# your ED

LISMORE REFLECTIONS
As the Floodwaters Rise

ENHANCING THERAPEUTIC MENTAL HEALTHCARE

AOTEAROA
Health System Reform

A TRUE GEM IN EMERGENCY MEDICINE
Geriatric Emergency Medicine

GLOBAL EMERGENCY CARE
Papua New Guinea

Cover:
iStock.com/davidf
Lismore, Australia – March 31st, 2022: Flooded streets in Lismore, NSW, Australia

# Australasian College for Emergency Medicine




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

**Your ED**



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

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




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

# Contents

Your ED | Autumn 2022


*ACEM in the Media*
2

*President's Welcome*
4

*CEO's Welcome*
6

*ACEM Presidents Farewell CEO, Dr Peter White*
7

*As the Floodwaters Rise*
10

*ACEM Wellness Week*
20

*Wellbeing and Gender Equality*
22

*Enhancing Therapeutic Mental Healthcare in EDs*
24

*A True Gem in Emergency Medicine!*
26

*Aotearoa Health System Reform*
28

*ACEM Core Values*
30

*Member Profile*
33

*Trends and Characteristics of Geriatric ED Presentations*
34

*Community Member Engagement in ACEM Activities*
36

*Trainee Profile*
38

*ED Ultrasound eLearning Resources*
39

*We Live in a Digital World: Increasing Emergency Care Capacity in Papua New Guinea*
42

*Clinical Review Meetings*
46

*My First Day on the Job*
48



*Inga Vennell*

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


## Message from the Editor

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

In this issue we celebrate the leadership of our departing CEO, Dr Peter White, and hear from ACEM Past Presidents as we say farewell.

We feature stories of the Lismore floods. We look back at the harrowing challenges from some of the doctors in the area, as they reflect on the floods that changed the landscape of their town forever.

This edition also features ACEM's Wellness Week which advocates for wellbeing in the workplace, and we hear from Dr Shantha Raghwan on Wellbeing and Gender Equity in medicine. This quarter, we highlight ACEM's Core Value of *Integrity* and Dr Rebecca Day and Dr Steven Chiang muse on what integrity in the workplace means to them.

Associate Professor Timothy Wand reflects on Enhancing Therapeutic Mental Health Care and we hear about how the relatively new specialty of Geriatric Emergency Medicine (GEM) is progressing their goals of highest quality care for ageing patients.

Our Global Emergency Care story this issue comes from the experiences of doctors and nurses in Papua New Guinea as we increase emergency care capacity across the country through digital learning.

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 **February**, ACEM endorsed a joint statement with several other medical colleges that featured in the media addressing the threat of climate change and calling for the Australian Government to commit to stronger 2030 targets. The statement indicated 'climate change is the biggest current threat to the future of the healthcare system'.

In **February**, the College issued a statement setting out its South Australian state election priorities, seeking commitments to significantly improve the public health system. In a joint statement with the Royal Australian and New Zealand College of Psychiatrists ACEM welcomed South Australian Labor's mental health pledge.

In **February**, ACEM released a statement congratulating Dr James Taylor upon receiving the Medal of the Order of Australia for his service to Emergency Medicine and to the community.

In **February**, Dr Peter Allely, Chair of the ACEM Western Australia Faculty, was interviewed on ABC news in relation to the delayed opening of the state's borders, urging the Western Australian government to 'give the state a solid opening date in order to plan accordingly'.

Dr Allely also pointed out that emergency department (ED) overcrowding remained a major threat to patient safety and the healthcare system. 'I fear that overcrowding in WA hospitals could kill more people than COVID-19 in 2022. Currently, we don't even have the surge capacity to cope with a weekend, never mind a pandemic', said Dr Alley in a comment published by *Croakey*.

In **February**, ACEM released a statement responding the Australian Government's $24 million commitment for ED research and welcomed the federal recognition of the extraordinary strain and pressure that EDs are under.

In **February**, the College released a statement announcing the launch of a low-and middle-income country (LMIC) Delegate Subsidisation Scheme in 2022, to provide a centralised process to support clinicians to apply for subsidised registration to attend the International Conference on Emergency Medicine 2022.

In **February**, ACEM Immediate Past President Dr John Bonning told RNZ and Newstalk ZB that Aotearoa New Zealand must be prepared for Omicron, adding that it would put huge pressures on already busy hospitals. He said, 'Currently we are very busy and very full with a lot of people with non-Covid illness, and so it is going to be tough, and particularly in emergency departments'.

Dr Bonning told Newsroom, 'We're all just waiting for the wave to break. We've seen what's happened in Australia. It's going to be tough. The Omicron surge is inevitable, but generally it's not causing a significant number of people to become significantly unwell. Where it will cause pressure is in primary care, emergency departments and to some extent in the wards'.

In **February**, Dr Nicole Liesis, Deputy Chair of the ACEM Western Australia Faculty, spoke to 6PR in response to elective surgeries being placed on hold. She said, 'Emergency departments have been overfull and brimming and busting at the seams for a long time, because we can't actually get patients from the emergency departments to be admitted into the hospital and we call this access block'.

In **February**, ACEM was among 80 health organisations to sign an open letter to the Treasurer and Federal Health Minister coordinated by the Foundation for Alcohol Research and Education stating that the Government is sending the wrong message by considering alcohol tax cuts.

In **March**, Dr Kim Hansen and Dr Shantha Raghwan, Chair and Deputy Chair of the ACEM Queensland Faculty Board respectively, spoke to ABC radio, and featured in *InDaily* and *The Age*, in relation to the impact of recent floods on care.

Dr Raghwan said, 'Due to floodwaters, many healthcare workers are unable to get to hospitals to work, so there are significant staffing pressures being experienced across Queensland and northern New South Wales. Some healthcare workers are stuck at hospitals and have worked back-to-back shifts. Many staff are sleeping at hospitals, as they cannot leave, and everyone across the healthcare system is working hard to provide care to people who need it while worrying about the wellbeing of their own loved ones, homes and communities'.

In **March**, Dr Kate Allan, Chair of the ACEM Aotearoa New Zealand Faculty, spoke to *RNZ* about the worsening staff shortages facing hospitals. She said, 'Hundreds of frontline staff are off across... hospitals, either with COVID, or caring for family members'.

In **March**, Dr Michael Edmonds, Chair of the ACEM South Australian Faculty, appeared on ABC news in relation to adverse patient outcomes due to ambulance ramping. Dr Edmonds also wrote an opinion piece that featured in *The Advertiser, Adelaide Now, Daily*

*Telegraph* and *Gold Coast Bulletin* in response to hospital overcrowding and the strain this places on healthcare workers.

In **March**, the College issued a joint statement with the College of Emergency Nursing Australia, warning of the need for urgent investments in the healthcare system and greater communication and coordination with EDs to prepare for future disasters.

In **March**, ACEM issued a statement reaffirming its commitment to closing the gap in health outcomes, in partnership with Aboriginal and Torres Strait Islander peoples.

In **March**, the College released a statement congratulating Peter Malinauskas and the South Australian Labor Party on their 2022 election win.

In **March**, Dr Allely was interviewed on Channel 7 in Perth, urging people to get vaccinated after the number of unvaccinated patients being treated for COVID-19 increased in Western Australian hospitals. He also spoke to ABC radio Perth regarding the dangers of overcrowding in emergency departments.

In **March**, ACEM responded to the 2022 Australian federal budget and acknowledged the commitments aimed at delivering improvements to Australia's healthcare crises.

In **March**, ACEM President, Dr Clare Skinner told *The Sydney Morning Herald* that the Omicron wave had caused severe staff shortfalls, compounding pressure on hospitals. She said, 'We are seeing higher volumes of patients, and they are getting sicker. We are seeing more people with high acute care needs, including cardiac issues, acute shortness of breath and people with chest pain as patients deteriorate with chronic conditions'.

Dr Skinner was interviewed on *ABC Radio Sydney*, commenting on healthcare system pressures, partly due to healthcare worker burn out. She also appeared on Channel 7 news responding to excessive wait times in emergency departments.

In *The Courier Mail*, Dr Skinner spoke about the excessive strain on many emergency departments, specifically in Queensland.

In **March**, Dr Mya Cubitt, Chair of the ACEM Victorian Faculty, featured in *The Age*, responding to overcrowding in EDs and said, 'We've seen deaths while people are ramped in ambulances or in ED waiting rooms. Ambulance ramping is due to access block. It isn't normal, it isn't safe and it can be fixed'.

Dr Cubitt, was also interviewed on 3AW and said, 'Patient welfare is being put at risk. If you can't get into an emergency department and you were waiting in a waiting room or on an ambulance trolley, you will have delayed diagnosis, delayed recognition of your acute care needs and that leads to real health outcomes and complications'.

In **April**, Dr Allely, spoke to *WA Today*. He said, 'We're seeing substantial numbers of COVID patients, but the majority are coming in with COVID, rather than for COVID'. Dr Allely, was also interviewed on ABC radio Perth.

In **April**, ACEM issued a statement welcoming the Australian Labor Party's aged care polices, stating they could potentially have positive impacts on ED pressures.

In **April**, Dr Cubitt spoke to *The Age*, in response to reports of nine major Melbourne hospitals experiencing significant ambulance ramping. Dr Cubitt said, 'The Australian government also has a role to play in the solution to ramping in Victoria. Greater investment in the National Disability Insurance Scheme (NDIS), aged care and mental health is required to ensure patients requiring these services can be discharged safely and promptly'.

In **April**, Dr Allan spoke to RNZ in response to the COVID-19 settings review before cabinet. She said, 'We're very concerned about influenza, we're very concerned about measles, we're very concerned about children who have been missing their childhood immunisations in the resurgence of some of those infections'.

In **April**, Dr Skinner, spoke to ABC radio responding to reports of access block in EDs across the country. She said, 'This is actually a national phenomenon. At the moment we're seeing unprecedented levels of pressure on our emergency departments'.

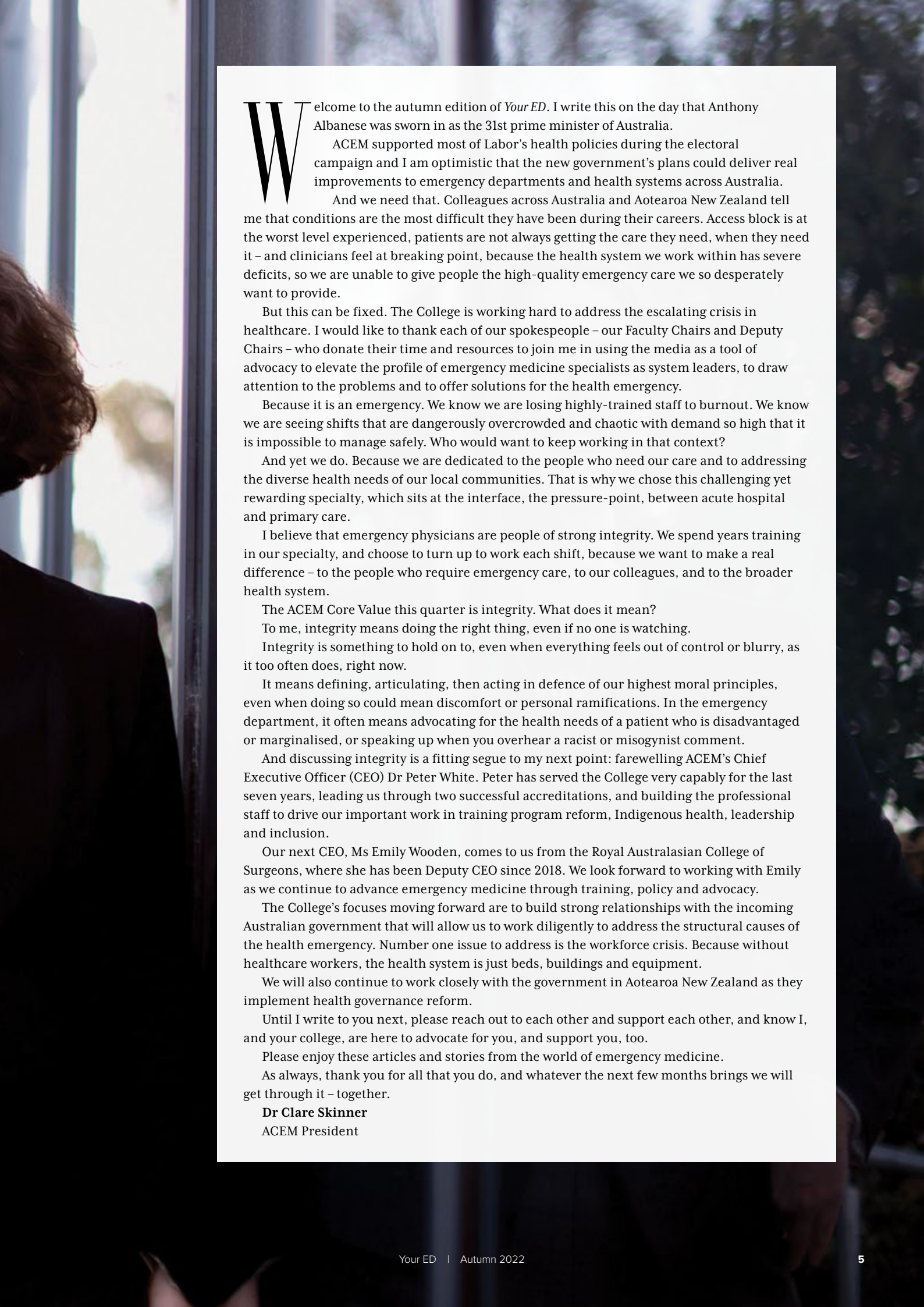
In **April**, ACEM issued a media release urging all parties to prioritise healthcare in the lead up to the 2022 Australian federal election.

In **April**, ACEM was mentioned on Radio National after releasing a statement acknowledging the Australian Labor Party's election commitment to fund urgent care clinics. The College urged caution to avoid models that may duplicate or divert resources from existing primary care models.

In **April**, ACEM issued a media release responding to Dr Mark Monaghan's report on the Southern Adelaide Local Health Network. The report reviewed unplanned and emergency hospital admissions and also highlighted systemic failures within the healthcare system.

In **April**, ACEM issued a media release welcoming the announcement by the Australian Labor Party to review and improve the NDIS should it win the federal election.

# PRESIDENT'S WELCOME



Welcome to the autumn edition of *Your ED*. I write this on the day that Anthony Albanese was sworn in as the 31st prime minister of Australia.

ACEM supported most of Labor's health policies during the electoral campaign and I am optimistic that the new government's plans could deliver real improvements to emergency departments and health systems across Australia.

And we need that. Colleagues across Australia and Aotearoa New Zealand tell me that conditions are the most difficult they have been during their careers. Access block is at the worst level experienced, patients are not always getting the care they need, when they need it – and clinicians feel at breaking point, because the health system we work within has severe deficits, so we are unable to give people the high-quality emergency care we so desperately want to provide.

But this can be fixed. The College is working hard to address the escalating crisis in healthcare. I would like to thank each of our spokespeople – our Faculty Chairs and Deputy Chairs – who donate their time and resources to join me in using the media as a tool of advocacy to elevate the profile of emergency medicine specialists as system leaders, to draw attention to the problems and to offer solutions for the health emergency.

Because it is an emergency. We know we are losing highly-trained staff to burnout. We know we are seeing shifts that are dangerously overcrowded and chaotic with demand so high that it is impossible to manage safely. Who would want to keep working in that context?

And yet we do. Because we are dedicated to the people who need our care and to addressing the diverse health needs of our local communities. That is why we chose this challenging yet rewarding specialty, which sits at the interface, the pressure-point, between acute hospital and primary care.

I believe that emergency physicians are people of strong integrity. We spend years training in our specialty, and choose to turn up to work each shift, because we want to make a real difference – to the people who require emergency care, to our colleagues, and to the broader health system.

The ACEM Core Value this quarter is integrity. What does it mean?

To me, integrity means doing the right thing, even if no one is watching.

Integrity is something to hold on to, even when everything feels out of control or blurry, as it too often does, right now.

It means defining, articulating, then acting in defence of our highest moral principles, even when doing so could mean discomfort or personal ramifications. In the emergency department, it often means advocating for the health needs of a patient who is disadvantaged or marginalised, or speaking up when you overhear a racist or misogynist comment.

And discussing integrity is a fitting segue to my next point: farewelling ACEM's Chief Executive Officer (CEO) Dr Peter White. Peter has served the College very capably for the last seven years, leading us through two successful accreditations, and building the professional staff to drive our important work in training program reform, Indigenous health, leadership and inclusion.

Our next CEO, Ms Emily Wooden, comes to us from the Royal Australasian College of Surgeons, where she has been Deputy CEO since 2018. We look forward to working with Emily as we continue to advance emergency medicine through training, policy and advocacy.

The College's focuses moving forward are to build strong relationships with the incoming Australian government that will allow us to work diligently to address the structural causes of the health emergency. Number one issue to address is the workforce crisis. Because without healthcare workers, the health system is just beds, buildings and equipment.

We will also continue to work closely with the government in Aotearoa New Zealand as they implement health governance reform.

Until I write to you next, please reach out to each other and support each other, and know I, and your college, are here to advocate for you, and support you, too.

Please enjoy these articles and stories from the world of emergency medicine.

As always, thank you for all that you do, and whatever the next few months brings we will get through it – together.

**Dr Clare Skinner**
ACEM President

# CEO's Welcome

**Dr Peter White**

As always, the content of this edition of *Your ED* is testament to the range of activities being undertaken by the College. This includes activities taken in service of the core functions that ACEM is judged against when it is accredited by regulatory bodies, as well as activities that have, over time, become embedded as part of the work that the College undertakes for the betterment of society.

As I write this column, we are one week away from the commencement of the 2022 International Conference on Emergency Medicine (ICEM). Arrangements for the hybrid event have been years in the planning, with the College committing to the conference in Melbourne in 2016 – a long time prior to the arrival of COVID-19.

There have been some nervous times during the planning period. Indeed, it is only relatively recently that we have been able to look with confidence on delegate numbers, both those attending in-person and those choosing to attend virtually. The work involved in getting ICEM 2022 to this point is enormous, and I thank and congratulate all involved for the commitment and determination they have shown.

I extend a particular thanks to Dr Simon Judkins for the leadership he has shown as Chair of the Local ICEM 2022 Organising Committee (LOC). Having previously worked with Simon in his role as ACEM President for two years, it came as no surprise to me that he approached the task of LOC Chair with a vigour and determination that has resulted in – at this stage – 1,280 delegates from 65 countries registering to attend ICEM 2022, with more than 800 registering to attend in-person in Melbourne.

It remains now only to ensure, as we have intended all along, that all delegates get the best possible experience that we can offer, in whichever format they choose.

I will also take this opportunity to congratulate Dr John Bonning and Dr Barry Gunn for their receipt of the award of the ACEM Medal. I have worked closely with both during my time at ACEM, and I have seen first-hand the work that they have done for the College and the speciality more generally. They are both fitting recipients of the highest award that the College can bestow.

I also congratulate Georgina Anderson on her receipt of a Distinguished Service Award (DSA), for her contributions to the College as a staff member over almost seven years. Georgina was an integral part of the planning and guidance associated with the two accreditation assessments undergone by the College and her professional commitment and wisdom have been integral to the College's positive outcomes on both occasions. She is the fourth ACEM staff member to be awarded a DSA for her contributions to the College.

Finally, this is my final column for *Your ED* as the Chief Executive Officer (CEO) of ACEM.

While it is tempting to look back at what has happened during the last seven years, I would simply like to look at where the organisation is right now. I will leave the judgement to others as to whether any contributions I have made have left the College better placed than when I started.

On objective measures, the College is currently well-placed regarding its accreditation requirements. It is also financially sound, it has solid underpinning governance arrangements, and it is clear in its purpose and priorities.

Through its new Strategic Plan for the period 2022 to 2024 (Building on Success) and the corresponding Business Plan, the College is aware of what it is intending to achieve over the next few years, and it has communicated that to the outside world confidently, and with certainty.

A review of the 2019 – 2021 Business Plan for ACEM's June meeting of the Board indicated the enormous amount that was achieved across all sections of the College in that period. This included that which was unanticipated but needed to be done because of the COVID-19 pandemic.

Indeed, the achievements across that period reflect two principles I have consistently applied through my time at ACEM, and reinforced to both College staff, members, trainees and others. These principles are that, firstly, we are here to make ACEM the best organisation that it can be. Secondly, to progress that, ACEM requires collaborative relationships between College members, trainees, staff, and any other stakeholders.

On that note, ACEM is truly fortunate to have the range of considerable contributions that it has. These contributions come from ACEM's members – who commit to the range of pro-bono work required – and from its committed staff, who each work for the betterment of the organisation and the communities that benefit from its work. Increasingly, these contributions also come from community members involved in the work of the College.

I thank all those with whom I have worked. I particularly thank those who have held the office of President in this time: Dr Anthony Cross, Professor Tony Lawler, Dr Simon Judkins, Dr John Bonning and current President, Dr Clare Skinner. The role of president is a complex role that requires a skillset and time commitment not associated with any other role in the organisation.

As have the other presidents with whom I have worked, Dr Skinner has done an excellent job of leading the College in what continue to be difficult times. I thank her sincerely for her commitment to the work of the College, her commitment to the members, trainees and staff of ACEM and for her support of me.

It has been a privilege to have been the CEO of ACEM since the middle of 2015. I am confident that the organisation I depart on 1 July 2022, is healthy and well-positioned to take advantage of the commitment of its members, trainees, staff, and others who contribute to it.

I shall watch with interest the development of the College, and I thank all with whom I have had the privilege of working over the past seven years.

**Dr Peter White**
ACEM CEO

# ACEM Presidents Farewell CEO, Dr Peter White

*On 1 July 2022, after seven years of service, Dr Peter White retired from his role as the Chief Executive Officer (CEO) of the College. The five ACEM Presidents who served during Dr White's term as CEO reflect on his contributions and achievements – and say goodbye.*

### Dr Anthony Cross, ACEM President 2012 – 2015

I was President at the time of Peter's appointment to the College.

He hit the ground running and settled in very quickly – it was a very easy transition, from a practical point of view. I think this was particularly impressive given the College was in the process of two major changes: the new/revised FACEM Curriculum and modernisation of the governance structure. The changes in governance were implemented remarkably smoothly.

The changes in the FACEM Curriculum – especially the changes in examination format – gave Peter many opportunities to have in-depth discussions with some of our more senior examiners about a wide range of problems they perceived with the new examinations.

He was always professional and diplomatic. But I noticed that he continually channelled Sir Humphrey Appleby from the British television series Yes Minister with his declaration 'I'm merely a civil servant. I simply do as I am instructed by my master'. Nobody really believed that!

I thank Peter for all his contributions to the College and wish him all the best for his retirement.

### Professor Tony Lawler, ACEM President 2015 – 2017

In 2015, Peter White took his position as the CEO just before I became President.

Before that I had known him only as the gruff, no-nonsense chap with whom I had sat on a couple of College committees.

However, I couldn't have delivered as President for two years without him.

During my term, ACEM faced significant internal cultural challenges. Events required us to face the reality that our own profession was not necessarily what we always thought it had been. Peter brought a level head, and wise counsel, to facing these issues of professional identity head-on.

Because much of the visible leadership in addressing this has been provided by Fellows, I don't think people are necessarily conscious of just how crucial Peter's role was and is. He supported the College leadership, assisted in robust and fair responses, and worked with key internal and external stakeholders to first understand and then to navigate to where the College needed to be.

Peter has led an explosion of activity and achievement at the College. In the last seven years, we have moved more fully into advocacy and representation as a core part of our being. Our contribution to and role in the medical workforce planning journey has been acknowledged as an exemplar by the Commonwealth Department of Health.

Peter brought a keen eye for governance, process and structure to ACEM. In 2015 he inherited a fairly new governance structure and has since assisted the ACEM Board, Council of Advocacy, Practice and Partnerships and Council of Education, and College entities and office-bearers to incrementally strengthen it to the point that it is a model of specialist college governance.

This enables what is, after all, an almost entirely volunteer medical workforce to work hand-in-hand with College staff to deliver a huge agenda with high-quality results.

Peter's leadership of the highly professional, motivated and committed College staff ensured our members and trainees continued to feel connected and supported through the pandemic, and today.

On a personal note, I can't thank Peter enough for the support and friendship he has given me during his time at the College.

The role of President is frequently a lonely one, and the relationship between President and CEO is key to making it both productive and rewarding.

Peter is a thoroughly professional, decent and insightful colleague, and at many points in my term was a rock in fairly troubled waters.

ACEM owes Peter a great deal, and I wish him well in the next phase of his adventure!

### Dr Simon Judkins, ACEM President 2017 – 2019

Peter and I developed a solid relationship quickly and worked very well together. We had daily frank and honest discussions on pertinent issues.

I could see the influence of the teaching background in him. He is structured and organised – unlike me! – as well as methodical, with a great eye for detail.

The role of CEO in a member organisation can be challenging. There are members with strong views on many issues. Peter consistently gave wise advice and consistent support, but he was pragmatic. He offered a realistic perspective on what was achievable. He rarely said no to ideas, even when he might not agree with them, but instead worked to find the right path to get the results required.

During this time, Peter led ACEM through a governance restructure and a challenging accreditation process. He oversaw the College expanding its roles in health advocacy, international supports, new committees, leadership programs and in a significant expansion of member engagement.

But we always found time to discuss our families and how they were doing. His family were always a focus. He was, and still is, very proud of his daughters.

Peter has been an incredibly strong leader, with high expectations of his staff, and of himself. He has brought us to a point of strength in governance, accountability, and finances.

He leaves ACEM a better place, and I am grateful for the support he has given me.

### Dr John Bonning, ACEM President 2019 – 2021

When the ACEM Board hired Peter in 2015, we understood he had lived experience of education and of binational specialist medical colleges. We felt that he truly understood our world and believed that he was the person to help guide us to the next stage.

And we were right. Peter was an important driver of the period of significant change and maturation of the College that brought us up to appropriate governance standards, and into the vital, dynamic, agile, respected organisation we are today.

In 2017, he steered us through the extremely challenging Australian Medical Council / Medical Council of New Zealand accreditation where he advocated for ACEM to achieve the recognition it deserved as the pre-eminent provider of emergency medicine specialist training in Aotearoa New Zealand and Australia. In 2021, Peter helped guide us through again – with flying colours.

We didn't know it in 2015, but Peter also had the skills needed to guide the College through the tumultuous seas of the pandemic. Together, we steered the team of over 6,000 members and trainees, and the College staff. Through my pandemic presidency Peter and I talked most days, and I always knew he was helping us make decisions through the enormous challenges that the pandemic threw at us.

We needed someone like him, at that crucial point. His strong leadership may not have been to everyone's taste, all of the time, but a strong leader he was, and a strong leader we needed to get through trials and tribulations of a troubled accreditation, through the turmoil and pandemic, to get to where we are today.

Peter helped guide ACEM from a band of enthusiastic amateurs in 2015 to the seasoned and respected cohesive College we are in 2022: a leader amongst the colleges, with others coming to us for advice and following our example.

Peter and I get on very well. During my time as President, when travel permitted, we would meet for a meal, at the Boulcott Bistro in Wellington, or at Sud in Melbourne or a memorable trip to Prague in 2019 for the European Society for Emergency Medicine Conference. There are plenty of problems you can solve over a good meal, an IPA or a glass or two of pinot noir.

He is a family man, always enjoying talking about his daughters, their family adventures in France, and his other great passion – golf.

I wish Peter, and his wife Fiona, all the very best for the next chapter of their lives, and I wish Peter a happy and restful retirement, although I cannot imagine he will be idle or rest for long.

### Dr Clare Skinner, ACEM President 2021 – 2023

Out of each of the presidents, Peter and I have had the least time working together, but I am keenly aware that, since 2015, Peter has brought great expertise and experience to ACEM.

He has led the College through times of growth, change and uncertainty: through a global pandemic, and numerous other challenges, both anticipated and not.

The College he helped lead is now vastly different to the one he inherited in 2015 with projects, plans, professionalism and a profile that could only have been dreamed of in earlier times.

Peter's attention to detail and his capacity to work late into the night, making sure every word in a policy document or letter is perfect, is second to none.

I warmly thank Peter for all that he has brought to ACEM and I wish him and his family, all the best for Peter's retirement and for the next stage in their lives.

# DEVELOPING EM

## A CONFERENCE WITH A CONSCIENCE

26 - 30 September 2022
Darwin, Australia & Online

DevelopingEM 2022 offers a unique opportunity to experience practice-changing education and insights into the delivery of acute healthcare, as well as exploring the challenges of healthcare for First Nations people in the NT and around the world.

The conference program was developed by community and clinical leaders and offers expert speakers, workshops and interactive panel discussions. In-person or online participation is available for all levels of medical and nursing professionals.

Join the DevelopingEM community in an incredible location, to broaden your skills and broaden your horizons.

2022 program includes:

- Practical pre-conference workshops in ultrasound, toxicology and emergency nursing.
- Adult EM and Critical Care.
- Trauma.
- Paediatric EM and Critical Care.
- First Nations Healthcare.
- Social networking opportunities in the fascinating Northern Territory.

**FIND OUT MORE & REGISTER AT DEVELOPINGEM.COM**


+61 3 9903 0666
admin@developingem.com
DevelopingEM.com
DevelopingEM
@DevelopingEM
@DevelopingEM


AlfredHealth Emergency

ACEM ACTIVITY APPROVED for CPD hours

IMAGE: Watarrka from above. Tourism NT / Matt Glastonbury


# As the Floodwaters Rise

*Monday 28 February 2022 changed the landscape of Lismore, New South Wales irrevocably. We read the stories and watched the news with bated breath, praying the floodwaters would recede, but what followed was a disaster of unseen proportions in the region. We reached out to the doctors who were there, on the ground and in the air, facing the harrowing and overwhelming force of nature. These are some of their stories.*

iStock.com/davidf

**Dr Anne Drinkwater**

I moved to the north coast (Bundjalung country) 20 years ago. I came for one year, but I forgot to leave. I was seduced by the relaxed lifestyle, the welcoming creative community, the amazing landscape – the beaches, waterfalls, the many rivers, rainforests, and national parks. The variety and acuity of the emergency medicine presentations was also a draw card.

At the start of 2022 Lismore was thriving, having finally recovered from the 2017 flood. Summertime is storm season, due to the sub-tropical climate in which we live. The difference this summer was that it had been raining heavily almost every day since November. The water table was full. When the intense weather system arrived in late February the rain was relentless. It was literally the perfect storm. No one was prepared for just how bad this flood would be.

This was a disaster in the true sense of the word. The community was amazing. Civilians saved lives, volunteered in the evacuation centres, provided food, shelter, clothes and blankets. It was unbelievable what members of the general public achieved during those first few days and weeks. Their efforts are ongoing.

Initially the community was relying on the ED for more than medical care. People needed somewhere dry and warm. There was nowhere else to go until the evacuation centres were established. The sheer numbers of homeless and destitute people were unbelievable. People had lost everything, including their identity.

Our community is traumatised. I'm tired of the constant use of the word "resilient". The flood victims are not resilient. They are in pure survival mode. Surviving each day is all they can manage. There will be no quick recovery from these difficult conditions.

The community will slowly move on, but the sound of rain on the roof will no longer be pleasant or soothing for many.

I can't see how Lismore and the many other communities further down the river can recover. It will take years to physically rebuild. Where this should occur is up for debate. The emotional toll is immense. There are many people who will have no choice but to move back to Lismore. I'm not sure how they will cope.

I have friends and colleagues who have lost everything, who are living with friends, family, wherever they can. Even if their homes can be rebuilt, the time frame given is more than a year.

The other word we hear all the time is "unprecedented", defined as "never known before".

We have known many floods before. The science tells us that such events will continue to happen, more frequently and with more severity.

This was not a one in one hundred year flood (we had that only five years ago).

This flood arrived on February 28, and then we had another flood four WEEKS later. It's happening now, and it's not unprecedented.

When disasters strike, I believe Emergency doctors are natural leaders. We quickly assess a situation, weigh up the options, make a decision, then act.

My role during this disaster was mainly one of logistics - checking on staff safety and well-being, reworking the roster to attempt to cover three emergency departments, liaising with executive.

Some of our FACEMs also work for our regional helicopter retrieval service. They were obviously very busy during the first days of the flood. Some creative rostering was required. Luckily, we were still relatively COVID free amongst our staff.

Communication became a major issue very early on. Fortunately, I had mobile phone reception for the majority of the first 24 hours.

The evacuation centres required doctors, nurses, social workers and counsellors, drug and alcohol workers, pharmacists. This was a massive job, and many people volunteered for days.

As the roads flooded, basic supplies, including food, water, petrol, and diesel (needed to run the hospital generator) were in very short supply.

In terms of lessons learned to prepare us for future natural disasters, from an emergency physician's perspective I would say, value your ED skill set, but keep within your skill set. Trust your colleagues and your team, as they will give it their all and do an amazing job.

*When disasters strike, I believe Emergency doctors are natural leaders. We quickly assess a situation, weigh up the options, make a decision, then act.*

Prepare for the failure of all electronic communication, and have a back up. Review the disaster plan – again.

From a personal perspective, I am still assessing my response. There is definitely a sense of guilt. I live on the plateau, 140m above sea level. It doesn't flood where I live. I did not experience the terror of the flood.

I found the huge numbers of helicopters hovering about me for days slightly disconcerting. When the army trucks arrived, I felt like I was in a war movie.

I am fortunate to have had the support of family, friends and colleagues throughout.

Our dedicated staff have worked hard, adapted, and provided outstanding care for our patients and the community. Many have their own horrific stories of escape, survival, and loss.

Due to the relentless nature of our work, ongoing access block, a post flood (and Bluesfest) COVID outbreak, we haven't had time to stop and debrief – hot or cold, wet or dry.

We need to take care of ourselves and our colleagues.

We should celebrate all the good in life, the sunshine when the opportunity arises.

ED people definitely have that skill set.

Below are individual accounts of the flood from some of our medical team.

**Dr Richard Lane**

I left for work at 9:30 am instead of 2:30 pm as I knew getting to work itself would be a mission and only likely to get worse, and found an obscure way to get to work, which took 90 minutes instead of 50 minutes but was not too hard on my 10 year old Corolla.

My first glimpse that something really bad was happening started with the amount of cars towing boats, all headed towards Lismore. At that time of the day, you would be expecting them to be headed east towards the coast.

Upon arrival at the hospital I ran into one of our senior ED nurses. He was completely drenched as he had just rescued his cat from his flooded home, after first helping his wife and newborn baby to safety. His wife then came in to meet him in our emergency department (ED) staff area and they embraced, looking completely shocked and distraught after what they had just been through.

*I remember talking to a distraught paramedic who was not sure how many people were still in their homes at that time.*

Upstairs on the ED floor there was a sense of unease but no loss of control. Wet people with stunned looks on their faces were scattered everywhere throughout the department.

The loss of control would happen about 30 minutes later when we lost our electronic medical records (EMR) system and then all our phone communications. Mobiles were still somewhat functional to take calls.

We soon got ourselves organised with whiteboards everywhere and lists of phone numbers. Being a big department in area, we split into geographical teams. I was in resus with some registrars and senior nurses.

One of first patients we had in resus was a non-flood related shortness of breath/Hypoxia/Rapid AF. The CT radiographer said we could maybe do a contrast scan but there was a chance it would crash our CT completely as it was on the generator. Luckily we made the right call. The CT did not die and the patient had a massive saddle embolus.

As the afternoon went on, our resus became full of more and more cold, hypothermic elderly patients. Each one, once they were warmed, had terrifying tales of survival. They all had shell-shocked looks on their faces. I think the coldest patient we saw was 28 degrees but luckily no-one went into VF. We did have quite a few slow AFs but all the bear huggers and fluid warmers in the hospital were in our resus bay and being put to more use than they have ever experienced.

At one stage we were told an entire nursing home was being evacuated to our emergency department. All our beds and waiting room were full, so luckily the higher up management was able to divert, as the evacuation centres in Goonellabah were getting established.

No one even thought about a break. At about 8:00 pm the resus bay seemed to settle down as the SES had to stop evacuation due to safety concerns in the dark. I remember talking to a distraught paramedic who was not sure how many people were still in their homes at that time. It was estimated that there could be dozens of stranded people. This only further darkened the mood in the department.

I stayed overnight on a miniature mattress in our registrar's room and got a couple of hours sleep. Our night registrars were luckily able to get into work and did a great job. Things were still chaotic in the morning with ongoing lack of EMR and communications, but fortunately some fresh doctors were able to get in to take over logistics, as I was

iStock.com/davidf

certainly in no state to be particularly useful.

I think overall everyone did a great job. Our paramedics and SES workers, as well as the hundreds of locals who became resucers that day in particular, were inspiring.

We definitely got a lesson in disaster management and there were possibly a few things that we could have done differently, but it was a pleasure to work with such a great team.

**Dr Irfaan Jetha**

It had been a really wet summer, and over that weekend like so many other days, it had been raining non-stop. An hour before my evening shift, there was flash flooding in my neighbourhood blocking both exits, which subsequently delayed my arrival to work. I had to wait for the water level to lower enough to safely cross it in my SUV.

At work, it was business as usual and throughout the evening, there was no feeling that Lismore was about to experience its worst and most devastating flood ever. Later that evening however, it became apparent that Lismore was likely to flood as there were reports that the two roads into Lismore were already flooded in parts, and that the evening staff may have difficulty getting home. As I was on-call that night and working early the next morning, I decided to just stay at the hospital and not risk it, as others who left were giving reports of being turned around by emergency vehicles.

After handing over the department to the night staff, I wandered down to the ED administrative offices and found an unused mattress in the corridor and some sheets, and laid it down in an office to try and get some shut-eye. I was shortly awoken by an announcement around 2:00 am for staff to move their cars to higher ground as the levy had broken and the CBD was starting to flood.

I awoke again at 7:00 am to try and get a grasp on the situation and check on the department, and also to find out what staff would be able to come to work that day. This was mostly coordinated by our DEMs who were working frantically to redeploy staff to be able to provide cover for our three hospitals and the retrieval service.

*To complicate things further the hospital lost power and we lost communication and computer access.*

The next few hours were a blur as the first of many evacuated patients began arriving with nowhere else to go. Some of them required medical treatment and admission to hospital; others were just waiting on transport to be organised to take them to the evacuation centres which were already being set up on higher ground. To complicate things further the hospital lost power and we lost communication and computer access. So myself, the other ED consultants, and senior nurses quickly got together and made a plan on the fly - how to set up the department, distribute our staff into different teams, allocate our limited resources, and keep track of all the patients in the department.

This was true disaster mode medicine, which we had never had to do before at such a level (at least in my experience). I'd worked at Lismore in the past during floods, which is a regular occurrence here, but it had never been like this!

Nevertheless, it was remarkable how we were able to quickly adapt and continue to provide a service to the community, with no adverse effect on patient care. It was a reminder of how dedicated our doctors and nurses are, and how as emergency workers, we are able to adapt to any situation and provide quality care no matter how little capacity or resources we have!

iStock.com/davidf

**Dr Matt Verdolini**

Reflections from day one retrieval:

I was working as a retrieval specialist for Lismore Helicopter services Sunday night/Monday morning…the day the flood hit.

It was eerily quiet, the weather terrible making flying an impossibility.

It was well known that Lismore was going to flood but what was not known was the height and extent of damage.

Our pilot was tasked with monitoring the situation. At 11:00 pm Sunday night we decided on our plan: the helicopter base would be cut off by road, but the call was made to stay on base due to its supporting infrastructure (fuel, engineering, medical gear/restocking). Flying in and out of our "island" would not be a problem.

At 4:45 pm a recheck of the weather predicted up to a metre of water may come through the base. In a mad rush we lifted gear up above the predicted flood line and stockpiled what essential gear we could muster to shift to the helipad of the hospital.

As the early grey light dawned a cow wandered across the helipad. Slowly we saw the whole of the airstrip of Lismore airport was a river which was rapidly rising. Sea containers and light aircraft were floating away.

The water level was lapping at the apron and a local helicopter landed from Rotor wing….a family operated helicopter business with a hangar at the northern end of the strip. A mother clutching her baby and two-year-old unloaded – she told us how she woke to a wet floor and looked out of their "donger" to see water lapping at the belly of their helicopter. As they flew off, their home washed away with their dog.

The husband flew off to perform the first helicopter rescue of the day in an attempt to save the Rural Fire Service (RFS) helicopter which was also parked on our concrete apron - the highest ground of the area.

He did a daring hover on the roof of a nearby hotel to pick up the two aircrew who only just managed to save their chopper before ANOTHER 1.6M of water washed through the base destroying the entire rescue helicopter base. That RFS chopper went on to perform a multitude of rescues over the coming days.

Initially my job was to unload the helicopter and facilitate a crew swap for the new day as the situation unfolded. Unfortunately, the weather significantly impeded the ability to rescue people in the early hours of the day.

In Lismore ED it quickly became apparent how few staff would be able to make it into the hospital, so I stayed on to do a day shift. Power and all EMR shut down so we were on generator power, tracking patients on whiteboards, writing paper notes and paper ordering investigations - a real throwback to the past!

Initial patient load was light as access to the hospital was so incredibly limited, but slowly as rescues occurred throughout the community, the full effects of the utter devastation became apparent.

It has been a roller coaster that will continue for months/years to come. An overcoming sense of loss for the community and guilt of being among the unscathed. A sense of pride to be part of the overwhelming community spirit that helped in so many ways to support affected people.


**Dr Simon Jones**

My day started at 5:00 am with a WhatsApp message informing me that the Lismore helibase was under water.

The day shift team were to rendezvous at Ballina Airport. I descended the stairs, pirouetted around a water feature in our lounge ceiling, ate a piece of toast that I had burnt and headed out into the monsoon. The road to the airport was rapidly disappearing but still passable. It was clearly a one-way street. I grappled with and eventually reconciled the notion that I wasn't going home that night and pushed on to our new base, a disused and decommissioned aviation management office. Mission control. Despite its modest dimensions, it contained the salvaged equipment for mission readiness. The team was briefed and received a handover from the night crew and headed off on our first job. A 70 year old male with chest pain on a property, a 20 minute flight to the South West, cut off by flood water.

At 1000ft the aerial survey was confronting. The northern rivers were an archipelago of high ground and Colourbond roofs adorned with the desperate occupants of the inundated homes that lay beneath them. Anything that floated and had some form of propulsion snaked between Colourbond islands, rescuing the ambulant: civilian canoes, kayaks, tinnies, jet skis. Police launches, SES, ADF. Mick Fanning. Joel Parkinson.

We cut circuits above an isolated roof, on it three people. There was no watercraft in sight. They beckoned to us. Desperate. Scared. But we had a brief: To complete missions assigned. We were a medical asset. Those who did not have an immediate life threat were to be rescued from land/water assets. Of course there were no land assets and we had no way of communicating with those on roofs. No way of determining life threats. No mobile reception. Patchy internet. Just blind faith that the canoes, kayaks, tinnies and jet skis would reach them. Our crewman Jethro recorded their coordinates. We pressed on. Our patient, it transpired was stable. Frail, vulnerable and scared, but stable. I wondered. Were those three on that roof stable? They were weighing on our minds. We loaded our patient and transported him to Lismore Hospital via Jethro's pinned way point. The SES were mooring at their roof. A collective sigh of relief percolated through our headsets.

We performed three more missions along the same lines. Same guilt. Same frustration. Same blind trust. Back to back. Enroute to patient four we were redirected to a Priority 1 at an isolated hinterland community called Main Arm. There were bystander reports of a major landslide with one person trapped. The roads were impassable and no other resources available. Jethro locked in the coordinates obtained from the informant's triangulated mobile and we made a bee line. Under us, what once was pristine subtropical rainforest punctuated by small clearings for nefarious agriculture, had V shaped lacerations scoured into each hillside. Torrents took place of roads and the bridges that once straddled the valleys annihilated by maelstroms in mutant rivers.

We arrived at our destination. Below us, a landslide two hundred meters in length carved through the rainforest, a Colourbond roof at its toe. After four circuits we determined that landing on was impossible. There was no clearing large enough and a paucity of even remotely flat ground.

The only possible winch insertion point was between two sets of power lines and a colossal gumtree 100ft tall.

The terrain underneath lurched at 30 degrees. Now the textbooks will tell you never to winch near powerlines. There's a good reason for that. But with the helicopter in a stable hover 120 feet above terrain Aaron, our critical care paramedic, had completed his checks and was winching in. He radioed back shortly after with a situation report.

*We cut circuits above an isolated roof, on it three people. There was no watercraft in sight. They beckoned to us. Desperate. Scared.*

'It's horrendous. I'm gonna need the doc down here'. Horrendous. Hmm. I took the hook and followed Aaron's plumb line in. The insertion site was about 50 metres from the scene. All I had to do was traverse the slope until I met the landslide then walk up its apparently smooth skin to rendezvous with Aaron. My first step onto its surface didn't go the way I would have liked. My legs disappeared from under me. Up to my waist in mud I reached out over to a fallen tree and hauled myself out and onto a piece of corrugated steel. Not a good start. The edges of the landslide looked more stable. I clambered up its periphery.

I found a women covered head to toe in mud, her hands bleeding, digging furiously. 'Are you a patient'? I asked. 'What'? she replied. What indeed I thought. What a stupid question. 'There's a man beneath me and his mother is down

there', she screamed over the din of rotor blades, pointing at the Colourbond roof. I couldn't see anyone. Aaron appeared. 'Where are the patients'? I asked. He pointed towards the roof. I couldn't see anyone. We walked down the stable edge and found a person of indeterminate gender or age prone. A mummified head with eyes glued shut, ears plugged by mud. A parched tongue. I found an empty ice cream tub amongst the twisted metal and shattered glass, filled it with water from a brook to our left and cleaned the eyes and mouth. A lady, perhaps in her seventies emerged. Thank you, she whispered. I cleaned a finger and attached a pulse ox. Sats 92%, PR 110. She needed further care but not before we had assessed patient 2. We told her that her vital signs were reassuring and we'd get her out. We headed back up the slope to check the status of patient 2.

He, a male in his 40s was buried up to his neck, his right arm was mangled, pus streamed from his right eye. His cornea pitted by the elements. He was covered by a metre of putrid smelling dirt beneath which a wooden structure was across his chest. Trapped by compression. A smashed toilet and effluent pipe lay by his head, the contents of the septic system all around. 'Can you take a deep breath'? I asked, 'Almost' he lisped through cracked lips. His face expressionless. He looked broken. Pulse ox on. His vitals didn't do this man's situation justice. Normal. 'I could do with some drugs I think' the man said wryly. I laughed though I didn't mean to. This was absurd. 'What hurts?' I asked. 'Well…. I can't feel much…but I've been here a long time', he replied in monotone. Thirty-six hours to be exact. It transpired that their house had been hit by the landslide at 9:00 am the previous morning. He had been trapped in his current position since. Two days and a long, lonely night, his only company mosquitoes, snakes, jumping ants and leaches. Waiting to die. He deserved some drugs.

I popped in a cannula, gave 500mls hartmans followed by a fentanyl and ketamine chaser, whilst Aaron considered the extrication plan. It was clear that we were going to need more manpower and cutting equipment. He radioed to Aeromedical control requesting further air assets to respond.

With patient two tripping pleasantly, we refocussed our attention on patient one. We started digging with our hands through the debris. With a mound of foul earth removed, a twisted bed frame complete with mosquito net emerged, coiled around her abdomen like an iron python. Her legs were cocooned in a carpet. One leg released. The other one further in. It was delivered mottled and pale. We assembled the winch basket, log rolled her in and lifted her onto the piece of corrugated steel I had prepared earlier and chocked it to the horizontal. I looked up. Another doctor and critical care paramedic had appeared on scene. 'Where did you come from'? I quizzed. 'Sydney via Tamworth', they replied. I was speaking figuratively, I thought. We provided a MIST report and transferred care to our GSA HEMS colleagues.

*Torrents took place of roads and the bridges that once straddled the valleys annihilated by maelstroms in mutant rivers.*

With fading light, we ascended the slope back to patient two. Our head torches projected rays through the steam rising from the mud. Swarms of biting insects lit up like fireflies. An army MH-90 appeared. Five or six soldiers were winched out. The scene was transformed. Now war like. The soldiers brought with them an axe, bolt cutters, a saw and a crowbar. We mustered around the head of patient two. Aaron's extrication plan was discussed and then actioned.

The wooden structure was prised off the chest by way of a cantilever system using branches from fallen trees then chocked with rocks and logs. The wooden cage chopped into sections by a burley infantry man. Cantilever, more chocks. With the wall removed, his chest and abdomen were exposed. Engorged leaches hung from his mottled skin, his pelvis and lower limbs were hidden under another metre or so of rubble.

The only access was under the precariously cantilevered debris above. It was too risky to dig them out. A change in tack was required. We strapped his torso and head into an extrication brace. I administered 500ml hartmans, a K-hole dose of Ketamine, an amp of bicarb and 10mls of calcium chloride, found solid footings and prepared to pull him out like a cork from a wine bottle. Pull on three, Aaron bellowed. One, two…….three. One pelvis and two thighs. Heart rate stable. One, two ……three. Two mottled feet. More leaches. The war was not over but this battle had been won. We packaged him into our winch basket and so not to lose momentum carried him 20 or so meters down the solid border of the landslide, made a right turn over a fallen tree and up the 30 degree slope to our extrication point by the colossal gum. Patient one was hauled to the same point. She by this point was showing signs of deterioration and the decision was made to prioritise her for the first winch extrication. The sound of rotor blades echoed around the valley once more. Helmets on, visor down. Westpac 1 appeared from the east and entered a stable hover above. The winch hook descended; its path highlighted by the glowstick attached. Winch basket attached, a big thumbs up and they ascended like a phoenix. This glorious moment was interrupted. My bottom lip had gone numb. I pinched it. It felt weird. I gesticulated wildly to Aaron who focused the beam of his head torch on the area of interest. With my central vision blinded by his torch light a gloved hand entered my mouth from the periphery, then a pulling sensation. This was unexpected. His torch beam focussed now on his thumb and index finger, between which was a leach. That was a first for me. 'You are a hero, Aaron. A true hero.' A proclamation.

A rumble flowed back into the valley followed by a strobe of red and white light. Westpac one manoeuvred into position by the gum, I curled my hand into a fist and positioned it above my head. The signal that I was ready for the hook. The rain had started to fall again, a luminous abstracted hook levitated just out of reach. Aaron moved over the patient,

grabbed it and placed it in my hand. Click click. A thumbs up and we were closing in on the helicopter's yellow and red belly. Two green discs glowed in front of me. The crewman's Night vision cutting through the darkness. We synchronized three head nods and the patient was swung inside and secured to the airframe. Aaron was hauled in with our packs. Door pulled shut. We yawed to the left, the nose pitched, and we were out of there.

Now, I wouldn't be home for another 14 hours, but my story ends here. It had been an emotional day for everyone.

### Dr Mo Haywood

I'm not going to write about the unfathomable loss and pain that these floods have incurred on our special community – there are others far more eloquent and worthy to put that into words. Instead, I will write about my experience as the FACEM in charge of the Ballina ED when we were tasked to evacuate, and about the ongoing hardships faced by my patients.

The Lismore flood levee was breached in the early hours of Monday 28 February, submerging the town in a matter of hours, with numerous other towns and villages hit soon after. Emergency evacuation orders sent by text at 2:00 am went unnoticed whilst the locals slept and by the time they awoke it was too late.

The inland flood water made its way downriver towards Ballina a day or two later. This mass movement of flood water coincided perfectly with the king tide; a devastating coincidence that resulted in rare flooding of the coastal towns.

On Tuesday 1 March, my Ballina ED afternoon shift began pleasantly, with fewer than usual presentations because, with many local roads submerged, people were forced to stay at home. At around 6:00 pm, three hours before the evening king tide was due to hit, staff were contacted by local authorities and instructed to evacuate the hospital. Over the next three hours, we had to evacuate the hospital's 60 patients all the while juggling the ongoing care of our existing sick ED patients and the increasing stream of new patients arriving at our doors. At the same time, we had to gather and transport enough equipment, medication, and supplies to create a fully functioning field hospital and ED in a nearby school. This was not something I had prepared for in the fellowship exams and there was no protocol to follow.

What followed was the most awesome display of multidisciplinary, multiservice, and community teamwork that I have ever seen. The SES and police arranged coaches for the ambulant patients, ambulances for the bedbound, vans for all our equipment, and had 60 inflatable mattresses ready to offload the patients onto at the other end. By the time the last of us arrived at the school, an explosion of


iStock.com/davidf


iStock.com/davidf

*What followed was the most awesome display of multidisciplinary, multiservice, and community teamwork that I have ever seen.*

volunteers from every discipline was there ready to help, and more continued to flow in over the entire 48 hours that the field hospital existed - many of whom had themselves suffered significant personal loss due to the floods.

Within the first hour of creating our new field ED we were treating patients with profound hyponatraemia and AKI, small bowel obstruction, CCF, dog bites and sepsis. Everyone present handled the chaos with calmness and grace. Despite the dire circumstances, it was a remarkable and humbling display of human compassion that I was lucky to be a part of.

Tragically, after beginning the clean-up process, the region was ravaged again by flash flooding on Tuesday 29 March. The terrible impact of these events on the people, environment, wildlife, and livestock is still visible everywhere. There is a palpable collective sense of loss that can be seen on the faces of every patient I treat. As medical professionals, we must start an open dialogue to acknowledge this significant psychological trauma and find ways to offer the intensive psycho-social-spiritual support needed for our community to heal.

**Dr Iri Sahgal**

My wife (a nurse) and I heard Ballina District Hospital was being evacuated late on Tuesday evening. Upon hearing the news, we headed down to the hospital to see if we could help. Buses had already begun to take mobile inpatients across to a school in Skennars Head, where the temporary hospital was being set up. The scene in ED was remarkably ordered, the evening team had done a wonderful job in preparing for the move. We loaded what we could into our car and headed to the school.

When we arrived we entered and found an army of volunteers, several physicians, surgeons, nurses, allied health, from both the hospital, some off duty and also the community. They were settling in the patients as they arrived. We held a brief senior staff meeting to decide the layout, utilising around six classrooms and an indoor assembly area to house a 60 bed inpatient unit (rehab, palliative care, and general medicine), a makeshift ED and a triage/waiting room. My task was to prepare the emergency area, so after going through some logistics, and arranging traffic control for ambulances we used one classroom as a reception triage and waiting area, and used another classroom to place six ‘acute’ beds – for which we used air mattresses, and one resus bed with a monitor and an airway trolley. For this we used

our only hospital bed. We made a medication area with help from pharmacists, sorted out how we would keep track of patients and communicated with ambulance and Lismore Hospital to plan how we would arrange transfers and remain operational. I can remember standing back at one point and feeling like I had just done another fellowship OSCE, but this time the situation was real!

Our patient load was manageable, helped enormously by local GPs who essentially ran several fast track clinics throughout the evacuation center and at triage, and volunteer doctors from Tweed ED, Lismore and some just passing through. However, we still had usual emergency patients to manage – a dislocated shoulder, potential snake bites, septic patients, possible ectopics, cuts and bumps and chest pains, all of whom were treated appropriately and safely and as well as if they had arrived at the usual Emergency Department.

The most difficult part of it all was communication. Local phone services were all but down with only patchy 3G phone service and clouds interfered with the satellite phone we had. This made communication with Lismore difficult and time consuming, but not impossible.

The commitment of everyone who was there was mind boggling, the teamwork shown was beyond exceptional, and our thanks to all the staff who helped, many after losing their homes the same day, and the community who provided us with endless coffee, food and treats, could never be quantified. We simply could not have done it without everyone pulling together. It was an absolute honour to work with everyone there.

**Dr Alex Booth**

I am writing this to give recognition and express my deep gratitude to the Casino District Hospital team I had the opportunity to work alongside during the recent flood disaster.

I had commenced a night shift as the Medical Officer in Casino ED Sunday, 28 February when the flood hit.

Due to the situation, I elected to provide emergency cover in the Casino District Hospital until such a time as it was ethically appropriate to handover care and relieve my duties. As the situation worsened, we rapidly evolved into a functioning Flood Disaster Centre for the community.

It was only in hindsight that I could truly appreciate the magnitude of what our team in ED faced as we managed our own slice of the disaster – everything from delivering newborns and managing traumatic head injuries without imaging or pathology, to troubleshooting all the logistical medical issues of an entire township cut off from their regular medications, displaced from their homes, a lot of whom had loved ones missing in the maelstrom.

I say out of the greatest respect and in sincerity, for what was faced those initial hours and days in Casino, I could not have asked to be in a better health centre when it came to the quality and conduct of the staff whom I worked alongside at Casino District Hospital.

Despite the setbacks in tele-communication and emergency retrieval, and with every single team member either pulling back-to-back double shifts, sleeping in the hospital due to forced evacuation from their homes as the flood peaked, or ensuring loved ones were safe and accounted for, each member from Darren the NUM, the RN's, security guards, wardspeople and kitchen staff stepped up, gave their all and demonstrated a pride of place and community spirit that had me streaming in tears as I eventually drove home.

*The department faced a surge of presentations, staggering to comprehend, yet each team member did what was required and the presenting population were treated with dignity and respect.*

The department faced a surge of presentations, staggering to comprehend, yet each team member did what was required and the presenting population were treated with dignity and respect. In the context of an unprecedented flood disaster and an almost impossible healthcare task, I say almost impossible save except the fact that the Casino District Hospital team had the attitude and cohesion of a world-class performing team and just got the job done.

Period.

I never once heard a team member snap at a colleague, lose their composure in front of a patient, or behave in a manner consistent with anything other than compassion, openness, respect and resilience. All at a time when circumstances would give most a reason to feel like the contrary.

I wish to say what an outstanding asset the whole team at Casino District Hospital are to their community and the LHD, and while I can't recall all of their names individually, I will never forget the acts of kindness and hospitality they showed one young Medical Officer when he found himself scared stiff in a defining moment in his life at Casino.

*Author: Inga Vennell, Editor of Your ED*

# ACEM Wellness Week

*'Each year, ACEM hosts Wellness Week to remind us that, while we care for others, we must never stop caring for ourselves.' – Dr Clare Skinner, ACEM President*

In May, the College hosted ACEM Wellness Week 2022, encouraging members and trainees across Australia and Aotearoa New Zealand to find opportunities, individually and as a community, for reflection and restoration as we all begin the journey to recovery following a challenging two years.

ACEM Wellness Week focused on the need for recovery at all levels, from interfacing with hospital executives to maintaining one's own health and wellbeing. Site-based initiatives resulted in some restorative activities in emergency departments (EDs), with an emphasis on long-term commitment to self-care at work. This year's initiatives aligned with the revised ACEM Quality Standards developed to assist clinicians implement quality standards in their own ED and other services providing emergency care.

## Background

In the past four years, the College has truly demonstrated its commitment to 'develop and support activities that contribute to the wellbeing of doctors and other health professionals delivering emergency medical care'.

In 2017, the inaugural ACEM Staff Scholarship was bestowed, enabling an analysis of the gap between member and trainee wellbeing needs and experiences.

In 2018, ACEM supported the American College of Emergency Physicians (ACEP) Wellness Week. The College went further in 2019 by establishing the Membership and Wellbeing Unit with three employees, along with documenting its commitment for tangible strategies and outcomes in the 2019-2021 Business Plan and again supporting ACEP Wellness Week.

In 2020-21, the College cemented its commitment to member and trainee wellbeing with the introduction of ACEM Wellness Week and the role of Regional Wellbeing Champions across all states, territories and Aotearoa New Zealand.

### The theme – Reflect, Restore, Recover

Informed by ACEM's Regional Wellbeing Champions, the year's theme was Reflect, Restore and Recover.

### Wellness Week webinar

Leading into Wellness Week, ACEM hosted a webinar where members and trainees came together to hear Dr Úna Harrington in conversation with Dr John Bonning, Dr Charlotte Durand and Dr Rajesh Sehdev.

Panellists shared their experiences and thoughts on reflective practice, Learning from Excellence (LFE), and concepts for restoration, both as an individual and a department. They also explored what a recovered ED and workforce could look like in the future.

### Engagement

It was encouraging and inspiring to see many EDs engage in Wellness Week activities. From staff massages to foxtrotting, skydiving and streaming DJs on Twitch, emergency staff, along with other disciplinaries, came together to celebrate and support each other.

ACEM also got into the spirit of Wellness Week with activities for its staff including a reflection and rejuvenation space, a table tennis competition, staff resus trolley, a presentation on Compassion Burnout, and everyone's favourite, pet therapy with Delta Dogz.

### A focus on ACEM Quality Standards

During Wellness Week, the College focused on the recently revised ACEM Quality Standards and associated toolkit, highlighting the Standards and Objectives that are relevant to the wellbeing of the workforce in their ability to provide care:

- 2.5 Standard: Workforce Safety Objective B: Safe Workload, Safe Working Hours
- 2.5 Standard: Workforce Safety Objective D: Individual Health and Wellbeing
- 2.6 Standard: Organisational Management Objective B: Interface with Hospital Executive
- 3.3 Standard: Advocacy Objective C: Advocacy for Workforce Safety and Wellbeing
- Standard: Cultural Safety

### Call to action

The College would like to thank all emergency and healthcare workers. We hope ACEM Wellness Week provided a platform for reflection and rejuvenation, and connection and togetherness.

Beyond Wellness Week, ACEM encourages members, trainees, departments and organisations to use the ACEM Quality Standards and toolkit to enact long-term change, ensuring EDs deliver quality care and cultivate a workplace culture focused on patient and workforce quality and safety.

*Authors: Michelle Hackney, Membership and Culture Officer and Andrea Johnston, Manager, Membership and Culture*

# Wellbeing and Gender Equality

**Dr Shantha Raghwan**

A couple of years ago I was asked to speak about gender equity and wellbeing at an ACEM New Fellows Workshop. This is the junction of two areas I feel passionately about.

At first glance, these two topics only appear to be indirectly related – obviously, we would all have greater wellbeing if there was more equity in the world. The reality is, however, that these two topics are quite intimately related. And, in my opinion, the lack of gender equity (while allowing inequitable practices to flourish) is a direct cause of burnout and the sacrifice of wellbeing.

Did you know the burnout phenomenon has a greater incidence in women? According to Hu et. al in their 2019 *NEJM* article, this increased incidence is wholly due to gender-related microaggressions, sexual harassment and discrimination.

Did you see the landmark paper published by the National Academies of Science, Engineering and Medicine (NASEM) showing that 50 per cent of female medical students experience sexual harassment? Amongst female physicians in the USA, 30 per cent continue to experience sexual harassment.

Things aren't much better at home. In 2016, the Australian Medical Association Western Australia asked its members about their experiences of sexual harassment. Of 950 respondents, 31 per cent had experienced sexual harassment in the workplace, including while applying for a job or training program. Eighty-one per cent of those reporting sexual harassment in the workplace were women.

In a 2015 survey, the Royal Australasian College of Surgeons found that 49 per cent of female members had been subjected to discrimination, bullying, harassment or sexual harassment.

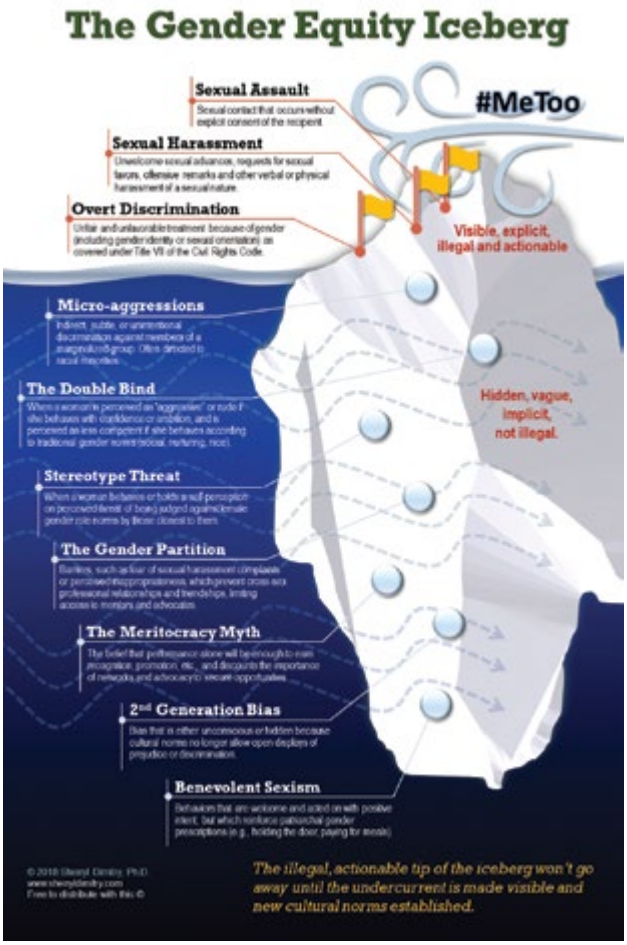
In 2017, in ACEM's discrimination, bullying and sexual harassment survey, we found that 34 per cent of respondents had experienced bullying, 21.7 per cent discrimination, 16.1 per cent harassment, and 6.2 per cent had experienced sexual harassment.

Bullying and discrimination is widespread, which is unacceptable for any of us. But being a woman in this environment means having to battle through even more and achieving less. Despite increasing numbers of women entering medicine, and, in fact, now having more female than male medical school graduates annually, women are leaving the medical professions post-training in numbers far surpassing men.

Where do they all go? Why aren't they represented in positions of authority?

The evidence shows that much of this has to do with gender-based discrimination.

Gender-based discrimination is often described as a spectrum, with apparently "harmless" comments or "banter" at one end, and gross misconduct such as sexual violence at the other end. It's accurate, but I find this analogy difficult




to translate into practice. While it's easy to spot gross misconduct, calling out subtle discrimination at the other end of the spectrum can be interpreted as "soft" or "being too sensitive", which can make it harder to speak up.

Instead, I'd like you to think about gender discrimination as an iceberg. The top, visible part are those things we all know and easily recognise as gross sexual misconduct – sexual assault, sexual harassment and overt discrimination. But everything underneath the water defines and builds a culture that allows sexual misconduct to thrive.

While events occurring at the tip of the iceberg can be addressed with criminal and punitive repercussions, we can't prevent or eradicate gender discrimination until we address everything underneath. And while we can all spot what's happening on top, it's the hidden bulk that causes the damage – after all, that's what sunk the Titanic, right?

So what are these hidden, vague, implicit behaviours? Dimitry, Murphy and associates classify them into seven separate but connected behaviours: Micro-aggressions; the Double Bind; Stereotype Threat; the Gender Partition; the Meritocracy Myth; Second Generation Bias; and Benevolent Sexism.

Let's dig a little deeper into a couple of these behaviours.

### The Meritocracy Myth

While merit might seem like the solution for achieving equity, research indicates that, if there remains an objective imbalance in the workplace between men and women (for example, women being underrepresented in senior roles), women will be unfairly discriminated against.

This is because there exist unconscious biases in the way we assign positive or negative attributes. We will assign positive attributes (and therefore roles and opportunities) to people that look, speak and think the same way.

There is a personality type that has been traditionally associated with emergency medicine. There's a confidence, a physical presence, a way of speaking. You know what I mean – it's that person we learnt to be when doing simulations and OSCE practice. Right? But we also know it's not the only personality that makes for an excellent emergency physician.

Now, unfortunately, even with the best of intentions, unless we actively consider this bias, we tend to overlook those less stereotypical personalities when considering promotions or hiring. And those less stereotypical personalities include most women.

When this happens, we reinforce the cycle, making it even harder for someone who doesn't fit the mould to get a look in. So, when a coveted portfolio or job in your department comes up, or when there are social networking opportunities – think about this and make sure to include everyone. The same phenomenon can also occur in meetings and groups. Think about the room; has everyone had the opportunity to speak? Has the credit for thoughts and ideas been given to the right person?

### Stereotype Threat

This is a phenomenon that occurs when we judge people based on stereotyped gender roles.

One of the huge misunderstandings about the gender gap is that it's due to women leaving to have babies and then not wanting to return to work. It's preposterous to assume all mothers spend years, if not decades, working their asses off, sacrificing their time, friends and family, but would give it all up without a moment's hesitation once they've had children.

It's equally as preposterous to assume all fathers want to spend no time with their children, that they will take little to no parental leave, and wish for no responsibilities outside of work.

Despite being illegal, women are still being asked about their motherhood plans at job interviews, or when being considered for more challenging roles, in a way that men are not. And men are being left out of parenting discussions and spaces, still being relegated to the role of 'goofy dad' who doesn't know how to take care of the kids.

We must address the systemic culture that allows these sorts of opinions and unconscious biases to occur – its detrimental to everyone, including men.

Find out about your department's parental leave policies and speak up if they are unjust. Women, make sure you are not being overlooked for roles because you may become or already are pregnant. And men, take your parental leave, all of it – you are a parent and you are entitled to it.

### The Double Bind

This is when a woman is perceived as aggressive or rude if she behaves with confidence or ambition and is perceived as less competent if she behaves according to traditional gender norms.

A 2021 systematic review of gender bias in medical residency reference letters by Khan et al concluded that: 'Eighty-six per cent … noted that women applicants were more likely to be described using communal adjectives, such as "delightful" or "compassionate", while men applicants were more likely to be described using agentic adjectives, such as "leader" or "exceptional". Several studies noted that reference letters for women applicants had more frequent use of doubt raisers and mentions of applicant personal life and/or physical appearance. Only one study assessed the outcome of gendered language on application success, noting a higher residency match rate for men applicants'.

Next time you are writing a reference or an assessment, or describing a trainee or colleague, think carefully about your assessment and the adjectives you are using. Would you use the same description if they were a different gender? Try to be as objective as possible and consider your own internal biases. Is that trainee 'bossy' and 'unfriendly'? Or are they really demonstrating appropriate leadership and graded assertiveness?

By tackling these underwater behaviours and thinking patterns, we can change culture. And by changing culture, we are able to discourage and prevent gender-based discrimination and sexual harassment, thereby finding a path to equity.

The illegal, actionable tip of the iceberg won't go away until the undercurrent is made visible and new cultural norms are established.

So, back to the beginning. What has this got to do with wellbeing?

Brené Brown adds 'B for Belonging' when talking about Diversity, Equity and Inclusion (DEI+B). That's what it boils down to. By creating a culture where everyone belongs, we create an environment that promotes and sustains wellbeing.

For those of us who belong to minority groups, and who have been subject to discrimination, having an environment that welcomes us as ourselves is life-changing. And, for those of us who've had the privilege of little or no discrimination, learning, growing and standing up instead of just standing by is hugely empowering. It gives us a path to being effective allies – a role and a purpose.

And having purpose is part of what keeps us well.


**References**

1. Dimitry S , Murphy A. Beyond #MeToo: The Gender Equity Iceberg. https://www.academia.edu/35921937/Beyond_MeToo_The_Gender_Equity_Iceberg
2. AFHW Emergency Medicine Report – November 2017.
3. Level Medicine: www.levelmedicine.org.au
4. NoWEM: www.nowem.org.au
5. Leah Ginnivan. Gender pay gap: is it a thing? Yep. Innominate Magazine. Nov 24, 2016. https://innominatemagazine.wordpress.com/2016/11/24/gender-pay-gap-is-it-a-thing-yep/
6. Be Ethical White Paper: http://sheleadshealthcare.com/wp-content/uploads/2018/09/Be-Ethical-Campaign.pdf
7. Shannon G, Jansen M, et al. Gender equality in science, medicine, and global health: where are we at and why does it matter? The Lancet. 2019; 393(10171):560-569.
8. Time Magazine. Oct 2019. https://time.com/5709759/harassment-physician-burnout/
9. Burgart A. Physician Sexual Assault: The Moral Imperative for Gender Equity in Medicine. American Journal of Bioethics. 2019 Jan;19(1):4-6.
10. Catalyst: www.catalyst.org
11. ILO Convention on Work Violence: https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_711891/lang--en/index.htm
12. Khan S, Kirubarajan A, Shamsheri T, et al. Gender bias in reference letters for residency and academic medicine: a systematic review. Postgraduate Medical Journal. Published Online First: 02 June 2021. doi: 10.1136/postgradmedj-2021-140045

# Enhancing Therapeutic Mental Healthcare in EDs

**Associate Professor Timothy Wand**

Associate Professor Wand, University of Sydney and Sydney Local Health District and Nurse Practitioner, Mental Health Liaison, Emergency Department Royal Prince Alfred Hospital.

Responding to the growing number of people presenting to emergency departments (EDs) with mental health, drug health and behavioural concerns is a significant clinical challenge internationally. EDs have traditionally relied on segregated and in-reach models, usually funded by local mental health services and focused primarily on providing EDs with mental health assessments. However, this is no longer sufficient to deliver prompt therapeutic care, reduce ED length of stay, and enhance support for ED staff.

To address this burgeoning issue, a nurse practitioner (NP)-led extended hours mental health liaison nurse (MHLN) team was established in the Royal Prince Alfred Hospital (RPAH) ED in Sydney in 2012, and subsequently evaluated. The evaluation identified substantial benefits associated with this model of care for patients and the ED.[1,2]

Following the success of this trial, the NSW Health sponsored a multi-site project to test and refine this model of care in different ED contexts. This project (funded by a Translational Research Grant from NSW Health and Medical Research) involved a re-evaluation of the MHLN service at RPAH, and implementation and evaluation of this model of care in two rural hospitals (sites B and C). The ED-based MHLN model of care established at RPAH, and evaluated across the two rural sites is based on the following key principles.

- An NP as clinical lead to a designated team of specialist MHLNs based in the ED on an extended hours basis, seven days a week
- Available to see patients (of all ages) with undifferentiated mental health, drug health and behavioural problems as close to the point of triage as possible
- A close working relationship with the ED nursing and medical team
- A complementary relationship with the psychiatry service, including not having to discuss patients with a psychiatrist
- A coordinated system of referral and follow-up.

No additional resources were provided to the two rural sites, which did prove challenging for the local health services involved. Sites were required to re-purpose current resources to align with the model of care and agreed to provide cover from 7:30 am – 10:00 pm seven days a week. An NP as clinical lead for the MHLN teams was recommended for the rural sites. At Site B, the health service employed an NP to be based in the ED during business hours, with two nurses from the community team based in the ED every evening. At Site C, the MHLN team was led by a nurse consultant, and, while based in the ED, the whole team was also responsible for consultations across the general hospital.

### Key findings from the multi-site study

This mixed-methods translational research project produced a large volume of data, synthesised here in the presentation of key findings and transferable lessons.

Despite resource challenges across the three sites, the MHLN teams demonstrated safe and responsive care. Patients were seen promptly by the MHLNs, there was a reduction in ED length of stay, a low admission rate, minimal did-not-waits, and effective follow-up. There were 3,843 patients seen over the 12-month evaluation period. Triage category three presentations (urgent) accounted for 49 per cent of MHLN team workload. The majority of presentations were undifferentiated mental health problems (n=1549, 40%), suicidal/self-harm (n=661, 17%) and drug and alcohol/toxicology (n=342, 9%).

Median wait time from triage to MHLN involvement was 66 minutes at RPAH and 47 minutes across the rural sites. Median time spent in ED for discharged patients was 4.8 hours at RPAH and three hours across the rural sites. This constituted a reduction in ED length of stay for all sites. There were zero did-not-waits at RPAH and only four across rural sites reported following MHLN team intervention. Despite the high acuity, the percentage of patients seen by MHLN teams and subsequently admitted was low (8.6 per cent at RPAH and 36.3 per cent for the rural sites). There was only one Severity of Assessment Code (SAC) 2 incident related to MHLN teams, reported by one rural site, highlighting the safety of the model of care.

From surveys and interviews conducted with ED patients (n=58), and emergency and psychiatry staff (n=52), MHLN teams were rated highly for promptness, the intervention provided, and for being competent and professional. Patients valued the therapeutic qualities of the MHLN role and being involved in decisions about their care and follow-up. 95 per

cent of staff and 85 per cent of patients recommended the model be implemented in other emergency settings.[3]

### Listened to and understood

Patients highlighted the therapeutic value of the MHLN role, improving their ED experience.[4,5]

> *It's just so nice to have someone specialised in that field that can actually just listen, and just get it. Patient 16 RPAH*
>
> *Having someone there to talk to that did understand what I was going through. It's just completely different. Well, a standard nurse doesn't really, to me, understand mental health issues. Patient 19 Site B*
>
> *First thing is, they don't judge you, you know. There was a little bit of talking but a lot of listening, you know what I mean. Patient 10 Site C*
>
> *So I think, the direct positive is that you're giving people options other than taking their lives, or that the mental health nurses are. Patient 5 RPAH*

### Spotting the difference

Across the two rural sites, patients noted a positive change in their ED experience.[5]

> *I expected to sit in there for hours in the emergency room and I didn't even have to. I sat there for a little bit and then they called me in, which was great. Patient 12 Site B*
>
> *I've had better experiences this year than in the last few years. I've had some pretty bad experiences. But this was pretty good. Patient 11 Site C*
>
> *They took me straight in. I didn't have to be out with all the people. My anxiety was still bad, but yeah, previous times, I've just had to stay out in the emergency room and wait. Patient 13 Site B*
>
> *I actually got the help I needed this time. I actually got to speak to a face-to-face type of someone, instead of a video screen. Patient 7 Site C*

### Mainstreaming and streamlining ED mental healthcare

At the rural sites, staff recognised that embedding the new model of care in the ED impacted positively on ED culture, thinking and practice, and helped to streamline ED care.[5]

> *There's an improvement and it boils down to just having someone based in the ED, who is approachable and can think outside the box and think about patients, particularly outliers in more rural areas that would normally filter down through to [Site B]. Often, we can prevent transfer of those patients by coming up with a sensible plan over the phone. #3 ED Consultant Site B*
>
> *I think, actually having them there on the ground, physically, is a good idea. It helps with staff relief and smoothing things over and having a heads up about what's happening. So, I think it's definitely helpful having the staff located in the ED and working with the emergency team there. #11 Psychiatry Consultant Site C*
>
> *The rural MHLNs identified numerous benefits associated with locating the service within the ED, such as providing prompt access to care, normalising mental health presentations to ED and role modelling positive engagement, providing education, and acting as a resource.*[6]
>
> *It means that we are there all the time. I think that being there has actually meant better relationships, for the most part, especially with the doctors. #2 MHLN Site B*
>
> *However, at Site C, where the MHLN team had a broader general hospital role, participants recognised this impacted on their availability to the ED.*
>
> *We also see people on the wards. I don't think that should be our role. I don't think we should be leaving the emergency department. I think we should be there, on board, all of the time. I'd like to see it as a team approach. #1 MHLN Site C*

### Owning the MHLN teams

Governance of the MHLN teams emerged as a key theme in this study, with senior ED staff expressing a desire to have greater influence over recruitment, staffing, rostering and performance. Moreover, members of the psychiatry team acknowledged the value of aligning the clinical governance of MHLN teams within the ED, and how this reduced their workload, freeing them up to concentrate on their broader general hospital role. McClimens et al[7] acknowledge the challenge of 'ownership' of ED mental health patients is amplified when mental health teams function separately from the ED. This reinforces the division between physical and mental health. These authors argue there must be some form of physical connection, not just in hands-on delivery of service, but also in administrative support for an integrated service, to be successful. The consensus across the three sites was that the MHLN teams should be fully funded and managed under ED governance.[4,5,8]

> *I think that the key is full participation in every way in the local emergency department; being part of the team under our governance, with our support. # ED Physician Site C*
>
> *Because of the administrative issues, with the service being funded and staffed and administratively responsible at the mental health nursing district level, there's a real disconnect. #9 ED Consultant RPAH*
>
> *Ideally, they would function as part of the emergency team. They would have backup by the senior doctor on duty, but are able to initiate everything, obviously within their own scope of practice. # ED Physician Site B*
>
> *So, ED owns it and I think that's why this model is appealing to emergency physicians because they have control over it. If they want to decongest their department, they don't need to rely on external referrals to do so. # Psychiatry Consultant RPAH*

### Transferable lessons

The key principles of the MHLN model of care were supported by the recent multi-site study findings, reinforcing the importance of a designated team of clinicians based in the ED, and led by an NP.

The study also demonstrated that deviation from the key principles diluted the impact and benefits of the model of care. For example, at Site B, the after-hours MHLNs rostered on from the community team did not connect with the ED team as well as the NP who was based in the ED.

At Site C, where the MHLN team had a broader general

hospital role, all staff (including the MHLNs) recognised that this diminished their availability to the ED.

At RPAH, the evaluation coincided with staff shortages across the mental health service, with MHLNs redeployed to cover gaps in inpatient and community mental health. This impacted on MHLN staffing and, ultimately, waiting times to be seen in ED. However, when adequately resourced, we believe the key principles of this model of care are transferable to a range of ED contexts.

### Room for improvement

More work needs to be done on improving the response to people in mental distress presenting to EDs. This includes initiatives aimed at reducing the reliance on security staff and use of restrictive and coercive practices such as involuntary detention, restraint and forced medication. We know that the majority of people experiencing mental health challenges have a history of trauma and adversity, and our efforts should be to ensure we don't contribute to this. Our EDs are healthcare facilities, not correctional facilities.

### Unfinished business

Given the success of the completed multi-site study, NSW Health have committed to partner in another multi-site study that will build on the body of work (and knowledge and experience gained) by the investigators, facilitating the spread of the model of care to more EDs. This will include testing and evaluating the MHLN teams under full ED clinical and administrative governance.

Our aims are to build the capacity of EDs to meet the needs of people presenting in acute states of agitation or distress, and provide greater support for ED staff. Embedding mental health services within EDs reinforces that mental health is 'core business' for EDs, enabling greater ownership of this patient group.


**References**

1. Wand T, D'Abrew N, Barnett C, et al. Evaluation of a nurse practitioner-led extended hours mental health liaison nurse service based in the Emergency Department. Aust Health Rev. 2015 Feb;39(1):1-8.
2. Wand T, D'Abrew N, Acret L, et al. Evaluating a new model of nurse-led emergency department mental health care in Australia; perspectives of key informants. Int Emerg . 2016 Jan;24:16-21.
3. Wand T, Collett G, Cutten A, et al. Evaluating an emergency department-based mental health liaison nurse service: A multi-site translational research project. Emerg Med Australas. 2021 Feb;33(1):74-81.
4. Wand T, Collett G, Cutten A, et al. Patient and clinician experiences with an emergency department-based mental health liaison nurse service in a metropolitan setting. Int J Ment Health Nurs. 2020 Dec;29(6):1202-1217.
5. Wand T, Collett G, Buchanan-Hagan S, et al. Patient and staff experience with a new model of emergency department based mental health nursing care implemented in two rural settings. Int Emerg Nurs. 2021 Jul;57:101013.
6. Wand T, Collett G, Keep J, et al. Mental health nurses' experiences of working in the emergency department of two rural Australian settings. Issues Ment Health Nurs. 2021 Oct;42(10):893-898.
7. McClimens A, Kelly S, Ismail M, Breckon J. Evaluation of a mental health liaison team. Part 2: The themes and their effect on practice. Emerg Nurse. 2017 Dec;25(8):23-26.
8. Wand T, Crawford C, Bell N, et al. Documenting the pre-implementation phase for a multi-site translational research project to test a new model of emergency department based mental health nursing care. Int Emerg Nurs. 2019 Jul;45:10-16.


# A True Gem in Emergency Medicine!


**Dr Nemat Alsaba**

Dr. Alsaba is an emergency physician at the Gold Coast University Hospital, an A/Professor in Medical Education and Simulation at Bond University, passionate about Geriatric Emergency Medicine and improving older adult patient care and outcome.


Geriatric Emergency Medicine (GEM) is a relatively new subspecialty.[1] GEM aims to provide the highest quality of emergency medicine (EM) care for older patients. There is a lot of work to be done in this field to educate medical students and EM trainees, to understand the pathophysiology of aging and frailty, to recognise its impact on the acute presentation of older people in the emergency department (ED), and to identify its effect on treatment choices and patient outcomes.[2]

How did I fall in love with GEM? I was once asked by a senior colleague and mentor, 'Why GEM? There's nothing interesting or challenging about GEM'.

My interpretation of my mentor's comment is that GEM is not 'sexy' enough to be considered a subspecialty, let alone an attractive one. I politely disagreed with my mentor and pointed out that I think GEM is more challenging than any other EM subspecialty. Take, for example, GEM trauma. An older person can have a fractured pelvis simply by rolling out of bed; they can even walk into your ED with fractured ribs and hemothorax after a fall at home, and yet they sit in our waiting room on a chair for hours because they don't follow the expected trauma presentation that has been imprinted into our 'critical care' brain.

There is no normal or typical presentation of any disease. A fall can be a symptom of myocardial infarction; a pulmonary embolism can present as delirium; lethargy and loss of appetite can be the only symptoms of sepsis. There is indeed great challenge in GEM!

After defending my choice as a subspecialty, I went home that day reflecting on my mentor's comments. I thought deeply about why I had in fact fallen in love with GEM and this is what I discovered.

Reflection upon Daniel Kahneman's well-known masterpiece Thinking, Fast and Slow[3] and linking it to how we practise medicine, I believe, is one of the reasons why I was attracted to GEM. System 1, 'thinking fast', in medicine is our rapid, unconscious, effortless pattern recognition of disease which also helps us distinguish 'sick' from 'not sick'. On the other hand, System 2, 'thinking slow', is the deliberate, effortful, controlled mental process seeking new or missing information to make decisions. EM is a balance

iStock.com/Ridofranz

between System 1 and System 2. GEM has forced me to shift my 'thinking fast' mode to 'thinking slow' more often and consciously, which has not only improved my System 2 approach, it has also enriched my System 1 approach. To physically and mentally slow down, observe with curiosity, listen attentively, reflect carefully, and put all the clinical puzzle pieces together is a joy and gratification beyond description. Dave's story is an example of this gratification.

Dave was an 80-year-old man who came to ED struggling to prepare and cook his meals. He was given an ATS (Australian Triage Scale) score of 5 and was flagged as a quick case needing only social worker input to ensure appropriate community services were in place. But when you grab a chair, sit down with Dave, and listen to his story – really listen – and then conduct a comprehensive geriatric assessment, you realise there's so much more to the story, and much more we can offer.

Two weeks ago, he was a fully independent 80-year-old who lives alone and cooked for himself, but in the last week he's been finding it difficult to prepare a meal because his hand grip has become weak. You spend more time with Dave to gather history and conduct a physical examination, which confirms that Dave has had a stroke.

We spend most of our time teaching students and trainees to answer the question that's on the forefront of our minds: What is the matter with the patient? What is the diagnosis so we can treat the problem? Of course, that's the core of medicine, to help identify the condition or disease and provide treatment. However, GEM adds another layer to this approach, which is: What matters most to the patient? This was an eye-opener for me and changed my mindset, not just in GEM, but in EM.

My final discovery about what led me to GEM was the pursuit of respect, love and honour.

### It's honourable to care for those who once cared for us

Our grandparents, fathers, mothers, aunties and uncles. It's rewarding to give back and pay respect to our seniors, to whom we are in debt for their service and sacrifice in building the country and communities in which we live. Giving back through GEM ensures that our older people have equitable access to health care services, with care delivery that caters for their unique needs.

I was once told that GEM is lucky to have a group of clinicians who are passionate advocates, but the truth is that we are the lucky ones; we found GEM and rediscovered deep respect, love and honour in medicine. Simply put, how we care for older people in our community is a great test of our moral, cultural and professional integrity.

I owe GEM for making me a better doctor, a better thinker and a better person.

**Reference**


1. Mooijaart S, Carpenter C, Conroy S. Geriatric emergency medicine—a model for frailty friendly healthcare. Age and Ageing. 2022; 51(3). https://doi.org/10.1093/ageing/afab280
2. Ringer T, Dougherty M, McQuown C, et al. White paper-geriatric emergency medicine education: Current state, challenges, and recommendations to enhance the emergency care of older adults. AEM Education and Training. 2018; 2: S5-S16. https://doi.org/10.1002/aet2.10205
3. Kahneman D. Thinking, fast and slow. Penguin UK. 2011.

# Aotearoa Health System Reform

**Dr Kate Allan and Léonie Walker**

Following the extensive New Zealand Health and Disability System Review[1] published in 2020, many of the recommendations were drafted in the Pae Ora (Healthy Futures) Bill[2], setting the foundations and legal framework for the largest reform of the health system in Aotearoa New Zealand in a generation.

Key drivers for the reform were the complexity and ballooning costs of the public health system, and inequitable (particularly for Māori) access and health outcomes from the current system. See Diagram 1.

Prior to July 1st, access to services was variable depending on where in the country patients live, creating a 'post code lottery'. For many regional and rural communities (Māori in particular), access to health services can be difficult, requiring considerable expense and travel. Many of the 20 existing District Health Boards (regardless of their large, partially elected governance boards) had consistently run large financial deficits despite increased funding. Planning, especially for highly specialised and expensive facilities and services, or for the replacement of long-neglected infrastructure, has proven fractious and politically fraught, pitting boards and clinicians against one another in a bid to protect their own services.

With the existing lack of IT compatibility and transparency, there is clearly scope for improvement in how we use new technologies effectively to deliver better coordination, communication and efficiencies.

Pae Ora came into place on 1 July 2022 and replace the previous New Zealand Health and Disability Act 2000. The structural changes are more than cosmetic, bringing fundamental changes to the design and commissioning of services, placing partnership with Māori and health equity at the centre of the reforms. This signals a move away from the current concentration on tertiary hospital services, towards pro-active and accessible primary healthcare, health promotion, and a wider emphasis on the social determinants of health.

The Ministry of Health of New Zealand will retain oversight of the Public Health Agency (a new business unit within the Ministry, bringing together the 12 public health units) and overall stewardship of the health system. The Ministry will be the principal advisor to the Health Minister, with overarching responsibilities for strategy, policy, regulation and monitoring. Two new entities, Health New Zealand (HNZ) and the Māori Health Authority (MHA) have come into force.

The New Zealand Government supported the United Nations Declaration on the Rights of Indigenous Peoples[3] in 2010 but its aspirations in the sphere of health, especially, have been largely unrealised since then. In November 2016, the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575)[4] put the Government on notice to improve health inequalities for Māori. The main outcomes from the review and subsequent reforms (Pae Ora) aim to give effect to the Tribunal directive. See Diagram 2.

HNZ is now the largest employer in the country with a workforce of about 80,000, an annual operating budget of $20 billion and assets worth about $24 billion. It leads health system operations, planning, commissioning and delivery of services, working with the MHA. The MHA has been established as an independent statutory entity to co-commission and plan services with HNZ, commission kaupapa Māori services, and monitor the performance of the system for Māori.

There is concurrent development of a New Zealand Health Charter that provides common values, principles and behaviours to guide health entities and their workers. There will also be a new Code of Consumer Participation setting out how health service providers and organisations will work effectively in partnership with consumers and whānau.[5]

The Minister of Health (Andrew Little) established a Transition Unit and interim MHA and HNZ as departmental agencies within the Ministry and has appointed board members. The new boards are currently advising the Minister, including on the structures and leadership teams of the new entities.

### What will this mean for FACEMs?

Initially, services will be delivered and clinicians employed in the same emergency departments, in the same hospitals, and on the same employment contracts as at present. There will, however, be inevitable disruption in many of the structures we currently rely on for governance, funding decisions and oversight.

Perhaps the biggest opportunities and challenges will come from proposed changes (with no detail as yet released) related to the training and development of the medical workforce. The Minister of Health has told the Pae Ora Legislation Committee that Health New Zealand will have a specific mandate for workforce development[6], although this is not included in the Pae Ora Bill. After a decade of stagnation and ineffectual workforce planning by Health Workforce New Zealand, more centralised planning and funding of trainee places, at the very least, is likely to be tried. Rapid and effective member consultation and timely responses to requests for representatives on working groups will be crucial to ensure our voices are heard.

It's essential that clinicians with the knowledge and skills to lead transformative change are centrally involved in system design and improvement. Clinical governance will be vital to the successful implementation of the reforms and to the operation, planning, commissioning, and delivery of health services. A commitment to clinical governance requires establishing staffing levels that allow senior doctors access to appropriate non-clinical time to enable them to contribute. In the wake of year-on-year increases in patient numbers and acuity, leading to increased workloads and burnout of staff, further exacerbated by COVID-19, better whole-of-hospital system design and urgent attention to workforce sustainability are needed to realise the potential benefits of the reforms.

ACEM is well placed to take a lead among medical colleges in Aotearoa New Zealand in this regard. The *Manaaki Mana* strategy,

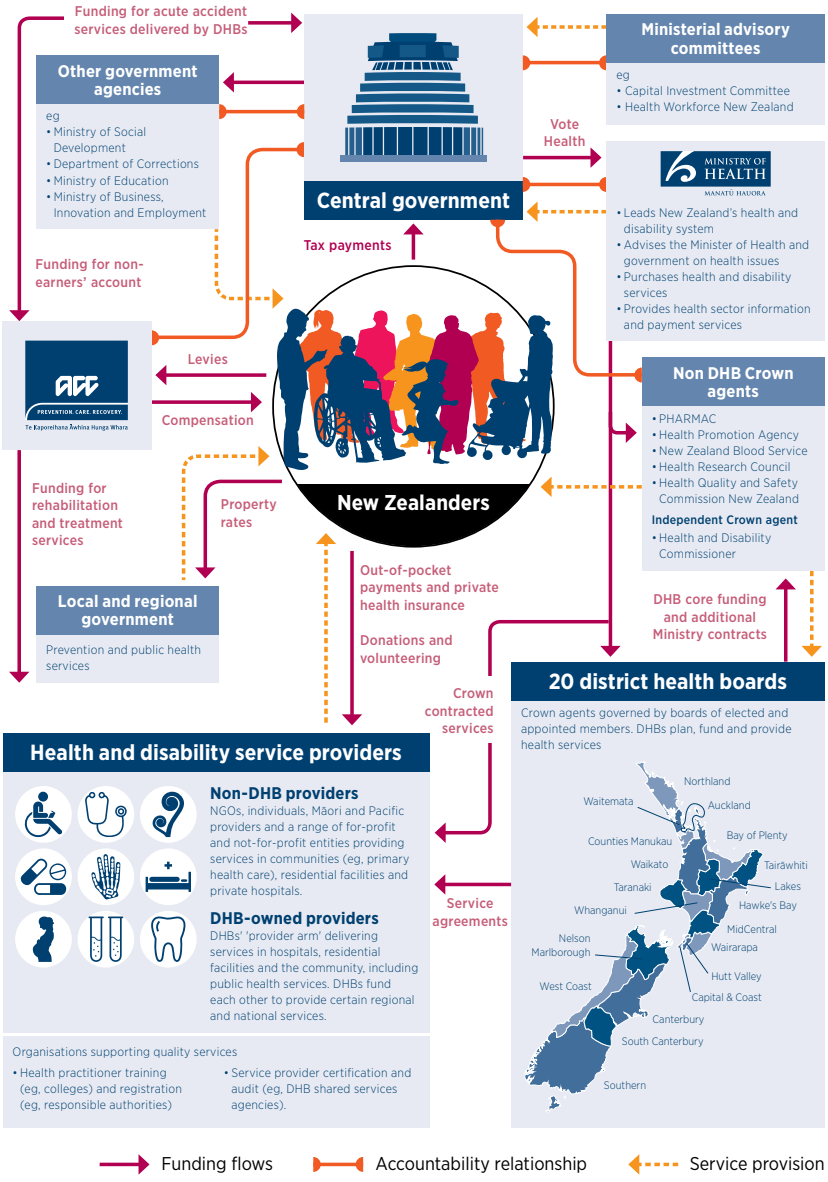
supplemented by high level support in the education space for FACEM cultural safety, are promising in leading change. The refreshed *Manaaki Mana strategy* and accompanying actions are timely and essential.

There's no doubt there will be a time of further disruption and uncertainty as the health reforms settle in. There is certainty that our patients will continue to seek emergency care. We will continue to deliver emergency medicine expertise to our communities and strive for an equitable emergency health service for Aotearoa, while advocating for and developing a sustainable emergency medicine workforce.


**References**

1. Health and Disability System Review. 2020. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR. www.systemreview.health.govt.nz/final-report/
2. Pae Ora (Healthy Futures) Bill https://legislation.govt.nz/bill/government/2021/0085/latest/LMS575405.html
3. United Nations Declaration on the Rights of Indigenous Peoples. https://www.tpk.govt.nz/en/whakamahia/un-declaration-on-the-rights-of-indigenous-peoples
4. Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575). https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/
5. DPMC, April 2021: Our health and disability system: Building a stronger health and disability system that delivers for all New Zealanders https://dpmc.govt.nz/sites/default/files/2021-04/heallth-reform-whitepaper-summary-apr21.pdf
6. Hon Andrew Little 24 March 2021: The case for change in the health system. https://www.beehive.govt.nz/speech/case-change-health-system-building-stronger-health-and-disabilitysystem-delivers-all-new


**Diagram 1** Overview of the New Zealand health and disability system.




Source: New Zealand Health Strategy Future Direction.

**Diagram 2** Te Tiriti and Pae Ora.


Source: Whakamaua Maori Health Action Plan 2020-2025.

# ACEM Core Values

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

In this issue of *Your ED*, we sat down with Dr Rebecca Day and Dr Steven Chiang to discuss integrity, the second of the four core values.

## Integrity

*We care for one another, for patients and for other health professionals. We practise in ways that are honest, authentic and upright, and uphold the guiding principles and standards of emergency medicine.*

### Dr Rebecca Day

*Dr Day, from Darwin the Northern Territory, is based at Royal Darwin Hospital and Palmerston Regional Hospital and has a particular interest in education. She's currently on sabbatical refreshing her brain and studying infectious diseases intelligence.*

**What are your current roles and titles?**

Acting Deputy Director and Senior Staff Specialist in Emergency Medicine.

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

Emergency medicine was a very happy accident for me. I had wandered my way thorough surgery and anaesthetics but they just didn't resonate with me. When I came to Australia, the easiest registrar job to get was in emergency medicine, so that's what I did and I'm still here 15 years later. It's the variety and unpredictable nature of the emergency department (ED) that keeps me interested. No two days are ever the same. I don't think any other specialty can drag you through belly laughs, tears, empathy, frustration and fear all in the same day quite like ED can. I love working with a team and I particularly enjoy being surrounded by a troop of knowledge-hungry juniors. Watching them soaking up all of the crazy new experiences on a busy shift is really something.

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

From a clinical perspective, it used to be the adrenaline of the resus room, procedures and high acuity, 'sexy' stuff, but I'm just as happy having a good yarn with a patient that has a sore toe or haemorrhoids these days. It's the colourful and interesting people that make the work enjoyable. Darwin has plenty of quirky characters who are happy to tell you a gnarly story. I was Director of Emergency Medicine Training (DEMT) for six years and gave it up last year to take on a new role. It was definitely my career highlight and I miss the supervisory role a lot. You learn as much from trainees as they do from you. For me, being involved in Fellowship teaching and examining is certainly the best way to keep myself sharp.

**What does work-life balance mean for you?**

I know I've got work-life balance about right if I'm craving free time when at work, but also missing the stimulation of work when I've had a few days off. For me, the divide between the two is a bit fuzzy, because I genuinely love both in the right doses, so they tend to blend into each other quite easily. On the right day, I get as much fun from work as I do from a wander round my garden, a book and a glass of wine at the end of the day. Every now and again I need a longer stretch off work to go wander up some mountains for a few days and get the recharge that being in fresh air and nature gives you.

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

You have to be believable to earn people's trust. People can see when you aren't listening intently and they generally know when you are faking it or just going through the motions. I'm sure everyone has experienced that moment where they can see that the person they are talking to has just glazed over and isn't present, and it really isn't a great feeling. In ED, patients are telling you things that are very personal, which can put them in a really vulnerable space, so as ED doctors we are in a privileged position. It's for this reason we owe it to our patients to be as honest, engaged and authentic as we can.

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

I can't recall a specific event and it makes me cringe writing about some awesome thing I might have done. I do try to

make sure that I always do my share of the grunt work on the clinical floor. It can be tempting to delegate the less glamorous tasks or the patients that you anticipate are going to be interpersonally challenging, but I think it erodes respect and doesn't set a good example to the junior staff. Juniors really do notice when you pull your weight and work just as hard as the rest of the team, and they definitely notice the opposite!

**How do you foster a work environment that allows honesty and authenticity?**

It's about being non-judgemental and accepting that there is a broad spectrum of normality. We don't all fit into the same mould and we all have our quirks. Making allowances for differences of opinion and accepting that we can learn from alternative views or ways of doing things is really important. I think, in terms of setting a good example to the juniors, it's important to make it clear that doctors are also humans and we do make errors. It's in reflecting on less than perfect events and learning from them that you can become a great ED physician.

**Are there any moments you can recall when you witnessed a colleague demonstrate integrity?**

I've seen a number of colleagues over the years stand up in Morbidity and Mortality meetings and take full responsibility for when things may have been less than ideal. It takes a lot of courage to stand in front of a room of very smart people and lay it all bare. Watching them share their mistakes and reflections for the benefit of others is incredibly powerful and inspiring.

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

COVID-19, for all of its horrors, did have silver linings and generated a lot of interdepartmental cohesion in the hospital. It became more obvious that the place is jam-packed full of healthcare staff that are great humans with a lot of integrity, who really care about patients. It can be easy to get stuck in your own bubble in ED and feel like the rest of the hospital is against you, but I certainly learned through the pandemic that the vast majority of people are genuinely trying to do the right thing.

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

I started off life as a surgical trainee in the UK and despite being great at admitting and managing surgical patients in Accident and Emergency, I was pretty average (bordering on useless!) when it came to operating in theatre. I had an incredible supervisor who I was very much in awe of for both his surgical abilities and the way he interacted with patients and colleagues. When it became obvious to him that I would only ever be a 'just ok' surgeon, he steered me away from a surgical career with such respectful honesty. I'm very grateful for his kindness and suspect my trajectory would have been a lot less awesome if he hadn't been the person he was.

**An honest and authentic relationship with a patient is key in emergency medicine. Is there a time where this was reinforced for you?**

I've been involved recently in answering patient complaints, which has been really eye-opening for me. I used to get a bit nervous when I picked up the phone to call a patient about a complaint, particularly if a mistake had been made or I knew they were angry. I came to realise that, in the vast majority of cases, all people want is to feel listened to and to try and ensure a bad outcome doesn't happen to someone else. People really seem to appreciate an honest and open dialogue when they are feeling disgruntled. I've had some incredibly rewarding and meaningful conversations with people as a result.

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

The Core Values now pop up frequently in ACEM communications and other College material, so they are always there as a gentle reminder about what it is that we should be striving for as emergency physicians. I think seeing them regularly gets people thinking about what their own personal set of values are and how they want to be portrayed personally and professionally. When I'm teaching, supervising and mentoring, I try to link back to the ACEM Core Values because I think linking them back to real world examples can really help people to see the importance of them.

**Is there anything else you would like to say about Integrity in emergency medicine or about the ACEM Core Values themselves?**

ED is a very stressful and busy specialty that can easily lead people to exhaustion and cynicism. I usually know when I've got to this point because I notice myself being less diligent about behaving as the best possible version of myself. When I feel that, I know I have to find a way to address my own wellbeing, take a break and reset. It might be something small like going to my office to have a cuppa tea and a breather, or bigger like going on sabbatical to have a proper recharge (highly recommended!). Proper self-care and awareness of my own wellbeing needs really help me to uphold the values I believe in. I don't always get it right, of course, but then I've got plenty of amazing colleagues who have enough integrity to point it out for me.

### Dr Steven Chiang

*Dr Chiang is a FACEM Training Program Advanced trainee from Adelaide, South Australia, is based at Lyell McEwin Hospital and has special interests in trauma, point-of-care ultrasound, and medical education*

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

I am currently working as an Advanced trainee at Lyell McEwin Hospital, South Australia. I am also the regional trainee representative for South Australia as well as Chair of the Trainee Committee.

**Why emergency medicine?**

Despite my current unfaltering passion for EM, it was not the first speciality that I had in mind after I left medical school. Initially, I wanted to be a plastic and reconstructive surgeon. However, my experience in emergency departments from a final year medical student to PGY-2 really reinforced my fondness and respect for emergency medicine.

My passion for EM developed over a period of three years that involved multiple institutions. It started when I was doing my medical school final year clinical placements at Lyell McEwin Hospital in Adelaide. I saw a critically ill patient together with Dr Penny Conor (FACEM) and we had to resuscitate in a time sensitive manner. The experience was a very positive one and it ignited my passion for EM. My appreciation for emergency medicine was reinforced further as an intern at Bundaberg Base Hospital Emergency Department under the guidance of outstanding FACEMs Dr Ben Waterson and Dr Peter Kas. During my end-of-term assessment, I was informed that I should consider a career in EM because I possessed the qualities that best suited the emergency environment. At that stage, I was still keen on a surgical career. It wasn't until I did my ED rotation at Flinders Medical Centre that my love for EM reached the tipping point. I have been a FACEM Training Program trainee ever since and it was the best decision ever. I would like to express my sincerest gratitude to Dr Sam Lam for being a great mentor throughout these years and Dr Ina Schapiro for being a great DEMT when I was just starting out as a fresh trainee. These are just a few of many inspirational FACEMs that I have crossed paths with. You may have guessed by now, one of the main reasons why I absolutely enjoy working in this field.

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

Aside from many inspirational FACEMs, I really enjoy the acuity and unpredictability of emergency medicine. One minute, you might be suturing a simple laceration but the next minute you might be performing a crash intubation on a critically ill patient. The vast range of presentations from sick paediatric patients to level 1 trauma calls makes emergency medicine a very exciting and rewarding career.

Emergency medicine isn't complete without mentioning teamwork. Emergency departments foster a very cohesive environment where both medical and non-medical professionals work together towards a common goal of providing a patient with the best treatment possible. This can only be accomplished by treating each other with respect and integrity. This is the sort of work environment that keeps me going and motivated.

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

I think the most enjoyable part of my role is treating critically ill patients as a team in a timely fashion and advocating for the most appropriate disposition and definitive care. Teamwork is essential in emergency medicine and, when it is done well, it gives me the greatest satisfaction. Roles may be different between team members, but the end goal is always the same – which is providing the best care possible to the patient.

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

When people think about work/life balance, many tend to separate the two completely and speak about the balance in terms of 'work time' and 'non-work time'. I think I have a unique perspective on this subject. I don't see 'work' and 'life' as two separate entities but as a single multicomplex. To me, a good work/life balance is not about leaving work on time or not bringing work back home but is more about feeling a sense of accomplishment at the end of every shift. When you feel great at the end of your shift, you also bring that positive energy back home, which ultimately influences your 'life'. This is also true in reverse of course. If you are joyful and content with your life, it positively affects your work as well.

Outside of work, my fiancé and I are foodies, and we enjoy trying out many different places, be it fine-dining or street food. I keep both physically and mentally fit by regular exercises such as jogging or visiting a gym. I am also an avid gamer. I mainly play computer games but also enjoy occasional console games.

**An honest and authentic relationship with a patient is key in emergency medicine. Is there a time where this was reinforced for you?**

I had a patient who was a young Indigenous woman that had a head strike whilst intoxicated. She was brought in under a care and control by paramedics for further assessment. From a medical perspective she needed to have a full physical examination and investigations. However, she was getting quite agitated with hospital staff and got quite aggressive. Initially, security guards were called due to escalating behaviour and I was told that chemical sedation might be required. When I reviewed the patient, I could tell that she was petrified and was clearly not fond of hospitals. I managed to de-escalate the situation and had a good honest conversation with the patient. She stated that she was not trying to be aggressive but being in hospital was associated with bad omens in her culture. She also mentioned that many of her family members died in the same hospital. At this stage, the patient was successfully de-escalated and was assessed to have full capacity. She remained voluntarily in the hospital and consented for appropriate physical examinations and investigations. Ultimately, I managed to avoid a less desired outcome by building an honest and authentic relationship with the patient and advocated for the best practice. This incident really reinforced the importance of integrity in emergency medicine.

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

I think the ACEM Core Values accurately reflect what we should strive to be as emergency physicians and they help promote the spirit of EM.

# Andrew Perry

*There is a special sort of camaraderie that is forged in working in such imperfect environments*

*Consultant, The Queen Elizabeth and Royal Adelaide Hospitals EDs, South Australia*
*Pre-Hospital and Retrieval Medicine Consultant, MedSTAR, South Australian Ambulance Service*
*Training Lead, ACEM Emergency Medicine Education and Training, SAPMEA Hub*

**Why emergency medicine?**

I was fortunate to know that I wanted to do emergency medicine (EM) in my second year out of medical school. This was shortly into a rotation that year in my hospital's emergency department (ED) – a department that I still work in to this day! I was (and still am) attracted to how dynamic EM is, with an unknown number of patients arriving with unclear pathology who may be very unwell. I perversely enjoy how imperfect the ED can be in terms of resources of all descriptions – human, material and other – and making the best with what you have got. There is a special sort of camaraderie that is forged in working in such imperfect environments and I find the doctors, nurses and sundry other members of the team, including security and orderlies, are tight knit.

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

The uncertainty of almost every part of the job – how many patients will be in the department when you turn up? How many staff have called in sick? What piece of infrastructure isn't available or working, like CT? What does that patient with perplexing symptoms have? And can you discharge them? Trying to bring some sort of order to this environment is very intellectually satisfying. A good resuscitation is also something I never turn down.

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

Not enough. I make an effort to exercise – however that is predominantly through replacing driving with cycling, which is mainly to and from work. This has the added benefit of turning up to work having been refreshed and stimulated by riding and being able to wind down on the way home.

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

Organising a number of events that have contributed to the professional development and camaraderie of my peers and colleagues. This includes running or assisting in a number of EM conferences, chairing an ACEM education committee, and being the Training Lead of an Emergency Medicine Education and Training (EMET) Program Training Hub. Furthermore, I have recently established consultant funds at each of my work sites whereby almost all of the consultants working there contribute an amount each pay that is then used to fund activities or items that improve wellness and morale in the department.

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

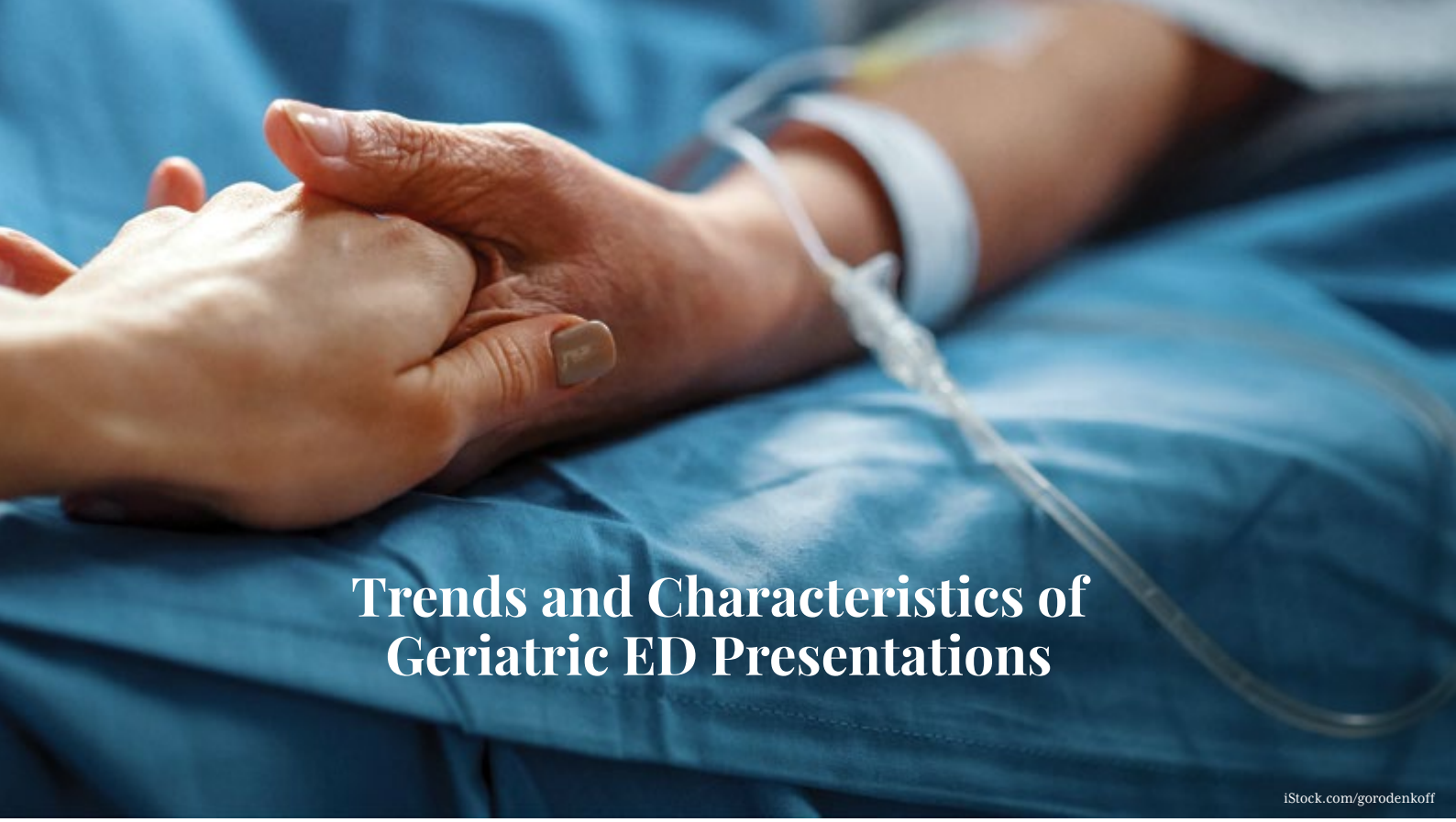
As I answered earlier, I do feel that emergency medicine has an incredibly important role in the health system and that of patients.

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

Your job interview for a consultant position starts when you start your first emergency medicine rotation. Whilst the selection process has a formal pathway in terms of application letter, CV and interview, it is your track record to date that will be the biggest determinant of your job prospects.

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

A world where there is no ramping and overcrowding. But seriously, I look forward to us increasing our professionalism and knowledge base e.g. use of ultrasound and becoming established amongst our peers and the community as a specialty of significance.



# Trends and Characteristics of Geriatric ED Presentations

iStock.com/gorodenkoff

The proportion of Australian people aged 65 and over (geriatric) doubled between 1946 and 2020, and the Australian Bureau of Statistics estimates this will increase from 15 per cent of the total population in 2017 to between 21 per cent and 23 per cent in 2066, with those aged 85 years and above projected to grow from two per cent in 2017 to four per cent of the total population in 2066.[1] The growing population of older people has increased the demand for healthcare beyond primary care. Old age is associated with increased frailty and complexity of health needs, which often require immediate attention through the emergency department (ED).[2]

Geriatric patients accounted for up to 22 per cent of all presentations to Australian EDs nationally,[3] an over-representation compared to their proportion in the Australian population at 17 per cent.[4] Older patients generally present a greater diagnostic challenge than other patients, requiring more complex care and prolonged treatment times. Connected to this, older patients are at greater risk of experiencing access block[5] and subsequent harm and mortality associated with longer ED waits. Contrastingly, the inappropriate transfer of geriatric patients to the hospital through an ED could also pose unnecessary harm and adverse complications to their care.

Serving as an interface between community and acute hospital care, EDs are a setting where timely and continuity of care is critical for a patient's survival. It is concerning that there is currently no interoperability of different data systems between EDs and other community or primary health services, including the residential aged care setting. This poses an additional challenge to ensuring the appropriate transition of patient care, which is especially critical for vulnerable geriatric patients.

Understanding the trends and reasons for ED presentations among geriatric patients is crucial as the fundamental step to identifying primary areas of their emergency care needs and informing resource allocation where needed. To do this, an age-specific analysis was performed on the National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD, de-identified data) held by the Australian Institute of Health and Welfare to compare the demographic profiles and characteristics of ED presentations among geriatric patients with other adults (aged 15-64) and paediatric patients (up to age 14).

## Ten-year trends in geriatric ED attendances

The increasing demand for emergency services among geriatric patients was evident, with the number of attendances increasing 54 per cent over the last 10 years (n=1.23 million in 2011-12 to n=1.89 million in 2020-21). The number of geriatric ED presentations continued to grow despite the reduction in the total ED presentations (of all age groups) in 2019-20 due to the impact of the COVID-19 pandemic and restrictions.

ED presentation rates (attendances per 1,000 population) among geriatric populations significantly exceeded those among other patient groups (Figure 1). The rates of geriatric ED presentations per 1,000 population steadily increased over the years, from 2011-12 to 2018-19, a 17 per cent increase. The rate dropped slightly (three per cent) in 2019-20 at the start of the COVID-19 pandemic, then started to bounce back in 2020-21.

Time series forecasting in Tableau was used to predict the five-year trends (between 2020-24) in geriatric ED presentations based on the monthly ED attendances for the prior five years. The annual geriatric ED presentations in the financial year of 2019-20 were estimated at 1.90 million in the prediction model, compared with the actual reported number of 1.82 million, with the deficit associated with COVID-19 restrictions and changes affecting healthcare

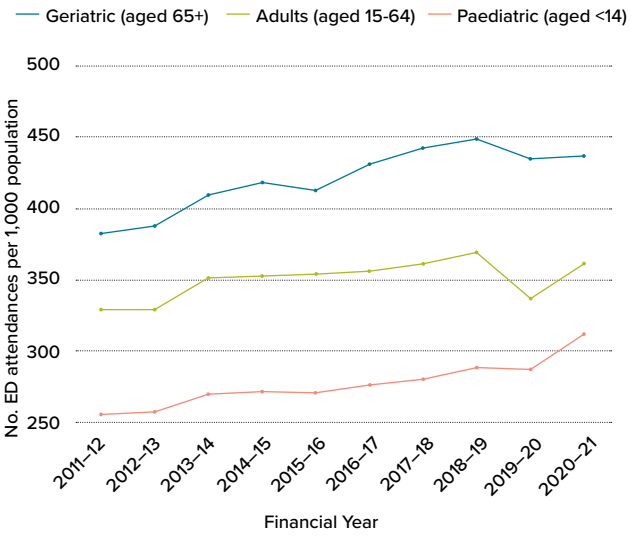



**Figure 1. ED presentation rates (attendances per 1,000 population), comparing geriatric, adult, and paediatric presentations.**

Note: The ten-year trend should be interpreted with caution, considering (i) the changes in the reporting EDs over the years (for example, between 2012-13 and 2013-14, the number of reporting EDs increased from 204 to 289, with NSW increasing their reporting from 83 per cent to 99 per cent of all emergency occasions of service); and (ii) the impact of the COVID-19 pandemic (in 2019-20 and 2020-21).

provision commencing February 2020.[6] The model predicts a four per cent annual increment in geriatric ED presentations within the five years, bringing the estimated annual geriatric presentations to over 2.2 million in 2023-24.

## Demographic profiles and characteristics of ED presentations

Not surprisingly, rates of ED presentations increased by age, from age group 65-74 (330-370 attendances/1,000 population), 75-84 (510-580 attendances/1,000 population), to the highest rate among those aged 85+ (741-906 attendances/1,000 population). Males were generally more likely to receive ED care than females (906 male attendances versus 741 female attendances/1,000 population among those aged 85+).

The ED presentation rate was two-fold higher among First Nations Australians (901 attendances/1,000 population) compared with other Australians (464 attendances/1,000 population). The rates also varied across jurisdictions, with the Northern Territory and Western Australia recording over 1,000 geriatric ED presentations per 1,000 population among First Nations peoples, while Tasmanian EDs reported the lowest rate of 426 attendances per 1,000 population.

Geriatric patients (52 per cent) were significantly more likely than adult (22 per cent) or paediatric (nine per cent) patients to arrive to the ED by ambulance. Similarly, their ED presentations were more likely to be classified as urgent based on the Australasian Triage Scale (ATS) classification as ATS 1-3, and less frequently classified as ATS 4-5, compared with adults and paediatric presentations. The proportion of ED presentations that resulted in hospital admission among geriatric patients (55 per cent) was two to three times higher than that of adult and paediatric patients (28 per cent and 16 per cent, respectively). Geriatric patients were also more likely to be transferred to other hospitals for admission (three per cent). Preliminary analysis of the ED length of stay suggests that a significantly higher proportion of geriatric patients waiting to be admitted were access blocked compared to adult and paediatric patients.

As reflected in the differences in patient acuity, the reasons for ED presentations varied across different age groups. Circulatory system illness was the most common major diagnostic block (MDB) among geriatric presentations, whereas single site major injury was the most common MDB in adult and paediatric presentations. Geriatric patients were also significantly more likely to present to EDs due to neurological system illness, while younger adults were more likely to present with mental health-related disorders. Paediatric ED presentations were more likely to be associated with system infection and ear/nose/throat illness. When examining the principal diagnosis of geriatric presentations for different age groups, those aged 65-74 were more likely to present to EDs for less severe or undifferentiated diagnoses, such as back pain, cellulitis and unspecified soft tissue disorders. Patients in older age groups (75+), on the other hand, were more likely to present to EDs for reasons such as syncope or collapse, fall-related pain or injury, heart failure, and urinary system disorders.

## Conclusions and future direction

As reflected in their ED attendance rates, emergency care demands among geriatric patients exceeded those in other age groups, with a steady increase in their annual ED presentations despite the impact of the COVID-19 pandemic. Findings also provide insights into the characteristics of geriatric ED presentations, including the differences in the reasons for presenting compared to other adult and paediatric patients. Future research is needed to identify potentially avoidable ED presentations, particularly visits that could be more appropriately catered for by primary healthcare. Integrated surveillance of ED presentations among geriatric patients, with better data linkage with primary and/or residential aged care, is crucial for improving the quality of care provided for older Australians.

*Authors: Jolene Lim, Manager, Research and Katie Moore, General Manager, Research and Partnerships*

**References**

1. Australian Bureau of Statistics, 2018. Population Projections, Australia. Available from: https://www.abs.gov.au/statistics/people/population/population-projections-australia/latest-release
2. Shenvi C, Platts-Mills T. Managing the elderly emergency department patient. *Annals of Emergency Medicine*. 2019;73(3):302-7.
3. Australian Institute of Health and Welfare 2021. Emergency department care 2020-21: Australian hospital statistics. Health services series no.65. Cat. no.HSE 168. Canberra: AIHW. Available from: https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care
4. Australian Bureau of Statistics, 2022. Population by age and sex. Available from: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release
5. Australasian College for Emergency Medicine. Care of older persons in the emergency department. Policy P51. v6.0 April 2020. Available from: https://acem.org.au/getmedia/bfd84f83-fcb2-492a-9e66-47b7896e5c70/Policy_on_the_Care_of_Older_Persons_in_the_ED
6. Australian Institute of Health and Welfare 2021. Emergency department care activity – Impact of COVID-19 on ED activity. Australian hospital statistics. Health services series no.65. Cat.no. HSE 168. Canberra: AIHW. Available from: https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed

# Community Member Engagement in ACEM Activities

ACEM engages members of the community on its Board, councils, committees, entities and groups, to provide different perspectives from College members and trainees to the deliberations of the governing body or entity to which they are appointed.

ACEM Community Members: provide advice and feedback; offer alternative views obtained through experiences or communication with groups outside of ACEM; give suggestions for quality improvement; and actively participate in decision-making with ACEM.

ACEM Community Members are not expected to be experts in the subject area of the governing body or entity to which they are appointed. However, they may have had experiences of emergency medicine from a community perspective that enables them to bring a different, non-medical viewpoint to matters under consideration.

### Why does ACEM have Community Members?

The expectation from accrediting bodies, external stakeholders, and the community more generally, is that the specialist medical colleges obtain input into their activities from the perspective of external groups such as consumers. ACEM has responded to this expectation by appointing Community Members to its governing bodies and a range of College entities, including working groups, as well as seeking their involvement in other specific activities as the need arises.

Greater involvement by members of the community has many potential benefits, including improved relevance of research to patient needs; greater accountability; improved quality and outcomes; decreased costs; more effective research translation; and improved public confidence.[1]

The fundamental importance of involving members of the community in activities is increasingly recognised to deliver effective, person-centred care.[2,3] By diversifying the membership of entities through the inclusion of members of the community, ACEM is able to understand a wider range of views, needs and wants of the community. This enhanced understanding assists in improving how ACEM functions for members, trainees and emergency medicine practices.

Importantly, in the field of emergency medicine, ACEM Community Members are not expected to be frequent users of emergency departments (EDs). Emergency medicine has a unique engagement of consumers, and the College reflects that through its strategy and use of the term ACEM Community Member instead of 'community representative'.

Partnership with members of the community provides the College with an alternative perspective on its work, also tapping into the specific experiences and expertise of the member. For example, the ACEM Community Member on the ACEM Research Committee is an ex-Director of the University of Melbourne Research Office, providing a unique perspective on the academic research and funding landscape. The College also has an ACEM Community Member who is an ex-coroner and has provided valuable insight into the interface of coronial inquiries and healthcare providers.

ACEM aims to have members of the community on a range of its governance bodies and their entities. There are currently 21 Community Members appointed to ACEM entities, including one as a member of the ACEM Board. The Council of Advocacy, Practice and Partnerships has recently appointed an ACEM Community Member, and all seven committees under its purview have ACEM Community Members who have continued into their second two-year term of service.

Similarly, the Council of Education (COE) has an ACEM Community Member, and there are seven ACEM Community Members across six COE entities.

### What do ACEM's Community Members do?

ACEM Community Members sit on College governing bodies and other entities and participate as any College member or trainee does. This means ACEM Community Members have great impact at the highest levels of governance.[5] Community Member engagement should be an ongoing and reflective process. ACEM does this by setting reasonable expectations for Community Members' involvement and coordinating efforts so that the same individuals are not called upon for multiple roles.

### How do we support ACEM Community Members?

Positive engagement has been identified as important in effective partnerships with members of the public in effective decision-making.[5] ACEM actively seeks to maintain engagement with its Community Members through treating them as full members of their entity, and ensuring ACEM members, trainees and staff understand and are committed to the role of ACEM Community Members, valuing the knowledge and experience they bring to our work. ACEM provides its Community Members with defined roles to manage the expectations of the Community Members themselves, members, trainees and staff.

ACEM believes that by providing a framework for members, trainees, staff and community to interact, the College can collectively build a unique and valuable perspective on health and medical policy, practice and research, as well as education and training practices. Through this valuable combination, College entities ensure polices, practice and research, as well as ACEM training and education, is relevant, impactful and always undertaken with

iStock.com/DigitalStorm

the patient, carer and/or family member perspective at the forefront of minds.

ACEM also recognises that it is important to be culturally sensitive to the needs, norms and values of the community, and reflects this by ensuring that members of the community are recruited in a culturally and linguistically appropriate manner. This also ensures we reflect our actions under the ACEM *Reconciliation Action Plan* and the *Manaaki Mana Strategy*.

## Looking ahead

The number of Community Members appointed to ACEM entities has significantly increased in recent years. To further complement this and enable a more coordinated involvement of the group as a whole, the ACEM Board, at its most recent meeting, approved the formation of an ACEM Community Member Reference Group. Like all ACEM entities, the group will operate according to defined Terms of Reference and will be chaired by the Community Member appointed to the ACEM Board.

The establishment of the Reference Group is considered a logical step in the involvement of Community Members in ACEM's work. It will provide a coordinated source of advice on matters where wide Community Member input is required, enable a more coordinated approach to matters such as induction of Community Members, and assist in the selection of new Community Members for ACEM entities and succession planning.

*Author: Cassandra Beer, Policy Officer*

## More information

For more information relating to the role of Community Members in ACEM activities:
ACEM *Policy on the Appointment and Remuneration of Community Members*: https://acem.org.au/getmedia/4eda0e4b-a3e1-468a-91cf-510f204384e0/COR498_v2_Community_Representatives_Policy.aspx
ACEM Community Member Position Description: https://acem.org.au/getmedia/92ff1ee6-0b32-44ba-acf1-90839da82628/PD117_v2_Community_Representatives


**References**

1. Cancer Australia. Why should I involve consumers in research? https://consumerinvolvement.canceraustralia.gov.au/researchers. Published 2021. Accessed December 15, 2021.
2. Gunatillake T, Shadbolt C, Gould D, et al. Embedding consumer and community involvement within an established research centre: moving from general recommendations to an actionable framework. *Res Involv Engagem*. 2020 Oct;6(64). https://doi.org/10.1186/s40900-020-00241-2
3. Safer Care Victoria. A guide for health services. https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/health-services. Published 2021. Accessed December 15, 2021.
4. Australian Commission on Safety and Quality in Health Care. Partnering with Consumers Standard. https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard. Published 2021. Accessed December 15, 2021.
5. Consumers Health Forum of Australia. 'Unique and essential': a review of the role of consumer representatives in health decision-making. Canberra: CHF; 2015.

# Dr Alice Rogan

**Why emergency medicine?**

It took me quite a while to decide which acute specialty I wanted to work in, as I think it does for everyone. I have the type of personality that makes me want to have a go at everything; both at work and at home. So I guess that's why I was drawn to emergency medicine. I enjoy the variety and the fact that no shift is ever the same, as a colleague once said to me, 'It's the best and worst 15 minutes of every specialty'! I also love that you are always working as part of a team, so you are always supported, journeying through highs and lows together.

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

I think it has to be working as a Match Day Doctor when the British and Irish Lions played the All Blacks in Wellington, Aotearoa New Zealand.

I grew up in the UK with a sports mad family, so many family get-togethers revolved around sporting events. Some of my most cherished childhood memories were moments spent watching sport with my family. My dad, grandad and I would regularly attend Burnley Football Club home games at Turf Moor. I remember reading about the team doctor in the matchday program and often watched with intrigue as they attended to injured players during the games. I remember once saying to my dad, 'Maybe I could do that one day…'

When I came to Wellington, and began working in the emergency department (ED), Dr Sarah Adlington, one of my role models, invited me to become a Match Day doctor in Wellington. I absolutely loved every moment and I remember calling my dad when I was asked to work at the Lions game. My mum and dad both watched the game in the UK and saw what can only be described as a blur of me on TV. They sent me a photograph of the 'blur' and told me how proud they were. It was a true childhood dream come true… a dream that was possible because of the skills I had learnt working in emergency medicine.

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

I was recently awarded a Health Research Council of New Zealand Clinical Research Training Fellowship, which is supporting me whilst I complete my PhD. I am completing a project aiming to investigate if clinical biomarkers can be used to improve clinical pathways for traumatic brain injuries in ED. I am studying this part time whilst I continue my FACEM specialty training. I would love to have a career that is a mix of clinical research and clinical emergency medicine, so receiving this grant has not only made this possible, but also given me confidence that I can continue to aspire to this.

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

When I first started working in ED, during a welcoming session, the clinical director at the time asked, 'What is emergency medicine'? A range of answers were offered and discussed, but never quite convincingly answered the question. After a pause, the director then shared their opinion with us. 'Emergency medicine is, anyone, with anything, at any time'.

It really resonated with me at the time and still does to this day. I feel both humbled and privileged to know that this is exactly what emergency medicine is. To know that I am learning the skills and attributes required to do this, and that as a profession we truly will continue to treat anyone, with anything, at any time, inspires me to keep pushing on. As we continue to strive for equitable care for all, this is something as a profession we can all continue to be proud of.

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

There must always be something else! Never let your life be consumed by emergency medicine. As rewarding as it can be, it is also one of the hardest and most challenging environments to work in. Every shift comes with a variety of different pressures, both personally, professionally and socially. Burn out is real and it affects everyone; and you may not always be aware of it as it creeps into your life. Which is why, there must always be something else. Prioritise yourself, your family/whanau and your friends. Do not give up hobbies; start new hobbies; and always take leave when you can.

I would also advise finding a professional side interest that you can develop alongside ED training. For me at the moment that is research, and hopefully it is something that will build into the rest of my career. We will all be consultants for the majority of our working careers; so there is no rush to get through training, despite how it often feels like it while you're "in it".

Try everything you want to try, learn everything you want to learn, and find what your side interests are that can be built into your career; so that you can stay refreshed and continue to sustain an enjoyable working life in ED.

# ED Ultrasound eLearning Resources

Since February this year, new eLearning modules have been released to support the development of knowledge and skills relating to the five core applications of ultrasound in the emergency department (ED), including E-FAST, AAA, procedural guidance, FELS and lung ultrasound, as well as Governance and Physics. This exciting project was initiated and supported by the ED Ultrasound Committee (EDUC) of ACEM's Council of Education and developed in collaboration with the ACEM Educational Resources team.

## Recognising the need

Recognition of the growing diagnostic, therapeutic and procedural utility of ultrasound in emergency medicine practice has led ACEM to articulate this in the revised FACEM Curriculum. Trainees are expected to achieve an "independent" level of mastery in the five core ED Ultrasound applications by the end of the FACEM Training Program and it is embedded in the curriculum via assessment through WBAs and examinations.

Despite the recognition of ultrasound as a core skill for emergency medicine specialists, there is considerable variation in the scope of ultrasound education, training and determination of competency across Australasia. Whilst some EDs have their own ultrasound credentialing program, recognition of that credentialing is rarely accepted at other hospitals if the clinician transfers between institutions. The lack of a clear established pathway to achieve competency in ED ultrasound has led many FACEMs to pursue formal ultrasound qualifications. However, the costs involved, and time required to attend external workshops, and differences in requirements between ultrasound education providers, continue to pose challenges for those who want to gain further training in ED ultrasound and achieve competency.

In order to address the gap in ultrasound education provision, EDUC recommended the development of a suite of ED Ultrasound eLearning modules to support trainees and FACEMs in the development of knowledge that underpins performance of these important skills. The EDUC recommendation was approved by the Council of Education in 2020.

## eLearning development

Content for the modules was provided by Emergency Medicine Ultrasound subject matter experts who formed the *Ultrasound Authoring Group*, with some members generously providing resources they had already developed and used in the provision of ultrasound education and training. Additional content development, including multimedia and interactive material, has further enhanced the quality of the modules. Pre- and post-tests for each module were included to assist participants to assess their knowledge acquisition.

The first of the ultrasound modules and quizzes were released in February 2022 and others were added as their development and testing was completed. Announcements about the release of the ultrasound resources were distributed via ACEM's communication channels, including the weekly bulletin, regional faculty bulletins and trainee news.
The ultrasound modules and quizzes available include:

- Introduction to ED POCUS (Point of Care Ultrasound)
- Governance
- Physics
- AAA (Abdominal Aortic Aneurysm)
- EFAST (Extended Focused Assessment with Sonography in Trauma)
- Thoracic/Lung
- FELS (Focused Echo in Life Support)
  - Anatomy and Views
  - Pathology and Clinical Integration (to be released in July 2022)
- Procedural Guidance
  - Vascular Access
  - Thoracoabdominal Cavity and Joint Procedures
  - Regional Anaesthesia

| Time | Main activities |
|---|---|
| **December 2020** | Formation of the Ultrasound authoring group |
| **January 2021 – July 2021** | Content and quiz question authoring |
| **July 2021 – May 2022** | eLearning module development and test question set up |
| **January 2022 – May 2022** | Content sign off, technical testing and edits |
| **February – May 2022** | Ultrasound eLearning module release and promotion |

## Access to the Ultrasound eLearning modules

The ultrasound resources have been made available to FACEMs, trainees and all other ACEM members. External health practitioners can register on ACEM's eLearning website to access the resources.

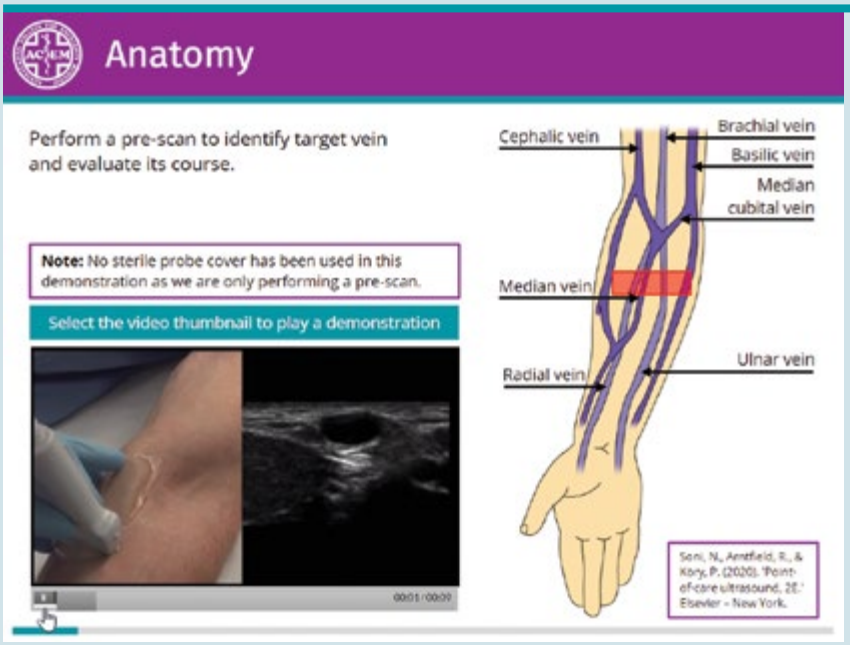



**Figure 1:** Content from the Procedural Guidance: Vascular Access module

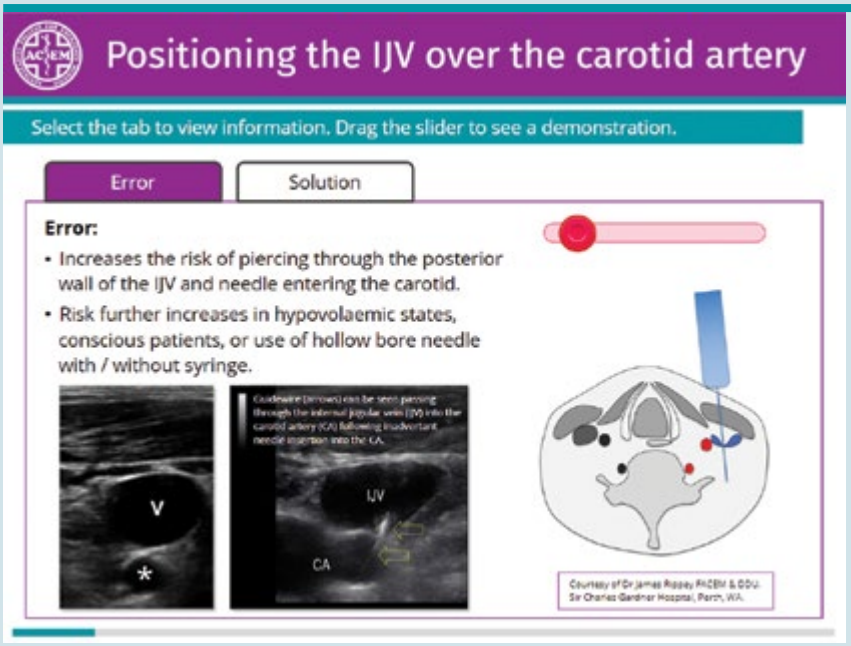



**Figure 2:** Content from the Procedural Guidance: Vascular Access module

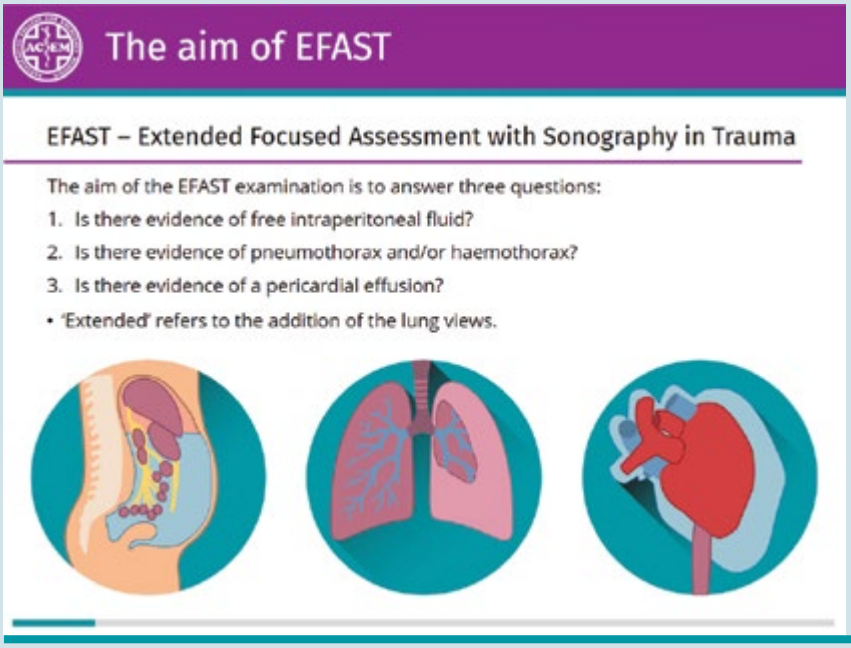
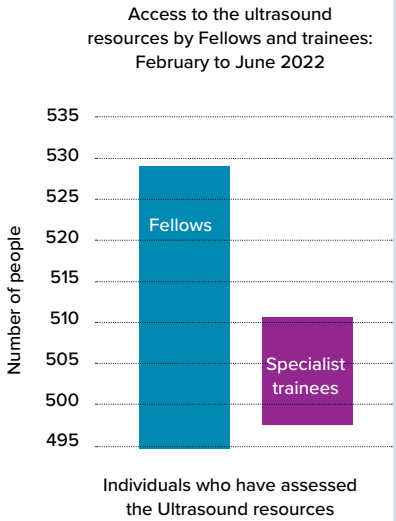



**Figure 4:** Content from the EFAST module

**Figure 3:** Access to the ultrasound resources by Fellows and trainees, February to June 2022




Source: ACEM Educational Resources website, June 2022

The numbers of individual ACEM Fellows (529) and FACEM Training Program trainees (508) accessing the ultrasound resources at least once between February and June are shown on the opposite page (Figure 3), indicating the enormous interest that the ultrasound resources have attracted during the short time that they have been available. Early feedback surveys indicate that 93% of 147 survey respondents would recommend the modules to others.

Further analysis of access to these resources will be undertaken to inform ongoing evaluation and enhancement. Members who would like to provide specific feedback on the modules may do so by completing the feedback survey https://www.questionpro.com/a/TakeSurvey?tt=pnnyH7jlPq0%3D) or by emailing the Educational Resources team at educationalresources@acem.org.au.

**Acknowledgments**

Thanks to members of the ED Ultrasound Committee during 2021 and 2022 for their great support with development of content and collaboration for the release of the ultrasound resources.

Completing the ultrasound quizzes and modules will support emergency medicine clinicians and their patients in the following ways.

**Emergency Departments**

The capacity of EDs to train emergency physicians in the core areas of ultrasound, as outlined in the FACEM Curriculum, will be enhanced. It is expected that the essential knowledge provided by the modules will save clinicians time, otherwise needed to travel to locations away from hospital sites to undertake training.

**FACEM Training Program trainees**

The ultrasound eLearning modules and quizzes are required for completion during the FACEM Training Program and will support knowledge for the DOPS Procedural Requirement. Specific requirements for FACEM Training Program trainees include:

- The ultrasound eLearning modules must be completed by the end of Training Stage 2
- An ultrasound DOPS (as one of 12 Core DOPS in the Procedural Requirement) must be completed by the end of Training Stage 4.

**Continuing professional development (CPD) for Fellows for Fellows**

Completion and duration of the ultrasound Pre- and post-quizzes and modules by Fellows will automatically populate into CPD records in the My ACEM CPD Portal as Educational Activities.

*Author: Katharine Ebbs, Manager, Educational Resources*

### More information

The Ultrasound eLearning modules can be accessed on the ACEM Educational Resources website (https://elearning.acem.org.au/course/view.php?id=951).

Any questions about access to the ultrasound resources can be directed to educationalresources@acem.org.au.

# We Live in a Digital World: Increasing Emergency Care Capacity in Papua New Guinea

Dr Donna Piamnok, Sr Wilma Sebby and Sarah Bornstein

Dr Donna Piamnok is a Senior Emergency Physician at ANGAU Memorial Provincial Hospital (AMPH), Papua New Guinea (PNG).

Sr Wilma Sebby is an Emergency Nurse Specialist and Nurse Unit Manager (NUM) at AMPH.

Sarah Bornstein is an Emergency Nurse Specialist and the Project Lead for the PNG Emergency Care Capacity Development Remote Training and Support Model Project.

'We haven't used online learning before. We've just been doing our own in-house trainings here with the local team', said Sr Wilma Sebby, NUM at AMPH Emergency Department (ED) in Lae, PNG.

'I think on our own we wouldn't know where to begin really. It would have been like being thrown in the middle of the Pacific Ocean and asked to swim', added Dr Donna Piamnok, AMPH ED physician.

There are two things you can't help but notice in Lae – the weather is wet, and the potholes are big and many. With the city's reputation as 'rainy Lae', the gardens are tropical, the grass is green, the weather is sticky, and power outages are common. Lae is PNG's second largest city, located in Morobe Province. It is a port and industrial city, and a gateway to the Highlands Region. AMPH is PNG's second largest hospital, and was built in 1964. In 2016, the redevelopment of AMPH, including the commissioning of a new ED, commenced. The project is a joint effort between the Papua New Guinean and Australian governments, including strong relationships with the PNG National Department of Health and the Provincial Health Authority.

In preparation for transition to the new ED, in late 2020 a team from ACEM began working with Johnstaff International Development (JID) and alongside PNG emergency care colleagues at AMPH to remotely support the development and implementation of an evidence-based model of care. At the forefront of the team at AMPH ED were Dr Piamnok and Sr Sebby. Dr Piamnok is a Senior Emergency Physician at AMPH with extensive medical experience in the public and private sectors in PNG and has been a Senior Medical Officer at AMPH ED since 2019. Sr Sebby is an Emergency Nurse Specialist and has been the NUM of AMPH ED since 2000. They both have over 30 years of clinical experience and they are both pawa meris: powerful, strong women and experts in their chosen fields. Dr Piamnok and Sr Sebby led the AMPH ED Technical Advisory Group for the commissioning of the new department.

Together, we designed a model of care that would be fit for purpose in the new ED and included triage, patient flow and data management. We then set out to develop and deliver a PNG-specific training program encompassing each aspect of this model of care using entirely digital methods. The concept of introducing a new model of care, new assessment skills and new processes, via a new learning platform, with a team that was based across two countries (PNG, Australia) and four cities (Lae, Melbourne, Sydney, and Townsville) was bold to say the least. But these are unprecedented times…

When asked to reflect on triage processes used at AMPH before the project, Dr Piamnok smiled, 'I know in an emergency department it's supposed to be organised chaos, but I really would say it was quite chaotic and very stressful for our staff.' The Integrated Interagency Triage Tool (IITT) was chosen as the preferred triage system for implementation in the ED. The IITT was developed collaboratively by the World Health Organization (WHO), International Committee of the Red Cross (ICRC) and Médecins Sans Frontières (MSF), and is a novel, three-tier system purpose designed for developing emergency care (EC) settings. In partnership with local clinicians, ACEM has previously supported the successful implementation of the IITT in two other EDs in PNG and it has been well received by staff in those locations. In 2019, Dr Piamnok and Sr Sebby visited one of the sites, Mount Hagen Provincial Hospital. They observed the education program about triage and patient flow, followed by implementation of the IITT. Sr Sebby recalled, 'We were practising triage previously, but it wasn't really organised, and having a sneak peek of it when I went to Hagen. I saw that it was really organised, so we wanted to implement it here'.

Planning for training and implementation of the new model of care was affected by COVID-19 from the outset, with international border restrictions limiting travel. But, of course, a global pandemic wasn't going to deter the devoted AMPH ED team. Dr Piamnok said, 'We had no idea of course when COVID first hit our doorstep but like in any other emergency department you've just got to throw yourself into it and just plough and keep ploughing'. The project team were forced to be adaptable and innovative and embrace digital media. For 16 months, the teams from Australia and PNG have met weekly via Zoom to collaboratively create a digital learning program suitable for delivery in PNG. 'Neither I nor Sr Sebby had any experience with Zoom conferencing… honestly, I didn't think it would work at first… but that's the thing, as a team we found ways and means to make things happen, and we've had really great support', Dr Piamnok said.

Dr Piamnok conducting handover at the newly created patient tracking board. Photo: JP Miller/ACEM


Sr Wilma Sebby cutting cake at KHS Graduation. Photo: ACEM

The online program developed was named the Essential Emergency Care Systems Training Program and comprised 10 courses addressing triage, patient flow, the IITT, data and documentation, as well as a recap of essential emergency care skills, IPC and ED equipment. The program was launched on a digital learning platform named Kumul Helt Skul (KHS) – kumul being the Tok Pisin word for bird of paradise and emphasising a locally led and designed program.

With the support of a design team from Catalpa, the digital learning provider, the learning platform was customised to suit the needs of emergency care staff in PNG. Many of the training participants did not readily have computer access or stable internet, so a smartphone-friendly platform was designed with offline capability and downloadable resources that would update once a connection was restored, and images and videos were low-bandwidth friendly. There was limited time for teaching and no dedicated work hours for self-directed learning, so the courses were designed with a micro-learning approach that used short lessons and courses to make up the program. Learning content previously available was rarely contextualised to the Pacific context, so a graphic designer was used to develop Melanesian-specific imagery and animations, with examples taken from the PNG setting, using voiceovers recorded by local clinicians. 'All of us were keen to try something new, it was a huge learning experience for us' Dr Piamnok said.

With coordination by the Project Delivery Office (managed by JID), live seminars were planned that would be delivered via Zoom to provide a 'face-to-face' component to the training and an opportunity to discuss the material and answer questions. We designed flowcharts and posters to be hung around the ED, as well as a quick reference guide containing all the information required to understand the new system, so that participants had their own resources to use for the training program, and for use after implementation. 'I think the bulk of us use pictures and diagrams and colour coding and all of that. The tools that were used, I think they greatly helped our team', said Dr Piamnok.

In early 2021, during the development phase of the project, a third wave of COVID-19 hit PNG and had a dramatic effect on the community, hospitals, and their front-line care providers. Meetings were interrupted by internet and power outages, COVID-19 outbreaks in the ED, nursing strikes and community protests, but the dedication of the team at AMPH ED was unwavering throughout. Balancing the coordination of a busy regional ED during a global pandemic as well as the commitments of family and community is impressive enough, but to add on an extra workload in designing and developing a novel training program to benefit EC staff across PNG is truly exceptional. Triumphantly, KHS launched at AMPH in July 2021 and was then expanded to the ED at Port Moresby General Hospital, PNG's largest hospital, in the country's capital. This resulted in over 130 EC staff registering across both sites to participate in the online training whilst concurrently responding to the country-wide pandemic, and both EDs committing to implementation of the new model of care.

The already fragile health system in PNG faced significant pressure with recurrent COVID-19 surges, limited testing capacity, stretched resources and insufficient COVID-19 isolation areas. Business as usual emergency care systems had to be modified to accommodate surge support. This stretched already limited resources and impacted both patients and staff. Noting the challenges both facilities were facing in the wake of COVID-19, the Australian Government supported a team of clinicians, including six emergency nurse specialists

to deploy to PNG from Australia to provide rapid training and COVID-19 system development support. This meant that in addition to the online training from KHS, Australian clinicians were available to concurrently provide face-to-face training opportunities and support ED staff with preparations for and implementation of the new model of care during their "go live" weeks.

Many participants were excited to try online learning for the first time and, while there were plenty of challenges, having Australian clinicians in-country meant there was support for access and troubleshooting, and the Zoom seminars could be delivered in-person for a combined approach that maximised participation. Dr Piamnok explained, 'Having face-to-face training was very good because we had immediate responses to questions and demonstrations at the bedside. Different people have different ways of learning, some are classroom-oriented people… others of us, we would like to diversify things'. Following completion of the online training, the team supported preparation for the new model of care in ED including clinical redesign, minor infrastructure improvements and data support for the new, custom-designed data management system.

The night before the launch of the new model of care, an eager Sr Sebby slept in ED to get an early start on preparations, and there was excitement in the air for ED staff. We separated each ED into dedicated areas to align with the IITT and applied coloured tape and signs to make each area clear to staff and patients. Each ED has triage, resuscitation, acute, fast track, and respiratory areas. The local staff then used the knowledge they had gained from the KHS training, including case studies and triage scenarios, in the real world. 'It has brought a lot of clarity to us, seeing how we can manage patients according to the type of problems that they present with at the ED, especially attending to the very sick ones quickly', Sr Sebby said. Dr Piamnok added, 'It gives us a tool not only to help us quickly identify emergencies, but it forms a basis for us to be able to explain to our presenting population what constitutes an emergency, and why we can't see everybody at the same time. It helps the public understand and cooperate with us.'

The COVID-19 pandemic affected every phase throughout the project period. Respiratory screening and isolation areas were incorporated into the IITT and new patient flow processes, though limited resources meant that access block and staffing difficulties were dominant during the introduction of the new model of care. These conditions were not ideal for the introduction of new systems and processes,

**Summary of Monitoring and Evaluation Data from AMPH**

Training delivery

100%

of *EC staff agreed or strongly agreed that the Kumul Helt Skul (KHS) learning platform was easy to access, use and navigate

100%

of EC staff agreed or strongly agreed that the digital teaching methods were appropriate for their learning needs

100%

of EC staff agreed or strongly agreed that the learning content was interesting and engaging

100%

of EC staff agreed or strongly agreed that the learning content made it easy to understand new triage and flow processes

Triage and flow process

100%

of EC staff agreed or strongly agreed that the triage and flow system has improved patient flow in the ED

100%

of EC staff agreed or strongly agreed that implementation of the triage and flow system has improved their job satisfaction

5%



under-triage rate for the three months following triage implementation **(target <10%)**

41%

over-triage rate for the three months following triage implementation **(target <60%)**

but the commitment of local staff and the leadership of Dr Piamnok and Sr Sebby have seen use of the IITT continue. 'You either sink with the ship or you keep it afloat, knowing there are innocent lives on the ship with you… so I think it's the instinct to survive that's really kept us going', Dr Piamnok said.

Despite ongoing challenges, Dr Piamnok and Sr Sebby both have an optimistic outlook for the future. Sr Sebby explained, 'online training and the new model of care implementation has given us a lot of help in how we can manage patients in the ED. Going forward, it's not only the Kumul Helt Skul that we'll be continuing, but we can also do refresher courses and if we need some more Zoom training we know that our counterparts from Australia will always be there to support us and they will help us out through future online trainings'. Dr Piamnok agreed, adding, 'it's definitely my hope and my belief that the ED will not be where it is right now, it will improve greatly. In the new ED I can see that we will have much better control of patient flow, and I can see that the space will be huge, so our current problems with space will be pretty much eliminated. Our challenge is those factors that are out of our control – the pharmaceutical challenges, staffing problems, administration problems – those are pretty big-ticket items that we have no control over. If we can correct all those constraints, it will definitely be a really nice hospital for the Morobe people, the Highlands people, the Southern region people, and even the Islands people.'


### Acknowledgements

The PNG Clinical Support Program (CSP) is funded by the Australian Government and managed by Johnstaff International Development (JID).

Donna, Wilma and Sarah would like to thank Dr Colin Banks and Dr Rob Mitchell for their ongoing commitment to this project and more broadly to emergency care development in PNG. We thank emergency care advisor deployees Leigh Elton, JP Miller, Travis Cole, Angie Gittus and Bronwen Griffiths for their valuable contribution in 2021. Finally, many thanks to Sarah Körver for overseeing the project.

We would also like to acknowledge all healthcare workers in PNG and the Pacific who are working tirelessly in challenging environments during the COVID-19 pandemic.


Implementation process

**100%**

of EC staff registered for the Essential Emergency Care Systems Training Program (EECSTP)

**81%**

of EC staff completed one or more courses

**63%**

of EC staff have completed the core courses of the training program (courses 1-7)

**94%**

of EC staff attended one or more live training sessions

**100%**

of EC staff agreed or strongly agreed that they felt confident to carry out all key components of the IITT at the end of the EECSTP

**14%**

increase in EC staff knowledge scores between pre and post training quizzes*

PNGAus Partnership

* emergency care (EC)
* further increase anticipated following refresher training (in a post-COVID environment)

# Clinical Review Meetings

Clinical Review Meetings (CRM), also known as Morbidity and Mortality meetings, have been taking place in various forms for more than a century. Traditionally, CRMs were used to analyse adverse outcomes in patient care through peer review, but, more recently, CRMs have also been used to highlight successful patient care outcomes. ACEM has developed a guideline for CRMs, which is now available through the Standards library on the ACEM website. This guideline applies to all Australian and Aotearoa New Zealand emergency departments (ED) and urgent care centres.

CRMs are essential in emergency medicine and provide practitioners, trainees, and other ED staff with the opportunity to develop reflective practices, audit clinical outcomes, learn from both incidents and excellence, and effect change. CRMs are a vital aspect of maintaining safety and quality standards in EDs, as well as education for junior ED staff.

CRMs are also used to acknowledge that emergency medicine experiences challenge, which mean that some poor outcomes are unavoidable, despite the correct and diligent decisions and actions of staff. Challenges that are inherent to emergency medicine include undifferentiated patients, clinical uncertainty, disease evolution/progression, and high-risk procedures. Further, access block means that patients who need inpatient treatment are forced to stay in EDs for longer periods of time, potentially increasing adverse events seen in the ED.

In Aotearoa New Zealand, 12.9 per cent of hospital admissions are associated with adverse events.[1] Similar numbers are seen in Australian hospitals, with 6.9-16.6 per cent of patients experiencing an adverse event during a hospital admission.[2] EDs have a higher rate of adverse events than non-emergency hospitalisations,[3] reflecting the unique and complex environment in which emergency medicine is delivered.

### Clinical Review Meeting procedure

To run a successful CRM, focus should be on identifying the phenomena (system/process) that led to the death or incident, or success, and not on individuals who provided care. CRMs should focus on opportunities for system improvement, including identifying where previous system changes have worked or failed. This aim should be stated explicitly, both in the invitation and at the commencement of the meeting itself. These system issues should be divided into a standard framework to ensure clarity around the event and recording of outcomes. For example:

- patient factors
- department process factors
- hospital system factors.

Cases should be de-identified, describing only the facts of the case in an objective manner, including any confounding factors such as hindsight bias, ED overcrowding, length of wait time, triage score, and location in department.

Discussions should be used for educational purposes and not for apportioning blame to individuals. The content should focus on measures that can be implemented to improve outcomes or prevent a similar incident or adverse outcome. These discussions should not continue outside of the CRM to maintain patient confidentiality and to ensure that CRMs remain a safe and secure place for practitioners to discuss cases. Cases discussed should be recorded and an outcome of the discussion and the issues identified recorded in a log that is accessible by all ED staff.

iStock.com/Anton Porkin

The methodology used to analyse and reflect upon a case should be consistent, whether the clinical outcome of the case was favourable or not. CRMs should therefore also include cases with excellent clinical outcomes, with a similarly in-depth analysis. The NSW Government and Clinical Excellence Commission guidelines [4] for conducting and reporting CRMs provide six core principles, which ACEM replicates in its CRM guidelines:

1. Safety. Providing a safe space for learning through discussions that are blame-free and education-focused.
2. Multidisciplinary. Enhancing active participation across disciplines.
3. Methodology. Undertaking root cause analysis of patient factors, department process factors, and hospital systems factors.
4. Open Discussion. Generating actionable learning and/or system improvement.
5. Lessons Learned. Documenting outcomes and disseminating recommendations to ensure action.
6. Governance. Opening pathways for reporting to support learning and recommendations.

## Case selection

Cases can be selected for presentation at department CRMs from a range of sources including:

- deaths that occur in EDs and within 24 hours of admission
- cases referred by a clinician
- cases referred via the organisation's clinical risk management platforms, patient safety committee or complaints officer.

## Meeting frequency

CRMs should be held regularly. It is essential that protected time is set aside in all participants' schedules for the meeting. Meetings may be held monthly, bi-monthly or quarterly, determined by the size of the ED. All ED staff should be invited to attend to allow discussions across disciplines and specialties, and reflect the diversity and complexity of interacting systems.

## New guideline on CRMs

The new ACEM CRM guideline is of relevance to ED medical, nursing and allied health staff, and will support trainees who choose a CRM to fulfil the FACEM training program requirement (quality improvement activity). This guideline is intended to serve as a practical guide for setting up, running and participating in high quality ED CRMs.

The new guideline is available through the Standards library on the ACEM website.

*Author: Cassandra Beer, Policy Officer*


**References**

1. Davis P, Briant R, Schug SA, et al. New Zealand Quality of Healthcare Study. The University of Auckland; 2021 [cited2022Apr6]. Available from: https://auckland.figshare.com/articles/report/New_Zealand_Quality_of_Healthcare_Study/14036534/4
2. Ranasinghe I, Hossain S, Ali A, et al. SAFety, Effectiveness of care and Resource use among Australian Hospitals (SAFER Hospitals): a protocol for a population-wide cohort study of outcomes of hospital care. BMJ Open. 2020;10(8):e035446.
3. Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
4. Clinical Excellence Committee. Morbidity and Mortality meetings. Cec.health.nsw.gov.au. 2021 [cited 6 April 2022]. Available from: https://www.cec.health.nsw.gov.au/improve-quality/teamwork-culture-pcc/be-a-voice-for-safety/morbidity-and-mortality-meetings

# First Day on the Job

**Dr Rebecca Wong**

I had slept over at my parents' after going out in the city.

I woke to a shriek, 'Dad's leaving?'

No … 'Dad's seizing' My dream had tricked me. My father had stopped breathing. Mum's alert prompted my brother and I to the bedside.

000.

'Get him on the floor! Start CPR'! I yelled out the instructions.

Soon the sirens of the fire brigade were echoing louder. Their pitch altering as they neared. My family started the compressions and breaths. I let the firies in.

I was asked to leave the room; clearly looking like a stunned damsel. I had no idea what to do. What good was I? Graduation was next week. I called my sister, she rang the cardiology registrar on call; her friend.

He was zapped again and again… and again…

As we drove far behind the ambulance, Peter prepared me for the possibilities, 'Dad could have the function of a vegetable you know'.

I couldn't cry. It was my first day in the emergency department (ED) (waiting room). Not knowing. Just hoping. No news, no updates.

Eventually I was told to sit outside the ICU waiting room. Then told to return home. What was happening? The next day I was allowed to see Dad, he had just roused. 'What happened'? he scribbled on a whiteboard, the tube still in his throat. This was the same message he wrote one minute earlier. He scribbled it again.

It was on this day I knew I wanted to be an emergency physician. This first day in ED. I wanted to be one of the invisible team who knew what Brugada syndrome was and knew what Dad needed. I am so grateful to every single person involved. Who was the overnight registrar? Can I thank them one day? And I strive to make that extra effort for someone's family.

# Assistance program

## ACEM Assist

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


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

Australasian College
for Emergency Medicine

34 Jeffcott Street
West Melbourne VIC 3003
Australia

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

acem.org.au