

# your ED

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MANAAKI MANA  
SABBATICAL

‘THE THINGS THAT  
HURT, INSTRUCT’:  
*Lessons from the Pandemic*

STANDING IN  
SOLIDARITY  
*with our Myanmar Colleagues*

BUILDING HUMANITY:  
*a Taranaki Emergency Medicine  
Conference*



# Australasian College for Emergency Medicine

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## **Your ED**

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## Message from the Editor

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

In this issue, we hear from Dr Kate Anson on her Manaaki Mana sabbatical and her experience as Co-Chair of Te Rautaki Manaaki Mana, ACEM's strategy for excellence and equity in emergency care for Māori patients, their whānau and staff.

We also hear from Professor Daniel Fatovitch on lessons learnt throughout the pandemic for both Australian and New Zealand ED's and Dr Peter Jones delves further into ED crowding and Hospital Access Targets. We take a look at the annual increase in public hospital ED presentations and how 'avoidable presentations' are unfairly scapegoated in ED delays as ED's get busier.

In this issue's Global Emergency Care stories, we learn more about the current crisis in Myanmar and how we can stand in solidarity with our Colleagues overseas. We also hear from Dr Claire Brolan, Dr Bailey Meyers and Larry Marabee from the Australian Red Cross, about the protection of healthcare workers in international conflict zones during the pandemic.

Finally, Dr Mark Sagarin writes about his experience at the Taranaki Emergency Medicine Conference, and we hear from the newly formed ACEM Regional Wellbeing Champions and why they chose to get involved.

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



# ACEM in the Media

In **January**, ACEM President Dr John Bonning featured in *The Australian* discussing systemic issues leading to increasing pressures on the country's emergency departments (EDs), following the release of new data from the Productivity Commission.

'We need more resources across the system for this relatively predictable number of patients. Because at the moment, the lack of resourcing is manifest in the emergency department, where we end up carrying the risk, carrying the can', said Dr Bonning.

This story generated follow-up interviews on ABC Radio Melbourne and FIVEaa in Adelaide, where Dr Bonning further discussed the issues.

In **February**, Dr Bonning featured on 6PR Radio in Perth discussing concerns the College had raised with the Western Australia Health Minister over major ambulance ramping and access block issues at the state's hospitals.

'The situation is becoming untenable', said Dr Bonning.

'Our people in emergency departments are suffering ... we need some action.'

Later in February, with the state election looming, the College's Western Australia Faculty Chair Dr Peter Allely

highlighted that urgent action was needed in an opinion piece published by *WA Today*.

'Access block is a health and hospital-wide issue manifest in the ED with overcrowding. The consequences are drastic, affecting all patients', said Dr Allely.

In **February**, ACEM's Victoria Faculty Chair Dr Mya Cubitt featured in the media discussing Victoria's ongoing mental healthcare crisis, in the context of the temporary closure of some Melbourne mental health beds due to a COVID-19 outbreak.

In **February**, ACEM issued a statement in support of emergency medicine colleagues in Myanmar facing immense personal and professional challenges, and calling for the restoration of democracy in the wake of a military coup in the country. 'We stand in solidarity with and support our Myanmar colleagues in their denouncement of injustice, and in their protest calling for peace and democracy', said Dr Bonning.

In **March**, the College issued separate media responses to final reports of the Royal Commission into Victoria's Mental Health System and the Commonwealth Government's Royal Commission into Aged Care Quality and Safety.

'There is much that is very welcome in this final report and in the Government's commitment to implement all of its recommendations. The mental health system is broken and requires urgent reform', said Dr Cubitt, in

response to the Victorian report.

'However, the state's mental health crisis is happening now, and the College again stresses the urgency of implementing solutions.'

ACEM President-Elect Dr Clare Skinner responded to the aged care Royal Commission report, noting that older people deserve access to timely, affordable, appropriate and high-standard healthcare, and that, where feasible and appropriate, this should be delivered in the environment of their choice.

'We urge the Government to commit to properly funding and implementing the recommendations in the Commission's report, and look forward to hearing more details about how and when this will occur', said Dr Skinner.

In **March**, ACEM South Australia Faculty Chair Dr Mark Morphet provided an opinion piece published in *The Advertiser* (Adelaide), calling for solutions to the state's ambulance ramping and access block crisis.

'The situation as it stands is life-threatening and South Australia's ongoing ramping crisis must be fixed', said Dr Morphet.

In **March**, the College issued a media statement raising concerns that 'GP-type patients' were once again, disingenuously, being blamed for crowding in Queensland hospital EDs, while the root systemic causes of access block remained unaddressed.

'Public narratives which lay blame at people presenting to EDs, usually

for very valid reasons, are deeply unhelpful and distract from the need to address the dangerous underlying systemic factors contributing to hospital access block – a whole of system issue manifest in the ED', said ACEM Queensland Faculty Chair Dr Kim Hansen.

In **March**, the College issued a media statement welcoming the announcement of government support to help address Papua New Guinea's COVID-19 crisis but calling for more support to be offered as needed.

'We acknowledge and welcome commitments to support vaccination efforts in the Pacific, but we should be prepared to respond in a timely manner if the situation changes and additional support is needed', said Dr Bonning.

In **March**, Dr Bonning featured extensively in New Zealand media highlighting the extensive pressures being experienced by New Zealand's EDs, hospitals and health system.

'It manifests in emergency departments, but it requires system-wide investment by the Ministry of Health', said Dr Bonning.

'We need the Minister and the Ministry of Health to sit up and listen to the crisis that is occurring.'

'Winter is coming. It's not going to be very good. We're going to have patients stuck in ambulances because there is no physical space in the emergency department, so this is a crisis that requires investment in people as well as infrastructure.'

The interview sparked a flurry of follow-up media

interest in the lead-up to a meeting between New Zealand's Minister of Health and College representatives.

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In **April**, ACEM featured in Western Australian media, following reporting of a tragic incident involving the death of a child at Perth Children's Hospital.

'We are thinking of the affected family, just as we are our colleagues at Perth Children's Hospital', said Dr Bonning.

'The focus must be on providing the necessary support to everybody affected, and ensuring that any systemic factors identified ... as contributing to this tragic outcome by a transparent investigation, are addressed immediately.'

Dr Allely also featured in the media discussing longstanding systemic issues being faced by Western Australia's EDs, hospitals and health system, requiring urgent attention.

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In **April**, ACEM featured in the media in South Australia following news of the resignation of the Central Adelaide Local Health Network mental health director over concerns about the state's mental healthcare crisis.

'The Minister is ultimately responsible for ... all the elements of healthcare in this state, and as part of his portfolio he would do really well to take a long hard look at how we're going in a number of areas that we've seen play out very publicly as areas of stress', said Dr Morphet, in calling for action on a range of issues the state's

emergency clinicians have been raising for some time.

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In **April**, ACEM featured in significant media coverage in Tasmania calling for parties contesting the upcoming state election to outline their whole of system vision and plans to address the state's well-documented acute hospital access crisis.

With hospital access block, ED crowding and ambulance ramping remaining major and dangerous issues in the state, Dr Bonning told *The Examiner* (Launceston) that major commitments were needed to address systemic issues which continued to manifest in EDs.

'As the healthcare system continues to fall short compared to other states on a range of measures, we need parties, at the very least, to commit to targets to reduce ramping, overcrowding and access block to meet national benchmarks', said Dr Bonning.

Tasmania Faculty Chair Dr Juan Ascencio-Lane also featured in *The Mercury* (Hobart) calling for major improvements and commitments from parties contesting the election.

'This is, literally, a life and death matter', said Dr Ascencio-Lane.

'We can't wait.'

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In **April**, Dr Bonning featured in the media discussing the New Zealand Government's announcement of plans to centralise the delivery of hospital services.

'This is a good move to centralise coordination. Services were becoming a

bit fragmented, potentially inequitable', said Dr Bonning.

'We think this is a great opportunity for the Government and the ministry to take leadership of healthcare across the country.'

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In **April**, Dr Bonning joined with the presidents of other emergency medicine colleges and societies as a signatory to a statement, coordinated by the International Federation for Emergency Medicine, calling for the release of the President of the Myanmar Emergency Medicine Society, Professor Maw Maw Oo, following his arrest and detention during the country's military coup.

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In **April**, Dr Bonning featured in *The Age* commenting on the major pressures being faced in Victorian hospitals, noting the acute hospital access crisis was unsustainable.

'We need systemic support and planning to get solutions in place and are in productive talks with the Government, and ongoing discussions with other clinical groups and medical bodies to achieve these', said Dr Bonning.

'There are opportunities to radically change the system to better serve patients and improve outcomes, and we appreciate recent efforts by the Government to understand the issues and bring together stakeholders to develop solutions.'

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In **April**, *Medical Journal of Australia InSight* published an opinion piece by former ACEM President Dr Simon Judkins examining extreme pressures being faced by

EDs across Australia, as well as potential systemic solutions to issues of access block, ambulance ramping and ED crowding.

'The solution is not bigger canaries, but a collaboration from all parts of the system, from GPs through EDs, to inpatient care and beyond, to ensure we all understand the risks patients are facing, and work to rebuild a better system for all in a post-COVID-19 world', said Dr Judkins.

The piece sparked significant follow-up interest, with Dr Bonning providing interviews to SBS and the ABC on the issues.

'This has been coming for a number of years and we feel like we've hit a ceiling of capacity', said Dr Bonning.

'This is not an unexpected blip. This is not really a post-pandemic thing and, yes, the levels of inability for patients to be admitted in overcrowded emergency departments are unprecedented.'

Dr Hansen also featured in local media speaking to the issues in that state.

'Most hospitals are seeing record numbers and they just don't have the staff or beds to cope', said Dr Hansen.

'The system was already at full capacity and now it's swamped.'

Dr Skinner also spoke to ABC Radio's *The World Today* program on the issues and the need for solutions.

'I think we need to see large-scale, courageous change to the way we structure our health system', said Dr Skinner.

# PRESIDENT'S WELCOME

**A**otearoa New Zealand and Australia are confronting major healthcare system challenges despite our two countries, at the time of writing, remaining in relatively strong positions internationally where the management of COVID-19 is concerned.

The devastating scenes we have seen unfold in India are reminders the pandemic is not over. Our thoughts are with colleagues and communities around the world.

In our two countries, the ongoing potential for lockdowns, as well as delays and recalibrations of our vaccination programs tell us we still face risks requiring attention. Theme for 2021: "it isn't over yet".

However, some semblance of pre-COVID life has been able to return due to our relatively fortunate positions. This has included the trans-Tasman travel bubble, which – although at the mercy of the aforementioned risks – provided me an opportunity to visit Australia for a few brief days in late April, and again in May, the first times since March 2020.

Although I have been in regular contact with colleagues across our two countries since our world dramatically changed, it was great to visit several EDs in Melbourne, western Sydney and the Hunter/Central Coast region, to see and discuss in person some of the distinct issues and experiences.

I have now visited 11 EDs in Australia and met a number of members social events. I am keen to cover more ground, meet members in their EDs, listen to their issues and advise the support in terms of political advocacy that we can offer. COVID-19 arrangements permitting, I plan to return to Australia in late June, for more comprehensive meetings and visits right around Australia.

Challenges at different locations are distinct, but there are many similarities. Worsening access block and staff distress are universal across Australia and Aotearoa New Zealand. Despite the duress, it was excellent to see strong leadership and camaraderie among ED staff buoying the troops.

Clearly, our EDs, hospitals and healthcare systems are struggling under the pressure of steadily increasing demand. Demand that has been increasing predictably for years, with issues of widespread systemic, staffing and under-resourcing across the entire hospital system – all resulting in access block and immense pressures on frontline staff.

In our public advocacy we have emphasised this is not a blip, nor post-pandemic surge. We are experiencing a continuation of trends obvious for years – presentation numbers going up and up, inefficient hospital admission processes and other systems issues compounding in the bottleneck in our EDs. We have reached a ceiling in terms of the care we are able to provide to the steadily increasing numbers of people turning to our EDs for acute care.

Politicians and system leaders, to varying degrees, are acknowledging things need to change – health ministers publicly accepting we need more bed capacity and residential aged care facilities (RACF) spaces, so the message is getting through. We must build on this momentum to secure the genuine whole-of-system improvements required.

Amid challenges, it is important to look for hope. There is so much to admire and take heart from in the work carried out daily in our specialty of emergency medicine. The pages of this magazine are testament to that. So too is the fact that the vast majority of our patients get world-class treatment, great outcomes, and are grateful to us.

There are many supportive resources available. Among the most valuable is the experience of our members and trainees. We are always eager to find ways to ensure that wisdom and expertise is imparted and shared and that our members and trainees are supported.

The launch this year of the ACEM mentoring program, Mentor Connect, is one such example, and I encourage you to learn more about the program via the College website (<https://acem.org.au/mentoring>).

ACEM is what we make it. By working together, supporting each other and promoting kindness – to ourselves, each other and our patients – we are all stronger for it.

Kia kaha,

Dr John Bonning

ACEM President





*In our two countries, the ongoing potential for lockdowns, as well as delays and recalibrations of our vaccination programs tell us we still face risks requiring attention.*



## CEO's Welcome

Dr Peter White

The way in which things can change at the moment is underlined by the difference in circumstances when the College President wrote his Welcome for this edition of Your ED and those that exist a very short time later as I write this. In essence, during that short time, Victoria has been subject to a seven-day lockdown period to deal with an outbreak of COVID-19 that arose from hotel quarantine arrangements in South Australia, that lockdown has been extended as other clusters arise, and concerns around the arrival of the Kappa and Delta variants of the virus have led to the original seven day lockdown being extended in Melbourne, with probable restrictions relating to travel out of the state capital to regional Victoria over the approaching Queen's Birthday long weekend.

Little wonder that the theme for this year is, increasingly, 'It ain't over yet'. Indeed, there are flashbacks to the circumstances of 2020 as compulsory mask wearing again becomes the order of the day, aged care and daily case numbers becomes topics of significant coverage, and we again deal with the complexities of running an organisation like ACEM in times where certainty is in short supply, but significant demand. The President has written of the demand situation in EDs across our two countries and I will not repeat his points; enough to say here that the College is doing what it can to support and advocate for its members and trainees so that they are able to provide the standard of care that is desired, and that our populations expect and deserve. The issues, though, as we all know, are many, and they are also complex.

At a College level there is significant work happening, albeit in the context of the circumstances provided by COVID-19 where College staff in Victoria are again working from home. Having submitted our required follow-up reaccreditation submission to the Australian Medical Council (AMC) in early May, the reaccreditation process is progressing, with a group of senior Fellows and staff meeting (by Zoom, of course) with the accreditation assessment team appointed by the AMC in mid-June to discuss the submission and areas that the team may be seeking further information on. Arrangements for meetings of the accreditation team with representatives of college entities during the period 10 – 12 August are in progress, as are arrangements for meetings of the accreditation team with members, trainees and others in nominated hospitals in the lead-up to that period, as well as

distributions of surveys that the AMC runs with stakeholders as part of the reaccreditation process.

As I have written previously, the accreditation of the College, indeed all of the specialist colleges, is one of the most significant activities that we are involved in, due to the primacy of that activity in regard to what is the absolute core function of the colleges; the training, education and Continuing Professional Development (CPD) of specialists in the field of practise. To continue to have the right for FACEM to be recognised as the standard for acceptance as specialist practice in emergency medicine across Australia and Aotearoa New Zealand is a privilege and core to the reason for which ACEM was established. I thank in advance all involved in the process of assisting the College to demonstrate its ongoing suitability for holding that privilege, whether as a contributor to the process so far, or as a contributor to activities, such as helping to organise or attending meetings with the assessment team in your hospital.

The contents of this edition of Your Ed are an excellent reflection of the intention of setting up the publication; that is, to highlight the work being done by the College, its members, trainees and others, for the benefits of those in need of emergency medical care. In the remainder of this year, the College will be developing its Strategic Plan for the period following 2021, the current document having been drawn up of the period 2019 – 2021. As part of preparations for the June meeting of the ACEM Board, the College staff have been updating progress of the College against the current Strategic Plan, as well as the accompanying Business Plan. Analysis at a broad strategic level, as well as a more focused, outcome level, demonstrates the vast amount of work that the College has done over the period covered by these two documents, along with the commitment of all associated with the organisation to ensuring that it is a forward-looking, outward-focused organisation that is aware of its responsibilities and objectives, and committed to achieving these.

The Board will consider the timeframe and mechanism for the construction of the next Strategic Plan at its June meeting. Needless to say, the input of all involved in the College will be needed to compile that document. While such an undertaking may seem much removed from the day-to-day delivery of emergency medical care under trying circumstances, it is a core part of the societal expectations of a modern organisation, and one of the ways in which the organisation can be held accountable to all stakeholders, as well as being to measure its own achievements.

In writing this piece I have looked back upon those I have written over the past year or so as COVID-19 has changed the way in which we go about our lives. Just over a year ago, I indicated that the recent months had been seen as many things, including 'unique', 'extraordinary' and 'unprecedented'. Clearly, we know far more than we did at that time, and we now have vaccines available to mitigate the effects of the virus. Some things, though, have not changed all that much and there is an unnerving truth to saying, 'It ain't over yet'. Despite this, I have seen the commitment of all involved in the College and its work to continuing to do good things in the face of difficult times. I thank you all for those efforts and for your ongoing commitment to the work of the College and its objectives to do good for all.



# Mental Health in the Rural ED

ACEM has long recognised that patients presenting to the emergency department (ED) with mental health issues experience longer waiting times than many other patients. The landmark report *Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions* (ACEM, 2018) indicated that, while mental health presentations account for only four per cent of ED caseload, they experience access block at much higher rates than other patients. This is even further exacerbated in rural and regional locations.

There are many causative factors in these stark differences. One of the strategies adopted to narrow the differences is improved access to educational resources that describe best contemporary approaches to mental healthcare in emergency settings. ACEM accessed funding through the Australian Government Department of Health's Specialist Training Program to develop an online resource – the Mental Health in rural ED (MHrED) website. The site will be launched in mid-2021 and primarily caters for staff in smaller, more rural settings, where there are typically fewer onsite specialist staff and services.

The information on the website is organised around nine key presentation themes (see Figure 1), each of which is supported with evidence-based material addressing patient assessment and management. The website is 'profession-agnostic' and includes a core skills tool to support learning across a wide range of skills. It can be used in structured learning, informal upskilling, formal teaching sessions, or as a quick reference.

It's hoped that access to, and use of, the resources on this site may contribute to enhanced patient experience and outcomes of care, as well

as highlighting opportunities for process improvements in service delivery.

In addition to the presentation themes, the site offers resources and guides that support staff mental health and an 'after the ED' section designed to support the mapping of locally available mental health services.

As the site evolves, more resources will be added and there will be a periodic newsfeed to update users on relevant College initiatives, jurisdictional mental health guidelines, and initiatives from external organisations such as Headspace, Beyond Blue and Head to Health.

Future enhancements to the website, subject to funding, may include webinars and training packages for local use.

The College will provide it's members and trainees with an update prior to the launch; in the meantime you can also check its availability at: [www.edmentalhealth.acem.org.au](http://www.edmentalhealth.acem.org.au)

ACEM would like to thank the many individuals and organisations that contributed to the site's development, in particular, the project's advisory committee, and the staff in rural EDs and urgent care centres across Australia who gave their time generously and enthusiastically.

Author: Ilana Lewis, Project coordinator

## More information

More information about ACEM's mental health initiatives is available at [acem.org.au/mhed](http://acem.org.au/mhed)

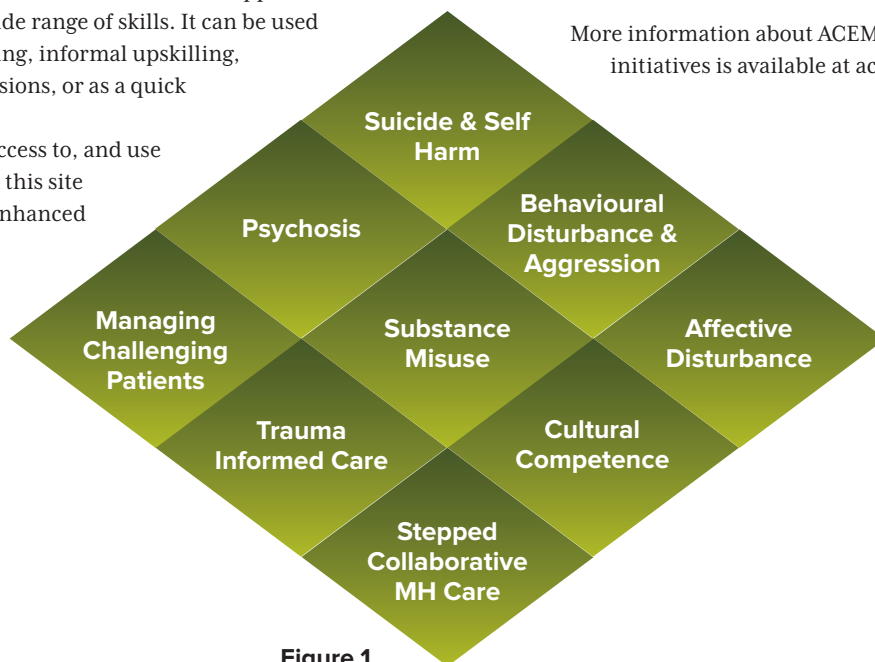


Figure 1



## Release of the Royal Commission into Victoria's Mental Health System Final Report

**T**he Royal Commission into Victoria's Mental Health System delivered its final report on 3 February 2021 and it was tabled in Parliament by the Victorian Government on 2 March 2021. The report is the culmination of a 24-month inquiry. It includes 65 recommendations for a redesigned mental health and wellbeing system, which build on the nine recommendations made in the interim report in November 2019. The problems facing Victoria's mental healthcare system have been well-documented and examined by this Royal Commission, with similar issues being experienced in every jurisdiction across Australia and Aotearoa New Zealand.

The Royal Commission has finally given a voice to people with a lived experience, their carers and families, and the wide array of people working in the mental health system. ACEM strongly welcomes the acknowledgement that

emergency departments (EDs) are being called on to provide a volume, range and complexity of mental health services without the resources, infrastructure or systemic support necessary to provide timely and appropriate care. This is long overdue, with the College advocating for many years for resourcing and systemic reform to improve care for members of the community seeking mental health support, and to address unsustainable pressures on hospital EDs.

There is much that is very welcome in this final report and in the Victorian Government's commitment to implement all of its recommendations. Alternative options to the ED, as well as a range of outreach initiatives and recommendations for additional mental health clinical support for frontline emergency responders, will all contribute to a positive blueprint for a system overhaul.



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## Key recommendations relevant to concerns previously raised by ACEM include:

- 100 additional acute beds (170 already committed through an interim report)
- 50 to 60 new Adult and Older Adult Local Mental Health and Wellbeing Services operating after-hours
- 22 new Adult and Older Adult Area Mental Health and Wellbeing Services providing 24-hour telehealth crisis response and outreach teams
- 13 new Infant, Child and Youth Area Mental Health and Wellbeing Services
- At least one highest-level ED for mental health and alcohol and other drug (AOD) treatment per region
- One drop-in or crisis respite facility for adults and older Victorians per region
- Four safe space facilities (mixed drop-in spaces and crisis response services) for young people per region
- Emergency services' responses to mental health crises to be led by health professionals rather than police
- A new non-government agency led by people with lived experience of mental illness or psychological distress
- System-wide roles developed for the participation of people with lived experience
- Aim to eliminate the use of seclusion and restraint within 10 years
- Incentive scheme to attract and retain rural and regional mental health and wellbeing workers
- New statewide service for people living with mental illness and substance use or addiction
- Prioritise increase to the number of addiction specialists (physicians and psychiatrists)

Given the scope and volume of recommendations and initiatives, ACEM has publicly commented on the need to ensure these services are properly resourced and supported, and integrated as part of a whole system, particularly where state and federal initiatives intersect and interact. Where new governance models and structures are proposed, these must contribute to better outcomes for people needing mental health support, rather than duplication or additional administrative burden. There is also a need to recognise and address the significant workforce and resourcing challenges which already exist.

In regard to the report's recommendation that there be at least one highest-level ED suitable for mental health and alcohol and other drug treatment in every region, ACEM has urged the Victorian Government to ensure this does not result in over-centralisation, or other unintended consequences. More information is needed, as well the evidence-base behind this initiative.

Within the implementation there must be clear metrics for measuring success, including who will be accountable for ongoing failure. This should include mandatory reporting of 12-and-24-hour ED stays for people in need of mental healthcare to the hospital executive and Minister for Health, respectively.

Over the medium term, the ACEM Victoria Faculty looks forward to working with other stakeholders, including the proposed Victorian Mental Health and Wellbeing Commission, to implement these reforms. However, the state's mental health crisis is happening now and measurable improvements are needed within the next six months. It's not fair to expect Victorians in distress to wait any longer for quality care. Genuine solutions must be the ultimate outcome of this Royal Commission.

*Author: Emily O'Connell, Manager, Policy and Advocacy*



# Manaaki Mana Sabbatical

Dr Kate Anson

*Ko wai au? Ko Kate Anson tōku ingoa. He tākuta au i te tari ronogoā  
ohore i te hohipera o Middlemore i te tonga o Tāmaki Makau Rau.  
Nō Ingarangi, nō Wera, nō Kotarana, nō Itari ōku tīpuna, he tauwiwi au,  
engari ko Aotearoa te kāinga o tōku ngakau inaianei.*

**W**ho am I? My name is Kate Anson. I'm an emergency medicine doctor at Middlemore Hospital in South Auckland. My ancestors are from England, Wales, Scotland and Italy. I'm a settler here, but Aotearoa New Zealand is now the home of my heart.

Last year, I was lucky to have a three-month sabbatical travelling around Aotearoa, despite a pandemic raging across the world and outbreaks occurring in South Auckland. Te Rautaki Manaaki Mana, launched in May 2019, is ACEM's strategy for excellence and equity in emergency care for Māori, and applies to patients, their whānau and staff.

As co-chair of the group that helped create the strategy and is now charged with overseeing its implementation, I wanted to visit as many emergency departments (EDs) as I could, to help bring this strategy to life. We believe that to create meaningful change on the ED floor, we need Manaaki Mana champions, or kaikōkiri, in every department, and the support of senior medical and nursing teams to begin the grassroots work.

I wanted to meet those who'd already put their hands up to be Manaaki Mana kaikōkiri and see what work was underway; to seek out champions and allies in other EDs and help link EDs and Māori health teams. I also wanted to find examples of what excellence looks like and experience the realities of our regional and small town EDs. I wanted to learn more about the reasons for health inequities and the often less than beautiful history of this beautiful land. I wanted to learn how to be part of the solution.

I ended up visiting 32 EDs – all the larger training-accredited EDs, all the EDs with at least one FACEM, and run by Rural Hospital Generalists & GP's – these doctors have additional training & qualifications to general practice. However small, they all had a resus room that any of us would feel at home in. I did a whole lot more driving than originally planned, due to being in a remote South Island location with my dog and an old 4WD when Auckland went back into Level 3 lockdown last August. This kept me away from home for seven weeks. I want to thank all who hosted me, sometimes literally in their homes, and took time out of their working days to listen, talk and show me their workplaces.

I spoke to numerous ED Senior Medical Officer (SMO) groups. Often, these meetings were attended by Māori health

teams, sometimes bringing people together for the first time. Other times I met with Māori health professionals separately. I noticed that it's rare for Māori health teams to be embedded in the ED, though they might get asked to come in times of crisis. Typically, they are funded to provide care to inpatients and link whānau with services on discharge.

I also talked with ED junior doctors, ED nurses, service managers, charge nurse managers, a CEO, intensivists, ICU nurses, paediatricians, rural hospital medicine physicians and Māori GPs.

Many rural hospitals are located in areas with a high proportion of Māori and have cultural and attitudinal expertise that ACEM could learn from. Geographic isolation in Aotearoa creates additional barriers of access to quality healthcare in a timely manner. Access to GPs, medical centres and hospitals is often dependant on locums or a largely overseas-trained workforce, limited access to diagnostic labs or imaging, difficulties with patient transfer to larger centres due to communication issues, weather, limited ambulances or crew, a perception that larger centres treat those from the regions differentially – these are equity issues that often disadvantage Māori.

I found active Manaaki Mana groups or individuals in Tauranga, Whakātane, Rotorua, Wellington, Whangārei, Palmerston North, Blenheim, Christchurch, Middlemore and Waitematā, though activity levels fluctuated widely.

In some places like Taranaki, Nelson, Whanganui, Dunedin, Invercargill, Hastings, Gisborne, and Greymouth, my visit prompted the first champion meetings, or at least a presentation to the SMO group and/or Māori health about the goals of Manaaki Mana.

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I spent time on marae (a communal and sacred place of refuge) and at places of historical significance to Māori. I visited Tauranga's unique 'kaupapa ward', which provides culturally appropriate care to Māori. Interestingly, this ward is increasingly popular with non-Māori too, perhaps because of the holistic care offered. I was privileged to visit Māori whānau in their homes when travelling with the nurses of Te Kaha Medical Centre, in the lands of Te Whānau-a-Apanui, east of Whakatāne, and hear their tales of community support during the Level 4 lockdown.



In Rotorua Hospital's bright and spacious atrium, it was great to join the staff in their daily ritual of karakia (prayer) and waiata (song) to start the day. I admired whakatauki (proverbs) on the walls of the waiting room and ambulance bay in Whanganui, together with Māori-inspired art on new hastily installed COVID-19 walls in Whakatāne ED.

In Palmerston North, there are te reo Māori instructions on the ED public address system announcing the imminent arrival of critically ill patients. Several hospitals such as Timaru, Taranaki, Rotorua and Hastings had comprehensive bilingual signage. Some hospitals have virtually no signage in te reo Māori and others a smattering.

I found rongoā (traditional Māori medicines and other healing practices) in use alongside western medicines in Rotorua Hospital and Rawene, in the Hokianga. I experienced a taster of the renowned Hapai te Hoe cultural orientation program led by Māori of Whanganui District Health Board, listening to a local history lesson while paddling a waka (canoe) on the Whanganui River.

I saw many EDs with Māori names that, to be honest, few could recall or pronounce. Whakatane ED has the most beautiful name – Te Ahuru o Rehuaariki – which refers to te ahuru as a haven or place of safety, and the star Rehua or Antares in the constellation of Scorpius, a star that guides people in times of crisis or need.

Whangārei and Kaitiā hospitals have beautiful carved entranceways. In Wairau Hospital ED in Blenheim and in Auckland City Hospital, I saw tikanga (etiquette) reminders on food tables and lifts. The only place I saw Te Tiriti o Waitangi (The Treaty of Waitangi) was on the wall in Invercargill Hospital, where I was proudly shown the new Māori section in the hospital library.

I met with staunch Māori nurses from Gisborne ED, where they make up 40 per cent of the ED nursing workforce, the highest percentage I encountered. Gisborne's population is 50 per cent Māori, with that percentage increasing as you head north up the coast.

I found that more and more ED doctors and nurses are embracing te reo Māori themselves. In Wairau, Blenheim, if you are happy to give te reo a go, you can wear a badge that identifies you as such. In Taupō, I joined the weekly hospital waiata (song) session along with others from the ED – bringing together all staff.

I learnt of land gifted by Māori for hospitals in Auckland, Rotorua, Thames and Blenheim.

In Waikato, although the hospital is built on land confiscated by the Crown during the Land Wars of the late 1800s, the late Māori Queen, Te Arikini Dame Te Atairangikaahu, symbolically gifted the land to the hospital for the health and wellbeing of all people, and as an act of healing for Māori.

I felt encouraged to meet so many passionate people doing great work. And, overall, I was heartened by the openness with which I was received, especially when broaching the uncomfortable topic of racism and white privilege.

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This has also been a personal journey of inward reflection. I've realised that if we want to see health equity, we can't ignore the reasons why health inequities exist and persist in the first place. We need to learn to talk maturely about racism and not run from the discomfort this brings those of us who benefit from the way that society is structured to favour us.





‘The system isn’t broken – it was built that way.’  
 ‘Inequity is not a bug in the system – it’s a feature.’  
 These are the words of Dr Rhys Jones, a Māori public health physician and lecturer at Te Kupenga Hauora Māori at the University of Auckland’s medical school.

Institutional racism can be defined as pursuing policies and practices that consistently result in worse health outcomes for minority racial groups, failure to act to remedy these inequities, and instead placing the blame on the victims of these policies and practices.

I’ve learnt that racism and the white supremacy that underlies it, is so much more insidious and complex than overt hatred and discrimination. I learnt that my own thoughts and actions can be racist despite this being contrary to what I consciously and rationally believe, so I have committed myself to what is likely to be a life-long journey to gain the knowledge, self-awareness and skills I need to be a culturally safe clinician and an anti-racist.

However, I’ve also learnt that being a culturally safe clinician isn’t about becoming an expert in another’s culture (not that this is possible or desirable), but about examining my own values, beliefs and biases and how they might impact on the care I provide. And that it’s the patient and whānau who get to decide whether I’m culturally safe, not me.

I’ve seen how the dominant Pākehā culture has defined what is normal or standard in Aotearoa New Zealand and how Māori have been, and continue to be, marginalised by colonisation and the institutions of this country, including the health service. I now understand that the process of colonisation – claiming lands and exploiting people and resources that were clearly occupied and owned by others – was justified by the false science of racial hierarchy, which places whiteness at the top.

‘This is not us’ was the overwhelming voice of white Kiwis in the aftermath of the Christchurch mosque shootings. But of course – it is us.

We like to think of ourselves as liberal, tolerant, broadminded and welcoming of difference and of having the ‘best race relations in the world’. We don’t like it when someone like Taika Waititi, the film director and screenwriter, points out the inconvenient truth that ‘New Zealand is as racist as f\*\*k’. We become uncomfortable and defensive instead of pausing to think.

We do this because we equate racism and white supremacy with violence, hatred and overt discrimination. We equate racists as bad people who are ignorant or evil and morally wrong. This is an oversimplification of racism. I’m not saying that any of us are bad people who are consciously making decisions that lead to inequitable outcomes. I’m saying that we, whatever our heritage, are the products of socialisation in a society that surrounds us with messaging about who is good, deserving and of value.

Racism historically evolved as a means of justifying exploitation of people and resources. It can be subtle and invisible to those who benefit most from it. At its core, it’s about power and fear of the loss of that power, particularly in societies with a history of colonisation by white settlers (Robin DiAngelo, *White Fragility*). By refusing to acknowledge racism and white supremacy, by denying its existence, we render it invisible, we protect the system and ourselves from close examination, and thus become complicit in its perpetuation.

So what can we do?

As individuals in the organisations we work for, we need to be culturally safe, anti-racist, pro-equity and good treaty





All images supplied by Dr Kate Anson

partners – this slide is the work of Te ORA, the association of Māori doctors and medical students, and summarises what they would like to see us embrace.

We can make the provision for culturally safe care a personal priority. Take some implicit bias tests. Examine your assumptions. Be aware of your personal privilege and power and use it to lift up those less advantaged. We can learn to show manaakitanga (care and respect for others). When I visited Māori-led services, the key difference that people spoke of was they felt they received manaakitanga.

Manaakitanga: Their mana (honour) was upheld, they felt welcomed, as did their whānau, names were pronounced correctly, they felt seen and heard without prejudice and assumptions, they were treated kindly and with dignity and respect, and were involved in decisions about their care.

This starts at the front of house with triage nurses and ward clerks at reception, and it continues with everyone else. If we don't get it right in ED, people leave before being seen, self-discharge against our explicit advice, don't trust or follow our recommendations, or don't come at all unless critically ill. Peoples' experience in ED impacts the rest of their hospital stay. We are at a pivotal place in the health service – the gateway and the bridge between the inpatient teams and the community. What we do and how we do it matters.

Mana and manaakitanga flow both ways. When we do authentically engage and are able to show kindness and compassion, not only do our patients benefit, but we also create those connections which give our work meaning.

Learn some te reo Māori – at least enough to pronounce names and places correctly. Use 'kia ora' at every opportunity – it can be used as hello, goodbye and thank you. I'm told that to hear te reo Māori spoken in a health context, can itself be healing.

We can learn about the history of Aotearoa New Zealand, especially history local to our workplaces.

We emphasise the importance of history taking in clinical assessments and yet we often function without awareness of the historical context in which we are working. Pākehā have been adept at collectively forgetting and selectively remembering events that remain highly traumatising to Māori today.

Learn about decolonisation – what might a decolonised ED look and feel like?

We can honour the treaty and learn what it means to be good treaty partners. Far from being an irrelevant historical document, the treaty has been called a 21st century prescription for Māori health. It provides the framework for the way we can work together to resolve historical wrongs and build a future that provides Māori with the self-determination they were promised.

Commit to being anti-racist. Remember, being 'not racist' is not a neutral place to be. Being 'not racist' supports the status quo continuing unchallenged. We can all learn the skills and self-awareness to be anti-racist. It starts with self-reflection and those awkward conversations that we prefer to avoid. We need to get comfortable with being uncomfortable.

We can be pro-equity. Make sure that all our actions and policies are working to create equitable health outcomes. Start auditing how your ED is performing.

Become a Manaaki Mana kaikōkiri or champion, or support the work of your local group.

Work alongside and be guided by your local Māori health professionals. Advocate to have their service embedded in the ED, not restricted to inpatient teams.

Responsibility for change must lie with those with the power to change social structures. Māori can't achieve health and other equities without the non-Māori majority being part of the solution. It's up to us to do the work at an individual, workplace and societal level. We are all in this together. He waka eke noa.



# Lessons for Australian and New Zealand EDs from Pandemic Research

**Professor Daniel Fatovich**

Professor Fatovich is an emergency physician at Royal Perth Hospital, Western Australia where he is also the hospital's Director of Research. He is Head of the Centre for Clinical Research in Emergency Medicine, Harry Perkins Institute of Medical Research. He loves clinical research.

Research is hard and getting harder. It's been said that the administrative overload of grant applications and reviews, and the increasing regulatory burden is killing innovation and high impact research by gifted people.<sup>1</sup> My career and recent experience affirms this. After obtaining a grant for a 12-month project, it took nine months to get to the point of advertising the position to be paid for by the grant.

Unfortunately, colleagues share similar and worse experiences with me. Many complain about 'ethics creep', where simple surveys require ethics approval, thus distorting the original purpose of ethics review, which is to reduce risk.<sup>2</sup> Conversely, Facebook can 'enrol' 689,003 users into their research without such hurdles.<sup>3</sup>

Patients are more protected in a research trial than in routine clinical care. Unwarranted practice variation or the introduction of unproven treatments into practice exposes patients to unregulated risk, but researchers who try to study these risks in a risk-reducing way are hampered

by burdensome regulation.<sup>4</sup> We'd be better off thinking about a continuum between clinical care and research, and demanding a similar level of oversight for both.<sup>4</sup>

The COVID-19 pandemic has demonstrated that some countries have established robust systems to integrate clinical research with clinical care. We marvel at the UK's RECOVERY Trial (<https://www.recoverytrial.net>): pragmatic trial design; streamlined recruitment and consent processes (with a waiver); and hundreds of hospitals involved, recruiting thousands of patients to provide evidence to inform practice.

These are lessons that we should heed to address our Byzantine regulatory system. Why has the UK been so successful? Angus et al describe several reasons. Perhaps the most important is that a decade earlier, the UK government had constructed a strong, integrated foundation for clinical research.<sup>5</sup> The National Institute of Health Research (NIHR) was established and coordinated with the National Health Service (NHS) to initiate the Clinical Research Network (CRN), which provides direct funds and support



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to NHS hospitals of all sizes (academic and community) for participation in clinical trials. This NIHR CRN support is only available for trials prioritised by national oversight committees (such as recognised Clinical Trial Networks).<sup>5</sup>

Priority clinical trials have funding sent directly to hospitals to promote participation and offset costs. This funding is dependent on enrolments. As such, hospitals not only want to participate, but want to create systems that maximise trial recruitment. Other steps taken to facilitate clinical research included establishment of a national Health Research Authority to reduce the operational burden of clinical research and provide a national regulatory framework for clinical research, and creating digital and information technology infrastructure to facilitate trials.<sup>5</sup>

Community attitudes are supportive of this approach, which aligns with the goals of clinicians, administrators and organisations. This research system meant it was possible for research leaders to create and disseminate pandemic response priorities, overtly supported by the chief medical officers. An Urgent Public Health committee was set up to prioritise studies for the NIHR CRN based on the underpinning science, relevance and feasibility during the pandemic, and to avoid interference with other studies.<sup>5</sup>

Despite the challenge of the COVID-19 caseload, the UK was able to achieve successful clinical research, with tens of thousands of patients enrolled in clinical trials. These include the Randomised Evaluation of COVID-19 Therapy (RECOVERY) platform trial (more than 37,000 patients) and the Randomised, Embedded, Multi-factorial, Adaptive Platform Trial for Community-Acquired Pneumonia (REMAP-CAP) (more than 5,600 patients). Robust evidence has

been generated on the benefits of corticosteroids, as well as convincing data on a lack of benefit for convalescent plasma, hydroxychloroquine and lopinavir-ritonavir.<sup>5</sup>

We should learn that it's vitally important to have already established research systems in place that integrate clinical research and clinical care. It's often not appreciated that research-active hospitals have better clinical outcomes, including lower risk-adjusted mortality.<sup>6</sup>

A report by the Australian Clinical Trials Alliance found that the return on investment in CTN clinical trials was 5.8:1 and for every dollar awarded in National Health and Medical Research Council clinical trials, a return of \$51.10 was achieved.<sup>7</sup> They conclude that investigator-led networks are an effective and cost-effective mechanism to undertake important public-good research. All of this emphasises the importance of having an emergency medicine research network to advance patient care.

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# ED Crowding and Hospital Access Targets

Dr Peter Jones

The emergency department (ED) is the best place for providing care to the most severely injured and unwell, and society's safety net for when urgent care is not accessible elsewhere. The ED is 'a window into the healthcare system, revealing what is right and what is wrong with the care delivery system'.<sup>1</sup> This makes the ED an excellent place to measure health system performance, but not the only place where that performance may improve.

Crowding in the ED is a sure sign of failure of health systems, reflecting a mismatch between the demand for care and the resources available to provide care. It results from a complex interplay between input (the number and type of people presenting to the ED), throughput (the quality and efficiency of how patients in the ED are cared for), and output (the efficiency of transfer out of the ED, whether this is a discharge from ED to the community or an acute admission to hospital).<sup>2</sup>

Crowding can be measured using the intimately related factors of workload, occupancy and time. Although predictable, workload is largely not controllable and doesn't stack up as an indicator to use to measure crowding or attempts to reduce crowding. Occupancy is associated with patient outcomes but is very variable within short timeframes. So it's a good trigger to initiate short-term solutions on the shop floor to prevent immediate harm, but it's less useful over the longer term to use as a performance indicator to stimulate system changes.

Length of stay in the ED is also associated with patient outcomes. If departments have many patients with inappropriately long stays, then outcomes are worse for those patients and new patients arriving in the ED. That said, some patients will need a bit longer in ED for correct diagnosis and treatment, so for some individuals, a longer stay until their ED care is complete is appropriate and will result in less harm.<sup>3</sup>

Time targets for ED length of stay have been around for over a decade. A recent review on their utility commissioned by ACEM found that they are associated with improved outcomes for patients, including improved mortality in some settings.<sup>4</sup> The key to this is that the focus is on improving the system of care, not the target number.<sup>5</sup> This requires buy-in from health ministers, health ministries, hospital management, in-patient specialists and ward staff; not just the ED.

With undue focus on the ED and the target number alone, gaming and inadvertent adverse events will occur.<sup>6</sup> There needs to be sufficient pressure from the top to encourage system improvements, but not so much that people are compelled to fudge the numbers (or worse, move people out of ED before their care is complete).

Hospitals need to run at less than 90 per cent capacity so that predictable surges in acute demand can be accommodated. We need to minimise wasted time for patients (no long waits for investigations or beds in the hospital), our systems need to be resourced adequately for the workload, and we need to integrate planned and unplanned care in the hospital, so they do not compete for the same resources.

ACEM is advocating for new hospital access targets. Access targets are not intended to be the stand alone measures of quality, but to show when system-wide improvements are needed. These targets are evidence-based, reliable and understandable.<sup>7</sup> As emergency physicians, we need to support ACEM's position and promote these hospital access targets within our own hospitals and to our health ministries. Without them, our EDs will be more crowded, we'll be at higher risk of burnout and our patients will be marginalised and suffer preventable harm.

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# Dr David Mai



Dr Mai is an emergency physician at Western Health, Victoria, and is a co-Director of Emergency Medicine Training (DEMT) at their Footscray campus. He has a special interest in decision making and cognitive bias.

## Why emergency medicine?

I love emergency medicine. It can be so broad and complex, ranging from the sexy fast-paced resuscitation to the intricate social / medical interaction and yet, at the end of the day, it's also pretty simple – getting people from the triage door to wherever they need to be, safely and efficiently. My lizard brain likes that clarity of mission.

I chose to start training in emergency medicine because as a junior doctor, it was the first place I felt I was let into the thought processes of the registrar or the consultant and I was allowed to ask questions. It felt like the work had an immediately recognisable point – all the choices you made in a shift had obvious consequences.

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

I worry about maintaining connections. So much of the joy of our job is working in a team and as we get driven, not just by KPIs but simply by patient demand, the time for staying connected as a team gets compressed and more precious. I find I have to be more conscious about seizing upon a teaching opportunity or asking a nursing colleague about their day. Really, our patients are in this team circle too. I wish that I could say it was automatic, but it takes me some discipline to remember to ask those one or two extra questions that adds value to someone's day.

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

I really wish I'd paid more attention when they tried to teach us meditation in med school! We all just fell asleep instead. I love music and I sing with a jazz choir and dabble in song writing. It's humbling – every song you start writing reminds you to have patience and faith that good things can come from small and warbly beginnings. Singing with other people, like in my choir Vox Chops, or even in collaboration remotely, like with Clare Skinner's ED Musos project, remind me how satisfying it is to create with other people, and how there are some things that you just can't do alone. But seriously, if anyone can help me with meditation, hit me up, I need more focus!

## What do you consider your greatest achievement?

I was very proud to help my friend and another FACEM, Jamie Roberts, put together a song parody video called

“Old ED”. We put it out at the end of 2019 as a thank you to our Western Health ED staff, which at the time we felt was one of the longest years ever (bless our innocence). We worked really hard over months to get little clips to include so many different people in our department and it was so satisfying to recognise them all. It is sitting at 25k views on YouTube but still does not hold the title of most viewed video by a FACEM in our department!

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

I am very inspired by our team. I'm constantly learning something new from so many different corners of our department, from nurses to the interns to the peri-fellowship trainees to the PSAs. The DEMT team I work with are continual sources of guidance and wisdom (hi Kent, Luigi, Ruth and Karen!). Sometimes, on a hard day, when I see the enthusiasm and grit our junior staff throw at the job it reminds me to pull up my socks and keep up. It really does help.

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

Get comfortable asking questions. The best time to ask what you think are dumb questions (although they're usually not) is when you're a junior doctor and the best time to keep asking dumb questions is when you're a bit more senior and you think you know everything (usually don't). Spend as much time asking about reasoning as you do about facts – the how's, why's and when's are as important as the what's. I was very question shy as a trainee and was just lucky I could observe some great clinicians who were graciously also very transparent in their thinking.

# Not the Problem: ‘Avoidable Presentations’ Unfairly Scapegoated for ED Delays

**E**mergency departments (EDs) are getting busier. The annual increase in public hospital ED presentations in Australia significantly exceeds the rate of population growth.<sup>1</sup> The increase in demand for ED services has not been matched by a similar increase in resourcing, leading to a situation in which EDs are frequently overcrowded and under pressure.

Governments and hospital administrators often claim that the number of non-urgent or ‘GP-type’ patients presenting to public hospital EDs is the main cause of overcrowding and suggest we develop strategies based on encouraging ‘avoidable presentations’ away from the ED. This assumption, however, is not reflected in the experience of ED doctors or research in the area.

## What is an ‘avoidable’ presentation?

Despite the term being used frequently, there’s no consensus on what an ‘avoidable’ presentation actually is. It’s often used to describe GP-type patients, although other groups of patients can also be perceived as ‘avoidable’ presentations.

## What is a ‘GP-type’ presentation?

ACEM defines a GP-type patient as one who self-refers to the ED, does not arrive via an ambulance, and whose medical consultation takes less than an hour. Alternative definitions may define a GP-type patient by the urgency and severity of the illness and level of care needed. The Australian Institute of Health and Welfare (AIHW), for example, defines lower urgency ED presentations as those at public EDs where the person:

- had an emergency presentation to the ED
- was assessed as needing semi-urgent (ATS 4) or less urgent care (ATS 5)
- did not arrive by ambulance, police, or correctional vehicle
- was not admitted to the hospital, was not referred to another hospital, and did not die.

In 2018-19, 35 per cent of all Australian ED presentations (2.9 million) were classified as lower urgency based on the AIHW definition.<sup>2</sup> It has been proposed that these lower urgency ED presentations contribute to ED overcrowding.

## Do GP-type presentations cause delays in the ED?

No. GP-type patients typically take up less time and resources than other patients and contribute proportionally less to demand for ED services. As they are not admitted to the

hospital and rarely require trolleys or extended stays for tests, they don’t contribute significantly to access block or overcrowding. Access block (defined as the situation where patients become stuck in the ED for more than eight hours because of a lack of inpatient beds or services to be transferred to the next stage in their care<sup>3</sup>) and overcrowding are the top two ED workplace stressors faced by FACEMs and trainees.<sup>4</sup>

Research has found that GP-type patients use less than three per cent of ED costs and resources, as well as being easier to deal with and not imposing upon the key functions of an ED: assessment of sick patients, complex treatments and resuscitation.<sup>5</sup>

ACEM analysis has shown that, in Australia, there’s no association between the total number of lower urgency ED presentations (based on the AIHW definition) and the time taken for most patients (90 per cent) to depart the ED.<sup>6</sup> In fact, as the total number of lower urgency presentations increases, the time for most patients to depart the ED decreases.<sup>7</sup>

The length of stay for ED patients is also unrelated to the number of arrivals in the ED (including GP-type presentations). It’s patients with more serious needs who require admission to hospital that experience the longest delays and might experience access block.<sup>8</sup>

## Should GP-type patients present at the ED?

The healthcare system works more effectively and efficiently when patients present to the appropriate facility, but we understand that, often, particularly out-of-hours or in rural locations and areas of socioeconomic disadvantage, the ED may be the only accessible option for many patients.

Preventative measures or early healthcare intervention should be employed as much as possible to reduce the numbers that present to the ED. However, assuming that patients should see their GP instead of going to a hospital is an overly simplistic solution that will not reduce access block.

GPs have a crucial role in our healthcare systems, but whole of healthcare system solutions are needed to ensure people have access to additional, affordable, and appropriate options. The ED should not be their only choice.

## Are there other types of avoidable presentations?

There are a number of demographics identified in research on lower acuity ED presentations as over-represented in EDs, suggesting that these groups are more likely to present to the ED unnecessarily.





These groups include:

- Aboriginal and Torres Strait Islander peoples and Māori
- People with drug, alcohol and mental health issues
- Older people
- People with chronic diseases
- People living in rural areas
- Frequent ED attendees.

The reasons for the over-representation of these groups varies according to their specific and diverse needs, as well as in relation to the health service and broader social and cultural environment. However, there are common factors identified that influence their presentation to EDs for conditions that could potentially be treated outside of the ED. These include:

- Complexity (patients who consider their condition too complex for primary care)
- Urgency (perceived urgency of the condition)
- Cultural (cultural barriers to receiving primary care)
- Social (patients aren't able to present to primary care for socioeconomic reasons)
- Accessibility (time and/or cost and/or geographic barriers to alternative forms of care)
- Specific service requirements (tests or procedures not provided in primary care).

The over-representation of these patients, whose presentations may be seen as avoidable, and the complex combination of causes as to why they have no choice other than to present to the ED, is the starkest reminder of the scale of inequities that exist in our healthcare systems, and in our societies. Often, through no fault of their own, these patients have nowhere else to go and should not be considered 'avoidable'.

### Will more services outside of the ED reduce demand?

Policymakers often see the simple solution to access block, waiting times and overcrowding, as reducing the number of avoidable presentations. They will resource initiatives that, as explained above, have a limited impact on issues like access block. These initiatives can include extending primary care services, and expanding community-based acute care or remote advisory services. Often, these measures will fail to have an impact on reducing the number of presentations to EDs. Few studies have been able to demonstrate a direct link between these types of interventions and a reduction in ED demand.<sup>9</sup>

This doesn't mean that governments should not attempt to provide alternatives to EDs for patients who can be safely and

cost-effectively treated elsewhere. But to be effective, these strategies need to be based on a sophisticated understanding of the specific needs and preferences of patients, their past experiences of healthcare, and the broader health service environment. EDs do not exist in isolation and the issue of inappropriate demand needs to be seen from both a patient and a health system-wide perspective.

### Three simple solutions to reducing access block, waiting times and overcrowding in EDs:

1. Increase hospital and alternative care capacity, including increases in physical inpatient bed capacity and the workforce of public hospitals.
2. Extend inpatient and community mental health services outside of 'business hours'.
3. Increase inpatient staff specialists and/or senior decision-makers working after hours and on weekends to ensure inpatient beds are made available in a timely and clinically appropriate fashion.

*Author: Jonathan Longley, Policy Officer*

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# Recharging in a Regional ED

Dr Simon Judkins

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

*'Break on through to the other side ...  
break on through ... break on through  
... yeah, yeah, yeah, yeah ...'*

It was one of the stranger moments of the last 18 months for me. I smiled at the police officer as I showed her the letter permitting me to come through the so-called 'ring of steel' surrounding Melbourne during the second wave of the COVID-19 outbreak. A long-term aficionado of The Doors, I couldn't help but appreciate the irony of having this great song turn up on my play list as I drove through the check point. With a smile, the police officer waved me through. It was a few songs later that Van Morrison's 'Bright side of the road' really had me enjoying this trip.

I was on my way to Echuca for my first shift in Echuca Regional Hospital Emergency Department (ED).

2020 was a year we'll never forget. Everyone will have their own memories. Some good, some bad. Some very distressing. My memories are very mixed. I think I learnt what burn-out is, accepted that I was and made changes in my life to address those things that dragged me down. I also learnt a bit about recovery.

I've spent the last 20 years in a tertiary ED. I initially started without admin roles, but that changed as I moved into roles as Deputy Director, Director, Chair of the Senior Medical Staff, roles with ACEM, peaking as the College President ... There's a list which I'm very proud of, but also a list of roles which added pressure and stress.

I've loved every one of those roles and all of the challenges, relationships and friendships. And I've always been in awe of all the great people I've met along the way. I'm still engaged and involved, despite a very difficult period at the end of 2020.

But my first day in Echuca ED was like a hand and a glove. It was a natural fit. It's an ED filled with dedicated staff, well-designed, with good support from the hospital, and a desire to expand its roles and capabilities. I wanted something new to reinvigorate my enthusiasm, to help make a difference, and Echuca seemed like the right place.

Five months later, I'd signed the dotted line to take on the role as ED Director. That role had been vacant for almost two years. After a number of conversations with my wife and kids (well, my young adults), we felt that the commitment to a regional ED, to Echuca ED, was the right thing to do.

So, every Tuesday morning, I set the play list, listen to some news and a podcast or two, and drive 2.5 hours from my home in Melbourne to work in Echuca. A few meetings, a clinical shift, another the next morning, some admin work,

and I head back home. Dinner with the family at about 7.30 pm. All good ... sometimes I'll stay the extra night and head home on Thursday.

I tend to the administrative stuff through Zoom and email, but we've also developed a team of excellent clinicians who love 'our little ED' and make sure things run smoothly. Divested and engaged leadership.

I still do some work in my old stomping ground. I can't let go completely. The staff mean too much to me.

There are a number of reasons why I've found the experience in Echuca so positive. The first is that, while I'm writing this article, I'm sitting by the Murray River, watching kangaroos munch on the grass, with a glass of local wine and a nice cheese to go with it.

But I also feel that I am reinventing my career, reinventing my clinical skills and contributing to a community that relies on their local hospital and ED to be there when they need it. The ED had an ad hoc senior experienced clinical presence, with an unhealthy reliance on locum agencies. Now the ED has regular engaged and dedicated medical staff. We've only just begun, but working with the team who've been looking after the hospital for so long, and doing an amazing job, I feel that we are developing a great model, improving care, mentoring our Doctors in Training (DiTs), and providing good supports.

I've joined the Rural Doctors Association and met an excellent group of docs on a call to discuss regional mental health issues in the lead up to the release of the Royal Commission into Victoria's Mental Health System. The challenges in regional and rural Victoria (as with all other states) are great, but if the dedication of this group is anything to go by, there's change afoot. We are hopeful that the recommendations in the Royal Commission are followed through as a priority for rural populations. Having witnessed the challenges of access to mental healthcare in the regions, the limits of the local facilities, and the pressure on families when a loved member is transported to Melbourne for their inpatient care, I have a much better appreciation of the desperate need for reform.

There's still much to do. Staffing, as you would all be aware, is the biggest challenge in EDs (and other parts of these facilities). Despite many different approaches, the gap remains significant. We've been fortunate in Echuca to attract a good team, but most EDs fall well short. Stories of having one intern covering an ED overnight in a large rural town have recently attracted attention, but this is not unique. I don't need to highlight the risks this presents for patients who need their ED, and to staff who have to work in these unsafe environments. ACEM is reviewing all things related to



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workforce, including regional and rural training posts, in an effort to change the workforce footprint and see high-level ED care across Australia. Working with other organisations is key. No one owns this space, but we need to play our significant part and, hopefully, lead change.

I think part of the solution lies with individuals who want to step up, contribute, and make a difference for themselves and communities who need their skills and experience. I would strongly appeal to those ACEM values we all embrace: equity, respect, integrity and collaboration. I'd strongly appeal to all of you who have been 'stuck' in a role for 20 years, to all new FACEMs looking for a substantial start to a career, to ED directors who may have the capacity to partner with a regional facility and create networks to support training and staffing – make a change and make a difference.

It's worked for me. I feel like I'm doing good things and there's more to come. I've made a commitment to making changes for the better for me, my family and (hopefully) the community I work for.

There are opportunities out there. A satisfying and fulfilling career awaits if you find the right place, work with the organisation, and think laterally about how you can contribute. It will not suit everyone, but regional Australia doesn't need everyone ... but it does need more FACEMs who have a desire to make a positive impact.

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**i More information**

ACEM has launched its inaugural *Rural Health Action Plan*, outlining the College's commitment to improving health equity across rural, regional and remote Australia and Aotearoa New Zealand. To view visit <http://www.acem.org.au>



# Islands of Wealth: How EM Forster and Michael Marmot Might Inform ED Doctors

**Dr Marianne Cannon**

Dr Cannon is an emergency physician working in Brisbane and Northern Rivers, Queensland. She sits on the ACEM Public Health Committee and has been involved in drafting the ACEM Sustainability Action Plan.

The author EM Forster, in *Howards End*, writes – against a backdrop of wealthy people ‘meddling’ in working people’s lives – of wealth as being like ‘an island ... against which we may be protected against the rising tide of fate or misfortune’. Who of us, when in a foreign country, having lost our wallet or access to means, has not felt the panic of how close we would be to ‘the streets’ except that we have that spare credit card.

Some of us have seen our own families traverse the stormy and uncertain sea of job loss, loss of health and working capacity, rendered dependant on relatives, welfare or insurance ‘benefits’, if we have been able to afford them in the first place. Those of us who have worked in systems outside Australia have seen such misfortune first hand, and have been changed for life by some of our experiences.

A vivid memory from Baltimore in the US, where I worked for several years in the 90s, was Nancy, a 46-year-old single mother of three, working two (or three?) jobs to pay rent, put food on the table and buy clothes for her kids. Health insurance and sick leave come with some jobs, but not others in the US. She had neither. That’s just how it was. She was working more than one job to make ends meet and to save a little to ‘put one of the kids through college’, which was, incidentally, the catchcry of many of the ageing nurses I met in my time in Baltimore.

Nancy had ignored her symptoms (shortness of breath and hoarseness) for several months, as she could still work and needed the money. Among her few pleasures were cigarettes. She didn’t (as I recall) drink alcohol to excess or gamble. She lived in modest rental accommodation in a suburb east of Baltimore.

If she missed two weeks of work, she would be evicted. Like for many Americans, this is just how it is. She proudly kept her head above water, but at a price. She couldn’t afford to take a day off, let alone pay the doctor who would charge her an unknown but considerable sum to have her symptoms investigated. One day she went to work as always, presumably feeling a bit worse than usual. Around lunchtime she told her workmates she wasn’t well, then collapsed after becoming short of breath.

She was taken, semi-conscious, (by private ambulance) to the ED where I worked, and was intubated shortly afterwards with severe respiratory failure and right heart failure. She

was in intensive care for several weeks (and had every body cavity CT scanned) before she was weaned off the ventilator. At extubation, someone recalled the abnormal looking vocal cords they had seen in the ED before the tube went down.

She had throat cancer as well as severe lung disease, and approached the (charity) hospital for a reduction in the cost of her care. Her children, faced with the several hundred thousand dollar bill, went into debt to pay. I can only assume that college became a dream. Nancy would never work again and her family would have to decide how her cancer treatment would be paid for, if at all. She was 46 years old.

I saw many people like Nancy from different walks of life in Baltimore. The uninsured, the underinsured (whose insurance companies’ fine print didn’t cover them for heart attacks), who lost their homes to pay hospital bills and the well-heeled. At that end of the scale, I saw (at Johns Hopkins Hospital) well-known patrons of the city, multimillionaires, being asked for donations by a fully funded hospital department, which tracked inpatients down in the cancer wards as they ‘faced their makers’.

Then there was the guy in our neighbourhood, who, after Managed Care inserted itself into the complex US healthcare equation, walked around wearing a sandwich board asking why XXXX Managed Care Company had ‘refused to do a CT scan on my wife to find her brain tumour until it was too late’. Somehow, it was the Nancy-like stories that stuck with me and coloured my views.

Sir Michael Marmot did a landmark study in public health tracking the health outcomes of a large cohort of British civil servants over several decades. Expecting to find that the wealthier and ‘stressed’ executive types would do worse, his results were surprising. He showed that across every level, from lowly paid clerks and cleaners to office workers and senior managers, the trend was the opposite.

The more wealth (and seniority in the service) you enjoyed, the healthier you were and the longer you lived. In other words, poverty was a risk factor for disease (in the same way as we know diabetes or hypertension is a risk factor for heart disease). Marmot’s work confirmed what may seem obvious (at least on a global scale this seems clear), but here was a gamechanger within British society itself. We now refer to his findings (and such risks in general) as the socioeconomic determinants of health. They are just as real

as the other risk factors we use to predict disease. How might this inform our views?

Fast forward to 2014 in a tertiary hospital setting in Australia and it's clear that Marmot's work has not reached the ear of many physicians who might benefit from knowing it. I still hear – even in the open at handover – terms like 'XXX is a loser' in the context of patients whose catastrophic life events have pushed them to overdose or the 'teeth to tats ratio' as shorthand for 'this patient is not like us and should be treated somehow less well than we would expect to be treated'. Or maybe it's code for something else, I'm not sure.

I call it socio-economicism. Like racism, sexism and elder abuse, it surely doesn't have a place in our workplaces. The smug smiles and aimless superiority (ironically from we who should be advocating for those in our care), which can follow, is a testimony to just how much we have to learn. Perhaps we should try being a patient with difficult life circumstances, illness and low income, before we jump on this dodgy 'feel good' wagon of superiority. Maybe we do it to keep our distress at being overwhelmed at bay. Or maybe we could pause and get a top up on empathy, which most of us once had. We are better than this I'm sure.

At a health systems level, the Nancies of this world have informed my views on the value of a robust universal prepay healthcare safety net system (like Medicare), as well as the roguish nature of some of the commercial elements that try to insert themselves into a good system.

By World Health Organization (WHO) standards, we do have a very good (albeit arguably imperfect) health system in Australia. In fact, it's one of the best, by many measures. If you doubt me, you can go to the US without insurance and get sick (I paid \$47 for a salbutamol MDI there recently!) or you can read Marmot, as well as the WHO website on health systems. Or maybe just pause and think 'there but for the grace of God ...' before judging patients at their most vulnerable times.

George Orwell also has some interesting observations about wealth and the lack of it in *Down and Out In Paris* and

*London* and *The Road to Wigan Pier*. As an ex-Eton student, he headed to Burma (now Myanmar) as a policeman. He rejected his family's offers of money and decided to live the experience of the down and out in poorer areas in the UK in the pre- and then post-war periods. Both books are readable and may even challenge your world view, provided, of course, that it's open to change.

I'm not speaking from a position of superiority or perfection, but rather as someone who has made a journey that transformed my views. 'Black humour' has been (and no doubt will be) a release valve for junior doctors in a high pressure workplace. But I don't believe it has to extend to disrespect or contempt for people, especially those on a journey we may never have ourselves, nor would we wish on anyone.

In Baltimore, one day, I'd had a bad shift with yet another difficult and demanding patient, and was muttering audibly about 'white trash'. I was feeling annoyed, put upon and close to the end of my usually long rope. My now good friend, mentor (and on this day nurse) Shirley Edwards said quietly, without anger, and without looking up from her work, 'They don't choose to be that way Dr Cannon'.

As a veteran of the civil rights movement and now as an older African American nurse who had 'seen it all', I saw (and still see) Shirley as a friend and wise elder, someone for whom I should sit up and take notice. She was so right.

From my own island of wealth and advantage, I had taken it upon myself to judge folk based on their access to education, meaningful work, an abuse-free childhood, and who knows what else. I felt ashamed and stupid. It was not what I had been taught as a kid and an intern. I'd let my values run thin in a culture of 'clever doctors' who fixed broken people and sometimes forgot they were just that, people each with a unique story.

It was a lightbulb moment. Only later, doing my Master of Public Health, did I discover Marmot, who pulled it all together academically and told me yet again what I already knew and had forgotten more than once.

Thanks always to Ms Shirley Edwards, Registered Nurse, Baltimore County, America.

*I'm not speaking from a position of superiority or perfection, but rather as someone who has made a journey that transformed my views.*

# How Cognitive Bias in ED Impacts on Patient Safety

By Maureen Williams

Maureen Williams has over 40 years of advocacy behind her. A speaker at many medical conferences and hospitals and a Committee member for ACEM and Monash University.

I've been living with Addison's disease for 42 years. In that time, I've had well over 100 admissions to ED. My observations are that cognitive bias is a significant and ongoing issue in emergency departments (EDs).

I recently wrote an assignment on cognitive bias as part of my master's degree and I felt there were aspects of my research that could be useful to share.

Just over 40 years ago, when studying to be a professional singer, I became extremely unwell. I was vomiting, had itchy rashes, lost weight and looked jaundiced. All the doctors told me there was nothing wrong. I was labelled an attention seeker, a malingerer and a Munchausen. After almost 18 months, I was finally diagnosed with Addison's disease and hypothyroidism. When I was finally diagnosed, I was close to death.

Later, when running support groups for Addison's disease, I heard several stories where patients died before being diagnosed. All of the stories were tragic, preventable and, I believe, related to bias.

My own personal experience, and the stories shared with me, suggest that there's a bias towards patients who do not look sick. An ED resident suggested to me that as I 'looked really well', perhaps I had marriage problems? Can you imagine? Your marriage is falling apart and you chose to go to ED and lie down with sick people! I don't think so.

Another time I presented to ED in the country late at night. The triage nurse looked at me and suggested that, as I was a local, I should go home and see my GP the next day because they were extremely busy. I asked her to take my blood pressure and when she saw the result I was admitted immediately.

My endocrinologist recently sent me a coroner's report for the avoidable death of a 38-year-old man in Victoria. He had a medical history of childhood medulloblastoma and hypopituitarism resulting in secondary adrenal insufficiency. He presented with an infected lump on his chest. His history was continually overlooked as three of the clinicians treating him wrote that 'he appeared very well' and was 'generally enjoying life'. These assessments led to no clinical observations being recorded and no specimens sent to

pathology, even though the badly infected lump was, in fact, sepsis.

The patient saw a doctor shortly before his death, complaining of severe gastrointestinal upset and loss of appetite. Once again, these are indeterminate symptoms, but they are alerts for adrenal insufficiency. However, the doctor recorded that he was 'systemically well' and sent him home. He was found dead three days later.

To me, one of the most important aspects of patient safety is diagnostic error. It's a major contributor to adverse outcomes for patients. The Organisation for Economic Cooperation and Development (OECD) states that medical error is the fourteenth leading cause of the global disease burden. A systematic review of medical mistakes in the US found that 37 per cent to 77 per cent of medical errors were associated with cognitive bias.

An article in the *Medical Journal of Australia* in 2020 states that one in seven patients has an unnecessary event of pain, suffering or death. It was also reported that 80 per cent of diagnostic errors are deemed preventable and, further, that 75 per cent of these errors are attributable to cognitive factors.

Cognitive biases are symptomatic, unconscious, automatic patterns of thought that sometimes distort thinking and potentially lead to errors.

Some of you will be familiar with Croskerry, whose work on bias is seminal. He writes, 'The study of cognitive bias is underrepresented in education and neglected in clinical practice'. Also, 'Cognitive errors are not caused through a lack of knowledge, but rather how decisions are made'.

O'Sullivan and Schofield write, 'By raising this issue, physicians' understanding of how their innate behaviours impact on their work will reduce the adverse effects suffered by patients as a result of bias'.

And finally, Dr Lucian Leape writes that, 'The single greatest impediment to error prevention is that we punish people for making mistakes'.

I totally agree with the last statement, as I believe that a medical error is a systems error. Punishing the perpetrator engenders a negative environment and is a lost opportunity for learning.

*Punishing the perpetrator engenders a negative environment and is a lost opportunity for learning.*



My research identified the three most prevalent biases encountered in ED:

**Anchoring bias** is where the physician stays locked into an initial diagnosis despite evidence to the contrary. This is considered to be the most common cognitive error.

**Availability bias** is jumping to a diagnosis that comes readily to mind because it's most common, prevalent at the time, or otherwise noteworthy.

**Framing effect** is allowing the story to be framed by others, for example, if the treating physician allows a medical report, the patient story, or outside information to overinfluence their diagnostic conclusions.

My research concluded that the greatest impediment to dealing with cognitive bias in medicine is the physicians themselves. In one study, although physicians claimed to be excellent decisionmakers and free from bias, in formal testing, they all scored poorly. As Croskerry says, 'The trick for clinicians is knowing when one's intuition should engage with deliberate analytical thinking'.

In my opinion, there's a general lack of insight across the entire population of one's own biases. The reality is that there are a great many biases and we all have them – we just don't want to own them. Cognitive bias is not intrinsically bad. We all come from different world views and life experiences, and this informs our way of being in the world.

We are all naturally judgmental. Think about the first time you meet someone: you immediately form an impression and it's not always right. Another important aspect of bias is how it affects communication. The most common complaint from patients is that they don't feel they have been really acknowledged or heard. I believe this can be a result of bias. If the physician has made an unfavourable judgment about a patient regarding their health literacy, or their social or cultural status, it's less likely that they will effectively communicate with the patient as a person.

The Clinical Excellence Commission (CEC) found that when patients are asked a question by the doctor, they are usually interrupted within 11 seconds and no longer than 30 seconds. The reality is that, as a treating physician, you'll probably spend, at most, a few hours with a patient. Whereas that patient has lived in their body 24/7 for their lifetime. They are experts in their own experience. They know the truth of what's happening in their body and, while they may not be

able to describe it, they will give valuable clues if they are authentically listened to.

The disappointing news is that, although there have been many interventions to reduce cognitive bias in the literature, they resulted in no significant measurable improvement.

I did find two that appear to have real benefits. The first is computer games, which are being designed specifically to identify the biases of the player. The premise is that computer games are more engaging and dynamic than instructional videos or lectures and can provide a more effective continuing education program. Certainly, their results demonstrated that game-based learning was more effective than normal instruction.

The second idea is a narrative exercise using metacognition. A physician writes down the details of an adverse event, the patient writes down their version, and then there's a meeting of all concerned to examine the reports and discuss the way forward. The premise is that the process of writing down the details engenders self-awareness and demonstrates to the physicians how biases have affected their diagnostic outcomes.

Emergency physicians, such as yourselves, are exceptional people who are responsible for the lives of patients in their care. A study on interruptions in ED found that doctors are interrupted 6.6 times per hour and in 11 per cent of all tasks. They multitask 12.8 per cent of the time and fail to return to 18.5 per cent of interrupted tasks. The conclusion was that interruptions can trigger cognitive failures, including lapses in attention, memory and perception. Interruptions can impact significantly on cognitive overload, increasing stress and anxiety. Critically for patients, it was found that on returning to a task, there's a tendency to rush through it to make up for lost time.

From my perspective, as a patient of 40 odd years, cognitive bias has been a significant concern. From a patient safety perspective, it's an important issue. Given the magnitude of responsibilities associated with the work of an emergency physician, would it not be beneficial to address this issue?

Maureen is a patient advocate who has worked with ACEM for eight years. She's been a patient advocate for many decades and has had extensive experience in the healthcare field, working with medical professionals in research, conferences and healthcare committees.

# ‘The Things That Hurt, Instruct’: Lessons From the Pandemic.

*Three emergency department directors share what the pandemic taught them.*

## **Professor George Braitberg**

Benjamin Franklin said, ‘Those things that hurt, instruct’. The COVID-19 pandemic really has hurt us. It has hurt us as a society, it’s hurt us as a community, and it’s hurt us as a profession.

2020 was a year unlike any other I’ve experienced in my 35 years as an emergency physician.

We emergency physicians know how to manage a crisis. But when we are faced with an unrelenting crisis that isn’t over in hours or a few days – it isn’t Bourke Street Mall, it’s not thunderstorm asthma, this is something that’s going on as we speak – how do we cope?

We manage overcrowded emergency departments (EDs), we multitask, we escalate our concerns, we de-escalate confronting situations, and, on top of this, we have to manage EDs through COVID-19.

Remembering Benjamin Franklin’s quote, 2020 hurt us. Three colleagues offer their reflections on how 2020 instructed us. How did we cope? What did we learn? And what will we take with us?

## **Dr Megan Robb**

There’s nothing like a crisis to make you think of speed and creativity.

I’m the Director of Emergency at Northern Health in Melbourne: it was one of the epicentres of COVID-19 in Victoria. It’s a small hospital, just 330 beds, but we are the busiest ED in the state and see 300 to 350 patients a day. We started planning for the pandemic early in 2020, expecting an avalanche of presentations.

I became a quasi-engineer. I now have so much knowledge about ventilation systems and how best to separate my department: how best to flow patients and ambulances? What are the best areas for COVID and non-COVID patients? How can we physically distance our patients, especially in our waiting rooms, when we know they’re notoriously small?

What processes can we use to keep our staff safe?

We only had one negative pressure room, so we had to develop contingencies in case more than one patient had to use it at once. We had to be flexible with our models of care, depending on demand in numbers and types of presentations.

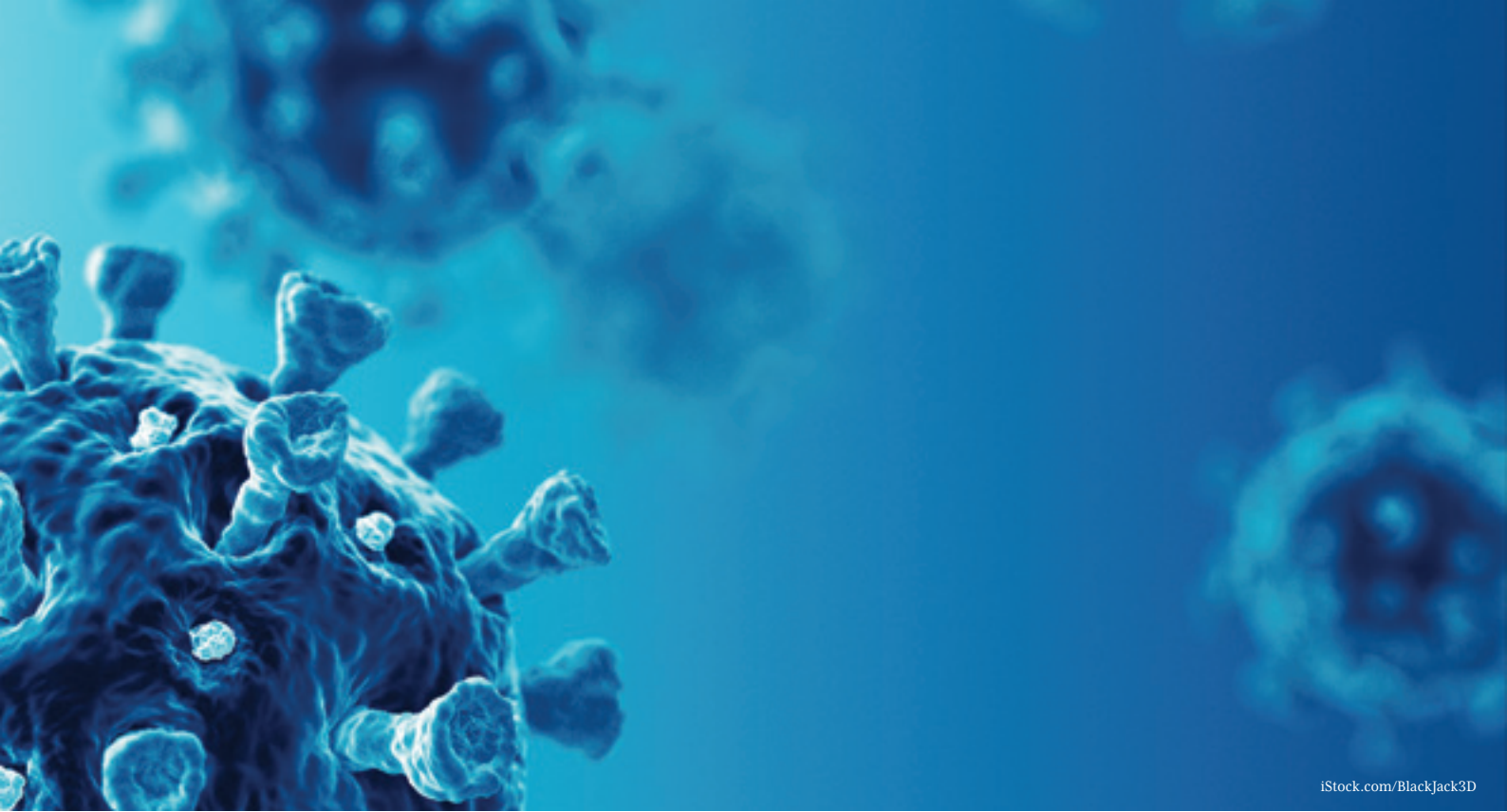
Waiting rooms were recognised early on as not adequate for what we needed. I was lucky: I was able to get two shipping containers brought in to use as triages and a temporary structure to use as our SCOVID (suspected COVID) waiting room, which is still there today. It has heating, cooling and electricity, and is great to separate our patients and keep them safe. I hope exec keeps it there or builds a permanent one.

One of the biggest challenges was keeping our staff informed about what was happening: the rapidly changing PPE requirements, screening requirements, where patients were going to go. It felt like it changed every day or, worse, every hour.

It was so important to address the understandable fear and anxiety amongst the staff. We developed a daily report with updates from our morning COVID pandemic committee. It was then updated through the day. It included PPE instructions, screening questions, how we were running the department, and where our patients were going. It gave us the opportunity to answer common questions from our staff. We had three daily huddles on the floor at 9.00am, 2:00pm and 11pm. We sent daily emails, had Facebook and WhatsApp updates, and we spent a lot of the time on the floor reassuring staff and answering questions. We developed COVID update boards in each area of the department, with a space for staff to ask anonymous questions. I’ve lost count of the number of Zoom and Teams meetings I did.

We did PPE training – how to don and doff – and introduced buddy systems to ensure staff safety.

One of the best things we did was our collaboration and teams training across all specialties and disciplines. Over three to four weeks, we did multiple COVID simulations and



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daily intubation training with the anaesthetic team in situ in our resus and negative pressure rooms. We tested all our codes including CODE Stroke, Trauma, STEMI, BLUE and Grey. We involved all the relevant staff, which allowed us to test procedures needed in a COVID-safe world.

Luckily, numbers of presentations dropped. This gave us time to make all these new processes become business as usual. The training allowed us to identify gaps and address them. Some of the key learning was that PPE takes time and really delays things.

One of our essential key pillars was our focus on staff wellbeing. It was a really scary and uncertain time. There was information overload. We asked our staff to stop sharing and posting everything that they were reading and being sent, and to look to the ED leadership team for information. We then had to make sure we provided information in a timely and accessible way. We also developed lots of wellbeing initiatives: yoga, gin tasting and book clubs. This was so important.

*I tried to be grateful, although some days this was very hard. Above all, I tried to keep a sense of humour. – Megan*

We had a staff shout out board where everyone could leave post it notes thanking a colleague for something they'd done during the day. We still continue to do it today.

One of the most stressful times was when we had an outbreak amongst our staff. One of our colleagues ended up in ICU. Communication and reassurance needed to be ramped up.

The situation changed every day and so did our models of care. We had to close half our ED and separate into hot and

cold zones. The hot zones were for staff who had worked in the ED during the outbreak and cold zones were for those who had been on leave or were from different departments. The two sides of the department couldn't interact. We had markings on the ground that we couldn't cross; we jokingly called it the Berlin Wall. We had to furlough every staff member for a two-week period before they could work on the cold side. I was awake many nights trying to figure out how to do it.

How did we get an outbreak? We still don't know. Huddles before work were banned and we closed our tearoom. Teaching went online, we did clinical support time from home, and we split our leadership into two teams, each doing one week on and one week off.

We called all our furloughed staff once or twice a week, sent care packages, and had regular Zoom meetings to check in and keep everyone updated. Little things like coffee delivery to staff in hot zones helped with staff morale.

I felt an enormous sense of responsibility to get it right and protect staff and patients.

I spent time at the start of the pandemic preparing strategies to allow me to cope with the huge cognitive load and stress of what we were facing. I made sure I had a good team around me, accepted all offers of help, and asked for help when I needed it – and it came, freely and fast. Other ED directors understood and the network of support was invaluable. I reached out to my mentors and saw a psychologist to help. I tried to ensure I looked after myself outside of work – I read books and made my kids watch endless classic movies with me. I tried to be grateful, although some days this was very hard. Above all, I tried to keep a sense of humour.

I hope we can take what we learn during COVID into the future. I believe it makes us better and allows us to provide higher quality care to our patients. Above all, I hope for the improved hospital flow to continue.



### **Dr Shyaman Menon**

I'm the Clinical Director of Emergency Services at Peninsula Health, a major metropolitan hospital in the South East of Victoria. We service about 300,000 people. In the ED we have two departments, a main campus at Frankston Hospital and an ED in Rosebud. We see about 100,000 patients a year across both EDs.

*We were open and honest. There were things that we didn't know and we would put our hands up and say, we don't know, we'll get back to you. We were transparent. Staff knew what was happening. This included if staff had become unwell, what our PPE supplies were like, or any changes in guidelines. That level made our staff a lot more engaged. – Shyaman*

On 12 March 2020, the Federal Health Minister came to our department to make an announcement. We focused on preparing to keep our staff and patients safe for the pandemic ahead.

We made sure we had structure and focused on being transparent with engaging our staff and building a level of trust. We were flexible and agile with our responses.

We quickly set up an incident command centre that was staffed throughout the whole pandemic response. It currently still operates. From there, we had regular meetings and coordinated a lot of our responses and planning. Staff knew where to go to if they had questions or concerns.

One of the problems we had is that our staff rotate across both our ED departments. When COVID-19 arrived, we had to get clear about how staff moved between the sites and ensure that our models of care were consistent. There were challenges as the departments are built differently. But we kept to our principle that it's one service.

We developed portfolios that we had a proven record with to minimise changes. We had someone look after the department's IT requirements, along with staffing and workforce processes, and communications. It all came together in a collaborative way.

One of the biggest challenges was developing our communications strategy and keeping our staff engaged. Comms became an important cornerstone; fifty per cent of my day was spent in comms.

We needed to know where our true north was. Where was our information coming from? Staff kept looking towards one place – our command centre. There was a lot of information coming through. There were lots of questions and constant changes. Our staff worked across multiple EDs and there were inconsistencies in processes and PPE guidelines – we had to learn to coordinate that better.

I've learnt about comms fatigue during this pandemic. How do you manage it?

We had many staff posting new research or guidelines on to our comms, so we had to change our strategy. We started four WhatsApp groups: social, COVID, normal communication and notifications.

We had to be cognisant of staff stress levels, as everyone responds differently. Someone posting a lot may stress someone else. We had to read the team carefully. I had to ask team members to moderate their posts a few times. Sometimes people needed time off to manage stress. We used Facebook for daily updates.

We were open and honest. There were things that we didn't know and we would put our hands up and say, we don't know, we'll get back to you. We were transparent. Staff knew what was happening. This included if staff had become unwell, what our PPE supplies were like, and any changes in guidelines. That level of communication made our staff much more engaged.

### **Dr Mark Putland**

As emergency workers, we can anticipate trouble before others; see patterns coming. I think we could see trouble coming before others could. We looked like lunatics, but everyone caught up to our thinking soon enough.

It's hard to remember how frightening things were back then, as news was coming in from New York and Italy about how bad things were there. It didn't end up happening in Australia, but people were very worried.

I'm the Director of the ED at the Royal Melbourne Hospital.

It was clear to me that there were two really real risks. First, that our people were going to get hurt. Second, that if we didn't do our job well in leadership in hospitals, then, at some point, people might walk away from their roles. Then we would have a real catastrophe of patients being abandoned.

It felt really important to switch gear and focus on supporting our staff to do their jobs. They are extraordinary people who just need to be supported to feel like they can do it.

We created a WhatsApp working group. Initially, this was a coalition of the willing. We grabbed the people who had the energy to do it, or time, or skills we needed. We tried to get a broad range of skills. We pulled nursing, clerical and medical staff into our COVID working group. We had very open communication. We took people off the floor, filled them with casual staff, and figured we'd worry about the finances later. Fortunately, the Government gave us a cost centre to put it into.

It was important to start filling the space for the desperate hunger for information. It wasn't a vacuum, as it was full, and it was often full of stuff that wasn't helpful. There were constant things being shared across the whole system: texts, WhatsApp messages, emails, messages from colleagues of colleagues of colleagues in the US, who maybe didn't even exist, telling us about the catastrophe there and that it will be like that here. Suddenly, everyone was an expert in aerosols, contact, droplets, cautions ...

There was a real risk of chaotic information flow. We had to get hold of it a bit because, with the level of worry that was going on, it could've gone in any direction.

We did a few things to bring people back from the desperate places they'd gone to in their minds, worrying about things. We kept them updated on what the hospital was doing, what it was planning on doing, what we thought was happening, with input from our best infection control and disease prevention epidemiologists. We tried to bring it all together and give people information, while addressing the things that people were frightened of.

There was a week where we discovered that COVID could actually infect children and cause something a bit like Kawasaki disease. Suddenly, everybody was picturing all their children suffering from this. I did a rapid literature review on Kawasaki disease and the population of Australia – what all the numbers meant in Australia – and delivered it in a way that made people feel that at least someone was taking care of this stuff.

*It felt really important to switch gear and focus on supporting our staff to do their jobs. They are extraordinary people who just need to be supported to feel like they can do it.*

– Mark

I started writing a weekly ramble: an update of what we were doing, what was in the news, and the politics that was going on. I just tried to give an ED Director perspective. Everyone got the update, from our cleaners to our control centre.

It was vital to stay up to speed on the things that were constantly changing. It went from no PPE, to wearing N-95 masks, to patients wearing them, to we're not wearing N-95 masks anymore, we're wearing gloves, we're not wearing gloves ... testing instructions changed several times a day. There would be a major change most Friday nights.

We reached out to people we knew in the health department to get ahead and anticipate the big announcements.

For people to feel they are secure and taken care of, and working in a safe, coordinated place, it was very important that the hospital was seen to be responding to the rapidly changing landscape. This will remain very important.

As others did, we made wellbeing a big thing. Physical safety and comfort were important. Little things like having water and snacks in the breakout room so people could take their mask off, rehydrate, have a snack, put moisturiser on the bridge of their nose, and recover from the N-95s when we had to wear them.

*People need to know that you care about them and that they are your number one priority. If they are going to keep turning up and putting themselves in harm's way each day, they need to know someone's looking out for them.*

– Mark

We made sure the roster was sensible. Nobody wanted to take leave but we made sure they did. We'd ask people to take one week off every five weeks because if things got bad, shifts might be longer and leave might disappear. It didn't get to this point, but the expectation was set so when people started to feel a bit ratty, it was easy to say to them, 'When did you last take a week off?' Very little leave did get taken, but it gave people permission to take time off when they were feeling overwhelmed. It also built expectations into the roster that allowed us to deal with absenteeism as a result of furlough and test swabbing.

At the beginning of each shift, the consultant would ask, how are my staff today, is anyone away? How is everyone looking? Is anyone looking fragile? Then there would be a safety run-through about PPE and other stuff that's familiar now, but it wasn't at the beginning. Who are we testing today? A meatworks? A church? How many in the ICU? Do we have beds? Are there COVID patients in? This way people got a broad overview.

We should do this for every shift.

So much of what we did last year we should always do. It's so important to always have a wellbeing focus. People need to know that you care about them and that they are your number one priority. If they are going to keep turning up and putting themselves in harm's way each day, they need to know someone's looking out for them.



# Standing in Solidarity with Our Myanmar Colleagues

Dr Rose Skalicky-Klein and Dr Georgina Phillips







Like every other country around the globe, 2020 was the year that COVID-19 dominated the actions of the government and the people in Myanmar. Health resources were increased to cope with the national pandemic response and essential healthcare workers unified, working towards the common goal of beating COVID-19. Despite the mental, physical and emotional exhaustion that battling this unseen enemy formed, health workers and Myanmar citizens alike expected some respite and hope in 2021.

For emergency medicine (EM) there was a sense of success – the academic program had continued and all exams completed, despite the complex challenge of ongoing service provision during the pandemic. COVID-19 cases were starting to decrease and healthcare staff were on the frontline of the vaccination program. However, this hope shattered in a moment of greed and power.

In the early morning of 1 February 2021, the Myanmar military staged a coup to detain key leaders of the democratically elected government immediately before the first sitting of the new parliament. In response to the subsequent declaration of military rule, the citizens of Myanmar took to the airwaves, the web and the streets, to peacefully protest their outrage and unreserved rejection of this unlawful and anti-democratic act.<sup>1</sup>

Within days, emergency doctors and other health workers around the nation were leading peaceful resistance through the Civil Disobedience Movement (CDM). On 8 February, when Professor Zaw Wai Soe made his speech closing the University of Medicine 1 (UM[1]), Yangon, in support of CDM, all other medical and nursing universities quickly followed, and all government hospitals closed their doors to clinical service, leading to a health system suddenly in crisis.<sup>2</sup>

The threat to the nation of Myanmar and civil society function is overwhelming. Fifty years of previous military rule failed to develop the health system and instead enshrined poverty, inequality and inadequate medical care.<sup>3</sup> Until recently, government spending on health was amongst the lowest in the world, and decades of neglect, isolation and armed conflict resulted in poor health outcomes and a high rate of catastrophic individual health out-of-pocket expenditure.<sup>4</sup> Emergency care systems have been established in recent years as an essential, but previously absent, component of a universal healthcare response.<sup>5</sup> A return to this preceding situation is no longer acceptable.

EM doctors and all healthcare staff are now bearing a heavy emotional toll for their decisions of protest. Duty of care for patients is a doctor's first priority,<sup>6</sup> but how can this be done under an unlawful, undemocratic and oppressive military system? Yet how can a service be withdrawn – particularly for civilian patients? Limiting access to life-saving interventions presents an acute and complex ethical challenge, notwithstanding the significant risks to the public.

With government hospitals closed, EM and civil healthcare workers turned to charity and private hospitals, returned to their clinics, opened new clinics and worked on the streets amongst the protesters.<sup>7</sup> Many EM doctors have returned to their hometowns to provide healthcare for protesters,<sup>9</sup> as retaliation against protesters has expanded into even the most remote areas of the country. However, these small or private facilities have neither capacity nor finances for comprehensive care.

EM specialists have led the clinical COVID-19 response in Myanmar. Until recently, the government emergency departments (EDs) were performing screening, testing and early critical care for COVID-positive patients. In collaboration with global health partners, systems were robust and resource stewardship sound.<sup>8</sup> An immunisation program had commenced, prioritising first-line responders. Since the military takeover, the COVID response has stalled; testing is minimal, clinical care restricted, and immunisations have paused.

Mass public rallies and protests are serving a critical function for resistance and unity, but are also likely super spreader events for virus transmission. Without adequate testing, public compliance and goodwill for isolation, access to acute clinical care, and continued immunisations, the implications for COVID spread, morbidity and mortality are substantial.<sup>9</sup>

Within this dreadful context, senior EM doctors, specifically, have ensured that government hospitals were prepared and ready to respond to mass casualty incidents; checking drugs and equipment daily. Graduates of the EM program are on the streets coordinating transport and preparing the public for mass events of violence that have increased in frequency and severity over recent weeks.

Sadly, this has been the case over multiple days the past few months, with an ever-growing number of deaths. On one bloody day, Yangon EM doctors saw over a hundred gunshot wound (GSW) casualties with close to 40 deaths. Our colleagues report:

‘... more and more violence in Myanmar. Yesterday was a very sad day: Yangon General Hospital ED, 39 GSW and today another 15. Total deaths 13. Today I’m recording post-mortems and collecting bullets. I will never forget that scene.’

Our colleagues are united in their courage and care:

‘What I liked about EM was the unity of EM doctors in this response. Many of them (who) live close to the hospital came back quickly to care for the patients.’

As the civil protest continues and grows, so do the retaliatory actions of the military regime, legalising their acts of violence through law changes that allow the arbitrary removal and detention of protesters and those they see as a threat to the military regime.<sup>10</sup> Contrary to international humanitarian law,<sup>11</sup> healthcare workers are now targeted for peaceful protesting when they are treating patients on streets and even inside hospitals.

There have been videos shown of ambulance personnel being dragged out of their ambulance and beaten.<sup>12</sup> Hospitals have been shot at while patients are being treated inside,<sup>13</sup> and hospital access has been blocked. Healthcare workers have been arrested and others forced to flee their homes. Hundreds of doctors and medical students have now been arrested, with many still detained.<sup>14</sup>

Most shocking to the global EM community has been the arrest of Professor Maw Maw Oo, Head of EM at UM<sup>1</sup>, and Yangon General Hospital (YGH) on 12 April. He was taken from his office, while on duty, at YGH ED. Over the past months, he had been coordinating care of all people, including the victims of violence, and was instrumental in negotiating the release of many healthcare workers. He is President of the Myanmar Emergency Medicine Society, and a key leader in the past and future development of EM and disaster preparedness and response in Myanmar. Professor Zaw Wai Soe, past Rector of UM<sup>1</sup>, ‘Father’ of EM in Myanmar, and leader of medical education reform, is now in hiding. Emergency Nurse Kaung Myat Htun was arrested and is yet to be released.<sup>15</sup>

Myanmar’s government health system has effectively collapsed. Recent work over the last decade to address inequality of access and outcome, and to build a modern health education, clinical services and public health system are under threat. In the short term, we are seeing national pre-hospital, triage and ED systems falter from lack of personnel and resources.

With increasing harassment and arrest, the workforce is being critically reduced. Reversion to military rule and subsequent expected financial neglect, coupled with global isolation and sanctions, are likely to result in critical deterioration of both public health measures and clinical services. Access to essential medicines and supplies may be restricted, and global partnerships for research, education and capacity development will falter.

ACEM had a formal, meaningful partnership with the Myanmar Ministry of Health and Sports for development of EM over the last decade, and continues to have a strong bilateral partnership with the Myanmar EM Society, with

many member affiliates of ACEM. Despite the apparent disintegration of emergency care in the government system, we can be encouraged that EM doctors and nurses are still using their training and skills daily for the good of their community. Our colleagues are training, coordinating and assisting at pre-hospital, village and rural clinic levels in ways that will only help future emergency care development. The lessons learnt through almost a year of battling COVID – teamwork, perseverance, solidarity, courage – are now standing them in good stead as they face a long battle ahead.

Our College has been in the forefront globally, advocating for Myanmar EM and other health colleagues, and will continue to do so. We all have a part to play now and into the future. For now, members should call out the inhumane treatment of fellow health workers in Myanmar – this is unacceptable. For the future, we should be prepared to comprehensively assist our colleagues as they rebuild their emergency care system at every level.

Our colleagues plead to us, ‘do not forget us’.

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# Protecting Emergency Healthcare Personnel in Conflict Zones During the COVID-19 Pandemic

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**T**he COVID-19 global health emergency adds another layer of complexity to healthcare systems, services and resource allocation around the world. The pandemic has stretched sophisticated health infrastructure and resources in the most developed of countries to breaking point. Yet, in fragile and conflict-affected countries where health systems and infrastructure have already been ravaged by civil unrest, neglect and war, COVID-19 poses an added threat.

In such countries, health information and disease surveillance systems are usually weak or have altogether collapsed. People uprooted by conflict live in close proximity. Life-saving resources like clean water, soap, food, essential medicine, and trained healthcare personnel in personal protective equipment (PPE) to combat infectious disease transmission (and its impacts), are in short supply.

Compounding this, local communities in conflict zones may have low levels of health literacy for effective COVID-19 preventative healthcare or receive misinformation spread through social media. Use of modern communication technology has created new digital forms of aggression and challenge for humanitarian actors, not only in negotiating safe, timely healthcare access to affected and at-risk populations, but also in negotiating the security of their own health or medical staff.

Emergency healthcare workers, who courageously work in such complex and dangerous settings, are owed a number of protections under International Humanitarian Law (IHL), the international legal framework that governs armed conflict. Such protections are owed regardless of whether the healthcare worker is from the local population and reports to the Ministry of Health, or belongs to international humanitarian, non-governmental, military or peace-keeping organisations.

It's critical that all healthcare personnel operating in armed conflict and complex emergency settings understand their rights and obligations, and the remedies available should their rights be violated in the performance of their professional duties. Although effective use of IHL and humanitarian principles requires emergency care workers to navigate the reality of conflict and COVID-19 on the ground,<sup>4</sup> knowledge of IHL can help ensure healthcare workers are better equipped – and protected – in the face of potential and actual harm or deliberate attack against themselves or their patients.

## **Conflict and the COVID-19 pandemic**

Healthcare workers are at the frontline of all kinds of emergencies. As first responders, emergency care personnel provide crucial medical support to the sick, injured and wounded in armed conflict and civil unrest, as well as during floods, earthquakes and other natural and human-made





disasters. However, in 2020, the COVID-19 pandemic brought into sharp focus the critical importance of emergency care, as well as the safety, health and wellbeing of those who provide it.

In addition to the clinical care role paramedics and emergency health workers have played in the worldwide pandemic response, they've also played a significant role in collaborating with governments and multi-stakeholders to develop timely, cost-effective, localised public health emergency policy and planning solutions to contain and prevent the spread of COVID-19 at both the health systems and service level. The experience and knowledge of emergency care personnel will continue to be instrumental in the COVID-19 vaccine roll-out in practice and in policy.

Yet even with vaccines, diseases are often hardest to eradicate in conflict zones.<sup>5-8</sup> In certain locations and contexts, COVID-19 and conflict appear to have a symbiotic or bi-directional relationship.<sup>9,10</sup> Evidence is emerging that circumstances associated with armed conflicts may give rise to greater spread of COVID-19 within and across borders. In turn, COVID-19 can create conditions for the exacerbation of poverty, social tension, displacement and violence. For instance, warring factions may exploit government weakness or a lack of international attention due to the pandemic to gain political advantage and territorial control, which in turn impinges on national, regional and the international community's capabilities to effectively deal with the COVID-19 health emergency.<sup>11,12</sup> These conditions leave citizens and displaced persons exposed to COVID-19 and have been reported as constituting an indirect method of warfare.<sup>13</sup>

#### **Harm to healthcare workers responding to COVID-19**

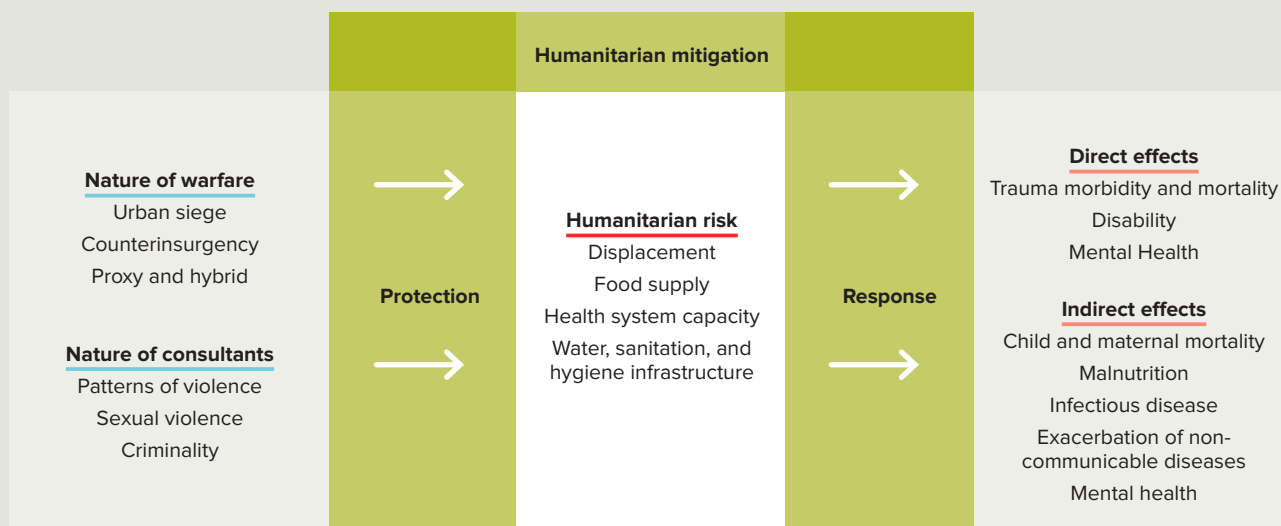
Armed conflicts are intensely dynamic and contextual. The protection of healthcare workers and non-combatants for the safe provision of health and humanitarian services must continually flex and adapt. This creates new challenges for health service access and equity, medical supply chains, healthcare worker security and, ultimately, direct and indirect health (morbidity and mortality) outcomes in local populations (Figure 1).<sup>4</sup>

For emergency healthcare workers providing vital medical and public health services in weak, fragile and conflict-affected states, COVID-19 has added complex layers to already highly volatile healthcare environments nested in weak to non-existent health systems. Violence against healthcare workers and facilities has been widely reported on and documented extensively.<sup>14,15</sup> A Declaration condemning increasing incidents of such attacks was issued in May 2020<sup>13</sup> by medical and humanitarian organisations, with signatories including the International Committee of the Red Cross (ICRC).<sup>16</sup>

Sadly, the experience of harm and violence against healthcare workers at the hands of state and non-state operatives during infectious disease outbreaks is not a COVID-19 phenomenon. Ten years ago, the ICRC and Red Crescent Movement launched the Health Care in Danger (HCiD) initiative to respond to growing incidences of violence against health workers, patients, health facilities and vehicles, and to promote safe access to and delivery of healthcare in armed conflict and other emergencies.<sup>17</sup>

Banjul, The Gambia – rush hour at the ferry terminal iStock.com/mtcurado

**Figure 1. Humanitarian mitigation of adverse health outcomes in areas of armed conflict.<sup>4</sup>**



**What is International Humanitarian Law according to the Australian Red Cross<sup>20</sup>**

‘International Humanitarian Law (IHL) is a set of international laws that set out what can and cannot be done during an armed conflict.

- Their main purpose is to maintain some sort of humanity in armed conflicts, saving lives and reducing suffering.
- To do that, IHL regulates how wars are fought, balancing two aspects: to weaken the enemy and limit the suffering.
- The rules of war are universal. The Geneva Conventions (which are the core elements of IHL) have been ratified by 196 countries. Very few international treaties have this level of support.
- Everyone fighting a war needs to respect IHL, both governmental forces and non-stated armed groups.
- There are consequences if the rules of war are broken. War crimes are documented and investigated by States and international courts. Individuals can be prosecuted for war crimes.

**In short, the laws of war mean:**

You do not torture people. You do not attack civilians. You limit as much as you can the impact of your warfare on women and children. You treat detainees humanely.’

**Key points on what the laws of war do (or ought to do).**

12 key points in the context of protecting and promoting human health and wellbeing, health service provision, and promotion of the underlying determinants of health.

1. Protect those who are not fighting, such as civilians, medical personnel or aid workers.
2. Protect those who are no longer able to fight, like an injured soldier or a prisoner.
3. Prohibit targeting civilians and medical personnel. Doing so is a war crime.
4. Recognise the right of civilians to be protected from the dangers of war, as well as receive the help they need (including equitable, non-discriminatory access to health services). Every possible care must be taken to avoid harming civilians, their houses or destroying their means of survival and underlying determinants of health, such as water sources, crops or livestock.
5. Mandate that the sick and wounded have a right to be cared for, regardless of whose side they are on. This is also part of everyone’s human right to health (and to access health services) without discrimination.
6. Specify that medical workers, medical vehicles and hospitals dedicated to humanitarian work cannot be attacked.
7. Prohibit torture and degrading treatment of prisoners.
8. Specify that detainees must receive adequate food, water and shelter (critical underlying determinants of health) as well as be allowed to communicate with their loved ones.
9. Limit the weapons and tactics that can be used in wars, to avoid unnecessary suffering.
10. Explicitly forbid rape or other forms of sexual violence in the context of armed conflict.
11. Protect historic buildings, monuments, works of art and other cultural treasures.
12. Not only must medical personnel and the healthcare services they provide be respected and protected, but they must also receive such support and assistance that they require in order to fulfil their medical mission. This includes access to any place in which their services are essential, subject to such supervisory and safety measures deemed necessary by the party to the conflict that is in control of the area.

Adapted from the 11 points on ‘what the law of wars do’ outlined by the Australian Red Cross<sup>20</sup>



Despite the HCiD initiative's intensive efforts on the ground, more recent attacks against healthcare workers responding to Ebola outbreaks in West Africa have been reported, for example.<sup>18</sup> Perhaps the most striking example of the strategic and deliberate targeting of medical facilities, ambulances and personnel by both sides of a conflict is in the civil war in Syria, where hospitals have been bombed, ambulances looted, and healthcare workers systematically targeted, with executions of doctors, nurses and other frontline health workers reported.<sup>19</sup>

### The laws of war and the special protection of healthcare workers

IHL is also known as the law of armed conflict or law of war. The main body of IHL is primarily found in the 1949 Geneva Conventions and their 1977 Additional Protocols, as well as in a number of international treaties. IHL reminds us that conflict-affected areas should not be viewed as ungoverned locations but rather 'contested settings, in which an array of state and non-state actors exert or vie for control'.<sup>4</sup>

IHL provides a comprehensive framework of rules aimed to regulate how wars are fought and protect those who are wounded, sick or injured (civilians and military combatants) and in need of medical treatment. Box 1 sets out what the laws of war are and why they exist. Box 2 expands on how the laws of war specifically protect and promote access to safe health service provision and underlying determinants of health.<sup>20</sup>

Importantly, IHL provides special status and protections to healthcare workers in armed conflicts, and to hospitals, clinics, ambulances and other medical infrastructure. IHL protects emergency care workers from attack and the effects of fighting, and their ability to provide healthcare without fear of punishment or reprisal.

To be clear, individuals who violate IHL and target healthcare workers or those in their care face prosecution for war crimes. Attacks against medical personnel, wounded and sick combatants and/or medical infrastructure, by either side during an armed conflict, is the most serious kind of violation of the laws of war. Attacks against medical personnel, for example, attract universal jurisdiction under IHL and may be investigated and prosecuted by any State as a war crime, regardless of where the violation occurred.

Also central to IHL is the rule that wounded, sick and injured combatants must be protected and cared for, without discrimination or adverse distinction. This means emergency care workers must provide treatment to the wounded and sick based solely on their medical and healthcare needs, regardless of which side the patient is fighting on or may be loyal to. Under IHL, if healthcare workers are captured and detained by an adverse power during an armed conflict, they must be allowed to continue their professional work wherever possible. The dual obligations of medical treatment for wounded soldiers and civilians, and protection for those administering such medical treatment, originally arose out of the 19th century battlefields of Europe, which gave rise to the first Geneva Convention in 1864 and the Red Cross and Red Crescent movements. This dual obligation remains at the very core of IHL today.

Finally, armed conflicts can present a demanding context for the application of medical ethics by healthcare workers. For instance, healthcare workers may struggle to protect patient confidentiality in armed conflict zones vis-a-vis COVID-19 contact tracing and compulsory infectious disease reporting under the International Health Regulations.

IHL recognises the importance of medical ethics and protects the independence of medical personnel in two ways: (1) by prohibiting the punishment of persons for carrying out medical activities, so long as the activities are being carried out in accordance with medical ethics; and (2) by ensuring that medical personnel are not compelled to act, or refrain from acting, contrary to medical ethics.

IHL also gives legal mandate or force to medical personnel to determine issues of healthcare prioritisation and resource allocation based on clinical need and medical grounds.<sup>21</sup> IHL seeks to ensure that medical personnel are free from pressure to participate in acts of torture or other ill-treatment of the sick and wounded or detainees.

Healthcare workers cannot and should not be punished for disobeying an unlawful or medically unethical order. In circumstances where healthcare workers are punished or harmed, in violation of IHL, both the perpetrators and their superiors will be accountable and may face prosecution for war crimes. For more information on the practice of medical ethics in conflicts, see the *World Medical Assembly (WMA) Regulations in Times of Armed Conflict and Other Situations of Violence* of 1956 (revised latest by the 63rd WMA General Assembly in 2012).<sup>22</sup>

In light of new strains of COVID-19 emerging, demand for healthcare workers who are skilled in emergency medicine will continue, especially in fragile and conflict-affected areas in all regions of the world. Further still, scientists warn that zoonotic disease pandemics like COVID-19 are on the rise due to ecological, behavioural or socioeconomic change, combined with global warming.<sup>23,24</sup> Climate change will also continue to impact the ferocity and frequency of natural disasters that can exacerbate armed conflicts and disease outbreaks and transmission.<sup>25</sup>

As emergency health events like COVID-19 and different types of conflict sadly continue to arise in our world (or remain protracted), it's crucial that emergency healthcare workers have an overview of the protections they are owed under IHL when working in dangerous conflict zones, including during the COVID-19 pandemic. The Australian Red Cross offers training and support to organisations that deploy personnel in conflict-affected regions, including from defence, government, and the humanitarian and health sectors.

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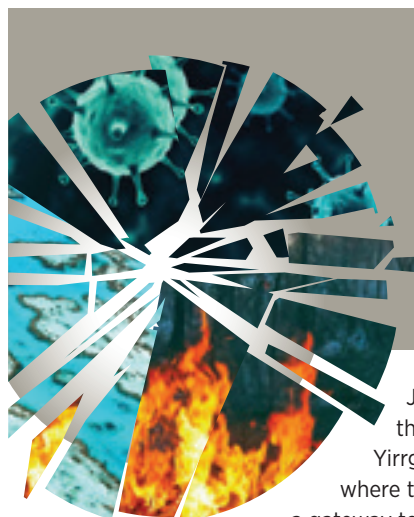
### More information

Additional information is available at the following websites:  
<https://www.redcross.org.au/get-involved/take-action/take-action-on-an-issue/what-is-international-humanitarian-law>  
<https://www.redcross.org.au/ihl-courses>  
For further information on IHL training resources and opportunities, contact [lmaybee@redcross.org.au](mailto:lmaybee@redcross.org.au).



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# ACEM WINTER SYMPOSIUM 2021

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## Social Program

<b>Welcome Reception</b>	<b>Date:</b> Tuesday 27 July 2021 <b>Time:</b> 18:00 – 20:00 <b>Venue:</b> Paper Crane @ Riley
<b>Cairns Aquarium By Night</b>	<b>Date:</b> Wednesday 28 July 2021 <b>Time:</b> 18:00 – 19:00 (Tour) & 19:00 – 21:00 (Dinner) <b>Venue:</b> Cairns Aquarium
<b>3 Wolves Gin and Whiskey Masterclass</b>	<b>Date:</b> Wednesday 28 July 2021 <b>Time:</b> 18:15 – 20:15 <b>Venue:</b> 3 Wolves
<b>Symposium Dinner</b>	<b>Date:</b> Thursday 29 July 2021 <b>Time:</b> 19:00 – 23:00 <b>Venue:</b> The Tanks Arts Centre

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# Building Humanity: a Taranaki Emergency Medicine Conference

**Dr Mark Sagarin**

Dr. Sagarin is an Emergency Medicine Specialist in New Plymouth with an interest in wellness.

In August 2020, several colleagues and I considered the possibility of creating our own in-person emergency medicine (EM) conference in Taranaki, Aotearoa New Zealand. The cancellation of other conferences due to COVID-19 had created a need: many in our specialty in New Zealand felt a desire to connect in person with colleagues.

Some thoughtful physicians in our group had specialised areas of interest, and others around the country were keen to share their knowledge. We wondered if we might be able to pull this off and thus, Humanity: a Taranaki Emergency Medicine Conference was born. We chose dates in early February 2021, in late summer, an optimal time of year to visit Taranaki.

Organising a conference around the theme of 'humanity' seemed appropriate and timely: the ongoing global pandemic highlighted the interconnection and reliance on each other as humans.

Being physicians and nurses on the frontline of acute medicine during COVID-19 put a spotlight on the importance of wellness. The term 'humanity' recognised what was at stake with a contagion ravaging millions worldwide, while also focusing on the good we can do by pulling together as a team.

There was some uncertainty, as none of us had organised a conference before. The potential for a return of COVID-19 cases in New Zealand, causing a shutdown, hung over us, but we could provide refunds to participants if necessary. To optimise attendance, we sought to create just the right balance between the outstanding lecture program and a stellar wellness program.

Early on, Dr John Bonning, ACEM President, agreed to attend and speak, which helped legitimise our conference. Dr Ashley Bloomfield, the New Zealand Director-General of Health, agreed to join us by videoconference, and five other excellent speakers from around the country also signed on.

Melanie Clark, a web designer working for Taranaki District Health Board (TDHB), set up an outstanding web page and helped with our promotions. Simon Barrett in the TDHB finance department handled our invoices and payments. These two energetic individuals repeatedly went above and beyond the call of duty to make the work of organising many times easier. Cassandra Pizziol from ACEM also helped us with promotions via ACEM publications.

Despite courage by a few Wellington and Dunedin doctors who signed up in October 2020, registration was sluggish for the first few months. We planned to cancel the event if fewer than 20 doctors and nurses signed up, but we felt that anything over 40 would be a success.

The 91 people who attended definitely exceeded our expectations. Of the attendees, 74 per cent were consultant physicians (nearly all in EM and mostly FACEMs), 10 per cent junior doctors, 10 per cent nurses, 4 per cent nurse practitioners, 1 per cent dentists, and 1 per cent physiotherapists. Twenty-seven participants came from TDHB, seven from Wairarapa, six each from Waikato and Waitemata, five from Hawke's Bay, four from Middlemore Hospital in Auckland, and four from Dunedin. The conference was held at the Novotel New Plymouth.

The first day, 4 February 2021, began with a Māori pōwhiri (welcoming ceremony) and brief welcome from New Plymouth Mayor Neil Holdom. Lecture highlights of the day included: Dr Bonning, outlining the vision and priorities of the College in his usual engaging style; Dr Bloomfield discussing the COVID response and wellness during this crisis; and Dr Kate Anson FACEM and Dr Kim Yates FACEM considering health equity and Manaaki Mana.

Other well-received talks included: Dr Paul Leccese on cardiopulmonary ultrasound; Dr Susie Flink FACEM on key articles from recent EM literature; Dr Alastair Maclean FACEM on testicular ultrasound; and cardiologist Dr Ian Ternouth discussing CT coronary angiography. I presented a novel, highly successful technique for shoulder reduction, the Taranaki Maneuver.

After this engaging first day, some of the participants took part in waka (Māori canoeing) organised by Nathan Tuuta, a TDHB emergency department (ED) nurse. In the evening, everyone enjoyed an Indian-style buffet at a surf lifesaving club that overlooks our coastal walkway. The views and the food were superb.

Day two, 5 February 2021, had many highlights. Dr Renee Garcia FACEM joined us by videoconference from a COVID hospital in California to discuss the emotional toll of dealing with the pandemic. This former Hawkes' Bay HOD demonstrated incredible fortitude in the midst of tragedy. The head of the New Zealand Medical Assistance Team, Dr Emma Lawrey FACEM discussed her team's overseas response to the 2019 Samoa measles outbreak, assisted by Dr Kirsten Bond FACEM. Dr Kelly Austin FACEM from TDHB had the highest-rated lecture with her discussion about surviving a Health and Disability Commissioner investigation.

Additional positively reviewed talks included: Dr Michael Connelly FACEM on violence in the ED; Dr Brad Ellington FACEM on teaching EM in Mongolia; Dr Leccese on COVID-19 treatment; and Dr Mike Jones FACEM discussing treating COVID-19 patients in the US. Near the end of day two, I discussed wellness and resilience for EM physicians, carrying themes of self-care and pride in our work.



Our beautiful 'humanity' conference logo, designed by two of my daughters (ages 21 and 11), was shown on posters and emblazoned on t-shirts. We had many fun t-shirt giveaways for our lone physio, our early birds and serious procrastinators, and people from hospitals with a good turnout.

After two long days of conference, those keen to relax sampled brews and nibbles at three local breweries on Dr Chris White's Taranaki Brewery Trail. Those surviving this gauntlet enjoyed a choice of recreational activities the following day. An intrepid group of about 20 woke early on Saturday to climb Mount Taranaki. This strenuous hike rewarded these adventurers with spectacular views. Others did a moderate hike to the Tarns, a yoga class near the beach, or a surfing lesson. These activities helped conference attendees get to know one another in a relaxed environment.

We sought feedback on each lecture and the conference as a whole, on a scale from one to 10 (terrible to excellent). The feedback was largely positive: the average of all lectures was 8.7, and the average of the two videoconferences was 9.4. The overall conference content rated 8.8, organisation rated 8.9, and fun rated 9.3. We were especially proud that people had so much fun while learning new things at a medical conference.

We organised this conference wondering if anyone would show up. In the end, we felt successful in providing a rare in-person venue during a pandemic. Many left the conference refreshed and renewed, while reminded of what makes the practice of EM so special and important. Perhaps this can be done again in the future, possibly in early 2023, hopefully along with some overseas colleagues.



# Regional Wellbeing Champions

*This year, ACEM is pleased to introduce Regional Wellbeing Champions, a group of FACEMs who will facilitate improved communication between ACEM members and trainees and the College to optimise its wellbeing initiatives and resources to best care for ACEM members and trainees.*

The Regional Wellbeing Champions have been selected from across faculties in Aotearoa New Zealand and Australia. The champions will:

- promote ACEM initiatives that support wellbeing at local, regional and national levels through events and regional faculty meetings
- ensure appropriate reporting to and liaison with the relevant regional faculty board;
- provide input into any review or development of College initiatives that support wellbeing of ACEM members and trainees; and
- review external wellbeing resources for substantiation, merit and relevance to emergency physicians.

**We're pleased to introduce your inaugural Regional Wellbeing Champions.**



**Laura Brown**  
(New South Wales)

I am an Emergency Physician in Sydney. I believe that wellbeing at work is crucial across all levels of experience. I believe that practicing and promoting wellbeing is a skill that requires as much attention of any facet of our training, and I encourage myself to think of it not as a soft skill, but as one that is as robust and important in my role as learning to lead a trauma team or to insert a chest drain. I am really interested in the science behind how civility, kindness and wellbeing practiced by individuals and organisations impacts patient care. I am very excited to be involved in this role with ACEM, and it is wonderful to see the College giving weight to this important topic.



**Dane Chalkley**  
(New South Wales)

Wellbeing is a serious issue. Mental health issues (including suicide) are disproportionately common in medics.

Added to this, there is strong evidence that improving healthcare staff wellbeing positively impacts on patient outcomes.

But, paradoxically, there is often a negative response when wellbeing is mentioned – it's a cult, a movement, a waste of time and money, a nonsense promoting yoga and meditation.

We need to address the cultural, physical and psychological issues that impair our wellbeing.

But we also need to reset the perceptions of wellbeing and inform the sceptics better.

Then we and our patients will be better off.



**Bishan Rajapakse**  
(New South Wales)

Doctor wellbeing is a topic close to my heart. I have been exposed to many scenarios of struggle in medicine and in emergency medicine, as well as some sad tragedies. Burnout, moral injury and mental health struggles are commonplace in our arena of providing emergency care, but are still hard to address in the face of more urgent, yet, ironically, associated issues such as staffing and access block. Prioritising self-care and looking after our own physical, psychological and social wellbeing can be incredibly hard to achieve in many medical workplaces. I'm excited by being in this regional role as I would like to be able to support and promote the conversation about wellbeing, kindness and humanity in healthcare. I also look forward to learning about where good workplace culture is being practiced against the odds, and being able to support and connect other like-minded FACEMs and trainees and wellbeing advocates on this difficult but important journey.



**Minnie Seward**  
(Victoria)

I'm an emergency physician at University Hospital Geelong and Ballarat Base Hospital. I have a special interest in medical education, wellness and practitioner wellbeing, as well as wilderness and adventure medicine.

**Mentorship + practitioner wellbeing**

The COVID-19 pandemic has had a huge impact on the hospital staff and the wider community. I have implemented wellness challenges and programs in my emergency department, which has demonstrated benefit to staff morale and stress levels. I also provide formal staff mentorship and peer support.

**Adventure + wilderness medicine**

I love the outdoors and spend a lot of my free time hiking, camping, travelling and maintaining my own personal fitness. I am fortunate enough to be able to combine my adventure interests with my medical skills whilst attending Australian and international sporting events and overseas adventure travel. My highlights so far have been working at the Commonwealth Games and hiking the Kokoda Track over Anzac Day.



**Una Harrington**  
(Queensland)

I'm an emergency physician at the QEII Hospital in Brisbane. I'm the medical lead of our multi-disciplinary ED Wellness Interest Group. I'm the co-founder of Wellness, Resilience and Performance in Emergency Medicine (wrapem.org). I'm a proud Irish Expat, wife to an affable surgeon and mum to a voracious toddler.

It's my strong belief that staff wellbeing is inextricably linked to performance. And that this concept of 'optimal performance' applies not only to the quality of our patient care, but also to the quality of our lives outside of the workplace too.

This is my first role with ACEM. It took me a little while to get here. I'm here now because there is a real opportunity for FACEMs and trainees to own the advocacy space in ED workforce and wellbeing. I hope to bring some of what I have learned so far to the role of ACEM Regional Wellbeing Champion.



**Andrew Dean**  
(Victoria)

I am keen to be involved with ACEM wellbeing because it is an area we need to focus on. FACEMs and emergency department (ED) staff across Australia and Aotearoa New Zealand are under such pressure in so many ways. As well as advocating for system change, it makes sense to focus also on individual resilience and wellbeing strategies. Many other industries incorporate formal wellbeing strategies, so why not us? From my own experience with mindfulness, I know that this "stuff" works to keep me enjoying my work as a clinician, educator and FACEM.



**Rajesh Sehdev**  
(Queensland)

The role of ACEM Regional Wellbeing Champion is important to me because it brings the resources and support of the College into the dialogue around staff wellbeing that is occurring at emergency departments.

It will help to promote wellbeing as a professional responsibility and as an important component of achieving improved performance in the systems in which we work.

The role enables networking across state and territory borders, and across the Tasman, to share ideas and keep a broad perspective on the topic.



**Andrew Tagg**  
(Victoria)

I've been interested in wellbeing for a long time but I recognise there is only so much I can do on my own. I can share a smile with a tired colleague, I can buy coffees for the day shift, I can check in with the team after a hard day, but I am just one person.

Being a wellbeing champion means learning from others, advocating not just for patient-centered care, but also for carer-centred care. It means creating a culture in which we can ask for help and not be seen as weak. It means making a difference.



**Shani Raghwan**  
(Queensland)

I'm a new FACEM working at Logan Hospital in Brisbane and the team leader for its multidisciplinary wellbeing interest group THRIVE. Like all of us, my journey to becoming a FACEM had many highs and lows – lows which I now recognise as episodes of burnout and during which I was unsure how or who to turn to for help. These experiences have pushed me to be that someone to turn to for others and to push for a better system of recognising and addressing the factors that lead to burnout in medicine. As a wellbeing champion I hope to help make wellbeing a priority at all sites and to make strategies for improving it more visible and accessible.



**Cheryl Martin**  
(Tasmania)

I'm delighted to take up the ACEM role of Wellbeing Champion for Tasmania and to portfolio this role at department and hospital level locally.

Why is this important to me?

Several years ago, I attended the ACEM conference and noted the final day for the first time was entirely devoted to "wellbeing" activities. I was recently post-fellowship and feeling a little "spat out" the other end. I began to seriously explore and question what is workplace "wellbeing"? What does it look like? How do we measure it? Why does it matter?

Encouraged by international literature and experience, I hope to we can start to define, collaborate, measure and implement evidence-based strategies at organisation, department and individual level to support emergency physicians and trainees achieve career satisfaction and longevity. I value my colleagues and the important work they do. Ultimately the wellbeing of our workforce matters because it has potential to impact the quality of patient care.



**Jo Cole**  
(Aotearoa New Zealand)

Kia ora kōtou,

I am an emergency physician in Tauranga, Aotearoa New Zealand.

Our people are our biggest assets in healthcare and the teams we work in are the centre of all that we do.

Caring for these teams and each other is essential – prioritising our own wellbeing is key to ensure that not only are we equipped to provide the best patient care possible but – equally importantly – that we thrive, both at work and in our lives away from work.

I am really excited to be one of the Regional Wellbeing Champions this year and look forward to connecting and collaborating with ED teams across Aotearoa New Zealand and Australia.

Ngā mihi nui



**Mike Nicholls**  
(Aotearoa New Zealand)

The major reason we in healthcare come to work is to ensure high-quality care can be provided for patients and whānau. High-quality care in EDs is safe, timely, effective, equitable, efficient, and patient-focused. As well, high-quality care is integrated within the overall health system and provided by staff whose wellbeing is considered vital to the provision of that care.

I am keen to contribute to that delivery of that care by advocating for the wellbeing of staff in Australia and Aotearoa New Zealand emergency care and beyond, especially throughout our Pacific Island neighbourhood. As well as attending to personal and workplace culture factors, system factors that are barriers to workplace wellbeing must be addressed. It is fantastic that the ACEM champion roles have been established as a means to contribute.



**Mark Sagarin**  
(Aotearoa New Zealand)

I studied at Harvard Medical School (MD,1996) and was in the first group of trainees at the Harvard Emergency Medicine Residency Program (1996-2000). In 2014, I moved to New Plymouth, Aotearoa New Zealand. For years I have enjoyed running, rowing, reading, and playing guitar. My three daughters are ages 11, 16, and 22 and soon I will become a grandfather. In 2015, my younger brother in America was suddenly killed while cycling by an intoxicated driver. The driver was also taking opioids. This tragedy heightened my interest in personal wellbeing (including mental health) for those of us in emergency medicine. I felt fortunate to have some background in mindfulness as well as a focus on my physical health. Employee assistance program counselling was also useful. My colleagues and I organised Humanity: a Taranaki Emergency Medicine conference for February of 2021, with 91 attendees. This conference renewed my love and appreciation for EM.

### **i More information**

Please visit the ACEM website to read more about the ACEM Regional Wellbeing Champions and other College initiatives to support you and your wellbeing. [acem.org.au/my-wellbeing](https://acem.org.au/my-wellbeing)



# Dr Aruna Shivam



Dr Shivam is a dual trainee in ICU and ED and her interests include global emergency care and the environment.

## Why emergency medicine?

There are a few things that I am at my very core. 1. I am a problem solver. I love a good puzzle and a crisis and feel like my brain works best when I am presented with one and need to work against a clock to fix it, just like we do all the time in resuscitations. Along with that, the ability to see and fix almost anything in medicine appeals to me.

As emergency physicians, we can see and solve almost everything that comes through the door. 2. I am also a bleeding heart and, in my internship, and residency came to become very fond of the 'down and outs' in the emergency department. So, the frequent flyers that nobody else wanted to pick up and the belligerent patients were very much my favourites and still are.

I also really liked the idea of being on the floor, working and seeing patients just like everyone else in the department.

I couldn't enjoy being in a clinic or having registrars and residents do my rounds for me and put in cannulas and report back. Especially now, as I approach the end of my training and see the light at the end of the tunnel, I am glad I get to still work on the floor, where I can socialise, teach, and work

side by side with junior doctors, medical students, nursing staff and allied health in a horizontal hierarchy rather than the vertical hierarchy you see in many other fields. I couldn't imagine working any other way.

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

The variety is by far the most enjoyable and challenging part of the job. I never know what the day is going to throw at me and there is no way I can predict it either. Anything and everything could walk through the door and no two patients are alike. So even if two people have the same condition, they may get managed completely differently.

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

Wellbeing in junior doctors became a huge focus for me a few years ago. I became incredibly passionate about this and started a well-being portfolio within our department with my DEMENT (Dr. Nikki Woods) and one of the senior nurses (Kathryn Prothero). I spent lots of time reading and writing about how to maintain wellness in and around work, how to debrief yourself, how to debrief others and spent lots of time listening to residents and registrars about how we could make the department a better place for them to work. We implemented snacks, yoga sessions, check-ins after tough shifts and teaching around this and things were ticking along well when I realised that whilst I spent so much time helping others be well, I spent so little time helping myself be well. I was exhausted, burnt out and constantly giving. I had compassion fatigue and needed a break.

## What do you consider your greatest achievement?

My greatest achievement was the year of 2017. I have been working in resource-poor settings in various capacities since the age of 16. I have spent time in India, Nepal and Uganda and always had an interest in Global Medicine which drove me to do my MIPH at Sydney University. I then went on a rotation through my

then home hospital to Gizo, in the Western Province of the Solomon Islands at the end of 2016 and absolutely fell in love with it. I fell in love with the people, the medicine, the environment, and it really re-ignited a passion to do something useful in me. On my return in 2017, I set to work with a few friends. We set a goal of raising funds initially through a workplace giving program and then using it to provide valuable resources to Gizo hospital, facilitate education and training opportunities for nursing staff and to help implement systemic change using their ideas and plans. We successfully enrolled nearly 300 people to donate and raised more than \$50,000. That year, I also got a 'registrar of the year' award and was nominated for the ACEM wellbeing awards which really helped me keep the energy up!

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

I think seeing that there is still so much we can achieve in healthcare inspires me to continue working. Every time I turn on the TV, I read about people living through poverty, pandemics, civil wars, and natural disasters. Speaking to others who do incredible work in places like these makes me really look forward to having the time again to be able to do the same.

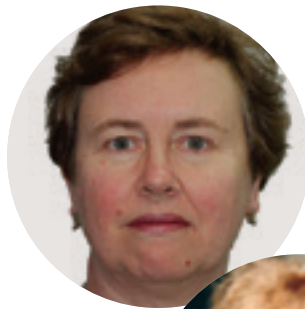
## Tell us a piece of advice that you would have liked to receive as a trainee or early on in your career.

There is ALWAYS more to learn and know. It never stops, you'll never feel like you know enough and that is a good thing! Learning leads to progress both individually and systemically. We can't make the world a better place unless we keep finding the flaws in it and figuring out how to fix them.

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

Everything! But mostly, cultural change to make work and life more balanced, to make women have a stronger place in the world, to give everyone the opportunity to learn and teach, to break down the walls we create between our hospital departments and to discover ways to deliver healthcare to people who need it the most. Everyone deserves the right to be well and until we achieve that, our job isn't done.

# My First Day on the Job



## Dr Pip Wills

'These are the triage cards, the patients are in the waiting room. Ask me if you need anything', the nurse said. I looked from the box of cards, through the door into the waiting room. There were real people who had come to the hospital expecting to see a real doctor. And it was only me.

That was my emergency department (ED) orientation as an intern in small town New Zealand many years ago, just six weeks out of med school. No medical supervision, no ED physician to call. I was both terrified and excited. This was what I thought medicine was. Not filling in paperwork and doing what the registrar told you to.



*"You're the doctor?" they said with a mixture of disbelief and concern. I wanted to say "I know! Isn't it ridiculous?"*

But actually seeing and treating sick people.

I picked up the first card and called them in. "You're the doctor?" they said with a mixture of disbelief and concern. I wanted to say "I know! Isn't it ridiculous?" Instead, trying to display a confidence I did not feel, I reassured them that indeed I was.

I managed that sprained ankle, and all that followed, and I loved it. By asking the incredibly knowledgeable nursing staff, and consulting text books, I made diagnoses, treated patients, and no-one died. At the end of the 16 hour day I was pumped! I couldn't wait for my next ED shift.



38th

## Annual Scientific Meeting

Ōtautahi, Christchurch  
Te Pae, The Christchurch Convention Centre

7-11 November, 2021

Join us at this year's Annual Scientific Meeting in Ōtautahi, Christchurch, Aotearoa New Zealand, the country whose COVID-19 response is recognised by the World Health Organization as one of the strongest on the planet, in the city that birthed HealthPathways and whose integrated health care system is internationally recognised.

Nestled between the Pacific coastline and the spectacular Southern Alps, the garden city of Christchurch has risen from the rubble of both natural and man-made disasters to emerge a strong and innovative global metropolis.

This conference is changing the way we do ACEM Annual Scientific Meetings with highly interactive sessions taking place in-person and online for those that can't make it to New Zealand. This

includes evolving clinical scenarios led by diverse panels of clinical experts, and quick fire presentations aimed to give delegates greater access to research updates from our international emergency medicine community. In addition, enjoy a fine selection of teamwork and wellness activities, social engagements and lectures from passionate leaders of the non-medical world.

Check out all the stunning scenery Christchurch has to offer with walks along the crater rim, strolls around the Botanic Gardens, punting on the Avon or relaxing on our beautiful uncrowded beaches. Tickle the taste buds with gourmet cooking classes, wine tasting or craft beer tasting. Stoke the adrenaline at Christchurch Adventure Park with mountain biking or roganing.

**Join us for education, exploration and inspiration. Come to Christchurch for an unforgettable adventure.**

### Key Dates

**23 July 2021**

Call for abstracts closes

**9 August 2021**

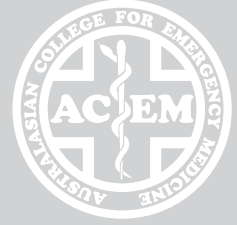
Early bird registration closes

## Register Now

[www.acem2021.com](http://www.acem2021.com)

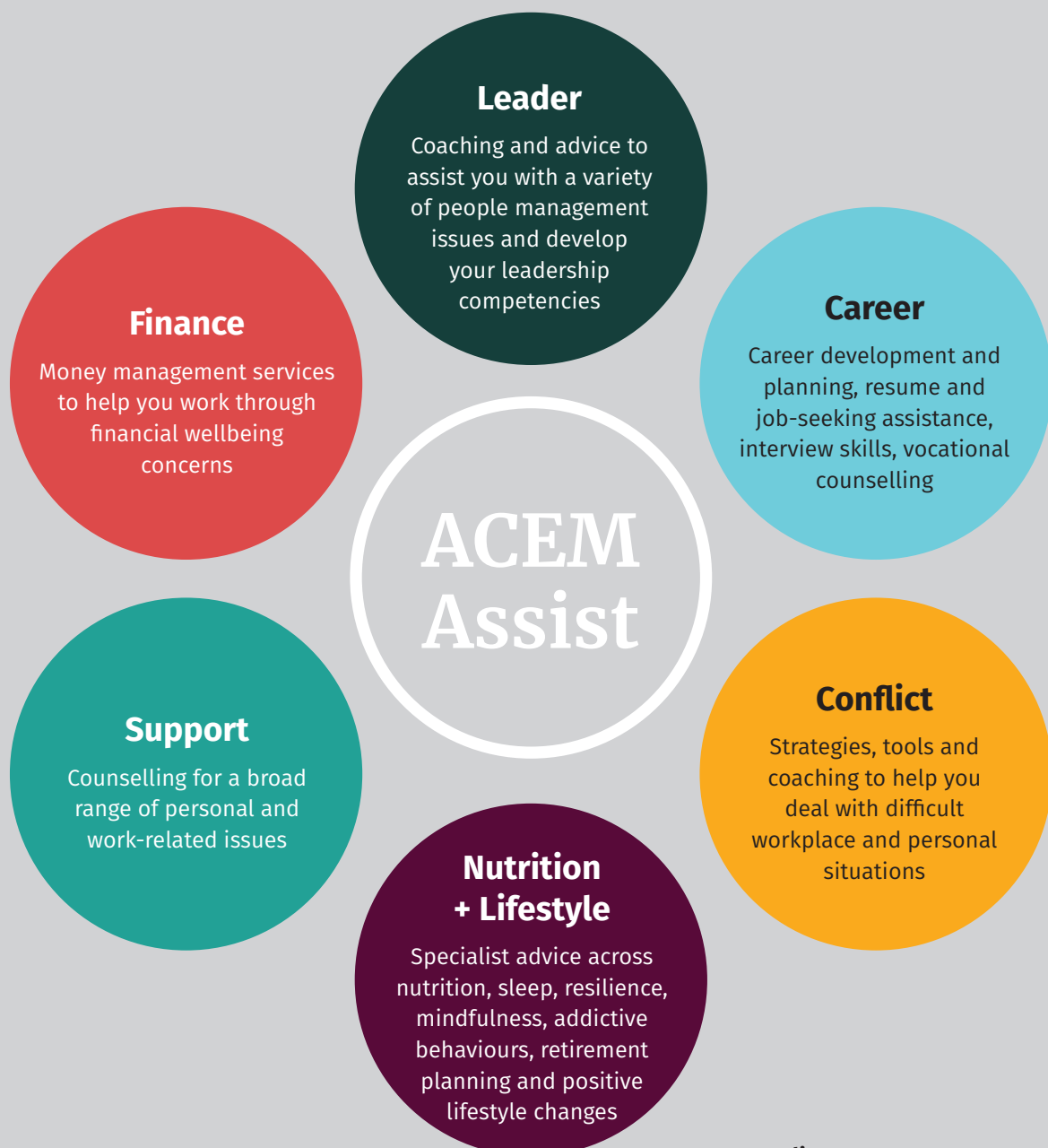
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