organisation just wanting to sell a product. We were just a bunch of enthusiastic doctors trying to get a college together.'

He decided to take it into his own hands. Bryan said, 'It was completely spontaneous. I came into work – maybe Monday or Tuesday after we had the College meeting – and said, "Can anyone give me a hand with this?" Dr David Eddey, at the time an intern and now an emergency physician, said "Oh, I'll have a go".'

Back then, there would only be a couple of patients left in the emergency department overnight so the doctors who were on that day had some free time in the morning. David and Bryan sat down at the workstation to determine what elements they would use in the logo. Bryan said, 'Imagery is quite important because it's your public face. If you've got something that whenever people see it, they think about you, that's a really powerful connection.'

This was especially the case when establishing a medical college that needed to fight to be seen as a legitimate specialty. In the 1980s, when the logo was developed, it was paramount that it acted as a symbolic marker of the College's place within medicine, as a way to legitimise its very existence.

They decided to place the ancient medical symbol, the Rod of Asclepius – the snake wrapped around the staff – as a centrepiece, to symbolise medicine and healing.

The Rod of Asclepius is globally recognised as a symbol of medicine, and features in logos of major health organisations across the globe, including the World Health Organization and as part of the Star of Life symbol for emergency medical services. The staff has also been attributed to medical practitioners and has symbolic associations with wisdom and knowledge. In Ancient Greece, physicians would often carry rods as they had to transport medicine and equipment to the patients they visited, and the rod helped them navigate across rocky terrain[1].

The first reference of the rod is in an ancient Egyptian document called the *Embers Papyrus*, one of the first recorded medical records dating back to around 1550 BC.

In this text, a procedure for treating *Dracunculiasis* – or Guinea-worm disease – is described. This procedure involved physicians making a slit in the skin just in front of the worm's path and wrapping the parasite around a rod to remove it from the patient's body[2].

A drawing of a worm wrapped around a stick is thought to have been displayed outside the homes of people who could perform the procedure – and who could often perform other medical practices.

The symbol can also be found in the Jewish Torah, or Old Testament, dating back to 1410 BC, illustrated in the Book of Numbers. The Israelites were growing impatient during their 40-year journey through the desert and, in response to this, God sent fiery serpents among them, and many died from poisonous snake-bites. The Israelites implored Moses to help them, so Moses prayed to God, who instructed him to place a fiery serpent upon a pole. Moses then crafted a snake from bronze and all the Israelites who gazed upon it survived their bites, reinforcing the image of a snake as a symbol for the dual nature of harming and healing[3].

Bryan said, 'The snake and the staff of Asclepius pointed a bit towards toxicology which we're pretty good at – snake and snake bites – and towards renewal.'

Snakes are often used to symbolise rejuvenation and recovery, due to the way in which they shed their skin, this process seeming to impart them with new life.

Bryan said, 'The snake takes off its skin and renews itself, and is sort of fresh and clean every season, which is exemplified a bit by what emergency medicine is: Something new and fresh and clean and continuing to refresh itself.'

The College almost accidentally used the Caduceus – a similar symbol that has two entwined snakes around a winged staff, that is used largely in the American medical field but was originally aligned with commerce, gambling, and thievery.

Bryan said, 'A couple of people wanted the double-winged one, but the double-winged one has got nothing to do with medicine.'

istock.com/ Wavebreak

The cross in the middle of the logo is a reference to the red cross, widely recognised as an international symbol for protection and neutrality in armed conflict.

Initially designed in 1863, the red cross was created in honour of Jean-Henri Dunant, whose advocacy for wounded soldiers in 1859 inspired the formation of the International Foundation of the Red Cross. The cross references Dunant's Swiss heritage, as an inverse of the Swiss flag[4].

On a more practical level, the cross was designed to be easily recognisable from a distance to prevent people from being shot, and to be the same symbol for friends and foes.

Nowadays, it is often seen as generally being aligned with health and emergency services. The cross was also chosen to represent the fact that emergency medicine is largely hospital-based, with a plus sign often used to indicate hospital or medical settings.

The logo's circular design also holds relevance. Circles have associations with security, continuity and protection. The lack of hard edges in this design reinforces semiotic associations with wholeness, perfection and completeness, as well as associations with warmth and community. When designing the ACEM logo, Bryan wanted to include a ring to symbolise inclusivity, as emergency doctors look after a broad range of other specialties.

*'In the early days we were all called casualty doctors,' said Dr Bryan Walpole. 'A lot of people said that we had no place in medicine. Everybody in all the other specialties said, "We look after our own emergencies, we don't need you." What we had to sell is that the department's got people, and we've got time. And developing a logo gave us an identity.'*

He also wanted it to represent the warmth and community among other emergency physicians. From its inception, there has been a real fellowship between emergency doctors. He said, 'You were usually underseen – it was just me, the interns and a few second years sorting out a whole heap of problems, which now go through the consultants and registrars, so there was a real camaraderie.'

'Everybody used first names, compared with just about every other branch of medicine where people were referred to as "doctor" or sometimes called "mister", but always by their surname. Yet we established early on that we were all in this together as a fellowship, so we all used first names.'

David agreed. 'Bryan was my first boss ever as a doctor, and emergency medicine was a pretty dynamically evolving specialty,' he recalled. 'I loved it. Bryan was a great mentor, a real character, very charming and personable and witty, so we got along really well. It's one of the reasons I fell into emergency medicine.'

The colours in the logo are also deliberate and symbolic, and Bryan and David worked together to choose them.

According to Bryan, the big red 'ACEM' across the logo gives it emphasis, and it references the blood emergency doctors often see as they try to stop bleeding and tend to wounds. David believes the red ACEM placed across the centre of the design made the logo immediately and easily recognisable to emergency physicians.

Traditionally, the colour red is associated with emergency services because it is easy to sort by the human eye, allowing people to recognise highlighted critical information emphasised with red more quickly and easily. This is because human eyes are 'generally' more sensitive to colours with longer wavelengths such as red, orange and yellow. Furthermore, while green is most visible from a distance, red is the most easily visible colour when visibility is hampered by fog or smoke, as these tend to filter out shorter wavelengths of light[5].

The ACEM emergency department sign guidelines state that emergency signage should be standardised with white lettering on a red background, so mimicking this colouring in the logo aligns the College with the physicality of emergency departments in its design[6].

The gold was chosen to reflect the gold standard that the College aspires to. It also relates well to other depictions of the Rod of Asclepius, which portray the snake as golden; perhaps in reference to the biblical depiction of the bronze snake statue.

The green colour was chosen in reference to the international colour of hospitals.

Green was established as the colour of hospitals in the early to mid-20th century but has since fallen out of use. The association of green with hospitals began in 1914 when Harry Sherman, a surgeon in San Francisco, found it difficult to differentiate anatomical features under the too-bright white lights of the operating rooms, which would have created glare against the white tiled surfaces. Sherman used colour theory to determine that the contrast of the red against green allowed him to focus on the detail and texture of the wounds without his eyes having to compete with glare. Throughout the 1920s, more surgeries began adopting this colour scheme.

In conjunction with this, the field of 'colour therapy' was evolving. Architect William Ludlow argued that white was a negative therapeutic colour, and that soft greens promoted rest and contentment as, due to evolution, the eye is most comfortable in mostly green environments. The field really gained popularity in the 1930s, led by Faber Birren who aimed to incorporate colour into every hospital and was convinced that green hues would calm and ground both patients and hospital workers. The 1950s was the height of this movement, when a neurosurgery unit at the Royal University Hospital in Saskatchewan, Canada, opened an entirely green tiled operating suite. This would be a major feature in hospitals well into the 70s and remains a symbolic marker of hospitals to this day[7].

With all the elements decided, David went away and worked on the logo in an on-call office at the hospital, looking over Fawkner Park. In between calls he would draft the logo with ink, pen, and compasses and protractors borrowed from the Alfred audio-visual department, as well as "Letraset" rub-on lettering purchased from Eckersley's on Commercial Road.

*'Imagery is quite important because it's your public face. If you've got something that whenever people see it, they think about you, that's a really powerful connection.'*

'I think it's a simple, basic design that conveys a message', David said. 'It conveys what the organisation is without being too fancy or complicated.'

The design took approximately 10 days to refine and get ready for presentation. After Bryan saw David's design, he was so confident in it that it was the only one he put forward for acceptance, despite having other designs sent to him for consideration. In return for his efforts, Bryan presented David with a telescopic metal 'plessor' which David still uses today.

David's design received unanimous support.

Bryan said, 'Seventy per cent of the credit goes to David Eddey, because he provided the direction and the input and the presentation of the College.'

David noted that most of his more junior colleagues don't know that he designed the logo and are surprised when he tells them about his crucial involvement in it. Nonetheless, he feels very proud and fortunate to have contributed to ACEM in this way, as well as his other contributions to the College through mentoring and his time as an ACEM examiner.

Both men feel that the logo helped solidify the profession as a legitimate specialisation.

'In the early days we were all called casualty doctors,' said Bryan. 'A lot of people said that we had no place in medicine. Everybody in all the other specialties said, "We look after our own emergencies, we don't need you." What we had to sell is that the department's got people, and we've got time. And developing a logo gave us an identity.'

Almost 40 years later, and the logo remains. Bryan said, 'No one has ever thought about changing it, so we did a pretty successful job.'

Dr Bryan Walpole and Dr David Eddey

*Author: Amy Kayman, Media and Communications Officer*

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# The Other Side of You

**Dr Bec Cole**
Dr Cole is an Emergency Specialist at Royal Hobart Hospital, Tasmania.

*Impostor syndrome, also known as impostor phenomenon, is the persistent inability to believe that one's success is deserved or has been legitimately achieved as a result of one's own efforts or skills. It manifests in doubts around abilities, talents, or accomplishments, and the relentless internalised fear of being exposed as a fraud.*

istock.com/useng

Dear Department,

Although you are a stretch of inanimate corridors and cubicles, your walls are far from idle. They are passive observers of fear, inefficiency, chaos, grief and love. You need to know these emotions are not limited to your patients.

You've seen me develop from a lost, naive, and partially educated, but enthusiastic, medical student, to a mildly competent and somewhat nervous intern. Later, you gave me the opportunity to become a bubbly, energetic very junior registrar, where allegedly you coined the term "the ED golden girl". I morphed and grew with you.

The growth was not linear for me. There were some hard battles that you, the Department, witnessed. Some were horrendous patient tragedies; some were incredible patient wins and others were battles in the dark of the ambulance ramp in the form of night shift cricket (they were the days!).

You shared in my personal battles that at times, physically presented themselves to you, or emotionally, as I sat in various isolated quiet places to shed some excess eye salt. Your every space has challenged me clinically, professionally and personally.

My senior registrar years and transition through Fellowship to specialist life was torturous. As a Department you embraced me, you held my hand and continued to provide a wealth of wisdom from both your staff and clientele, with a VERY steady and bountiful flow of sick patients through your doors.

Now I'm here.

I have an office, a title with some post nominals and a regular generous pay that drops into my account every fortnight like some sort of perpetual reminder I've achieved something.

The truth is, Department, I am a complete imposter within your walls and corridors.

I might be able to recall the scratch marks etched in the seclusion room, the peeled Banana in Pyjama stickers in paeds and the grief and blood lost in resus. In fact, I recall handwritten notes, yellow Nokia phones and Arnott's scotch fingers.

But…

I can't recall all the correction formulae in a blood gas, the outcomes of the HINTS (head impulse, nystagmus and test of skew) exam or the eponymous fractures I once knew. I used to know all the nurses by name, it was a privilege to share a shift with them. I used to know where all the equipment was meticulously stocked. I used to open a drawer on a trolley, just once, and be guaranteed the item I needed. Instead, now you hear a chorus of drawers and baskets opening simultaneously as I sift for that piece of gauze or packet of lubricant.

The specialists you grew before me have set a tremendous standard and inspiration. They are exemplary pillars that hold your walls accountable. I continue to aspire to that level, but it all seems insurmountable right now. I might wear black, but perhaps that's a camouflage for my own head.

I feel you trust in me, but I don't trust in me. The juniors supply a running dialogue of patient details, some useful and some not. I try to interpret this and attempt to provide some "consultoid" wisdom and guidance. Instead, I vomit back to them some safe caveated medical advice, with a reference check because my detailed knowledge has decayed somewhere within your walls and floors.

It's hard having known you for more than a decade, but not knowing how to belong in your space.

It's hard to lead like the leaders. Your cubicles divide us. I don't see the leaders at work anymore. We operate in your silos, your flight decks and fishbowls. I'm blinded by you and your deluge of patients. I can't lead when I can't see.

So, Department, what is your disposition? What is my prognosis? Because right now, I again feel very lost, naive, only partially educated and struggling to maintain my enthusiasm.

It's so hard to be on this side of you.

Kind regards,

*Your new FACEM*

# What is Rural Medicine?

**Dr Juan Carlos Ascencio-Lane**
Dr Ascencio-Lane is a FACEM living in Hobart, Tasmania and is the Deputy Chair for ACEM's Rural, Regional and Remote (RRR) Committee.

What is rural medicine? This is a question that I've often been asked. It's one that at times colleges try and address and a role that clinicians often describe themselves as doing. Yet, each time the response is always different. It's a question that I love to be asked and an answer that always intrigues me.

My first memory of a rural emergency department (ED) was back home in Ireland. I was about 13 years old and had just been hit across the head in a crossfire during woodwork with a plank of wood. A teacher drove me straight to the accident and emergency department. Now, this was the local hospital for a country town in rural Ireland. It was staffed by one nurse, there were two beds and the doctor who came and saw me was called down from the ward. I know he wasn't a consultant, but other than that I had no idea what level he was. It intrigued me though, that as a young doctor he had the confidence and ability to assess and treat me (I know it was only a minor injury), but I was fascinated by the responsibility put on this young doctor and began to form my concept of rural medicine.

My next exposure to rural medicine was as a fifth year medical student, when I chose to do a medical elective in Cape Town, South Africa. I know that Cape Town is a large city and that it may not hold as rural medicine, but when you step out into the townships and work in somewhere like Manenburg, you quickly realise that this is certainly rural medicine – at least a form of it. On my first day, I turned up as an eager fifth year student and was quickly expected to be a key part of the team. I was expected to assess and begin forming plans for patients, and at times even manage these patients. I felt like I was exploding into my career and was certainly given a taste of what I wanted for my future in medicine. Whilst I felt independent, I always knew that I had the backup of the senior staff – I never felt alone. What did astound me was the range of presentations to this small rural hub. Burns, severe trauma, gunshot wounds, HIV, meningitis, tuberculosis, adults, paediatrics, geriatrics. All of these were managed with limited resources – at times without even having access to x-ray. Yet, there was nothing that was turned away. There was nothing that the staff there would not or could not manage. I knew that this was what I wanted to do.

During my final year in med school, I was yearning for that rural exposure again. I chose to do my internship in rural locations – a trend that most of my friends chose not to do. Ideally for most, you would stay in the big centres to further your career and you would be exposed to most things. It was not the path for me, so I went off to two different locations for six month rotations at each, to complete my gen med and gen surg mandatory internship. Both of these hospitals were bigger than the first ED I went to as a child when I split my head open. They had far larger EDs and more comprehensive inpatient units, yet they were still seen as rural. There were more people working within the ED and certainly more resources than what I saw in Manenburg. As the surgical intern, it was my job to look after the ED post-midnight. This was a massive responsibility and one that at first scared me so much, I would never sleep on my 36 hour shift, weighed down by the responsibility of it all. What I quickly realised though, was that I had an incredible team by me. I was never left alone and when we did get critical patients, everyone joined in. Members from all the services would band together and help to get the best possible care for the patient.

During my career I have been fortunate to have worked across numerous rural sites in Aotearoa New Zealand and Tasmania. I have cherished every one of them and the incredible people that I have worked with. Not one of them have been the same from a geographical, functional or operational standpoint.

Being involved with RRR, ACEM and Emergency Medicine Education and Training (EMET) in Tasmania, I hear of other stories about rural medicine – all being so different, but having common themes.

So we go back to – What is rural medicine?

For me rural medicine is about the experience and people – there is always somewhere more remote and so perspective can change the identity of rural medicine. Rural medicine is an area filled with amazing clinicians, who have the ability to work and care exceptionally well for their patients with whatever they present with, often with much more limited resources than a busy city hospital. It is an area where teamwork is paramount, and everyone, no matter their role, is considered an important player. It is an area that is welcoming to all patients and staff, and an area that helped me to grow, both as a doctor and as a person.

istock.com/Benoit Blanchot

Master Monty Tomaszewski and Mrs Y. Cheng, Toronto, Canada. May 2022.

# Around the World in 80 Days: A Churchill Fellowship Journey to Learn About Improving Care for Older People in ED.

**Dr Rebecca Heath**
Dr Heath is a FACEM at Royal Hobart Hospital, Tasmania. MBChB FACEM MRes BSc(MedSci) Dip(MtnMed) CF

I must confess I knew nothing about The Winston Churchill Memorial Trust or the fantastic Fellowship Scheme they offer when I moved to Australia from the UK. What a privilege though, to get to travel the world (albeit COVID delayed), and learn about the incredible initiatives happening within the super subspeciality of geriatric emergency medicine (GEM) to help inform our GEM strategy at the Royal Hobart Hospital (RHH).

My interest in GEM started when I moved from Alice Springs, Northern Territory to Hobart, Tasmania and was struck by how different the population age demographic was, and how much of my time in the emergency department (ED) was spent working with older people. I felt I needed to learn more to provide optimal care to them.

In Australia, indeed worldwide, there is increasing recognition of significant population aging. ED presentations for people over the age of 65 years are proportionately the same as paediatric presentations to ED (approximately 22 percent) and yet the training and curriculum requirements are quite different for these two cohorts. There are paediatric logbook requirements, department teaching accreditation requirements, and the specialist qualification examinations have a minimum percentage of questions that must cover paediatrics. This is not yet the case for GEM, despite evidence of increased risk of missed diagnoses, iatrogenic complications, and mortality.

We know that older people are far more likely than any other age group to arrive by ambulance, more likely to experience access block in the ED, more likely to be admitted, and more likely suffer harm as a result. When you consider that those over 85 years old are only 2.3 percent of the Tasmanian population but occupy 22 percent of the acute medical beds and are predicted as a cohort to increase by 85 percent by 2040 (not that far away!), it is clear we need to critically re-think how we provide urgent and emergency healthcare to this group. Older people often represent tough diagnostic challenges and consults typically take more time. This is made even more difficult in a fast-paced time-poor environment. However, we have increasing evidence showing us just how devastating the consequences of lengthy stays in EDs and hospital admissions for older people are.

I wanted to learn more. At the time that I searched, there didn't seem to be a GEM equivalent of Emergency Trauma Management (ETM), Advanced Paediatric Life Support (APLS), or a Basic Assessment and Support in Intensive Care (BASICS) course. There were conferences, but I wanted clinical experience, teaching about the fundamentals and


Dr Rebecca Heath

then about the nuances of providing optimal care to older people in the ED. What I wanted to do was sub-specialise. So, I set out looking for GEM Fellowship programs. I found them in the US, Canada and the UK but couldn't easily find something equivalent in Australia at the time I was looking several years ago. I ended up creating my own version of a Fellowship at the RHH and worked a year 0.5 in geriatrics as a registrar and 0.5 in ED as a Fellow on the consultant roster, with a longer-term plan to develop a formal GEM Fellowship program at RHH. There are now six sites with accredited special skills terms in GEM already established (listed on the ACEM website) including the first GEM term that was established at Hornsby Ku-ring-gai Hospital a number of years ago.

### But it was supposed to be a small project...

I was fortunate to receive the 2020 MPST Churchill Fellowship Award to establish a GEM Fellowship at the RHH. As a family, we navigated visas and COVID testing requirements, spent 55 hours flying on planes, travelled through five different time zones and navigated feeding a toddler anaphylactic to nuts, milk and egg in countries that don't have standard allergy labelling. As part of my Churchill Fellowship, I visited GEM

Dr Rebecca Heath, Associate Professor Michael Stern, Dr Tony Rosen

Professor Jay Banerjee, Dr Rebecca Heath, Professor Simon Conroy

experts in Sacramento (Dr Katren Tyler), Toronto (Associate Professor Ivy Cheng), New York (Associate Professor Michael Stern and Dr Tony Rosen), London (Professor Simon Conroy) and Leicester (Professor Jay Banerjee). Despite starting the project with a view to learning about GEM Fellowships around the world, it quickly became apparent that the learnings needed were much broader.

Some of my key experiences included learning about different models of acute frailty care and pre-hospital programs that EDs could consider for improving the experiences of older people, as well as Patient Reported Outcome Measures (PROMS), for patient centered quality improvement standards. I also observed and learned about physical and environmental design changes, in order to make EDs more older person friendly. These learnings are now being used to inform the re-build and re-design of the RHH ED, which will aim to be GEM friendly throughout.

Associate Professor Stern set up the first GEM Fellowship in 2005 at the New York Presbyterian Medical Centre (NYP) and continues currently as the director of the GEM Fellowship program there. Interestingly, during my Fellowship I found out Dr Carolyn Hullick (a past chair of the ACEM GEM Network), spent her year as a Harkness Fellow at NYP in 2009 and was similarly looking at GEM models of care across the USA. Associate Professor Stern was also instrumental in the design and implementation of the US Geriatric Emergency Department Accreditation (GEDA) with the American College of Emergency Physicians (ACEP). This is a three-tier accreditation system that recognises EDs as providers of optimal geriatric emergency medicine care, which could be adapted for Australia and Aotearoa New Zealand.

### Commonalities in GEM Fellowships across the world

All sites had a 50-50 admin/clinical time split to support self-directed learning and quality improvement or research projects. No Fellowship program had any formal assessments and were a mix of one-to-two year programs (with the option to complete a Masters-level degree in a second year). All sites allowed Fellows to choose from a selection of rotations based on personal preference and had a memorandum of understanding (MOU), with rotation specialties ensuring that Fellows were there to be an educational sponge, rather than provide service delivery.

### What about the Australian context?

The crux of geriatric emergency medicine is a patient-centred approach. Any service or program needs to be tailored to the local population and culturally sensitive with consideration of, and acknowledgement to, Aboriginal and Torres Strait Islander people and other culturally and linguistically diverse (CALD) groups living within the catchment area. The International Consortium for Healthcare Outcome Measurement (ICHOM) have developed a freely available older person data set, assisting those planning service changes with the considerations of what matters most to older patients. The Australian partner for this work is the Australian Commission on Safety and Quality in Healthcare. These surveys provide useful guidance alongside cultural considerations, for developing services within the local context.

### What is different internationally?

The most striking difference was the broad understanding of frailty. Frailty is embedded in the UK medical lexicon and the Clinical Frailty Scale by Rockwood (CFS) was being used at triage, in short stay units and on acute medical wards. The ability to describe frailty and understand how frailty can predict outcomes (when based on a CFS assessment two weeks prior to presentation) in the urgent care context and as part of shared clinical decision making was advanced and widespread.

After the Silver book was published in 2012, NHS England recognised the need to address the care requirements of older people. This resulted in the Acute Frailty Network (AFN). Since its inception, this incredibly impressive program has

seen all 126 hospitals in the UK complete training through collaborative learning, focusing on the best ways possible to improve acute care for older adults with frailty.

Since the AFN, multiple models of care have been developed to provide improved acute care to those with frailty. It was invaluable to be able to visit some of these programs that provide alternative urgent community or same day emergency care options. Many strategies were aimed at changing the care trajectory for older patients at the beginning of an acute health crisis. This resulted in reduced hospital admissions, which would be associated with functional decline, compounding of clinical problems and mortality. Improved pre-hospital services, early identification of frailty in ED, access to comprehensive geriatric assessment and alternative review options other than conveyance to ED or admission to hospital, were all fundamental.

### The highlights

Spending the time to get to know and learn from worldwide experts in-person about an area of medicine I enjoy (particularly post-COVID) was such a treat. Professor Jay Banerjee (who is an exceptional cook) and his lovely family hosted us (toddler and all!) at their incredible 400 year old home, with Professor Simon Conroy and his wife, and this was a real highlight. Another was having a home cooked beautiful Chinese lunch with Dr Ivy Cheng in Toronto followed by chatting about complex system change on a bench while my 18 month old played with my husband in the park. Another was chatting over delicious breakfast burritos with Dr Katren Tyler (who after becoming a FACEM moved to the US and then also completed the American emergency medicine exams), about all the fantastic GEM changes she has led, resulting in UC Davis ED recently being awarded a level 1 GEDA accolade. Being able to personally connect with Associate Professor Stern and Dr Tony Rosen and see the new area of their department, specifically designed to be older person friendly, as well as learn about their impressive telehealth set up used by many older people, was also a real highlight.

### The lowlights

All having COVID and isolating in an ant infested basement flat in Toronto, followed closely second by the three hours stuck on a plane on a runway unable to disembark from the flight into Canada (probably where we caught COVID!). Or perhaps it was the six hours on London public transport in a heatwave (those who have lived in London will know their public transport is not built for a heatwave!).

### The most valuable lessons

The people that I met with generously shared their resources, insights and experiences and it was a privilege to be part of a community who set such value on knowledge exchange. One key takeaway was the acknowledgement of the fact that implementing sustainable system change can be frustrating and daunting. Creative tension was described by Peter Senge as the experience of 'realising what something could be versus current reality'. Trying to focus on making the process of minimising the gap between reality and what you are aiming to achieve, as a constructive rather than a destructive process, is important. Also, being reminded that the process is a marathon, not a sprint, you cannot do this alone and to spend time nurturing the working relationships with those around you who have the same working values as you was so important.

### The future of GEM

I am excited for the time when the list of recognised subspecialities for ED reads GEM, Paediatric Emergency Medicine (PEM) and Pre-Hospital and Retrieval Medicine (PHRM). Times are changing and we need to change, learn, and grow with them in order to provide the best possible service to the growing number of older people. We need to shift how we think about frailty, and how we deliver urgent care, as well as how to make our outcome measures more patient focused and to consider whether we could use a similar GEM accreditation system in our EDs in Australia and Aotearoa New Zealand.

It is worth joining the ACEM GEM Network to learn more about what is happening across Australia to improve care for older people in ED. The GEM Network also provides an opportunity to understand the different models of care that exist and to meet others interested in GEM. Some states in Australia and Aotearoa New Zealand have already introduced CFS in pre-hospital settings, at triage and at hospital levels, as well as implementing models of care to better treat this cohort. Change is already happening, GEM is growing and it is exciting (and necessary!).

If you're interested in subspecialising and doing a GEM Fellowship at the RHH or special skills term at the other sites around Australia, please get in touch with myself or those listed on the ACEM website under the GEM special skills terms.

Thank you to the MPST Foundation and The Winston Churchill Memorial Trust for their generous support, and to all the hosts around the world who so generously gave up their time and shared their knowledge with me during my Churchill Fellowship. Thank you too to my husband who put his PhD on hold to come around the world with our 18 month old while I completed my Churchill Fellowship.

I would encourage you to think about one of the international Fellowships, it opens your eyes to so many possibilities in emergency medicine.

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### *i* More information

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


Kim Hansen presenting at ICEM 2022's "Development of gender equity and equality systems in emergency medicine" session.

# Women in Emergency Medicine Around the World

**Dr Kim Hansen**
Dr Hansen is an experienced FACEM and works as a Medical Director for Metro North in Brisbane, Queensland. She was ACEM's inaugural Chair of the Advancing Women in Emergency (AWE) Network Executive from 2018-2022 and is the current Queensland Faculty Chair.

While the ACEM Advancing Women in Emergency (AWE) Network and the Network of Women in Emergency Medicine (NoWEM) have been busy championing gender equity locally, the International Federation for Emergency Medicine (IFEM) has had a very proactive 12 months highlighting this important area. Creating a fair and equitable environment for those of different genders to work together in emergency departments (EDs), without bias, is a very deliberate process. It is a continuous evolution led by many individuals who are passionate about equity and empowered to act by their own experiences or their positions in leadership roles. While there are legal discrimination protections and enterprise bargaining agreements, the Australian Tax Office (ATO) data shows a gender pay gap exists, even in emergency medicine. ACEM has made concrete changes to move towards gender parity in its highest decision-making arena, the ACEM Board, which up until 2018 had no females. There remain challenges with parity in leadership positions in EDs across Australia. The AWE Network Executive continue to hear of the challenges that female emergency doctors are faced with in their workplaces. In an ideal equal department, all doctors are empowered to contribute, and to develop themselves, their EDs and our speciality for the better.

In November 2022, the AWE Network hosted a webinar entitled "Is your ED being smart about gender?". Presenters were Dr Priyadarshini Marathe, Consultant in Emergency Medicine from Oxford University Hospitals NHS Foundation Trust, England and Dr Imron Subhan, Senior Consultant and Head of Department of Emergency Medicine at Apollo Hospitals in Hyderabad, India. They have conducted Gender Equity and Equality workshops across the world and are committed to practical and positive approaches tailored to local conditions. Dr Marathe and Dr Subhan are active members of IFEM's Gender Specific Special Interest Group.

IFEM is a federation of over 70 national and regional emergency medicine organisations. Its mission is to advance the growth of high-quality emergency medical care through education and standards, to lead the collaboration and networking necessary to establish universal equality in service and care, and to promote the creation and growth of the specialty of emergency medicine in every country.

IFEM's Gender Specific Issues Special Interest Group (GSI-

Leadership Workshop at ICEM 2022 run by the AWE Executive team.

SIG) was founded in 2014 and is the global representative body to advise on international issues pertaining to gender issues in emergency medicine. The group is ably led by Dr Gayle Galleta, based in Massachusetts, USA. Notably, Dr Galleta was recruited to help establish Norway's first emergency department in 2012. She was instrumental in getting the specialty approved by Norway's Ministry of Health in 2017, was grandfathered in as one of Norway's first emergency medicine specialists. The GSI-SIG aims to provide leadership and mentorship to women in emergency medicine and assist in the development of sustainable career paths for female emergency medicine physicians.

In June 2022, ACEM and IFEM supported the 21st International Conference on Emergency Medicine (ICEM) in Melbourne, Australia. The development of gender equity and equality systems in emergency medicine was highlighted in a plenary session by Dr Marathe and Dr Subhan. This was followed by a full session and panel discussion on gender that contemplated what barriers still exist, short- and long-term strategies to address these barriers, and how to involve other genders in these processes. Local representatives Associate Professor and (then) IFEM President Sally McCarthy and Dr Kim Hansen were joined by representatives of many corners of the globe – Kaushila Thilakasiri (Sri Lanka), Mulinda Nyirenda (Malawi), Roberta Petrino (Italy), Liliana Caceres (Argentina) and James Ducharme (Canada) – as well as plenary speakers from the United Kingdom and India.

In December 2021, IFEM and the Canadian Association of Emergency Physicians (CAEP) hosted a virtual symposium in their "around the world" event series on issues facing female emergency medical care workers – what needs to change, and what can be done in the workplace to take steps towards gender equality. The focus was on gender equality as a human right, which is essential to the achievement of peaceful societies with full human potential. Research has shown that gender balance in the clinical workforce can affect patient outcomes. Although gender equality is recognised as one of the most important determinants of healthcare development, gender equality remains a complex issue in the clinical workforce with progress towards international targets being slow.

The symposium, "Women in Emergency Medicine Around the World", which is freely accessible through the CAEP website, compared the working conditions in North America, South America, Europe, Australasia, Africa, and the Middle East. It explored how organisations like IFEM and CAEP can support women in emergency medicine and remains very relevant to ACEM members.

IFEM acknowledges that gender disparities are widespread and vary among countries. Illustrative of this is the proportion of females in the workforce, in leadership positions and attitudes towards females in general. As documented in IFEM's *White Paper on Gender Diversity and Inclusion*, women are notoriously underrepresented in emergency medicine leadership positions. It is acknowledged that there is a "leaky pipe" phenomenon, where women drop off as one moves up the leadership ladder. Reasons cited for this attrition at each step of the career ladder include the "lack of fit" model, where inconsistency, or lack of fit, between stereotypes about women and perceived requirements for success leads to the perception that women are not well suited for them, producing negative expectations about their likely performance.

These expectations, in turn, lead to the presumption that those individuals, usually female, lack the competence necessary to do well in these positions and are unlikely to succeed. This contributes to and compounds: Less mentoring and fewer role models, lack of managerial support, lack of opportunities and recognition, negative performance assessments and challenges with work-life integration.

The 2022 Advancing Women in Emergency Executive team at ICEM 2022 (from left Kim Hansen, Shantha Raghwan, Krupa Mehta, Jocelyn Howell, Jenny Jamieson, not present- Danika Thiemt)

Data shows that male ED leaders were typically sponsored by senior leaders who provided advancement support and opportunities. Females, however, typically advanced through their own effort without the same support.

Globally, doctors have taken note of manels (all male panels) at conferences, and the overall paucity of female organisers and speakers. This contributes to the lack of role models and lack of opportunity for career advancement. The Society for Emergency Medicine in India and ACEM have made a conscious effort to reverse this trend and have been increasing the percentage of women invited to present at national conferences.

It is virtually universal, due to entrenched and persistent gender stereotyping within societies, that women are responsible for the majority of household chores and childcare. Traditional gender stereotypes can be challenged by organisations focusing on, for example, "parental" or "caregiver" leave, and providing flexible work arrangements to men and women alike. In many countries, this is a reason why more women than men work part-time and are less likely to take on leadership positions. This gender stereotyping means that women, especially those in early to mid-career, have been more heavily burdened with parental responsibilities. There is broad agreement that medical mothers need support to achieve career success due to a "motherhood penalty", which is driven by assumptions that a woman will be less committed, less competent, and less interested in her career than she was prior to becoming a mother. These gender inequities in medicine contribute to the well-recognised gender pay gap and burnout. Lack of role models can prevent women moving into not only leadership positions, but also from entering the specialty entirely.

Sexism and a "male-dominated work environment" (numerical male dominance, where policies and informal practices are dictated by men and detrimental to women's personal and organisational wellbeing), perpetuate a culture of systemic bias. This embedded and difficult to identify system of bias produces a workplace that is advantageous toward men and filled with hidden barriers for women.

In this context, women may be told they have "imposter syndrome", which holds women responsible for experiencing doubt regarding their abilities and directs the viewpoint toward fixing women at work, instead of fixing the places where women work. Alternatively, when taking on a leadership persona, women may be accused of being abrasive or aggressive.

Gender bias can range from unconscious bias, to overt harassment. Unconscious bias often manifests as microaggressions such as repeated sexual jokes, insults, and putdowns. These accumulate over time and undermine female doctors' confidence and ambition. An ACEM survey found that 12 percent of female ED doctors experienced sexual harassment, 26 percent experienced discrimination and 34 percent were bullied. In the US, 26 percent of women emergency medicine physicians cite weekly experiences of workplace gender-based disrespect, appallingly making our speciality the highest of all clinical specialties. In Canada, women who shared their stories about harassment and abuse in the medical profession uniformly professed the fear that raising concerns would get them labelled as troublemakers or, even worse, blacklisted.

A 2022 report by the Royal College of Surgeons of England (RCS), uncovered racism and sexism and reflected upon its homogenous leadership. Over the long history of the RCS, it has had only one female president. Women and minorities did not feel represented by their professional organisation. The RCS has pledged that, within two Presidential terms, the Leadership and Council will reflect the diversity of the wider medical workforce and will commit to investing in a Parents in Surgery study and strategy, a new flagship program. This is very rapid and encouraging progress.

IFEM is committed to promoting gender equity worldwide and has had a productive year highlighting this issue. By collaborating with a geographically and culturally diverse group, IFEM's GSI-SIG has been able to make better informed observations and recommendations while acknowledging that each country is on its own trajectory toward gender equity, and not every solution will work in every country. While IFEM cannot control gender inequities in emergency medicine in individual countries, it can acknowledge that implicit gender bias and sexism exists, as well as collect and publish data relating to leadership positions and awards, raise awareness and provide training tools.

IFEM and the AWE Network recognise that non-gender conforming individuals and racial or ethnic minorities are also disenfranchised within emergency medicine and that inequity exists with respect to treatment based on patients' gender. Achieving gender equity also benefits men's health and wellbeing, and creates more equitable societies, workplaces, and relationships for all genders. By removing barriers that prevent women from practicing emergency medicine and being leaders, IFEM hopes to increase the number of women emergency medicine physicians to better reflect our patients' diversity and improve emergency care for the patients that are served globally. AWE is delighted to partner with IFEM to achieve these aims.

ACEM
WINTER
SYMPOSIUM
2023

# Transitioning the coalface

18 – 21 July 2023

**NEWCASTLE EXHIBITION & CONVENTION CENTRE**

## Save the date

We invite you to the Winter Symposium in Newcastle, on the traditional country of the Awabakal and Worimi peoples.

The theme of the Symposium is **Transitioning the coalface.** The last couple of years have been a rollercoaster ride with climate change and the pandemic. The climate at the coalface in ED needs to transition, it needs to cool down.

The Symposium will create a space to discuss, reflect and introspect on this transition, with the aim to generate ideas from lived experience and improve the future practice of emergency medicine. The scientific program will provide expert workshops on toxicology, resuscitation, and paediatrics. Concurrent sessions will showcase the works of emergency researchers and focus on delivering high value scientific content. All of this while catching up and sharing ideas with colleagues from around Australia, Aotearoa New Zealand and beyond.

Newcastle, the largest coal exporting harbour in the world, has faced a significant transition in recent decades, and as such, is the perfect venue to host such an interesting conference topic. Once a blue collar, industrial town, Newcastle now hosts a multicultural, cosmopolitan population.

Join us in Newcastle as we explore cutting-edge knowledge, and our future.

**See you in Newy!**

*Destination NSW*

## Key dates

| | |
|---|---|
| **Registration Opens** | **18 January 2023** |
| **Call for Abstracts Closes** | **22 February 2023** |
| **Early Bird Registration Closes** | **18 April 2023** |

**Abstracts now open**

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# IFEM Humanitarian of the Year

**Associate Professor Gerard O'Reilly**
Associate Professor O'Reilly is a senior emergency physician at the Alfred Emergency and Trauma Centre in Melbourne, Victoria.

*Associate Professor O'Reilly, the recipient of the International Federation for Emergency Medicne (IFEM) Humanitarian of the Year Award, sat down with us to discuss his astonishing and varied life and career in Global Emergency Care so far.*

What a privilege it has been, it is, to "work" in Global Emergency Care.

It's the people…yes, the people…the ones I have been lucky to join with in their own country, their own environment. The enthusiasm and persistence shown, and the endless days of hard work that our doctor and nurse colleagues endure globally. And it's also the vulnerability of people. Individuals and their families travelling huge distances to seek care, any care. Or others who are seeking care en-masse in the midst of fleeing, or enduring, conflict, hunger, and sudden natural disasters. It's the honour to even be in a position where one might envisage, idealistically and somewhat naively, making a positive difference, a positive impact… just maybe.

Before medical school, I dreamt of working in far-away lands. But medical school progressively drained, or at least temporarily distracted me, of the energy for that vision. However, travelling from Hong Kong to Kolkata by a circular land route during a year off before the final year of medical school, sowed the seeds again.

Joining the relatively new "do it all" specialty of emergency medicine helped. But then the images of the Rwandan genocide flicked the switch. And the stories of a med school alumnus from the depths of the Srebrenica massacre poured more fuel on the fire. But ironically, there was a primary examination to complete first, an unusual moment of patient discipline shown by me in the midst of a dream of escape. Finally, with a bunch of emergency, gen-med, paeds, anaesthetics, ICU rotations and a six month Diploma of Obstetrics and Gynaecology just completed, I boarded that flight, ostensibly for a Médecins Sans Frontières (MSF) mission in North Afghanistan, but really it was a flight to a wonderfully fulfilling and lifelong adventure in Global Emergency Care.

The conflict erupted in my first week in country. Frontlines to the north and south, a closed border to the west, the physical border of the Hindu Kush to the east. A rooftop in our street enthusiastic with its anti-aircraft fire was an early briefing, that from when we first heard the artillery fire to when the aircraft bomb would land, allowed us only eight seconds to reach the subterranean concrete bunker (stocked with a radio for comms and a half dozen bottles of Turkmen vodka smuggled in by the French logistician for the long-haul).

As just two expatriates in the province of one million Afghans, our duty was to identify shelled-out buildings to set up (furnish, lime and staff), clinics to support the resilience of an internally displaced population, who was vulnerable to everything from diarrhoeal disease, pneumonia, measles, leishmaniasis, typhoid, land-mine injuries and more. We met local warlord commanders to seek reassurance for their protection of the independence, neutrality, and impartiality of our activities. I was introduced to all as Dr Gigi, because that was the name our French-Belgian administrators assigned me on arrival into the coordinating compound at mission-HQ in Mazar-i-Sharif. At my going-away gathering with the local staff seven months later, our chief translator decided to confide in me (with a twinkle in his eye) that the sound of "gigi" (i.e. my adopted name for all), in Farsi, was like a diminutive term for breast. I reflected on all of those intros to heavily armed and guarded commanders… as, well, Dr Boob. Maybe that title reassured them that newborn nutrition was well in hand. As in the mayhem of any emergency department (ED), we like to remember and share the lighter moments amidst the relentless chaos and desperation of the people we try to help.

The desire, on debriefing in Brussels, to immediately take on the next mission offered (in this case Mozambique), is hard to contend with. But the wish to stay (relatively)


Dadaab refugee camp

grounded, with a home base and further professional development won the day. Twelve months working in Belfast followed (my first days were welcomed this time by the tragedy of the Omagh bomb), and then a 12 month stint in the amazing, not-quite-home-yet of the Top End of Australia. Intermittent retrieval flights over the vast landscape to the country's most remote clinics, and a brief period in Timor Leste, preceded the real return home (to Victoria) for Fellowship Exams.

A marriage proposal in Scotland before a pre-wedding MSF mission to Kenya, seemed a fair trade at the time. The Dadaab refugee camp, with more than 130,000 refugees, mostly from war-torn Somalia, was the biggest and longest-standing refugee population at the time.

My rudimentary snapshot of the intractably tragic life-journey for the young refugee women, even with the health system being supported by an international non-government organisation, remains vivid. The frequency of obstructed labour, not helped by genital mutilation some years prior. This led to foetal distress and the consent for Caesarean sections resting with suspicious grandfathers. And even at 24 hours of second-stage labour (waiting, pleading, for that mandatory consent), an occasional live birth, cementing the ongoing reluctance for Caesarean sections, with its legacy of dangerous non-operative births for the expected large families. Then the consequent fistulae leading to divorce and community rejection…and a visit from the fistula surgeons sometime in the six months to follow. What to say? It's very difficult to put into words the repeated futility of reactive emergency care and disaster response, in the context of global inequity, vulnerability, and a wasteland of resilience.

*The conflict erupted in my first week in country. Frontlines to the north and south, a closed border to the west, the physical border of the Hindu Kush to the east.*

Again, we ED folk like to highlight and share the lighter moments, stemming from the occasions where there is no visible light to share. Ah, this one might help. In Dadaab, we each lived in our own tukul hut in the military guarded compound. In the middle of one night, I got out of bed and headed for the tukul door to the outside

loo….I felt lots of squelching under (bare) foot turning on the lights and bending down to check out the hundreds of black things on the concrete slab floor, all the while these same black things fell from above onto the back of my neck. Forced to investigate, looking up at the ceiling; a new hole in the roof recess had opened up and a trail of maggots moved in a procession; it seemed they had discovered a tasty dead bat. A fresh tukul was quickly organised for my stay…

Back home to belatedly help with the wedding plans,

*What to say? It's very difficult to put into words the repeated futility of reactive emergency care and disaster response, in the context of global inequity, vulnerability, and a wasteland of resilience.*

I dived into my public health education, and my 'geekish' fulfillment of a Biostats masters followed. My bosses at the Alfred rapidly identified, encouraged, and fostered my Global Emergency Care passion. On the other side of a disaster response mission to post-tsunami Aceh, Indonesia, I was developing a deeper appreciation of the intersection between disaster response and emergency care systems. As teams from the ED, we have had the opportunity to at least try and help to address disaster responses prior to the inevitable next disaster: the development of sustainable and resilient trauma and emergency care systems. And we have enjoyed the great privilege of partnering with colleagues, particularly in Asia (Sri Lanka, India, Vietnam and Myanmar), but also with those I get to work with in a Melbourne ED and those engaged in a similar passion with the enduring support of ACEM. I was further wonderfully mentored in bringing my passion for global trauma and emergency care system quality improvement and data to a doctorate. I pursued this dream across a sabbatical to the shiny offices of the World Health Organization in Geneva and elsewhere. Additional opportunities to join teams participating in emergency and trauma care training and system development work were repeatedly hosted over the last couple of decades by colleagues in Iran, Papua New Guinea, China and Tanzania.

Humanitarianism is best embodied by those with whom we are privileged to work alongside in settings less privileged to our own. Regardless of how embedded we are in a project away from our "home" base, our collective hard-work, mentorship, training, and the occasional making of a positive and sustained impact, still comes in relatively "parachuted" visits. Notwithstanding the rise of the internet in global emergency collaboration, we can leave the visited countries of our projects; we get to come home to consistent safety

Training Somali midwives

and comfort. Our local Global Emergency Care partners don't leave. They turn up, every day. And not only do they not leave their country, their emergency care duty or post, some, such as our emergency care friends in Myanmar, are unable to leave their vengeful prison detention… for years. Or for the many humanitarian women looking to train or practise any medicine in Afghanistan, they cannot leave the imprisonment of an abominable social code, entrenched in law. Our humanitarian friends in Sri Lanka cannot take guilt-free leave from their ED posts, even in the midst of the current impact of institutionalised corruption and incompetence.

So, most of all, I say thank you to the multitude of humanitarians turning up to work in emergency care in all corners of the globe. Thank you to those who have generously welcomed and hosted me, and worked alongside me, with eternal patience, enthusiasm and diligence, on behalf of the current and future patients of your country's emergency care system. Your efforts will not be wasted. And we will meet again.


# Global Emergency Care: How Can it be so Different?

**Dr Sandy Inglis**
Dr Inglis is a peripatetic millennium FACEM. A resident in France, he now splits his career between humanitarian work, expedition medicine and occasional locums. He has experienced the best and worst of emergency medicine and to make even a small difference, is what still drives him.

I gawk with hidden horror through the shards of a broken window into the shell of the emergency room. A seven-year-old girl has just been dragged in by her extended family and a chaos of wailing and shouts surround her. She has been hit by a rickety bus on the dusty crowded streets of this hot sub-Saharan city and, in the absence of any first responders or ambulances, has been literally man-handled down the streets and into this emergency area.

It is a makeshift room that previously served as the dermatology clinic, with littered stains on the floors and walls, a few disconsolate bent benches serving as stretchers and broken windows, allowing easy access of the heat and dust of the Haboor, which frequently blows in here from the Sahara. She is limp, not moving and her eyes are closed; an oozing abrasion adorns her forehead. There are no monitors, no IV lines, no meds. The trolley teeters dangerously on three rusted wheels.

A nurse tries to calm the distraught family and a doctor wanders in from her desk next door. She absent-mindedly prods the child's belly and starts to scribble on a scrap of paper. No stethoscope, no blood pressure, no oxygen saturations, no X-rays. She proffers the note to the family and directs them to an outside pharmacy where they may purchase an IV and some fluids and pain-relieving anti-inflammatories. She advises them to try and get a CT of the child's head, but that the nearest neurosurgeon is hours away in another city. They leave and the child lies quietly gurgling on her back.

Meanwhile, in another corner of the world, the black helicopter glints in the sunlight as it arches over the ship below, blades thudding through the crisp polar air. It settles gently onto the aft deck, skids neatly aligned with the bright yellow H. Chic fur-clad passengers slip out. The mood is upbeat. Polar bears and whales have been spotted, gaping glaciers viewed, and a mountain top landing made, with magnificent views alongside the obligatory glass of Moët.

I shoulder my medical bag and return to my onboard 'hospital'. I admire the set up. A Zoll state-of-the-art defibrillator with full monitoring capabilities including ECG, O2 sats, NIBP and ETCO2. Not only can I defibrillate with it, but it is geared for heart pacing too. Between the three ships on our private expedition, we have no less than seven AEDS's. I have a massive trauma kit backpack with all the latest clotting agents, surgical kits and tourniquets.

I have full intubation capabilities, a small ventilator, electrical suction, magnifying head loupes and even an ultrasound machine. My medication cupboards are generously stocked. The other two ships have extensive medical capabilities and equipment all organised for on-board tele-medical communication.

*I love extremes - the mountains and valleys, hot, cold, highs and lows. But this year's emergency medicine extremes have left me somewhat bewildered, maybe empty.*

I noted too a Kendrick extraction device, leg traction and air splints and an oxygen concentrator. After a week on board I've dispensed some Sudafed, Strepsils and Imodium. A chef had a minor burn and the pilot strained his knee. The crew and passengers are thankfully fit and healthy. But I'm there just in case.

Emergency medicine has transported me to many corners of the globe but never have I felt so acutely the gaping abyss in health care between the rich and the poor, as I have this year. My work with an international humanitarian organisation has taken me into hell holes ravaged by war, coups and revolutions, where basic health care is largely non-existent. Infrastructure is wrecked, supply chains stripped and expertise scant. Corruption prevails, taps are dry, and latrines overflow with

Arctic photo credits: Coulson and Tennant Photography.

stinking sewage. But the result is always the same. People suffer. No antibiotics, no pain relief, no IV fluids, no water. Desperation creases grim pleading faces and mothers sob for dying infants. We do our best. We fix, we procure, we teach, we supply. But how will it last?

And then the pendulum swings, my humanitarian contract ends, and the lure of arctic adventures draws me to the ice and the polar regions. Then I experience a fantasy world of decadence and excess where budgets don't exist. Medical equipment, medications, and an emergency medicine specialist are small change and are there to pamper the rich, to cover the 'wotif'. I revel in this remote wilderness but feel vaguely guilty and somehow redundant.

*Emergency medicine has transported me to many corners of the globe but never have I felt so acutely, the gaping abyss in health care between rich and poor, as I have this year.*

I love extremes – the mountains and valleys, the hot and cold, the highs and lows. But this year's emergency medicine extremes have left me somewhat bewildered, maybe empty. What is this world we're living in? Why is it so unfair, so unequal? And what can we do about it? Can one exist without the other? And what draws me to them? Adventure, altruism, curiosity, humanity?

I'm reminded about the concept of cognitive dissonance, which is the mental or psychological conflict that ensues when one's beliefs or assumptions are contradicted by new information. There is an inconsistency between thoughts, or between thoughts and actions or experiences, which leads to a feeling of discomfort (dissonance), which might then motivate changes in thoughts or behaviour. It can also be thought of as a psychological stress, which arises when someone participates in an action or activity that goes against his/her/their feelings, ideas, beliefs or values. I seem to have had a double dose this year, from the seemingly futile desperation of my humanitarian work to the decadent excesses of top end polar exploration.

For now, I'm not sure, but a call comes through alerting us to a polar bear on the sea-ice on the port side, and I vaguely wonder if my next humanitarian mission will be in Ukraine.



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# Decolonising Language

Language has the power to shape people and cultures. The language we use can influence how we are perceived, how we impact others, and how effectively we work together. For ACEM, and specifically for our Global Emergency Care (GEC) work, this means critically reflecting on the language we use to talk about our work in global health and considering its impact on the communities we work with.

ACEM welcomed recent and ongoing conversations with our international colleagues about decolonising global health in order to achieve health equity. The key message at ICEM 2022, shared by Dr Seye Abimbola, was the need to be self-aware, and to think deeply about our feelings, motivations and reactions, especially in our global partnerships.

ACEM's commitment to equitable partnerships in GEC compels us to reflect on the potential for our activities to unintentionally reinforce colonial power imbalances that undermine both the work itself and the communities we are working with. Global disparities in access to funding and training opportunities are further compounded by the dominance of Western knowledge and methods over those of Majority World countries. 'Majority World' is a term used to describe those countries combined who hold most of the world's population (Asia, Africa and South America). Yet the dominance of Western knowledge and Anglo-languages includes a global health vocabulary that is rooted in racism and colonialism. Opposing classifications such as 'developed' versus 'developing' and 'resource-rich' vs 'resource-limited' create false hierarchies that can reinforce a sense of superiority or inferiority .

ACEM commits to continued self-reflection across its GEC programs and activities. The College strives to demonstrate respect and integrity in its workplaces and in developing and delivering publications, policies, programs and services for our members and the communities they serve.

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*We strive to demonstrate respect and integrity in our workplaces and in developing and delivering publications, policies, programs and services for our members and the communities they serve.*

Reviewing and addressing how we use language in GEC is one of the first steps ACEM is taking to challenge the implied hierarchies in current global health vocabulary. For the College, decolonisation means reflecting on global racist systems and histories and taking steps to recognise and replace harmful language. For example, we actively discourage the use of the terms 'Third World' versus 'First World' that imply racial hierarchy , and we are in the process of phasing out the use of 'developed' versus 'developing country' in favour of more nuanced descriptors that acknowledge the increasing dissimilarities and the unique economic and social variables that define each country's needs.

Policies addressing gender inclusivity have been shown to reduce gender-based thinking. By being intentional about the words we use (and don't use), we play a small part in breaking the cycle of systemic racism and oppression that impacts Bla(c)k, Indigenous, and communities of colour.

ACEM acknowledges that decolonising the language of GEC requires sustained effort over time, however the College is already taking steps to increase our accountability.

- ACEM is developing a Diverse, Equitable and Inclusive Language Guide to guide how staff use language respectfully and inclusively when writing about and referring to diverse groups and individuals. This goes beyond GEC and ACEM will honour this commitment in our First Nations Health Programs.
- The Global Emergency Care Committee (GECCo) and GEC Desk are conducting a review of ACEM's Developing Country Policy to reflect on how we write, speak and think about the countries that we partner with.
- Changing the description of ACEM members and trainees who are independently supporting GEC activities to 'Fellow in country' and 'Trainee in country', respectively.
- Reviewing our feedback and complaint mechanisms to ensure accessibility and transparency.
- Increasing two-way communication about the College's work in GEC.

We are aware that challenging racist and colonial language is an ongoing practice. Language evolves, and doing better requires commitment, accountability, and responding with humility. We hope to keep this conversation going and invite feedback and suggestions from College members and trainees. Please contact the GEC Desk: GECnetwork@acem.org.au

*Author: Juliette Mundy, Coordinator, Grants*

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# Dr Carissa Herbert

*You can't pour from an empty cup.*

Dr Herbert is a freshly minted FACEM currently working in Te Whatu Ora – Te Matau a Māui (Hawkes Bay).

**Why emergency medicine?**

Emergency medicine hadn't really been on the career list when I left medical school, but after a few weeks into my first run as a PGY2, I started to really enjoy it. The emergency department (ED) is a combination of all the things I love about medicine – the challenge of the undifferentiated patient, the adrenaline rush of a critical resuscitation and working within a dynamic team. As a big picture person who enjoys procedures, teaching and problem solving, it suits my personality and it's a challenging but interesting place to work.

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

As most ED trainees will know, the challenge is trying to advocate and do the best by your community in such a resource limited setting. Managing frustrations from patients, whānau, colleagues, the wider community and hospital staff can lead to very difficult interactions, which quickly become arduous. Importantly, positive interactions where you provide timely and excellent care for whānau is the best part of my job – it is very easy in the thick of a shift to forget the huge impact we are having and taking some time to appreciate and reflect on this makes the job incredibly rewarding.

**What do you do to maintain wellness/wellbeing?**

Taking time to pause and move. Cycling to work is a great way to start the day – fuel efficient, fresh air and easy parking. Having a core group of family and friends for support. Realising the things in your life that are depleting you and either minimising, delegating or eliminating them completely. I'm not perfect but when I commit to a regular meditation practice I think it makes a huge difference. You can't pour from an empty cup.

**What do you consider your greatest achievement?**

I have a spirited, inquisitive and hilarious toddler who will always be my biggest achievement. Professionally, like a number of trainees, COVID-19 really threw me a curve ball. At the start of the pandemic I had committed a year of study to the Fellowship exam, was isolated from my partner and family during the first lockdown, was the Senior Registrar at a tertiary centre, and lucky to be pregnant. It took a huge shift in focus, an 18-month delay in exams and became a tricky juggle to get through the pointy end of training, but I am proud of the way that I tackled that and grateful for the village that supported it.

**What inspires you to continue working in this field?**

The job is fun! Busy, challenging, interesting, dynamic – all the things I want in a career. In the ED we are doing incredibly important, meaningful and rewarding work, and that's what makes me come back to work every day.

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

You are going to make mistakes. As a junior registrar I missed an important diagnosis on an initial consultation with a patient who went on to require significant emergency intervention. At the time it was a confronting and traumatic experience and made me rethink my career in ED and medicine. I would encourage trainees to think about this, and who they will reach out to for support if it does happen, remembering that it occurs for the vast majority. I initially felt like I was isolated in this experience, and hesitated to reach out to colleagues and mentors, when what I needed was the opposite. These experiences make us human and better equipped to support our trainees and colleagues in the future. If possible, I would probably also take the opportunity to tell myself that a worldwide pandemic was going to screw up my five-year plan – try not to panic.

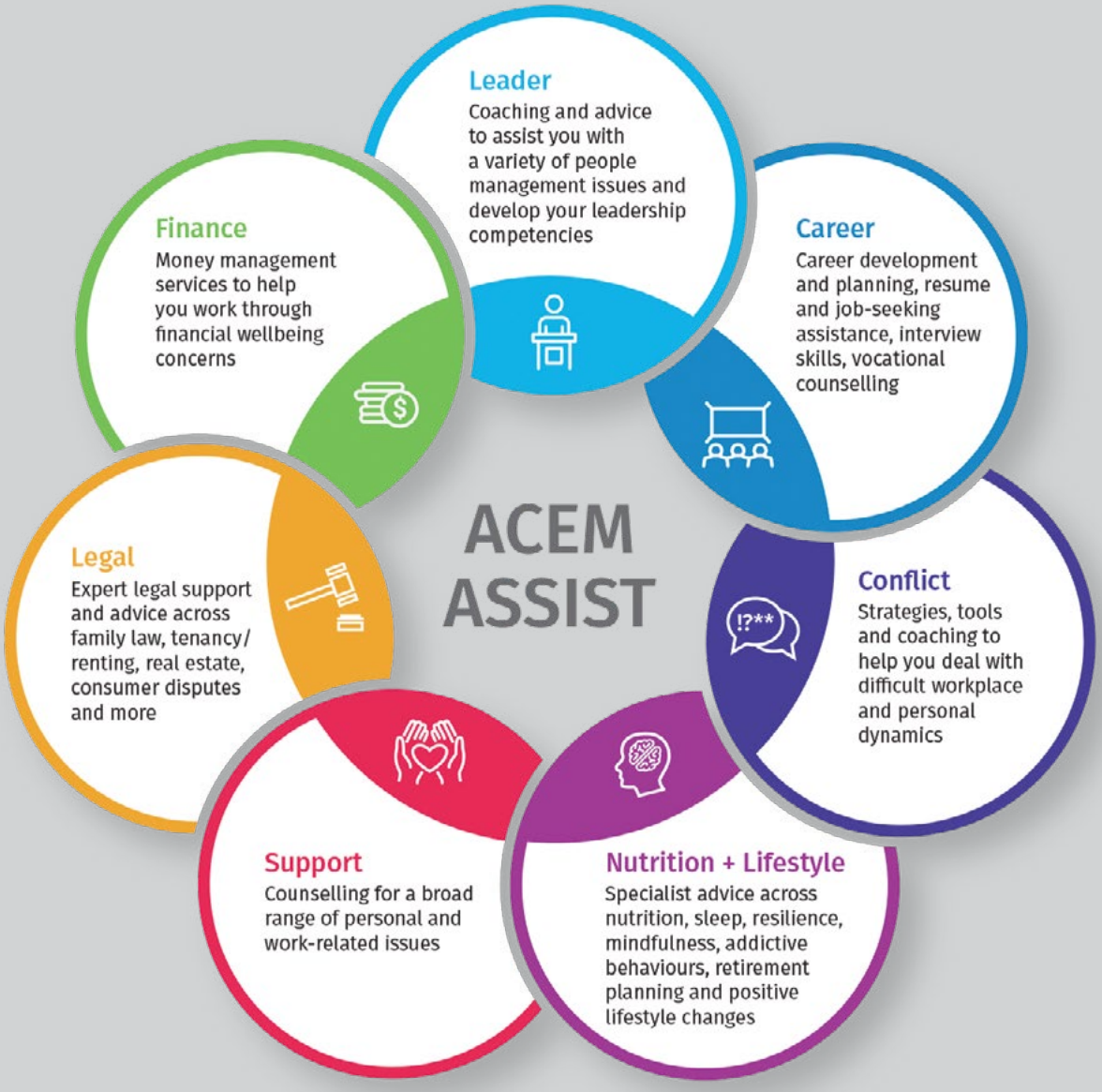
**What do you most look forward to in the future of emergency medicine?**

The work that Manaaki Mana is currently doing to reduce inequities for Māori in ED is incredibly exciting and inspiring. I'm looking forward to being part of that shift and seeing how we can do better for our whānau in Hawkes Bay and Aotearoa.

# 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.

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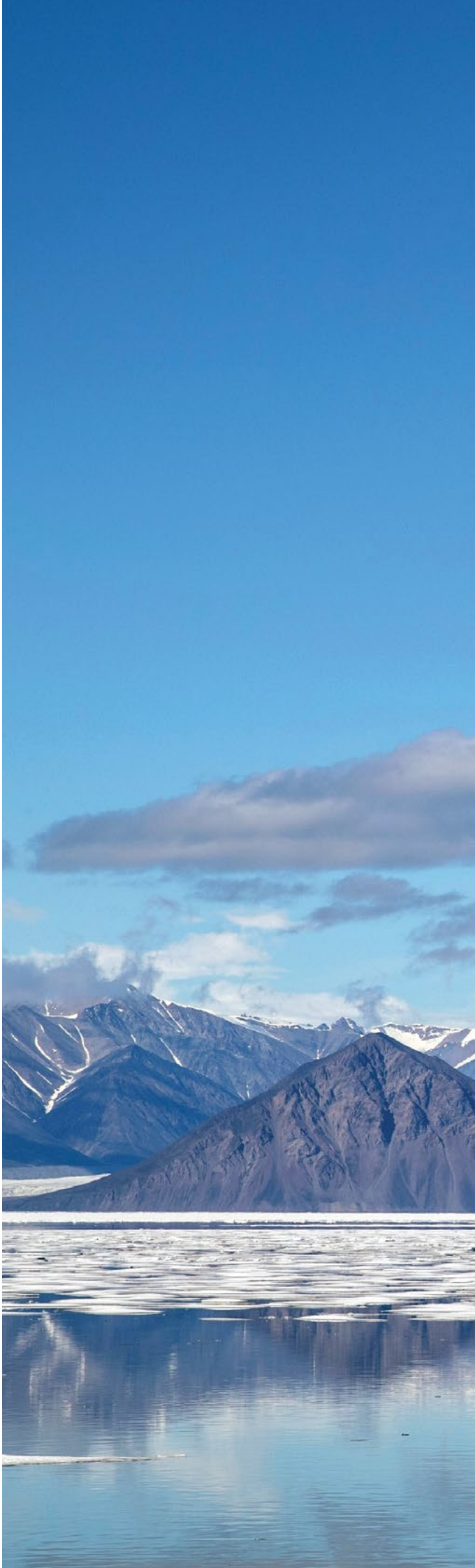
**Aotearoa New Zealand:** 0800 666 367



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