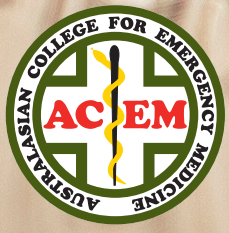
FROM STRENGTH TO STRENGTH

The first 35 years of the
Australasian College for Emergency Medicine, 1983–2018



Dr Toni Sherwood

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The first 35 years of the
Australasian College for Emergency Medicine, 1983–2018

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acem.org.au

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While every effort has been made to ensure the accuracy of the contents, ACEM and the author welcome any information that will assist a future publication.

Warning: Aboriginal and Torres Strait Islander peoples should be aware that this publication may contain names and images of people who are deceased.

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DEDICATION

ACEM dedicates this book to the first President of ACEM, Dr Tom Hamilton.

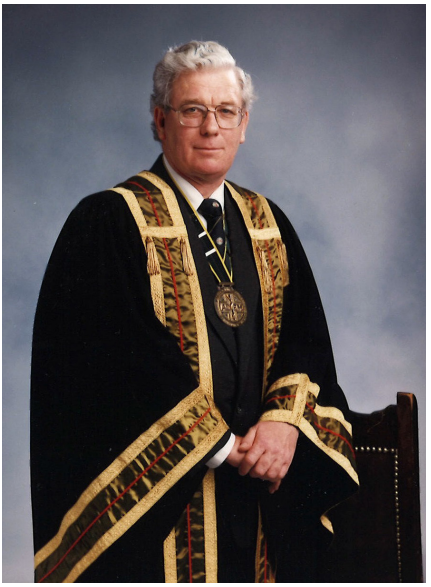
Tom was the first person who I ever heard say, "it is a privilege to look after our patients". A principled man, he believed that there always needs to be someone who takes responsibility for patients, and he thought this should be in the ED. "Send them here," he'd say to other medical practitioners. "Send them to 'cas'. We'll sort them out."

We were close professional and collegiate friends for over thirty years. I met him following his return from the US where he got a PhD. He'd been extruded from the surgical training program in Edinburgh, because he was a strong personality. He combined the wiliness of a Scottish street fighter with a post-enlightenment and scientific humanism in the tradition of David Hume.

He was fearless and sharp. A strident critic of the status quo. These are natural characteristics of the emergency physician, then as now.

We spent an enormous amount of time together as we developed the basic curriculum for emergency medicine. He slept out the back of my house, in the spare room, and I would often travel to Perth. We sat down and we spent dozens of hours together working out the intellectual foundations of the basic sciences that were necessary for emergency medicine. Tom said, 'If you want to change the house, you have to learn the rules of the house. So, we're going to learn the rules and then we're going to change them'.

He energised and inspired the small group that was to become the foundation fellowship of the college.



We never had a disagreement. Never. Perhaps because we never worked a clinical shift together! But, really, because we were united in the need to set up another specialty. We were motivated, both of us, by the need to provide for the initial reception and early management of all acutely ill patients, and, secondly, to have a group of clinicians who were intelligent and moral and committed to looking after them and providing their care.

And now we do.

Dr Joseph Epstein
ACEM President, 1988–1992

FOREWORD
COLLEGE PRESIDENT

Kia ora koutou katoa

Welcome to this account of our College history, outlining the first 35 years of the Australasian College for Emergency Medicine, from 1983 when we were first incorporated, to 2018. From the outset I would like to thank the College's History Project Steering Committee and Dr Toni Sherwood, whose efforts have been instrumental in bringing this book to fruition.

It is striking just how far our specialty has come. Compared to the early days of A&Es or casualty departments run by second- and third-year house officers corralled by experienced nurses, the emergency departments of today – and the highly skilled and trained staff who work in them – are barely recognisable.

It was Douglas Adams who coined the phrase "I may not have gone where I intended to go, but I think I have ended up where I needed to be." Emergency Medicine has evolved significantly since the birth of our College, accepted as a stand-alone, independent specialty in 1993, with 67 Foundation Fellows, having been once labelled "a Holden speciality, not a Rolls Royce", by a Plastic Surgeon. One might discuss what vehicle analogy might be made now; something fast, adaptable, still rapidly developing, - perhaps the Tesla of Medicine; not perfect, but cool, innovative and looking to save the planet.

By design, this evolution of our specialty has occurred in parallel with the evolution of our College. From ACEM's inception, the work of our founding Fellows has been built on, to the point where our College is the robust, mature, agile and professional organisation we recognise today.

This evolution extends beyond improvements in the care provided, the training of emergency physicians and the maintaining of professional standards. ACEM is also now recognised as a sophisticated advocate on issues of importance to our members and trainees, as well as for the people and communities who we serve in Australia, Aotearoa New Zealand, and even further afield.

So how did we get where we are?

Above all else, "he tangata", it is people. From our Foundation Fellows – the giants upon whose shoulders we all stand – to the generations of members and trainees who have advanced so much – together, we are the College.

Special acknowledgement must go to the inaugural ACEM President, Dr Tom Hamilton, who – as with so much of his involvement in the College – was passionate about this project. Following Tom's passing in August 2020 and in light of his immense contributions, he is fittingly acknowledged in these pages.

It is Tom's legacy, along with the legacy of all our Foundation Fellows, that we seek to honour – through this book, through the care we provide our patients, through our College work and in living its core values of equity, integrity, respect and collaboration.

The first 35 years is not the end of the story. As the epilogue notes, we continue to mature, and new challenges continue to emerge – not least of all the COVID-19 pandemic.

However, just as has been the case for more than 35 years, our training, skills and professionalism, as well as the compassion and kindness we show each other, and our patients, will continue to see us through.

All of this is supported by our College. And in another 35 years, let us all hope we can reflect on how that College has gone from strength to strength … to strength.

Dr John Bonning
ACEM President

FOREWORD

CHAIR OF THE HISTORY PROJECT STEERING COMMITTEE

I remember when I was 17, just finishing high school and hoping that I would get the marks to follow my grandfather's path and study medicine. He was a GP, a very good GP, and I wanted to be like him. Little did I know that at the same time I was contemplating my future, my future was being changed with the birth of the Australasian College for Emergency Medicine. Women and men, who I had never met, some of whom later became my teachers, my mentors, my Emergency Medicine heroes, had realised their dream of creating a college for emergency medicine in Australia and New Zealand.

Fast forward to my intern year. I did rotations in Traralgon and Moe EDs, did some work in Moorabbin ED and started to get a taste for emergency medicine and it is notable that all three of those departments do not exist now. But it was when I first stepped foot in the busy and bustling ED at Monash Medical Centre in my second year, I knew I had found my tribe. The deal was done and dusted; I was hooked. Emergency medicine was my thing and I have never doubted my choice.

This book outlines the history of ACEM, and the great people involved in taking the idea of ACEM from a thought to where we are today; a thriving College and a thriving specialty, with over 3,000 Fellows, almost 3,000 trainees in the FACEM and other training programs, and over 100 staff. ACEM has grown in stature and influence; has impacts on politics and policy and is stepping up to be a lead body in advocating for the health systems of Australia and New Zealand, ensuring that access and equity to emergency medical care is the right of our communities.

Our reach is expanding beyond our shores, with our Fellows having an enormous impact in the South Pacific, through Asia and stretching to the Middle East and Europe with the development of training and education for EM across all of these regions.

We have achieved a great deal in a very short time. I hope that reading this history will help you understand the motivations, the values and the passion of those founding members and all the amazing people who have shaped ACEM and emergency medicine in Australia and Aotearoa New Zealand since then. I hope it inspires each of you to take on the future challenges of our health care systems with new knowledge and the combined influences and ideals of those who came before you. I hope it strengthens your resolve to do what emergency physicians do best…to make a difference, to change lives, to advocate and care for all those who come to our doors each and every day.

Dr Simon Judkins

Chair, History Project Steering Committee
ACEM President, 2017–2019

PREFACE
STRENGTH TO STRENGTH

This publication commemorates the 35th Anniversary of the foundation of the Australasian College for Emergency Medicine and was conceived as an opportunity to honour the achievements of the past while also looking toward the future.

This history traces the College's beginnings as little more than an idea through to its evolution as a mature organisation. It has a focus on the organisation and the contribution of the people who made it, rather than the development of the specialty of emergency medicine.

ACEM is uniquely a college "for" rather than "of" its discipline amongst the medical specialist colleges in Australia and New Zealand. This is an important distinction that speaks to the heart of the College and its Fellows. The preposition "for" was purposefully chosen and indicates a commitment to the development and provision of emergency care. As a discipline, emergency medicine grew out of the need to provide a new type of care in a changing environment.

Like any successful organisation, ACEM owes much to its people, and throughout its history it has benefitted from the outstanding leadership of successive Presidents and Censors-in-Chief supported by Councillors, Censors and Fellows. Jenny Freeman – the College's first employee and inaugural Chief Executive Officer – has observed that the College's early leaders had 'qualities that seemed to suit the stage of development that the College was in at the time' and together with the support of Councillors, Censors and Fellows 'had the particular drive and dedication required to create something worthwhile and life changing for so many needing emergency care'. This observation is equally accurate today; College leaders and members remain committed to the College and the specialty.

The history has a chronological structure with each of the seven chapters documenting a specific and significant period of College development. Although focused on major and important developments in the life of the College, each chapter generally includes discussion on issues of College governance and developments in education and training. The chronological structure although at times difficult to manage gives a sense of all that was happening in the College at a particular time as well as the increasing complexity of both College activity and the environment in which it operated.

The history has been written predominantly from primary College sources, including the minutes and papers of the ACEM Council and more recently the ACEM Board, annual reports, consultation and discussion papers. College publications such as *Your Direction* and *yourED*, the editorial and College news sections of the College journal *Emergency Medicine Australasia* and the College website have also been very useful. ACEM has evolved against a background of increasing government oversight and regulation, and where appropriate and required various government sources have been consulted.

Interviews with a number of Presidents, Fellows and staff also inform the history. These interviews, while always interesting and informative are particularly important for the "human touch" they enable. The obvious pride and commitment of those interviewed, the determination to push on – particularly in the early days – shone through and colour this history. The result is a detailed and comprehensive account of the College journey so far and the contributions of many Fellows over a number of years.

In the interest of readability and to avoid unnecessary repetition, I have generally avoided using any title, for example "Dr", when referring to College Fellows and trainees. When the College was founded it was more usual to refer to the "emergency department" than the "ED". Over time this convention has changed and now "ED" is the preferred term and one most often used. Similarly, in recent times it has become the preference within the College to use "Aotearoa New Zealand", rather than "New Zealand". In both the above cases, rather than adopt one or the other for use throughout the history, both are used and stand as a reflection of changing conventions and terminologies.

In researching and writing this book I have been assisted by many generous and helpful people. I am grateful to the members of the History Project Steering Committee for their guidance in determining the structure of the history, and advice on events of significance in the College's early history, commentary on early drafts of the history and reflections both written and oral. David Taylor generously provided notes of earlier work he had done towards preserving the College history. Liv Cameron, a long-time College employee, provided valuable assistance in locating early records of the College and happily shared her knowledge of many aspects of College life. Jenny Freeman provided many valuable insights about aspects of College history. Thank you also to those Fellows who gave generously of their time and agreed to be interviewed.

Many members of the current College staff have provided significant support. In particular I am grateful to the CEO Peter White and Georgina Anderson for their recent contributions to the completion of this history.

It has been a rewarding task to document the College's development, significant achievements and challenges, and I am grateful for the opportunity to make this contribution to the ACEM journey.

Dr Toni Sherwood

October 2020

CHAPTER 1

BEFORE THE COLLEGE 1973–1983

In the space of 60 or so years, emergency medicine has developed as a distinct medical specialty, delivering expert and timely care to the acutely ill or injured patient. Before this, patients relied on the casualty departments of public hospitals to deliver unplanned care.

In the traditional mid-twentieth century casualty department, patients arrived and were seen first by a nursing sister. Next, they were examined by an inexperienced junior doctor who would then contact the supervising consultant of the day. Staffing was distributed among all consultants and often considered a burdensome addition to an already busy schedule. In such departments, care could be 'erratic', patient outcomes were often dismal and public health benefits minimal.[1]

This service may have seemed adequate at the time – there were few effective operations, anaesthesia was risky, and serious trauma was likely to result in death. However, this situation changed from the 1950s with the introduction of significant medical advances, including the widespread use of defibrillation for cardiac arrest in the 1960s, and the emergence of effective drug therapy for anticoagulation, cancer and heart failure. Better surgical techniques and improved sterilisation processes resulted in newly effective management of acute vascular disease, bowel obstruction and intracranial pathology. These surgical and treatment advances, along with the development of new techniques in radiology and pathology, improved clinicians' ability to diagnose and treat a number of emergency conditions with time-dependent outcomes.[2]

As these treatments became available, people expected their governments to provide them. From this point, it was inevitable that the traditional model of the casualty department needed to change. Another significant catalyst for change was Sir Harry Platt's report on British accident and emergency services, published in March 1962. Important recommendations of this report included the phasing out of inexperienced junior medical staff in casualty departments, and the appointment of consultants to supervise patient management and instruct trainees in the new discipline of emergency medicine. Platt also recommended renaming the casualty department "Accident and Emergency" to better reflect the care provided.[3]

With these developments, emergency medicine evolved simultaneously in the USA, the United Kingdom, Canada, Australia and New Zealand. Although there are differences in the trajectory of the development of the specialty in each jurisdiction, all began with the appointment of interested medical practitioners to leadership roles in casualty departments (or, in the USA, the "emergency room"). In these individual environments, attention was paid to the development of systems to provide optimal care for patients with medical emergencies. From such beginnings, emergency medicine has evolved 'as a coherent discipline with a unique set of cognitive, administrative and technical skills for managing all types of patients with acute illness or injury'.[4]

Australian and New Zealand Beginnings

In Australia and New Zealand, the first senior casualty appointments were made in the 1960s. Robert Duncan Scott, known as Duncan Scott, was appointed as the first full time senior casualty officer at the Christchurch Hospital in 1963. Scott – a GP anaesthetist who had served as an army doctor during the Vietnam War – introduced training and orientation for his resident medical officers, as well as clinical and administrative protocols. In Australia, Geelong Hospital was the first to install a casualty director, with the appointment of general practitioner Vic Henton to the role in 1967.[5]

The Association of Casualty Supervisors of Victorian Hospitals (ACSVH) was the first body in Australia to focus on emergency medicine as a discipline. Its formation followed Peter Bush's 1973 report on the Royal Melbourne Hospital's casualty department, and his observations of similar facilities in Western Australia, the USA and the United Kingdom. Returning to Melbourne after his study tour, Bush put forward a number of suggestions for improving the current problems at the RMH and developing emergency services more generally. He was also aware that overseas emergency medicine was developing as a specialist area of medicine 'requiring particular skills and knowledge' and embracing 'many fields of professional expertise'. Noting that the American Medical Association had already recognised emergency medicine as an area of specialist practice, he supported the development of both a training program and a career structure in Australia.[6] This recognition underpinned his support for the formation of a professional association in Victoria.

The Association's development also had the support of David Race, the chairman of the Hospital and Charities Commission (HCC) – forerunner of the Health Department of Victoria – and Chief Medical Officer for Victoria. ACSVH's membership originally included doctors and nurses, as well as clerical and ambulance staff, but was soon reduced to only doctors and nurses.[7] The members met regularly for clinical and business meetings, and rapidly expanded to 50 or so people drawn from metropolitan and country hospitals. The Association formed subcommittees for education, to gather statistical information, and to develop guidelines for emergency admissions in order to make recommendations to the HCC about the development of emergency services.

From its inception, the ACSVH was committed to improving emergency medical services for the community. It enjoyed considerable political success, much of which was attributed to the fact that its membership included both doctors and nurses. In October 1976, outgoing President John Hurst acknowledged that the group had been 'well-accepted as a responsible body by the Ambulance Services, the HCC and the Association of Medical Superintendents, and [was] instrumental in changes to the blood alcohol system'. The Association soon garnered support among medical superintendents and senior medical personnel. The Director of Medical Services at the Western General Hospital, speaking at the ACSVH's Annual General Meeting (AGM) in October 1977, supported the development of casualty services and urged the members present to 'stay with their chosen field and help develop a meaningful career structure'.

At this point in time, Victoria was the only jurisdiction with a formally constituted organisation for emergency medicine. In Western Australia since the 1977 arrival of Tom Hamilton as Director of the Emergency Department at Sir Charles Gairdner Hospital, a group of doctors had met informally to discuss local problems and share clinical information. This group consolidated itself as the Western Australian Society for Emergency Medicine (WASEM) and had the specific aim of improving standards of practice, training and research in emergency medicine in Western Australia.

Other states were less formally organised. In Queensland, Frank Garlick (Royal Brisbane Hospital) and Noel Stevenson (Princess Alexandra Hospital) instituted training and developed systems for better management. They also provided inspiration for young doctors working in their departments. Both were instrumental in setting up the Queensland Casualty Association in the late 1970s.[8]

In South Australia, Allan Hunt reports irregular meetings in the late 1970s of those in charge of the casualty departments of the major public hospitals. However, there was no formal organisation until discussions about an Australian Casualty Association began in 1979. South Australia subsequently formed the Association of Casualty Supervisors of South Australian Hospitals, which soon became the South Australian Casualty Supervisors Association (SACSA).[9]

In Tasmania in the mid-1960s, casualty facilities were established at both the Royal Hobart Hospital and the Launceston General Hospital. From 1964, the Royal Hobart Hospital had a purpose-built casualty department where Harry Jamison combined the duties of coordinator of casualty services for the hospital with the responsibilities of Deputy Superintendent and relieving Surgical Registrar. He had the assistance of another practitioner and a registrar 'from time to time'. The Launceston General Hospital had a full time Casualty Officer from the mid-1960s, with another appointed in the early 1970s. Until 1978, the casualty department consisted of a room with one bed for serious cases and an underground general clinic known as "the Tunnel".[10] Doctors working in Tasmanian casualty departments did not establish a formal organisation for education and training. In New South Wales, there was no formal organisation for emergency personnel before 1979; however, the major hospitals – much like those in other states – were developing Accident and Emergency Departments throughout the 1970s.

The Australian Society for Emergency Medicine

The concept of a national organisation for education and advocacy in emergency medicine originated with the ACSVH in early 1978. This concept was pursued throughout the year and, at the October AGM, members were informed that representative organisations in all other states had been contacted and considerable enthusiasm expressed for formation of a national body.[11] In August 1979, members of ACSVH were invited to Sydney to discuss the formation of an Australia-wide group to be known as the Australian Casualty Association (ACA), with a branch in each state.[12] Tom Claffey, an orthopaedic surgeon and the Emergency Director of St Vincent's Hospital, chaired the meeting. After this meeting, ACSVH was reasonably confident that a national body would be formed along the same lines as the ACSVH, and a second meeting was organised for November in Melbourne.

At this meeting, participants agreed upon the name "Australian Casualty Association", discussed a proposed constitution and agreed that membership of the association would consist of medical and nursing staff 'who may in future want to form their own "Divisions" within the Association'. A subsequent meeting was scheduled for March 1980.[13]

Support for the ACA was not unanimous. Western Australia indicated it would not attend the March meeting,[14] while the New South Wales doctors failed to reach a unified position regarding whether or not nurses should be included in the membership of the proposed association. Graham Yule, Director of the emergency department at the Royal Prince Alfred Hospital (RPA) since 1976, together with John Rolleston from the Royal North Shore Hospital (RNS), opposed the idea and advocated for an alternative medical practitioner-only group. A series of informal discussions took place between directors of emergency departments in New South Wales, culminating in a meeting at RNS on 24 June 1980 at which 18 people were present. The meeting voted overwhelmingly not to support the New South Wales Branch of the ACA. It also foreshadowed the formation of the Association of Accident and Emergency Physicians, whose membership would be open to medical practitioners who worked in the area.

To progress this issue, Yule and Rolleston surveyed directors of emergency departments throughout Australia to gauge both the level of support for the ACA and interest in the formation of a medical practitioner-only group. New South Wales, Western Australia, the Northern Territory and Tasmania favoured the latter option, while Victoria, South Australia and the ACT indicated a preference for the ACA model. Both the Victorian and South Australian groups, however, indicated they would work with a medical body.[15] Queensland was undecided. On the strength of this result, Yule proposed the formation of a national body which would be called the Australian Society of Emergency Medicine (ASEM), and invited those interested to a meeting in Sydney on 20 February 1981.[16] ACSVH remained committed to the formation of the ACA, but at the same time realised the importance of a united front and assured Yule and his associates of the ACSVH's co-operation.[17]

Six people attended the February meeting – Bryan Walpole representing ACSVH; Tom Hamilton (WASEM); Graham Yule, John Rolleston and Tom Claffey (New South Wales); and Des Owens (SACSA). Tom Hamilton took the chair and presented WASEM's constitution. The group was firmly of the opinion that membership of the national body should only be open to medical personnel. Bryan Walpole, convinced of the national impetus for a specialist medical group, agreed to make this case to Victorian doctors, and to organise a meeting in Melbourne later that year, with the aim of demonstrating the strength of the movement to form an Australian society.[18]

This meeting took place at the Danish Club in Melbourne on 3 July 1981. It brought together sixteen representatives of various state bodies. The New South Wales contingent included Graham Yule, John Rolleston and Gordian Fulde. Tom Hamilton and Valendar Turner represented WASEM, while Peter Malycha was the lone South Australian representative. The Victorian group included Edward Brentnall and Anne D'Arcy, both of whom were staunch supporters of the ACA. Bryan Walpole remembers that the 'weather was abysmal, freezing cold with rain hounding the windows, but the atmosphere [inside] was heady'.[19] Tom Hamilton remembers the meeting as a 'cathartic and therapeutic session' in which directors from around Australia discovered that their 'individual gripes and concerns were universal'.[20]

Those present found enough common ground to move forward as a unified group, with the WASEM constitution acting as the basis for that of the ASEM. The stated aims of the fledgling Society were to:

- achieve recognition of emergency medicine as a specialty in its own right;
- define a career structure for medical staff in emergency medicine;
- establish training programs for emergency medicine;
- encourage research in the field;
- improve patient welfare;
- facilitate co-ordination of community facilities involved in delivering emergency healthcare; and
- advocate for emergency medicine in academic, administrative and political circles at state and national levels.[21]

Tom Hamilton was proposed as the inaugural President. Anne D'Arcy was elected Vice-President, and Graham Yule and John Rolleston were elected as Honorary Secretary and Honorary Treasurer, respectively. Ordinary membership was available to registered medical practitioners who: possessed an acceptable postgraduate qualification and had significant and active involvement in emergency medicine; or who, in the opinion of the Council, were making a significant contribution to emergency medicine. Membership fees were set at $100 for full membership and $25 for associate membership. The group agreed to hold a scientific and business meeting in Sydney later that year.

Intention to form a College

The Sydney meeting, organised by Graham Yule, was held at the Camperdown Travel Lodge near RPA on Friday 4 December 1981. Some 40 of the 80 practitioners invited attended the Friday meeting that included a tour of RPA, followed by clinical and business meetings. After lunchtime discussions at a poolside barbecue, the afternoon clinical session was abandoned to allow sufficient time for the business meeting. During the course of the afternoon, Edward Brentnall again raised the possibility of the formation of a body such as the ACA that would include both doctors and nurses in its membership. Based on the Victorian experience, he believed a mixed professional grouping had the best chance of successful political advocacy. He met with stiff opposition and, in what he described as a 'fit of temper',[22] suggested that they should just go ahead and form a college. His proposal was met with stunned silence, which Gerry FitzGerald remembers as a 'glorious moment'.[23] Some concern was expressed that the group was too small to become a college in its own right. However, this concern was quickly assuaged with the claim that the Royal Australian College of Medical Administrators (RACMA) had formed with a small number of members. Perhaps a better example was the American College of Emergency Physicians (ACEP) which was founded in 1968 in Lansing, Michigan, with a Fellowship of eight. From this tenuous beginning, ACEP achieved recognition as the USA's twenty-third specialty in 1979 and by 1991, there were 16,000 emergency physicians practising in the USA.[24]

At the conclusion of discussions, the motion 'That the Australian Society for Emergency Medicine be converted to the Australian College for Emergency Medicine with the intention of forming a training and examination programme' was put to the meeting. The motion, proposed by Edward Brentnall and seconded by Des Owens, passed overwhelmingly, with 31 of those attending voting in favour.[25] The decision was made with very little preparation and discussion; however, given the aims of the Society and the successful development of the specialty overseas, it was likely inevitable. Certainly, no one in the room realised the enormity of the decision – or perhaps had any idea about how to become a college.

Bryan Walpole, referencing Ian McWhinney, volunteered that to become a recognised specialty or discipline required the development of a distinct body of knowledge, specific criteria for entry, an educational program and an active area of research. He then reeled off a barrage of tasks necessary to progress the formation of the college, with the suggestion that the responsibility should be shared between states.[26] Obvious priorities were the establishment of the proposed college as a legal entity, the design and implementation of a training program, and the creation of entry criteria.[27]

The ASEM executive appointed in July 1981 that would spearhead these preparations was enlarged to include Des Owens as the South Australian representative, with Gerry FitzGerald representing Queensland and Bryan Walpole as a second Victorian member. Edward Brentnall, Allen Yuen and Des Owens agreed to prepare preliminary documents about governance, research policy and education, respectively for the next meeting. In the spirit that was to characterise College endeavour in its formative years and beyond, these documents were available for the Council's consideration when it met in March 1983. The Council commended the submissions, and proposed

they form the basis of further development by a working party. David Taylor describes the Yuen and Owens contributions as 'benchmark documents' for the fledgling organisation.[28]

With regard to forming the college, it was agreed that Tom Hamilton would prepare Articles of Association and a Memorandum of Association based on those submitted by Edward Brentnall, and borrowed from RACMA. The document would then be subject to legal review before the College sought incorporation under the *Companies Act 1961*. Considering finances, or lack thereof, were of paramount concern, it was agreed the college would be incorporated in the Australian state with the cheapest fees. Eligibility for membership of the College was set as Society members currently working full-time in the specialty, in a capacity senior to that of registrar, for a period of at least three years.[29]

At ASEM's 2nd AGM in Melbourne in July 1982, the secretary reported he had distributed ASEM material to 96 people, of whom 47 were full members of ASEM and 11 were associates. Thirty-two of those contacted remained non-financial members of the society. There were 48 members present at the AGM, with two apologies. Tom Hamilton explained the process for incorporation of the college, and informed the meeting that following communication with colleagues in New Zealand, the Council had agreed to include New Zealand practitioners. Consequently, the Society would become the Australasian Society for Emergency Medicine, and the college would be developed similarly as an "Australasian" entity.

> *In March 1982, I received a phone call from Bryan Walpole – now at the Alfred A&E – saying they were meeting in Melbourne to consider forming a College for Emergency Medicine in Australia, and asking what our plans were in NZ. As I only knew of seven other full time senior ED doctors in NZ, I responded that we were too small to go it alone and could we come to the planned Melbourne meeting to put our case for an Australasian College. I coerced David Snow (Director of A&E Auckland Hospital), and Peter Bamford (Director A&E Dunedin Hospital) to come with me to that Melbourne meeting. At the meeting we were supported by Bryan Walpole and Joe Epstein and the proposed College subsequently became the Australasian College for Emergency Medicine.* [30]
> **Peter Rodwell**

The meeting unanimously resolved to grant authority to the Council of ASEM to register the Australasian College for Emergency Medicine under the Companies Act 1961, with the existing members of the Council – and others as it decided – listed as the subscribers to the Memorandum and Articles of Association of that Company.

In other business, Des Owens outlined the proposed development of an education program and promised to formulate an outline of training and certification. Allen Yuen also led a discussion about research development, and a resolution was passed that the next AGM would be held in Queensland.[31]

An Approach from the Royal Australasian College of Surgeons

While the ASEM Council was pushing forward with plans to form the Australasian College for Emergency Medicine, it was approached by the Royal Australasian College of Surgeons (RACS) with a view to incorporate the specialty of emergency medicine into its organisation. An informal meeting was held on 4 November 1982 in Melbourne – the day prior to the ASEM Council meeting. Attending this informal meeting were: RACS President Dr John Clareborough; Dr Ross Holland of the Faculty of Anaesthetists, RACS; and Tom Hamilton, Graham Yule and John Rolleston representing ASEM. Clareborough proposed the possibility of incorporating the emergency medicine group into RACS. He indicated his opposition to the growing number of 'small' colleges and considered that smaller medical specialist groups were better organised as part of the major colleges. He offered to pursue the matter with the Royal Australasian College of Physicians (RACP) and to have 'meaningful information' available by February 1983. In a subsequent conversation, Clareborough confirmed that discussions had taken place with the RACP about the possibility of joint involvement in the field of emergency medicine.[32]

The ASEM Council discussed the issue at length. Joining with RACS offered significant advantages: immediate specialty recognition for emergency medicine in Australia and overseas; access to the facilities and resources of a larger established college; possible financial assistance; involvement in the sections of RACS relating to road trauma, trauma, burns and intensive care; and better access to training posts in surgery, anaesthetics and intensive care. Arguments against joining with RACS were: loss of autonomy for the specialty – as part of another college it may not be in charge of its own destiny; concern that the specialty of emergency medicine was more medical than surgical; inappropriate surgical content in training and examinations; and, ultimately, a delay in establishment of the specialty while negotiations with RACS proceeded.

> *It was clear to those of us involved in these early explorations that we were neither physicians nor surgeons. Experience had shown that our daily tasks were pertinent to the whole range of medical disorders, all of which might present as emergencies. … Training appropriate to the specific needs of emergency medicine was clearly required, together with an examination system at least equivalent to that of other disciplines. The only way to achieve these ends would be to establish an autonomous College.*[33]
> **Tom Hamilton**

In view of these discussions, and at the suggestion of Tom Hamilton, the Council resolved to incorporate ASEM so it could be an official negotiating body, and to delay incorporation of the college while discussions with RACS proceeded. At the same time, the Council was of the opinion that it should be in a position to determine its future direction by the time of the ASEM AGM in July 1983.[34]

When the ASEM Council next met in March 1983, no further communication from RACS had been received. In view of this, and mindful 'of the strongly felt wish of the last AGM that education and certification in

Emergency Medicine should proceed as a matter of urgency',[35] the Council resolved to proceed to constitute the Australasian College for Emergency Medicine. Tom Hamilton was charged with carrying out this responsibility immediately upon his return to Perth.

With this decision, momentum was building towards formation of the new college. ASEM was due for incorporation at the end of March 1983. Des Owens provided comprehensive details of the proposed syllabus for the primary examination, which the Council duly endorsed. Dates were chosen for the inaugural Primary and Fellowship Examinations (late 1984 and 1985 respectively). Owens was suggested as the obvious candidate for Censor-in-Chief, and a Board of Censors was suggested, comprising – Gordian Fulde (New South Wales), Noel Stevenson (Queensland), Joseph Epstein (Victoria), Ron Hirsch (Western Australia) and Peter Bamford (New Zealand). Names were also put forward for the Credentials, Primary and Fellowship Examination Committees of the Board of Censors.

The inaugural meeting of the new College was scheduled for Friday, 8 July 1983. Plans for the proceedings of this meeting included the election of an Interim Council, the election of office bearers, the election of fellows without examination, and the appointment of the Board of Censors.[36] Graham Yule formally announced the decision to form the College to Society members and encouraged them to support the Annual Scientific Meeting (ASM) at Surfer's Paradise. Yule also requested that all those who would like to be considered for election to Fellowship without examination by the Interim Council forward a full and detailed Curriculum Vitae immediately.[37]

The Council was also encouraged by the official endorsement of ACEP, which congratulated the 'Australian (sic) body on its foundation' and offered future cooperation to achieve common goals.[38]

College Foundation

When the Council next met in July 1983 – immediately before the ASEM ASM – it considered again the possibility of joining with the established colleges. This followed receipt of information from RACS that a joint RACS/ RACP working party had been established and its recommendations – training programs and examination and a possible fellowship of both colleges – submitted for consideration. The hope was again expressed that potential fragmentation of the profession would be avoided. Correspondence from the Royal College of Surgeons Edinburgh (RCSEd) supported the RACS/RACP position and expressed the view that those engaged in emergency medicine in Australia should align themselves with the established colleges.

The issue again received due consideration. Yule appeared to waver when he reminded his fellow councillors of the responsibility of an independent undertaking, and the heavy administrative load required. Tom Hamilton, incensed that the working party had not sought any input from the Society – and had assigned it only a minor advisory role in future development – made the salient point that association with the two major colleges would separate emergency medicine from other relevant specialties such as obstetrics and gynaecology, paediatrics and psychiatry.[39] In correspondence with RACS,

he had pointed out that a joint examination was neither appropriate nor acceptable for trainees in emergency medicine.[40] As encouragement for the ASEM Council, he cited the success of ACEP which, from very modest beginnings involving a few dedicated individuals, had developed as a 'most substantial, effective and recognised institution within ten years'.[41] He predicted a similar trajectory for the Australasian endeavour.[42]

On the strength of this plea, and with a sense that much hard work lay ahead, the Council resolved not to accept the offer from RACS, but to proceed with the development of the Australasian College for Emergency Medicine (ACEM), along with its training and certification program. The meeting heard from Tom Hamilton that both the Articles and Memorandum of Association for ACEM were finalised and signed, but awaiting the addition of small procedural details before registration was complete. In the meantime, he received legal advice that ACEM could proceed as an unincorporated body, and then later ratify any decisions made before final incorporation. Des Owens reported that the Primary Examination Subcommittee-elect was active and had already written a syllabus, and arrangements were underway for its circulation.[43]

In other meetings that week, the Council completed preliminary business for formation of the College. As subscribers to the ACEM Memorandum and Articles of Association, the Council elected itself as the Interim Council and, in turn, elected the first group of Foundation Fellows-elect.[44]

ASEM 1983 Annual Scientific Meeting

There were 120 delegates at this meeting, which included a comprehensive academic program and invited international speakers, including Peter London of the Birmingham Accident Hospital and Glen Hamilton of Wright State University, Ohio.

The ASEM AGM was held on the last day of the meeting, with 72 ASEM members in attendance and seven apologies. Tom Hamilton outlined recent negotiations with the established colleges, along with ASEM's decision to go ahead and form ACEM. The meeting fully endorsed the Council's decision.

The list of 67 Foundation Fellows-Elect of ACEM was then read:

Palita Abeywickrema	Richard Bonham	John Enright
Kenneth Abraham	Nicholas Broadbent	Gordian Fulde
Ian Audley	Peter Bush	Gerard FitzGerald
Richard Ashby	Carolyn Cooper	Paul Fitzgerald
Christopher Armson	Peter Crossley	Nicholas Forgione
David Alltree	Richard Cockington	Paul Gaudry
Mary Buchanan	Philip Cumpston	Frank Garlick
Peter Buchanan	Anne D'Arcy	G. Michael Galvin
Edward Brentnall	Linus Dziukas	R. Anthony Harrison
Peter Burke	Malcolm Ellis	E. Victor Henton
Peter Bamford	Joseph Epstein	Harvey Hunt

Thomas Hamilton
Ronald Hirsch
M. Henry Jamison
Margaret Keaney
Edward Kaan
Phillip Kay
Lawrence Lau
David Lewis-Driver
William Monaghan
Barry McIlroy
John McNee
James Ogilvey
Desmond Owens
Garry Phillips
John Potts
Elaine Robinson
John Raftos
John Rolleston
Peter Rodwell
Maurice Sinclair
Noel Stevenson
David Snow
Lindsay Stewart
Appiah Tharmarajah
Richard Tsa
Valendar Turner
Sylviane Van der Harr
Pamela Woodruff
Bryan Walpole
Geoffrey Williamson
Kenneth Wardill[45]
Johannes Wenzel
Allen Yuen
Graham Yule

It was noted that the College constitution allowed for election to Fellowship without examination for a period of three years after incorporation, but only those elected within the first six months would be designated Foundation Fellows. Foundation Fellowship was later awarded to Derek Clark, Michael Clark, Linda Dann, Ranjan Fernando and Angela Pitchford. The Council recommended an initial joining fee of $250, and an annual fee of $250 due each January.[46]

When a College was first proposed, the intention had been for ASEM to become ACEM. However, on the eve of the College's foundation – and in light of ASEM's recent incorporation – the Council recommended that the Society continue as an active body, thus allowing some involvement for those awaiting entry to the College and providing associate membership for residents and registrars. Initially, it was recommended that the College and the Society share the same Council, and that the Society make available up to 75% of its funds for activities of the College relating to education, certification and research. College members were encouraged to continue to support the Society, and fees remained at $100 for ordinary members and $25 for associates. This was agreed upon by those present.

In the final item of business, the present ASEM Council was elected as the first ASEM Council following incorporation. It was also elected as the Interim Council of ACEM.

CHAPTER 2

THE FORMATIVE YEARS 1983–1987

In 1983 the College, under the aegis of its Memorandum of Association, accepted responsibility as the peak body for the advancement of the principles and practice of the discipline of emergency medicine in Australia and New Zealand. It undertook to establish the highest standards of learning, skill and conduct within the field, and accepted responsibility to arrange and supervise adequate postgraduate training and conduct examinations for admission to Fellowship. Other responsibilities stated in the Memorandum of Association, included 'co-ordination of the community facilities involved in the delivery of emergency care', and 'the representation and promotion of emergency medicine within organised academic, administrative, political and medical circles'. As part of its commitment to the discipline, the College agreed also to promote and advance research through publications and the acquisition of a library of scientific works.[1]

At the time of the College's foundation in 1983, none of the above was in place and the road ahead may have seemed daunting. The College lacked a training program, a detailed syllabus, or indeed any certainty about a career structure for its trainees. It was without administrative or governance procedures and had no formal legitimacy within organised medicine at either the professional or the government level.

In the space of a little over four years, however, much of this work was achieved. The College had conducted two successful Fellowship Examinations and established a training program, and hospital accreditation visits were planned to begin in 1988. After early difficulties, the College administration was beginning to show improvement following its move from Sydney to the premises of the Royal Australasian College of Medical Administrators (RACMA) in Carlton, Victoria. The employment of Jenny Freeman to manage this growing administration also contributed to the College's administrative development. Acceptance as a member of the international emergency medicine community was accompanied by a commitment to host the 2nd International Conference on Emergency Medicine (ICEM) in Brisbane at the end of 1988. Significantly, the College's Fellowship was gaining gradual acceptance as the preferred qualification for emergency medicine specialists in most Australian and New Zealand hospitals. While not officially recognised as a specialty by the National Specialist Qualification Advisory Committee

(NSQAC), the College's opinion and assistance were also increasingly sought within government circles.

The following sections document the College's early achievements and challenges as it set about establishing itself and gaining acceptance within organised medicine.

The College and the Council

The College's early success and development was largely due to the hard work and commitment of its early Councillors – both those appointed as Interim Councillors in July 1983, and those elected in July 1984 (who remained in office until the next Council elections in September 1987). In many cases, Councillors' responsibilities extended to membership of the Board of Censors (BOC) or primary or fellowship examination subcommittees.

Councillors 1983–1984	Councillors 1984–1987
Tom Hamilton (Western Australia)	Tom Hamilton (Western Australia)
Anne D'Arcy (Victoria)	Anne D'Arcy (Victoria)
Bryan Walpole (Victoria)	Bryan Walpole (Victoria)
Peter Bamford (New Zealand)	Peter Bamford (New Zealand)
Harry Jamison (Tasmania)	Harry Jamison (Tasmania)
Gordian Fulde (New South Wales)	Gordian Fulde (New South Wales)
Peter Buchanan (New South Wales)	Peter Buchanan (New South Wales)
Des Owens (South Australia)	Noel Stevenson (Queensland)
Gerry FitzGerald (Queensland)	Garry Phillips (South Australia)
	David Snow (New Zealand)
	Phillip Cumpston (ACT/NT)

Tom Hamilton provided exceptional leadership as College President from 1983–1988. An academic surgeon with an international reputation and who was widely published in the field of breast cancer surgery, Hamilton had cut his political teeth as a British Medical Association (BMA) representative while attached to the Edinburgh University. As such, he was well qualified to lead negotiations for recognition with the established colleges. He possessed a clear vision for the College and was convinced that its aims were both appropriate and correct. He negotiated tirelessly, purposefully, and always with confidence and optimism. He was well supported throughout this period by the Council and its officers: Anne D'Arcy (Vice-President), Gordian Fulde (Honorary Secretary), Peter Buchanan (Honorary Treasurer) and Censors-in-Chief (CICs) Des Owens (until August 1985) and Garry Phillips (from August 1985).

The Council developed as a small, tight-knit group with multiple responsibilities, both within the Council and its committees. David Taylor states that the early Councillors were younger and more inexperienced than their counterparts in other established colleges, and were not hampered by tradition or propriety. They were resourceful, down to earth and prepared to

work hard. As such, they achieved an enormous amount in a relatively short period of time.[2]

By early 1987, the Council was sufficiently developed in its processes to consider the introduction of subcommittees. However, this motion was withdrawn after in-principle agreement to establish the subcommittees at a later date. In the meantime, it was decided to establish ad hoc committees of Council to consider particular areas of policy. A further indication of maturity and confidence was the Council's decision to formally establish an Executive – comprising the President, Vice-President, Honorary Secretary and Honorary Treasurer – to meet via teleconference between Council meetings.[3] Likewise, the Council empowered the BOC to consider particular areas of policy and report its actions and decisions to Council.[4]

Examinations

The future success of the College – and the development of emergency medical services – depended upon a transparent and credible examination process capable of producing high quality, competent graduates. From the outset, the College was committed to the traditional medical examination structure of a primary examination followed by a fellowship examination and had steadily worked towards this goal.

Des Owens – ACEM's first CIC – undertook much of the preliminary work to establish a syllabus in the years leading up to the foundation of the College. In March 1983, he proposed a syllabus and format for the Primary Examination. On the strength of his work, the Council recommended the first such examination should be held in the second half of 1984, and proceeded to draft recommendations for a Board of Censors, a Credentials Committee, a Primary Examination Subcommittee (PES) and Fellowship Examination Subcommittee (FES).

Joseph Epstein, Bryan Walpole, Allen Yuen and Linus Dzuikas (all Victorian based), Val Turner from Western Australia and New Zealander Kenneth Wardill all participated as corresponding members of the PES, while Anne D'Arcy (in her capacity as Vice-President) was also a member. Joseph Epstein chaired the Committee and was well qualified to do so: he had taught basic clinical science to medical students and, while an academic surgeon attached to the Department of Surgery at the Royal Melbourne Hospital, had set up the dental postgraduate clinical science examinations.[5] Gordian Fulde, who had recently passed the RCSEd Fellowship in Accident and Emergency, initially chaired the FES before handing over to Paul Gaudry in July 1984. Other members of this committee were Peter Buchanan from New South Wales, Queenslander John McNee, Ron Hirsch from Western Australia, and David Snow from New Zealand. In both cases, as funds were short, the groups were set up to facilitate regular meetings of a core group without incurring prohibitive travel expenses.

On the recommendation of the BOC, Courts of Examiners for both examinations were appointed for 12 months in November 1985. Membership of both Courts was drawn from the Council and its existing committees.[6]

The Primary Examination

Soon after its foundation, the College released a document, "Information for doctors interested in a career in emergency medicine in Australia and New Zealand", detailing the Primary curriculum and examination format, information about the second part (Fellowship) examination, training positions and career prospects.

This document proposed that candidates for the Primary Examination would be examined in the following subjects:

- Anatomy, with an emphasis on applied and radiological anatomy rather than histology and embryology (only examined where relevant to emergency medicine);
- Physiology, including some biochemistry, with a stress on biochemical correlations of acute medical pathology;
- Pathology, including microbiology, with a focus on common infections and their epidemiology; and
- Pharmacology, with a strong emphasis on therapeutics.

The document advised a three-hour written examination for each subject.[7] This examination would comprise an essay, a short answer section and 40 multiple choice questions (MCQs). There would also be two 20-minute oral examinations, one covering Anatomy and Physiology, and the other Pathology and Pharmacology.[8] It was intended that the first Primary Examination would be held in June 1984, and the Fellowship Examination in May 1985;[9] however, an early decision was made to delay both examinations by twelve months to allow for adequate preparation – including the involvement of members of other colleges as external examiners – and to enable the use of MCQs from the question bank of the Royal Australasian College of Surgeons (RACS).

The first Primary Examination was held in Melbourne over the period 11–14 June 1985. Candidates were eligible to sit the Primary Examination during, or subsequent to, their junior resident medical officer year, and were charged a $400 entry fee. Forty-one applications were received for the examination, which was held in the basement of the Alfred Hospital, adjacent to the kitchens and cafeterias. The written papers were sat on Tuesday, 11 June and Wednesday, 12 June, with the oral examinations beginning on Thursday, 13 June 1985.[10] The examining panel included five Foundation Fellows of the College and four external examiners – two each from the Royal Australasian College of Physicians (RACP) and RACS.[11]

Reportedly, all did not go without issue. During the written examinations, the candidates had to contend with the noise from the adjacent cafeteria. The examiners received a 'vote of no confidence' in the College from some of the candidates at the conclusion of the MCQ paper over a misunderstanding, or miscommunication that the anatomy sections would focus predominantly on the upper and lower limbs.

The oral examinations, originally scheduled to be held at the anatomy school at the University of Melbourne, were moved to the Alfred Hospital, which meant that all the required specimens had to be transported to the new location. The examination was delayed after union representatives were made aware of what was happening. Joseph Epstein eventually brokered a resolution, and the examinations proceeded.

To conduct the exam, we needed to deliver about 20 wet (formalin soaked) cadaveric specimens to the basement of the Alfred next to cafeteria 1. We were using cafeteria 2 [which was] normally unoccupied. During morning tea time the busy cafeteria was full and the odour of formalin spread to the staff. There was some disquiet. Then the local shop steward … threatened to blockade the exam until the specimens were removed – a catastrophe for the first ACEM exam.

Joe took him aside and pointed out we were a young, poor College. Coincidentally, that morning's Age had a story on the car park death of a 55-year-old woman discharged from ED after chest pain. Joe politely showed him this story … and explained that he was producing a type of doctor to perhaps prevent this happening to him, or his mother, and could he please bear the smell for a few more hours. Joe also gave him his home phone number, if any of his family should become unwell.

A sweet smile. 'Certainly doctor, go ahead, I shall speak with my members. This is too important for a small smell to worry us.' Problem solved.[12]

Bryan Walpole

From the outset, the College had determined it would use external examiners in order to ensure a transparent and credible process, which would hopefully 'facilitate acceptance by … professional colleagues in related specialities'.[13] However, there were some teething problems, including the fact that the RACS representatives required candidates to have a much more detailed knowledge of anatomy than the ACEM Fellows thought necessary, with the College Fellows unable to convince the RACS representatives otherwise.[14]

Only seven of the 41 applicants passed the overall examination. Despite this low pass rate, the College considered the examination a success. Tom Hamilton reported favourable feedback from the external examiners who considered the 'conduct and content of the examination … appropriate to the aims and objectives of the College and on a par with the other examinations for postgraduate diplomas'. He conceded that a 'a number of lessons were learned', but that the College's standing on a national level was significantly enhanced as a result of the process.[15]

Some modifications followed the first examination – the written format was changed so that, for each subject, candidates would answer one essay question and five short answer questions, and also sit two two-hour MCQs papers on all four subjects.[16] These changes were reflected in an updated handbook, which also included an expanded pharmacology syllabus, a list of recommended texts and a brief guide to the Primary Examination contributed by the recently appointed CIC Garry Phillips.[17] David Taylor comments that 'for all subsequent primary examinations, the curriculum document outlined exactly what had to be known'.[18]

In 1986, the Primary Examination was held regionally in Melbourne, Sydney, Perth, Adelaide and New Zealand, with the written papers conducted on 17, 18 and 19 June and the oral examinations held on 3 July in Melbourne. All prior examiners agreed to examine again. There were 36 candidates, 20 of whom were successful, delivering a 56% pass rate.

The same format was followed for the 1987 Primary Examination, held regionally on 9–11 June, with the oral component held on 2 July in Melbourne. Fifteen of 31 candidates were successful in the examination. ACEM's satisfaction with this examination was such that there would be only one change in procedure for 1988 – the time between the written and the oral examination was increased to four weeks. From 1989, the increasing interest in emergency medicine as a career path necessitated two Primary Examination dates each year.[19]

The Fellowship Examination

At the time of the College's foundation, no measures were in place for the Fellowship Examination beyond a proposal that candidates should be eligible following the successful completion of the Primary Examination and three years of approved training. It had also been decided that the first examination would be held in May 1985. This decision was later revised so that entry to the Fellowship Examination would be determined by the Credentials Committee until a period of three years after the first Primary Examination in June 1985.[20]

Work to develop the Fellowship Examination began in early 1984, and by April, the College had a proposal outlining the conditions for entry to the Fellowship Examination and a detailed examination format, and was able to advise that a syllabus outlining the core curricular material for candidates was currently in preparation.[21] This proposal was developed as the College's first *Training and Examinations Handbook*, coordinated by Gordian Fulde. This handbook included a detailed syllabus, and outlined the principles and conditions for advanced training, as well as the format for the examination.[22] The College received good feedback on the quality of this document, as well as some constructive criticism and helpful advice from RACS.[23]

The College's preparations for this examination, while undertaken with a degree of trepidation, were thorough and developed from a variety of sources. The College decided on an eight-section format for the examination. The written component comprised MCQs, Short Answer Questions (SAQs) and Visual Aid Questions (VAQs), while the clinical component included one set of long cases, two short cases and two viva (oral) components. The long and short case formats were adapted both from other college examinations and the RCSEd Fellowship Examination in Accident and Emergency. According to Bryan Walpole, the examiners 'sourced real patients from the wards of RPA for the long and short cases'. He describes this as a 'huge effort and risky [as] one patient became unresponsive during the exam!'[24]

The first Fellowship Examination was held in Sydney in July 1986 at the University of Sydney and the RPA Hospital. Candidates sat the written examination on the first day and the clinical examination over the next two days with results received on the third day. In the interest of transparency, it was agreed that each of the written papers would be marked by one external and two ACEM examiners, with College Fellows to mark the papers at the conclusion of the examination, followed by transportation to the external examiner's home that evening.[25] The examination fee was set at $600.

Eight candidates from a total of 14 were successful. The successful candidates were Chris Baggoley, George Jelinek, Stephen Meaney, Paul Pielage, Patricia Saccasan, Graeme Thomson, John Vinen and Jeff Wassertheil – many of whom would make significant contributions to the College in its developmental years. David Taylor says of these new Fellows that they 'did the College proud'. They built reputations quickly, many going on to make significant contributions to medicine and, through their efforts, 'the Fellowship gained considerable respect quite quickly'.[26] Tom Hamilton likewise praised the 'quality and calibre' of the new Fellows.[27]

The only modification made to the format of the Fellowship Examination for 1987 was the introduction of a considerable separation between the written and the viva (oral) components. In 1987, nine of the 19 candidates who sat the examination were successful.

Training, Accreditation and Credentials

Training protocols and policies, together with accreditation of hospital posts for training in emergency medicine, were the province of the BOC. Members of the Board appointed in July 1983 were Des Owens as CIC and Censor for South Australia, Gordian Fulde (New South Wales), Noel Stevenson (Queensland), Joseph Epstein (Victoria), Ron Hirsch (Western Australia), Harry Jamison (Tasmania) and Peter Bamford (New Zealand). In August 1985, Des Owens resigned and Garry Philips, also from South Australia, was appointed CIC. Bryan Walpole joined the Board as the Censor for Tasmania.

Board of Censors, July 1983–August 1985	**Board of Censors, August 1985–September 1987**
Des Owens (CIC)	Garry Phillips (CIC)
Gordian Fulde	Gordian Fulde
Noel Stevenson	Noel Stevenson
Joseph Epstein	Bryan Walpole
Ron Hirsch	Joseph Epstein
Peter Bamford	Ron Hirsch
Harry Jamison	Peter Bamford

The BOC, although appointed in July 1983, met formally for the first time in July 1984. At this meeting, Joseph Epstein was elected as Deputy Censor-in-Chief (DCIC) – a role he continued until April 1991. A recommendation was also made that the Board should act in a de-facto capacity as the Credentials Committee, holding responsibility for decisions regarding exemption from the Primary Examination and admission to Fellowship without examination.[28] This role was extended to accreditation of basic and advanced training, granting of partial exemption from advanced training, and decisions regarding eligibility for the Fellowship Examination. This obligation accounted for much of the BOC's work. After March 1986, the BOC regularly dealt with 20 or so queries of this nature each time it met.

In November 1985 the Council, on the recommendation of the BOC, made some significant decisions with regard to training. It determined that after 4 April 1988 – the fourth anniversary of the College's incorporation – the College would no longer accept the primary examination of other Australasian colleges as equivalent to the ACEM Primary Examination. Similarly, the Council agreed that there should be no reciprocity for overseas qualifications. However, it did accept that overseas experience may be adequate for ACEM training requirements, provided an application for accreditation was submitted in advance. More prosaically, it agreed that advanced trainees would be levied an annual registration fee of $25.[29]

In March 1986, the BOC recommended the introduction of a five-year advanced training program to replace the existing three-year program. At that time, two of the requisite three years were required to be spent in an approved emergency department in Australia or New Zealand, with the third year spent in either an approved emergency department or in an approved post in another branch of medicine.

The new regime proposed three years with the same expectations as the earlier program with the addition of posts in anaesthesia, ICU, medicine, surgery and paediatrics for the remaining two years of Advanced Training. The BOC also approved a potential period of up to twelve months' research (subject to approval by the CIC).[30] These changes were approved and the regulations were changed accordingly, with the new program commencing on 1 January 1988.[31]

In 1986, the College instituted a central register of training for advanced trainees and, throughout 1987, it developed an annual record of training that incorporated a report from the Director of Training.[32] This record was accepted for distribution in early 1988.[33] Significantly, in 1984 ACEM became the first college to introduce part-time training during postgraduate training.[34]

The BOC developed accreditation protocols for hospital training posts during this early period. Initially, the BOC collected basic information from regional censors regarding training posts and programs for advanced training,[35] from which it compiled an interim list of suitable hospitals. These would be supported by documentation and inspection at a later date.[36] In August 1986, it was agreed – in principle – that inspections were required, but that posts would continue to be accredited regionally until an inspection could be undertaken. It was accepted that, in some circumstances, a department could be accredited even when its Director was not a Fellow of the College.[37]

In September 1986, the BOC submitted to Council a list of hospitals with emergency departments, and an evaluation of their suitability for training.[38] Several hospitals that could not be accredited on the basis described above were inspected, and the list was revised accordingly.[39] In November 1987 it was agreed that accreditation panels for 1988 inspections would include the appropriate Censor, a nominee of the state committee and an interstate Censor or Councillor.[40]

Research

Promotion of research in emergency medicine was both a central tenet upon which the College was formed and a necessary aspect of its development as a specialty. This need was recognised in documentation prepared by Allen Yuen before the College was founded. At the College's foundation, Yuen was appointed chair of the Research Committee. From there, an active subcommittee was formed, presenting a comprehensive list of recommendations to the Council outlining the objectives of emergency medicine research. These included appropriate clinical and systems analysis projects. The document also stressed the importance of adequate planning, accurate data analysis and ethics approval.[41]

Despite these solid preparations and some obvious enthusiasm, the College struggled to excite interest in research. This may simply have been a combination of limited resources – both in terms of finance and people – and the competing imperative of establishing a high-quality assessment process, including formal examinations.

Perhaps the only effective research undertaken under the College's auspices in this period was Gerry FitzGerald's study of "Manpower in Emergency Medicine in Australasia" – a survey with the primary objective of providing information on the available human resources for the development of emergency services. It was a comprehensive survey that sought information about current services, attendances and staffing arrangements, with the aim of assisting the College to develop an information base from which it could plan the development of emergency medical services. Specifically, the study aimed to deliver information about the current status of specialty staffing in emergency departments, the availability of registrar training posts, and future workforce requirements for emergency medicine specialists.

The survey was first distributed in April 1984, but was ongoing over a number of years. Its completion was not advised until the College's AGM in September 1987, at which point it was announced that the survey results were available upon request.

In early January 1987, Gerry FitzGerald informed the Council that the subcommittees for manpower/research and computers had merged into one committee. He reminded Council of the College's obligation to foster research and proposed the formation of a Research Society, the purpose of which would be to conduct further research into emergency medicine, with the aim of raising the profile of the discipline among both the wider medical community and the public. In line with this proposal, he suggested that a committee of Council be established to develop a constitution and structure for the society. He further proposed that the matter be discussed at a general meeting held in conjunction with the Sydney ASM.[42]

In his report to the September 1987 AGM, FitzGerald stated the committee's aims were to develop ways to stimulate interest in research into all aspects of emergency medicine. Suggested strategies included the introduction of a prize for the best registrar paper, assistance with research proposals, a register of current research to ensure coordination, the establishment of a clinical bulletin, and workshops to share expertise.

College Administration

A necessary early priority for the College was to establish a base from which it could conduct its business. To this end, a lease was taken for serviced office space on the 66th floor of the MLC Centre in Martin Place, Sydney. This iconic, Harry Seidler–designed building had the distinction of being the tallest building in Australia from 1978 until 1992 and was a prestigious address. Under the terms of the lease, ACEM and the Australasian Society for Emergency Medicine (ASEM) had use of an office for two half-days per week, telephone answering services, and an address for correspondence. It was planned to engage a stenographer for one half-day per week, and to contract additional secretarial services and facilities as necessary.[43] After Gordian Fulde became Honorary Secretary, it was agreed he would attend the office every Thursday afternoon between 2:00 pm and 5:00 pm.

Although prestigious and with magnificent views, the MLC premises proved expensive and unsatisfactory. Almost immediately, there were concerns about associated costs. During Council meetings throughout 1984, Peter Buchanan expressed his concerns. When presenting the combined College and Society accounts, he noted that the expense of maintaining the secretariat was the main item of expenditure.[44] In late 1984, in an effort to contain costs, it was decided to remove the College and Society files from the MLC premises and keep it only as a postal and telephone address.[45]

This achieved a significant saving, however, the lease was ultimately terminated in July 1985. The secretariat moved to the premises of RACMA in Victoria at 35 Drummond Street, Carlton. Under the terms of its lease, ACEM had access to a secretary for eight hours per week, exclusive use of a room in the building, as well as access to word processing and use of the Council Room for meetings. This proved a much better arrangement, and Tom Hamilton was pleased to report in March 1986 that a plaque for the College was placed outside the building. This was in stark contrast to the MLC experience where, in two years of tenancy, ACEM and ASEM had not managed to get their names on the board in the building foyer.[46]

College business was eventually centralised at Drummond Street, rather than conducted through the local resources of individual Council officers. Achieving this cultural change was quite difficult and occurred over a number of years. In March 1987, the treasurer expressed significant concern regarding aspects of College organisation and inaccurate record keeping by the secretariat.[47] These difficulties were finally resolved with the employment of Jenny Freeman as a College employee, to manage these growing administration needs.

College Regalia

The exact nature of suitable raiment for public display by the 'prestigious and academic body'[48] the College hoped to become was extensively discussed in the early stages of the College's existence. Although such concerns may now seem trivial and unimportant, at the time, they were important as symbols of professional and public recognition and deemed 'essential to the furtherance of [the College's] lofty aims'.[49] The responsibility for progressing this issue

fell to Bryan Walpole, who was then Director of the Emergency Department at the Alfred Hospital in Melbourne. When it came to designing a College logo, he outsourced the task to his staff.

Several designs were put forward, but the outline presented by intern David Eddy – who went on to become a Fellow of the College and Director of the Emergency Department at Geelong Hospital – was considered 'by far the best'. He and Bryan Walpole chose the colours together: red for emergency, green according to the international standard for hospitals, and gold for the standard to which the College aspired.[50] The British Colour Council later allocated these as cherry BCC185, bronze green BCC79, and buttercup BCC53.[51] Designs for a logo, seal and academic gown were tabled at the May 1984 Council and, according to Tom Hamilton, caused great excitement.

The logo and colours were subsequently presented at the Perth ASM in July 1984, where they were accepted. They remain the College logo and colours to this day. However, as financial prudence was paramount in the early days, it was some time before other elements of College regalia could be progressed. The College seal was finalised in November 1984, 200 College ties were ordered in early 1984, and the President's gown and chain were purchased in late 1985.[52]

In 1991, Council approved a design for a College gown and offered them for sale through the College office. Council purchased 13 gowns for the use of its Councillors on ceremonial occasions such as the College Ceremony.

Perth jeweller Allan Linney designed the presidential medal using Australian gold in 1991, under Tom Hamilton's direction.[53] Joseph Epstein was the first College President to wear the medal at the 1991 College ASM in Hobart, this was also the first occasion that newly elected Fellows were presented with their diplomas as part of the College Ceremony to open the ASM[54] and the first, and only, time that Councillors wore the College gowns.

In introducing the gowns, the intention had been to add a degree of gravitas to the Ceremony with gowned Councillors entering the ceremony in procession; however, as Jenny Freeman recalls there was 'somewhat of a revolt' against wearing the gowns and the procession, and with the exception of the President and the Censor-in-Chief 'Councillors never wore gowns again nor did they enter in procession'. Freeman considers that on balance this development served the College well as over the years new Fellows and their families have appreciated the absence of any 'sense of division or strong sense of hierarchy' associated with the College Ceremony.[55]

The Ceremony, remains an important occasion on the College calendar, providing an opportunity to acknowledge Fellows who have made significant contributions to the affairs of the College, teaching and research and to welcome new College members. The Tom Hamilton Oration – established in 1990 in honour of the inaugural President of the College – is delivered annually at the conclusion of the event.

The College has two awards that recognise significant service by an individual. In 1991, the ACEM Medal for distinguished service by a College Fellow to the affairs of the College was established. The medal, made of gold and with a diameter of 32mm, is embossed with the College emblem on the obverse side while the reverse is engraved with the recipient's details.

Inaugural recipients of the ACEM Medal were Joseph Epstein and Gerard FitzGerald in 1993. In 2018, the College established the ACEM Distinguished Service Award in recognition of significant service to one or more areas of College activity over an extended period of time. ACEM Fellows, members, trainees, College staff and community members are eligible for this award.

In 2003, the College stuck a commemorative medal to celebrate the 20th anniversary of its foundation. The medal was known as the *Foundation 20 Medal* and awarded by Council in appreciation of significant contribution to the development of the College during the period 1983–2003. Just over 100 of these medals were awarded.

Recognition and Representation

An important focus for the early Council was to establish the College as a representative professional medical and training body. As a first step to achieve the former, Tom Hamilton was charged with announcing the College's formation to the specialist medical colleges, medical societies and associations (including the Australian Medical Association [AMA]), major teaching hospitals and government entities in Australia and New Zealand.

In his correspondence, Hamilton described a growing awareness, both in Australasia and overseas, of emergency medicine as a definite specialty. He promoted the 'advent of the College' as 'a logical consequence of the need to provide experience and training appropriate to the wide range of knowledge and skills embraced within the specialty'. He underlined the College's commitment to recognition of emergency medicine as a principal specialty, and the belief that 'Fellowship of the College should become the appropriate qualification for hospital consultant practice'.[56]

In order to achieve true legitimacy and acceptance within organised medicine, it was necessary that emergency medicine gain recognition as a principal specialty from NSQAC. This body was formed in 1972 (following the introduction of higher benefits payments for medical services rendered by an appropriate medical specialist) and aimed to establish national standards for recognition of specialist qualifications. As a general principle, NSQAC stated (in 1988) that 'registration or recognition as a specialist is based on completion of a program of supervised vocational training covering a minimum of 5 years following medical graduation and examination leading to a higher qualification … by the relevant specialist professional college in Australia'.[57]

In the period from the College's foundation to December 1987, ACEM made two applications to NSQAC for specialist recognition. The first, made in 1984, was unsuccessful. As Joseph Epstein recalls, this was a 'cheeky gesture, that was expected to have little chance of success'.[58] It was essentially an ambit bid, made in the knowledge that 'recognition and approval was unlikely prior to the inaugural Fellowship Examination in July 1986'.[59]

Indeed, NSQAC acknowledged the 'concept of emergency medicine as a specialty or sectional specialty' as 'relatively new' and suggested re-application after the Fellowship Examination in May 1986 and the 'emergence of the first diplomates from the College'.[60]

The College made a second application on 29 August 1986, following the Fellowship Examination. This was a one-page submission, providing NSQAC with the results of the 1985 and 1986 Primary Examinations and the recent Fellowship Examination. It also outlined developments in training and education, including the recent decision to extend the advanced training program to five years after January 1988, and the cessation of reciprocity arrangements with other Colleges from 4 April 1988 – the fourth anniversary of ACEM's incorporation.

NSQAC acknowledged the application in November 1986 and advised that it would undertake a two-tier investigation of the matter. In the first instance, it would consider whether emergency medicine should be recognised as a principal specialty in Australia and, if NSQAC decided in the affirmative, it would then consider if "FACEM" was the appropriate qualification for specialist recognition. ACEM was informed that the Committee had begun its work but was warned that 'an early conclusion should not be expected as the investigation could take some time'.[61]

Some 10 months later, in August 1987, NSQAC advised the College that the principal colleges – RACS, RACP, the Royal Australian College of General Practitioners (RACGP) and the Royal Australian College of Obstetricians and Gynaecologists (RACOG) – did not consider that emergency medicine should be recognised as a principal specialty. Significantly, NSQAC signalled that members of the principal colleges, while accepting that emergency medicine was a specialist area of medicine and training was required, remained unconvinced that a separate college was necessary.[62]

Despite NSQAC's second refusal, Tom Hamilton remained optimistic. In his 1987 Presidential Report, he informed the membership that State Health Departments and Commissions were predominantly 'favourable to the concept of emergency medicine and supportive of [the] College objectives', and that medical colleges (with the exception of those named above) were supportive of specialty recognition for emergency medicine. It was his view that the NSQAC decision was a 'temporary setback'.[63]

It was, nevertheless, important to secure NSQAC's approval, for while it was only an advisory body, it had developed as the de-facto authority for recognition by hospital administrations, and its approval would go a long way towards alleviating the current confusion about the status of the Fellowship qualification.

In Victoria, some individual hospitals accepted "FACEM" as the appropriate qualification for staff specialists and provided industrial entitlements accordingly. However, the Health Department had not given formal recognition, despite the fact that it expressed 'warm support' and included the College on its high-profile Consultative Council of Emergency and Critical Care Services. In New South Wales, the Health Department had given its formal support, but the New South Wales Medical Board refused specialist recognition. In Queensland, emergency medicine had an intermediate status between "no recognition" and "full recognition". In South Australia, emergency medicine did not have specialist recognition, but was recognised as a specialty by the South Australian Medical Board. While there was no formal recognition in the ACT and in Western Australia, Royal Perth Hospital and Fremantle Hospital were accepting Fellowship of ACEM as

the appropriate qualification in emergency medicine, even though the Medical Board of Western Australia did not recognise it as a specialist qualification. In Tasmania, emergency medicine was not recognised as a specialty at this time,[64] nor was the ACEM Fellowship recognised as a specialist qualification by the Medical Council of New Zealand (MCNZ).

Notwithstanding the College's continued difficulties, its reputation within organised medicine was considerably enhanced in this early period, predominantly through Tom Hamilton's membership of the Committee of Presidents of Medical Colleges (CPMC). The CPMC was formed in July 1986 at the instigation of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to provide a forum for intercollegiate discussion of issues of mutual concern to the specialist colleges, and to present a united front of hospital specialists in negotiations with various governments and government organisations in Australia and New Zealand.[65]

ACEM was included as one of 15 members of the CPMC and, as an independent College, had full voting rights. This was in contrast to the representative of the Faculty of Anaesthetists, who was not granted a vote, as the Faculty was linked to RACS, rather than a specialty in its own right.

Tom Hamilton shrewdly insisted that financial contributions should be equal and not dependent on size and resources of individual colleges. He reasoned that this was potentially disadvantageous for smaller colleges and would perpetuate a hierarchy with the older established colleges holding more power than those smaller and newer. Equal rights were assured through equal financial contributions from all colleges, and membership of this group delivered the College a forum in which it could contribute on an equal footing with the older, more established colleges. It also provided an opportunity for the College to demonstrate its credentials as a specialist body. Over time, ACEM has historically enjoyed significant influence within the CPMC; Joseph Epstein was elected Honorary Secretary of the first executive in late 1990 and Chris Baggoley was President from 2000–2002.[66]

Also significant was the College's acceptance among the international emergency medicine community. The College's international connections were first established in its pre-foundation days. They were strengthened after foundation through Tom Hamilton's attendance as a guest of the American College of Emergency Physicians (ACEP) Scientific Assembly in 1984, and ACEM's significant contributions to the first ICEM, which was held in London in 1986. Indeed, Australia was well represented at the London ICEM, with 40 delegates, 14 of whom presented papers.

At the 1984 ACEP Scientific Assembly, Tom Hamilton was involved in discussions regarding the possibility of holding the 2nd ICEM in Australia in 1988. A group of Queensland Fellows – Gerry FitzGerald, Richard Ashby, Phillip Kay, Noel Stevenson, Frank Garlick, Ian Knox and Rooks Pillay – accepted responsibility to organise the meeting, which was planned for November 1988. Organisation for the conference was well in hand by the end of 1987.

In 1989, ACEM stood beside ACEP, the British Association for Accident and Emergency Medicine[67] (BAEM) and the Canadian Association of Emergency Physicians (CAEP) as a founding member of the International Federation for

Emergency Medicine (IFEM). At its formation, IFEM aimed to facilitate the international exchange of ideas on the delivery of emergency care, promote education, and assist other countries in developing the specialty of emergency medicine. The founding organisations agreed that IFEM membership would only be offered to national organisations of emergency physicians.

ACEM, ACEP, BAEM and CAEP signed IFEM's charter in 1991 at the ACEP Scientific Assembly in Boston.

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At the end of 1987, the College was poised for its next stage of development. It had confidence in its examination and training processes, and some of the early administrative issues appeared to be resolved. For Tom Hamilton the way ahead was clear, and emergency medicine's eventual recognition as a specialty was inevitable. He argued for a 'more forceful presentation of the cause of Emergency Medicine', underscoring his comments with the example of the British and United States experience where 'skirmishes and setbacks were not unknown'. He urged all Fellows to 'lobby' for support of emergency medicine at a local level, and to raise the profile of the discipline by 'providing the highest standards of service and care'.[68]

Joseph Epstein expressed a similar view in his paper, "Emergency Medicine in Australasia: What Does the Future Hold?", which he presented at the Sydney ASM in September 1987. In this paper he promoted strong, reasoned, informed and sustained argument as the way to achieve the College's aims. He also encouraged the presentation of overwhelming evidence to those who doubted that FACEMs were the appropriate people to deliver emergency care. As he would often repeat, emergency medicine was a just cause – 'History is on our side. Emergency Medicine is intellectually and morally worthy of our efforts … being on the side of good and true means we will win in the end'.[69]

CHAPTER 3
ESTABLISHING THE COLLEGE 1988–1996

For the College, the nine-year period beginning in 1988 was one of growth, consolidation and achievement, during which it built upon the foundations laid in its early formative years. The College moved forward with confidence and purpose and achieving specialty recognition remained high on the agenda. In 1996 – 13 years after the College was founded – the new specialty was firmly established within Australasian hospital systems, and governments, bureaucracies and other medical colleges regarded the College as the peak body for emergency medicine. Its opinions were sought and respected; it had made significant contributions to debates in a number of areas, while also setting the agenda in others.

The College, 1988–1996

Writing in 1989, Joseph Epstein described the 'viability' of the College as 'assured beyond any doubt' and asserted that emergency medicine was 'established as a vigorous and vital specialty' with a 'strong demand for diplomates' in both Australia and New Zealand.[1] Indeed, this was a period of strong growth for the profession, with emergency medicine increasingly recognised as providing the best practice for the coordinated delivery of safe and expert, urgent medical care.

Public and private hospitals alike either increased the size of existing departments or developed new ones. The number of emergency departments accredited by the College for training rose from 45 in 1987 to 68 in 1996. Corresponding with this development, available positions for consultants and registrars also increased, particularly as larger departments employed emergency physicians in roles other than directors and assistant directors of departments.[2] Senior staff positions in Australia grew from 85 in 1980 to 180 in 1995, while registrar positions in Australian emergency departments increased from 84 in 1987 to 193 in 1989.[3]

In New Zealand, emergency medicine developed more gradually. Ten New Zealand doctors were elected to Foundation Fellowship in 1983; however, following resignations and retirements, the number of active Fellows actually decreased to five in 1990. Numbers were boosted following the success of New

Zealand-based trainee, Chris Curry, in the 1989 Fellowship Examination and the arrival of recent graduate Anne-Maree Kelly.[4] Michael Ardagh – the first New Zealand trainee to complete the College's five-year training program – was awarded Fellowship in 1993 and began working in Christchurch the following year. Registrars were employed in a number of major centres from the mid-1980s and New Zealand Fellows were actively involved in teaching. In 1990 a formal teaching program for registrars was established in Auckland.[5]

With the development of undergraduate programs in Christchurch and Auckland, and a promise from the Medical Council of New Zealand (MCNZ) in 1991 of specialty recognition, steady progress was made. From 1994 the College supported the conduct of a Primary Examination Workshop annually in Christchurch. The benefit of this development was immediately apparent as three of four New Zealand candidates were successful in the February/April 1994 Primary Examination.[6]

In late 1994, the emergency department at Auckland Hospital had been without a Fellow for 12 months and risked losing its training accreditation.[7] Foundation Fellow Edward Brentnall – recently retired as the Director at Box Hill Hospital Emergency Department – was approached to fill the Director's role. He arrived in early 1995 and Ian Rogers followed soon after. Following their arrival, as well as British trained emergency physician Peter Freeman, Auckland Hospital was able to re-establish itself as a leading training centre for emergency medicine.[8] For Brentnall this marked the beginning of a substantial "post-retirement career". His time in Auckland was followed by stints at various hospitals in Australia and New Zealand including the Sir Charles Gairdner Hospital in Western Australia, Cairns Base Hospital, Queensland, the Queen Elizabeth Hospital and the Lyell McEwan Hospital in South Australia.[9]

In 1996, the New Zealand Faculty reported that a significant number of its trainees were preparing to sit the Fellowship Examination. Consequently, it was expected that New Zealand's specialist ranks would increase significantly over the following twelve months.[10] This was indeed the case, with the number of New Zealand Fellows rising to 20 in 1997.[11]

College Fellow and trainee numbers increased significantly in this period. In August 1989, there were 100 Fellows throughout Australia and New Zealand. This number rose to 126 in June 1990, and to 225 in June 1996. By mid-1992 the College had reached the point where Fellows by Examination equalled the number of Foundation Fellows. Following specialty recognition in August 1993, trainee numbers likewise increased. In 1993, there were 61 new trainee registrations. The following year there were 108, rising to 129 in 1995, with 120 further registrations in 1996. By 1996 there were 467 trainees registered with ACEM for basic or advanced training, while a further 34 had completed advanced training requirements, but not Fellowship requirements.[12]

The Council, 1988–1996

In the College's formative years, there had been advantages to keeping the Council small and College affairs concentrated in the hands of a few; however, as College business expanded and the number of Fellows increased, the Council actively sought to involve more Fellows. The expansion of

Council from 11 to 14 members was one way it did this; other ways included the establishment of regional faculties and the introduction of a Council committee system.

The Council in 1988 comprised only Foundation Fellows, many of whom had served for a number of years. Councillors elected for 1988 were Tom Hamilton, Anne D'Arcy, Joseph Epstein, Peter Buchanan, Gordian Fulde, David Snow, Gerry FitzGerald, Bryan Walpole and Richard Cockington. The only new face on the Council was South Australian Foundation Fellow Richard Cockington.[13] Tom Hamilton continued as President, with Anne D'Arcy as Vice-President. Joseph Epstein was appointed Honorary Secretary and Peter Buchanan remained as Honorary Treasurer until his death in July 1988.

Buchanan's death was a cause of great sadness for the closely knit Council. Tom Hamilton paid tribute to him as the founder of the "Gosford School" of emergency medicine trainees and commented that the 'fruits of his personal and professional integrity [would] live on in the many young doctors influenced by association with this genuine gentleman'.[14] Other Fellows remember him as a wise and prudent honorary treasurer for the College. David Taylor describes him as a 'canny old fellow [who] was very careful with finance' while Bryan Walpole remembers him as a wise and humble man fond of reminding Councillors 'we are not a wealthy College, stop behaving like one'. In recognition of his significant contribution to the early life of the College, the prize for the best candidate in the Fellowship Examination was named the Buchanan Prize in his honour.

After eight years at the helm of the emergency medicine movement in Australasia, Tom Hamilton retired as President in November 1988, and Joseph Epstein was elected in his place. Epstein shared his predecessor's passion and commitment to the discipline of emergency medicine and specialist recognition for the College, and was likewise a surgeon and a persuasive political advocate. Council had little hesitation in endorsing him as the right person to lead the College as it continued its quest for specialist recognition. Anne D'Arcy resigned as Vice-President and Gordian Fulde was elected in her place.

Richard Ashby, who replaced Peter Buchanan as Honorary Treasurer in July 1988, continued in that role, while Gerry FitzGerald was appointed Honorary Secretary. Both were regarded as excellent and experienced administrators, and together they set about reforming most aspects of College governance, administrative and financial arrangements, moving quickly to update College procedures and develop draft regulations for meeting procedure and Council elections, along with guidelines for the conduct of future Annual Scientific Meetings.

Although the College Executive remained stable throughout Epstein's four-year presidential term, there were significant changes to the composition of the Council. In September 1989, Tom Hamilton and Anne D'Arcy resigned from Council and were replaced by Mike Galvin and Edward Brentnall respectively, while Angela Pitchford was elected as the second Councillor for New Zealand. John Potts was elected as the Councillor for the Australian Capital Territory in November 1989 – a position he held until his death in 1992. Kenneth Abraham was elected as a Councillor for New South Wales.

In November 1989 – in the interest of creating a more representative Council – the College agreed to elect an extra Councillor for each of New South Wales, Victoria and Queensland. Richard Ashby – Honorary Treasurer from outside Council since August 1988 – was appointed as Queensland Councillor, Paul Gaudry (Council member as Censor-in-Chief [CIC]) was appointed as third NSW Councillor in his own right, and new Fellow Graeme Thomson became the third Councillor for Victoria.

Foundation Fellows continued to dominate Council, but with the increasing involvement of Fellows by Examination. Graeme Thomson has the distinction of being the first Fellow by Examination to sit on the ACEM Council. Chris Curry was appointed in November 1990 as New Zealand Councillor (and Censor); and the following year, John Vinen and Jeff Wassertheil – both of whom were successful in the 1986 Fellowship Examination – joined as Councillors for NSW and Victoria, respectively.

Richard Ashby replaced Joseph Epstein as President at the end of 1992 and, for the first time, Fellows by Examination were elected as members of the Executive: Chris Baggoley joined Council as CIC in 1992, and Graeme Thomson was appointed Honorary Secretary. Mike Galvin was Honorary Treasurer from 1992 until 1994, after which time Michael Cleary, elected to Council in 1993 and also a Fellow by Examination, assumed the role.

From this point a steady stream of new Fellows were welcomed to Council. Diane King succeeded Richard Cockington in August 1993 as South Australian Councillor. Jamie Hendrie replaced Joseph Epstein as a Victorian Councillor in August 1993. George Jelinek joined as Western Australian Councillor in July 1994, although as President of the Australasian Society for Emergency Medicine (ASEM) between 1989 and 1991 he had been an invited guest at Council meetings during that period. At Council elections in November 1995 John Roberts replaced Margaret Keaney as the Councillor for the ACT and Sue Ieraci joined as a Councillor for New South Wales following Paul Gaudry's retirement. Victorians Peter Cameron and Carolyn Cooper replaced Jamie Hendrie and Jeff Wassertheil, and Chris Baggoley was elected as the Councillor for South Australia in Diane King's place.

Faculties and Other Council Developments, 1989–1996

The introduction of regional faculties was investigated throughout 1989, and a recommendation was made in November for their formation, with membership of each faculty to include a regional Councillor and Censor and up to four other elected Fellows. This development provided an opportunity for new Fellows to become involved in College activity, improved communications between the Council and the membership, and helped create a 'strong and visible College presence' at the local organisational level.[15]

In July 1989, the Council discussed Bryan Walpole's suggestion for the formation of College subcommittees, with agreement reached to establish five subcommittees with the chairs as listed:

- Credentials and Regulations – Ken Abraham
- Standards of Practice and Conduct Committee – Bryan Walpole
- Workforce and Industrial – Gerry FitzGerald

- Quality Assurance (QA) and Continuing Medical Education (CME) – Gordian Fulde
- Scientific Advisory Committee – Richard Cockington

Joseph Epstein associated the subcommittee structure with diversification of College business and promoted it as increasing the College's capacity to 'respond positively and constructively to a full range of issues', thus contributing to health care as an equal, alongside the other professional colleges.[16]

As a reflection of both the increasing amount and complexity of College activity, the original committees were restructured in March 1992.[17] In line with the College decision to develop a CME process (made at the 1991 AGM), a separate CME committee was formed. The Standards of Practice and Conduct Committee became Standards, and assumed responsibility for quality assurance, workforce, development of clinical indicators and emergency department design. It also took responsibility for College representation on multiple national committees, including Standards Australia, the Australian Council on Healthcare Standards (ACHS), the Australian Resuscitation Council (ARC), the Institute of Ambulance Officers Australia and the National Disaster Organisation.[18]

Research was added as a subcommittee of the Scientific Advisory Committee, and the Journal Subcommittee was renamed Publications. An Undergraduate Education Committee was added to the existing committees of the Board of Censors, with Anne-Maree Kelly – the first FACEM appointed to an academic position – appointed as the Chair.

From 1993, in recognition of the College's increasing responsibilities and involvement with government, medical and statutory organisations, a number of subcommittees of the Standards Committee were operational: Casemix and Information Systems; Quality Assurance and Clinical Indicators; Emergency Department Design, and Workforce and Industrial. The Specialist Recognition Committee (later the Private Practice Committee) was formed in August 1993, following recognition of Emergency Medicine as a principal specialty. Two further subcommittees – Rural Emergency Medicine and Pre-Hospital Care – were added in 1994.

Administration, 1988–1996

As College business increased, so too did its administrative responsibilities, resulting in modest administrative expansion. Jenny Freeman's weekly hours – contracted through the Royal Australasian College of Medical Administrators (RACMA) – were increased from twelve to sixteen in early 1988,[19] growing to 20 hours by April 1989. Throughout 1989, ACEM was in protracted negotiations with RACMA regarding the terms of its lease agreement at Drummond Street, Carlton. It eventually renegotiated its contract such that Jenny Freeman was directly employed by ACEM, and only floor space and some facilities were rented from RACMA. From 1 August 1989, Jenny Freeman became ACEM's College Officer and its first employee. In January 1990, an assistant was hired, and the secretariat expanded into the front two rooms at the RACMA premises.[20] In mid-1991, College business was such that it was necessary not only to further increase Jenny Freeman's

hours, but also to employ an assistant for 24 hours per week. Lavinia (Liv) Cameron – who remained with the College until December 2018 – joined the College as Assistant Secretary in mid-1991.[21] A further employee was engaged in 1995 to manage the journal and examinations. In 1996, despite the College's burgeoning responsibilities and multifarious activities, the staff remained at three, reflecting the manner in which colleges such as ACEM were governed and run at that time.[22]

Intercollegiate Associations

An important area of College development and expansion was the establishment of liaison groups with other colleges. The first steps in this direction were taken in 1988, following an approach from Royal Australasian College of Surgeons (RACS) for an 'improvement in relations between the two Colleges'.[23] From this beginning, a constructive working relationship was gradually established. Similar affiliations were later established with the Royal Australasian College of Physicians (RACP), the Australian College of Paediatrics (ACP),[24] Royal Australian College of General Practitioners (RACGP), the Australian and New Zealand College of Anaesthetists (ANZCA), and the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

The College first met with the RACP in November 1990 to discuss the training programs of each College, addressing in particular areas of overlap. The development of this relationship provided a useful vehicle for the College to inform the RACP about the evolution of emergency medicine and gain insight into the standard of clinical care in emergency departments. The College also encouraged the RACP to include emergency department exposure as a component of physician training programs.[25]

The College met with the ACP in June 1991 and from this a very productive relationship was developed. Working together the two Colleges finalised a "Joint Policy on Hospital Emergency Department Services for Children" in early 1992.[26] The ACP provided ACEM with assistance in the planned introduction of experience in paediatric emergency medicine as a compulsory requirement for completion of advanced training. ACP representatives advised ACEM about aspects of the training program and assisted the College to accredit posts for paediatric training. The ACP also agreed to investigate paediatric emergency medicine becoming an essential component of paediatric training.[27]

The two Colleges liaised in development of emergency medicine casemix and information systems to address paediatric elements, and develop compatible systems for specialist paediatric and general emergency departments. A consequence of the liaison was the establishment of a Special Interest Group in Paediatric Emergency Medicine within the ACP.

ACEM worked with ANZCA – following its formation in February 1992 – to write the joint policy document "Minimum Standards for Transport of the Critically Ill".[28] The Colleges reached early agreement to exchange details of approved training posts (with a view to streamlining cross-specialty training), to hold joint scientific meetings and produce joint policy documents.

The College met with the RACGP for the first time in early 1993, with a Joint Consultative Committee between the two colleges established in 1994

to address issues related to emergency medicine training for rural general practitioners. Liaison with the RANZCP was established in 1994 in the hope that this arrangement would lead to an improvement in emergency mental health issues throughout Australasia.[29]

In each case these groups provided an opportunity for the College to promote itself as a responsible entity and educate the other Colleges about the work it did. Importantly, it demonstrated the College's capacity to work with other specialties, establishing it as a valuable and cooperative contributor within organised medicine in Australasia.

Achieving Specialty Recognition, 1988–1993

Specialty recognition in Australia

In July 1989, with new President Joseph Epstein at the helm and in light of the continued growth and development of the specialty and ACEM, the College Council decided to apply once more for specialty recognition. It was agreed that, to have the best chance of success, the College would need to prepare a 'formal detailed submission' for the consideration of the National Specialist Qualification Advisory Committee (NSQAC).[30] Preparations were thorough, and included consultation with Professor Priscilla Kincaid-Smith, the then chair of NSQAC and Immediate Past President of the RACP.[31]

Throughout 1990, every effort was made to secure support from each of the thirteen Colleges of the Committee of Presidents of Medical Colleges (CPMC)[32] and in September of that year, Council authorised expenditure of up to $10,000 for preparation of the submission, with a draft document considered in April 1991 and submitted in September 1991 after further revision.

The submission was a comprehensive document and made a strong case for recognition of emergency medicine as a principal specialty, with College Fellowship as the appropriate qualification for specialist registration and recognition in Australia. It outlined the development of emergency medical services in Australia, and argued that since the College's establishment in 1983 there had been significant improvements in emergency care, both in quality of care and the organisation and administration of emergency departments. The introduction of FACEM-led innovations such as 'triage principles based on urgency, and systems for the initial reception and early management of time-critical illness'[33] had a significant impact in this respect.

The submission held that universal access to acute medical care was a central tenet of an affluent society such as Australia, and that the best way to meet this 'prime social goal [was] to have properly equipped hospital emergency departments staffed by fully trained and experienced emergency physicians'.[34]

The submission also described the development of emergency medicine throughout the world, detailed the aims and objectives under which the College was established, and outlined its commitment to continuing education, training and examinations in addition to the extent of its Fellows' involvement in emergency medical services throughout the region. The 79-

page submission was supported by a further volume of reference material, and five volumes of appendices. Edward Brentnall describes the preparation of the submission as a 'massive' undertaking, which was at times 'long and tedious.' He comments that Joseph Epstein led a 'small task force' whom he sometimes 'worked' long into the night in order to complete the submission in time.[35]

A NSQAC Working Party discussed the submission in late 1991, before instructing the College to supply eight further copies of the document for distribution to several other colleges. In January 1992, the College was asked to supply further information to alleviate the concerns of the other colleges, with the President replying on the College's behalf.[36]

The RACP and RACS both pledged formal support for ACEM's application for specialty recognition early in 1992. At a joint meeting on 5 March 1992 the RACP representatives agreed to recommend to its Council that it support the College's NSQAC application.[37] The following month the College met with RACS who had some concerns about continued access to training in emergency departments for its trainees in the event of specialty recognition. Assured this was not the case, a letter of support was forwarded to NSQAC. In similar vein, ACEM assured ANZCA it would not seek privileges to administer general anaesthetics in the emergency departments, but would administer drugs for airway management.[38] With this concern alleviated, ANZCA too pledged its support for ACEM's NSQAC application.

In July, the Council was disappointed to learn that, as replies from all eight colleges had not been received in time, the matter would not come up for discussion for a further twelve months.[39] ACEM understood that – with the exception of the Royal Australian College of Obstetricians and Gynaecologists (RACOG),[40] which had strong reservations about the ability of other practitioners to deal with gynaecological emergencies[41] – all of those who responded agreed to support the application. To progress the matter, it was resolved that the President should convey the College's concerns to the Chair of NSQAC in a letter to be hand delivered the following day. Councillors were also requested to raise the issue with their local NSQAC representatives.[42] Council sought the support of the Federal Minister for Health, Brian Howe.[43] Joseph Epstein flew to Perth, where he successfully persuaded RACOG's recently elected president, Con Michael, to support the application for specialty recognition.[44]

Council's efforts to achieve specialty recognition proved effective, with then President Richard Ashby informing the Council in December 1992 that the NSQAC Working Party had recommended recognition of FACEM, and that attempts were underway to arrange an early date to enable NSQAC to ratify its decision. By this time, the Australian Medical Council (AMC), the MCNZ, and all of the learned medical colleges had recognised or supported the recognition of emergency medicine as a specialty.[45] However, at the time Ashby wrote the 1993 Annual Report, he regretted he was 'unable to inform Fellows when the full NSQAC [would] finally consider [the College] application and the recommendation of its Working Committee'.[46]

Official notification was eventually received on 2 August 1993, and reported by Richard Ashby to Council on 8 August 1993. The President recorded his thanks to all involved in the submission, and recognised the contributions of

Tom Hamilton and Richard Cockington in their absence.[47] The contributions of Joseph Epstein and Gerry FitzGerald in preparation of the successful NASQAC application were acknowledged with the award of the inaugural ACEM Medal in August 1993.[48]

Specialty recognition in New Zealand

The journey toward specialty recognition in New Zealand was spearheaded by New Zealand Faculty Chair, Peter Rodwell. In conversations and meetings with the MCNZ, Rodwell learnt that specialist recognition required the recommendation of the MCNZ for an amendment to the *Medical Practitioners Act 1968*.

In late 1989 he and Joseph Epstein travelled to Wellington to meet with the Minister for Health, Helen Clark.[49] Rodwell records that they were given a good audience with the Minister who advised them of the steps that needed to be taken in order for emergency medicine to be recognised as a specialty, and also promised her support.

Within eight weeks of this meeting, the Minister had 'completed all she said she would do', including directing the area health boards that in 'view of the planned recognition of the specialty that ACEM Fellows should be paid at the specialist rate'. All agreed to this directive – although, 'some more slowly than others' – according to Rodwell.

It took a further two years for the College to meet all the requirements of the Ministry of Health and the MCNZ. In that time Rodwell made many trips to Wellington. On one occasion he recalls:

> *taking the required 15 kg of typed paper … my full baggage allowance so with a toothbrush, a change of underwear and socks tucked into my pockets off I went to Wellington for two days of meetings and negotiations.*[50]

This hard work was rewarded in late 1991 with a 'promise of recognition' from the MCNZ. It was welcomed by Council and its receipt included in correspondence with NSQAC going forward. Emergency medicine was formally added to the "Schedules to the Specialist Regulations" under the New Zealand *Medical Practitioners Act 1968* in 1995. Other specialities seeking recognition at that time were occupational medicine and rehabilitation medicine.[51]

Finding a Home

As with all Council activity, the decision to purchase property was carefully considered and planned. The issue was first raised at the Council meeting of November 1989, at the end of protracted negotiations with RACMA about the terms of the College's rental agreement. At that stage, although College finances were sound, it was thought that the maximum the College could afford to commit to purchase a property was $325,000.

Almost a year later, a possible property was found in Melbourne and although the College did not proceed to purchase, discussions at that time clarified concerns about finance and the best location for College headquarters. Sydney, Melbourne and Canberra were all initially suggested

as possible locations, with Melbourne emerging as a clear favourite. Sydney was dismissed as too expensive and Canberra was considered too difficult to access. Councillors concluded that Melbourne offered the best value, and was the most convenient in terms of access for New Zealand and Western Australian Councillors. The consensus of Councillors was that the upper limit the College could pay for a suitable property was $450,000.[52]

Some eighteen months later, the Council implemented a strategy for purchase of suitable 'College Headquarters'[53] within two years.[54] Such a property was found in the course of 1992 and its purchase discussed in detail, with the Council agreeing to proceed with negotiations and empowering the Executive to negotiate on its behalf. An Executive teleconference in December 1992 approved the purchase of 17 Grattan Street, Carlton. The purchase was assisted with a levy of $500 from all Fellows, and an increase in the Annual training fee for 1993 to $200.

Richard Ashby described the purchase as a 'milestone for the College'. He commended the building for its 'fine position' and 'excellent layout' and expressed the opinion that 'the economic wisdom of the purchase decision [would] certainly be evident to future generations of Fellows'. He added that the purchase was supported by the generous subscription of 102 Fellows.[55] The Honorary Secretary, Graeme Thomson, shared his enthusiasm and pride, describing the Grattan Street building as a 'fine Victorian style terrace in excellent condition' and its purchase as a 'major event'. He considered that the extra space 'enhanced both the functioning of the office and the image of the College'.[56]

The College held its first Council meeting at Grattan Street in March 1993. At its final meeting for 1993, the Council recorded a formal vote of thanks to the staff for the 'marvellous work done in renovating the College headquarters and keeping the College working … in difficult circumstances'.[57] Over the next year, office equipment was progressively upgraded, with the addition of new networked computers and a scanner. The capital was paid down during the next four years, and the debt discharged in early 1997.

Establishing an International Profile

ACEM members were significant contributors to the 1st International Conference on Emergency Medicine (ICEM) in London in 1986, and were hosts of the 2nd ICEM in Brisbane in 1988. They co-sponsored – with the Canadian Association of Emergency Physicians (CAEP) – the 3rd ICEM in Toronto, where it was agreed to form the International Federation for Emergency Medicine (IFEM) with the following member organisations: ACEM, the American College of Emergency Physicians (ACEP), the British Association for Accident and Emergency Medicine (BAEM)[58] and CAEP.

Joseph Epstein hailed this agreement as a 'watershed in the international recognition of the achievements in emergency medicine in Australia and New Zealand and an important historical marker in the development of emergency medicine'.[59] He saw the Federation as having the potential to become involved in the development of emergency medicine throughout the world, as well as having an advisory role in areas such as disaster medicine and aspects of pre-hospital care.

The matter was progressed at the ACEP meeting in Boston in October 1991, where the basic institutional arrangements were agreed upon. Joseph Epstein reported that the inception of IFEM had aroused interest in Europe, Asia and Africa, while ACEM's 1991 NSQAC submission promoted IFEM as a vehicle to provide advice to developing countries.

The IFEM charter was signed on 10 October 1991 in Boston by the Presidents of each of the four foundation member organisations. The Federation was founded as an unincorporated body on the basis of an equal financial commitment and equal voting rights for each foundation member.

It was agreed that the IFEM headquarters and the IFEM chair would rotate every two years to the country in which the next ICEM would be held. As the 1994 meeting was held in London, IFEM headquarters were in London and the President of BAEM was nominated as the Chair of IFEM from May 1992 until April 1994. Following the London meeting, IFEM headquarters shifted to the offices of ACEM, with then ACEM President Richard Ashby assuming the role of IFEM Chair between May 1994 and 1996.

IFEM allowed four categories of membership:

1. Foundation Members: ACEP, BAEM, ACEM and CAEP.
2. Collegiate or Full Members: Organisations with an established, high standard emergency training and an assessment by examination system in place, with a CME program and whose membership comprised between 50 and 200 members admitted by examination.
3. Associate Members: Organisations that did not satisfy the above criteria but fulfilled a significant role in the practice of the ideals of emergency medicine in a country or identifiable group of countries.
4. Affiliate Members: Individual medical practitioners with a demonstrated commitment to emergency medicine.[60]

ACEM commemorated IFEM's foundation with four hand-drawn Charters, which included an illuminated logo.[61] The Charters were produced by nuns from the Carmelite Monastery, Melbourne. ACEM presented them as gifts to its foundation partners at the 4th ICEM in Washington, D.C..[62]

The College hosted the 6th ICEM in Sydney from 17 to 22 November 1996. Delegates from each of the founding member organisations of IFEM, along with delegates from Europe, South Africa and Asia, attended the conference, which was:

> *...voted an outstanding success both for the scientific content, and an opportunity for those involved in emergency medicine throughout the world to come together and share information and develop new associations.*[63]
> **John Vinen**

Emergency Doctor: Developing an Australasian Journal

In February 1989, the first issue of *Emergency Doctor*, the official newsletter of ASEM, was published. It was seven pages in length and edited by George Jelinek. The publication was an update of the ASEM newsletter and intended as a vehicle for the exchange of clinical and industrial information. The first

issue included an editorial, a message from the ASEM President, a summary of FACEM recognition around Australia, case reports, and the first instalment of a series documenting the history of emergency medicine movements in Australia and New Zealand.

In this early phase, George Jelinek's role as editor included all aspects of production. He produced the newsletter with a desktop publishing program at Fremantle Hospital, and transferred the finished product to a floppy disk, which he then took to a local printing franchise. It was then folded, put in envelopes by resident emergency department staff and addressed before transport in a 'large plastic bag' to the Fremantle Post Office.[64]

In the September 1989 editorial, Jelinek asked for debate about whether or not the College could establish an academic journal of its own. The question for consideration was whether the expertise currently existed within Australasia to produce a publication of sufficient quality on a regular basis.

Opinions were divided. Gerry FitzGerald argued there was enough expertise and considered that the publication of *Emergency Doctor*, the hosting of annual scientific conferences over ten years, participation of members in ICEM, and a number of publications in other journals attested to this fact. Added to this was the requirement for trainees to publish before being awarded Fellowship.

The problem as FitzGerald saw it was more administrative and managerial in nature, and could be overcome with clear organisation and spread of workload. Others, however, saw things differently. An anonymous contributor to the same issue argued that the present publication was sufficient for current needs, and considered that a college of less than 200 Fellows could not support a journal. The contributor considered the current workload for the College was sufficient and that articles on, or about, emergency medicine could be directed to a journal in wide circulation, such as the *Medical Journal of Australia* (*MJA*), or existing emergency medicine journals.[65]

At the same time, there was growing support for an academic journal from within the College. The matter was discussed at a joint ASEM/ACEM executive meeting in November 1989, and a subcommittee of the Scientific Advisory Committee (SAC) – comprising Richard Cockington (chair), FitzGerald, John Vinen and Jelinek – was formed to investigate further development of a journal for Australasia.

During 1990, *Emergency Doctor* went from strength to strength, with Vinen and FitzGerald joining Jelinek to form an editorial board and John Maguire and Paul Mark joining as editorial assistants. Original contributions gradually increased, with the clinical component of the September 1990 issue of 26 pages (three times the size of the first edition), focused solely on hyperbaric medicine.

Both ASEM and the College expressed strong support for development of the journal at their respective AGMs in 1990, and the time was considered right to proceed with the development of a true journal. Accordingly, with the December 1990 issue, the name was changed to *Emergency Medicine*, and Bryan Walpole joined the Editorial Board, with a commitment to peer review all submitted articles.[66] This issue was 35 pages and included case reports, original reports, ASM abstracts, and news items.[67]

The following year, ACEM ceased its subscription to the *Archives of Emergency Medicine* and subscribed instead to *Emergency Medicine*.[68] In November 1993, ACEM increased its involvement when it took up a 50% equity in the journal, with an agreement to provide capital equipment and share ongoing expenses equally. At this meeting, a possible expenditure of $20,000 was announced to develop the journal. George Jelinek resigned as editor (but remained as scientific editor) while Gerry FitzGerald was contracted as an independent editor.[69]

In his first editorial, FitzGerald commended George Jelinek for taking 'a seven-page newsletter and in five years [creating] a high-quality scientific journal'.[70] He explained that his own interests lay in management and organisation and, in taking up the editorship, he hoped to restructure the management of the journal and involve more people in its editorial processes and management. Planned changes included expansion of the editorial team to include James Taylor as publishing editor with responsibility for printing and publication and the appointment of a business manager with responsibility for finance and advertising. The Editorial Board was expanded to include section editors. The panel of referees was also expanded. FitzGerald commented that he hoped to broaden the journal's subscription base and increase corporate sponsorship to ensure its future financial viability.[71]

The administration of the journal was transferred to College headquarters in 1994, where College staff assumed responsibility for the day-to-day business of the journal. George Jelinek, reflecting on 25 years of the journal, pays tribute to the 'fastidious and extensive input of College staff Gabrielle Whiting and Jenny Freeman'. Gabrielle Whiting 'handled every paper published, liaising with authors, peer reviewers and editors', while Jenny Freeman proof-read every article.[72]

The journal enjoyed some progress. However, in 1997, its future was not assured. Gerry FitzGerald identified three areas of concern: the journal had yet to achieve *Index Medicus* listing (now *Medline TM*); it needed a broader subscription base; and it required strategic alliances with other journals to allow sharing of index pages and co-publication of articles as appropriate.[73]

After a submission for *Index Medicus* listing failed in late 1997, significant changes were made to the journal. Production and publication were handed over to Blackwell Science Asia. George Jelinek returned to the journal in the position of Editor-in-Chief, Tony Brown was appointed Editor, and Anne-Maree Kelly and Geoff Hughes were appointed as assistant editors for Australia and New Zealand, respectively. In order to ensure a cross-cultural balance within the journal's structure – and in recognition of the growing global importance of emergency medicine – the International Editorial Board was expanded to include representatives from Hong Kong, South Africa, the United Kingdom, Canada, and the United States of America. The cohort of section editors was similarly expanded to deliver peer review across fifteen different areas. Broadening the scope and aims of the journal in this way – along with deliberate international promotion – delivered a 50% increase in submission and publication of original research papers and strengthened the overall scientific content of the journal.

On the strength of the editorial changes and the alliance with Blackwell, the journal again presented itself for *Index Medicus*' selection process and was accepted in June 2001. Its success was hailed as a milestone for the College, and on par with NSQAC specialist recognition insofar as it signalled both the journal's and the College's acceptance within an international academic community.

In December 2003, Tony Brown was appointed Editor-in-Chief in place of George Jelinek who became the journal's Emeritus Editor. Under Brown's leadership the journal continued to progress and change, beginning in February 2004 when it was renamed *Emergency Medicine Australasia (EMA)* and relaunched with a redesigned cover and the *EMA* logo.

In 2008 *EMA* was selected for indexing and abstracting in the *Science Citation Index Expanded (Sci Search)* and the *Journal Citation Reports* (Science Edition). Tony Brown welcomed this development as a 'rare mark of respect for a Southern Hemisphere journal' and a 'clear acknowledgement of the strength and global value of the practice of emergency medicine in Australasia'.[74] The journal's inaugural Impact Factor (IF) of .91 was announced in 2010; with improvement to 1.6 in 2014 and rising slightly in 2019 to 1.69.[75]

In 2009 *EMA* transitioned from Blackwell publishing to the Wiley *Interscience* platform and subsequently to the new web-based platform *Wiley Online Library* in August 2010.

After ten years as Editor-in Chief, Tony Brown stepped aside following publication of the 25th Anniversary edition of the journal in February 2014 and Geoff Hughes was appointed in his place. Since then the journal has evolved in a number of ways to maintain its relevance in the current social media environment while at the same time protecting its intellectual rigour as a peer-reviewed academic journal.

ASEM's involvement in the journal continued until early 2018 when negotiations to transfer full ownership of *EMA* to the College were successfully completed.

The Emergency Medicine Research Foundation

The concept of an entity for research promotion and development was discussed as early as 1985 when Fellows voted to allow the Council to establish a Research Trust. This matter was not progressed further until Mike Galvin joined Council in 1989 and undertook drafting of arrangements for the Emergency Medicine Research Foundation (EMRF). These were presented to Council in November 1991, but it took several more years before the Foundation was formally established.

In February 1992, Garry Phillips, Gerry FitzGerald and Richard Cockington accepted membership of a proposed Research subcommittee of the Scientific Advisory Committee. In the 1994–1995 financial year, the EMRF was finally constituted as an independent company with a charter to facilitate emergency medicine research in Australasia and to be managed by the College.

The Foundation was established with a grant from the members of the Taylor and Morson families ($10,000), with ACEM making an equivalent

grant in each of the first two years of the Foundation's operation. The College continued to contribute smaller amounts to the EMRF, and to provide administrative support. It was intended that the EMRF would become self-supporting, but fundraising proved difficult and activities were never developed beyond the granting of the Morson Taylor Research Award. This was awarded for the first time in 2000, with Stephen Priestley as the inaugural recipient.

In 2012, ACEM's various philanthropic and research funding entities were consolidated under the umbrella of the ACEM Foundation. The Foundation created a clear philanthropic profile for the College and provided opportunities for College Fellows, the community, industry and philanthropic organisations to contribute to the future of emergency medicine in Australasia and support international development.

Developing the National Triage Scale

The National Triage Scale (NTS), later the Australasian Triage Scale (ATS), was introduced in 1994 as the standard urgency descriptor for Australasian emergency departments. The scale used the following descriptors: resuscitation; emergency; urgent; semi-urgent; and non-urgent. Triage codes 1–5 were used respectively to categorise patients on arrival in the emergency department. The NTS specified treatment acuities that varied from 'immediately' for triage code 1 patients through to two hours for patients categorised as non-urgent.

The NTS evolved from the work of a number of Fellows, beginning with Edward Brentnall at the Box Hill Hospital, Victoria from the mid-1970s. When Brentnall arrived at Box Hill in 1975 as the Director of the Accident and Emergency Department, he found a busy but poorly organised department where interns – with very little supervision – provided the main workforce. The hospital on the eastern margin of Melbourne, served an estimated population of 750,000 and saw about 46,000 patients each year including more road trauma than any other hospital in the metropolitan area. Brentnall recalls that 'waiting times were long, and there were many mistakes' with the occasional patient developing 'serious symptoms' while waiting in the waiting room.

Keen to find solutions for these problems, Brentnall working closely with the Nurse Manager Noel Pink, developed and introduced a three-tier triage system in March 1976 with the categories urgent, semi-urgent and non-urgent, colour coded as yellow, blue and white, respectively. Formal triage procedures were conducted by an experienced nurse stationed at the front door of the department. A patient information leaflet carefully explained the triage system and with rare exceptions, the patients and relatives understood the need for such a system. Over time, a five-tier system evolved, with the addition of a resuscitation category (coded orange) and an intermediate category (coded blue-yellow) for patients between urgent and semi-urgent. Waiting times and waiting limits that related only to triage categories – rather than the activity of the department – were developed in the late 1970s. The Box Hill Hospital system 'spread to a number of other hospitals', including the Royal Canberra Hospital where John Potts introduced the system following a visit to Box Hill.[76]

Gerry FitzGerald from the Ipswich Hospital in Queensland took the five-tier Box Hill system and developed it as the Ipswich Triage Scale (ITS). The ITS was introduced operationally in 1986, and over three years its utility and relevance were studied. Like the Box Hill scale, the ITS was a time-based scale that used a patient urgency test – varying between seconds and days – to discriminate between categories. The study proved the validity of the scale by demonstrating that an overall urgency assessment of patients presenting to an emergency department was predictive of their outcome, consistent with other measurements of severity, and relevant to the clinical care of the patient. In further research, George Jelinek confirmed the repeatability and validity of the system.

On the basis of this research, the College developed the NTS as a modified version of the ITS.[77] The NTS also included indicator thresholds, which represented reasonable standards of achievement in emergency departments.

National Triage Scale	Triage Code	Treatment Acuity	Indicator Threshold
Resuscitation	1	Immediate	98%
Emergency	2	Within 10 minutes	95%
Urgent	3	30 minutes	90%
Semi-urgent	4	60 minutes	90%
Non-urgent	5	2 hours	85%

The NTS was the first national triage scale in the world. Both the Manchester Triage Scale (MTS) and the Canadian Triage and Acuity Scale (CTAS) were developed on the basis of the Australasian system.

The NTS – significant as the first nationally accepted triage scale anywhere in the world – has further significance as the cornerstone of early College negotiations in the medico-political arena. The impetus for College development of the NTS was the Commonwealth proposal to introduce Casemix-based funding as the basis of its hospital funding arrangements with the Australian state and territory governments. It was also important for College negotiations with the Commonwealth to achieve specialist rebates for specialist emergency physicians in private practice.

Casemix and the NTS

The Australian Federal Government's interest in the casemix funding system – developed in the USA in the 1970s – dated from the early 1980s. It was progressed after research conducted by health economist George Palmer suggested the system could be adapted for Australian conditions.[78] A casemix development program was commenced in 1988, with a focus on inpatient services. From this work, Australian National Diagnostic Related Groups (AN-DRGs) were established, based on American DRGs.

At that time little work was done on classifying and costing ambulatory services, such as hospital outpatients, emergency departments and

rehabilitation services. In the early 1990s, two projects – largely for demonstration purposes – were conducted to test overseas ambulatory classifications. These projects – the National Ambulatory Casemix Project, Sydney and Flinders Medical Centre Ambulatory Encounters Project, Adelaide in conjunction with Royal Children's Hospital, Melbourne – identified issues in the Australian setting.[79]

College Fellows involved in these studies raised some concerns about 'condensing the complexity and uncertainty of clinical problems faced in emergency medicine into a simple coding system' according to the overseas classifications and argued that more research was needed to develop 'reliable methods of measuring workload indices or casemix funding'.[80]

The College concerns were heeded by the project team and reflected in its report. The report – delivered in July 1992 – rejected the overseas Ambulatory Patient Groupings as inappropriate for the Australian setting and recommended a 'detailed and comprehensive study' in emergency departments to 'address the need to have a single casemix system to capture all patients presenting to emergency departments and to examine the costs of admissions to the departments'.[81]

The College endorsed the findings of the report and formed a Casemix Committee – with members Richard Ashby (Chair), Joseph Epstein, John Vinen, Ken Abraham, Michael Clark and George Jelinek – to lead College involvement in this area.

The Committee considered that there was a need to link triage to performance and funding and suggested Urgency Related Groups (URGs) as the basis of casemix funding for emergency departments. To progress this concept it was agreed that a nationally accepted triage system be developed, incorporating the use of sentinel codes to monitor performance, and from this a casemix system could be devised. Richard Ashby considered that the College was in a good position to develop this because of work done by George Jelinek in the development of URGs and Gerry FitzGerald's development of the ITS. The meeting agreed that Richard Ashby, George Jelinek and Gerry FitzGerald would seek funding for multi-centric validation of the system.[82]

The College's proposal was presented to the National Casemix Implementation Board where it was favourably received. Subsequently, Queensland Health nominated College Fellow Michael Cleary as the state's representative on the Australian Casemix Clinical Committee. This was an influential committee that provided clinical advice on classification issues, and which had ultimate responsibility for ensuring that the final casemix system was clinically meaningful and relevant.[83] With Bryan Walpole as chair of the AMA Casemix Subcommittee, Richard Ashby considered that the College had good opportunities to articulate its concerns and suggestions for a rational and equitable casemix system for emergency departments. Importantly, Ashby believed that the College involvement was constructive and 'well received by government and the wider profession'.[84]

Subsequent testing validated the College proposal. The "Outpatient Costing and Classification Study" recommended that in the 'short term [an] urgency and disposition-based structure' should be adopted as the basis for classifying and funding services in Australian emergency departments.[85]

The NTS and private practice rebates

Following NSQAC recognition of Emergency Medicine as a principal specialty in August 1993, it was some months before the College received official confirmation from the federal minister responsible for health, Graham Richardson.[86] Richard Ashby explained the delay as ministerial consideration of the Medicare implications,[87] particularly the possibility that public hospital emergency departments would be privatised and major cost-shifting would result.[88] The letter of confirmation was eventually received in December. It acknowledged retrospective recognition from 2 August 1993 of the NSQAC decision and informed the College that payment of Medicare benefits would be made 'for specialist services provided to referred patients in private practice'.[89]

In early 1994 – following discussion of an appropriate strategy – the College opened negotiations with the Commonwealth for relaxation of the referral requirement for private emergency specialist services. Initial discussions were with the Health Care Advisory Division, where the College advised that most patients treated by an emergency physician would be unreferred. The College came away from this meeting reasonably hopeful that new Medical Benefits Schedule (MBS) item numbers covering emergency medicine and based on the NTS categories could be developed.[90] The College developed a definition of "emergency" utilising the NTS categories 1–4. Patients in these categories – acutely ill or injured and requiring medical care within one hour – were considered by the College as bona fide emergencies where the referral rule should not apply.

At this early stage the College sought the assistance of the AMA for its negotiations with the Commonwealth.[91] The College definition was presented to the Commonwealth Health Insurance Commission (HIC) as a basis for negotiations but was rejected for 'imminent danger of death requiring continuous life-saving treatment' as an alternative definition of "emergency".[92] Acceptance of this definition would have precluded approximately 90% of emergency medicine practice from the MBS system. The HIC's caution was attributed to concerns about the potential development of private practice in public hospitals; however, as Richard Ashby pointed out, the College was 'strongly opposed to any two-tiered system of care within the emergency departments of Australia's public hospitals'.[93]

Negotiations continued in 1995, with the definition to define the scope of specialist practice in emergency medicine published in the *Medical Benefits Schedule* in November 1995. The definition described an emergency as a situation where treatment was delivered within thirty minutes for a potentially life-threatening injury or illness, or where the patient was suffering from a drug overdose or other toxicity or experiencing a severe psychiatric episode.

Examinations and Training

For ACEM's Board of Censors (BOC) this was a busy period in which its regular work – the conduct of examinations, credentialing and accreditation activities – increased significantly as trainee numbers swelled and emergency

departments were established in both Australia and New Zealand. As well, the BOC oversaw a number of other developments. These included the introduction and development of a five-year advanced training program and review and reform of both College examinations.

The achievements of the BOC in developing the College's examinations and training programs relied on the contributions and leadership of several people. Paul Gaudry, as CIC (1988–1992), provided the impetus for change, with comprehensive review of examinations and training and subsequent publication of his analysis. Chris Baggoley as Deputy Censor-in-Chief (DCIC) (1991–1992) and CIC (1992–1995) provided sound leadership. As DCIC he increased the efficiency of credentialing and accreditation systems, and, as a result of this work, the DCIC role was split into a Chair of Credentials and Chair of Accreditation. As the CIC he drove changes to the training program and was committed to ensuring the Fellowship Examination developed as a fair and rigorous process with an improved pass rate.[94]

Allen Yuen – Victorian Censor from 1992 until 1999 – made a significant contribution to development of the College's accreditation processes. Appointed inaugural Chair of Accreditations in 1992, he developed guidelines for accreditation of departments for paediatric emergency training. On completion of the first round of accreditation visits at the end of 1994 – by which time the College's accreditation teams[95] had completed 109 inspections in 76 hospitals and two helicopter retrieval services and accredited 64 hospitals[96] – he undertook review of the College's accreditation processes.

Paul Mark was appointed inaugural Chair of Credentials in 1992. He revised the Annual Record of Training in 1993 to include provision for four evaluation reports per year for each trainee. This development enabled the College to better monitor trainee progress and provide more timely feedback for trainees about performance. He also developed and introduced annual trainee reports on the quality of supervision.[97] Chris Baggoley commended this work as putting the College's credentials processes onto an 'extremely professional level' and making the difficult task of maintaining an up to date register of progress for a 'burgeoning number of trainees … look very easy'.[98]

Fellows more generally also made significant contributions to the work of the BOC as Directors of Emergency Medicine Training (DEMTs), examination committee members or examiners. The Court of Examiners was established in 1985 with nine members, with further appointments in subsequent years. With four examinations each year – requiring up to 20 examiners at any one time – membership of the Court was a significant commitment. This commitment increased after the College accepted the inclusion of the Objective Structured Clinical Examination (OSCE) in the Fellowship Examination and ceased using external examiners for any examinations from 1995. Calls were made regularly for Fellows to join the Court of Examiners and the response was always positive.

With the retirement in 1995 of examiners appointed in 1985, concern that there would be a shortage of examiners, led to the creation of a Senior Court of Examiners.[99] Admission to the Senior Court was by invitation and was limited to one five-year term. Senior examiners Lionel Dzuikis, Bryan Walpole, Joseph Epstein, Gordian Fulde, Tom Hamilton and Allen Yuen were appointed in 1994, and Paul Gaudry in 1995.[100] With these appointments and

the addition of a further 13 examiners in 1996, the College's pool of examiners at the end of 1996 was just over 50.

The Fellowship Examination Committee (FEC) and Primary Examination Committee (PEC) traditionally based in Sydney and Melbourne respectively – were expanded to include more regional representation. The PEC included representatives from the regional Faculties from early 1994.[101] In 1991, with future Fellowship Examinations planned for Brisbane and Melbourne the FEC was enlarged to include Queensland and Victorian Fellows.

Training

College surveys of successful Fellowship candidates conducted in the early 1990s confirmed a wide variation in trainee experience. Some were critical of a lack of support from both the College and their emergency departments, and commented that much of their training was undertaken with very little FACEM input, while others considered they had received 'excellent teaching' in the lead-up to the Fellowship Examination. Some felt that there was not enough emphasis on the administrative aspects of running an emergency department or research in emergency medicine.

There was general agreement that a more structured approach to training would be helpful. Trainees suggested set rotations that included paediatric emergency departments, ICU, anaesthetics and medicine would be helpful for rounded training. Exposure to both teaching and district hospitals was also mooted as beneficial.[102]

These findings were reflected in development of training following introduction of the College's seven-year training program in January 1988. From this time trainees registering with the College entered a program, of 24 months basic training and 60 months advanced training. The advanced training period comprised 24 months compulsory experience in an accredited emergency department, 24 months compulsory non-emergency experience, and a further 12 months either in an emergency or non-emergency setting. In the years after the program was established, regulations were introduced, and recommendations made, to ensure the broadest training experience and to introduce some structure and standardisation into the program.

The first priority for the College as it set about developing a more structured program was to establish a compulsory paediatric component during advanced training. In 1990, on the BOC's recommendation, Council approved a minimum of six months compulsory paediatric emergency medicine experience. Implementation of the program was complicated and time consuming. It included liaison with the Australian College of Paediatrics, curriculum development, definition of criteria for approval of a general hospital emergency department for paediatric training and accreditation of suitable hospitals.[103] The list of hospitals was finalised at the end of 1992[104] and paediatric experience became compulsory from 1 January 1994.

Other developments aimed at delivering a broader experience included acceptance of a six-month obstetrics and gynaecology term in an approved post as a component of non-emergency department training,[105] and from July 1995, regulations were approved allowing trainees to include a period of 12 months research or six months medical writing as part of compulsory non-

emergency department training time. Six months at the Victorian Institute of Forensic Medicine was also approved.[106]

In 1991 the BOC recommended that the minimum advanced training requirement of 24 months in an approved emergency department include six months in a tertiary referral centre and six months in a designated non-tertiary hospital.[107] This recommendation was formalised and approved by Council in late 1992 after preparation of a list of accredited tertiary referral hospitals.[108] In order to progress this recommendation, Council directed the BOC to develop the concept of a Regional Training Program to become effective by 1 January 1996. This proved difficult, however, and remained in development for a number of years. Compulsory tertiary and non-tertiary experience was not introduced as a component of advanced training until 1 January 2003.[109]

To encourage progression through the program in a timely manner and ensure – as Chris Baggoley stated – that the focus of advanced training was 'attainment of specialist capabilities rather than … study of the basic sciences',[110] the number of years of advanced training that could be credentialed before achievement of the Primary Examination was gradually reduced. Initially, the College imposed no limitations in this regard, but from 1 January 1991 the agreed period was 36 months,[111] and reduced to 24 months from 1 January 1995.[112] From 1 April 1997, success at the Primary Examination was required before trainees could begin the second year of advanced training.[113]

With the aim of ensuring that training was a 'planned exercise and not an accredited afterthought',[114] a number of regulations were progressively introduced. These included:

- Restricting the maximum period of overseas training that could be accredited for advanced training to two years (including twelve months in an accredited emergency department).[115]
- From 1 January 1991 the minimum commitment of 24 months in an approved emergency department needed to include 12 months in a department approved for two years of advanced training.
- From 1 January 1995 non-ED training would not be accredited without a letter of support from the supervising consultant.
- No retrospective accreditation of emergency department training from 1 January 1996.[116]

Regulations were also introduced limiting accreditation of the core compulsory emergency department training to those where the trainee was involved in a role that included decision making, team leadership and responsibility.[117] To ensure adequate FACEM input during training, accreditable emergency department training was restricted to those departments where the DEMT was at least 0.5 FTE and the total FACEM input was at least 1.0 FTE.[118]

Developments in Examinations

The Primary Examination

During this period measures were adopted to ensure – as Pamela Rosengarten and Anne-Maree Kelly attest – that the examination developed as 'consistent, relevant, fair and objective'.[119] The examination was reviewed at College workshops in November 1989 and July 1990, with the second workshop including analysis and advice from the Educational Testing Centre, University of New South Wales.[120] The review, endorsed the examination's multimodal structure – Multiple Choice Questions (MCQs), essay and Short Answer Questions (SAQs) and Viva Voce – but made a number of recommendations with the aim of providing 'each candidate every opportunity to pass'.[121] Measures adopted included the chance for candidates who passed the written sections but failed the oral sections to resit only the oral sections in the next two examinations.[122]

From 1993 the College adopted selective presentation to the viva voce. With this development, candidates who clearly failed the written sections and would not be able to pass the Primary Examination were not invited to sit the oral component. To accommodate this change the interval between the written and the oral sections was extended from four to eight weeks.[123] Subject posts were introduced from 1995 for candidates who failed just one subject. These candidates were able to resit only the failed subject in one of the next two sittings of the Primary Examination.[124]

The viva voce section was modified with the aim of creating a fairer and more objective examination. Modifications included individual marks for each of the four subjects from 1991, and from 1993, different examiners for each subject, rather than two pairs of examiners – one pair examining anatomy and physiology and the other pathology and pharmacology. Objectivity and consistency were improved from 1994 after the viva topics were pre-determined by the PEC, rather than individual examiners. In 1996 the PEC introduced examiners' meetings where topics were agreed, along with the path of questioning and the level of knowledge expected for a pass.

A major change to the Primary Examination occurred in 1993 when the College opted to cease its reliance on the MCQ bank of RACS. When this arrangement was terminated the College chose to develop its own bank of questions using only type A questions (one correct answer from five possible alternatives). The pathology syllabus was also revised with the aim of increasing its relevance for emergency medicine.[125]

Although the 1990 review of the Primary Examination had endorsed retaining all sections of the examination, later review recommended that the essay be dropped on the basis it was a 'poor test of factual knowledge covering only very limited subject matter, and that scoring [was] subjective and may be influenced by writing skills'.[126] In the revised examination – introduced from 1995 – the written components comprised 45 MCQs and six SAQs for each section. The following year, the SAQ section was also eliminated after comparative studies demonstrated that its removal did not adversely affect candidates' performances.[127]

From October 1996 the Primary Examination was bimodal, with an MCQ

component of 60 MCQs and a Viva Voce in each subject. The examination was held over two consecutive days, with the MCQs papers in each subject held on the first day and the viva voce on the second day. All candidates attended both examinations and received their marks at the end of the second day. A pass in each subject was required to pass the examination.[128] This development had advantages for both candidates and examiners. It offered objective and rapid assessment using computerised marking systems, eliminated the long delay between the written and oral sections and considerably reduced the workload of examiners.[129]

Peter Cameron as Chair of the PEC developed the College's MCQ bank in 1993, while his successor Pamela Rosengarten oversaw the significant changes to the examination format introduced from 1995.

The Fellowship Examination

The original Fellowship Examination devised in 1986 had eight sections (a combination of written, oral and clinical) and could be sat anytime in the final year of training. To pass the examination required a satisfactory overall performance and could be achieved with success in six of the eight sections. Between 1986 and 1991 the examination was held annually in Sydney and from a total of 166 attempts, 78 candidates were successful. The average pass rate in the first seven examinations was 47%.[130]

The examination was reviewed internally at ACEM workshops in November 1987 and April 1990. A further workshop, conducted in April 1992, reviewed the format, administration and results of examinations held to that date and had the input of outside educational experts. Based on this work as well as Paul Gaudry's reviews of examinations and training, a report was presented to Council in October 1992. The report proposed significant changes to the format of the examination. These included upgrading the MCQs, the use of the OSCE format in the written and replacement of the current short cases and vivas by an OSCE. It was proposed at that time to retain the long case format. Other recommendations included a greater focus on training and assessment of examiners and improvement in the feedback process, especially for failed candidates.[131]

Following wide consultation with the Faculties, Council accepted 40 recommendations that it progressively implemented from March 1993. Recommendations related to entry criteria to the Fellowship Examination and the development of systems of examiner accreditation were introduced as soon as possible, however, those related to the format of the examination were delayed until the beginning of 1995 to allow adequate preparation for both the College and the candidates. Andrew Singer, appointed Censor for New South Wales in 1993 and Chair of the FEC in May 1994, was largely responsible for progressing the considerable changes associated with introduction of Structured Clinical Examinations (SCEs) and OSCEs.

The revised Fellowship Examination introduced in 1995 comprised six rather than eight sections. The written component included 60 Type A MCQs, SAQs and 12 Visual Aid Questions (VAQs) while the Oral/Clinical Component included 1 long case, a viva voce comprising one 20-minute viva, three OSCE stations and a short case section, with each candidate undergoing testing on the same organ systems, but not with the same patients.[132]

From the second examination in 1995 the Viva Voce/SCE section was altered to include only SCEs, with no additional viva.

Selective presentation to the oral/clinical examination components was introduced from the first examination in 1995. Candidates who failed all three of the written components and had no chance to pass the overall examination were not invited to the oral/clinical examination.[133]

A research component as a condition of the award of Fellowship was suggested by the BOC in 1989 for introduction from 1992. This was developed as Regulation 4.10/70, which stated that candidates for election to Fellowship should have published a paper or have presented a paper at a recognised scientific meeting. From the outset, this requirement proved a significant barrier to Fellowship for some. Chris Baggoley noted in 1993 that few trainees had completed projects at the time they passed the Fellowship Examination, resulting in significant delays before the award of Fellowship.[134]

Over time the changes implemented by the College delivered an improvement in pass rates for both examinations.

Uncertain Times – 1996 and beyond

Andrew Singer, reflecting in 2014 on the College's performance in its first 30 years, flags several events of this period as important milestones in its overall development. Recognition of emergency medicine as a principal specialty was undoubtedly the most significant event during this period. Other College milestones included ACEM's role as one of the four founding organisations for IFEM in 1991, development of the journal *Emergency Medicine* from 1989, the purchase of College headquarters at 17 Grattan Street in Carlton in early 1993,[135] and the Australia-wide adoption of the NTS in 1994. Other achievements of note included: working with the ACHS to draft and publish new standards and clinical indicators in emergency medicine and trauma; the establishment of the EMRF; and the initiation of a continuing professional development program. Also significant in this period were organisational changes within the College, particularly at the Council level.

In 1983 the way ahead had been clear, but as 1996 drew to a close the College – although proud of its many achievements – looked cautiously towards the future. It had enjoyed unprecedented growth in the three years since specialty recognition, signing up more than 100 trainees each year and experiencing increasing demands for its specialists. However, throughout 1996, the College was increasingly concerned about the future development of its workforce. Its current 250-strong specialist workforce was inadequate to meet demands for its services, however with more than 550 trainees – many with very little experience – it worried it would soon face an oversupply of emergency physicians. Moreover, specialists and trainees alike went to work each day in increasingly overcrowded emergency departments where patients experienced unacceptable delays. These issues presented a number of challenges for the College as it moved towards the new millenium.

CHAPTER 4

EXPANSION AND COMPLEXITY 1997–2007

By the mid-1990s, the College was established within the Australian and New Zealand healthcare systems, and emergency medicine was recognised as a specialty integral to the quality delivery of emergency medical care. It was, as Peter Cameron observed, a 'central component to the healthcare process, acting as a link between community and hospital medicine'.[1] The College as an organisation could boast both 'strength' and 'maturity'; it had established, as noted by Richard Ashby, an 'educationally sound curriculum, a transparent and equitable accreditation and credentialing process, and relevant and fair examinations'.[2] Its governance processes were considered sound and well established, and its finances secure.

The College's solid foundations allowed it to expand its influence and interest beyond its core responsibilities of education and training underpinned by sound governance, and to make contributions in areas such as public health, disaster medicine, workforce planning and mental health. Strong support was also provided for the development of emergency medicine internationally, both through the College's contribution to the International Federation for Emergency Medicine (IFEM) and the establishment of the ACEM International Development Fund.

While the College was successful, it also experienced significant challenges. Workforce management, access block and negotiations with the federal government about fee structures for private practice emerged as major issues from the mid-1990s. These were difficult and complex problems and required the College to engage significantly over time with government to secure improvement. Patience, hard work and a willingness to negotiate eventually delivered progress in each of these areas.

Overall, the College rose to the challenges presented and thrived. As a young and developing College, it demonstrated an ability to grow, adapt and lead in a challenging and dynamic political and medical environment. Still though, at this time the College staffing resources were low and College Fellows continued to take responsibiity for progressing much of the developmental work of the organisation.

The Council

The College continued to benefit from committed, enthusiastic and innovative leadership from successive Councils and Presidents. Chris Baggoley – President from November 1997 until November 1999 – was a cautious and respected leader, who proved himself a very strong negotiator and good communicator. He provided a steady hand throughout a period where the College looked to find the most appropriate approach to take in relation to workforce and training issues, as well as access block. He was acknowledged as an 'outstanding ambassador for the College [who] helped introduce emergency medicine to the federal medico-political scene'.[3] He resigned as College President after he was elected Chair of the Committee of Presidents of Medical Colleges (CPMC) for 2000/2001; an achievement that was acknowledged as affording 'great honour to the College'.[4] Reports from Baggoley's time as Australia's Chief Medical Officer (August 2011–July 2016) further confirm his abilities and the respect in which he is held outside the specialty of emergency medicine.

Peter Cameron brought both optimism and enthusiasm to the presidency. He encouraged research around access block and pointed to the necessity for national solutions, while also suggesting that emergency medicine practitioners should become drivers of change in this area, as well as workforce management. Committed to the development of emergency medicine internationally as a specialty, he resigned his presidency in September 2001, following his appointment to an academic position in emergency medicine at the Chinese University, Hong Kong.

Ian Knox succeeded Peter Cameron; he joined Council in July 1997, and in 1998 was appointed as inaugural chair of the Private Practice Committee. As President he successfully negotiated with the Commonwealth for a revised Medical Benefits Schedule (MBS) for private specialist emergency medicine attendances and worked hard to focus media and government attention on the problems associated with access block.

Andrew Singer was elected President on Ian Knox's retirement in November 2004. Singer was an ideal leader for the College in the lead-up to Australian Medical Council (AMC) accreditation in 2007. He had served a long apprenticeship with the Board of Censors (BOC) in various roles before becoming Censor-in-Chief (CIC) in 1999 and, importantly, he was involved in early development of AMC accreditation processes. He was appointed Councillor for the ACT in November 2003.

As Council business increased, the Vice-President's role was formalised to include responsibility for special projects, coordination of cross-committee issues, development of position papers and deputising for the President when necessary.[5]

Sue Ieraci – Vice-President from November 1997 until November 2000 – made a significant contribution, with a focus on refinements to the National Triage Scale (NTS) and development of the Australasian Triage Scale (ATS), along with the development of workforce policy. Ian Knox, Vice-President 2000–2001, continued to focus on the issue of private practice MBS numbers, as well as the development of a media strategy for the College. Diane King – who served a first term as the Councillor for South Australia between

1993 and 1995 – returned to Council in September 2001 and immediately assumed the Vice-President's office. In this role she led the College's early preparations for AMC accreditation in 2007. Sally McCarthy, Vice-President from 2005 until 2008, represented the College on the National Organ Donation Taskforce, was the chief organiser of the 2008 Access Block Summit and became President in 2009.

While the presidency changed a number of times, there was an element of stability and continuity within the Council Executive. Richard Ashby returned to the Executive in November 1997 as the Honorary Treasurer – a position he retained until November 2005. Paul Gaudry, Councillor 1989–1995, and CIC, 1988–1992, returned to Council in 1999 and served as Honorary Secretary from November 1999 until September 2004.

Regular elections, an increasing Council workload, and professional commitments, meant that Fellows often served only one term on Council. Councillors to make significant contributions, other than those already mentioned, included Mike Ardagh, Steven Doherty, Geoff Hughes, Tony Joseph, Marcus Kennedy, Andrew Maclean, Bhavani Peddinti, Drew Richardson and David Smart. CICs during this period were: Paul Mark, 1995–1998; Andrew Singer, 1999–2003; and Wayne Hazell, 2004–2007.

The increasing demands of government bodies accounted for a significant expansion in College business throughout this period. The College worked with the Australian Medical Workforce Advisory Committee (AMWAC) in 1996 and 2003 as it conducted a review of the emergency medicine workforce on behalf of the Australian Health Ministers Advisory Council (AHMAC). It made submissions to the Medical Training Review Panel's (MTRP) 1998 review of trainee selection processes and a later review of Australian specialist medical colleges undertaken by the Australian Competition and Consumer Commission (ACCC) and the Australian Health Workforce Officials' Committee (AHWOC). The College was also involved in the Australian Government's complex Relative Value Study.

Administrative and financial consolidation

Judicious financial management over a number of years delivered financial security for the College, making it fiscally very well resourced to meet various challenges, and expand its educational and training activities. In early 1997, the debt on Grattan Street was fully discharged and accumulated funds were sitting at $780,000. The College's financial position was consolidated in the next few years, with accumulated funds passing $1 million for the first time in 1998 and reaching almost $7 million in 2006. The College's strong financial position allowed it to support emergency medicine in developing countries, provide funding for research, and develop educational programs and consultancies.

Administrative and financial processes were extensively reviewed and upgraded in 1996 and 1997 with the introduction of computerised financial systems, the development and launch of a College website and introduction of other information technology to streamline and improve office function.

Throughout this period the College was fortunate to have the service of loyal and competent staff. In 1996, the College staff consisted of Jenny

Freeman as College Officer, Liv Cameron as credentials secretary and one further staff member with administrative responsibility for the journal *Emergency Medicine* and examinations. This role, created in the early 1990s, had a number of incumbents before Gabrielle Whiting was employed in July 1997. Dee Reynolds was also employed in 1997 to provide administrative support for hospital accreditation and accounting procedures, as well as secretarial assistance for the College Officer. In late 1998, Jenny Houlden was employed as the College receptionist.

The contribution of these staff members to the College was recognised and appreciated by Councillors, Fellows and trainees alike. In the 1999 Annual Report, Chris Baggoley paid tribute to this committed cohort of stable employees as 'quite expert in their relevant areas, yet able to contribute to a wider effort when required', while also acknowledging their 'major contribution to the smooth running' of College business.[6]

Jenny Freeman's role within the College had increased substantially as the College had increased its involvement in a number of government and policy areas and in recognition of her responsibilities as the College Officer her title was changed to Chief Executive Officer (CEO) at the November 2000 AGM.[7]

In 2000, a faculty office was established in New Zealand and Denise Tringham was appointed as a New Zealand–based administrative officer. The New Zealand Faculty welcomed this development as increasing 'the efficiency and sophistication of dealings with governing bodies, other specialist colleges and … faculty members'.[8]

New staff members were employed as the need arose to provide assistance with accreditation, credentialing and examinations; however on the scale of things – and in comparison with other college administrations – staff numbers remained small. In 2005, Council appointed a Director of Education (DOE). This appointment recognised the increasing training and educational obligations of the College and assisted preparations for the College's accreditation by the AMC.

Nevertheless, when the AMC accreditation submission was submitted in September 2006, the College staff cohort totalled 8.0 Full Time Equivalent (FTE).

The fact that the College could function and fulfil its responsibilities with so few staff for so long is due to several factors, among them its competent and loyal staff, and the commitment and capacity of its Fellows. The College website – launched at the 1997 Annual Scientific Meeting (ASM) – was developed with the significant input of College Fellows Richard Ashby and Richard Waller. Andrew Singer, likewise, made a major contribution to development of the College database.

New Committees of Council

Changes to the committees of Council in 2002 reflected the College's expanding involvement in activities and issues beyond the regular work of the College. The Public Health Committee was established in 2002 and the Disaster Subcommittee of Standards – established in 1999 – was brought under its umbrella. The Public Health Committee's work in this period included the development of College policies on organ donation, domestic

violence, alcohol misuse and access to care for mental health disorders. The Disaster Subcommittee made contributions in areas such as workforce management in disaster medical responses, the development of national multiple casualty triage standards and government planning for possible pandemics following the outbreak of SARS (Severe Acute Respiratory Syndrome) in 2003 and Avian Flu in 2005.

As a reflection of the growing importance of rural health, both within the College and governments more generally, the Rural Emergency Medicine Subcommittee of Standards was renamed the Rural and Regional Committee and elevated to a Committee of Council in 2002. This Committee promoted emergency medicine in rural areas through support for rural training for FACEM trainees, participation in education programs for rural general practitioners and support for FACEMs working in rural and regional areas.

In 2006 the Trauma Subcommittee of the Standards Committee was established to 'consider trauma issues that affect the College'.[9] Inaugural Chair Andrew Pearce summarises the subcommittee's interests and aims as being:

> *keen to foster relationships with other trauma bodies around Australasia in an effort to improve the delivery of trauma care to patients, coordinate a national trauma plan, standardise training requirements for advanced trainees, collaborate in research and advise government in best practice in trauma management.*

The subcommittee moved quickly to establish links with a number of professional and government bodies, including the Royal Australasian College of Surgeons (RACS), the Royal Australian and New Zealand College of Radiologists (RANZCR), the Australasian Trauma Society, the Australian and New Zealand College of Anaesthetists (ANZCA) and the College of Emergency Nurses of Australia (CENA). Other involvement included participation in credentialing of trauma centres around Australia through representation on the RACS Trauma Verification Subcommittee and the development of best practice guidelines in conjunction with the National Institute of Trauma Education and Research in Clinical Standards.[10]

Special Interest Groups

College activity also expanded with the establishment of several Special Interest Groups (SIGs). Council approved guidelines for the formation of SIGs in November 1998 and, at the same time, approved development of the Paediatric SIG. The College, although uncertain of where SIGs 'should reside within the College hierarchy' supported them on the basis that their existence would enhance the development of education, policies and standards within the College, as well as promoting peer support and networking.[11]

In 1999 the Ultrasound and Intensive Care SIGs were established, with Marie Kuhn and David Cooper appointed respective Chairs.[12] The ACEM Ultrasound SIG developed a recommendation for the use of ultrasound in the emergency department by emergency physicians that the College adopted as policy in 1999.[13] Building on that, it developed a credentialing process that was endorsed by Council in 2000. In 2002, the Ultrasound SIG was established as a subcommittee of the Standards Committee.

The formation of both Intensive Care and Paediatrics SIGs were the first steps towards joint training programs with the respective colleges.

In 2004 the International Emergency Medicine SIG was formed with Chris Curry as Chair; a Simulation & Skills Training SIG followed in 2005.[14]

The College and International Emergency Medicine

The College's commitment to IFEM and the development of emergency medicine internationally more generally continued throughout this period. On a number of occasions, the College demonstrated leadership and initiative to ensure good governance and progress towards IFEM's commitment in 2000 to 'become the world's premier Emergency Medicine organisation for development and promotion internationally'.[15]

At the 6th International Conference on Emergency Medicine (ICEM) held in Sydney, 17–22 November 1996, several countries expressed interest in joining IFEM. ACEM was a strong supporter of expansion of membership to organisations in other countries, and believed it was particularly important that these developing organisations were incorporated under the IFEM umbrella. Determined to show leadership, the College developed a process for joining IFEM,[16] which was accepted the following year.[17] Following consideration by the four founding member organisations,[18] the Hong Kong College of Emergency Medicine was admitted in 1998, followed by the Chinese Association of Emergency Medicine and the Mexican Society of Emergency Medicine in 1999.[19] All of the organisations were admitted as collegiate (now full) members of IFEM.[20]

Following difficulties with the scientific content and general organisation of the 8th ICEM in Boston in 2000 – to the point where future ICEMs were in jeopardy – the College developed guidelines for the conduct of conferences, which the IFEM Board subsequently accepted.[21] In 2002, at the conclusion of the 9th ICEM in Edinburgh, College President Ian Knox was appointed as IFEM chair and the IFEM secretariat returned to the College in preparation for the 10th ICEM to be held in Cairns in 2004. In the two years leading up to Cairns, Knox, with Jenny Freeman's assistance, made a concerted effort to gather and organise all the IFEM paperwork in one place.

With the expansion of IFEM to 14 member countries in 2002, the rotating secretariat was no longer considered practical. Following the Cairns ICEM, the secretariat remained with the College, while the IFEM Board considered when and where to establish a permanent secretariat. Knox explained the decision as in part a consequence of the success of the College administration of IFEM affairs in the two years prior, but also a recognition of the inherent inefficiency of the rotating structure established at foundation.[22]

In 2005 IFEM approved a new governance structure, for introduction in 2006. Under the new structure, the IFEM Board included one member from each member organisation and an elected international honorary executive. It was agreed that the secretariat would be permanently located in the country of one of the four founding member organisations – Australia, Britain, Canada or the USA.

ACEM and the British Association for Emergency Medicine (BAEM) both submitted expressions of interest to host the secretariat. ACEM's submission was comprehensive and detailed. It argued a proven record in management of IFEM affairs since 2002, along with a demonstrated commitment to developing emergency medicine programs in the Pacific region. It promoted the College as a strong local organisation, with an international vision and an 'ability [to] facilitate collaboration between emergency physicians from around the world and … harness their energy and enthusiasm'. ACEM believed it had the 'operational skill' and physical infrastructure to support the expanded endeavours of IFEM.[23]

The College's application was accepted at the IFEM Board meeting held in October 2006, and the secretariat has remained with ACEM since then. At that Board meeting the first IFEM Executive was elected. ACEM Fellows Ian Knox and Peter Cameron were elected as Treasurer and Vice-President respectively. Other Executive members were Gautam Bodiwala (BAEM) as President and Frederick Blum (ACEP) as Secretary General.

IFEM governance arrangements were further revised in 2011. At that time there were 64 member countries and it was agreed that a new Board of 12 members should be established. The Board composition going forward included six office bearers, and representatives from the six geographical regions of Africa, Asia, Australasia, Europe, Central and South America and North America. ACEM involvement under this arrangement continues to be very strong. Peter Cameron served as the IFEM President from 2010 until 2014 and both Andrew Singer and Anthony Cross have completed terms as Treasurer. Sally McCarthy was appointed as the Australasian regional representative in 2012 and elected President-elect in 2018. In July 2020 she became IFEM's first female President. Tony Lawler was appointed Australasian regional representative in July 2016; Simon Judkins succeeded him in 2018, and was then elected as the Board member for Australasia in 2020. Nominated by the College for the role, in October 2020 current ACEM President John Bonning became the ex-officio IFEM Member-at-Large on the IFEM Board in the lead-up to the 21st ICEM to be held in Melbourne in 2022.

ACEM's leadership in IFEM was recognised with the award of the inaugural Order of the IFEM to Richard Ashby, Richard Brennan, Joseph Epstein, Tom Hamilton and John Vinen. The award was created in 2000 to recognise those individuals who have contributed significantly to the development of emergency medicine in their country and to the development of IFEM. In later years, others were similarly honoured: Chris Baggoley and Honorary Fellow Campbell MacFarlane in 2004; David Smart and Peter Cameron in 2006; Ian Knox, Andrew Dent and Phil Kay in 2008, and Andrew Singer in 2010. In 2018 Anthony Cross received this award, with the most recent recipient of the award being David Taylor in 2020.

In 2000 the IFEM Humanitarian Award was established. This award was presented to either an individual or organisation for contributions to a major humanitarian or public health benefit. In 2004, the College successfully nominated the AusAID sponsored project in Papua New Guinea for this award. Richard Brennan (2006) and David Brandt (2008) are other Fellows to receive this award. In June 2018, Chris Curry received the award for his extensive work in establishing emergency medicine as a specialty in the Asia-Pacific region.[24]

As well as a leading role within IFEM, the College has promoted the development of emergency medicine internationally, particularly in the Asia-Pacific region. In 2002 it donated $25,000 to fund a senior lecturer's position in emergency medicine at the University of Papua New Guinea. The donation followed the participation of ACEM Fellows in an AusAID project to establish emergency medicine training in Papua New Guinea. The project supported an emergency physician in residence and visits by seven others for periods of two weeks. It was enthusiastically received in Port Moresby and led to an agreement to introduce a Masters of Medicine (Emergency Medicine) at the University of Papua New Guinea. At the conclusion of the AusAid project, ACEM provided funding to ensure that the program continued.[25] Chris Curry was appointed to the Senior lecturer's position; later, other Fellows filled this position for rotations of up to nine weeks. Curry remains highly respected within the Papua New Guinea and Solomon Islands emergency medicine community as the founder of emergency medicine in the region.

The ACEM Council further supported the development of international emergency medicine with the launch of the International Emergency Medicine SIG (IEMSIG) at the Cairns ICEM. Council's objective in establishing IEMSIG was to provide a mechanism by which recommendations could be made to Council for 'suitable philanthropic ventures' in which it might become involved.[26] Chris Curry accepted Council's invitation to lead the group. He remained at the helm of IEMSIG until 2009, before handing over to Gerard O'Reilly.

The activities of IEMSIG members, information about available resources and opportunities to contribute in developing countries were publicised in the entity's newsletter, published from September 2004 until December 2014 and edited by Curry.

In 2019 Curry described IEMSIG as a

> *... loose collection of people with an interest in international emergency medicine who are prepared to share what they are doing in the hope of encouraging others.*[27]

Such modesty understates Curry's contribution to the development of this group. On his retirement as Chair on 2009, IEMSIG membership was approaching 200 and members had connections with more than 40 countries.[28]

By 2006, ACEM Fellows were involved in a number of projects throughout the world. These ranged from the major international contributions of Richard Brennan with the International Rescue Committee and David Bradt's work in complex emergency situations, to localised projects in developing countries, such as Simon's Young's adaptation of the Advanced Paediatric Life Support (APLS) course to the needs and working conditions of Vietnamese doctors and nurses.[29]

The College's commitment to international emergency medicine was consolidated with the decision to establish an International Development Fund (IDF). Council approved establishment of such a fund on the basis of Ian Knox's suggestion that the 'unexpected profit' of $152,000 from the Cairns ICEM gave the College 'an opportunity to establish something ... permanent

in terms of its benefits'. He proposed the establishment of a fund to 'support the development of emergency medicine in our region'.[30] Council endorsed Knox's suggestion and a further $48,000 donation was made from College funds to provide seed funding of $200,000.[31] It was intended that the Fund would provide financial support for projects initiated by Fellows in developing regions. Council accepted draft regulations to establish the fund in early 2007 and made ongoing donations over the next several years.

At first, funding was provided on an ad hoc basis and included initiatives such as Early Life Support (ELS) courses in Sri Lanka and Papua New Guinea; however, with the establishment of the International Development Fund Committee (IDFC) in 2011, a framework for awarding the International Development Fund Grant and selecting suitable projects was developed. Gerard O'Reilly – IEMSIG chair from 2009 – chaired the IDFC, which in 2011 approved the following projects for the inaugural award: Georgina Phillips – "ED nurse training in Papua New Guinea" and Sethy Ung – "Primary Trauma Care in Cambodia".[32]

ACEM's involvement in international emergency care has expanded considerably from this period and is a consequence of both the vision and advocacy of an expanded IEMSIG leadership group – Gerard O'Reilly, Chris Curry and Georgina Phillips – and the support of ACEM entities and staff over time. Since 2015, ACEM has supported IEM development through the International Emergency Medicine Committee (IEMC). Inaugural Chair Gerard O'Reilly described the IEMC as a 'one stop shop' that brought together all the functions of the IEMSIG and the IDFC and acted as an advisory body for the ACEM Foundation (which since 2014 has provided oversight for the IDF Grant). Other developments included a change of name for IEMSIG to the International Emergency Medicine Network (IEMNet) and replacement of the IEMSIG newsletter with *IEMNET News*.[33]

Most recently, ACEM has replaced the IEMC with the Global Emergency Care Committee (GECCo). GECCo is a standing committee of the Council of Advocacy, Practice and Partnerships (CAPP) and is supported by a dedicated section of the ACEM staff. GECCo is committed to improving the capacity of low- and middle-income countries (LMICs) to deliver safe and effective emergency care, particularly in the Indo-Pacific Region.

The reintroduction of a College magazine in the form of *yourED* in 2019 has provided a vehicle for raising awareness of the work of GECCo to a wide audience on a regular basis; while the assignment of a dedicated staff cohort has enabled its work to expand in scope and take better advantage of partnerships and external funding opportunities for capacity building projects. Recent examples of this work are to be found in countries such as Fiji, Papua New Guinea, Vanuatu, Solomon Islands and Tonga.

The Move to Jeffcott Street

When 17 Grattan Street was purchased in 1993, it was presumed it would meet College requirements for decades to come. However, by the middle of 2000 it was obvious that the College had outgrown its seven-room Victorian terrace and the Council, after carefully considering other options, agreed it would commence a search for new premises.

The property at 34 Jeffcott Street, West Melbourne was found in early 2002 and following due diligence it was agreed to move ahead with its purchase. Council agreed to a maximum price for the property of $2.5 million, with up to $1.5 million to be borrowed from the Commonwealth Bank. At the time of writing the Annual Report for 2002, it was hoped that the building would be renovated and ready for occupancy in April 2003. Negotiations for purchase were protracted as 'ownership of the laneway accessing the rear of the building had not transferred to an earlier purchaser [and the title] was, in fact, owned by an individual who had taken ownership more than 100 years earlier'. The situation was resolved once the Melbourne City Council agreed to take responsibility for the laneway.

At purchase, the building – used as a warehouse for many years – was an empty shell, which had the advantage that it could be purpose designed for the needs of the College. The floor area – three times larger than Grattan Street – was refurbished to include a reception area, offices and a workroom downstairs. Upstairs accommodation included two meeting rooms, a seminar room and a small library. The facility included 'state of the art' audio visual and telecommunications facilities (including videoconferencing), which would enhance the meeting and seminar facilities. In introducing the building to Fellows, Jenny Freeman believed that the 'facilities now available at College Headquarters [would] serve the Fellows well during the [College's] third decade and beyond'.[34]

The refurbishment was completed on time and within budget, with the move from Grattan Street occurring in October 2003.

In early 2006 the College had an opportunity to purchase the adjacent property at 36 Jeffcott Street – a 465 square metre parcel of land that included a building and a parking area. Council recognised that the ever-increasing scope of work of the College, both internally and as a result of external requirements, would require further staffing and that it was quite possible that College space requirements would exceed the available accommodation in the medium term. Council agreed that purchasing the property would ensure ongoing flexibility for the College without the need for a further move and would allow further development of space for educational use.[35]

This has certainly proved to be the case; with further developments in 2008 and 2014, the premises today comfortably accommodates a full-time equivalent staff of 105. Based on a recent valuation of the property for the purposes of the 2020 financial accounts, the building is now estimated to be worth some $12.5 million dollars. Recent consideration of accommodation requirements – including external expert consultant advice – indicates that the building should be sufficient for the anticipated needs of the College for at least the medium term without further significant renovation.

Focus on Training and Assessment

Aspects of training, education and assessment remained high on the College agenda throughout this period and ensured a busy period for the Board of Censors. A major review of the training program undertaken throughout 1997 resulted in the development of what was known within the College as

the "new" training program. The review was led by the CIC, Paul Mark, and reflected concerns about the perceived shortcomings of the 'current' program.

Mark describes the stimulus for the review as deriving from a 'number of sources'. These included the perception by 'many' College Fellows that there needed to be more emphasis on emergency department (ED) experience and that trainees should gain the experience in a minimum of two EDs during the course of training. Others considered that the non-ED component of Advanced Training needed to be more structured and that maximum times should be reduced for some other specialist areas. Also, there was concern that the current time-based paediatric component did not ensure that all trainees received adequate training in paediatric emergency medicine. External drivers for change included the MTRP's review of trainee selection processes in Australian medical colleges and the AMWAC review of the emergency medicine workforce.[36]

The "new" training program was introduced for trainees registering with the College from 1 January 1999. It was more structured than the five-year Advanced Training program begun in 1988 and was intended to deliver a broader and more uniform experience for trainees.

The program introduced the "provisional" training year, in which six months' ED experience was mandated, with a further six months that could be spent either in an ED or non-ED environment. At the completion of this year, doctors who had passed the Primary Examination and achieved a 'satisfactory rating' from a six month term in an accredited ED were eligible for appointment to the Advanced Training program.[37]

Andrew Singer, CIC when the program was introduced, considered that the introduction of the provisional training year, 'provided a decision point midway through training' and was advantageous for trainees, as well as the College. For trainees it provided an opportunity to assess their interest and commitment to the specialty, while for the College it provided a vehicle to assess the trainee's suitability for a career as an emergency medicine specialist.[38] Initially, 'suitability' was assessed on the basis of the Trainee Evaluation Form, however, after 2001, trainees were assessed through a combination of satisfactory Trainee Evaluation Forms and three Structured References.[39]

Following completion of the provisional year and acceptance into the Advanced Training program, trainees completed a further 48 months of training, comprising 30 months in an accredited ED and a further eighteen months in non-ED environments.

Advanced trainees were encouraged to spend a minimum of six months in both a tertiary and a non-tertiary emergency department, however, in 1999 this was not compulsory. In 2002 this was formalised, with changes to regulations making it compulsory for trainees to gain at least six months' experience in a Major Referral Hospital, and at least six months in either an Urban District Hospital or a Regional Hospital (all three as defined through ACEM regulations). The regulation came into effect in 2004 and was promoted as contributing to the eventual development of a regional training program (in which hospitals combine to provide a training package for a trainee).[40]

The non-ED component of Advanced Training specified a minimum 12 months in either anaesthesia, intensive care, medicine, surgery or psychiatry and included the option of a "special skills" term of up to six months non-ED Advanced Training in areas such as toxicology, retrieval medicine, medical administration, rural medicine, forensic medicine, general practice and public health.

The compulsory requirement for at least six months of an advanced paediatric training component, introduced in 1994, was retained; however, ongoing concern about the adequacy of this experience resulted in the introduction of a trainee logbook of paediatric patients seen and procedures completed.[41] Described as the competency-based minimum paediatric requirement, it equated to a minimum number of cases treated, rather than time completed in a paediatric environment.

At the beginning of 2006 a six-month critical care placement was established as a compulsory component of the non-ED training period.

The new program retained the compulsory research component (outlined in Regulation 4.10/70, and which had quickly become known as "the 4.10 requirement"), with trainees advised to complete their project prior to sitting the Fellowship Examination. The College considered the requirement important, as it encouraged trainee development in literature appraisal and basic research methodology, and developed academic writing and publication skills; however, there was concern that on occasion, completion of the research component led to a significant delay in the completion of training. A number of measures were introduced to encourage trainees to complete their training in a timely manner. After revisions in 2002, it became mandatory to complete this requirement within three years of passing the Fellowship Examination and, from 2004, trainees were required to fulfil the research requirement before being eligible to sit the Fellowship Examination.[42]

Mandatory learning objectives were also introduced in 2002 to provide trainees, supervisors and adjudicators with clear guidelines for the production of a satisfactory project.

Examinations

Throughout this period the College continued to revise and refine aspects of both the Primary and the Fellowship Examinations. Trainees had signed up in record numbers since specialty recognition and it was recognised as being in the best interest of both the College and trainees to encourage trainee progression.

Modifications to the Primary Examination were specifically aimed at aiding the trainee journey. From July 1997, candidates who were unsuccessful in two of the four subjects were offered subject posts for both subjects.[43] At the same time, feedback for unsuccessful candidates 'was substantially increased', with the aim of assisting preparations for subsequent examinations.[44] Later changes improved flexibility for trainees, allowing them to choose which of the four subjects they wished to sit at a particular sitting.[45]

Following the introduction of unlimited subject posts in 2001, candidates were no longer required to re-sit subjects they had previously passed.[46] In 2004, the College also approved subject passes in certain subjects for

candidates who had completed the Primary Examination of some other colleges, with the proviso that a pass in all four sections of the ACEM Examination must be achieved within three years of the first examination.[47]

Increased candidate numbers for the Fellowship Examination presented some logistical and organisational challenges that resulted in changes to the way the examinations were conducted. From 1998, if candidate numbers exceeded 24, two or more sites were used and in cases where candidate numbers exceeded 52 the examination was extended to three days.[48] The only structural change was a reduction of the Visual Aid Question (VAQ) section to eight questions from the first examination in 1998.[49]

High candidate numbers augmented the administrative burden and from 1998 regionally based subcommittees in New South Wales and Queensland were given responsibility for different sections of the examination.[50] This was developed over the next few years with the aim that the Fellowship Examination would eventually become a 'product of the whole Fellowship'.[51] With an ever increasing workload and the retirement of Fellowship Examination Committee (FEC) Chair Sylvia Andrew-Starkey at the end of 2002, the BOC took the opportunity to restructure and reconstitute the Committee, creating a number of smaller, nationally appointed subcommittees for each section of the examination,[52] with an Executive Committee consisting of the chairs of each subcommittee.[53]

Fellowship Curriculum review

In 2001 as part of preparations for AMC Accreditation due in 2006–2007, the College commenced a review of the Fellowship Curriculum. This was acknowledged as long overdue, as the original curriculum was developed by the Foundation Fellows of the College in the mid-1980s. The review was a staged process that included comparison with the equivalent curricula in the United States, Canada and the United Kingdom, consultation with the AMC, incorporation of the CanMEDs physician competency framework, consultation with other Australasian medical colleges, and a collaborative development involving various groups and individual Fellows of the College.

The new curriculum, published in March 2006, was included as part of the *Training and Examination Handbook 2006*. The curriculum was described as being 'more comprehensive than previous curricula'[54] and outlined Core Competencies, Learning Objectives and Levels of Practice. The core competencies were described as closely related to the CanMEDs framework for 2005,[55] comprising nine areas, three of which related to various aspects of Medical Expertise and which in turn were linked to ten categories of curriculum topics and associated learning objectives. The CanMEDs framework – developed in the 1990s by the Fellows of the Royal College of Physicians and Surgeons of Canada – is described as a 'guide to the essential abilities' physicians need for optimal patient outcomes'.[56] The framework was being widely adopted in relation to specialist practice across the globe and trainees were advised 'to make themselves familiar' with its concepts.

The curriculum occupied 37 pages of the *Training and Examinations Handbook* and represents a significant step in the development of the ACEM Curriculum Framework developed as part of the work of the Training and Assessment Review Working Group (TARWG) and the Curriculum Revision

Project (CRP) between 2009 and 20014, and which formed the basis of the revised FACEM Training Program introduced for the 2015 training year.

Hospital accreditation guidelines and support for Directors of Emergency Medicine Training

Preparations for AMC Accreditation also included review of the College's emergency department accreditation processes for the purpose of conducting FACEM training. Commenced in 2004, it was completed in 2006 and resulted in the document: *Guidelines for Adult and Mixed Emergency Departments Seeking Training Accreditation: Minimum Requirements*. The guidelines increased minimum trainee supervision requirements on the basis that the previous minimum of 1.0 FTE FACEM as Director of Emergency Medicine (DEM) was inadequate, given the increased administrative and clinical demands of the emergency department. The new DEM minimum threshold was set at 1.0 FTE FACEM, with a further 0.5 FTE FACEM as the Director of Emergency Medicine Training (DEMT).[57]

From 1997, the College introduced a number of measures aimed at supporting both trainees and DEMTs. Under Paul Mark's direction, liaison with DEMTs and trainees was formalised with the publication of *DEMT News* and *Connections*.

DEMTs were further supported with the development of an orientation package that provided information about both the Primary and Fellowship examinations, credentialing and accreditation processes, paediatric requirements and research training. A workshop held annually at the ASM also provided support, while DEMT News provided information about changes to regulations.

DEMT support was increased in the run-up to the AMC accreditation process, with the development of a training course and a formal application process for appointment.[58] The first training course was held in April 2005, with subsequent courses held in July and December 2005. The one-day course – held at the College – covered topics, such as College expectations of the DEMT, trainee performance and appraisal, examinations and the research requirement.[59] The courses were very well received and by mid-2006 almost 80% of DEMTs had completed the course.

Developing a trainee selection process

A trainee 'selection' process was developed in tandem with the new training program. Prior to 2001, entry to the training program required an application and payment of the modest $25 registration fee. From 2001, selection (progression) to Advanced Training required successful completion of both the provisional training year and the Primary Examination – this placed some onus on the trainee for commitment and progression.

Initially, the College intended to develop both a process for selection and apply a quota. Censor-in-Chief Andrew Singer suggested that the selection process should be developed before quotas were decided.[60] A workshop in March 2000 devised a selection process that comprised consideration of three structured references and a ranking process based on the candidate's results in the Primary Examination. Council approved the formation of a

Trainee Selection Committee as a subcommittee of the BOC to administer the process.[61] Paul Mark was appointed as the inaugural Chair of this committee, with other members drawn from each of the regional faculties. The Committee met for the first time in June 2001 and all 41 candidates who applied for Advanced Training were approved.[62]

The selection process was summarised by Peter Cameron as 'a more robust and transparent process … developed to clearly separate advanced trainees from provisional trainees who are interested, but not necessarily committed to the training program'. He considered that the process would contribute to the development of a 'more structured program and allow better monitoring of trainee quality and numbers'. He noted it was fortunate that there was 'no need to introduce quotas for trainee selection at this stage and there appears to be little Iikelihood of this in the near future'.[63]

The process quickly developed as an important part of the College's training processes that Singer described as:

> *… allowing us to identify trainees that need guidance or counselling at an early stage of their careers and to ensure that they are both suitable for and capable of completing training and becoming emergency specialists.*[64]

Joint Fellowship in Paediatrics and Emergency Medicine

Negotiations for a joint training program in emergency medicine and paediatrics began in July 1998 with agreement to form a joint ACEM/RACP working party to develop a proposal. An agreement was successfully negotiated in 2000, with the introduction of the program anticipated for 2001; however, the process stalled after an impasse developed between the two colleges over supervision arrangements for ACEM trainees in paediatric emergency departments.[65]

Attempts to resolve the situation were unsuccessful and the working group was disbanded in 2001[66] but reconvened in late 2002. A compromise was reached in early 2003, with ACEM agreeing that while the Director of Paediatric Emergency Medicine Training (DPEMT; responsible for supervising ACEM trainees in a paediatric ED) could be either a FACEM or a FRACP, close collaboration must occur between the DPEMT and the trainee's 'home-based DEMT', who might potentially be located in an adult-only ED.[67] Ian Knox described the agreement as the 'result of goodwill and persistence on both sides' and one that would be welcomed by Fellows and of great benefit to patients.[68]

In 2003, the College was hopeful that arrangements would be finalised for the program to begin in 2004. Negotiations, however, continued for some time, with Andrew Singer reporting in December 2005 that ACEM and the RACP had now reached formal agreement on a Joint Training Program in Paediatric Emergency Medicine (JTP-PEM). The agreement gave trainees in both Colleges access and guidance to either pursuing a Fellowship with either ACEM or the RACP with a special interest in Paediatric Emergency Medicine (PEM), or to pursue a dual Fellowship in PEM.

A Joint Training Committee in Paediatric Emergency Medicine (JTC-PEM) with equal representation from both Colleges and reporting to both ACEM and

the RACP was established to oversee the program.[69] Initial responsibilities included providing advice about suitable training posts, assessment of training requirements for individual trainees and development of policies related to the program. The JTC-PEM finalised and published the curriculum for advanced training in PEM in 2010. The curriculum was revised in 2013 and further refinements are expected following completion of the curriculum renewal process commenced by the RACP in 2019.[70]

In 2005, Andrew Singer welcomed the agreement and described it as a 'long time in coming'.[71] Although PEM trainees have always comprised only a small proportion of total ACEM trainees, interest in the program has been steady and sustained. The program officially commenced in 2007 with nine ACEM trainees, rising to 19 in 2009; in 2012, 54 ACEM trainees were registered as PEM trainees. In March 2016 this number had increased to 72 and was 86 in May 2017.

The JTP was established as a three-stage program and completion of all three stages resulted in the award of Fellowship of both colleges (ACEM and RACP) and from 1 July 2010 eligibility to register with the Medical Board of Australia (MBA) as a specialist in Paediatric Emergency Medicine – a title protected by the National Registration and Accreditation Scheme (NRAS) from that time. Under NRAS, paediatric emergency medicine was listed as a field of speciality practice within the specialty of Paediatrics and Child Health, and formal recognition as a specialist in Paediatric Emergency Medicine was accessible only to those who held, or had qualified for, Fellowship of the RACP.

Under the arrangements of the JTP-PEM, trainees who complete Stage 2 of the JTP are issued with a letter from the JTC-PEM certifying they have completed training requirements considered unique to paediatric emergency medicine. Thus, from 2010, for trainees whose parent college was the RACP, completion of stage 2 resulted in the award of FRACP and entitlement for registration as a Specialist Paediatric Emergency Physician under the NRAS. For an ACEM trainee, however, this entitlement was only available with the completion of Stage 3 of the JTP-PEM and completion of the requirements for Fellowship of both ACEM and the RACP.[72]

During 2017 and early 2018, ACEM – with the support of the RACP – completed negotiations for the removal of this inequity. Subsequently, the MBA announced a revised list of medical specialties, fields of specialty practice and related titles that included the field of Paediatric Emergency Medicine in the specialty of Emergency Medicine, as well as Paediatrics and Child Health. The revisions took effect from 1 June 2018 and from this point ACEM Fellows completing Stage 2 of the JTP-PEM, like their FRACP counterparts, are eligible to apply for specialist registration as a Specialist Paediatric Emergency Physician.[73]

Joint Training in Emergency Medicine and Intensive Care Medicine

Stimulated by the College's Intensive Care SIG, the ACEM Council initiated discussions with the Joint Faculty of Intensive Care Medicine (JFICM; jointly established by ANZCA and RACP in 2002) for a joint training program in emergency and intensive care medicine.[74] Discussions were progressed, with the aim of streamlining arrangements between the two training programs to

facilitate opportunities for those wishing to acquire both Fellowships.[75]

In November 2003 the BOC presented a proposed pathway for dual Fellowship to Council, with a request for endorsement and presentation to JFICM. The suggested pathway included completion of 24 months basic training, 30 months in ED, 24 months in an intensive care unit, 12 months of anaesthetics and six months general medicine. Trainees would also be required to complete the ACEM Primary and Fellowship Examinations, as well as the JFICM Fellowship Examination and the research requirements of both organisations to obtain dual Fellowship.

Council agreed to progress the matter through the formation of a formal liaison committee with JFICM; however, development of the program was ongoing over a number of years.

In 2006, Council heard that discussions were proceeding 'amicably', and that regulations and an information package for trainees were being developed.[76] In January 2010, following JFICM's establishment as the independent College of Intensive Care Medicine (CICM), discussions between ACEM and CICM resulted in an agreed pathway to streamline achievement of dual fellowship. Under the new agreement each college was responsible for assessing components of the respective training programs and formal concurrent registration as a trainee with both ACEM and CICM was essential.[77]

Today, these arrangements remain in place; ACEM requires that dual trainees in intensive care and emergency medicine complete the training requirements of both programs before ACEM Fellowship is awarded.

Trainee representation at Council

A significant step forward for the College was the formation of the Trainee Committee in 2006, which gave trainees direct representation at Council and on the BOC. From July 1996, trainees' interests were represented to Council and the BOC by the President of ASEM who attended both meetings as an invited observer.[78] After this arrangement ended in 2002, attempts were made to establish representation via a trainee-appointed DEMT Observer who would bring trainee concerns and suggestions to the meetings of the Council and the BOC.[79] This was a complicated and cumbersome arrangement that proved largely unsuccessful.

A proposal for the Trainee Committee was developed in 2005 and presented to Council in November of that year. The minutes note the proposed committee as a 'significant change' from the previous committee structure. The development satisfied a recent Australian Competition and Consumer Commission (ACCC)/AHWOC recommendation that Colleges consider mechanisms for trainee involvement in decision-making processes.

The Committee included one trainee representative from each region, with an appointed representative (Chair) to Council and the BOC, and other committees where trainee representation was desirable (the Paediatric Emergency Medicine Joint Training Committee was an example). The trainee representative was, however, not entitled to vote on any issue. Michelle Withers was appointed inaugural Chair of the committee and attended Council for the first time in March 2006.

Although resisted by the College, the formation of the Committee was embraced by both the BOC and the Council. Andrew Singer flagged this development as a 'step forward that has been long overdue'.[80] Wayne Hazell viewed the development as a 'very positive move' and welcomed the trainee perspective that direct representation provided and the opportunity for an 'increased level of engagement with trainees'.[81] The development provided the opportunity for trainees to bring matters of concern to the BOC and at the same time provided the BOC with an 'effective means of seeking input from trainees on appropriate matters'. Early consultation included the development of a Memorandum of Understanding to be signed by both the trainee and the College at the commencement of training and the introduction of a "Professional Development Portfolio" to assist DEMT and trainee interaction. Other work included the identification and setting of ongoing objectives.[82]

Developing an Emergency Medicine Workforce

In 1996, with 225 active Fellows and over 550 trainees, Richard Ashby expressed concern that, while at the current time the demand for specialists greatly exceeded supply, saturation of the specialist emergency medicine workforce could occur within the next decade.[83] The College's concerns about possible workforce oversupply were confirmed following completion of the AMWAC report into the emergency medicine workforce.

AMWAC was established in 1995 to advise AHMAC and the professions about the medical workforce and to inform the policy process. AMWAC's brief was to assist AHMAC with the development of a more strategic focus to national medical workforce planning. Its particular focus was the estimation of the number of medical practitioners required to meet (but not exceed) future population requirements.

Richard Ashby, Chris Baggoley and Sue Ieraci represented the College on the Emergency Medicine Working Party that included AMWAC officers and was chaired by Dr Bill Coote, Secretary General of the AMA.[84]

The working party surveyed emergency medicine clinicians, emergency departments, state health departments and private hospitals on issues relating to current and future workforce needs, with the intention that the information gathered would form the basis of projections and recommendations for the future development of the emergency medicine workforce.[85] Chris Baggoley observes that as emergency medicine was essentially a hospital-based specialty the model was 'simplified' to the extent that projections could be based on the number of emergency medicine specialists required to adequately staff the varying categories of emergency departments.[86]

The working party found that major referral hospitals would require 11 emergency physicians; with other capital city and major provincial hospitals, paediatric hospitals and major rural hospitals all requiring three emergency medicine physicians. In small rural and remote centres, it was anticipated that emergency services would continue to be provided by general practitioners (GPs) and organised critical care retrieval systems.[87]

Based on the College's preferred workforce model that emergency departments should be staffed by trained emergency specialists and specialists in training, it estimated an optimal workforce of 1,200 registered specialists (FACEMs) in 2007. To meet this requirement, AMWAC recommended an initial increase in training positions, before sharp reductions after 2003 to ensure that the workforce was not oversupplied. At the same time, the report confirmed the inadequacy of the current workforce – identifying 61 vacancies for specialists and 88 registrar (trainee) vacancies.[88] A workforce document produced by New Zealand Fellows in 1997 identified similar workforce shortages in New Zealand. Although the New Zealand Government did not commit to the hospital-based model recommended by AMWAC it did agree that in such a rapidly developing field, regular review of workforce requirements would be necessary.[89]

Council adopted the AMWAC report, even though it had some concerns about the accuracy of some of the data, the College's ability to meet the workforce predictions and whether trainee intakes would need to be adjusted downwards. This last issue was of greatest immediate (and ongoing) concern for the College. Council accepted that with trainee numbers now at 680, some future adjustment would be necessary in order not to 'flood the market place'.[90] However, Councillors worried that if the College moved to restrict trainee numbers as suggested, it would attract the attention of the ACCC.[91]

The basis of this concern was the ACCC's recent interest in the activities of RACS in relation to selection of advanced trainees in orthopaedic surgery. The ACCC investigations – conducted during 1998 and 1999 – resulted in a finding that the processes of RACS may be in breach of the *Competition Policy Reform Act 1995*.[92] Other Councillors were convinced that the College had nothing to fear from the ACCC if it introduced 'tailoring' because it was not involved in anti-competitive behaviour but, rather, managing workforce according to the AMWAC process.[93]

Another school of thought was that given the rapid expansion and evolution of emergency medicine since specialty recognition, tailoring would not be required.

> *Apart from clinical work in emergency departments, Fellows of the College are now involved in a wide range of activities including, teaching, research, disaster planning, retrieval, administration and public health. Many Fellows have accepted overseas posts and others have gone into private emergency medicine practice. Initial workforce estimates did not include the wide range of activities now being undertaken by our Fellows. There will be no shortage of positions for new Fellows in the foreseeable future!*[94]
> **Peter Cameron**

The College remained committed to the AMWAC process and consulted widely, but for a time made no decision one way or another. In late 1999, after the Federal Minister for Health, Michael Wooldridge, expressed his concern about the large number of trainees and indicated his support for the process, the College proceeded to develop a selection process.[95]

The College opted not to impose a quota on trainee registrations until after AMWAC had reviewed its original 1997 projections. Several factors supported the College request for further AMWAC review. These included a significantly slower increase in FACEM numbers than originally predicted, the changing work-life preferences amongst younger doctors and the failure of local jurisdictions – with the possible exception of Queensland – to adopt the AMWAC recommendations as policy to build an emergency medicine workforce. The College was also aware that opportunities for FACEMs had increased significantly and that the original 1997 projections took no account of future workforce developments; rather, they were based on historical workload and infrastructure information.

AMWAC agreed to a further review, which was scheduled for 2000/2001, but delayed until 2002. The College preparations began in early 2000 and included formation of a working party, ongoing surveys of Fellows, and a workshop at the November 2000 College ASM. The College's workforce agenda was expanded to include a significant focus on work practices, such as workload, conditions of employment, and the wellbeing of trainees and Fellows. A sustainable best practice model for emergency medicine was also developed.[96]

Of particular concern was the potential introduction of 24-hour shift work. The Council accepted this development as inevitable with increased FACEM numbers, but was concerned that it would lead to low work satisfaction. Other discussions focused on the make-up of the workforce. Peter Cameron pointed out that as FACEM numbers increased it was inevitable there would be fewer trainees in emergency departments and that it would be 'inefficient to see FACEMs as direct substitutes for trainees'. He raised the possibility of expanded roles for nursing and administrative staff, and alternative medical providers, such as Career Medical Officers and interns.[97] College endeavours developed *Guidelines for constructing an emergency medicine medical workforce* (G23), which Council adopted as policy and forwarded to AMWAC in late 2002.

The second AMWAC review, completed in August 2003, identified the current specialist workforce of 473 as inadequate to meet current demand and recommended that the 1997 recommendation to reduce trainee intake from 2003 not be acted upon. The review predicted that 1150–1500 specialists would be needed by 2013 and recommended an increase in the trainee intake to 130 per year from 2004 onwards to meet this demand. In New South Wales, where there were considerable and ongoing shortages, AMWAC recommended a trainee intake significantly higher than other jurisdictions. In New Zealand, Wayne Hazell and Peter Freeman produced a workforce document to inform Ministry of Health recommendations for medical and nursing staff levels in New Zealand emergency departments.[98]

The College welcomed the AMWAC review for the emphasis it placed on the increasing importance of emergency medicine and emergency physicians in Australia's health system,[99] while also providing a better understanding of the required size of the specialist workforce.[100] Overall, though, the review had little impact. AMWAC's influence had declined in recent years with the establishment of the Australian Health Workforce Advisory Committee (AHWAC) and AHWOC. Added to this, the Australian Government's focus had shifted from the medical workforce to the health workforce more generally,

with an increasing emphasis on developing collaborative models of care.

AHWAC established an Emergency Care Working Party in April 2004 to look at all elements of the emergency medicine workforce.[101] Discussion arising from this review favoured models of care in which nursing and clerical staff played a more active role in patient management.[102] The review was completed with very little ACEM input, although Ian Knox pointed out he had 'advised the working party that correction of access block would go a long way to correcting problems in the emergency department'.[103]

Reflecting this new direction, in early 2004 the College established contact with the College of Emergency Nurses Australia at both national and regional levels, as well as the corresponding body in New Zealand. Council intended that collaboration would include development of policies and statements on a number of workforce issues, including nurse practitioners, access block and violence in emergency departments.[104]

Against this background, workforce sustainability remained a significant concern for the College. Discussions in early 2005 suggested that the emergency medicine workforce may at last be transitioning from the traditional registrar-based workforce to a future consultant-based one. While this was the goal towards which the College had been working, there was a concern that Fellows would be left carrying a higher proportion of the clinical load without the support of middle-grade staff.[105]

College discussions urged vigorous defence of the consultant-based model as a critical component of quality and safety, but Council recognised it would be challenging to progress this view in the current health funding and policy environment. To address the current workforce issues, the Workforce Subcommittee – disbanded in 1996 – was reconvened in 2005, with Anthony Cross as Chair. Cross described the subcommittee's brief as guiding the College's position on a number of issues, such as recruitment and retention, clinical support roles, role substitution and quality of life issues.[106]

The subcommittee committed to revision of the 2002 *G23* guidelines. In the course of these revisions the content was expanded to include areas such as sustainability, quality indicators and risks. Clinical support time (previously non-clinical time) was quantified and clearly defined. Factors contributing to additional workload were also quantified. Council accepted the revised *G23* document in July 2008.[107]

Overseas Trained Specialists

The National Health Workforce Strategic Framework, released in April 2004, assumed an immediate priority for AWHOC and further overshadowed any potential effect of the recent AMWAC Review. The Framework promised a nationally coordinated response to workforce shortages, with the ultimate goal of achieving national self-sufficiency in health workforce supply.[108] However, acknowledging that the health workforce was currently undersupplied and concentrated in urban areas, it advocated overseas recruitment and a reduced length of training to address immediate workforce shortages.[109]

In the ten years up to July 2004, the College had processed approximately 30 applications for Fellowship from overseas qualified emergency physicians; however, when the focus of governments in Australia and New Zealand shifted to active recruitment of overseas trained specialists, the number increased over time.

College regulations for the assessment of overseas trained specialists were first introduced in 1994 in response to the AMC's request for all medical colleges to undertake this task on its behalf.[110] Applications for assessment were referred to the College once the AMC was satisfied that migration criteria had been met and the applicant's basic medical qualifications were in order. The College process – like that of other colleges – comprised an initial review of qualifications, training and experience, followed by a structured interview (if acceptance into Fellowship was a possible outcome) and a recommendation. Recommendations ranged from referral back to the AMC for assessment through their pathway to general medical registration; acceptance of the candidate into the advanced training program with the requirement to pass either one, or both of the College examinations, and complete the research requirement; acceptance into Fellowship after a period of supervised practice in an ACEM accredited emergency department and/or passing the Fellowship Examination. In some cases, applicants would be accepted into Fellowship without further training or examination.[111]

The Medical Council of New Zealand (MCNZ) followed the AMC pathway and referred overseas trained applicants to ACEM for assessment; however, unlike the AMC, the MCNZ retained authority to make its own decision about an applicant's suitability for registration within a vocational scope of practice. In this respect, the College's role was advisory only and occasionally the MCNZ would grant vocational registration to an overseas trained specialist that the College had not approved for Fellowship without conditions. On occasion this proved a source of tension between the MCNZ and the College, and created some difficulties for New Zealand Faculty and Councillors. This key difference in the assessment processes for the two countries continues to this day.

Guidelines outlining the principles of assessment and the process of conducting the structured interview were introduced and implemented in 2000 to address concerns about consistency between interview panels and the level of fairness and transparency under the current arrangements. The guidelines clearly stated the College's belief that all specialists in emergency medicine should be Fellows of the College and that Fellowship would be offered where the applicant's training, experience and current level of practice, could be predicted with a high level of confidence as being similar to that of an Australasian trained and registered specialist in emergency medicine. The guidelines also articulated the College's adherence to the principles of natural justice, and pledged to consider each case on its merits and ensure its recommendations were consistent over time. These guidelines were updated in 2002 and 2004 and reviewed as part of the AMC Accreditation process in 2007. At that time, the AMC found the College processes to be rigorous and sound and commended the College for clear provision of information about the steps in the assessment process.[112]

Assessments of overseas trained specialists were initially processed by the Censor-in-Chief; however, with the steady rise in the volume of requests from overseas trained emergency physicians, the BOC created the Overseas Credentials Committee (OCC) in early 2003. George Braitberg – Censor for Victoria – was appointed inaugural Chair[113] and, like the Accreditation and Credentials Committees of the BOC, its membership was made up of members of the BOC. The Committee's responsibilities included coordination of the specialist recognition process for overseas trained doctors, as well as approvals for Occupational Training Visas (OTV) and Area of Need (AoN) applications, all of which gradually increased year on year.

Applications for assessment gradually increased from 2004 and for five or so years averaged around 20 each year, before increasing to an average of 45 to 50 after that. Most of the applications were from doctors trained in the United Kingdom or North America and as the OCC was familiar with the training and assessment requirements of both the Faculty of Accident and Emergency Medicine (FAEM) – forerunner to the Royal College of Emergency Medicine (RCEM) – and the American Board of Emergency Medicine (ABEM), it was able to make recommendations with a high level of confidence that the applicant would practice emergency medicine at a standard consistent with a recently qualified Australasian trained specialist. However, as time went on, and the number of applicants from graduates of unfamiliar training programs increased, the work of the OCC became increasingly complex. In 2007, James Taylor, now the Chair of the OCC, noted that in the past twelve months the OCC had accepted 11 applicants into Fellowship and considered applications from Singapore, the Philippines and differing qualifications from the USA.[114]

In 2009 in association with the restructure of the BOC as the Board of Education (BOE), the OCC was restructured as a separate committee, and its membership enlarged to ten members, appointed from the BOE, Council and interview panels, with the aim of including regional representation and experience in OTS assessment. James Taylor continued as Chair of this enlarged committee. At the same time, membership of the interview panel was expanded to include 42 senior Fellows drawn from all regions in Australasia, with the aim of involving a local representative at each interview.[115]

Also in 2009 – in line with AMC protocol – the OCC established supervision guidelines for specialists with qualifications deemed to be of 'advanced standing' – FRCEM (UK), ABEM (USA) and FRCPSC (Canada) – generally, applicants with these qualifications, and from these countries would only require a minimum of three months supervised practice in an accredited emergency department before the award of Fellowship was approved.[116] From 2011, applicants from countries without advanced standing were required to complete the Fellowship Examination in addition to the usual supervision and research requirements.[117]

From 2010 the College regularly received around 50 applications annually for specialist assessment, as well as a number of Specialist in Training (SIT) and AoN applications. The increased workload, both in terms of numbers and complexity, resulted in further streamlining of application processes – which increasingly were able to be completed online, allowing decisions to be taken and recommendations made within a three-month window.

As the number of SIT and AoN applications increased, processes were reviewed and formalised. In both cases, as for specialist assessment, applications were only considered from applicants from countries with recognised programs and membership of IFEM.[118] AoN oversight was improved with the introduction of an annual teleconference interview during which oversight and supervisory arrangements were discussed, as well as the doctor's intention in relation to applying for specialist recognition. A consequence of this support was that AoN applicants were electing also to submit applications for specialist recognition. ACEM's selection criteria for suitable SIT candidates was circulated to all external agencies.[119]

College guidelines for the assessment of overseas trained specialists were extensively reviewed and updated during 2012, to ensure that standards remained high and in accordance with current best practice. Following on from this work, the OCC's focus in 2012 and 2013 shifted to development of a number of resources and initiatives intended to support overseas trained specialists. These included development of guidelines for management of the underperforming overseas trained specialist; and production of the *Information package for Directors of Emergency Medicine* to increase awareness, reliability and consistency of appropriate supervision of overseas trained specialists. Australian Government funding supported development of an induction package for overseas trained specialists beginning emergency medicine practice in Australia.[120]

Significant developments in the assessment of overseas trained specialists in Australia followed on from the House of Representatives Standing Committee on Health and Ageing's inquiry into registration processes of overseas trained doctors and the support available to them. The inquiry reviewed assessment for both general registration and specialist recognition, including the ways in which the specialist colleges conducted assessments according to the processes laid out by the AMC. The report of the inquiry, *Lost in the Labyrinth*[121], made a total of 45 recommendations, a significant number of which were applicable to the work of the specialist colleges.

Flowing from the report, a working group comprising representatives from the AMC, CPMC and the MBA was convened to develop guidelines clarifying the specialist college understandings of the expectations of stakeholders in relation to the assessment of overseas trained doctors – henceforth to be referred to as International Medical Graduates (IMGs) – for recognition as a specialist in Australia. The resulting document – the MBA's *Good practice guidelines for the assessment of specialist international medical graduates*[122] – took effect in November 2015. Following the introduction of the guidelines, along with the transfer of responsibility for the assessment process from the AMC to the MBA, ACEM undertook a systematic review of processes and requirements in this domain to ensure that its processes aligned with the new requirements.

As a consequence of this review, the OCC was reconstituted as the Specialist International Medical Graduate (SIMG) Assessment Committee – a standing committee of the Council of Education. The work of this committee has focused on extensive revision of the regulations and guidelines associated with SIMG assessment and has been responsible for ensuring that the College is capable of meeting the increased requirements of this complex aspect of

College activity, including, measuring College processes against benchmarks introduced by the MBA in 2018.

Negotiating Medical Benefit Schedule Item Numbers for Private Practice

Since 1994 the College had supported the development of *Medicare Benefit Schedule* (MBS) item numbers for private sector emergency medicine based on triage categories. The College was frustrated in early negotiations because of government concern about cost-shifting in the public sector from the States to the Commonwealth if MBS item numbers were introduced. In 1995 agreement was reached for emergency physicians to bill unreferred patients for emergency attendances in private hospitals using item 104 and 160 series descriptors for life-threatening attendances.[123] The item numbers were not unique to emergency physicians; rather, they could be applied to emergency attendances by any medical practitioner.

The announcement of the Relative Value Study (RVS) provided the opportunity for the College to revisit the development of specific item numbers for emergency medicine attendances. The RVS was jointly designed by the AMA and the Commonwealth Department of Health and Aged Care (Department of Health and Ageing [DoHA] from 2001). The study intended to review the services and fees of the existing MBS, with the aim of addressing perceived unfairness in the current system. It was conducted by the Medicare Schedule Review Board (made up of representatives of the Commonwealth Department of Health and Aged Care and the AMA).[124]

Stage I of the RVS reviewed consultation and attendance items. College preparations for this component began in early March 1997. Richard Ashby initially advised the Council about this matter, however, from early 1998, Ian Knox led discussions as Chair of the recently formed Private Practice Committee. The Committee developed a five-tiered system of item numbers based on triage scales and 'bundled' to include consultation and procedures together in one item number. The College proposal – supported by research around the development of the NTS in the public sector – was finalised in early 1998 and forwarded to the RVS executive with Council approval in July 1998.

Stage 2 of the RVS – ongoing between 1997 and December 2000 – comprised three technical studies: the Practice Costs Study; the Professional or Procedural Relativities Study and the Remuneration Rates Study. The College participated in all three of these studies, however, the RVS consultants elected not to include emergency medicine in the Practice Costs Study because it was not a 'rooms-based specialty'.[125] In response, the College funded an independent consultancy to look at emergency medicine practice costs. KPMG conducted the review; it was sent to the RVS Board, but beyond an acknowledgement of receipt, no detailed comment was received in response.[126]

The College was forced to defend its five-tier consultation system in the face of considerable RVS opposition. In early 2000, the College continued to negotiate this option on the basis that it was supported by 'good research' and was appropriate to emergency medicine practice. In the face of outright

rejection by the RVS Board of the proposal, and the need 'to be consistent with the general RVS process; eventually the College supported unbundling of procedures from consultation and eight tiers for consultation items'.[127]

The Private Practice Committee – particularly Ian Knox – put an enormous amount of work into participating in this study. The College was frustrated to learn that, despite its participation in all aspects of the study, it was eventually excluded on the basis that it did not have 'specialty specific items in the MBS'.[128] The College even considered a legal challenge, but did not proceed. The RVS – a six-year project costing $7.8 million – was never implemented after the Commonwealth and the AMA failed to find agreement on an appropriate funding model.[129]

Throughout protracted negotiations around the RVS, the Council continued discussions with the Health Insurance Commission for development of unique emergency medicine item numbers. As early as 1999, Knox reported the Commonwealth's informal agreement on this point but also that the parties remained 'a long way from getting agreement … on how this should occur'. He reported that Commonwealth concern was 'not so much with the private sector but with the opportunity for state governments to shift costs onto the Commonwealth'. However, Knox vowed that Council would 'maintain pressure on the Government to negotiate a way through this situation'.[130]

In 2001, Knox reported that the College – with the 'cooperation and support' of the AMA – had made a detailed submission to the Commonwealth Department of Health and Aged Care with the objective of establishing a scale of services as a basis for setting *MBS* fees for non-referred attendances to emergency physicians in private hospital emergency departments. The proposal was favourably received and while it did not guarantee any change in policy, the College had secured a commitment from the department to resolve ' problems and concerns'.[131] Negotiations continued throughout 2002 and were finalised in time for inclusion in the November 2002 update of the Commonwealth *Medicare Benefits Schedule*.

The agreement was the culmination of eight years of complex negotiations between the College and various government authorities. Two sets of descriptors were agreed upon: a series of five that described attendances that were not immediately life threatening and a further series of six covering life threatening situations. The first series covered most emergency consultations and items were content based, rather than time tiered. The second series – Prolonged Attendance Descriptors – covered 'patients in imminent risk of death' and who required a total emergency physician time longer than 30 minutes.[132]

Ian Knox welcomed the agreement, describing it as a 'significant advance', while also pointing out that there was a 'considerable distance to go' as practice costs were not included in calculations of the schedule.[133] Knox observed that those who 'had hoped to see the Commonwealth accept greater responsibility for funding ED attendances and provide patients with a better rebate [would] be disappointed'.[134]

For several years, Knox and the Private Practice Committee continued to lobby for change; and while there was general agreement between the College and the Commonwealth about the problem, solutions proved impossible

to find within the context of existing legislation.[135] Throughout 2005, the committee met with the Federal Minister for Health, the Managing Director of Medibank Private, the AMA and the Medicare Benefits Consultative Committee[136] and the following year, KPMG was appointed to review and update the 1999 Practice Costs Study. The review estimated that the average practice cost per attendance ranged between $148 to $764.[137] This information was included in a College submission forwarded to the AMA and subsequently presented to the Medicare Benefits Committee in 2007.[138]

Ian Knox resigned as Chair of the Private Practice Committee in July 2008 and with his resignation the impetus to progress the issue waned, to the extent that the following year, incoming Chair Yusuf Nagree noted that the issue of practice costs was revisited but not pursued, largely because of a lack of momentum from the private hospital sector or state governments.[139]

Today there are 30 private emergency departments attached to private hospitals in the Australian health system and there is a considerable demand for services, as more than 538,000 patients presented to these departments for treatment in 2015/16. Almost half of the Australian population (46.5%) has private health insurance (PHI); however, as funding arrangements remain unchanged from 2002, considerable out-of-pocket expenses are incurred for an attendance at a private emergency department.[140]

ACEM's current position is that private emergency departments are important components of acute health care services and are well placed to take a consistent and growing number of patients and relieve pressure on sometimes overstretched public emergency departments in local areas. The College considers that all privately insured patients should have reasonable opportunity to attend a private emergency department and have ready information about the costs involved. Recent advocacy – to both assist this situation and ensure professional equity – has focused on encouraging insurance companies to review the determination of private emergency departments as outpatient services (where the cost of the service is not covered by insurance), while also pursuing the government to allow for funding of the emergency care component for an insured patient with an acute illness. Such a development would give patients the security to utilise their PHI in a private emergency department without incurring additional out-of-pocket expenses.[141]

The Problem of Access Block

Access block emerged as an issue of concern in the mid-1990s and was initially attributed to the commitment of various governments to the politically expedient 'objective of elective waiting list reduction'. As a consequence, elective cases were preferentially admitted over emergency cases, irrespective of clinical need, resulting in a dramatic increase in waiting times, unacceptable delays for admission and ultimately ambulance bypass – described as the 'ultimate emergency systems failure'.

Eventually, this became a political problem, resulting in two states and the Commonwealth responding with counter-balancing incentives. Victoria introduced the *Emergency Services Enhancement Program* and New South Wales

the *Priority Access Strategy*. The Commonwealth, for its part, proposed locking emergency department performance indicators into the various Medicare Agreements with the states and territories. In writing his "Presidential report" in 1996, Richard Ashby was cautiously optimistic that these measures would improve the situation and provide 'equity of access for all patients – elective and emergency – to the public hospitals of Australia'.[142]

Optimism evaporated though after health planners, hospital administrators and the Commonwealth Government decided that the problem of access block and overcrowding in emergency departments had arisen because primary care patients were inappropriately using emergency care facilities after hours. It appeared that this notion had been 'given status'[143] on the basis of the article, "The Balmain Hospital General Practice Casualty: An alternative model of primary health care provision", recently published in *Australian Health Review*, a peer-reviewed journal widely circulated within the health industry.[144]

The Balmain practice described itself as 'a unique casualty style service, staffed and run by local general practitioners' and claimed its casemix was more like triage category 3, 4 and 5 patients presenting to an emergency department than the casemix of a general practice.[145] The Clinic's claims that it could efficiently and cost effectively treat patients presenting with minor ailments akin to the 'acute "bread and butter" general practice'[146] proved attractive to health bureaucracies and governments alike and, in consequence, the Commonwealth Department of Health proposed sponsoring an After Hours Primary Medical Care Trial.[147]

The College was incredulous that such a bizarre and apparently unsubstantiated proposal was so enthusiastically embraced, but its protests largely fell on deaf ears. Chris Baggoley, as a member of the steering committee for the Commonwealth project, was unable to dispel the myth that emergency departments were 'full of patients with coughs and colds'. The College's concerns were heightened with news that some hospitals were giving the notion serious consideration.[148]

With this development the College realised that health planners were, to a significant extent, ignorant of the work of emergency physicians and had little or no apparent appreciation that the NTS had been devised specifically for patients presenting to an emergency department, with no relevance to primary care patients. Moreover, health planners failed to understand that 'a lower degree of urgency for care did not equate with a lower complexity or severity of condition, nor for a lesser need for hospital assessment'.[149] Going forward, the College recognised it would need to educate accordingly and apply rigorous scientific evaluation if it was to effectively counter proposals of this nature.[150]

Accordingly, the College expanded its focus to highlight the effects of access block and emergency department overcrowding, and determined to target politicians, as well as health planners. In the April 2000 edition of *Your Direction*, the College's magazine-style publication of the time, Peter Cameron flagged access block and overcrowding in emergency departments as the most important issue facing emergency medicine and prevailed on his colleagues not to accept chronic overcrowding. He contended that it was 'unacceptable':

for major emergency departments to be 'bypassed' and patients put at risk, simply because lack of access to inpatient beds has resulted in overcrowding of the ED. Neither is it acceptable for patients to spend more than 12 hours on an ED trolley in a corridor. This is inhumane and a denial of basic human rights, resulting in loss of privacy, sleep deprivation and inadequate nursing care.

Cameron indicated that the College intended to highlight the issue with both regional health departments and the Federal Government in an attempt to develop a more logical approach.[151] At the same time, the College brought its concerns about after-hours general practice clinics as the answer to the problem of access for emergency patients before politicians from both sides of politics.[152]

In writing his "President's Report" for 2000, Cameron felt there had been some progress, insofar as College endeavours had clearly demonstrated access block prevented normal functioning of emergency departments and that its causes were multifactorial and varied with geographical location. He considered the College had been successful in addressing the issue, but that it needed to do more. He advocated for a national strategy and more effective use of the media.

As part of this focus, the ACEM Council endorsed a media strategy with the objectives of raising public awareness of the essential role of the emergency physician in the health system and promoting the clinical and scientific expertise of Fellows. A media consultant was engaged, and regional faculties were charged with coordinating groups of local Fellows to provide, at short notice, expert comment on relevant issues. In introducing the concept, Ian Knox pointed out that the strategy was not designed to be 'sensationalist nor political', but to inform the community of the role of the College and to give wider recognition to the expertise of its Fellows. The strategy was undertaken so that in the longer term the credibility of Fellows and the College was acknowledged and that the opportunity to influence and inform on a broader range of issues would follow. The College considered that if the College and its Fellows were seen to be clinical leaders, rather than activists, then their position would be strengthened.[153]

From these initiatives progress ensued, with College efforts contributing to bipartisan political support to improve outcomes[154] and increased understanding amongst politicians and bureaucrats that ED access problems would not be solved with after-hours primary care clinics located nearby.[155] An increasing number of articles written and researched by College Fellows and published in the wider health literature also contributed to this endeavour.[156]

In early 2004, the College took the significant step of 'focusing community attention on the real cause of the problem' with the release of its position paper *Access Block and Overcrowding in Emergency Departments*. This was a plain language, political, rather than scientific, document that included photographs of emergency department conditions and was 'intended as a graphic illustration of the actual situation'.[157] The document outlined the effects of overcrowding and described the causes of access block as lack of inpatient beds, nursing shortages, an ageing population, decline in nursing home capacity and funding arrangements that encouraged elective surgery

at the expense of acute admissions. It asserted that no scientific evidence supported the claim that emergency department overcrowding was caused by general practice patients choosing to attend emergency departments. The document also put forward a number of suggestions for moving towards a solution. These included a whole of system approach to reducing hospital occupancy to a target level of 85% capacity, extensive clinician involvement and funding models that rewarded achievement rather than failure.

The document was widely distributed – copies were sent to state and territory Ministers for Health, as well as the federal Minister – with covering letters and an invitation for further discussion with College members. It was also distributed to presidents of other medical colleges, along with a request for discussion at CPMC level. Ian Knox hoped it would provide an alternative perspective the next time a politician tried to shift the blame for ED overcrowding.

Following distribution of the document there was considerable media coverage. Knox reported he was personally interviewed across print, television and radio platforms on more than 20 occasions. Appearing in *The Australian* on 4 May 2004, "Corridors of Uncertainty" is one example of this coverage. The article, which references peer-reviewed and published research by ACEM Fellows, claimed evidence was mounting 'that emergency overcrowding created by access block [was] leading to people dying'.

With the release of the position paper, Knox believed the College had taken significant steps towards focusing community attention on the real cause of the problem. He contended that the College's 'firm statements' had effectively shifted the political debate quietly away from GPs and GP patients as the cause of overcrowding. The shift was underpinned by quality research from a number of Fellows, including Drew Richardson, Peter Sprivulus and Dale Hanson. The AMA was also involving itself in a positive way. Clearly, there was still work to be done to convert better understanding into effective action, but progress had definitely been made.[158]

Following this intervention, the College shifted its focus to research with a commitment of $30,000 per annum for two years to the Emergency Medicine Research Fund to commission specified research on the issue.

Arguably, four years later little had changed; Drew Richardson found that around 33% of emergency patients experienced access block during the four-year period between 2004 and 2008. He concluded that nationally access block was 'common, sustained and getting worse' and was associated with inefficiencies and long delays for treatment.[159] In the context of this deteriorating situation and the recent election of the Rudd Labor Government and proposed health reforms, the College conducted an Access Block Summit in September 2008. The summit, coordinated by Sally McCarthy, aimed to put the College views and concerns before all relevant stakeholders.

Australian Medical Council Accreditation, July 2007

In July 2007, the AMC accredited ACEM's education and training and maintenance of professional standards (MOPS) programs.

Preparations for the process included an extensive review of training

and examinations, resulting in a decision to appoint an expert in education to assist with preparatory work, the development of formal processes for measuring Fellow and trainee satisfaction, and the development of processes for the appointment and performance management of DEMTs, as well as for greater DEMT support.

The College's submission to the AMC was developed throughout 2006 and submitted in November 2006. The accreditation team visited hospitals in Auckland, Brisbane, Melbourne, Perth and Sydney in late February and early March 2007, before meeting with members of the BOC and Council during the week commencing 12 March 2007.

Subject to satisfactory annual reports, accreditation was granted for six years until 31 July 2013, with the provision for a four-year extension, provided that the annual report for 2012 was satisfactory. The accreditation report commended the College as a professional, well-run organisation, with a training program that consistently produced high quality specialists in emergency medicine, a well-established process for accreditation of hospitals for training, and a well-developed and accessible maintenance of professional standards program. The considerable contributions of College Fellows to training, supervision and assessment activities, particularly at the DEMT level, were acknowledged as a strength of the College.

Despite the relative infancy of the accreditation process, this outcome was a significant achievement for the College and the result of extensive preparation that was initially led by Diane King and Andrew Singer, with Wayne Hazell accepting more responsibility after he became CIC in January 2004. The College was fortunate that Singer was a member of the AMC Consultative Committee on Specialist Accreditation charged with developing the accreditation requirements during the summer of 1999–2000, and which the AMC adopted in February 2000. In introducing the requirements to the College Council, Singer said that, although some aspects of the process might challenge the College, overall, he believed the College would be comfortable with the proposed requirements.[160]

While successful accreditation was a significant endorsement of the College and its training program, it also highlighted areas requiring further development. Consistent with outcomes for other specialist medical colleges at that stage of the development and evolution of the AMC accreditation process, the report offered 31 recommendations to be considered by the College and addressed through annual progress reports.

These included concerns that the College's decision-making processes were largely centralised with the Council and the BOC, the adequacy of staffing arrangements, wider Fellow and trainee engagement and support. As such, the report provided a focus for change within the College, prompting the review of College operations, staffing arrangements, governance and infrastructure as the College moved into, and beyond, 2007.

John McNee of the Mater Children's Hospital (QLD) addressing the 1983 ASEM AGM in Brisbane. Seated to his right is Rod Kruger, SMO of the QEII.

2nd International Conference on Emergency Medicine, 1988 Brisbane, Queensland.
From L-R: Back row – Phil Kay, Gerry FitzGerald, Richard Ashby, Frank Garlick, Noel Stevenson.**Front row -** Penny Bright (conference organiser), Jack Allison (ACEP), Tom Hamilton, David Williams (UK), Jan Ahuja (Canada).

Emergency Doctor

Official Newsletter of the Australasian Society for Emergency Medicine

February, 1989 **Editor: G.A. JELINEK**

EDITORIAL

The Australasian Society for Emergency Medicine is pleased to be able to update its newsletter to its current format for this, the first quarterly issue of 1989. With the new format, comes a name change, and hopefully, renewed interest in using the newsletter as a vehicle for exchange of information, both clinical and industrial, across Australia. Members of the society who feel they have material of interest, particularly clinical, are encouraged to forward it for consideration for publication.

Western Australia is in the throes of a State General Election. Predictably, this has brought promises from both sides of the political spectrum, but of interest, Emergency Medicine has featured prominently in those areas discussed. The current Labor Government has promised a $2 million package to upgrade five peripheral hospital Emergency Departments in the Perth metropolitan area. Although this appears to pre-empt the findings of a recently convened Health Department Committee investigating the provision of Emergency Services in Perth, it is heartening to see Emergency Medicine being given the attention it deserves. Of concern, however, is the possibility that the upgrading of peripheral hospital emergency departments will divert attention from the very real deficiencies in space, staff and resources experienced by the major metropolitan teaching hospital Emergency Departments.

One can only hope that in the relative calm after the election, a more comprehensive approach to the problems facing Emergency Departments will be taken by the Government.

The Society is indebted to its major sponsor, the Medic Alert Foundation, and to Roche Products for their kind donation of the desk top publishing software.

G.A. JELINEK
Editor, Emergency Doctor.

President's Message

Dear Member,

The newsletter has a new image and editor, however, the President's Message will continue to be a feature. Our Annual General Meeting held prior to the Second International Conference on Emergency Medicine, was well attended and the Treasurer and President were re-elected. We have a new Secretary in George Jelinek and there were some changes in State Councillors. Your Executive and Council consists of:

President: R. Cockington; *Honorary Secretary:* G. Jelinek; *Honorary Treasurer:* P. Gaudry; *Councillors:* D. Green (QLD); J. Vinen (NSW); P. Gaudry (NSW); J. Hendrie (VIC); R. Vane-Tempest (TAS); R. Cockington (SA); G. Jelinek (WA); J. Potts (ACT); H. MacLaren (NZ).

The Constitution allows for there to be two Councillors from Victoria but at present the second position is vacant. It is to be hoped that the ASEM members in that State will consider this matter and elect another Councillor. The Constitution also allows for there to be a Councillor for the Northern Territory and members from that State may also wish to take up that option. At present I fill the positon of South Australian Councillor as well as President, but in fact our Constitution allows for there to be a President in addition to the State Councillor. In future I will be endeavouring to obtain full Council membership plus a President so the affairs of the Society may have the attention of a full team.

With there being a new editor I have passed on to our Honorary Secretary the responsibility for the acquisition of suitable articles for inclusion. I would urge Society members to contribute.

The series regarding the development of the Emergency Medicine movement in each State has continued in the Newsletter and it will do so until the entire Australasian picture is complete. Also the industrial round up has been included to keep members informed as to the status of F.A.C.E.M. in the various regions.

As foreshadowed in my last Newsletter Council has decided to no longer distribute Newsletters to non-financial members and I have written individually to these people urging them to reconsider their financial status. I do believe this Newsletter is an important ingredient in the cohesion of the Emergency Medicine movement in Australasia and hopefully those members who have allowed their membership to lapse will agree with this sentiment and re-establish their financial status.

In closing I would like to draw your attention to our Annual Scientific Meeting to be held in Melbourne, Sunday September 3rd, through Friday, September 8th. The Conference Organiser Dr. Jamie Hendrie, has put together an interesting programme and I would urge you to seriously consider attendance. Our Society did not have an Annual Scientific Meeting last year as a result of the International Conference and it is important that this year's meeting is a success. In case some members are not aware our Scientific Meeting will be followed by the 6th World Congress on Emegency and Disaster Medicine to be held in Hong Kong September 10th through 15th and then a Symposium on Emergency Medicine will be held in Beijing September 17th and 18th. An attractive package has been arranged by Jamie Hendrie for members attending our Scientific Meeting who wish to follow on to the Asian Meetings. Details regarding these latter meetings can be obtained from Dr. Michael Moles, Prince Philip Hospital, 34 Hospital Road, Hong Kong, who is Chairman of Organising Committee 6WCEDM.

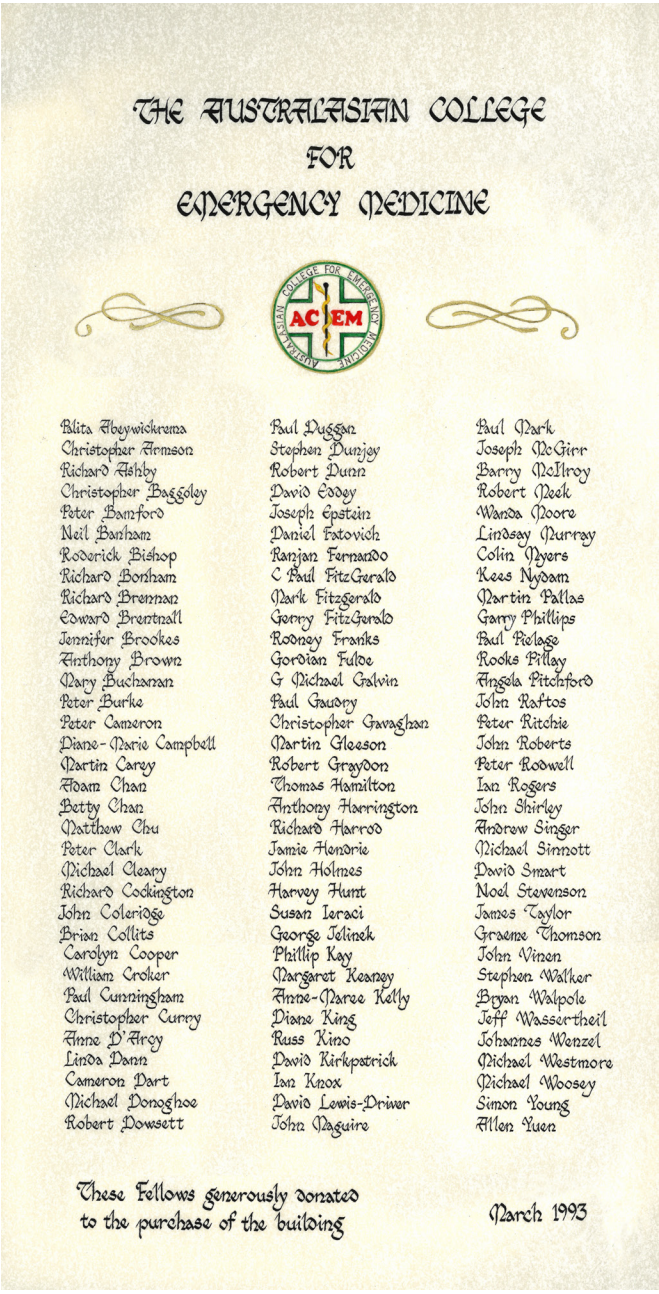
Our Society continues to grow and now, I believe, has a finite direction separate to that of the College. This is my third year as President and I note from our Constitution will be my last. I look forward to serving the Society further and hopefully leaving it stronger on my retirement. I hope all members will see what they can do to further promote the Society so that we may enter the nineties with strength.

Yours sincerely,

RICHARD A. COCKINGTON
President

Address for correspondence: FREMANTLE HOSPITAL, PO. BOX 480, FREMANTLE W.A. 6160 • FAX: (09) 335 9868

The first edition of *Emergency Doctor*, February 1989



Contributing members to the purchase of ACEM's first office.

NATIONAL SPECIALIST QUALIFICATION ADVISORY COMMITTEE

In reply please quote: 83/11257
MBD:(TP)
NH:KB

Please address correspondence to:

The Chairman,
National Specialist Qualification
Advisory Committee,
P.O. Box 100,
WODEN, A.C.T. 2606
AUSTRALIA

-3 SEP 1984

Dr T. Hamilton,
President,
Australian College of Emergency
Medicine,
c/o Accident and Emergency
Department,
Sir Charles Gairdner Hospital,
NEDLANDS. W.A. 6009

Dear Dr Hamilton,

The National Specialist Qualification Advisory Committee (NSQAC) discussed the matter of emergency medicine at its meeting in Canberra on 12 July. All material as supplied was submitted to the Committee.

As you are aware, NSQAC has not recognised emergency medicine as a specialty or sectional specialty. The 1984 meeting resolved not to grant such recognition at this stage.

The concept of emergency medicine as a specialty or sectional specialty is relatively new and the NSQAC Working Committee has had a watching brief on the subject for some time. On the evidence available so far, only two overseas institutions have created training courses resulting in awards in emergency medicine. These are:

Certificate, American Board of Emergency Medicine;
F.R.C.S. (Edin) - Accident and Emergency Medicine
and Surgery.

The Working Committee will continue to monitor the situation both in Australia and overseas.

The development of the Australian College of Emergency Medicine will be observed with interest by NSQAC. It is noted that the final examinations are scheduled for May 1986. The emergence of the first diplomates from the College would appear to be an appropriate time for further consideration of your College's request for acceptance and it is suggested that you approach the Committee again at that time.

Yours sincerely,

(J.E.D. Goldie)
Chairman

NSQAC letter advising emergency medicine will not be recognised as a specialty, but to approach the Committee after the emergence of the first diplomates, September 1984.

National Specialist Qualification Advisory Committee

In reply please quote:

81/3240
CO3 7666b

Please address correspondence to:

The Chairman,
National Specialist Qualification
Advisory Committee,
P.O. Box 100,
WODEN, A.C.T. 2606
AUSTRALIA

Mr T. Hamilton
President
Australasian College of
Emergency Medicine
C/- Accident and Emergency
Department
Sir Charles Gairdner Hospital
NEDLANDS WA 6009

Dear Mr Hamilton

The 1987 Annual Meeting of the National Specialist Recognition Advisory Committee (NSQAC) was held in Melbourne in late June.

The question of whether your College should be formally recognised by NSQAC was again listed for discussion. The NSQAC Working Committee had sought the views of the principal learned Colleges, RACP, RACS, RACOG and RACGP, as to whether emergency medicine was a necessary principal specialty or sectional specialty. None of these Colleges considered that emergency medicine should be recognised as a principal specialty. These views were conveyed to the National Meeting.

The matter of emergency medicine was discussed at length. The meeting acknowledged that emergency medicine was a specialty area of medicine and that it was an area in which people needed to be trained. The question was whether a separate college was needed.

The meeting resolved not to recognise emergency medicine as a principal specialty at this time. It instructed the Working Committee to continue to investigate the practice of emergency medicine both in Australia and overseas.

Yours sincerely

Nerida Hunter.

NERIDA HUNTER
EXECUTIVE OFFICER
4/8/87

NSQAC letter advising emergency medicine will not be recognised ‘as a principal specialty at this time’, August 1987.

National Specialist Qualification Advisory Committee

In reply please quote:

.....

Please address correspondence to:
The Chairman, National Specialist Qualification Advisory Committee
G.P.O. Box 9848, CANBERRA, A.C.T. 2601
Telephone:

Tel: (06) 289-7312
Fax: (06) 289-8509

The President
Australasian College
for Emergency Medicine
17 Grattan St
CARLTON VIC 3053

Dear Dr Ashby

I refer to your request to this Committee concerning the recognition of Emergency Medicine.

On 4 August 1993, the National Specialist Qualification Advisory Committee recognized Emergency Medicine as a medical specialty and accepted the Fellowship of the Australasian College for Emergency Medicine as an appropriate qualification.

This recognition was made in the NSQAC's capacity as a semi-official advisory body to the agencies concerned with medical administration in Australia.

The Minister for Health is presently considering the acceptance of the specialty under the Medicare Programme. This will enable the payment of benefits for specialist services provided to referred patients in private practice. Ministerial approval is required in this case as the recognition of emergency specialists will result in an increase in Medicare expenditure.

I expect this to be resolved shortly.

Yours faithfully

Craig Rayner
Secretary

26-Nov-1993

NSQAC letter advising the recognition of Emergency Medicine as a medical speciality and accepting Fellowship of ACEM as an appropriate qualification, November 1993.

The façade at 17 Grattan St, Melbourne.

ACEM Council, 1993.
L–R: Jenny Freeman, Lavinia Cameron, Gerry FitzGerald, Michael Clark, Graeme Thompson, Mike Galvin, John Vinen, Angela Pitchford, Richard Ashby, Paul Gaudry, Anne Maree Kelly, Richard Cockington, Jeff Wassertheil, Margaret Kearney, Chris Baggoley, Joe Epstein.

ACEM Council, 2005:
Back row L–R: Peter Freeman (NZ), Malcolm Johnston-Leek (NT), Tom Hitchcock (WA), Tony Joseph (NSW), Craig Hore (NSW), Anthony Cross (VIC), Di King (SA), Wayne Hazell (Censor-in-Chief) (NZ), Ian Knox (QLD), Bhavani Peddinti (NZ), Jenny Freeman
Front row L–R: Sally McCarthy (NSW), Andrew Singer (President) (ACT), Richard Ashby (QLD), Andrew Maclean (VIC)

Professor Tom Calma, AO delivering the ACEM Foundation Lecture at the 2018 ASM.

Members of the Manaaki Mana Steering Group, Wellington, August 2018.
L–R: Inia Tomas, Inia Raumati, Marama Tauranga, Kim Yates, Kate Anson, Cat Tauri, Claire Manning

May 2019, The launch of *Te Rautaki Manaaki Mana: Excellence in Emergency Care for Māori*, **ACEM's commitment to achieving health equity for Māori patients, whānau and staff.**

Wurundjeri Elder, Perry Wandin holds a smoking ceremony at ACEM's Jefcott St office, September 2019.

FACEM Liz Mowatt presenting ACEM's first Recognition Action Plan to President Tony Lawler, September 2019.

ACEM Presidents at the 2018 ASM Perth, Western Australia.
From L-R: Tom Hamilton, Joe Epstein, Richard Ashby, Christopher Baggoley, Peter Cameron, Andrew Singer, Sally McCarthy, Anthony Cross, Tony Lawler and Simon Judkins.
(Ian Knox absent)

The ACEM President's Medal.

Climate street march at the 2019 ASM, Hobart Tasmania.

CHAPTER 5

TIME FOR CHANGE 2007–2014

Coming off its first accreditation assessment by the AMC, the College entered a significant period of review, expansion and transformation. Governance processes were extensively reviewed, along with the curriculum for the FACEM Training Program, and significant changes introduced over a number of years.

The pace of change was brisk and increased as the period progressed. It began in 2007 with the decision to revise the structure of the Board of Censors; once this was completed, the review of FACEM training and associated assessment was underway. In 2011, there were significant changes: the College launched an extensive Curriculum Revision Project (CRP); CEO Jenny Freeman was farewelled after more than twenty years with the College; the administration was restructured; and agreement reached to review College governance structures and processes. Other developments included the receipt of significant government funding for the development of emergency medicine services and the introduction of the Emergency Medicine Certificate (EMC) and the Emergency Medicine Diploma (EMD).

By November 2013 the College was moving towards a new model of governance, transitioning to a new FACEM curriculum and training program, expanding its offices and venturing into new areas, including social media.[1]

Such significant changes were not achieved without challenge. The cultural adjustments required to effect such changes resulted in a level of internal discord and the development of tensions between key personnel. The College agenda was very full, staffing levels had increased significantly, and with the introduction of a professional management structure staff members were assuming more responsibility for aspects of College business. Such tensions were proactively managed when they arose, and the College found a way to move forward.

Despite the challenges, the College was not without achievement. The Access Block Solutions Summit in 2008 successfully focused attention on the continued problem of access block in both Australia and New Zealand and resulted in the introduction – in both countries – of time-based access targets for emergency departments. The EMC and the EMD training programs for emergency medicine were successfully introduced and, in Australia,

College advocacy was instrumental in delivering the government funded program of initiatives, *Improving Australia's Emergency Department Medical Workforce*.

Successive Presidents Andrew Singer (2004–2008), Sally McCarthy (2008–2012) and Anthony Cross (2012–2015) competently steered the College through this period of intense expansion, development and change.

After leading the College through a successful accreditation process, Andrew Singer set the College on the path to the future in the final two years of his presidency. He urged the College to use the AMC Accreditation report as an opportunity to guide future direction[2] and encouraged governance and administrative reform. He retired from Council in 2013 after twenty years of distinguished and varied involvement as Censor, Censor-in-Chief or Councillor, receiving the ACEM medal for distinguished services to the affairs of the College in 2011.

Sally McCarthy – the College's first female President – succeeded Singer after four years as Vice-President. She was (and is) a passionate and successful advocate for emergency medicine and provided sound leadership and guidance through a challenging period of major review and change as the College simultaneously developed its non-specialist emergency medicine courses, conducted the CRP and reviewed its governance structures.

Anthony Cross, Honorary Secretary 2010–2011, served a twelve-month period as Vice-President before becoming President in November 2012. He competently developed and expanded College advocacy and provided a steadying hand as the College implemented governance reform, and finalised and launched the revised ACEM Curriculum Framework and FACEM Training Program.

Throughout this period, Presidents were well supported by an experienced Executive. Peter Freeman served as Honorary Secretary in 2007–2008 and Vice-President from November 2008 until his retirement from Council in November 20011. Andrew Maclean completed a two-year term as Honorary Secretary in 2007 and was appointed immediately as the Honorary Treasurer. He served in this capacity until November 2011. Tony Lawler came to Council in November 2005 and served as Honorary Secretary 2008–2010 and again 2011–2012. He was Vice-President from November 2012 until July 2014. Censors-in-Chief during this period were Debra O'Brien 2007–2010; Yuresh Naidoo 2010–2013 and Diane King, 2013–2015.

Setting the College Agenda

Discussions about the way forward for the College began in July 2007 following receipt of the AMC report listing the areas of College activity requiring further development and the associated recommendations that would need to be addressed in annual reports to the AMC.

The primary recommendation was that in view of the College's rapid expansion, the Council consider devolving some decision-making processes in relation to training. The AMC Accreditation Team noted that decision making in relation to training was very centralised, with both the Board of Censors and the Council playing key roles; the College was encouraged to build

regional training structures and develop regional training committees. It also recommended a more prominent role for the Rural and Regional Committee (RRC), including direct representation of this committee on the Council.

The AMC's concerns about the need for organisational change were shared by the College and agreement was reached that governance and administrative changes were necessary if the College was to continue its work, expand its activity and meet the AMC recommendations. In 2007 the building, staff, College Councillors and Censors were working at capacity and change needed to occur for the College to be able to deliver its programs, maintain morale and mitigate potential risk.[3]

The AMC commended the recently revised FACEM Curriculum as 'detailed, comprehensive, inclusive, balanced and of a manageable size', however, the College was urged to take forward its work by further integration into the curriculum of the CanMEDs competencies and the specific needs of Aboriginal and Torres Strait Islander peoples and New Zealand Māori. Other areas in which the College was expected to expand its activities included an increased commitment to rural training, provision of educational materials for trainees, attention to the training needs of the high number of trainees whose primary medical training was completed outside Australia or New Zealand (in 2007, 440 trainees were practising on an OTV) and guidance for Directors of Emergency Medicine Training (DEMTs).

Based on feedback from Fellows and trainees, the College was asked also to investigate expanding its criteria for recognition of prior learning (RPL) and consider options, other than publication or presentation of a research paper, for completion of the Fellowship research requirement.

The AMC also noted that several Quality Improvement matters related to aspects of training and assessment required development. These included trainee feedback on training and the quality of supervision; revision of In-Training Assessments (ITAs) to more closely monitor trainee progress; and the development of instruments to ensure consistency of examination performance. Improved communication with jurisdictions, particularly in regard to emergency department accreditation requirements was also requested.

The necessity of addressing these educational and training issues guided the restructure of the Board of Censors (BOC) and underpinned the College decision for widespread review and reform of the FACEM Curriculum and the Fellowship Training Program from 2010.

Developing an effective strategy to draw the attention of politicians to the ongoing issue and impact of access block and ways to raise awareness of the contributions and importance of emergency physicians to the delivery of high-quality health care also formed part of College discussions about the way forward in 2007. Initially this developed as a focus on access block, however from early 2009 the College has pursued a broader advocacy agenda. Much of the impetus for the development of this focus came from Sally McCarthy, who used her first "President's Message" to announce that 'the College [would] be focussing increasingly on proactive advocacy in the public domain'.[4]

Restructuring the Board of Censors

In addressing the AMC's various recommendations, the College's first priority was to review the workload of the BOC. At the time, the Board consisted of the Censor-in-Chief (CIC), Regional Censors, the President and a trainee representative. It met three times a year and also sat as the Credentials, Accreditation and Overseas Credentials Committees. High trainee numbers and an increase in the number and complexity of assessment requests from overseas trained specialists wishing to work in Australia and New Zealand had significantly increased the work of the BOC and its support staff. The Primary Examination conducted twice yearly had become logistically very difficult, and credentials staff regularly processed 3,000 forms a year for the College's trainees. All these responsibilities ultimately lay with the BOC and resulted in very long meetings. At one point, the CIC – who was required to attend Executive, BOC and Council meetings – complained of exhaustion at the end of three days of meetings.

Following the Executive Strategic Planning Day in July 2007, a plan for change was presented to Council and in-principle agreement reached to restructure the BOC as the Board of Education (BOE) with Accreditation, Credentials and the Overseas Credentials operating as separate working committees of the BOE. In the interest of bringing all educational entities under one governance structure, it was proposed that Maintenance of Professional Standards (MOPS) would become a committee of the BOE and not Council.[5]

During the next twelve months a comprehensive plan for the restructure was developed. A draft proposal written by Andrew Singer and Debra O'Brien (CIC from November 2007) was discussed at the November meeting of the BOC, with further progress made at a workshop in March 2008, before presentation of the proposal to Council in July 2008.

The proposal recommended bringing all College education, training and assessment activities under a single governance structure, known as the BOE. The BOE would maintain regional representation and would function as an oversight and strategic planning authority. The Chairs of all BOE Committees would sit on the BOE, as would the President and a trainee representative. New committees with regional representation would be developed incrementally to an ideal membership of 8–12 members.

The Trainee Research Committee (TRC) and the Court of Examiners (later simply the Examiners Committee [EC]) were proposed as new committees of the BOE. The TRC's formation was recommended to 'oversee the research requirement of training and to review potential alternative pathways for achieving the learning objectives'. The EC was established to oversee the activities of the Court of Examiners and provide a direct reporting line from the Court to the BOE.[6] Its intended responsibilities included orientation of new examiners, peer support, maintenance of examination standards, succession planning and recruitment.

Council approved the new structure, and in August all Fellows received an outline of the committee redesign and its rationale, along with a call for expressions of interest for committee membership. Appropriate chairs of Accreditation, Credentials and the Overseas Credentials Committee (OCC) were appointed from within the BOC, with chairs of the TRC and EC appointed by

the BOC. Between December 2008 and March 2009, chairs of all committees arranged commencement meetings. At the Annual General Meeting (AGM) in November 2008, Fellows approved changes to the College's Memorandum and Articles of Association to reflect the transition of the BOC to the BOE.

The approved changes occurred throughout 2009, with the transition completed by November of that year. All committees reported a successful and active year with the new Committees functioning well and reporting to the BOE as envisaged. The TRC – with the help of a project officer and with Bob Dunn as the Chair – had reviewed the existing regulation for the research requirement. The Examiners' Committee, chaired by Ian Rogers, developed and began implementation of a formal policy for examiner entry, career pathway and retirement. The Committee also addressed the issue of improved feedback for candidates who failed either the Primary or Fellowship examination. Under the new process, feedback was prompt and, where possible, given by examiners, with the involvement of DEMTs.[7]

Honorary Secretary Tony Lawler commended the transition of the BOC to the BOE as among the most significant events for the College in 2009. He considered that 'more than simply a shift in nomenclature' the change streamlined the structure governing training and accreditation standards and led to more focussed BOE meetings and a devolution of much of the detailed work of the BOE to the various committees.[8]

Going forward, the work of these committees enabled the College to address satisfactorily several AMC recommendations. These included the TRC's work in developing alternate pathways to satisfy the research requirement. From 2010 this requirement could be satisfied by successful completion of either a research project or a minimum of two approved postgraduate subjects at an Australian university. In 2010, clinical epidemiology, biostatistics, research methods and evidence-based medicine were approved subjects.[9] Other recommendations satisfactorily met included the establishment of regional training committees and several recommendations relating to the training needs of registrars whose primary medical training was completed outside of Australia and New Zealand.[10]

In 2011, MOPS changed its name to Continuing Professional Development (CPD) thus bringing the College program into line with the majority of Australasian medical colleges and with the new Medical Board of Australia (MBA) terminology. Under the new Australian National Registration and Accreditation Scheme (NRAS) introduced in July 2010, renewal of registration required Fellows to be compliant with a specialty specific CPD Program (as had been the case in New Zealand for some time).[11]

Reviewing the Curriculum

With the transition of the BOC to the BOE completed successfully in 2009, the BOE's strategic focus shifted to a full review of the curriculum, training and assessment programs. The ACEM curriculum, had been revised as part of preparations for the AMC accreditation, however, further work was necessary to address the AMC recommendations, particularly incorporation of the CanMEDs competencies. The Fellowship Examination was virtually unchanged since 1995, and likewise the training program had changed very little from when it was adopted in 1999.

The review was planned as a two-part process that included an initial consultation process conducted by the Training and Assessment Review Working Group (TARWG) followed by development of recommendations. TARWG – established in early 2011 – included Fellows, trainees, representatives from Australian and New Zealand government health departments and emergency nurse organisations.[12] Fellows involved were chosen on the basis of their strong educational and/or ICT background and direct involvement in the training program.[13] Council expected that the work of this group would provide direction for the College to address some of the unresolved AMC concerns, particularly those relating to curriculum development, standard setting and reliability for examinations.[14]

After an extensive consultation process, TARWG's final recommendations were presented to Council in July 2011. Suggestions included rewriting the curriculum to develop and implement a Curriculum Framework for Emergency Medicine; revisions to the current Fellowship Examination and the introduction of Workplace-based Assessments (WBAs) throughout Advanced Training. TARWG also recommended the development of online learning resources, the expansion of teacher training activities and development and implementation of a continuous quality assurance and improvement process.[15]

The next stage of the project – the CRP – was launched in December 2011 with the appointment of sixty Fellows and trainees for an initial period of two years. The CRP was coordinated by a steering group that reported to Council via the BOE. Eight workgroups were appointed, with responsibility for aspects of the project varying from authoring a new curriculum, assessment, teacher training and development of operational resources.[16] Workgroup leads included both Fellows and professional staff.[17] At the end of 2013 – the halfway point of the CRP – membership of all groups and committees was refreshed.

The review proved a challenging process for the College. In October 2012 – less than a year into the CRP – complaints were made about a perceived lack of communication between the Director of Education (DOE) and the BOE. Some members of the BOE felt that 'strategic decisions were being made by staff rather than Council' and that this was symptomatic of the changes the College [was] experiencing'.[18] Sally McCarthy urged calm, and following extensive and robust discussion around the timeline, proposed changes to the examinations, the introduction of WBAs and the process of the review – and with some acknowledged differences – Council voted to continue with the project plan and timeline approved in July 2011.

However, some changes were made. Notably, the link between the CRP Steering group and the BOE was strengthened with the appointment of incoming CIC, Diane King as the clinical lead for the CRP. The Council considered this appointment crucial to establish a sense of accountability and leadership.[19] King was well qualified for this role, having served the College as Councillor for South Australia 1993–1995, Censor from 1997–2001 and Vice-President 2001–2005.

By mid-July 2013, King reported good progress with several aspects of the CRP; the curriculum was completed and available for review, draft learning outcomes were finalised and circulated to all Fellows and trainees for input, and planning around changes to assessment processes were well advanced.[20]

Later in the year, details of Emergency Medicine-Workplace-Based Assessments (EM-WBAs), and revisions to the Fellowship Examination were announced. Further preparations included the commencement of face-to-face WBA Assessor Training in 2013 (online from 2014) and the announcement that from 2015 Advanced Training would be separated into Early Phase (the first twelve months) and Late Phase (the next eighteen months).[21] In March 2014, the College elected to discontinue Basic Training.[22]

Changes to the Fellowship Examination were effective from the first sitting in 2015. From this point, candidates were required to complete a written and clinical component that were assessed separately. Changes to the written component included revision of the Multiple Choice Questions (MCQs), as well as an increase in the number, while the Short Answer Questions (SAQs) were revised and the use of Visual Aid Questions (VAQs) was discontinued. Extended Matching Questions (EMQs) were included as a new item.

Successful completion of Early Phase EM-WBAs was introduced as an eligibility criterion for attempting the Fellowship Written Examination, while eligibility for the clinical examination required successful completion of the written examination, completion of the Trainee Research Requirement and at least 36 months of accredited Advanced Training.

Revisions to the Fellowship Clinical Examination included discontinuation of both long and short cases as examination components and replacement with an amended OSCE-based format.[23]

At the end of 2014, the CRP was entering its final stages prior to introduction of the new program in the 2015 training year. Diane King acknowledged that many Fellows and trainees had contributed to this ambitious work. She describes the complex project as 'difficult at times' and commends the diligence of staff and Fellows to progress the project. While accepting there was 'naturally some concern about [the introduction of] such large changes', she was cautiously optimistic that:

> *the efforts in defining exactly what emergency medicine is and does, along with the modernisation of our assessment processes will stand us in good stead for some years. For the first time trainees at each stage of training will have clear signposts through training, and the skills and knowledge of an emergency physician will be well documented. Training and assessment will be significantly more embedded in the workplace with our patients and colleagues.*[24]

The new training program was launched in New Zealand on 8 December 2014 to coincide with the New Zealand training year and in Australia in February 2015.

Training a wider emergency medicine workforce

The establishment of the EMC in 2011 fulfilled ACEM's constitutional obligation to support emergency medicine education and quality in the wider community. Over the years, the College had attempted to do this in a number of ways. It had supported rural emergency medicine training for general practitioners in the mid-1990s through the development of an emergency care curriculum for rural general practice trainees and in 1996, Council agreed that the College would provide a MOPS program for non-specialists.

In early 1998, Council reached consensus for the development of a 3–6 months certificate course that was 'fully owned and developed by ACEM'.[25] A Joint Consultative Committee (JCC) was formed between ACEM, the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australasian College of General Practitioners (RACGP) to investigate the development of a Certificate of Emergency Care primarily for general practitioners in rural areas.[26]

Subsequently, the College developed a proposal for a Rural Emergency Care Certificate, however, while supported by the RACGP, it was rejected by ACRRM and planning was eventually suspended and the JCC disbanded.[27]

From 2003, ACEM's focus was development of a course for the 'benefit of non-specialists in emergency medicine in NZ', with the intention that it would eventually be adapted for use in Australia.[28] CIC Wayne Hazell, together with Steven Doherty – chair of the Rural and Regional Emergency Medicine Committee – led work in this area. In early 2004, Hazell presented a proposal for development of a diploma, rather than a certificate course for 'non-specialists'. Council endorsed continued development of the proposal; however, active planning was suspended at the direction of the Council Executive later in the year on the ground that 'logistical and resource issues meant that the concept was not viable for the College at present'.[29]

The development of ACEM-based non-specialist education programs returned to importance in 2008 with Queensland Health's decision to create a category of doctors to be known as Emergency Medicine Generalists in order to address the shortage of emergency medicine expertise in rural and remote areas. Under this proposal, Fellows of the RACGP or ACRRM, already working in outer urban and regional areas, would be credentialled as Emergency Medicine Generalists following completion of a further six-months training in emergency medicine under ACRRM supervision.[30]

This proved the catalyst for the College to finally take action, particularly as the Queensland Government seemed to be promoting the generalist practitioner as a substitute for FACEMs.[31] It was apparent at this point that if the College did not act it would miss the boat to provide leadership in the area of non-specialist emergency medicine education and training.

The matter was discussed at Council in July 2008, although no decision was taken. Sally McCarthy was a strong supporter of non-specialist education and firmly of the view that 'ACEM must own the second tier that [was] emerging'.[32] Others were reluctant to commit and were genuinely concerned that Fellowship training would suffer as a result. They also recognised that the project would need to be adequately resourced to be successful, and that the project risked being under resourced or putting added pressure on existing College resources. However, in November, agreement was reached to form a Non-Specialist Working Party (NSWP) for an initial two-year period to develop standards and a curriculum for training non-FACEMs in emergency medicine. Tony Joseph (Chair), Sally McCarthy, Paul Spillane, Peter Freeman, Bronwyn Pierce and Shane Curran were appointed to the working party.

In July 2009 the NSWP presented draft outlines for certificate and diploma level courses. They proposed six months for the certificate and 12 months post-certificate training for the diploma.[33] As part of their presentation, the

NSWP demonstrated widespread support for the program from Fellows of the College, federal and state governments and the RACGP. It argued there were both political and educational imperatives to proceed and for ACEM to take the lead in Emergency Medicine education and training in Australasia. Chief among them was that other agencies were 'already positioning themselves to take on the non-specialist, and even arguably specialist aspects of Emergency Medicine training'.[34] For example, New South Wales had already developed (with ACEM support) a non-specialist emergency medicine curriculum and training program coordinated by the Institute of Medical Education and Training (IMET).[35]

Council agreed to support development of the non-specialist courses as the College's preferred pathway to achieve non-specialist qualifications in emergency medicine. Going forward the College agreed to promote its courses with ACRRM, the RACGP and Queensland Health.[36]

The BOE had some objections to the urgency with which the project was being developed and rolled out. CIC Debra O'Brien stressed that the BOE was supportive of the development of the program and understood the political drivers and time pressures, however, it was concerned that there were substantial risks in proceeding with the current proposal. Despite its reservations the BOE sought, and was granted, an invitation to join the NSWP and to be involved in the evaluation process.[37]

The NSWP presented a comprehensive proposal and report to Council in July 2010 and sought approval to conduct a pilot of the certificate course in September 2010, as well as approval for a supervisors' course and support to engage a clinical education consultancy to assist with finalisation and delivery of online modules.

In November 2010 with the pilot underway, Sally McCarthy was optimistic that the pilot and the program would be a success. She reported that both the RACGP and ACRRM were enthusiastic about working with ACEM and that the ACEM non-specialist courses were well received and supported in recent discussions in Canberra and at the Council of Presidents of Medical Colleges (CPMC). The programs were well supported by the Fellowship with strong participation in the supervisors' workshops (180 Fellows had completed supervisors' training by March 2011).

In March 2011 the NSWP transitioned to a Committee of the BOE as the Non-Specialist Training Committee (NSTC). Tony Joseph was appointed inaugural chair.

The EMC program was launched in August 2011 following successful completion and independent assessment of the six-month pilot program involving 15 candidates at six hospitals throughout Australia. The following year, the Emergency Medicine Diploma (EMD) was launched and, as Tony Joseph explained, it was 'aimed at more senior doctors, who have completed the EMC or equivalent and were seeking more extensive training in all aspects of emergency medicine'.[38] The EMD required 12 months full time training and supervision in an 'approved' emergency department following completion of the requirements of the EMC, as well as completion of six months anaesthetic training (or three months anaesthetics and three months Intensive Care training).

Both the EMC and the EMD combine online learning and clinical experience with a requirement of direct supervision by an emergency medicine physician for at least 30% of workplace practice. Candidates for both qualifications complete online learning modules in addition to WBAs, Emergency Medicine Skills Workshops and a final online MCQ examination.[39]

In 2017 the content of the EMC modules was reviewed and updated and a CPD program for EMC and EMD qualified doctors developed. The program utilises the same categories as the Specialist CPD program and in 2017 required 50 hours of CPD activities and six procedural skills. Successful completion of the CPD requirement entitles Certificants and Diplomates to remain a member of the College and retain the right to use the appropriate post nominal.[40]

The programs have proved both popular and successful since their introduction with continued high enrolments and graduate numbers, and good participation of FACEMs and diplomates as clinical supervisors. At 30 June 2018, 824 doctors had completed the EMC and 42 the EMD, while 684 FACEMs and 19 Diplomates had completed the EMCD Supervisors' course.[41]

Participants in both the EMC and EMD programs are supervised by FACEMs and Diplomates in diverse rural, regional and remote locations in Australia and New Zealand, as well as other jurisdictions. In Australia the programs are supported by the federally funded Emergency Medicine Education and Training (EMET) Program. The program has assisted the College to employ Project Support Officers (PSOs) across the country to provide assistance and support to EMC/D candidates and supervisors, as well as to develop resources for online education modules.[42] Feedback from members and others suggests that both programs, with EMET support, have proved crucial to the development of a more skilled and sustainable emergency medicine service in regional and remote areas.

The National Program

Commonwealth funding for development of the EMET programs was delivered under the *Improving Australia's Emergency Department Medical Workforce* that commenced in 2011. Later called the *Emergency Medicine Program* it is known generally within the College as the National Program. Administered by the College, the program is funded as part of the Commonwealth's commitment to improving emergency care in Australia. Oversight for this program is currently undertaken by the National Program Steering Committee (NPSC), a committee of the ACEM Board, chaired by Sally McCarthy.

This program was the fulfilment of a suite of election promises made by Julia Gillard in 2010 that pledged to train more specialist emergency physicians and nurses, as well as upskilling medical practitioners in rural areas to provide emergency care. As President and Vice-President, Sally McCarthy had used every opportunity to lobby for improvements to emergency medical services, and was instrumental in delivering this funding. Following a meeting with the Federal Minister for Health, Nicola Roxon in June 2010 she was confident that there was 'an opportunity for ACEM to work with the Government' as the Minister was looking to the College to provide expert advice on a number of issues including identification of appropriate measures for access improvement and workforce development.[43] McCarthy's

influence was such that she was consulted on the weekend prior to the release of Gillard's *More doctors and nurses for Emergency Departments* policy document.[44]

The agreement between ACEM and the Department of Health and Ageing (DoHA) was signed in July 2011. Initial funding allowed development of the EMET program; provided increased funding for additional emergency medicine training posts (22 in 2012 and a further 22 in 2013) as part of the Specialist Training Program (STP) and research into the specific educational and training needs of International Medical Graduates (IMGs) training in emergency medicine.[45]

In 2012, the agreement was varied to extend the timeline and provide increased funding for additional projects. This included development of important and innovative projects, such as the *Indigenous Health and Cultural Competence (IH&CC) Project* in late 2012 and the Quality Mentoring Initiative and Best of Web EM in 2014. At the end of 2013, 17 projects were underway under the banner of the National Program.[46]

In 2016 a one-year funding variation was granted while the program was reviewed and in 2017 following the review, funding was announced for a further three-year period (2018–2020). By 2018 the National Program had expanded to include six components, only some of which (e.g., EMET) were unique to ACEM, with funding for initiatives such as the STP having been incorporated into the National Program. EMET continued to support regional, rural and remote emergency departments through site-specific educational programs. The STP program had been revised as the Specialist Training Placement and Support (STPS) program with more emphasis on providing support for trainees. The Tasmanian Project – established in 2012 – to support the training and retention of specialist doctors in the Tasmanian public health system funded six emergency medicine training positions in Tasmania. In 2015 the Australian Government announced the Integrated Rural Training Pipeline (IRTP) as an expansion of the STP, with the aim of providing rurally based training places. ACEM was allocated four training posts under the IRTP in 2017. From 2018 the Emergency Department Private Sector Clinical Supervision (EDPSCS) Program – first established in 2011 – has been administered by ACEM as a component of the National Program.

The sixth component of the National Program encompasses various support projects. In the new funding period, funding was awarded for two additional support projects. This funding has allowed the College, after a period of consultation, to launch the *Better Mental Health Care in Rural Emergency Departments* and the *Aboriginal and Torres Strait Islander Patient Experiences in Emergency Departments* projects, initiatives that have the potential to assist significantly in the delivery of improved emergency care to these specific groups of patients.[47]

Developing College Advocacy

Throughout this period College advocacy initiatives expanded considerably. In 2007 the focus of College advocacy was almost exclusively the continuing and worsening problem of access block in both Australia and New Zealand;

however, in later years it has pursued a broader advocacy agenda with a greater focus on building the 'profile of emergency medicine in a positive way' in the community and promoting College issues and opinions to government and stakeholders. Still, access block has continued to be a very high profile issue in relation to emergency medicine in all Australian jurisdictions, as well as New Zealand, with research into its effects now clearly demonstrating associations with increased morbidity and mortality.

Finding solutions for Access Block

From early 2007, the Council was actively looking for an effective strategy to draw the attention of politicians to the ongoing prevalence of access block and hospital overcrowding. This became more urgent after a miscarriage in an emergency department toilet at Royal North Shore in September 2007 resulted in two enquiries and placed emergency departments in New South Wales under intense public and media scrutiny.[48] Following this incident, the College recognised that it must become involved. Executive agreed that the 'overcrowding issue' needed to be 'strongly communicated' while also recognising it was important for the College to respond positively with solutions, rather than criticisms of the present systems. A media release reinforcing ways to effect positive change was agreed to, along with Sally McCarthy's appearance on Radio National a few days later.[49] Following on from this a working group was established to manage the College profile.[50]

In Australia, the election of the Rudd Government in November 2007 provided the opportunity for the College to become more actively and positively involved in the access block issue. Senior FACEMs, Andrew Singer and Peter Cameron, suggested a College-sponsored Access Block Solutions Summit, on the basis that the government intended to focus on better provision of emergency services and would welcome input and leadership from ACEM.[51]

The concept of the Summit was enthusiastically supported by the Fellowship and endorsed by Council in March 2008. Sally McCarthy, then ACEM Vice-President, assumed a leadership role in organising the Summit and was supported by a strong committee with representation from each Australian state, the ACT and New Zealand.

The Summit – funded and convened by the College – brought together state and federal politicians, health bureaucrats, hospital administrators, practising clinicians and media representatives, with the aim of educating them about the causes and myths surrounding access block. High profile journalist George Negus facilitated the meeting, while Nicola Roxon gave the opening address. Sally McCarthy chaired the Summit. High profile attendees included Christine Bennett, Chair of the National Health and Hospitals Reform Commission (NHHRC) and her fellow Commissioner, Dr Mukesh Haikerwal.

College preparations for the day were thorough and included commissioning a plain English pre-reading document that summarised current evidence from around the world, offered possible solutions and pointed out measures that had proved ineffective.[52] The College recognised that the success and effectiveness of the Summit depended on the attendance of key stakeholders and worked particularly hard to achieve this, in some cases, issuing personal invitations after a letter had failed to elicit a response.[53]

McCarthy considered the Summit a successful day in which the college was able to 'engage a large variety of external stakeholders and convince them of the dangers of emergency department crowding'. Moreover, she described the Access Block Solutions Summit as a 'milestone' for the College insofar as it 'represented the start of a new direction in advocacy where we will take a proactive approach to major issues affecting Fellows and trainees'.[54]

After the summit there were some welcome developments. In particular, the NHHRC report *A healthier future for all Australians* reflected the concerns of the summit and recommended additional funding for public hospitals to ensure sufficient bed availability for patients requiring admission from the emergency department. It also recommended the introduction of National Access Targets for waiting times in emergency departments.[55] In Western Australia the four-hour rule for access block commenced in April 2009.

In April 2010 the Council of Australian Governments (COAG) announced the introduction of the four-hour National Emergency Access Target (NEAT) as part of the health reforms for Australian emergency departments.[56] The College was not consulted prior to this announcement and spent some time developing its response, resulting in the development and publication of the *Statement on National Time-based Acute Hospital Access targets in Australia and New Zealand* in July 2010. The College supported the new initiative but made it very clear that 'time-based indicators should feature as part of a suite of system-wide indicators related to access' and that 'any move to a time-based indicator should be applied only when clinically appropriate on a patient-by-patient basis'.[57]

Following the Summit, the New Zealand Government implemented the *Shorter Stays in Emergency Departments* target, defined as '95% of patients will be admitted, discharged or transferred from an emergency department within six-hours'.[58] While New Zealand FACEMs contributed to the Summit and the New Zealand Health Minister and Ministry of Health personnel attended, New Zealand's adoption of the *Shorter Stays* target owed more to direct negotiations between New Zealand FACEMs, the District Health Boards (DHBs) and the Ministry of Health.

Intense and sustained lobbying by New Zealand FACEMs, frustrated at the persistence of access block and overcrowding in their emergency departments, resulted in a 'ground-breaking' meeting in Wellington in May 2008 hosted by the Ministry of Health. The meeting – the ED Quality Measures Workshop – was attended by a number of people from emergency departments and DHBs around the country.[59] Discussion was frank, robust and passionate. Mike Ardagh remembers that for the first half of the meeting clinicians vented their frustrations with the current situation before moving on with the aim of finding a solution.[60] They received a sympathetic hearing and at the end of the meeting there was unanimous agreement that long waiting times in emergency departments, either for treatment or inpatient admission, were unacceptable, as was the practice of 'caring for patients in corridors'. A concluding consensus was that a time-based target should be developed.

A review of emergency department services was subsequently agreed to, and the Working Group for Achieving Quality in Emergency Departments – with good College representation – was formed.[61] Active throughout 2008, the Group's report – *Recommendations to Improve Quality and the Measurement*

of Quality in New Zealand Emergency Departments – was published in December 2008 by the Ministry of Health. The report confirmed that New Zealand emergency departments were experiencing increasing problems of access block and patient overcrowding. The principal recommendation was the introduction of a "Health Target" as a 'formal accountability measure of ED performance'. The preferred measure was the 'percentage of patients admitted, transferred or discharged from the ED within six hours'.[62]

Receipt of the report coincided with a change of government and Tony Ryall's appointment as the Minister of Health. Ryall, who had a good working relationship with Ardagh and was a good friend of John Bonning, is described as 'very hands on' and keen to find solutions.[63] As a result the *Shorter Stays in Emergency Departments* target was announced in May 2009 for implementation from 1 July 2009.[64] Mike Ardagh was appointed to the role of National Clinical Director of Emergency Department Services or "Target Champion" to assist in achievement of the target.

Both the New Zealand and Australian initiatives have proved effective. Mike Ardagh's and Lynette Drew's review of the New Zealand *Shorter Stays*, indicates a significant improvement in national performance in the five-year period between 2009 and 2014. Anecdotally clinicians reported 'decreased ED overcrowding and generally more pleasant working environments'. While acknowledging that there was still much to do, Ardagh and Drew conclude that after five years the health target had seen a 'maturing "whole-of-system" collaboration with improved patient care'.[65] In Australia, the story is similar. A 2016 Queensland report – *The Four-hour Rule: the National Emergency Access Target in Australia* – concluded that although no Australian jurisdiction achieved an overall 90% NEAT compliance for any significant reporting period,[66] access to emergency care in Queensland and other jurisdictions had improved following the introduction of the NEAT.[67]

College advocacy in this area, continued to be very proactive. Following the federal government's 2014 decision to withdraw funding incentives for NEAT in the 2014/15 budget, the College has continued its support for 'whole of system' reform in this area. Both through direct representation to jurisdictions and publication of the *Statement on National Time-based Acute Hospital Access Targets in Australia and New Zealand*. The document, revised in 2016, makes a clear argument for continued use of appropriate time-based targets as an important part of a range of strategies to address access block and overcrowding.

Similarly, College media activity has successfully raised awareness of access block as not 'just an ED problem'.[68]

A wider advocacy agenda

Since 2011, the College has pursued a greater focus on raising its community profile, building better relationships with external stakeholders and increasing the effectiveness of its negotiations with government.[69] This commitment reflected member support for the College to 'develop and build a profile of Emergency Medicine in a positive way' in addition to maintaining focus on problems such as access block. These commitments were incorporated into the College's 2012–2015 Strategic Plan as the strategic priorities of Advocacy and Awareness and addressed through three strands of activity: increased

representations to government and other entities; public health initiatives which have raised ACEM's profile as a public health advocate; and community engagement through media activity.

Initially some consideration was given to engaging professional lobbyists to develop and promote key messages to the public and the media, before the decision was taken to develop this capacity within the College with development of the Policy and Research Unit and Andrew Gosbell's appointment as Director of Policy and Research in late 2011.

Since then, the College's capacity for formal engagement with government and statutory entities on matters relevant to emergency medicine has increased significantly. Sally McCarthy, writing in 2012, notes that the 'voice of emergency medicine' was heard through submissions, representation and participation in working groups, committees and collaborations. These included submissions on advanced trainee access to the MBS in private settings, the National Advanced Rural Training Plan and CPD requirements in New Zealand. Overall, the College made 35 submissions in 2012; more than double the number it made in 2011.[70]

Likewise, College interactions with jurisdictions and agencies through participation in workshops and representations has expanded. In 2014, Anthony Cross described the College's appearance before the Senate Inquiry into Health as an important opportunity 'for the College to represent our view, experience and knowledge to senior levels of government in the interest of our patients'.[71] ACEM raised a number of issues, including concerns about the effects of the Australian Government's proposal to introduce a co-payment for GP attendances; the maldistribution of the emergency medicine workforce in rural areas and the importance of EMET and STP funding, and the College's commitment to resource stewardship in the quality and cost of medicine.[72]

The Public Health Committee (PHC) – chaired by Diana Egerton-Warburton – has been particularly effective in promoting the College's public health credentials and raising the College profile in the wider community and amongst colleagues. In May 2012, the Committee hosted a successful *ACEM Working Together: Emergency Medicine, Disaster and Public Health Consensus Meeting* with the aim of introducing emergency medicine as a 'key player in public health'[73] and to explore partnerships in policy development and advocacy. The two-day meeting had an internal and external component and brought together ACEM Fellows and trainees, members of other colleges, and representatives from government and non-government organisations (NGOs). Issues discussed included emergency medicine's role in disease surveillance, injury and disease prevention, and healthcare access.

The meeting paved the way for the College to develop a number of projects. Most notably, in 2013 ACEM secured funding of $350,000 from the Australasian Preventative Health Agency (APHA) for the 'Reducing Alcohol Harm in ED' project – a point prevalence study of alcohol related harm in emergency departments.[74] Anthony Cross comments this project 'significantly raised' ACEM's profile and 'provided important data to inform and guide policy'.[75] Following on from this involvement, ACEM became a partner in *The Driving Change – Last Drinks project* – a collaborative multi-site project that uses emergency department data to reduce alcohol related harm. The project

is managed by Deakin University and funded by the National Health and Medical Research Council; it was launched in 2016 and will run until 2021. Egerton-Warburton – one of the lead researchers – commended the project as giving 'emergency physicians the opportunity to become part of the solution, not just mop up the end result of alcohol harm'.[76]

The meeting in 2012 also marked the beginning of the College's formal advocacy for improvements to Indigenous health access and service development in Australia. The PHC Indigenous Working Group – formerly the Indigenous Health Special Interest Group – met for the first time during this meeting and was immediately active.[77] Chair, Liz Mowatt was appointed to the CPMC Indigenous Health Subcommittee, discussions commenced with the Australian Indigenous Doctors Association (AIDA) to establish formal links and work began on the development of educational resources to address cultural safety and barriers to care for Indigenous patients.[78] The following year the Working Group was elevated to a subcommittee of the PHC and was working on developing resources for the IHCC project and a statement on the health of Aboriginal and Torres Strait Islander and Māori people.[79] Resources for the IHCC included e-learning modules and podcasts developed from a number of sources and in consultation with representatives of both AIDA and LIME (Leaders in Indigenous Medical Education). The publicly available program was the first of its kind in Australia and accessed by other specialist medical colleges including Royal Australasian College of Medical Administrators (RACMA) and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO).[80] In 2015 this work was recognised with an Australian and New Zealand Internet Award (ANZIA) in the "Diversity" category.

College support for improving Indigenous health has been ongoing since 2015 and significant progress has been made. Major projects have included the development of ACEM's first Innovate Reconciliation Action Plan (RAP) in Australia, the Manaaki Mana in New Zealand and an expanded encouragement for Indigenous doctors and medical students to undertake training in emergency medicine.

Modernising College Governance

In July 2011, with acceptance of responsibility for administration of DoHA funding available through the National Program, governance issues returned to the College agenda. Council revised and formalised processes for Executive out-of-session decisions and management of incoming and outgoing College correspondence. In March, Councillors were briefed on their responsibilities as the company directors of ACEM and legal risk management. Following on from this, members of the Executive attended a course for company directors offered by the Australian Institute of Company Directors (AICD).

In July, Council agreed to formally develop a strategic plan to guide College activity on a day-to-day basis. The plan was developed in late 2011 with enthusiastic member engagement and adopted in early 2012.[81] It formalised the College strategic priorities as Education, Advocacy, Member Support, Standards and Awareness (of Emergency Medicine as a specialist practice, body of knowledge and career).[82]

Throughout 2011, more general discussions were also held about the continued suitability of the College's current governance structures and processes. Tony Lawler suggested that a wide-ranging review of College governance structures and the responsibilities of College officers might be appropriate.[83] Informing Lawler's suggestion was unease about recent tensions between the BOE and members of the Council. In his view, 'it rankled' that under the existing governance arrangements 'the popularly elected Council could make decisions that overrode the opinions of [educational] experts' in the BOE. Yet at the same time, he recognised that the Council as the principal governing body had ultimate responsibility for College decisions and actions and therefore had to have its say. Similarly, he was concerned that the Council, which met for six hours three times a year, had competing focus points and could not effectively manage the organisation and fully discharge its legal governance duties.[84] Peter Freeman – on his retirement as Vice-President – proposed it might be timely to review this role, as well as the current process for election and selection of Executive officers. His suggestions included elevation and formalisation of the role of Immediate Past President, formalised election and selection processes and revised minimum and maximum terms for Executive positions.[85] Such realisations were not unique to ACEM; indeed, there was an increasing awareness, among the medical specialist colleges and the not-for profit sector more generally, of the limitations of traditional governance structures and procedures.

Councillors' concerns gained momentum and at the end of 2011 the College committed to an independent review of its governance structure, function and operation early in 2012. Kate Costello of Governance Matters was chosen to undertake the review on the basis of 'extensive experience with specialist college governance reviews'.[86]

The review's objective was to measure the performance of the governance of the College Council against a good governance benchmark. The process involved an initial face-to-face session to explain the role of a governing body and what others had done to improve governance. Following this, Councillors' and the CEO completed a governance evaluation survey of the Council's performance against the benchmark for a governing body. Costello reviewed existing College documents and members' responses to the 2011 strategic planning survey. A preliminary report was prepared, and a round of teleconference interviews conducted to test the survey results, before conclusions and recommendations were presented to Council.[87] The review was launched in early March, and findings presented to the Council Executive in June, before consideration by Council in July 2012.

Governance Matters' assessment of the existing situation was that the Council had evolved as a both a governing and management body. While this was necessary in the College's early years when staff were limited or non-existent, in a more complex regulatory environment, it was important to separate these responsibilities. The Council was large, met only three times a year and 'struggled to fulfil its ultimate responsibility for the performance of the College'. It was noted that the Council had delegated 'considerable responsibility to the Executive' which met more often. The consultancy noted that ACEM was not alone in this respect; it was common practice among

medical colleges although changing as many were converting Councils to Boards.

From the Councillors' perspective the most 'frequently suggested governance change' related to clarifying the relative roles and responsibilities of all parts of the current governance and management structure (particularly between the Council and Executive).[88] After this, Councillors were dissatisfied with the Council's size and frequency of meetings, and favoured a smaller, more efficient Council that met more frequently.[89] Another major concern was that the existing Council did not have the right balance of skills for successful governance.[90]

These concerns were reflected in the consultancy's principal recommendation that the College amend its constitution to create one governing body, known as the Board, whose membership comprised the President, President-Elect, the CIC and four other FACEM directors, with at least one these directors from Australia and one from New Zealand and with provision to appoint one or two external directors to fill identified skill gaps.

Other significant recommendations included direct election of the President by the wider Fellowship, rather than appointment from within the Board,[91] limiting to two years the terms of both the President and President-Elect and imposing a six-year term limit for any one director. In part this reflected Councillors' views that after 'six years or so one's energy … may have waned and there [was] room for new thinking'.[92]

Rather than the Council simply transitioning to the Board, Costello proposed the creation of two councils, both of which reported to the Board: one overarching all educational committees and functions, known as the Council of Education (COE), and the another to oversee all non-educational activity, known as the Council of Advocacy, Practice and Partnerships (CAPP). Costello argued that this arrangement provided an effective way to retain the College committee system – regarded by Councillors as a strength of the College – while also increasing efficiencies. Importantly, given recent tensions, it established the BOE as an independent entity from the Council with clear responsibility and accountability for educational decision making.[93] Costello suggested that the chairs of these two Councils should be members of the Board to allow appropriate information flow from each committee to the Board. Two further committees of the Board were proposed – the Audit and Risk Committee and the Governance, Nominations and Remunerations Committee.

Council considered these recommendations in July 2012. The main point of concern was that the proposed Board would not have regional representation. However, Council accepted that a move to a skills-based board would be advantageous and agreement was reached that further discussion and consensus building, both within Council and the wider membership, was warranted.

A survey about the proposed changes was subsequently developed and circulated to members. Feedback was generally positive, with notable support for direct election of the President-Elect; one respondent commented such a development was 'long overdue' while another supported a 'more transparent and structured' succession process. Others welcomed the creation of COE on

the basis that 'best educational practice and politics have never mixed well', while another respondent was 'delighted that the BOE [would] no longer be required to report to a large cumbersome council'. The membership, like the Council, expressed concern about the lack of regional representation on the proposed Board, but generally appreciated that the two Councils would ensure a 'regional voice'.[94]

On the basis of this feedback, and with the goal of incorporating the constitutional changes at the AGM in 2013,[95] Council established a working party with the brief of developing and communicating to the membership alternate proposals for the restructure. Vice-President Tony Lawler led this group, whose membership included Scott Boyes, Diana Egerton-Warburton, Andrew Singer, Chris May and Anthony Cross.[96]

Lawler presented the working party's proposed model to Council in March 2013, where direct election of the President and the inclusion of non-FACEM legal and financial experts as members of the Board of Directors remained sticking points. Lawler describes these as valid concerns that were alleviated after discussion. He promoted direct election as an opportunity to engage the wider Fellowship in governance affairs and alleviated concerns that someone with no experience of College governance could potentially be elected President with the development of selection criteria and a nomination process overseen by a Committee of the Board. Some Councillors favoured the inclusion of FACEMs with legal and financial expertise on the Board, however, Lawler convinced them this was too restrictive and, as it was incumbent on the Board to act in the College's best interest it was necessary to appoint the best people for the job.

In July 2013 Council accepted the proposal for a nine to ten-member Board of Governance that included the President, the President-Elect or Immediate Past President, the Chair and Deputy Chair of CAPP, the Chair and Deputy Chair of COE, two externally appointed non-FACEM directors: one with financial expertise and another with legal expertise and a trainee representative. Provision was also made for the inclusion of an additional director from Australia or New Zealand should there be no FACEM Director from either jurisdiction in the other positions. The Board's responsibilities would include governance, strategy, monitoring risk, compliance and responsibility for the financial position of the College.

The College Fellowship considered and approved the changes at the 2013 AGM for implementation in July 2014. The Board met for the first time in July 2014, with membership finalised from the end of 2014. College President Anthony Cross was appointed as the inaugural Chairman of the Board, other FACEM members included Tony Lawler – Chair of CAPP, John Bonning – Deputy Chair of CAPP, CIC Diane King and Deputy Censor-in-Chief (DCIC) Philip Richardson. Joe-Anthony Rotella was the trainee representative. Lawyer Michael Gorton AM and accountant Anthony Evans were appointed as expert external Directors.

The first presidential elections were held in October 2014, with Tony Lawler elected as President-Elect. Although only 466 from a total of 1,812 eligible Fellows exercised their right to vote, the College was pleased that the process ran 'smoothly and efficiently'.[97]

At the end of 2014, Cross reflected on the changes, admitting that while governance matters 'may be remote to many Fellows and of only limited interest', the recent changes were an important step for the College. He considered that:

> *[t]he new Board, formulated according to current best practice, is dynamic, responsive and able to draw on the legal and financial expertise of its non-FACEM members.*[98]

Likewise, CEO Alana Killen, noted that with the changes the ACEM Board was 'now reflective of current corporate governance principles and [would] provide important strategic oversight to the College's operations'.[99]

Developing College Administration

Just as College expansion and the changing regulatory environment throughout this period necessitated significant governance change, these factors also made it necessary to review and expand administrative structures and processes, and current infrastructure.

In 2007, the College relied on a competent, loyal and experienced staff of seven at College headquarters and an administrative officer in New Zealand. In mid-2007, as the College contemplated its future direction, CEO Jenny Freeman informed the Council Executive that 'the past and present culture of lean and highly efficient' staffing levels at College headquarters was no longer sustainable and that it would be necessary to increase the level of staffing to 'properly attend to the requirements of the College now and into the near future'. Moreover, she indicated that it was 'certain that no additional responsibilities [could] be incorporated based on the present staffing levels'.[100]

As the College was about to embark on development of the recently purchased premises at 36 Jeffcott Street, it was agreed that staff increases and a restructure to include a level of middle management would occur at the completion of planned building works. (The planned expansion would double the size of the present building and provide much needed meeting and office space.) On the basis of the impending building works, Executive approved an immediate staff increase of 1.5 FTE; and agreed that further staff increases and a restructure to include some middle management positions – especially a Director of Education (DOE) – would occur at the completion of the planned building works.

At the end of 2008 with the building work nearing completion, Jenny Freeman retired as CEO. She was farewelled at the 2008 ASM and her contribution to the College acknowledged with the award of an Honorary Fellowship. However, following the unexpected departure of her replacement, she returned to her role early in 2009. Under Freeman's leadership, the building works were completed and a realignment of staff roles and additional appointments occurred, bringing staff numbers to 16. Alana Killen was appointed as DOE and following her employment, the College was able to progress work on reviewing aspects of assessment processes and the curriculum'[101] as well as development of its non-specialist courses.

Freeman's return was intended as an interim measure until another CEO could be appointed; however, she remained at the College for a further

two years, before resuming retirement in early 2011. Alana Killen, after a successful period as the DOE, was appointed as her successor. She had made a significant contribution to the College in her role as the DOE, particularly in regard to development of e-learning resources and the non-specialist programs. Moreover, she had earnt the confidence of College Officers with Sally McCarthy commenting that Killen's 'educational background coupled with her management experience' ensured the College was in 'capable hands'.[102]

Under Killen's guidance, the administration was restructured to accommodate the increased workload and responsibilities associated with administration of the National Program, the CRP and the roll out of the non-specialist courses. Killen proposed replacement of the College's secretariat – a model whereby staff provide administrative support for the work of the various College committees – with a 'professional management model'. Under this model, administrative support for committees continued with the guidance of a manager or director. The model alleviated much of the work of committee chairs and provided a clear structure of administrative accountability and responsibility.[103] Four organisational units – *Education*, *Operations*, *Policy and Research*, and the *National Program* – were created and directors appointed to lead each of these entities. This was a significant change for the College – and some Councillors had reservations – but it was generally accepted as necessary to support the College's current and future direction.[104]

With these changes the College's capacity to implement its strategic priorities and develop resources and infrastructure was considerably enhanced. Director of Operations Peter Bain assumed responsibility for redevelopment of the College website, the introduction of a new finance system and redesign of the database, while Andrew Gosbell's appointment as Director of Policy and Research addressed the key priority of advocacy while also building capacity in emergency medicine research. Mary Lawson was appointed as the new DOE; her portfolio included e-learning, training and assessment, CPD and curriculum development.[105]

At the end of 2011 staff had increased to 33 members (from 19 in 2010) and the College had been substantially refurbished to accommodate the new management team and associated staff. However, staff expansion was such the following year it was necessary to lease office space offsite and consider expanding the existing premises. In July 2012, Council approved construction of two additional floors above the existing car park with completion expected in October 2014.[106] At the time Council approved the building it was expected that construction would commence early in May 2013 with completion twelve months later. It was, however, not until July 2014 that the slab was poured. Progress from this point was rapid, with building works completed in January 2015.

The College administration continued to evolve in response to changing circumstances and priorities. In 2015 it was expanded and reorganised when administration of the National Program was absorbed into other organisational units. The large Education portfolio was split into Education and Training and the DOE role split accordingly. Policy and Research was expanded to include communications (previously under the Operations

portfolio) and the directors of each unit, with the CEO, formed a Senior Leadership Team for more than 50 employees overall.[107]

The contributions of the expanded professional staff have been crucial for College development going forward and have played a significant role in facilitating and implementing the goals and objectives of the organisation.[108] In 2015, outgoing President Anthony Cross, pays tribute to the skill and dedication of professional staff and acknowledges that staff allows the College to carry out training, develop policy, engage in significant advocacy, develop educational resources and both develop and maintain standards 'on a scale and at a level that would be inconceivable if we were to rely solely on the work of volunteer Fellows'. At the same time, he acknowledges that the 'time and passion' many Fellows commit to the College demonstrates that ACEM is a 'College *for* emergency medicine – *for* our patients, their families and communities, our trainees and all our colleagues who work in health care'.[109]

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Although "unprecedented" is at risk of being an overused word in our fast moving and everchanging world, it is an apt descriptor for College changes, development and innovation during the eight-year period 2007–2014.

In this period, all aspects of College core activity had been reviewed and significant changes made. The changes and innovations were ambitious and often challenging, and difficult decisions had sometimes been required to ensure that progress was made.

Along with the major changes associated with College governance and its education and training programs, new activities such as development of the National Program and establishing the EMC and EMD programs had been successfully achieved. As well, the College was steadily developing a strong and committed advocacy agenda for both members and patient groups.

College leaders – aware of the College's significant achievements and the challenges encountered along the way – made time to pay tribute to the contributions of Fellows, trainees and professional staff. Anthony Cross acknowledged the role of staff in 'facilitating and implementing the organisation's goals and objectives, while also noting that the College was 'fortunate to have the benefit of enthusiastic and dedicated members who generously donate their, time, knowledge and expertise to the cause of emergency medicine in Australia and New Zealand'.[110]

CEO Alana Killen, likewise, acknowledged the commitment and dedication of Fellows and trainees who freely and willingly gave their time to the College and whose work was complemented by professional staff members striving to work 'collaboratively with ACEM members to achieve the collective goals of the organisation'.[111]

CHAPTER 6

INTO THE FUTURE 2015–2018

After the rapid and significant changes of the previous years, further changes within the College followed, prompted both by the need to consolidate those previously introduced and to develop a better understanding of what it meant to demonstrate 'best practice' in the College's core business from the perspective of those outside the college.

Since 2015 ACEM has consolidated its contemporary governance structure, and refined changes associated with the introduction of its revised FACEM Training Program and assessments. It continues to mature as a dynamic and outwardly focused organisation, committed to continuous improvement of all its training and assessment programs, and ongoing solid advocacy activities. College activity is guided by strategic priorities and its responses and decisions are considered and responsible.

The evolving maturity of the organisation is reflected in the ways in which ACEM has responded to recent challenges, both in regard to its activities, as well those found to be pervasive throughout the medical profession. Particular examples of note are the accusation of racial discrimination in College assessments, concerning levels of discrimination, bullying and sexual harassment in emergency departments, and broader issues of equity and access to high quality emergency medical care and education. ACEM's ongoing change agenda and maturity is also validated by the report of the Australian Medical Council's (AMC) Accreditation Team in 2018 following a full reaccreditation process.

New Approaches for a New Era

In 2015 as the College settled into its new arrangements it was cautiously optimistic that it was 'well placed to effectively address the broad range of emerging issues facing the specialty of emergency medicine'.[1] The College expected that its new structure of the Board as the peak governance body, supported by CAPP and COE – each with delegated authority to discharge specific functions – would allow an expanded program of work associated with 'the wide range of activities that constitute the College's core business'.[2]

Guiding the College as it embarked on its journey after the recent changes was its strategic plan *Into the Future*. Covering the years 2015–2018, the plan was developed following a survey of members and submissions from various working parties and subcommittees. This work identified the critical issues for the College going forward as ongoing concern about the pressure access block and overcrowding placed on emergency physicians, their departments and the health system more generally, along with the complexity of managing and developing a sustainable emergency medicine workforce. A detailed Business Plan – based on the Strategic Plan and its strategic priorities – guided specific work and outcomes.

Training and education remained the College's core priority, with a commitment to develop best practice programs and enhanced resources for member education, training and continuing professional development. Other priority areas included a pledge to represent, support and protect the interests of College members, and to take a lead advocacy role in policy debates in areas relevant to emergency medicine and public health. In this latter regard, College endeavours were increasingly focused on equity of access in areas such as Indigenous healthcare in Australia and Aotearoa New Zealand, and for patients presenting with mental health issues.

The College also committed to raise public awareness of emergency medicine as a specialty, expert body of knowledge and choice of career with concurrent development and implementation of best practice standards in emergency health care and a focus on College operations through developing organisational sustainability.

The intended focus for College activity in early 2015 included completing and publishing the 2015–2018 Strategic Plan, finalising the structure and membership of the newly constituted Council of Education (COE) and completing governance arrangements and compliance for its new entities.

Early challenges for the College were the unexpected resignation of the CEO Alana Killen in early 2015, as well as the Director of Education, Mary Lawson. The timing of these resignations coincided with the recognition that the College would need to undergo a full AMC reaccreditation before 31 March 2018 in order to maintain its status as a recognised provider of postgraduate vocational education and training in Australia and Aotearoa New Zealand. The College had not been subject to such a process since 2006/7 and since that time the expectations of external stakeholders had changed in ways that rendered the accreditation requirements and associated processes significantly different to those the College had experienced some ten years earlier.

Reaccreditation

Introduced in 2002, the AMC process for accreditation of specialist education and training programs was initially a 'voluntary quality improvement process in which all specialist medical colleges agreed to participate'. Since 2010 the process had been mandatory and linked to the Medical Board of Australia's (MBA's) recognition of specialist training programs and registration for specialist practice through legislation associated with the National Registration and Accreditation Scheme (NRAS) in Australia. In 2010 the

Medical Council of New Zealand (MCNZ) adopted AMC accreditation reports to guide its decisions about recognising medical training programs in New Zealand.

The AMC describes the purpose of accreditation as being to

> *...recognise specialist medical programs and education providers that produce medical specialists who can practice unsupervised in the relevant medical specialty, providing comprehensive, safe and high quality medical care that meets the needs of Australian and New Zealand healthcare systems, and who are prepared to assess and maintain their competence and performance through continuing professional education, the maintenance of skills and the development of new skills.*[3]

In 2015, in line with its remit, to 'respond to evolving health needs and practices, educational and training standards', the AMC developed new standards that – following MBA approval – came into effect in 2016. Changes to the standards included an enhanced focus on trainee wellbeing and patient safety and new standards relating to Indigenous health and medical education. Standards related to CPD were revised to align with MBA and MCNZ guidelines. A new Standard 10 relating to assessment of Specialist International Medical Graduates (SIMGs) was similarly developed to align the standard with revised MBA and MCNZ guidelines.[4] Additional requirements were embedded in individual standards to ensure that colleges whose remit was trans-Tasman were assessed against requirements unique to the MCNZ.

College preparations for AMC reaccreditation were boosted with the appointment of Peter White as CEO in mid-2015, following Alana Killen's resignation earlier in the year. White had been the CEO at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) during its AMC accreditation in 2013 and held postgraduate qualifications at doctoral level in education. Having served as a member of the AMC's Specialist Education Assessment Committee (SEAC) and Medical School Accreditation Committee (MedSAC) he was well qualified to guide the College through the accreditation process. Also of benefit to ACEM was a quickly established working relationship with Tony Lawler – College President from November 2015 – aided in part through a short crossover period when both were members of SEAC. Both were firmly committed to the reaccreditation process, endorsing it as important for ensuring that the College continued to serve its members and the wider community through achieving excellence in the delivery of emergency medicine training, assessment and education, while also providing an opportunity for the College to assess its performance and processes and identify areas requiring attention and action in the coming years.[5] Both were also very aware of the changes that the process had undergone over a period of time and that may, in some areas, prove challenging for the College to achieve without a change in understanding and approach.

Working together Lawler and White provided sound leadership throughout the process and were well supported by the appointments of Barry Gunn and Simon Chu as Censor-in-Chief and Deputy Censor-in-Chief, respectively, as well as the appointment in 2016 of Lyn Johnson as Director of Education

and Training. Like White, Johnson had a background in education, was experienced in the College sector and was well versed in the contemporary expectations of the accreditation process.

A review of the College's current programs and processes against the requirements of the accreditation standards was conducted and a program of work developed. Along with the College's Business Plan, this was adopted to guide activities at an operational level as the College enacted its strategic plan and prepared for reaccreditation.

Through the office of the CEO attention was focussed on organisational improvement and capacity building, further developing the College as an outwardly focused entity, understanding and appreciating the need for increasing external stakeholder and consumer involvement in College activities, and ensuring solid governance processes underpinned the College's activities.

Policies and regulations were revised and updated to suit the revised FACEM Training Program introduced for the 2015 training year. Membership categories were expanded to include Certificants and Diplomates as holders of the Emergency Medicine Certificate (EMC) and Emergency Medicine Diploma (EMD), respectively, and appropriate recertification pathways developed. A Retired Fellow category was created as part of the College's strategic plan to promote member engagement, and the process of assessment of SIMGs was scrutinised to ensure that it met fully the standards of both Australian and New Zealand regulatory bodies.

Educational priorities included ensuring that all training programs were appropriately resourced and that supporting governance processes were sound. A further priority included development of an integrated online portal system to manage all aspects of training and deliver real-time information about trainee status and progress for trainees, supervisors and assessors. Significant attention was also given to finalising and implementing revised Accreditation Standards for hospital and other specialist training sites, development of an education and training evaluation framework, and evaluation and enhancement of the college CPD programs. In other work online resource modules for the EMC and EMD programs were completely revised to ensure currency of information.

Prior to, and following the appointment of Lyn Johnson, the focus was on developing a system where members, trainees and college staff understood and appreciated the connection between sound education and training, and robust and defensible governance and administrative processes.

With a submission deadline of 1 June 2017, at the end of 2016, significant work remained in multiple domains. Work over the summer resulted in completed drafts of all ten accreditation standards by February 2017. By May a second draft of the submission was completed, with the final submission made in June 2017.

The College's submission was well received and interviews between the AMC Accreditation Assessment Team and College personnel took place in Sydney in November 2017 in conjunction with the College ASM. In December 2017 the College heard that the findings of the accreditation team were positive, although the final report was delayed while the accreditation team

considered the report of the Expert Advisory Group on Discrimination (the EAG), appointed in February 2017 to investigate the accusation of racial bias in respect of the new Fellowship Clinical Examination (OSCE) made in January 2017. The College's current accreditation was extended until 30 September 2018 to accommodate the delay.

The AMC delivered its final report in May 2018. It found that the College substantially met the accreditation standards, and on this basis granted accreditation for four years until 31 March 2022, subject to ACEM satisfying AMC monitoring requirements, including progress reports and addressing accreditation conditions.[6]

In making its report, the AMC acknowledged the magnitude of recent changes and the significant challenges the College had faced, while also expressing confidence that the College had the necessary leadership and governance to address these challenges in a professional and transparent way.

The AMC commended, the College's commitment to ensuring sufficient resources and management capacity to sustain and deliver its training and education functions, along with its strong outward focus. In this regard the AMC particularly noted, the College's commitment to the development of relationships and collaborations with international stakeholders, other specialist medical colleges and jurisdictions in relation to health advocacy and workforce planning. The AMC also commended the College's commitment to non-specialist training to address rural and regional workforce deficiencies. The College's strong relationships with Indigenous health groups in Australia and Aotearoa New Zealand were likewise commended especially the development of initiatives such as the ACEM Innovate Reconciliation Action Plan (RAP) and the Manaaki Mana strategy.

The report was positive about most aspects of training and assessment, specifically the clear and logical ACEM Curriculum Framework that encompassed all the domains of specialist practice, describing it as a 'meaningful guide to training'[7], and the alignment of assessment methods with curricular learning objectives.

The College was also commended for developing a selection process in consultation with stakeholders that ensured that candidates selected into ACEM training had the capability to become specialists. In regard to aspects of trainee wellbeing, the appointment of a Trainee Advocate to support trainees and establishment of the Discrimination, Bullying and Sexual Harassment Working Group were seen as positive steps.[8]

The report also noted progress in monitoring and evaluation of assessment and solid standard setting processes, and applauded the College's commitment to building capacity through the ACEM Policy and Research Unit.

The CPD Programs of the College, particularly the online components were commended as 'comprehensive, accessible and easy for fellows to access and understand'.[9] Processes for the assessment of SIMGs were likewise commended for their compliance with the requirements of both regulatory bodies, the timely manner in which they were conducted and the underlying ethos of ensuring that the standards of emergency medicine practice are maintained.[10]

Just as the accreditation report of 2007 had outlined 31 recommendations for perceived improvements that could be made as a result of that accreditation (an outcome consistent with the process as it stood at that time), the accreditation report of 2018 outlined 34 Conditions that needed to be met by defined timeframes, along with 22 improvement recommendations and 25 commendations.

In keeping with the way in which the College now approaches such matters, close attention has been paid to the conditions, with all those required to be completed by the time of submitting the 2018 and 2019 Progress Reports being met to the satisfaction of the AMC. The College is again due for a reaccreditation visit in 2021. While all of the standards will again be assessed, the focus of the visit will be developments since the 2017 assessment and the status of conditions due for completion in 2020 and 2021.

Addressing allegations of racial discrimination in assessments

In January 2017 a complaint was made by an anonymous cohort of Fellowship candidates who were unsuccessful in the 2016.2 OSCE and who self-identified as non-Caucasian candidates (NCCs). The complainants alleged that only 6.8% of NCC doctors were successful in the examination, compared with 88% of Caucasian candidates (CCs), and that this situation had arisen as a result of the introduction of the new Fellowship examinations from 2015. They argued this was statistically significant when 25% of the candidates were non-Caucasian.

The complainants were not all International Medical Graduates: some had been educated in Australia, and English was their first language; all had been assessed by FACEMs as performing at, or near, the level of an emergency medical specialist and many had worked in Australasian emergency departments for a number of years and progressed through the training program to the point where a pass in the Fellowship Clinical Examination (OSCE) was the only remaining requirement for the attainment of Fellowship. The candidates considered that as so few NCCs were successful, then race, rather than performance, was the factor underlying their failure. The complainants alleged unlawful racial discrimination in breach of the *Racial Discrimination Act* 1975 and sought statistical modification of the results of the 2016.2 OSCE to remove any element of racial bias.[11]

The College received the complaint at the same time that the media and the AMC were notified.[12, 13] Then President Tony Lawler admits that he was surprised by the allegations, which he felt did not fit with either the College or the many DEMTs and examiners who had supported the College over a number of years. However, he recognised that the allegations needed to be addressed, explained and understood.[14]

The College response to this was measured and immediate. It committed to a thorough investigation through the formation of an Expert Advisory Group on Discrimination (the EAG) and promised a 'fair and robust process' that was 'respectful of all parties' and from which 'clear facts' would emerge.[15] It immediately appointed the EAG, chaired by Dr Helen Szoke, a former Federal Race Discrimination Commissioner and Victorian Equal Opportunity

and Human Rights Commissioner. Other members were the Deputy Chair Professor Ron Paterson, a former New Zealand Health and Disability Complaints Commissioner, Professor Kichu Nair AM, Professor of Medicine and Associate Dean, School of Medicine and Public Health, University of Newcastle and world recognised expert in clinical education and assessment,[16] ACEM President-Elect Simon Judkins, Yusuf Nagree Chair of CAPP, recently qualified FACEM Mahesh Gangadharaiah and FACEM trainees Hussein Kadim and Danika Thiemt.[17]

The EAG provided an interim report in June 2017, with the final report handed down in October 2017. In presenting this report, Szoke acknowledged the investigation had been a complex and challenging process that had highlighted many issues, and that in reaching its conclusions the EAG had considered the human cost and anguish of trainees grappling with the examination process, the commitment and dedication of examiners who were keen to uphold standards of emergency medical care, and the recent changes to the Fellowship Examination process. She called upon the College to respond to the findings with a comprehensive and effective action plan, to provide redress for those impacted and 'to implement ongoing change to build the culture and effectiveness of the College into the future'.[18]

The EAG report cleared the College of racial discrimination, utilising expert external consultant reports to conclude that the poor pass rate for NCCs on the 2016.2 OSCE reflected a 'true difference in performance' between identified trainee cohorts undertaking the 2016.2 OSCE, rather than 'systemic bias, chance or error'. However, it was viewed that a number of factors associated with the introduction of the new Fellowship Examination from early 2015 had contributed to the complaint arising. In particular, it found that the College had not provided enough information about changes to the examination, adequately clarified its expectations or provided enough candidate support. It also recognised the change in examination feedback for unsuccessful candidates was perceived as insufficient, relative to that previously provided for the Fellowship Examination pre-2015.

Its principal recommendations related to changes to the conduct of the Fellowship Examinations, greater support for examiners, including induction, preparation and support during the conduct of the examinations, and constructive feedback for candidates about performance and concerns.[19]

While conclusions that real differences between the cohorts, rather than factors attributable to racial discrimination were the cause of the performance differences on the 2016.2 OSCE, the report acknowledged the significant impact on the failed candidates and made a number of recommendations for redress. These included an apology, a refund of examination fees for those affected, extension of training time by twelve months, conduct of College-run OSCE preparation programs, formative feedback and career counselling for those leaving the program.

The report also noted that legacy issues, such as the lack of significant barriers for entry to the training program, and questionable utility of ITAs to identify trainees in need of extra guidance had contributed to the failure rates. As a remedy it recommended the development of selection criteria for entry to FACEM training and consideration of alternative options for those unlikely to complete the FACEM Training Program.

The College was commended for the continuous improvement measures it had commenced prior to and following the complaint. These included general measures aimed at defining 'just at standard' candidates and tackling unconscious bias. Questions and marking processes had been improved for the Fellowship Written Examination. Calibration processes had been developed to ensure standardisation of the OSCE, feedback processes for candidates had been improved and examiners were provided with written feedback about their marking performance. Video recording of OSCE stations was in development.[20]

This work was carried forward in 2018 with the development of additional resources to assist candidates in examination preparations; further enhancement to examiner training, calibration and feedback processes; and the introduction of cultural competence training as a compulsory requirement for all personnel involved in examinations.[21] Marking centres were implemented for the Fellowship Written Examination and as a result inter-marker consistency and reliability have been enhanced.

The *EAG Final Report*, was accepted by the Board and – in the interest of transparency – immediately shared with the ACEM community and released publicly on the ACEM website.[22]

Tony Lawler welcomed the report findings, immediately apologised for the adverse impact that the experience had on the lives of some of those concerned and committed the College to continue to address the 'the very real concerns that have been raised'. He promised that the Board would carefully consider the EAG's findings and recommendations as the basis for development of a comprehensive Action Plan by February 2018. In the interest of a transparent and accountable process he welcomed continued feedback from members, trainees and other stakeholders.[23]

The *EAG Action Plan* was developed over the summer and released in February 2018 and committed the College to a reform and improvement program that would result in ACEM assessment processes being conducted on as optimal a basis as possible. Although the focus was on the Fellowship Clinical Examination, both it and the Fellowship Written Examination were subject to developments.

For example, the Fellowship Written Short Answer Question (SAQ) paper was trialled in an online platform for full implementation in 2020, the advantage being that candidates can provide editable and legible answers that examiners can access, review and score within a single scheduled day. Every answer is marked by two independent examiners and as at least 27 questions are included in the SAQ paper – a total of 54 examiners contribute to the final score for each candidate.[24]

In terms of the OSCE, the College has continued to consolidate work undertaken in previous years. Important initiatives include implementation of a two-day, 12 station OSCE; comprehensive examiner and role-playing briefings, station workshopping and calibration, ensuring a candidate's performance at each station is independently assessed by at least two examiners. A system of electronically generated feedback for unsuccessful candidates has been implemented, along with area of concern reporting. From the 2019.1 OSCE, videorecording of all OSCE stations was implemented

in accordance with the *Policy and Procedure for the Recording of Stations at the Fellowship Clinical Examination (OSCE)*.[25]

By the time of submission of the 2019 AMC progress report (in August 2019) the College had implemented all of the 70 actions to which it committed in the *EAG Action Plan*.[26] However, the matter has not ended as some of those involved in the original complaint remained dissatisfied with the College's response and continue to hold the view that the OSCE is discriminatory. College efforts to address these continuing concerns were unsuccessful and eventually a complaint was made to the Australian Human Rights Commission (AHRC). In July 2019, the AHRC terminated the complaint on the basis that there was 'no reasonable prospect of the matter being settled by conciliation'.[27] The matter has since progressed to the Federal Circuit Court of Australia.[28]

College Administration

Preparations for the College's reaccreditation assessment in 2017 included a significant focus on building staff expertise to enable the College to effectively deliver its core educational and training activities at the desired standard. The staff profile from this point has focused on an increased requirement for capacity to provide strategic direction and planning and support the delivery of that work. Additional to the appointment of Lyn Johnson, the Policy and Research department was enhanced with the establishment of a Project Management Unit (PMU).[29]

From late 2016, the College management structure centred around five organisational units – the Office of the CEO and President, Education and Training, Operations, Communications and Engagement, and Policy and Research. The CEO and the Executive Directors of each unit constitute the College's Executive Leadership Team (ELT). On the basis of the results of a staff engagement survey conducted in July 2018, an organisational review and restructure was undertaken, with the reduction of the number of organisational units to four through the distribution of the functions of Communications and Engagement to the newly developed Policy and Strategic Partnerships, and Corporate Services. Also arising from that review was a new band of staff denoted as General Manager (GM), whose role is to strengthen internal communications and provide direct support for the College's Executive Directors. In line with the College's strategic priorities, the restructure also facilitated extra resourcing into areas such as policy, research and evaluation, communications, media, global emergency medicine and regional faculty representation.[30]

Experienced and expert staff now drive many of the training and education activities of the College on a day-to-day basis and are recognised as crucial for the College to improve its capacities and deliver its functions. Importantly, an understanding has developed that staff are fundamental to the proper functioning of the College and that the work of the College is progressed through College members who contribute their time on a pro-bono basis and the professional staff employed at the College working together in partnership.[31]

An Outwardly Focused Organisation

While the College had focused to 2015 on internal issues, as its education and training programs were revised and governance arrangements modernised, more recently it has also developed an increasingly outward focus, placing a significant emphasis on developing its capacity for positive engagement with health care services and jurisdictions.

In part this reflects changed expectations about the role and function of the specialist medical colleges in Australia and Aotearoa New Zealand, which now extend well beyond selection and education of trainees, and encompass a broad combination of advocacy and representation at multiple levels of community and government.

Increasingly, College decisions and activities are informed by consultation and collaboration with various jurisdictions and agencies, and the membership of College entities has been widened to include community representatives, with the provision as required to appoint jurisdictional representatives. This ensures that the necessary breadth of stakeholder input is available to enable informed decision making.

Areas of significant collaborative involvement have included working with external entities to address complex workforce issues and consultations with the Indigenous health sector and Indigenous community organisations to develop effective programs for improving Indigenous health experiences and outcomes. Underpinning the College commitment to working collaboratively with Indigenous groups is the concept of equity of access. Work in this area is informed by the College's developing sense of, and commitment to, the principles of social justice.

Workforce planning and strategy

At the end of 2014, Tony Lawler acknowledged the continued evolution of the emergency medicine workforce was a complex and multi-faceted problem that required strategic consideration of workload, staffing models and the geographical distribution of FACEMs in Australia and Aotearoa New Zealand.[32] At that time, the immediate problems were projections of an oversupply of emergency physicians in metropolitan areas while significant shortages persisted in rural and regional centres. As John Bonning noted, the problem was maldistribution, rather than true oversupply, and characterised by a paucity of metropolitan jobs and a surplus of regional vacancies.

An oversupplied workforce was a new experience for emergency medicine, but growing anecdotal evidence suggested it was a reality. New FACEM graduates in Aotearoa New Zealand, reported 'exit block' – 'the phenomenon whereby new Fellows cannot find work in specialist roles'; while in Australia new Fellows were sometimes offered 'zero hours' contracts – employment by hospitals, without a guarantee of regular shifts.[33]

Studies from Health Workforce Australia (HWA) and Health Workforce New Zealand (HWNZ) added weight to these observations. The HWA's 2012 report *Health Workforce 2025 – Volume 3 – Medical Specialties* estimated that between 1,780 and 2,041 FACEMs would be needed in Australia by 2025. Based on 2009 data, HWA concluded that the FACEM supply in 2018 would likely equal

demand and that by 2025 supply would slightly exceed demand.[34] Likewise, HWNZ modelling suggested that employment prospects for emergency medicine specialists might be limited at some point in the next five years owing to the current relatively high ratio of trainees to consultants.[35]

Voices from within and outside the College called for workforce issues to be addressed. New Zealand authorities urged the College to develop better strategies for increased rural and regional placement of trainees,[36] while some New Zealand FACEMs were concerned about 'unlimited trainee numbers entering training'.[37]

The College proposed to address these issues through a strategy of targeted advocacy, supported by research and analysis.[38]

To this end, the College committed to a regular schedule of meetings between senior College office holders and staff and senior politicians and health bureaucrats, with the aim of creating opportunities for collaborative dialogue and finding workable solutions, while also providing an opportunity for ACEM to raise its concerns and understand jurisdictional workforce requirements. By mid-2017, the College had conducted an initial round of meetings with all Australian state and territory and New Zealand Ministers for Health and senior health department staff, and was collaborating extensively with workforce planners in both Australia and Aotearoa New Zealand.

At a College level, this strategic focus was informed by improved data collection in regard to the emergency medicine workforce and work in relation to factors that contribute to workforce retention.[39] From 2016, data collection has been enhanced with the implementation of the *Annual Site Census* which collects information from ACEM accredited emergency departments about workforce, workload and resources. The *New FACEM Early Career Survey* – a biannual survey distributed since 2014 – provides data on trends and themes relating to work profiles, future career paths, challenges and progression through the training pathway.[40]

The *Regional, Rural and Remote Emergency Workforce Project* – funded under the auspices of the National Program – was commenced in late 2016. Its aim was to 'understand and define gaps in regional, rural and remote emergency care provision'. The project collected data from almost 200 regional, rural and remote sites and has made a significant contribution to the College's understanding of the number and type of patients treated by non-metropolitan Australian emergency departments, many of which were unaccredited for FACEM training.[41]

Throughout 2016 and 2017, the College worked collaboratively with the Australian Government Department of Health (DoH) and the National Medical Training Advisory Network (NMTAN) to develop the report *Australia's Future Health Workforce – Emergency Medicine*. College collaboration was extensive and included data provision, working with the DoH Workforce Data, Analysis and Planning Team to review and provide advice on scenarios, analyses and interpretation of supply and demand modelling of the Australian emergency medicine workforce.[42]

All of the modelling indicated an oversupply of FACEM numbers across the timeline analysed (to 2030), along with the continuation of maldistribution of the overall available medical workforce.[43] As early as October 2016, the College

was aware that if the current trainee enrolment rate was maintained there was the prediction of a 100% oversupply of emergency medicine specialists by the mid-2020s. This modelling informed College discussions going forward and internally resulted in the formation of the Trainee Selection and Workforce Planning Reference Group (TSWPRG) as an advisory body to the College Board. The TSWPRG was tasked with strategic development of policy relating to both trainee selection and workforce planning.[44]

Key recommendations of the *Australia's Future Health Workforce* report included regular monitoring of supply and demand, and a reduction in the overall trainee intake (to approximately 122 by 2022), initially through standard-based entry selection processes and possibly in the future through setting limits on the number of trainees accepted into the training program.[45] Further stakeholder collaboration was also a key recommendation and one fully supported by ACEM.

Recognising the importance of ensuring access to an adequately trained workforce capable of delivering safe emergency care to regional, rural and remote communities, ACEM has worked proactively to improve emergency medical education in rural and regional areas in Australia over a number of years, notably, but not exclusively, through components that make up the National Program. Through the EMET program it has up-skilled workers (medical and allied health) in rural and regional areas without specialist emergency care. Similarly, since 2012 the Specialist Training Program (STP) has afforded opportunities to increase the range of settings in which FACEM training can be offered.[46] More recently, the Integrated Rural Training Pipeline for Medicine (IRTP) initiative and the Training More Specialist Doctors in Tasmania measure (the Tasmanian Project) have provided opportunities. There is some indication that these initiatives have proved effective with recent ACEM data suggesting a slight increasing trend for FACEMs to work in rural and regional areas. In 2014, 12.9% of new FACEMs were employed in rural, regional and remote areas; however, in 2018 this had increased significantly to 31.4%.

College data, consultation and collaboration extensively informed the Department of Health's review of the STP and the Emergency Medicine Program (EMP) (the National Program). This review was ordered in March 2015, with the general aim of identifying potential shortages or oversupply of specialties, and to suggest and identify reforms and efficiencies in both programs in order to ensure that future Australian Government investment in the program was well targeted.[47]

The initial review process concluded that both programs were effective in their current iterations and recommended that the present funding level continue.[48] However, on the basis of the NMTAN data and findings, the Department consulted with ACEM to determine an appropriate adjustment to the support provided by the EMP.

Discussions with DoH settled on a reduction in funded training posts from 112 to 77 in 2018 and 57 in 2019 and 2020, with 50% of the posts in rural and regional areas and 30% in the private sector. As part of the changes both the IRTP and the Tasmanian Project were brought under the auspices of the National Program, and in 2018, ACEM was allocated a further eight IRTP posts in addition to the four posts it had in 2017.

EMET funding was continued for a further three years[49] with the DOH agreeing that ACEM was best placed to deliver this respected emergency care training. Going forward though, it suggested that ACEM consult formally with key stakeholder groups on the future implementation and oversight of the programs in order to ensure that EMET funding was aligned appropriately to emerging regional health service needs.[50]

Although applicable to doctors practising in metropolitan areas, the rationale for the College developing and introducing the EMC and EMD programs was in no small way prompted by the EM workforce situation in rural, regional and remote Australia, and the desire for the College to have a stake in the provision of quality training and education to support the availability of an appropriately skilled workforce in these locations.

In 2018 ACEM commenced a review of both the EMC and EMD programs. Under the auspices of the ACEM Board, the review was conducted by the EMC/EMD Review Working Group, whose membership included representatives of ACEM, RACGP, ACRRM and the Division of Rural Health Medicine (DRHM) of the Royal New Zealand College of General Practitioners (RNZCGP). Underpinning this initiative was the need to ensure that the structure and content of the program remained in the best interests of all stakeholders, while also acknowledging developments, such as the push to recognise rural generalism as an area of specialist practice under General Practice of NRAS.

The working group's task was to examine the purpose, structure and content of both programs to ensure maximum synergy between these programs and those offered by other, non-EM specialist colleges (notably RACGP and ACRRM), while also ensuring maximum utility for potential workforce developments and initiatives.[51] The recommendation of this review was a three-tiered format with the EMC, EMD and new Emergency Medicine Advanced Diploma (EMAD) as "nested" curricula; that is, a structure that enabled completion of one program to build toward another. Notably, while the EMC would remain a program of six-months duration, the revised EMD program would require only a further six months, and the newly developed EMAD a further six months on top of that. The ability to complete the EMD program in twelve months, as distinct from eighteen was recognised as a key requirement if the EMD was to remain practical in the context of a changing environment.

On completion of EMAD, the review proposed that doctors would be sufficiently skilled to work as a director in an ACEM-unaccredited emergency department. The review has proposed that doctors who complete the EMAD would be well-suited to undertake ED management roles in rural and remote regions of Australia and Aotearoa New Zealand.[52] The proposal has been accepted by the Board, with introduction scheduled for trainees entering the programs from 2021.

While the College has on numerous occasions considered introducing a compulsory rural or remote rotation/placement as a component of FACEM training – a strategy championed most emphatically and consistently – by the College's Rural, Regional and Remote Committee, committing to such an approach and finding consensus has proved difficult, in part due to the differing views of groups within the College, as well as the complexities

involved in ensuring effective implementation for ACEM's very large trainee group.

Since 2014 the College has introduced 'Linked-ED accreditation' - usually for smaller regional centres and private EDs. Linked-EDs are formally linked to a fully accredited 6, 12, 18 or 24-month accredited ED or a network of fully accredited EDs, allowing them to access the educational resources of that site, such as weekly grand rounds and morbidity and mortality meetings.[53]

More recently, strategies have been aimed at the development of rural emergency care networks in Australia and Aotearoa New Zealand, either through initiatives such as the IRTP, or through discussions with individual jurisdictional health departments or their equivalents. Under this system emergency care in rural, regional and remote areas is provided in health facilities by staff across different specialty areas including general practitioners, rural generalists, nurses, health workers and paramedics with extended emergency care skills. Each healthcare facility has a unique model of service that reflects the skills of individual workers (and includes development of PHRM).[54]

The quest for a solution to the issue of maldistribution of the medical workforce in all areas, not just emergency medicine continues and the College is actively working at collaborative arrangements with governments in Australia and Aotearoa New Zealand to develop individual solutions, aware that a national workforce strategy continues to be an aim in both countries.

Since 2018, the Australian Government has taken forward work to establish a national medical workforce framework through the Medical Workforce Reform Advisory Committee (MWRAC) (NMTAN until March 2019). NMTAN was renamed to reflect the committee's broadening role.[55] MWRAC has advised development of a National Medical Workforce Strategy, which it describes as a collaborative vision for how the investment of individuals, doctors and organisations are best coordinated for Australia's health system. The first stage of development is the development of the National Medical Workforce Scoping Framework.

In Aotearoa New Zealand, the entity Health Workforce New Zealand, in operation from 2009 to 2019 has had its activities absorbed into a Directorate of the Ministry of Health. Similar to its neighbours to the West, Aotearoa New Zealand also suffers from a maldistribution of medical workforce - amplified by its smaller population and workforce numbers - as well as the distribution of funding through 18 District Health Boards (DHBs).

The College commitment to workforce planning and development remains strong but it has acknowledged that development of workforce strategies on both sides of the Tasman will, of necessity, guide further College activity in this area. Thus, while the College acknowledges the need for proactively undertaking considerable activity in relation to workforce reform, it recognises also that it is limited to the extent to which it can, in isolation, progress widespread workforce reform. Reforms such as a reduction in the number of emergency medicine specialists needing to be trained and adoption of models of care that are more reliant on appropriately trained non-specialists, can only be developed and implemented in consultation with other stakeholders.[56]

The continuing complexity and importance of workforce matters is reflected in the Board's August 2019 decision to reconfigure the Trainee Selection and Workforce Planning Reference Group as the Workforce Planning Committee reporting directly to the ACEM Board.[57] To further emphasise the importance of this aspect of work, Simon Judkins – the (by now) Immediate Past President – was tasked with the role of chairing this Committee and overseeing the process of discussions of potential bespoke solutions or initiatives with individual jurisdictions relating to EM workforce, particularly those aimed at addressing maldistribution.

Member support, awareness and advocacy

The 2015–2018 Strategic Plan indicated that going forward the College would actively work to represent, support and protect the interests of its members. The Workforce Sustainability Survey conducted in June / July 2016 initially informed work in this area. The survey was dedicated to understanding the issues around career longevity, physician wellness and burnout in the EM workforce and has provided guidance for ACEM to develop appropriate support strategies focused on maintaining emergency physician wellness and sustainable working practices. The College has developed a range of resources to assist members and trainees in this area. These include online resources such as those accessed through the ACEM Wellbeing Network and dedicated membership and wellbeing staff within the ACEM Membership and Culture Unit. A further initiative is the ACEM Wellbeing Award which is awarded annually and recognises members and trainees who are proactively putting in place strategies to encourage and promote the physical and mental health of emergency department staff. Commitment to member support also underpinned the College's initial undertaking to investigate the prevalence of discrimination, bullying and sexual harassment within the College and emergency medicine workplaces in 2015.

In keeping with the College's strategic commitment to raising awareness of the work of emergency physicians, a number of endeavours since 2015 have successfully extended the public profile of both the College and emergency physicians. An important contribution was the publication of *Emergency: Real Stories from Australia's Emergency Department Doctors* in 2015. *Emergency*, edited by Simon Judkins, is a collection of 'real stories from emergency physicians' from around Australia and Aotearoa New Zealand about their work, and seen as providing a way 'for the public to appreciate and understand the daily work of emergency medicine doctors and nurses'.[58] This work continues through the *Real ED* website that features some of the contributors telling their stories and invites others to submit their own story.[59]

ACEM's ongoing social media campaign successfully connects a virtual community of ACEM members and the wider community. Building on a limited profile established in 2011, the College took a step forward in 2015 by hiring dedicated staff to manage the official College Facebook, Twitter and Vimeo accounts and the websites of the ACEM Foundation, ACEM Events and *Emergency Medicine Australasia* (EMA). Utilising these accounts to share news, college events, training tips and educational updates, ACEM more than doubled its social media presence in 2015.[60]

From late 2016, ACEM's internal and external communications strategies were the responsibility of a dedicated Communications Unit and as a result ACEM's profile has grown substantially across all media platforms. The College's media profile since early 2017 has been successfully enhanced with regular media releases on a range of issues, including commentary on state and territory budgets, access block, health funding and public health warnings along with highlighting the achievements of ACEM members.

ACEM's new website, launched in February 2018, was also a major contribution in this area. Its development successfully makes 'accessible [for the general public] the breadth of work ACEM delivers across Australia and New Zealand'.[61]

Other communication improvements – contributing to raising ACEM's profile – have included more central College support and media liaison for the Regional Faculties enabling them to target local issues and raise awareness of emergency medicine care. Since early 2017 the College has provided remote staff support through its offices in Melbourne which, from an operational point of view, provides a level of support that ensures coordination of College activities at a regional and an overall level.[62]

The prospect of the reintroduction of a College magazine-style publication, missing since the decision to cease the publication of *Your Direction* in 2009 was revived in 2018. The rationale for this was that much that was being achieved by the College across all of its core and strategic areas of activity was falling through the cracks between *EMA* as a refereed academic journal and the (increasingly) electronic forms of communication, including social media platforms. This was particularly the case for "good news" stories, leading to the ACEM Board decision to introduce – on a two-year trial basis, and with a review after the first year – the magazine style publication *yourED*. Guided by a Publications Steering Group with diverse membership, the first edition of *yourED* appeared in July 2019.

Advocacy efforts have also substantially raised the College profile and from 2015, as Anthony Cross notes, the College has become involved in matters it hadn't before. These include public policy advocacy on issues such as the plight of asylum seekers, the harmful effects of drugs, alcohol and speed as well as environmental concerns.

In 2015 ACEM provided 50 submissions on a range of issues impacting on the practice of emergency medicine in Australia and Aotearoa New Zealand, and on training and education in the specialty. Involvement in the public health arena included a submission to the Queensland Parliament about the *Alcohol-fuelled Violence Legislation Amendment Bill*, and ongoing consultations and advocacy – in collaboration with RACS and the RACP – with the Northern Territory Government over concerns about open road speed limits. Contributions to public debate in areas such as climate change, alcohol harm and drug abuse helped raise ACEM's public profile during this period.[63] The Public Health Committee (PHC) remained very active with involvement in the *Choosing Wisely* campaign launched in 2015.

In subsequent years College submissions have continued to be substantial with an average of 40 submissions to external public consultations on an annual basis. The College's commitment to decreasing alcohol harm within

the community and emergency departments continues through activities such as its annual snapshot survey of alcohol presentations treated within a 24-hour period, the *Alcohol Harm in EDs* project and joint collaborations with other medical colleges, such as RACS and the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and organisations, such as the Foundation for Alcohol Research and Education.[64] Extensive work in this area was recognised in 2017 with a VicHealth Award for ACEM's fourth annual Alcohol Harm Snapshot Survey.[65] The New Zealand Faculty, likewise, undertook advocacy activities focused on drug and alcohol use and abuse.[66] In the Northern Territory, the Faculty engaged with police, other emergency services and social and community welfare providers on issues such as police presence at alcohol outlets, the reintroduction of the Banned Drinkers Register and met with the local Minister for Health to discuss a range of issues including alcohol reform.[67]

By 2018 ACEM's advocacy profile was well established and its initiatives effective. Simon Judkins reported 'enormous strides' in moving ACEM into a position of strength in advocacy, while also noting that 'there was still much to do'. At the same time the College proactively addressed issues of social justice with a focus on issues of equity and access on behalf of vulnerable patients and communities, particularly in the areas of mental health and Indigenous health reform.

Equity of access – Indigenous health

Throughout this period, the College has committed significant resources to ensure that the voices of Indigenous populations in Australia and Aotearoa New Zealand are heard. It has continued to develop initiatives that address Indigenous access to high-quality medical care and to develop pathways and support mechanisms for increased participation of Indigenous doctors in delivery of this care.[68] Significant in this respect was the development and launch of the ACEM Innovate Reconciliation Action Plan in early 2017 and the Manaaki Mana program in 2019.

Indigenous Health and Reconciliation Action Plans

The Reconciliation Action Plan (RAP) program is an initiative of Reconciliation Australia and provides a framework for organisations to support the national reconciliation movement. A RAP is a strategic document that includes practical actions to drive an organisation's contribution to reconciliation and supports development of respectful relationships and the creation of meaningful opportunities for Aboriginal and Torres Strait Islander peoples. Reconciliation Australia supports four types of RAP programs for workplaces – Reflect, Innovate, Stretch or Elevate.

Development of an ACEM RAP was first suggested in 2015 and immediately supported by the Board as key to ACEM's 'cultural maturation and strategic priorities'.[69] It was developed throughout 2016 by an ACEM Reference Group that included ACEM Fellows and trainees, Indigenous community representatives and organisations and senior ACEM staff, along with representatives of CAPP, COE and the ACEM Foundation. After an extensive consultation process, the Plan was endorsed by Reconciliation Australia before endorsement by the ACEM Board in October 2016.

The RAP is described as a 'series of practical, achievable and meaningful actions' embraced by the College to bring the culture and health of Aboriginal and Torres Strait Islander people into every facet of ACEM business'.[70] It promotes awareness and respect of Aboriginal and Torres Strait Islander cultural needs in emergency departments and encourages and supports Aboriginal and Torres Strait Islander medical graduates to undertake specialist training in emergency medicine. It also aims to close the gap in health outcomes through establishing and consolidating relationships, respect and opportunities with, and for, Aboriginal and Torres Strait Islander peoples.[71] ACEM, through RAP, also sought to provide enhanced employment opportunities in administrative areas.

In summarising the outcome of the first RAP, ACEM considered it had made good progress to embed reconciliation in College business. Achievements included creation of the head office as a welcoming environment for Aboriginal and Torres Strait Islander people, the provision of regular cultural competency training for ACEM staff and members, and development of human resources practices that encourage the recruitment and retention of Aboriginal and Torres Strait Islander professional administrative staff. College celebrations to mark NAIDOC week, National Reconciliation Week, Close the Gap Day, also foster cultural awareness and competency for all ACEM staff. In 2018 the College staff also celebrated Matariki and Te Wiki O Te Reo Māori (Māori language week).[72]

The RAP Steering Group has successfully established and consolidated partnerships with key Indigenous organisations such as the LIME Network (Leaders in Indigenous Medical Education) and AIDA (Australian Indigenous Doctors Association). In 2018 a Special Skills term for Indigenous Health was introduced for FACEM trainees. The placement allows trainees to develop the necessary knowledge and skills to work with Aboriginal and Torres Strait Islander patients and their families in a culturally safe way.

Reporting about the RAP to the AMC in 2019 in relation to one of the accreditation conditions, the College reported that:

> *Under the oversight of the RAP Steering Group … 95 of the 104 specific deliverables were completed, with the remaining nine (9) deliverables being categorised as 'in progress' in the RAP Final Status Report … and carried over to the College's 2019 – 2021 RAP.*

ACEM has taken this work forward with a second RAP for 2019–2021 that aims to build on the foundations of the first with a focus on supporting and growing the Indigenous emergency physician and ACEM staff workforce, further integration of cultural safety into emergency departments and ACEM staff practices, and continuing to strengthen relationships with key external stakeholders.[73]

Manaaki Mana

The College has an equal commitment to improving health outcomes for Māori and has developed a separate process to achieve this aim.[74] In 2017 the New Zealand Faculty commenced the Māori Engagement and Cultural Competence project that looked at a range of initiatives to attract Māori

medical students to emergency medicine, support Māori trainees, and heighten cultural competence in medical practice within New Zealand emergency departments.[75]

In March 2018 a meeting to explore the development of a strategy to address equity for Māori patients, their whanau (extended family and increasingly friends without kinship ties) and staff in emergency departments was held in Auckland. At this meeting a broad range of stakeholders working in emergency departments, health research and other colleges met to discuss ways in which ACEM could work in partnership to achieve equity for Māori in emergency departments. The meeting was a joint project between the Indigenous Health Subcommittee and the New Zealand Faculty.

After the meeting, the Manaaki Mana Steering Group was established to develop an appropriate strategy. This work resulted in development of the *Te Rautaki Manaaki Mana Excellence in Emergency Care for Māori, May 2019 – April 2022* (Manaaki Mana). Manaaki Mana outlines the College's commitment to achieving health equity for Māori patients, whānau and staff. Like RAP, Manaaki Mana has a focus on providing practical ways for delivery of health equity, while also seeking to redress imbalances and misunderstandings in both culture and care.[76]

The Manaaki Mana implementation plan has 18 goals – chief among them are clear communication of the vison of Manaaki Mana to stakeholders, development of partnerships to progress shared goals and advocacy to embed the Manaaki Mana strategy in emergency departments. Similar to a RAP, Manaaki Mana strives to create a welcoming physical environment in emergency departments that supports Pae Ora (healthy futures) for patients, whanau and staff. It aims to weave cultural practices of compassion and care into emergency care, and increase the Māori emergency medicine workforce to represent the community they serve, and create appropriate resources for all emergency medicine trainees and Fellows to support culturally sensitive and competent care in emergency departments.[77]

Supporting Indigenous doctors: the role of the ACEM Foundation

The College supports and encourages Indigenous doctors to become emergency physicians through its philanthropic arm, the ACEM Foundation. Launched at the 2013 ACEM ASM, it was initially proposed that the ACEM Foundation include, and oversee, the Emergency Medicine Research Fund (EMRF) and the International Development Fund (IDF); however, as the College's commitment to Indigenous Health has developed, this too has become an area for support. The Foundation now supports philanthropically three pillars of activity: Emergency Medicine Research, Global Emergency Care and encouraging and supporting Aboriginal, Torres Strait Islander and Māori doctors in undertaking emergency medicine training.

A number of scholarships have been recently established to support this latter initiative:

- The *ACEM Foundation Conference Grant: Promoting Future Indigenous Leaders in Emergency Medicine* was established in 2015 and supports Aboriginal, Torres Strait Islander and Māori medical practitioners, medical students and other health professionals to attend either the ACEM Winter Symposium or the ACEM Annual ASM.

- The *Joseph Epstein Scholarship for Indigenous Advanced Emergency Medicine Trainees* provides ongoing financial support (annual training fees and the cost of one attempt at the Fellowship examination) for Aboriginal, Torres Strait Islander and Māori Advanced Trainees.
- In 2019, the ACEM Foundation established the *Emergency Medicine Certificate Grant for Aboriginal and Torres Strait Islander and Māori Medical Practitioners* with the aim of increasing participation of this group in the ACEM EMC.

The Foundation further supports Indigenous medical education through sponsorship of the annual conferences of AIDA and LIME since 2015. It has also supported the Te ORA Hui-Tau Scientific Conference, as well as the Pacific Region Indigenous Doctors Conference (PRIDoC). The ACEM Foundation's support of these conferences is considered important as it provides an opportunity to actively promote the FACEM Training Program, the EMC and EMD, and other College initiatives.[78] The College's involvement at this level provides opportunities for increased recruitment, selection and engagement of prospective and current Aboriginal, Torres Strait Islander and Māori trainees and Fellows.[79] In the past three years six Aboriginal and Torres Strait Islander and eight Māori trainees have entered the FACEM Training Program.[80]

Beyond this the College encourages members and trainees of Aboriginal, Torres Strait Islander and Māori descent to self-identify as such with the aim of establishing with certainty, the involvement of Indigenous doctors in emergency medicine practice. ACEM has championed this initiative through the Council of Presidents of Medical Colleges (CPMC) in Australia and the Council of Medical Colleges (CMC) in Aotearoa New Zealand.[81]

In 2020, the College continues to strengthen its commitment to improving equity of access and outcomes for Aboriginal and Torres Strait Islander peoples and Māori. The Strategic Plan for 2019–2021 includes a commitment to champion cultural safety in emergency departments. As well, in June 2020 College members voted to include a new Object in the College Constitution stating the College's commitment to excellence and equality in emergency care for Aboriginal and Torres Strait Islander peoples and Māori in Australia and Aotearoa New Zealand. Current President John Bonning describes this as an important step that builds on the work undertaken in the past decade to improve cultural safety and partner with First Nations peoples to address health inequities.[82]

Equity of access – Mental health advocacy

The College interest in mental health advocacy dates from 2017 and reflects the concerns of many ACEM members that mental health patients presenting to the emergency department often experienced unexpectedly long stays while they waited for admission for specialist inpatient care'.[83] Members' concerns led ACEM to closer exploration of the issue and resulted in a snapshot survey of mental health presentations in Australian and New Zealand emergency departments accredited by ACEM undertaken in December 2017. The survey showed alarming rates of access block for mental health patients who required inpatient admission across all hospital systems. On the survey night, mental health patients while comprising approximately 4% of all ED

presentations, accounted for 25% of access block in urban hospitals and an alarming 47% in rural areas.

In February 2018, the results were published in a brief report *Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions*.[84] This development marked the beginning of an ACEM-led conversation in both Australia and Aotearoa New Zealand about how mental illness could be better managed in the acute care context and the broader health system. ACEM called for action from governments in Australia and Aotearoa New Zealand to address the issue and develop new policies to support shorter stays in the emergency department for this group of patients. Suggestions for improvement included alternative models of care with a focus on after-hours community care, reporting of mental health access block exceeding 12 hours to the relevant Minister or other appropriate body; improved ED design to better support the wellbeing of those patients experiencing acute mental and behavioural problems (quiet, low stimulus and private spaces away from noisy busy and brightly lit EDs) and increased funding for community-based and inpatient mental health and alcohol and drug services.

Launching the study and the campaign in Australia, ACEM advocated for a multidisciplinary approach to improve patient outcomes.[85] Similar calls to action were made in Aotearoa New Zealand where mental health presentations comprised 3.7% of total ED presentations, with 25% of these experiencing access block.[86]

Throughout the year ACEM met with politicians in Australia and Aotearoa New Zealand to advocate for health system responses that address discriminatory treatment practices and improve overall outcomes for this patient group. In May 2018 it made a submission to the Senate Inquiry into the Accessibility and Quality of Mental Health Services in Rural, Regional and Remote Australia and appeared before the Inquiry in August 2018. ACEM advocacy culminated in the Mental Health in the Emergency Department Summit held in Melbourne on 16 October 2018. This key event – jointly hosted with RANZCP – brought together more than 170 emergency doctors, psychiatrists, consumers, clinicians and key decision makers.

Following the summit, ACEM in collaboration with the RANZCP developed the *Mental Health in the Emergency Department Consensus Statement*. Published in May 2019, the statement was addressed to commonwealth, state and territory parliamentarians and made the following key recommendations:

- All Australian Governments act urgently to engage people with lived experience in reforms that deliver timely access to appropriate mental health care, with an immediate focus on after-hours care in the community.
- When psychiatric admission is required, processes need to be timely and streamlined so that acutely unwell people can access an appropriate inpatient bed any time of day or day of the week
- State and territory health departments adopt a maximum 12-hour length of stay in the ED, by providing accessible, appropriate and resourced facilities to allow for ongoing care beyond the ED, with mandatory notification and review of all cases embedded in the key performance indicators of public hospital CEOs

- All 24 hour waits in an ED should be reported to the Health Minister regularly, alongside any CEO interventions and mechanisms for incident review.

A further summit, held in Aotearoa New Zealand in June 2019, brought together 80 delegates (doctors, nurses, patient advocates and systems managers) who agreed that collective action was urgently required to improve the care of people suffering mental health crises across Aotearoa New Zealand, including within emergency departments.[87]

Welcome developments following the Australian summit have included the introduction of mandatory reporting of instances where patients with mental health presentations experience excessive wait times in emergency departments in both the Northern Territory and Western Australia. (These measures had been in place in Victoria for some time).[88]

More recently, ACEM has welcomed the Australian Government's focus on mental health in the country's *Long Term National Health Plan* announced in August 2019 and the New Zealand Government's, acknowledgement of the problem and $1.9 million investment in mental health services as part of its Wellbeing Budget.[89]

Addressing discrimination, bullying and sexual harassment

At the end of 2015 the College agenda had expanded to include a commitment to investigate the prevalence, if any, of discrimination, bullying and sexual harassment within the College. It was one of several initiatives focused on supporting the College membership to enjoy a 'long and rewarding career in emergency medicine'.[90]

The College's interest was motivated by claims of bullying and sexual harassment within RACS and brought to light in 2015 by surgeon Gabrielle McMullin. McMullin claimed that sexual harassment was rampant in the profession and that perpetrators of harassment and abuse acted with impunity. Her 'remarks sparked a firestorm in the press, [and unleashed] a wave of similar stories'. RACS appointed an EAG to investigate the claim and its final report published in September 2015 'detailed a culture of endemic bullying, sexual discrimination, and sexual harassment where power imbalances meant junior staff were afraid to speak out'. RACS was apologetic, with the CEO admitting that behaviours were not meeting the standards of the organisation and that while lip service was afforded the standards, 'the difficult task of ensuring standards were being maintained was not being undertaken'.[91]

Following release of the RACS report, the ACEM Board acknowledged that the College and the specialty of emergency medicine could have a similar problem, and that in the interest of the strategic priority of member support some investigation was warranted.[92] A working group was subsequently established within CAPP to develop a proposal for taking this work forward. Sally McCarthy, Simon Judkins, Didier Palmer, Suzanne Smallbane, Viet Tran and John Bonning formed the initial membership of this group, which in February 2016 presented a two-phased proposal for investigation and action along with the suggestion that the group should expand to include members of COE, trainees, new Fellows, and community members. The proposal

suggested data collection and member consultation, followed by development and implementation of solutions. In order to ensure confidentiality and safety for all members, the working group recommended engaging an external agency to undertake the work. The proposal was approved by the Board in April 2016, and formally announced as the ACEM Discrimination Bullying and Sexual Harassment (DBSH) Project in August 2016.

The DBSH survey was conducted in April–May 2017 and followed up with a series of member interviews and forums. Plans to commence this project were well underway, when anonymous allegations of racial discrimination in the 2016.2 Fellowship Clinical Examination OSCE were made in January 2017. Following receipt of these allegations, the questionnaire was expanded to include questions regarding College assessments.[93]

The survey and consultation findings were confronting for the ACEM Board and the problem much worse than first thought, being on a par with that reported in other specialities and in a range of local and overseas jurisdictions.[94] The survey indicated that an overwhelming 49.8% of respondents had been subject to discrimination, bullying or sexual harassment, with bullying the most common. Fellows, Provisional and Advanced trainees all reported they had experienced DBSH and with the exception of sexual harassment approximately 25% of respondents had experienced the behaviour in the past six months. Unacceptable bullying and harassment behaviours included belittling, anger tantrums, verbal abuse and inappropriate comments. The most common discriminatory behaviours were gender based and most often related to parenting, pregnancy, breastfeeding and sexual harassment. Exclusion was frequently reported as a discriminatory behaviour. Female survey respondents noted fewer rotation and learning opportunities than male counterparts along with being ignored, interrupted when venturing an opinion or having contributions dismissed as irrelevant. Racial discrimination was also common.

A summary of the findings was included in a membership consultation paper circulated in August 2017 seeking member input for the development of an action plan to address the survey findings. The paper also included a commitment to 'ensure emergency medicine [was] practised in a respectful and inclusive environment' and to 'engage with … members to bring about meaningful cultural change and address the problems caused by some members of our profession'.[95] On the basis of this consultation the ACEM *DBSH Action Plan* was developed and released in February 2018.

President Simon Judkins introduced the Action Plan with optimism and confidence that the plan would empower ACEM trainees and members to lead cultural change in emergency departments and hospitals. The Plan included a commitment to actively develop and support healthy workplace cultures; encourage leadership development and mentoring in both the College and the workplace; diversify membership of ACEM's governing bodies; strengthen existing complaints management processes and ensure that the education and training provided by the College was based on the principles of respect, transparency and professionalism. A key recommendation was the establishment of a *Diversity and Inclusion Steering Group* to develop and monitor a Governance Diversity Action Plan and to oversee implementation of the DBSH Action Plan.

The Plan was launched in February 2018 and progress since then has been significant, meaningful and effective. The Board moved immediately to establish the Diversity and Inclusion Steering Group (DISG). FACEMs Kimberley Humphrey, Anil Kumar and Clare Skinner and FACEM trainees Jessica Forbes, Renee Stamation and Ajith Thampi were appointed as the inaugural members with Simon Judkins appointed Chair and fellow Board member Michael Gorton also appointed.[96]

The DISG's first priority was to develop mechanisms by which greater diversity on the Board could be achieved. The group held its inaugural meeting in July 2018 and released a consultation paper in August seeking the views of ACEM members and trainees about the current diversity of membership across the three governing bodies – Board, CAPP and COE.

The consultation paper outlined current constitutional requirements and regulations relating to the composition of the Board, CAPP and COE along with demographic information about the current incumbents. While response to the consultation paper was disappointing, with only 64 members and trainees providing feedback, 78% of respondents considered that the current membership of these entities did not represent appropriate diversity to optimally inform strategic priorities and conduct College activities. Overall, it was considered there was poor representation of women in College leadership roles with the 100% male membership of the current ACEM Board, the issue of most concern. Respondents also considered that these entities were not representative of the general ACEM membership in terms of geographical location and cultural diversity.[97]

The current lack of diversity was attributed to a number of factors with the time commitment required to participate in these entities identified as the most significant barrier for participation of some cohorts. Particularly as, under the current governance model, contribution as a Board member required previous involvement at a high level in multiple entities, with four of six FACEM Board positions ex-officio and limited to the Chairs and Deputy Chairs of CAPP and COE.

Potential solutions included expansion or reorganisation of the composition of the ACEM Board to allow for more general positions, not associated with ex-officio arrangements, the introduction of gender targets or quotas and greater College advocacy for clinical support time to allow greater participation in College activities.

Following on from this consultation, the DISG circulated the *Diversity in College Governance Position Paper* for feedback from College members and trainees on a series of recommendations in relation to the structure and composition of ACEM's governing bodies. As the majority of comments received related to the need to increase the diversity of the ACEM Board, changes to the ACEM Constitution were developed focussing on this aspect of governance.

The proposed changes were intended to reduce barriers to membership of the ACEM Board. They included removal of the positions of Deputy Chair of CAPP and Deputy Chair of COE from the composition of the Board, creation of two positions on the ACEM Board to be filled by FACEMs appointed from the general membership and appointment of a community representative.

Members voted on the proposed changes during May and June 2019. A total of 936 Fellows voted, with a significant majority (95.3% and 87.4%) supporting both resolutions as proposed – these figures were well in excess of the 75% required for them to be adopted. The changes were incorporated into the Constitution in June 2019, with new appointments made in August. Following a call for nominations from the Fellowship, Rebecca Day and Melinda Truesdale were appointed as FACEM General Members and Jacqui Gibson-Roos as the Community Representative.[98] All three attended their first meeting of the ACEM Board in October.

With the position of the Deputy Chair of CAPP ceasing to be a member of the Board from the AGM in November, the proportion of female ACEM Board members rose from zero percent to almost 30% through this initiative.

Other DISG work has included development of the ACEM Core Values through member consultation and feedback, development and launch of the ACEM Diversity Award, the ACEM Wellbeing Award and a College-wide mentoring program. In August 2018, the DISG recommended making the RACS *Operating with Respect Module* accessible for general member use. The ACEM Board approved its use, acknowledging the general applicability of the matters raised and recognising that it would take significant time and resources to develop similar ACEM material.

Based on feedback about female leadership opportunities in the governance consultation paper,[99] Queensland Faculty Chair and CAPP member Kim Hansen initiated formation of the Advancing Women in Emergency Medicine Section (AWE). With the support of DISG member Clare Skinner, colleagues were contacted, and more than 150 signatures were gathered within 24 hours of circulating a proposal to form a section. The Board strongly supported this initiative and the Section was established in November 2018 to promote and support female leaders within the College and clinical practice as well as provide advice and guidance on gender equity-related matters.[100] The section opened to members in December 2018 and in late 2019 had more than 200 members – most of whom were women.[101]

An AWE executive was elected in April 2019 by Section peers, and a New Zealand appointment made in May 2019. Members of the Executive are Suzi Hamilton, Kim Hansen, Belinda Hibble, Kimberly Humphrey, Jenny Jamieson and Clare Skinner.

This work has been taken forward with development and publication in May 2020 of a *Gender Equity Position Statement* (S738).

Celebrating 35 Years

Throughout its history ACEM has taken various opportunities to reflect on milestones and celebrate anniversaries and achievements. This tradition dates back to 1991 and a series of articles published in *Emergency Medicine* documenting the early days of emergency medicine in Australia and Aotearoa New Zealand, along with the foundation of both the Australasian Society for Emergency Medicine and the College. As the College celebrated its 10th Anniversary in 1993, it also celebrated two other milestones: the National Specialist Qualification Advisory Committee's (NSQAC) recognition of ACEM as a principal specialty and the purchase of College premises at 17 Grattan

Street in Carlton. In 2003 the College marked its 20th Anniversary Year with the award of commemorative Foundation 20 Medals to Fellows and others in appreciation of their contributions to the development of the College in previous years.

The College acknowledged the 35th Anniversary of its foundation with a range of activities across Australia and Aotearoa New Zealand throughout 2018 that included a significant celebration at the 35th ASM in Perth.

Celebrations and commemorations involved development of a 35-year commemorative logo, a social media campaign that included interviews with key contributors to ACEM's development and an interactive timeline of major College events hosted on the ACEM website.

These significant celebrations reflected the ACEM Board's decision in 2016 to honour the work of earlier Fellows and to document and preserve the College's history. Other major projects included establishing a museum display at the College, organisation of the College archives and commissioning this history of ACEM's first 35 years.[102]

More than 900 Fellows and trainees gathered in Perth in November 2018 for the 35th ASM as the culmination of celebrations and commemorations throughout the year. The conference, aptly named "On the Edge", provided an opportunity to look back at the past and acknowledge the substantial work undertaken to make ACEM the organisation it was in 2018, while also looking forward to the future and the College's recent focus on diversity, inclusion and wellbeing.

This dual focus was reflected in the College Ceremony. The College recognised the significant contribution of each of its previous Presidents with the ACEM Presidential Service Medal. Nine of the ten Past Presidents were present at the ceremony to receive the medals and appeared on stage together for a memorable photo along with President at the time, Simon Judkins. The ACEM Board also awarded inaugural Distinguished Service Awards in recognition of significant and committed service to the work of the College, over an extended period of time. Thirty-five such awards – one for each year of the College's existence – were presented to College Fellows. A thirty-sixth award was made to Liv Cameron on her retirement after 27 years at the College working in a variety in a roles.

Looking to the future, Diana Egerton-Warburton delivered the Tom Hamilton Oration "One from the Heart" which was focused on kindness and compassion, while Western Australian FACEM Michelle Johnston opened the proceedings with an evocative performance narrative and a passionate "call to arms" in which she called for an end to bullying and harassment in medicine, gender inequity and discrimination of all kinds.

The ACEM Foundation Lecture was delivered by Professor Tom Calma, an Aboriginal Elder, who was instrumental in establishing the *Close the Gap* initiative in 2008 while *Aboriginal and Torres Strait Islander Social Justice Commissioner* at the Australian Human Rights Commission. His lecture outlined the persistence of the "gap" between life expectancies for Aboriginal and Torres Strait Islanders and non-Indigenous Australians and the importance of working with Aboriginal people to achieve cultural awareness in emergency departments. The lecture continued the trend of previous years

to focus on human rights and social justice and was in line with the ACEM Foundation's objective 'to broaden the remit of the College's pursuits'.[103] In 2016 Associate Professor Papaarangi Reid spoke about cultural safety and the role of the medical colleges, while in 2017 Emeritus Professor Gillian Triggs' lecture *Healthcare for Australia's vulnerable: how can we do better* was critical of Australia's human rights record and pointed out that the credibility and frontline experience of doctors made them essential allies in the human rights movement.[104]

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As 2018 drew to a close, College leaders reflecting on the year just past, acknowledged a 'positive and productive year of activity and growth'[105] in which the College had addressed some significant challenges, and reported pleasing progress in a number of areas. First and foremost was successful negotiation of the College's first full external accreditation in over ten years – an achievement that Simon Judkins acknowledged was a 'testament to all the hard work put in across the organisation'.[106] Other activities of note included implementing the recommendations of the EAG on Discrimination; progressing work arising from the DBSH Action Plan; ongoing development and improvement of the FACEM Training Program; the successful restructure of CAPP entities, along with delivering a big advocacy agenda including the Mental Health Summit. The College had pursued an increasing focus on clinician health and wellbeing, had progressed significant work to support cultural competence and the development and sustainability of the Indigenous health workforce and health outcomes in both Australia and Aotearoa New Zealand. It had collaborated with governments for progress in developing a national workforce strategy in Australia, while also working to secure a role in New Zealand developments.[107]

College CEO Peter White noted that the College was putting in place the culture, resources and infrastructure to ensure its future success. College decisions were increasingly informed by the input of community representatives and the benefit of external expertise, underpinned by robust governance processes. Likewise, College activity and strategy increasingly benefitted from the considered input of members, ably supported by skilled, specialist staff. Significantly, the College had developed a good understanding of the ongoing need to ensure that its activity must always consider the needs of communities and the expectations of external regulatory authorities. Going forward, White considered that these developments and the recently developed strategic plan for 2019–2021: *The Next Phase* set ACEM on a 'strong and stable course for the future'.[108]

At the end of 2018 the College, aware of its history yet focused on the future, was a far cry from when it was founded in 1983. Importantly, though, in its modern iteration it remains an entity '*for*' rather than '*of*' emergency medicine, committed to excellence in education and training, the delivery of emergency care of the highest quality in an equitable and accessible way, supporting the interests and wellbeing of its members, and advocating for, and supporting vulnerable patient groups.

EPILOGUE

THE NEXT PHASE 2019–2020

Although the period covering 2019 and up to October 2020 is outside the scope envisaged for this publication, given the magnitude of world events in 2020, a short discussion of this time is relevant in completing the story of ACEM since 1983 and describing its current position. During this time important work such as the restructure of entities within the Council of Advocacy, Practice and Partnerships (CAPP) and review of both the FACEM Training Program and the ACEM Curriculum Framework has been completed. Good progress has also been made with the significant cultural changes ACEM has embraced as a response to events that gave rise to the *EAG Action Plan* and the *DBSH Action Plan*. The College has continued its strong focus on mental health advocacy and Indigenous health advocacy, while also increasing its commitment to enhancing cultural safety and awareness in emergency departments. ACEM has also commenced new programs of work in relation to research support, global emergency care and advocacy for climate change.

Against the background of ongoing and new work, for most of 2020 ACEM activity has been dominated by the COVID-19 pandemic. ACEM's responses to the pandemic have been effective, and clearly demonstrate that, as the College moves beyond 35 years, it does so with competence and confidence and significant capacity to adapt in changing and challenging environments.

In 2020 the governance changes introduced in late 2014 are well established and proving effective. Three directly elected presidents have chaired the ACEM Board and the College's two Councils: CAPP and the Council of Education (COE) have seen more than one iteration of membership and adjustment of their associated entities.

While the arrangements associated with the structure of COE and its reporting entities have been relatively minor over that time, the review of CAPP committees – begun in 2016 and completed in 2018 – resulted in a significantly changed entity structure adopted for implementation in 2019. Under the new structure, a reduced number of committees are more directly aligned with ACEM strategic priorities, and activities more explicitly linked to the ACEM Business Plan. With this change, CAPP has adopted a more proactive role in identifying and responding to emerging priorities, as well as monitoring the progress of projects and directing College resources to where they can have the most impact.[1]

As part of the CAPP reorganisation, Sections were introduced as a new entity that could sit under the Board, CAPP or COE. The role of a Section is to promote a special area of practice or interest in emergency medicine. Sections are formed by application and have an Executive of 4–6 members, with unlimited wider membership that includes College members, as well as non-members.[2] Sections provide an opportunity for engagement in a particular aspect of activity without the need for a formal standing-committee like structure.[3] Essentially, they replace Special Interest Groups (SIGs), first introduced in the 1990s. In 2018 CAPP had Sections for Advancing Women in Emergency Medicine (AWE) and Geriatric Emergency Medicine (GEMSIG); two further Sections – the Clinical Trials Network (CTN) and the Emergency Department Epidemiology Network (EDEN) – are associated with the Research Committee. By 2020 Sections focused on Trauma, Paediatric Emergency Medicine, Pre-hospital and Retrieval Medicine, and Private Emergency Medicine had also been established.

Direct election of the President has been embraced by the membership, and offers a clear and transparent succession plan for leadership, while also ensuring stability. In the most recent election, more than 1,200 Fellows cast a vote. Clare Skinner was elected President-Elect and will take office following the Annual General Meeting (AGM) on 21 October 2020. Deputy Chair of CAPP since 2019, a member of the College's Diversity and Inclusion Steering Group and an executive member of AWE, she will become ACEM's second female president when she assumes office in 2021. Significantly, with her election and that of Shannon Townsend as the Trainee Member of the ACEM Board, along with the appointment of Libby Pallot as the external (non-FACEM) member of the Board with legal and governance skills, the ACEM Board – in a relatively short time – has moved from an all-male entity in 2018 to a 60% female Board following the 2020 AGM.

College activity from the beginning of 2019 has been guided by the *ACEM Strategic Plan 2019–2021: The Next Phase*. *The Next Phase* builds on the previous strategic plan, insofar as a commitment to excellence in education and training remains the College's core priority, while member support has been expanded to include wellbeing. *Equity through Advocacy* makes clear the ACEM commitment to achieve improved access and outcomes for communities and patient groups. *Research* has been added as a new priority, with a focus on excellence in emergency medicine research and a commitment to strengthen the College's research culture. The strategic priority of *Standards* includes a clear responsibility to set, monitor and maintain necessary standards to provide quality emergency care and commitment to develop member and trainee expertise in emergency medicine related patient safety activities. *Organisational Sustainability* has been widened to include awareness. The Strategic Plan is a meaningful and considered articulation of College strategic priorities where the six Strategic Priorities are underpinned by a total of 36 key outcomes. An associated Business Plan further identifies specific activities to achieve each of those outcomes.[4] Together these documents clearly indicate that the College understands its responsibilities towards the populations and communities it serves.

During this period, the CAPP restructure has allowed the College to undertake new initiatives in the areas of climate change, emergency medical

care in low and middle income countries (LMICs) and promotion of research in emergency medicine, through the CAPP committees of Public Health and Disaster; Global Emergency Care and Research, respectively. Support for these initiatives is provided by various of the College organisational departments, with resourcing linked to these and other strategic priorities.

Global Emergency Care (GEC) is a relatively novel term that emphasises emergency care is team-based and multi-disciplinary, is relevant in community settings as well as hospitals, and is essential irrespective of whether Emergency Medicine exists as a specialty medical discipline in a particular country. GEC is considered a more inclusive term than International Emergency Medicine (IEM) and it was in this spirit of inclusivity that ACEM's International Emergency Committee transitioned to the Global Emergency Care Committee (GECCo) in early 2019.

GECCo, chaired by Colin Banks, has a membership of 15, and its key objectives are to advocate for global health, improve the GEC Network, improve FACEM and trainee engagement in GEC and support capacity building for emergency care in LMICs and promote and facilitate GEC research. GECCo is assisted by ACEM staff attached to the GEC Desk. The GEC Desk provides a point of contact for College Fellows, other members and trainees interested in involvement in GEC, manages the portfolio of ACEM Supported International Projects and has responsibility for establishing partnerships that support locally led, capacity development in LMICs.

GECCo's current work is focused in the Indo-Pacific region with a commitment to collaborative capacity building (rather than crisis response). The College formalised its involvement in this region with a Memorandum of Understanding (MOU) signed in November 2019 with the Pacific Community (Secretariat of the Pacific Community; SPC). The SPC is one of nine members of the Council of Regional Organisation in the Pacific, it contributes scientific and technical expertise to the specific development needs of member countries.[5] Collaboration with the SPC benefits ACEM's ongoing commitments to support development of emergency care staff and sustainable health policies in the Pacific region.[6] The signing of a MOU with each of the Fiji National University and the University of Papua New Guinea in 2018 and 2019, respectively, further signals the College's desire to support the work now progressed through GECCo.

Earlier in 2019, ACEM in partnership with SPC, Monash University and the Australian Aid Program established the Pacific Region Emergency Care Priorities and Standards for Development. This milestone document reflects a consensus on priorities and standards for emergency care across all Pacific Island Countries (PICs) and provides a roadmap for future emergency care development activities in the Region.[7] Based on this work, ACEM developed advocacy infographics designed to educate Pacific Island Countries about the importance of emergency care. These eye-catching documents explain what emergency care is and why it is important for the health of the Pacific peoples.[8]

The College's recent focus on climate change as a public health priority has been spearheaded by the Public Health and Disaster (PHD) Committee. Activities for 2019 included development of ACEM's position statement on *Climate Change and Health* and declaration of climate change as a medical

emergency. The College's interest, concern and commitment for change was reflected throughout the 36th Annual Scientific Meeting (ASM) *The Changing Climate of Emergency Medicine* in Hobart in 2019. The ASM offered keynotes, plenary sessions and papers on topics ranging from warming oceans and bushfires and the contributions of hospital waste to climate change. Dr Bob Brown, former Australian Greens Senator, medical doctor and passionate environmentalist and activist delivered the 2019 ACEM Foundation Lecture in which he spoke about how emergency doctors can use their positions and expertise to advocate for change and action on the issues affecting their work, patients, hospitals, health systems, communities and world.[9]

Activities culminated with ACEM's declaration of climate change as a medical emergency during a climate-themed plenary session on the final day of the meeting. The declaration – made by President John Bonning – acknowledged the increasing pressures already-strained emergency departments will continue to face as the effects of climate change accelerate and become more pronounced. Before the plenary, delegates – some wearing scrubs and carrying placards – marched from the Royal Hobart Hospital to the conference venue during Hobart's morning "peak hour", to raise awareness of the issue – an action not frequently associated with specialist medical practitioners or their professional colleges.[10]

The ACEM Research Committee was established with a clear remit to provide leadership in Emergency Medicine research. It undertook an ambitious program of work that included exploring models to enhance coordination of clinical networks and facilitate multi-site research; increasing funding opportunities; enhancing research opportunities and support for trainees; and increasing the proportion of EDs that have research infrastructure including dedicated and funded research staff. As a first step, the CTN and EDEN were created as sections under the umbrella of the Research Committee. The CTN has focused on improving infrastructure for ED clinician led, multi-site trials, while EDEN has focused on developing options for a national ED linked dataset.[11]

At the conclusion of the 2019 Hobart ASM, the Committee hosted an inaugural research network symposium. This successful event brought together more than 40 researchers from EDs across Australia and Aotearoa New Zealand. As well as discussing the practical aspects of research promotion and development, the symposium included a number of high-quality research presentations on diverse topics.[12]

Establishing a set of core values that clearly define the expectations of Fellows, other College members, trainees and staff was the first recommendation within the DBSH Action Plan and a clear priority for the DISG in 2019. The Core Values – Equity, Respect Integrity and Collaboration – were developed with extensive member, trainee and staff consultation. The values are intended for adoption throughout all facets of the organisation's activities and represent behavioural expectations of all involved in the College. Work in this area has been consolidated with development of a Core Values Online Training Module for use by ACEM members, trainees and staff.[13]

Testing Times

Emergency physicians and their colleagues are trained to deal with the medical consequences of events that happen suddenly or with little warning. Every jurisdiction and hospital has in place a Mass Casualty Incident Plan for activation in response to events such as terrorist attacks, natural disasters and pandemics. In 2019–2020, a mass shooting and a volcano eruption in Aotearoa New Zealand, catastrophic bush fires in Australia and the pandemic of 2020 have tested ACEM members and others in ways not anticipated by even the most experienced of practitioners.

On 15 March 2019, a single gunman attacked worshippers at two Christchurch mosques leaving 51 dead and injuring many others. Some ten minutes after the gunmen opened fire the ED at Christchurch Hospital received its first casualties, including a pre-schooler with life threatening injuries. The hospital's Major Incident Plan was activated and in the next 45 minutes, a further 44 more critically injured victims arrived in the ED. Two hours after the first victim arrived the last one left the ED for theatre. In the intervening period ED physicians, trainees and nurses worked side by side with their colleagues from other parts of the hospital. FACEM Dominic Fleischer attributes Christchurch Hospital's success that day to 'teamwork like I've never seen before'. He describes the effort as the result of 'supreme teamwork, trust, innovate[ion] and workarounds' with everybody working very closely and cooperatively together. Fleischer recalls that everybody played their part – a cardiothoracic surgeon arrived offering to help, along with the Director of Medicine, cardiologists and respiratory physicians. The Blood Bank arrived with much needed supplies, ultrasonographers went from bed to bed, the ED pharmacist kept every team supplied with necessary drugs, orderlies were immediately available to get patients where they needed to be. Hospital cleaners 'worked like a Formula One pit crew', as a patient left a bay it was immediately cleaned and made ready for the next.[14]

For Christchurch Hospital ED, this was the third time in a decade that it had received large and unexpected casualty numbers. In September 2010 97 people were treated at the hospital following earthquakes in the city; five months later on 22 February 2011 a catastrophic earthquake destroyed large parts of the city and brought 231 patients to the hospital within an hour, with many more to follow. As a consequence, disaster planning is well honed – having been revised again and again as new challenges and disasters have visited upon that city – and it certainly proved effective when faced with this latest challenge.

Some nine months after the incident at the Christchurch mosques, Aotearoa New Zealand suffered a second mass trauma event. This time, the volcanic Whakaari / White Island in the North Island's Bay of Plenty erupted without warning on the afternoon of 9 December 2019, injuring 26 people and leaving 21 people dead. The injured were taken to Whakatane Hospital – a small regional hospital in the Bay of Plenty (48 kms away). Kelly Phelps, a FACEM at the hospital, received the news of the eruption and immediately gave the order to activate the hospital's mass casualty plan. Preparations were made – supplies were gathered and teams organised – two hours after receiving the news the first patients arrived. Phelps recounts that patients

arrived three or four at a time; the severity and critical conditions of patients was quickly recognised and every room in the ED became a resuscitation bay with airways, analgesics and comforting words the main priority. Patients were stabilised before transfer to major tertiary centres.

Twenty-one hours after the hospital was notified, Whakatane's last patient was transferred from the campus. In the aftermath, those at the hospital that day and the small community are attempting to recover. Phelps is proud to be a member of the Whakatane Hospital and the community. She expresses gratitude for the help and support received from many places and in many forms, while also acknowledging that 'some scars take a long time to heal'.[15]

In Australia, during the summer of 2019–2020, many parts of the country experienced intense bushfires that claimed the lives of 34 people and caused significant destruction of property, wildlife and livestock. Among the hardest hit locations was the small coastal holiday town of Mallacoota in Victoria's far north-east. On 29 December 2019, road access to the town was lost as a bushfire large enough to generate its own weather bore down on the town. Day became night and 400 people were forced to take shelter on the foreshore as the fire front approached.

ACEM Immediate Past President Simon Judkins and Scott Squires – an emergency physician with the Royal Australian Navy – participated in the emergency response. Squires arrived in Mallacoota aboard the HMAS *Choules* on the evening of 1 January 2020; he was one of two emergency physicians on board. The ship's role was to assist with bushfire relief and evacuate the town.

Squires and his colleagues were the first Australian Defence Force (ADF) personnel to arrive in Mallacoota. Contact was quickly established with the local police, the Country Fire Authority and the Ambulance Victoria Commander. From the outset, Squires writes, the 'teams worked seamlessly together'.

When Squires arrived, the medical centre was 'working well beyond its capacity'. The town's two GPs were assisted by holidaying GPs and nurses; however, the waiting room spilled into the car park, there was no triage facility, nor space to manage critically ill patients. Again, teamwork and cooperation were to the fore; the ADF quickly provided much needed supplies, while also liaising with the medical centre to set up an acute care room and space to manage more unwell patients in the event they were unable to be evacuated. A casualty control/triage facility was established at the front of the medical centre and saw 150 people on the first day.

The majority of the injuries were related to smoke inhalation, and while most people were mildly affected, others – those with asthma and chronic obstructive pulmonary disease – were more seriously affected. Minor burns and musculoskeletal injuries were also common, and many people were understandably anxious and stressed at being cut off from their families and care providers amid a prevailing air of uncertainty. On the first afternoon 45 medically vulnerable people were evacuated.

Simon Judkins arrived by boat on the evening of 2 January as a member of the Field Emergency Medical Officer (FEMO) program run out of St Vincent's Hospital Melbourne. He spent four days at the medical centre where his

role included triage, acute emergency care, sourcing supplies and liaising with others involved in the assistance effort. He too found a high level of cooperation, commenting that 'communication within the local emergency service teams was invaluable' and enabled 'everyone to work together to provide the best possible care in difficult circumstances'.

The most challenging aspects of his time in Mallacoota included adapting to working in an unfamiliar environment and the need to be pragmatic about what could and could not be achieved in limited circumstances.[16]

In April 2020, College President John Bonning, writing the "President's Welcome" for the summer edition of *yourED*, rightly acknowledges the Australian bushfires and the Whakaari / White Island eruption as 'critical life-changing events' that reinforce the potency of the natural world. He pays tribute to those Fellows who have shared their experiences in the current issue, commending their stories as 'really going to the heart of emergency medicine'.

Noting that 2020 'is turning into not quite what we expected', Bonning focuses on the novel coronavirus or COVID-19 and its inevitable impact on the College and its members. He writes that '[f]or now our hearts and minds and lives are occupied by COVID-19, which has upended health systems and the world as we know it'. He reminds readers that the College is there for them and will provide 'support in this fluid and rapidly changing time'.[17]

COVID-19 – the College Response

Australia recorded its first case of COVID-19 – a returning traveller from Wuhan, China – on 25 January 2020. Five days later the World Health Organization (WHO) declared the novel coronavirus a global Public Health Emergency. Following the WHO statement, ACEM called for a calm, respectful and unified response to address the ongoing novel coronavirus situation. The immediate concern for the College were reports of racist abuse being levelled at patients and staff in emergency departments, with the College calling on governments to address this issue and for the media to show leadership and social responsibility.[18]

Almost a month later, as the global situation worsened Australia's Prime Minister Scott Morrison, pre-empting WHO's 11 March declaration of a global pandemic, activated the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)*. With activation of the *Emergency Response Plan*, hospitals, jurisdictions and other health entities began preparations for managing this developing health emergency. After the government announcement, ACEM members and staff, in collaboration with Safer Care Victoria, began developing a set of clinical guidelines for the management of COVID-19 in Australasian emergency departments. As this work began, New Zealand recorded its first case of COVID-19 on 28 February 2020.[19]

The guidelines were completed at the end of March and published on the College website as *Clinical Guidelines for the management of COVID-19 in Australasian emergency departments*. The document provided a comprehensive framework for all emergency departments across Australia and Aotearoa New Zealand – regardless of circumstance – to work from as they planned and responded to the pandemic. Created as a 'living document', the guidelines

have been regularly reviewed and updated as necessary to ensure they remain current and reflect best practice in a continually evolving situation.

Recognising the crucial role that hospital emergency departments and their staff would play at the frontline of the COVID-19 response, College advocacy on behalf of its members and trainees and other frontline health workers assumed priority from early March. College President John Bonning immediately called on governments in Australia and Aotearoa New Zealand 'to provide the resources, policies and measures to mitigate risks to the community and healthcare staff, and to ensure that frontline efforts are sustainable'. Acknowledging the stress the pandemic would place on hospital emergency departments and their staff, the College called for the provision of a range of testing facilities and treatment options other than the public hospital ED, along with increased ICU and bed capacity.[20]

The College maintained this strong stance throughout March as the situation changed rapidly. Following an upsurge in presentations to emergency departments for coronavirus testing the College called for urgent improvements in community-based COVID-19 testing facilities. As concerns were raised about an adequate stockpile of Personal Protective Equipment (PPE), College representations directed at politicians, governments, CMOs and healthcare leaders highlighted that supply and security of PPE, as well as training in its use for frontline staff was a matter of workforce safety and must be an ongoing priority.[21]

The College response to the COVID-19 pandemic over time has been considered, responsible and effective, and clearly demonstrates the strength, maturity and capabilities of the organisation. From the outset, the College has focused on supporting its members and trainees and providing clinical leadership, while also finding ways to ensure that the College's core business of education and training continued throughout this period.

From the initial stages of the pandemic, College leaders prioritised communication with members, trainees and staff, recognising quickly that in a time of almost unparalleled uncertainty, the one thing being sought by some individuals and groups was certainty. Regular communication from the President, Council of Education (COE) and CEO kept stakeholders informed about latest developments and changes, offered support, gave reassurance and encouraged those in difficulty to seek help. Appreciating the importance of accurate and timely information, the College has provided updates and resources in a timely way and utilised new technology and traditional processes to accomplish this. Some examples include the introduction of a structured faculty communication tool (based on Microsoft Teams) to streamline communication and information sharing, the distribution of regular bulletins and the creation of trainee site representatives to inform decision making related to the FACEM Training Program. All of this, of course, with the incorporation of what may well be the word of 2020 – 'Zoom'.

When pandemic preparations began in early March, the College adopted a conservative approach towards its ongoing activities and operations. It intended that major events such as examinations and meetings would proceed as planned; however, by mid-March, as public health and hospital system responses in both countries evolved rapidly, these arrangements

and expectations were revised. With travel and leave restrictions in place, public gatherings limited, and some College staff transitioning to working from home, the College recognised that it would not be 'business as usual' for some time'.[22] Daily meetings were established between the President and the College's Executive Leadership Team (ELT) and all aspects of College business were reviewed, with a focus on taking as much pressure as possible off members, trainees and staff, while also enabling the organisation to provide services considered of practical use in the uncertainty of the current environment.

In mid-March, the College made the difficult decision to cancel meetings and workshops planned for the first half of the year, as well as the 2020.1 Primary Examination (Viva) and the 2020.1 Fellowship Examination Written. Recognising the significance for ACEM – and other providers throughout the medical education sector – of enabling examinations to proceed in order to facilitate trainee progression, it was intended, if possible, that other examinations would go ahead as planned. The College offered candidates enrolled to sit the cancelled examinations enrolment in the later examinations.

This announcement was followed with an assurance that the College would endeavour to ensure that no trainee would be unfairly disadvantaged as a result of illness, isolation, cancellation of services, rostering, operational or workplace requirements arising from COVID-19.[23] At the same time, the College indicated that decisions in regard to training and examinations would be undertaken with the protection of the health, safety and wellbeing of College members, trainees and staff in mind. The College would make every effort to minimise disadvantage to trainees, while also protecting the integrity of the FACEM Training Program.[24]

All aspects of training, education and assessment – completion of EM-WBAs, ITAs, examinations, placements, leave and site accreditation – were affected. In ensuing weeks, COE and relevant College staff worked through various aspects of all components of training, and by the end of April a number of decisions and modifications had been made. The nature of the pandemic and the response in terms of public attendances at EDs meant that EM-WBAs were still able to be conducted – indeed, during these times, College records indicate that the highest ever monthly numbers of EM-WBAs were completed. Where a trainee's progress in completing EM-WBAs was impeded as a consequence of the effects of COVID-19, remediation would not be imposed; although, if a trainee was considered to be performing below standard, then a decision for non-progression was warranted and would be applied. Trainees were also advised that COVID-19 related interruptions to training for a period of up to six months would not incur a training penalty. Realising that formal teaching sessions may be significantly reduced or cancelled, the College was investigating enhanced online opportunities for learning and encouraging training sites to implement these where possible.

SIMG assessment interviews scheduled before 30 June were cancelled, and it was planned that those scheduled after 1 July 2020 would be conducted by remote access. Site accreditation visits scheduled before 31 August 2020 were deferred until 2021. Reflecting advice from the MBA and the MCNZ, the annual CPD requirement for 2020 and the 2018–2020 cycle was waived, and random audits cancelled for 2020.

With these arrangements in place, conduct of the remaining ACEM examinations for 2020 emerged as both a priority and a challenge for the Board, COE and ACEM staff, and remained so for some time. At the time the above arrangements were put in place, the College intended to hold the examinations; however, unable to provide certainty, 'it committed to making decisions which provided as much clarity as possible' and to convey decisions as soon as possible after they were made.[25]

In early July an Examination Contingency Working Group (ECWG) was formed. Membership of this group included senior Fellows and College office bearers, trainee representatives, and senior staff of the College. The ECWG met weekly to consider the logistics and constraints associated with continuing to run the remaining examinations. Investigations were thorough and included discussions with specialist medical colleges and other organisations in Australia, Aotearoa New Zealand and overseas; new technologies were also explored to deal with what were an increasingly complex range of travel, associated quarantine and meeting restrictions in place across both countries.

In the course of these investigations it became increasingly evident that the effects of COVID-19 were likely to persist for some time and that the resultant restrictions on travel and gatherings may continue to change. Against this background, while the conduct of examinations in a format as similar as possible to 'normal' was desired, it was apparent that a number of variations would be necessary for different examinations and for trainees in different locations.

By the end of July, the ECWG had devised a plan – albeit a complex one – that reflected the myriad of intra- and inter-jurisdictional arrangements in place as a result of the pandemic and associated government decisions. COE approved the plan on 5 August and it was communicated to members and trainees on 7 August. All four remaining FACEM written and clinical examinations would be held, with arrangements to enable them to be conducted 'regionally', thus minimising the need for most candidates to travel outside their home state or region. Candidates for both the remaining written examinations able to access Clifton's centres in the major cities would sit their respective examinations there, while candidates unable to access these locations would sit their examination in Cairns, Darwin or Hobart with approved local invigilators.

The closure of the AMC National Testing Centre in Melbourne – where clinical examinations (Primary and Fellowship) are normally held – coupled with local COVID-19 restrictions presented significant challenges. The Primary Clinical Examination 2020.2 was scheduled for six major regional locations across Australia and New Zealand, with candidates in Tasmania and the Northern Territory expected to travel to Adelaide. Similar arrangements were made for the Fellowship OSCE 2020.2. For both these examinations, all stations would be marked onsite by an examiner and video recorded. To avoid any consequence of local bias, a candidate's performance would also be marked by two examiners after the examinations, using the video recordings of the stations.

The ECWG had seemingly covered every possible contingency around the arrangements felt to be within the College's 'control' – however considering reports from other colleges of technological issues related to external suppliers and the complications that could arise with high candidate numbers sitting examinations across a number of sites – the magnitude of the task was not lost on those involved.

The first of these examinations – the Primary Written Examination – was held on Friday 2 October and there was satisfaction and relief all round when every location reported the arrangements had been successful. The Primary Viva and Fellowship Written examination are scheduled for November and the Fellowship Clinical Examination (OSCE) in December, with an additional sitting of the Primary Clinical Examination (Viva) planned for early 2021 to deal with the numbers of candidates seeking to sit the examination following the cancellation of the 2020.1 sitting.

Continuing the College's examination program has proved a challenging process and – as John Bonning acknowledges – the fact that the program could proceed at all owes much to the tireless work of COE, members of the ECWG and ACEM's Education and Training Team.[26]

Against the background and disruption of COVID-19 and with College staff working from home since late March, the College has been able to successfully complete a number of regular programs, such as the review of the Fellowship Training Program and the associated Curriculum Framework, as well as reviews of the EMC and EMD training programs and all requirements necessary for implementation of the Diploma of Pre-hospital and Retrieval Medicine (DipPHRM) from the beginning of 2021. Necessary governance activities, such as the election of new Board members and members of COE to take office from the 2020 AGM, as well as a scheduled 'spill' of all COE entities have all taken place.

Throughout 2020, mental health remained a priority and considerable focus, culminating in the release of *Nowhere else to go: why Australia's health system results in people with mental illness getting 'stuck' in emergency departments* report in late September. The report, commissioned by ACEM, was prepared by the Mitchell Institute for Education and Health Policy at Victoria University. *Nowhere else to go* builds on work from 2018 and is an extension of the College's May 2019 consensus statement. It reaffirms the major resourcing and systemic issues contributing to the country's mental health crisis and includes recommendations for building an integrated and sustainable mental health system.

ACEM will use the report to inform continued advocacy for mental health reform, considered even more urgent in the wake of the COVID-19 pandemic.

Despite the disruptions of 2020 the College has made good progress against each of the 36 outcomes outlined in the Strategic Plan for 2019–2021. A recently completed 'mid-term report card' of College progress against those outcomes – prepared at the Board's request for presentation at the upcoming AGM – demonstrates sound progress in all 36 areas. Thirty one of the 36, have achieved at or above expectations, and while there are some concerns attached to the remaining five, there is confidence that the outcomes will be achieved.

The 37th Annual Scientific Meeting

In July 2020, the ACEM Board made the decision to replace the traditional ASM – scheduled to be held in Canberra – with a virtual (online) meeting. Again, this was not an easy decision, but one made in the context of the effects of COVID-19 and with the health and safety of delegates, staff, sponsors, exhibitors, and the wider community in mind.

The College is acutely aware that although the approach being taken for this meeting has been forced through the effects of COVID-19, there is a possibility that such virtual arrangements, or a "hybrid" approach will be required for meetings into the foreseeable future. With a commitment to host the up-coming International Conference on Emergency Medicine (ICEM) in Melbourne in June 2022, the College is taking the opportunity to develop systems that can be used to deliver high quality, value for money meetings through such arrangements.

The 2020 ASM is themed *No Going Back - An Opportunity to Redefine the Role of Emergency Medicine* and will include discussions around opportunities for redesigning the acute health system based on the necessities and learnings from the COVID-19 pandemic.

Conference organisers have developed an innovative program that includes keynote presentations and panel sessions, networking opportunities, a virtual social program and includes national and international presenters.

The program will include, as usual, the Tom Hamilton Oration, which this year will have a special poignancy as the first following Dr Hamilton's passing in August this year. Daniel Fatovich – from Dr Hamilton's home state of Western Australia – has been invited to deliver this year's Oration. Fatovich is Professor of Emergency Medicine at the University of Western Australia, Director of Research at Royal Perth Hospital and Head of the Centre for Clinical Research in Emergency Medicine within the Harry Perkins Institute of Medical Research. He is also an Executive member of the ACEM Research Committee and the Clinical Trials Network.

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On his passing, Tom Hamilton – Foundation Fellow and the inaugural President of ACEM – was remembered by John Bonning as a 'giant of the College', tireless in his work advancing 'ACEM's mission and vision and values' and a 'mentor and inspiration to many'. Bonning noted that in recognition of Dr Hamilton's significant contribution to the development of emergency medicine in Australasia he was made a Member of the Order of Australia in 1992 and received the ACEM Medal in 1999.[27] In further recognition of Dr Hamilton's significant contribution to emergency medicine, the ACEM Board has recently endorsed his nomination for posthumous award of the Sir William Upjohn Medal, an award made by the University of Melbourne every five years, that recognises an individual's distinguished services to medicine in Australia.

As the College continues its journey it seems fitting that an observation from Tom Hamilton should complete the history of the College so far. Reflecting in 2017 on the College's humble beginnings and its subsequent

achievements – as part of the preparations for this history – he concluded that the College had 'come a long way from two rented rooms and a part-time secretary.[28]

APPENDICES

Appendix 1

ACEM office bearers, Councillors and Censors July 1983–July 2014

Presidents

Thomas Hamilton	1983–1988
Joseph Epstein	1988–1992
Richard Ashby	1992–1996
Christopher Baggoley	1996–1999
Peter Cameron	1999–2001
Ian Knox	2001–2004
Andrew Singer	2004–2008
Sally McCarthy	2008–2012
Anthony Cross	2012–2014

Vice-Presidents

Anne D'Arcy	1983–1988
Gordian Fulde	1988–1991
Richard Cockington	1991–1992
Bryan Walpole	1992–1995
Christopher Baggoley	1995–1996
George Jelinek	1996–1997
Sue Ieraci	1997–2000
Ian Knox	2000–2001
Diane King	2001–2005
Sally McCarthy	2005–2008
Peter Freeman	2008–2011
Anthony Cross	2011–2012
Anthony Lawler	2012–2014

Honorary Secretaries

Graham Yule	1983–1983
Gordian Fulde	1983–1987
Joseph Epstein	1987–1988
Gerry FitzGerald	1988–1992
Graeme Thomson	1992–1996
John Vinen	1996–1997
Peter Cameron	1997–1999
Paul Gaudry	1999–2004
Marcus Kennedy	2004–2005
Andrew Maclean	2005–2007
Peter Freeman	2007–2008
Anthony Lawler	2008–2010
Anthony Cross	2010–2011
Anthony Lawler	2011–2012
Alan Tankel	2012–2014

Honorary Treasurers

John Rolleston	1983–1983
Peter Buchanan	1983–1988
Richard Ashby	1988–1992
Michael Galvin	1992–1994
Michael Cleary	1994–1996
Graeme Thomson	1996–1997
Richard Ashby	1997–2005
Ian Knox	2005–2007
Andrew Maclean	2007–2011
Chris May	2011–2013
Didier Palmer	2013–2014

Censors-in-Chief

Desmond Owens	1983–1985
Garry Phillips	1985–1988
Paul Gaudry	1988–1992
Christopher Baggoley	1992–1995
Paul Mark	1995–1998
Andrew Singer	1999–2003
Wayne Hazell	2004–2007
Debra O'Brien	2007–2010
Yuresh Naidoo	2011–2013
Diane King	2013–2014

Deputy Censors-in-Chief

Joseph Epstein	1984–1991
Christopher Baggoley	1991–1992
Ruth Hew	2011–2012
Philip Richardson	2012–2014

Councillors 1983 – 2014

Australian Capital Territory

Philip Cumpston	1984–1987
Patricia Saccasan	1987–1988
Philip Cumpston	1988–1989
John Potts	1989–1992
Margaret Keaney	1992–1995
John Roberts	1995–1996
Robert Dunn	1996–1998
Drew Richardson	1999–2003
Andrew Singer	2003–2013
Suzanne Smallbane	2013–2014

New South Wales

John Rolleston	1983–1984
Graham Yule	1983–1984
Peter Buchanan	1984–1988
Gordian Fulde	1984–1991
Kenneth Abraham	1988–1992
Paul Gaudry	1989–1995
John Vinen	1991–1997
Michael Clark	1992–1993
Paul Cunningham	1993–1997
Sue Ieraci	1995–2001
Janet Talbot-Stern	1997–1999
Joe McGirr	1997–1999
Steven Doherty	1999–2001
Paul Gaudry	1999–2004
David Kirkpatrick	2001–2003
Craig Hore	2003–2007
Sally McCarthy	2003–2014
Tony Joseph	2004–2009
Shalini Arunanthy	2007–2009
Kate Porges	2009–2014
Alan Tankel	2009–2013
Andrew Bezzina	2013–2014

New Zealand

Peter Bamford	1983–1987
David Snow	1987–1990
Angela Pitchford	1989–1994
Christopher Curry	1990–1993
Christopher Curry	1994–1997
Peter Rodwell	1995–1997
Sharon Kletchko	1997–1997
Michael Ardagh	1997–2001
Marjory Vanderpyl	1997–1999
Geoffrey Hughes	1999–2003
Bhavani Peddinti	2001–2007
Peter Freeman	2003–2011
John Bonning	2007–2014
Scott Boyes	2011–2014

Northern Territory

Malcolm Johnston-Leek	2004–2007
Elizabeth Mowatt	2007–2009
Didier Palmer	2009–2014

Queensland

Gerry FitzGerald	1983–1984
Noel Stevenson	1984–1985
Gerry FitzGerald	1985–1993
Richard Ashby	1989–2005
Michael Cleary	1993–1997
Ian Knox	1997–2007
Sylvia Andrew-Starkey	2005–2009
Chris May	2007–2013
Niall Small	2009–2014
Paul Cullen	2013–2014

South Australia

Desmond Owens	1983–1984
Garry Phillips	1984–1987
Richard Cockington	1987–1993
Diane King	1993–1995
Christopher Baggoley	1995–2001
Diane King	2001–2005
Michael Davey	2005–2007
Tony Eliseo	2007–2009
Judy Cornish	2009–2011
Sam Alfred	2011–2013
Thiru Govindan	2013–2014

Tasmania

Harry Jamison	1983–1985
Bryan Walpole	1987–1997
David Smart	1997–2003
Alastair Meyer	2003–2005
Anthony Lawler	2005–2014

Victoria

Anne D'Arcy	1983–2009
Bryan Walpole	1983–1987
Edward Brentnall	1989–1991
Joseph Epstein	1987–1993
Graeme Thomson	1998–2000
Jeff Wassertheil	1991–1995
Jamie Hendrie	1993–1995
Peter Cameron	1995–2002
Carolyn Cooper	1995–1997
Wanda Moore	1997–1999
Graeme Thomson	1998–2001
Andrew Maclean	1999–2011
Marcus Kennedy	2000–2005
Peter Ritchie	2002–2003
Anthony Cross	2003–2014
Peter Ritchie	2005–2009
Diana Egerton-Warburton	2009–2014
Simon Judkins	2011–2014

Western Australia

Thomas Hamilton	1983–1989
Michael Galvin	1989–1994
George Jelinek	1994–1997
Ashok Arasu	1997–1999
David Cruse	1999–2003
Tom Hitchcock	2003–2007
Yusuf Nagree	2007–2014
David Mountain	2008–2013
Peter Allely	2013–2014

Regional Censors 1983–2014

New South Wales / ACT

Gordian Fulde	1983–1993
Andrew Singer	1993–1999
Mark Gillet	1999–2004
Michael Bastick	2005–2012
Shalini Arunanthy	2012–2014

New Zealand

Peter Bamford	1983–1987
David Snow	1987–1990
Chris Curry	1990–1996
Michael Ardagh	1996–1998
Hamish McLaren	1998–1999
Wayne Hazell	1999–2003
Scott Pearson	2004–2006
Lou Finnel	2006–2012
Gina de Cleene	2013–2014

Queensland

Noel Stevenson	1983–1993
David Green	1993–1999
Geoff Ramin	2000–2005
Paul Bowe	2005–2009
James Collier	2009–2014

South Australia / Northern Territory

Des Owens	1986–1984
Garry Phillips	1984–1989
Chris Baggoley	1989–1997
Diane King	1997–2001
Robert Dunn	2001–2005
Phil Aplin	2005–2006
Diane King	2006–2007
Robert Dunn	2007–2011
Simon Chu	2011–2014

Tasmania

Harry Jamison	1983–1985
Bryan Walpole	1985–1994
David Smart	1994–1997
Paul Pielage	1997–2013
Terry Brown	2013–2014

Victoria

Joseph Epstein	1983–1992
Allen Yuen	1992–1999
George Braitberg	2000–2007
James Taylor	2006–2009
Ruth Hew	2009–2011
Barry Gunn	2011–2014

Western Australia

Ronald Hirsch	1983–1990
Paul Mark	1990–1998
Ian Rogers	1998–2001
Debra O'Brien	2001–2008
Ian Rogers	2008–2010
Yuresh Naidoo	2010–2011
David Cruse	2011–2014

Appendix 2

ACEM Officers, Board Members and Councillors July 2014 – December 2020

ACEM Officers

Presidents

Anthony Cross	2014–2015
Anthony Lawler	2015–2017
Simon Judkins	2017–2019
John Bonning	2019–

Presidents-Elect

Anthony Lawler	2014–2015
Simon Judkins	2016–2017
John Bonning	2018–2019
Clare Skinner	2020–

Immediate Past Presidents

Anthony Cross	2015–2016
Anthony Lawler	2017–2018
Simon Judkins	2019–2020

Chairs of the Council of Advocacy, Practice and Partnerships

Tony Lawler	2014–2015
Yusuf Nagree	2015–2019
Didier Palmer	2019–

Chairs of the Council of Education

Diane King	2014–2015
Barry Gunn	2015–

ACEM Board 2014–2020

FACEM members

Anthony Cross	2014–2016
Anthony Lawler	2014–2018
John Bonning	2014–
Diane King	2014–2015
Philip Richardson	2014–2015
Simon Chu	2015–2018
Barry Gunn	2015–
Yusuf Nagree	2015–2019
Simon Judkins	2016–2020
Gabriel Lau	2018–2020
Didier Palmer	2019–
Rebecca Day	2019–
Melinda Truesdale	2019–
Clare Skinner	2020–

Non-FACEM members

Michael Gorton AM	2014–2020
Anthony Evans	2014–2020
Libby Pallot	2020–
Craig Hodges	2020–

Trainee members

Joe-Anthony Rotella	2014–2016
Naveed Aziez	2016–2018
Swaroop Valluri	2018–2020
Shannon Townsend	2020–

Community representative

Jacqui Gibson-Roos	2019–

Council of Advocacy, Practice and Partnerships (CAPP)

Chairs

Anthony Lawler	2014
Yusuf Nagree	2015–2019
Didier Palmer	2019–

Deputy Chairs

John Bonning	2014–2017
Didier Palmer	2017–2019
Clare Skinner	2019–2020

Regional Representatives

ACT

Suzanne Smallbane	2014–

New South Wales

Andrew Bezzina	2014–2017
Sally McCarthy	2014–
Alan Tankel	2014–2019
Clare Skinner	2017–2019
Rhiannon Browne	2019–
Ellen Meyns	2019–

New Zealand

John Bonning	2014–2018
Scott Boyes	2014–2017
André Cromhout	2017–
Kate Allen	2019–

Northern Territory

Didier Palmer	2014–2017
Stephen Gourley	2017–

Queensland

Kim Hansen	2015–
Niall Small	2014–
Paul Cullen	2014–2015
Jessica Forbes	2020–

South Australia

Thiru Govindan	2014–2017
Tom Soulsby	2017–2019
Kimberly Humphrey	2019–

Tasmania

Anthony Lawler	2014
Domhnall Brannigan	2014 –2017
Juan Ascensio-Lane	2017–

Victoria

Diana Egerton-Warburton	2014 –2017
Simon Judkins	2014 –2016
Alan Whitehead	2015 –2015
Sara MacKenzie	2015 –2019
Suzanne Doherty	2016 –2019
Ed Oakley	2017–
George Braitberg	2019–
Belinda Hibble	2019–

Western Australia

Peter Allely	2014 –
Yusuf Nagree	2014–2019
Lynda Vine	2016 –2020
Nicola Liesis	2020–

Trainee members (Trainee Committee Chair)

Sarah Jones	2014
Viet Tran	2014–2016
Jessica Forbes	2016–2018
Nicholas Lelos	2018–2019
Harriet Jennings	2019–

Council of Education (COE)

Chairs and Censors-in-Chief

Diane King	2014–2015
Barry Gunn	2015–

Deputy Censors-in-Chief

Philip Richardson	2014–2015
Simon Chu	2015–2018
Gabriel Lau	2018–2020
Kate Field	2020–

Regional Censors

ACT

Andrée Salter	2019–2020

New South Wales

Gabriel Lau	2014–2018
Jules Willcocks	2018–2020
Miguel Taliana	2020–

New Zealand

Gina de Cleene	2014–2018
Stuart Barrington-Onslow	2018–

Northern Territory

Rebecca Day	2019–

Queensland

James Collier	2014–2016
Sharyn Smith	2016–

South Australia

Simon Chu	2014–2015
Robert Dunn	2015 –2018
Alistair Fergusson	2018–

Tasmania

Konrad Blackman	2014–2016
Kate Field	2016–2020
Viet Tran	2020–

Victoria

Barry Gunn	2014–2015
Joanne Dalgleish	2015 –2018
Jonathan Dowling	2018 –

Western Australia

David Cruse	2014–2016
Harry Patterson	2016–2020
Simone Bartlett	2020–

Trainee members (Trainee Committee Chair)

Sarah Jones	2014
Viet Tran	2014–2016
Jessica Forbes	2016–2018
Nicholas Lelos	2018–2019
Harriet Jennings	2019–

Community Representative

Jacqui Gibson-Roos	2015–

GLOSSARY OF TERMS

ABEM	American Board of Emergency Medicine
ACCC	Australian Competition and Consumer Commission
ACEM	Australasian College for Emergency Medicine
ACEP	American College of Emergency Physicians
ACHS	Australian Council on Healthcare Standards
ACP	Australian College of Paediatrics
ACSVH	Association of Casualty Supervisors of Victorian Hospitals
ACRRM	Australian College of Rural and Remote Medicine
ADF	Australian Defence Force
AGM	Annual General Meeting
AHMAC	Australian Health Ministers Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AHRC	Australian Human Rights Commission
AHWOC	Australian Health Workforce Officials Committee
AICD	Australian Institute of Company Directors
AIDA	Australian Indigenous Doctors Association
AMA	Australian Medical Association
AMC	Australian Medical Council
AMWAC	Australian Medical Workforce Advisory Committee
AN-DRGs	Australian National Diagnostic Related Groups
ANZCA	Australian and New Zealand College of Anaesthetists
ANZIA	Australian and New Zealand Internet Award
AoN	Area of Need
APHA	Australasian Preventative Health Agency
APLS	Advanced Paediatric Life Support
ASEM	Australasian Society for Emergency Medicine
ASM	Annual Scientific Meeting
ATS	Australasian Triage Scale
AWE	Advancing Women in Emergency Medicine Section

BAEM	British Association for Accident and Emergency Medicine
BMA	British Medical Association
BOC	Board of Censors
BOE	Board of Education
CAEP	Canadian Association of Emergency Physicians
CAPP	Council of Advocacy, Practice and Partnerships
CC	Caucasian Candidate
CENA	College of Emergency Nurses of Australia
CEO	Chief Executive Officer
CIC	Censor-in-Chief
CICM	College of Intensive Care Medicine
CMC	Council of Medical Colleges
COAG	Council of Australian Governments
COE	Council of Education
CPD	Continuing Professional Development
CPMC	Council of Presidents of Medical Colleges
CRP	Curriculum Revision Project
CSA	Casualty Supervisors Association
CTAS	Canadian Triage and Acuity Scale
CTN	Clinical Trials Network
DBSH	Discrimination Bullying and Sexual Harassment
DCIC	Deputy Censor-in-Chief
DEM	Director of Emergency Medicine
DEMT	Director of Emergency Medicine Training
DISG	Diversity and Inclusion Steering Group
DHB	District Health Board
DOE	Director of Education
DoH	Department of Health
DoHA	Department of Health and Ageing
DPEMT	Director of Paediatric Emergency Medicine Training
DRHM	Division of Rural Health Medicine (of RNZCGP)
DRG	Diagnostic Related Group
EAG	Expert Advisory Group
EC	Examiners Committee
ECWG	Examination Contingency Working Group
ED	Emergency Department
EDEN	Emergency Department Epidemiology Network

EDPSCS	Emergency Department Private Sector Clinical Supervision (program)
ELS	Early Life Support (course)
ELT	Executive Leadership Team
EM	Emergency Medicine
EMA	Emergency Medicine Australasia (Journal)
EMAD	Emergency Medicine Advanced Diploma
EMC	Emergency Medicine Certificate
EMD	Emergency Medicine Diploma
EMET	Emergency Medicine Education and Training
EMP	Emergency Medicine Program
EMQ	Extended Matching Questions
EMRF	Emergency Medicine Research Foundation
FACEM	Fellow of the Australasian College for Emergency Medicine
FAEM	Faculty of Accident and Emergency Medicine
FEC	Fellowship Examination Committee
FEMO	Field Emergency Medical Officer
FES	Fellowship Examination Subcommittee
FRCEM	Fellow of the Royal College for Emergency Medicine
FRCPSC	Fellow of the Royal College of Physicians and Surgeons of Canada
FTE	Full Time Equivalent
GEC	Global Emergency Care
GECCo	Global Emergency Care Committe
GEMSIG	Geriatric Emergency Medicine SIG
GM	General Manager
GP	General Practitioner
HIC	Health Insurance Commission
HWA	Health Workforce Australia
HWNZ	Health Workforce New Zealand
ICEM	International Conference on Emergency Medicine
ICT	Information and Communications Technology
ICU	Intensive Care Unit
IDF	International Development Fund
IEM	International Emergency Medicine
IEMC	International Emergency Medicine Committee
IEMNet	International Emergency Medicine Network
IEMSIG	International Emergency Medicine Special Interest Group

IF	Impact Factor
IFEM	International Federation for Emergency Medicine
IHCC	Indigenous Health and Cultural Competence
IMET	Institute of Medical Education and Training
IMG	International Medical Graduate
IRTP	Integrated Rural Training Pipeline
ITA	In-Training Assessment
ITS	Ipswich Triage Scale
JCC	Joint Consultative Committee
JFICM	Joint Faculty of Intensive Care Medicine
JTC-PEM	Joint Training Committee in Paediatric Emergency Medicine
JTP-PEM	Joint Training Program in Paediatric Emergency Medicine
LIME	Leaders in Indigenous Medical Education
LMICs	Low- and Middle-Income Countries
MBA	Medical Board of Australia
MBS	Medicare Benefit Schedule
MCNZ	Medical Council of New Zealand
MCQ	Multiple Choice Question
MedSAC	Medical School Accreditation Committee
MJA	Medical Journal of Australia
MOPS	Maintenance of Professional Standards
MOU	Memorandum of Understanding
MTS	Manchester Triage Scale
MTRP	Medical Training Review Panel
MWRAC	Medical Workforce Reform Advisory Committee
NAIDOC	National Aborigines and Islanders Day Observance Committee
NCC	Non-Caucasian Candidate
NEAT	National Emergency Access Target
NGO	Non-Government Oorganisation
NHHRC	National Health and Hospitals Reform Commission
NMTAN	National Medical Training Advisory Network
NPSC	National Program Steering Committee
NRAS	National Registration and Accreditation Scheme
NSQAC	National Specialist Qualification Advisory Committee
NSTC	Non-Specialist Training Committee
NSWP	Non-Specialist Working Party
NT	Northern Territory

NTS	National Triage Scale
NZMoH	New Zealand Ministry of Health
OCC	Overseas Credentials Committee
OSCE	Objective Structured Clinical Examination
OTS	Overseas Trained Specialist
OTV	Occupational Training Visa
PEC	Primary Examination Committee
PEM	Paediatric Emergency Medicine
PES	Primary Examination Subcommittee
PHC	Public Health Committee
PHRM	Pre-hospital and Retrieval Medicine
PICs	Pacific Island Countries
PMU	Project Management Unit
PPE	Personal Protective Equipment
PRIDoC	Pacific Region Indigenous Doctors Conference
PSO	Project Support Officers
RACGP	Royal Australian College of General Practitioners
RACMA	Royal Australian College of Medical Administrators
RACOG	Royal Australian College of Obstetricians and Gynaecologists
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCOG	Royal Aunstralian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists
RAP	Reconciliation Action Plan
RCEM	Royal College of Emergency Medicine
RCS	Royal College of Surgeons
RCSEd	Royal College of Surgeons of Edinburgh
RMH	Royal Melbourne Hospital
RNS	Royal North Shore (Hospital)
RNZCGP	Royal New Zealand College of General Practitioners
RNZCOG	Royal New Zealand College of Obstetricans and Gynaecologists
RPA	Royal Prince Alfred (Hospital)
RPL	Recognition of Prior Learning
RRC	Rural and Remote Committee

RVS	Relative Value Study
SAC	Scientific Advisory Committee
SACSA	South Australian Casualty Supervisors Association
SAQ	Short Answer Question
SCE	Structured Clinical Examinations
SCQ	Select Choice Question
SEAC	Specialist Education Assessment Committee
SIFT	Selection into FACEM Training
SIG	Special Interest Group
SIMG	Specialist International Medical Graduate
SIT	Specialist in Training
SPC	Secretariat of the Pacific Community
SR	Structured Reference
STP	Specialist Training Program
STPS	Specialist Training Placement and Support (program)
TARWG	Training and Assessment Review Working Group
TRC	Trainee Research Committee
TSWPRG	Trainee Selection and Workforce Planning Reference Group
URG	Urgency Related Group
VAQ	Visual Aid Question
WBA	Workplace-based Assessment(s)
WHO	World Health Organization

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114 Chris Baggoley, "Board of Censors News", *Emergency Medicine 6* (1994): 350

115 ACEM Council Minutes, 20 September 1989; amendment to Regulation 4.30/ 30

116 ACEM Council Minutes, 6 November 1994

117 ACEM Annual Report 1995, 11–15

118 ACEM Annual Report 1995, 14

119 Pamela Rosengarten and Anne-Maree Kelly, "Evolution and Quality Assurance of the primary examination of the Australasian College for Emergency Medicine", *Emergency Medicine 9* (1997): 45

120 ACEM Annual Report 1990, 7

121 ACEM Annual Report 1993, 11

122 ACEM Annual Report 1991, 9; see also Paul Gaudry, "The examination process in emergency medicine", *Emergency Medicine 3* (1991): 74

123 *Emergency Medicine 4* (1992): 128

124 *Emergency Medicine 6* (1994): 348-349; in the same issue Chris Baggoley noted that the pass rate for the Primary had risen to 71% in the recent examinations – old structure but with relaxed criteria. This was a marked improvement on 28% for the second Primary in 1992 (*Emergency Medicine, 4* (1992): 249)

125 *Emergency Medicine 5* (1993): 319

126 Rosengarten and Kelly, "Evolution and Quality Assurance", 46

127 Rosengarten and Kelly, "Evolution and Quality Assurance", 46

128 ACEM Annual Report 1996, 12

129 Rosengarten and Kelly, "Evolution and Quality Assurance", 47

130 Paul Gaudry, "The examination process in emergency medicine", *Emergency Medicine 3* (1991): 104

131 ACEM Annual Report 1992, 15; see also *Emergency Medicine 6* (1994): 248 for more detail

132 ACEM Annual Report 1994, 15

133 *Emergency Medicine 6* (1994): 78

134 ACEM Annual Report 1993, 13

135 Andrew Singer, "Emergency Medicine in the fourth decade: Angry young man or mid-life crisis?" *Emergency Medicine Australasia 26* (2014): 45

4 Expansion and Complexity, 1997–2007

1 ACEM Annual Report 1999, 5

2 Richard Ashby, *Emergency Medicine 8* (1996): 270

3 Peter Cameron, ACEM Annual Report 2001, 3

4 ACEM Annual Report 1999, 34

5 ACEM Council Minutes, 18 July 1997

6 ACEM Annual Report 1999, 5

7 ACEM Annual Report 2001, 5

8 ACEM Annual Report 2000, 23

9 ACEM Annual Report 2006, 5

10 ACEM Annual Report 2006, 24

11 Chris Baggoley, *Emergency Medicine, 10* (1998): 366. The College "Organisation Chart" for 2004 indicates SIGs were eventually assigned the same standing as liaison groups in the 'College hierarchy'.

12 ACEM Annual Report 1999, 5

13 ACEM Council Minutes, 9 July 1999; ACEM Annual Report 1999, 20

14 ACEM Annual Report 2005, 3

15 "IFEM Timeline: A History", https://www.ifem.cc/wp-content/uploads/2016/02/IFEM_HistoryTimeline.pdf accessed 4 December 2018

16 ACEM Council Minutes, 9 November 1997

17 ACEM Council Minutes, 13 March 1997

18 ACEM Annual Report 1997, 16

19 "IFEM Timeline: A History", accessed 4 December 2018

20 Email correspondence Carol Reardon to the author, 29 October 2018

21 ACEM Council Minutes, 19 November 2000

22 ACEM Annual Report 2004, 4

23 ACEM, "A Submission regarding the location of the Permanent Secretariat of the International Federation for Emergency Medicine", 25 August 2006

24 International Federation for Emergency Medicine Awards Ceremony, Thursday 7 June 2018 https://www.ifem.cc/wp-content/uploads/2018/08/IFEM-Award-Ceremony-booklet-2018_.pdf accessed 20 February 2019

25 Chris Curry, Carolyn Annerud, Simon Jenson, David Symmons, Marian Lee and Mathias Sapuri, "The first year of a formal emergency medicine programme (sic) in Papua New Guinea", *EMA 16* (2004): 343–347

26 ACEM Council Minutes, 9 November 2003

27 Bishan Rajapaske, "A Postcard from the Edge". https://litfl.com/a-postcard-from-the-edge/ accessed 22 July 2019

28 Tony Lawler, *Your Direction 10.1* (2009): 4

29 Chris Curry, "Taking emergency medicine international: What can we learn and teach?" *EMA* 18 (2006): 313–315

30 "Letter Ian Knox to Andrew Singer", ACEM Council agenda papers 29 July 2005

31 ACEM Annual Report 2005, 7

32 ACEM Annual Report 2012, 22

33 IEMSIG Newsletter, Volume 10, Issue 1, December 2014, 2–3

34 Jenny Freeman, *Your Direction*, 4.2 (2003): 23

35 ACEM Council Minutes, 10 February 2006

36 *Emergency Medicine 10* (1998): 182

37 *Emergency Medicine 10* (1998): 182

38 Andrew Singer interview with the author, 16 February 2018

39 ACEM Submission to AMC, September 2007, 19

40 ACEM Annual Report 2002, 8

41 ACEM Annual Report 2002, 8

42 ACEM Annual Report 2002, 9; In the interest of fairness, those trainees with the Fellowship Examination but not having fulfilled the research component were given a three-year time limit after the date of successfully passing the Fellowship Examination to complete the research component.

43 "Subject posts" – introduced in 1995 – allowed a candidate to resit only the failed subject at the next two sittings of the Primary Examination.

44 ACEM Annual Report 1997, 12

45 ACEM Anual Report 2003, 9

46 ACEM Anual Report 2001, 10

47 ACEM Anual Report 2004, 9

48 ACEM Anual Report 1998, 9

49 ACEM Council Minutes, 18 July 1997

50 ACEM Anual Report 1999, 11

51 ACEM Anual Report 2001, 11

52 ACEM Annual Report 2002, 10

53 ACEM Annual Report 2003, 10

54 ACEM, "Training and Examination Handbook March 2006", 84

55 ACEM Handbook March 2006, 84

56 http://www.royalcollege.ca/rcsite/canmeds/about-canmeds-e accessed 19 May 2019

57 ACEM Annual Report 2006, 9

58 ACEM Annual Report 2004, 8

59 ACEM Annual Report 2005, 9

60 ACEM Council Minutes, 25 January 2000

61 ACEM Council Minutes, 18 March 2000

62 ACEM Annual Report 2001, 9

63 ACEM Annual Report 2000, 4

64 ACEM Annual Report 2003, 11

65 ACEM Council Minutes, 19 November 2000

66 ACEM Council Minutes, 10 March 2001

67 ACEM Council Minutes, 14 March 2003

68 ACEM Annual Report 2003, 4

69 ACEM, 2010 Annual Progress Report to the AMC, 3

70 ACEM, 2019 Annual Progress Report to the AMC and MCNZ, 38

71 *Your Direction* 6.2 (2005): 2. See also ACEM Submission to AMC - September 2006, 42

72 ACEM Reaccreditation Submission to the AMC and MCNZ, June 2017, 84–85

73 "Change to the list of specialties", https://www.medicalboard.gov.au/News/Newsletters/May-2018.aspx accessed 16 September 2020

74 https://www.cicm.org.au/About/History accessed 6 February 2019

75 ACEM Annual Report 2003, 4

76 ACEM Council Minutes, 14 July 2006

77 ACEM Annual Report to the AMC 2010, 2

78 The ASEM President attended Council meetings from November 1989. At the 19 July 1996 Council meeting trainee representation to the BOC was discussed. ASEM President, Drew Richardson, promoted ASEM's credentials for this role, on the basis that ASEM exists 'mainly for trainees' and had an active Trainee Subcommittee.

79 Andrew Singer, *Your Direction* 6.2 (2005): 2

80 Andrew Singer, *Your Direction* 6.2 (2005): 2

81 ACEM Annual Report 2006, 12

82 ACEM Annual Report 2006, 12

83 ACEM Annual Report 1996, 5

84 Australian Medical Workforce Advisory Committee (AMWAC), *The Emergency Medicine Workforce in Australia*. North Sydney: AMWAC (1997)

85 ACEM Annual Report 1996, 18–19

86 Email correspondence Chris Baggoley to Geoff Murphy, 5 July 2019

87 AMWAC Report, 7

88 AMWAC Report, 7–8

89 ACEM Annual Report 1997, 21

90 ACEM Council Minutes 14 March 1997

91 The ACCC was established in 1995 following passage of the Competition Policy Reform Act (1995) https://www.australiancompetitionlaw.org/chronology.html accessed 2 January 2019. For the purposes of the Act (Part IV) professionals including doctors are considered competitors and subject to a range of prohibitions on anti-competitive conduct *(Medical colleges and competition Law, 6)*.

92 The RACS finding was delivered in 2000 (Royal Australian and New Zealand College of Radiologists, *Medical colleges and competition law: A discussion paper*, 2013, 7)

93 ACEM Council Minutes, 17 July 1998

94 ACEM Annual Report 1998, 5

95 ACEM Council Minutes, 21 November 1999

96 Paul Gaudry, *Your Direction*, 1.1 (2000): 3

97 Peter Cameron, *Your Direction*, 1.2 (2000): 2

98 ACEM Annual Report, 2003, 24

99 Ian Knox, *Your Direction*, 5.1 (2004): 3

100 ACEM Annual Report 2004, 3

101 ACEM Council Minutes, 23 July 2004

102 "AHWAC Emergency Care Working Party: discussion paper", ACEM Supplementary Agenda Papers, 21 November 2004

103 ACEM Council Minutes, 23 July 2004

104 ACEM Council Minutes, 23 July 2004

105 Anthony Cross, "Discussion Paper: Medical staffing trends in the emergency department", ACEM Council Agenda Papers, 11 March 2005

106 ACEM Annual Report 2006, 24

107 ACEM Annual Report 2008, 22–23

108 Australia Health Ministers' Conference, *National Health Strategic Framework*, Sydney (2004): 15

109 ACEM Council Agenda Papers, 12 March 2004

110 ACEM Annual Report 1994, 16

111 *Emergency Medicine* 6 (1994): 249–250

112 Australian Medical Council Limited, *Accreditation Report: The Education and Training Programs of the Australasian College for Emergency Medicine*, July 2007, 46

113 ACEM Annual Report 2003, 11

114 ACEM Annual Report 2007,9

115 ACEM Annual Report 2009, 12

116 ACEM Annual Report 2009, 12

117 ACEM Annual Report 2011, 13

118 ACEM Annual Report 2010, 11

119 ACEM Annual Report 2011, 13

120 ACEM Annual Report 2013, 16

121 Australia. Parliament. House of Representatives. Health and Ageing Standing Committee. (2012) *Lost in the labyrinth: report on the inquiry into registration processes and support for overseas trained doctors*. [Canberra: House of Representatives Standing Committee of Health and Ageing], http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/overseasdoctors/report.htm

122 Medical Board of Australia, *Good practice guidelines for the assessment of specialist international medical graduates*, 2 November 2015

123 ACEM Annual Report 2002, 15

124 "Relative Value Study" http://www.health.gov.au/internet/main/publishing.nsf/Content/health-rvs-overview.htm accessed 12 February 2019

125 ACEM Annual Report 1999, 17

126 ACEM Council Minutes, 9 July 1999

127 ACEM Annual Report 2000, 4

128 *Medicare Schedule review Board: A resource-based model of private practice in Australia – final report*, Volume 1 – Key Findings, December 2000, 22

129 Michael Wright, "Is there value in the Relative Value Study? Caution before Australian Medicare reform". *MJA* 203 (2015): 331–32

130 ACEM Annual Report 1999, 17

131 ACEM Annual Report 2001, 17

132 ACEM Annual Report 2002, 15

133 ACEM Annual Report 2002, 3–4

134 ACEM Annual Report 2002, 15

135 ACEM Annual Report 2003, 15

136 ACEM Council Minutes, 29 July 2005

137 ACEM Council Minutes, 14 July 2006

138 ACEM Council Minutes, 27 July 2007

139 ACEM Annual Report 2009, 19

140 ACEM, *Statement on the role of the private hospital emergency department*, July 2018

141 ACEM, *Statement on the role of the private hospital emergency department*, July 2018

142 ACEM Annual Report 1996, 5–6

143 Chris Baggoley, E*mergency Medicine* 10 (1998): 71

144 "*Australian Health Review* is a valuable resource for managers, policy makers and clinical staff in health organisations, including government departments, hospitals, community centres and aged-care facilities, as well as anyone with an interest in the health industry (https://www.publish.csiro.au/ah/AbouttheJournal accessed 15 July 2018

145 Patrick Bolton, Michael Mira and Mary Sullivan, "The Balmain Hospital General Practice Casualty: An alternative model of primary health care provision", *Australian Health Review*, 20 (1997): 100

146 Bolton et al, 104

147 Chris Baggoley, *Emergency Medicine* 10 (1998): 71

148 Chris Baggoley, *Emergency Medicine 10* (1998): 179

149 Chris Baggoley, ACEM Annual Report 1999, 4

150 ACEM Council Minutes, 13 March 1998 and 25 October 1998

151 Peter Cameron, *Your Direction* 1.1 (2000): 2

152 ACEM Annual Report 2000, 3

153 Ian Knox, "Media Strategy for the College", *Your Direction* 2.2 (2001): 6

154 ACEM Council Minutes, 30 September 2001

155 ACEM Council Minutes, 29 June 2001

156 Papers such as "Emergency Medicine and 'acute' general practice: comparing apples with oranges" written by Sue Ieraci et al and providing analysis of the Balmain Hospital GPC model and Cameron et al "Managing Access Block" both published in the *Australian Health Review* were important early contributions supporting the College position.

157 Ian Knox, *Your Direction* 5.1 (2004): 2

158 ACEM Annual Report 2004, 3–4

159 Drew Richardson, "Prevalence of

Access Block in Australia, 2004–2008", *Emergency Medicine Australasia 21* (2009), 472–478

160 ACEM Council Minutes, 18 March 2000

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1 ACEM Annual Report 2013

2 ACEM Annual Report 2007, 3

3 ACEM Executive Minutes, 16 July 2007 and ACEM Council Minutes, 27 July 2007

4 Sally McCarthy, *Your Direction*, 9.3 (2008): 3

5 ACEM Council Minutes, 27 July 2007

6 ACEM Annual Report 2009, 8

7 ACEM Annual Report 2009, 10

8 ACEM Annual Report 2009, 4

9 ACEM, Annual report to the Australian Medical Council Specialist Accreditation Committee May 2010, 12; see also "Commentary on the Australasian College for Emergency Medicine (ACEM) 2010 Annual Report".

10 ACEM, "Commentary", 2

11 ACEM Annual Report 2011, 11

12 ACEM, Annual Report to the Australian Medical Council Specialist Accreditation Committee, May 2010, 6

13 ACEM Council Minutes, 12 March 2010

14 "Commentary on the Australasian College for Emergency Medicine (ACEM) 2010 Annual Report"; ACEM Council Minutes 16 July 2010 note that TWARG intended to make recommendations to Council and BOE at the November meetings on what needed to be put in place to address remaining AMC accreditation issues.

15 ACEM Council Agenda Papers, 15 July 2011: 174–188

16 Curriculum authoring; investigation, development and coordination of assessment including examinations and WBAs; development of teacher training; development of a system of central trainee welfare and support; development of progression rule changes including recognition of prior learning (RPL); investigation and development of accreditation changes; development and communication of a transition process from the current to the revised program and development of operational aspects to support the new program including development of online learning resources and communication (Yuresh Naidoo, ACEM Annual Report 2012).

17 "ACEM Curriculum Revision Project: Where are we now?" ACEM Council Agenda Papers, 18 November 2012

18 ACEM Council Executive Minutes, 22 October 2012

19 ACEM Council Executive Minutes, 18 December 2012

20 "DOE report to the BOE", ACEM Council Agenda Papers, 8 March 2013

21 ACEM Annual Report 2013, 10

22 ACEM Council Minutes, 21 March 2014; see also "ACEM Annual update report to the AMC and MCNZ", April 2014: np

23 "Curriculum Revision Project Report", ACEM Annual Report 2013, 9–10

24 ACEM Annual Report 2014, 6

25 ACEM Council Minutes, 17 July 1998

26 ACEM Council Minutes, 25 October 1998

27 ACEM Council Minutes, 12 July 2002 and ACEM Annual Report 2002, 17

28 ACEM Annual Report 2003, 9

29 ACEM Annual Report 2005, 20

30 ACEM Council Executive Minutes, 14 May 2008

31 ACEM Council Executive Minutes, 5 June 2008

32 ACEM Council Minutes, 18 July 2008

33 ACEM Council Minutes, 17 July 2009

34 ACEM Council Agenda Papers, 15 November 2009

35 ACEM Council Agenda Papers, 15 November 2009

36 ACEM Council Minutes, 15 November 2009

37 ACEM Council Minutes, 15 November 2009

38 ACEM Year in Review 2016, 35

39 ACEM Year in Review 2016, 35

40 ACEM Year in Review 2017, 24

41 ACEM Year in Review 2018, 26

42 ACEM Annual Report 2016, 36

43 ACEM Council Executive Minutes, 30 June 2010

44 Sally McCarthy interview with the author, 2 July 2018

45 ACEM Council Agenda Papers, 20 November 2011

46 ACEM Annual Report 2013, 3 & 13

47 ACEM Year in Review 2018, 27–30

48 ACEM Annual Report 2008, 26

49 ACEM Council Executive Minutes, 27 September 2007

50 ACEM Council Minutes, 25 November 2007

51 ACEM Council Executive Minutes, 29 January 2008

52 Robert Forero and Ken Hillman, *Access Block and Overcrowding: A literature review*, https://acem.org.au/getmedia/17a40f20-fe57-4967-b062-371404e07e9e/Access_Block_Literature_Review_08_Sept_3.aspx

53 Sally McCarthy interview with the author, 2 July 2018

54 Sally McCarthy, *Your Direction* 9.3 (2008): 3

55 *A healthier future for all Australians – Final report of the National Health and Hospitals reform Commission – June 2009*, 5

56 ACEM Annual Report 2010, 3

57 Tony Lawler, ACEM Annual Report 2010, 4

58 Michael Ardagh, "How to achieve New Zealand's shorter stays in emergency departments health target" *New Zealand Medical Journal* (NZMJ). 123, 11 June 2010, 2; the announcement was made in May 2009 for implementation from 1 July 2009.

59 Working Group for Achieving Quality in Emergency Departments, *Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments*. Wellington: Ministry of Health, December 2008: 4

60 Mike Ardagh interview with the author, 28 November 2019

61 ACEM Annual Report 2008, 27

62 Working Group, 4–5

63 Michael Ardagh interview with the author, 28 November 2019

64 Michael Ardagh, "How to achieve New Zealand's shorter stays in emergency departments health target" *NZMJ*, 123 (11 June 2010): 2

65 Michael Ardagh and Lynette Drew. "What have five years of shorter stays in the emergency department done to us?" *NZMJ*, 128 (4 September 2015): 47–53

66 Clair Sullivan, Andrew Staib, Bronwyn Griffin, Anthony Bell and Ian Scott. *The Four Hour Rule: The National Emergency Access Target, Time to Review*. Queensland Department of Health, 2015: 40

67 Sullivan et al, 34

68 ACEM Annual Report 2014, 3

69 ACEM Council Executive Minutes, 28 January 2011

70 ACEM 2013 Progress Report to the AMC, 10

71 ACEM Annual Report 2014, 3

72 ACEM Board Minutes, 14 November 2014

73 "Public Health Committee, Report to Council 20 November 2011", ACEM Council Agenda Papers

74 ACEM Annual Report 2013, 25

75 ACEM Annual Report 2014, 3

76 "Emergency Department data to reduce alcohol-related harm, 28 July 2016" https://www.monash.edu/medicine/news/latest/2016-articles/emergency-dept-data-to-reduce-alcohol-related-harm.html accessed 26 June 2020

77 ACEM Annual Report 2012, 23

78 ACEM Council Minutes, 13 July 2012

79 ACEM Annual Report 2013, 25

80 ACEM 2014 Annual Progress Report to the AMC, np

81 The ACEM Executive Minutes for 27 October 2011 note that more than 600 responses had so far been received.

82 With some slight variation, these priorities have remained on the College agenda in successive strategic plans. College operations was added in 2015 and refined as 'Operational sustainability and awareness' in 2019 when 'Research' was also added as a strategic priority.

83 ACEM Council Minutes, 11 March 2011

84 Tony Lawler interview with the author, 2 March 2019

85 ACEM Council Minutes, 20 November 2011

86 ACEM Council Executive Minutes, 31 January 2012

87 Kate Costello outlined this process to the ACEM Executive, 20 February 2012

88 "Governance Review", ACEM Council Agenda Papers, 13 July 2013

89 "Governance Review"

90 "Governance Review"

91 "Governance Review"

92 "Governance Review"

93 ACEM 2013 Progress Report to the AMC, 8

94 Governance Review, ACEM Council Agenda Papers, 13 July 2012

95 ACEM Council Minutes, 18 November 2012

96 Since coming to Council in 2005, Lawler had served as Chair of the Constitution and Regulations Committee, Honorary Secretary from 2008 until 2010 and again in 2011–2012. He was appointed Vice-President in November 2012.

97 ACEM Annual Report 2014, 4

98 ACEM Annual Report 2014, 3

99 ACEM Annual Report 2014, 4

100 ACEM Council Executive Agenda Papers, 16 July 2007

101 ACEM Annual Report 2009, 3

102 ACEM Annual Report 2011, 5

103 ACEM Council Agenda Papers, 15 July 2011

104 ACEM Annual Report 2011, 6

105 ACEM Annual Report 2011, 8

106 ACEM Annual Report 2012, 5

107 ACEM Annual Update Report to the AMC and MCNZ, 2015, Appendix 7.1

108 ACEM Annual Report 2014, 3

109 "President's Welcome", ACEM Year in Review 2015

110 ACEM Annual Report 2014, 3

111 ACEM Annual Report 2014, 4

6 Into the Future, 2015-2018

1 ACEM Annual Report 2014, 5

2 ACEM Year in Review 2015, 3

3 Australian Medical Council, "Assessment and accreditation of specialist medical programs", https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/ accessed 19 May 2019

4 Assessment and accreditation of Specialist Medical Programs' https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/ accessed 10 December 2019

5 ACEM Year in Review 2017, 4

6 Australian Medical Council Limited, Accreditation Report: the Training and Education Programs of ACEM, May 2018, 2

7 AMC Accreditation Report 2018, 10

8 AMC Accreditation Report 2018, 13

9 AMC Accreditation Report 2018, 15

10 AMC Accreditation Report 2018, 16

11 EAG on Discrimination Final Report, 17

12 Anthony Klan, "Students accuse medical college of racism", *Weekend Australian*; Canberra: 28 January 2017

13 "Trainees hurl allegations of racism at Australasian College of Emergency Medicine", *Annals of Emergency Medicine*, 69.5, May 2017: 15A

14 Tony Lawler interview with the author, 2 March 2019

15 Tony Lawler quoted in Klan, 2 February 2017

16 https://www.newcastle.edu.au/profile/kichu-nair accessed 2 January 2020

17 EAG on Discrimination Final Report, iii

18 EAG on Discrimination Final Report, 1

19 EAG on Discrimination Final Report, 3

20 EAG on Discrimination Final Report, 46

21 ACEM Year in Review 2018, 16

22 Tony Lawler, "Expert Advisory Group on Discrimination update", October 2017

23 Tony Lawler, "Expert Advisory Group on Discrimination update", October 2017

24 ACEM Year in Review 2019, 10

25 ACEM Year in Review 2019, 10

26 ACEM, 2019 Annual Progress Report to the AMC and MCNZ, 44

27 Correspondence from the Australian Human Rights Commission to ACEM solicitors, 11 July 2019 quoted in AMC 2019 Annual Progress Report to the AMC and MCNZ, 44

28 ACEM Media Release, 19 October 2019; https://acem.org.au/News/October-2019/Statement-attributable-to-the-President-of-the-Aus accessed 6 August 2020

29 ACEM, 2019 Annual Progress Report to the AMC and MCNZ, 11

30 ACEM, 2019 Annual Progress Report to the AMC and MCNZ, 11

31 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 3

32 ACEM Annual Report 2014, 5

33 Cameron Rosie, "Is Australasia producing too many emergency physicians? Yes", *EMA* 27 (2015), 599–600

34 Health Workforce Australia 2012: *Health Workforce 2025 – Volume 3 – Medical Specialities*, 92 available at https://webarchive.nla.gov.au/awa/20150331211629/https://www.hwa.gov.au/sites/uploads/HW2025_V3_FinalReport20121109.pdf accessed 20 October 2020

35 Health Workforce New Zealand, Health of the Health Workforce, 2013 to 2014, Ministry of Health: Wellington, November 2014, 14

36 ACEM Annual Report 2014, 9 – the faculty report notes that with increasing numbers of IMGs remaining in NZ, locally trained graduates were leaving for overseas. HWNZ and the MCNZ were keen that the College 'promote strategies for increased regional and rural placement of trainees'.

37 ACEM Year in Review 2015, 27

38 ACEM Year in Review 2015, 24

39 ACEM, 2016 Progress Report to the AMC and MCNZ, 10

40 The 2017 Reaccreditation Submission (p.140) noted that comprehensive analysis of four years data would be undertaken in late 2017 to identify workforce trends and issues experienced by new FACEMs.

41 ACEM Year in Review 2017, 19

42 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 47

43 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 47

44 "Workforce Planning top of the agenda", ACEM Media release, 11 April 2018

45 Department of Health, *Australia's Future Health Workforce – Emergency Medicine*, November 2017, 3–4 and 36

46 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 4

47 Department of Health, *Review of the Specialist Training Program and Emergency Medicine Program, Final Report, March 2017*, 4

48 *Review of the Specialist Training Program*, 6

49 *Review of the Specialist Training Program*, 8

50 *Review of the Specialist Training Program*, 67–68

51 ACEM, 2019 Annual Progress Report to the AMC and MCNZ, 28

52 *Emergency Medicine Certificate, Diploma and Advanced Diploma Review*, 4 https://acem.org.au/getmedia/12be24aa-98f6-4f75-98b5-15376ae3fcdf/EMC_EMD_Review_Consultation_Paper_21_January_2019_FINAL_AH accessed 20 October 2020

53 ACEM, 2016 Progress Report to the AMC and MCNZ, 45

54 ACEM *Postion Statement: Rural Emergency Care*, June 2019 , 4–5 accessed at https://acem.org.au/getmedia/e366d8b3-ea60-4422-a882-b05e410cf794/S27-Statement-on-Rural-Emergency-Medicine-Jul-12-v02.aspx

55 NMTAN Communique 22 March 2019; https://www1.health.gov.au/internet/main/publishing.nsf/Content/36DE4AF3B0B86BCA257E6D001F0E59/$File/NMTAN%20Communiqu%C3%A9%20-%2022%20March%202019%20Meeting.pdf accessed 24 August 2020

56 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 21–22

57 ACEM, 2019 Annual Progress Report to the AMC and the MCNZ, 21

58 ACEM Year in Review 2015, 3

59 ACEM Year in Review 2015, 17

60 ACEM Year in Review 2015, 9

61 ACEM Year in Review 2018, 24

62 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 23

63 AMC Annual Progress Report 2016, 8–9

64 ACEM Year in Review 2017, 19

65 ACEM Year in Review 2018, 21

66 ACEM Year in Review 2017, 34

67 ACEM Year in Review 2017, 35

68 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 4

69 ACEM Board Minutes, 8 August 2016

70 ACEM Year in Review 2017, 20

71 ACEM *Innovate Reconciliation Action Plan, January 2017–December 2018*, 10

72 ACEM Year in Review 2018, 25

73 ACEM *Innovate Reconciliation Action Plan, September 2019–August 2021*, 4

74 ACEM RAP 2017-2018, 11

75 ACEM Year in Review 2017, 35

76 ACEM, 2019 Annual Progress Report to the AMC and the MCNZ, 24

77 ACEM, *Te Rautaki Manaaki Mana: Excellence in Emergency Care for Māori*, 10

78 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 52

79 ACEM, 2019 Annual Progress Report to the AMC and MCNZ, 68

80 ACEM, 2019 Annual Progress Report to the AMC and MCNZ, see tables 7.3–7.5 & pages 75–76

81 ACEM, Reaccreditation Submission to the AMC and MCNZ 2017, 51

82 https://acem.org.au/News/June-2020/Statement-on-equality-and-equity-of-access-to-heal accessed 22 June 2020

83 *The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments*, October 2018 available at https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018 accessed 26 June 2020

84 https://acem.org.au/getmedia/0857d22e-af03-40bb-8e9f-f01a2a2bf607/ACEM_Mental-Health-Access-Block.aspx accessed 26 June 2020

85 https://acem.org.au/News/Feb-2018/ACEM-mental-health-care-access-block accessed 26 June 2020

86 https://acem.org.au/News/Feb-2018/ACEM-calls-for-new-approach-in-managing-people-(1) accessed 26 June 2020

87 https://acem.org.au/getmedia/155a3761-26a8-4b03-82e9-8a39d2e9fb25/ACEM-Draft-Communique-on-Letterhead-7-June-2019-1 accessed 26 June 2020

88 https://acem.org.au/News/Jan-2019/ACEM-welcomes-WA-moves-to-improve-mental-health-ca accessed 26 June 2020

89 https://acem.org.au/News/August-2019/ACEM-Response-to-Federal-Government-Focus-on-Austr accessed 26 June 2020

90 ACEM Year in Review 2016, 19

91 Amy Coopes, "Operate with respect: how Australia is confronting sexual harassment of trainees", BMJ 2016;354:i4210 available https://www.bmj.com/content/354/bmj.i4210.full accessed 8 December 2019

92 ACEM Board Minutes, 5 October 2015

93 ACEM Board Minutes, 13 February 2017

94 ACEM Board Minutes, 19 June 2017 (note also that the EAG on Discrimination presented its interim report to the Board at this meeting)

95 https://acem.org.au/News/Aug-2017/ACEM-to-tackle-bullying-and-harassment accessed 4 August 2020

96 ACEM Board Minutes, 9 April 2018

97 *Diversity in College Governance Position Paper*, November 2018, 1

98 https://acem.org.au/Content-Sources/About/Our-people/ACEM-Board accessed 3 August 2020

99 Feedback from the consultation paper noted an inappropriate gender balance on the Board, and poor representation of women in College leadership roles generally – including CAPP and COE

100 https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Advancing-Women-in-Emergency-Section accessed 3 August 2020

101 ACEM Year in Review 2019, 20

102 ACEM Board Minutes, 16 December 2017

103 https://acem.org.au/Content-Sources/About/ACEM-Foundation accessed 14 October 2020

104 Amy Coopes, https://www.croakey.org/emergency-medicine-doctors-applaud-compelling-presentation-by-gillian-triggs-on-human-rights/ accessed 15 October 2020

105 ACEM Year in Review 2018, 8

106 ACEM Year in Review 2018, 4

107 ACEM Year in Review 2018, 4–5

108 ACEM Year in Review 2018, 8

7 The Next Phase, 2019-2020

1 ACEM Year in Review 2018, 11

2 ACEM Year in Review 2018, 11

3 ACEM 2019 Annual Progress Report to the AMC and MCNZ, 20

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