# your ED

A DAY IN THE LIFE OF A MAJOR TRAUMA CENTRE
*The Royal Melbourne Hospital*

THUNDERSTORM ASTHMA

REMOTE RETRIEVAL
*Alice Springs*

GLOBAL EMERGENCY CARE
*Papua New Guinea, Bhutan, Samoa and Tuvalu*

*'…from the faded industrial heartland of North East England to Alice Springs.'*

Dr Richard Johnson, Remote Retrieval

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# Australasian College for Emergency Medicine




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**Your ED**



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




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

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Your ED | Spring 2019




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## Message from the Editor

Welcome to the third issue of *Your ED*. The College is again pleased to share emergency medicine stories from across Australia, New Zealand and the world.

Our lead story in this issue highlights a day in the life of a major trauma centre, featuring interviews with emergency medicine specialists at The Royal Melbourne Hospital. We look into workforce planning for the future of emergency medicine, staff wellbeing practices and climate change (what can you do?), we welcome our new President from Aotearoa New Zealand, Dr John Bonning, and we have a moving personal piece from Immediate Past President Dr Simon Judkins.

This issue we also speak to FACEM Dr Michael Ben-Meir about his role assessing refugees and asylum seekers for medical transfer from Nauru and Papua New Guinea, a role we know many of our members played prior to the repeal of Medevac legislation in early December.

With the launch of the new Global Emergency Care Network, we are excited to bring you features from Papua New Guinea, Bhutan, the Pacific Games in Samoa and EM nurses in Tuvalu.

We hope you enjoy these perspectives on emergency medicine.

# ACEM in the Media

In **August**, ACEM featured strongly in Australian coverage of mental health issues. This included the College issuing a statement in response to the Australian Government and Health Minister's announcement it will prioritise mental health services in the country's Long Term National Health Plan. 'While investment is needed and welcome, the number of patients languishing in EDs is increasing', said ACEM President Dr Simon Judkins. Coverage of ACEM's concerns on the issue of ED wait times for mental health patients continued, with the College providing commentary on a NSW Bureau of Health Information report in to people's experiences of the state's mental health services. ACEM also issued a media statement in response to a Western Australian Auditor General's report into mental health services. 'The report starkly highlights an overreliance on Western Australian hospital emergency departments to deliver mental health care, despite EDs not being specifically funded, resourced or supported to do so', said Dr Judkins.

In **August**, ACEM also featured in New Zealand coverage of mental health issues, with the College's then-President-Elect Dr John Bonning offering comment on sobering suicide data released by New Zealand's Chief Coroner. 'We see the worst of what can happen to people at their most traumatised and saddest times', said Dr Bonning. 'Emergency departments around the country have become the default mental health service, in particular out of office hours.'

In **August**, ACEM's advocacy on ambulance ramping and access block at Cairns Hospital received extensive media coverage. A meeting between ACEM representatives, including Queensland Faculty Chair, Dr Kim Hansen, and Dr Simon Judkins, Australian Medical Association Queensland representatives, and hospital executives, was widely covered in the local media, including *The Cairns Post*, ABC, 4CA AM, WIN TV and Channel Seven. 'We really want to see concrete actions from the leadership in Cairns so that things can improve for the patients here', Dr Hansen told Channel Seven News.

In **August**, ED overcrowding and access block in New Zealand received comprehensive national coverage, with comments from Dr John Bonning featuring on the front page of the *New Zealand Herald*. An ACEM media release on the issue was picked up by various media, including: *Otago Daily Times, The Gisborne Herald*, Newstalk ZB, Radio New Zealand, One News and *Stuff*. 'It's absolutely critical that district health boards reinforce the importance of the Shorter Stays in Emergency Departments (SSED) initiative to support better outcomes for patients. The key to achieving this is improving access to care for admitted patients', said Dr Bonning.

In **September**, ACEM's involvement in the launch of a new triage system to improve emergency treatment at Gerehu General Hospital featured on the PNG Report website. ACEM also promoted its involvement in the launch of a similar initiative at the Mount Hagen Provincial Hospital (MHPH). In a media statement announcing the initiative, Chair of the ACEM Global Emergency Care Committee, Dr Colin Banks, said the system is an exciting development for MHPH.

In **September**, ACEM Northern Territory Faculty Chair, Dr Stephen Gourley, featured on ABC Radio in Alice Springs, in his capacity as emergency department head at the local hospital, to discuss alcohol reforms in the Northern Territory. 'It's transformed the emergency department as a much more pleasant place to work and I think it's a much more pleasant place for other patients to be', Dr Gourley said of a reduction in alcohol-related presentations at the ED.

In **September**, FACEM Dr Paul Quigley from Wellington Hospital featured in New Zealand media discussing the dangers of synthetic cannabis, following the release of figures from New Zealand's Chief Coroner. 'When they take even just their first couple of breaths, usually from a bong, they initially become paralysed and then they go into this zombie phase', said Dr Quigley in comments that were covered by Radio New Zealand, One News and the *Otago Daily Times* among others. 'For some victims, if they've got a cardiac condition, or in combination with some of their normal medications, their heart can go into a fatal rhythm.' Follow up coverage, including an interview with Dr John Bonning, featured on Newstalk ZB.

In **September**, an opinion piece by Dr Simon Judkins, asking our hospital EDs, health systems and staff 'RUOK?', was published on medical sector news website Croakey. The article sparked several weeks of public discussions, with a subsequent piece by an anonymous emergency doctor prompting further response pieces.

In **September**, ACEM's South Australia Faculty Chair, Dr Thiru Govindan, featured on FIVEaa radio in Adelaide to raise concerns about the ongoing ambulance ramping and access block issues affecting hospitals, health services and patient safety across the state. 'The current capacity of the bed pool within the hospital is not being effectively utilised and there is a significant lack of resources that has actually compounded the problem', said Dr Govindan.

In **October**, the New Zealand Emergency Department Conference, and its focus on equity and cultural safety, was covered by the New Zealand media. FACEM Dr Inia Tomas featured in a *Stuff* article discussing ethnicity-specific audits of health outcomes.

In **October**, ACEM continued to speak out on issues of access block

and ambulance ramping in South Australian hospitals. The College's response to a decision to take beds offline across Adelaide hospitals featured in *The Advertiser* and on local ABC Radio. 'Taking beds offline certainly isn't going to improve the situation, and to suggest this move is in line with best practice is simply beyond belief', Dr Simon Judkins said in response to the announcement. 'This can only result in worse outcomes for patients in South Australia.'

In **October**, ACEM received significant national media coverage for its involvement in a coalition of specialist medical colleges calling for the Medevac law to be retained to allow asylum seekers in offshore detention to access appropriate healthcare in Australia, following the release of a joint statement signed by 11 specialist medical college presidents. 'Every person should have access to necessary and appropriate medical care and, as clinicians, we have a duty to uphold this basic human right', read the statement.

In **November**, Dr Simon Judkins appeared on 3AW's Talking Health program for a wide-ranging discussion on the work of the College, and the current state of emergency medicine and EDs across Australia and New Zealand. 'One of the issues that we do deal with is that emergency departments are very much the canary in the coal mine of all the other things that seem to go wrong in the health system', said Dr Judkins.

In **November,** FACEM Professor Diana Egerton-Warburton featured in the media as part of coverage of a Music Festival Industry Forum, involving representatives of Victoria Police, medical professionals and the Australian Festival Association. 'We see a lot of harm coming out of music festivals and as the deputy (police) commissioner said it really is because of a combination of environmental factors, drugs and alcohol', Professor Egerton-Warburton told media at the event.

In **November**, ACEM featured extensively in coverage of the significant issues facing Tasmania's healthcare and hospital systems, after releasing new data demonstrating the Hobart and Launceston hospitals were experiencing the worst access block in Australia. The report was released in the lead up to a meeting with the state's Health Minister and was covered extensively across print, radio and television. 'The rest of Australia has the same problems as Tasmania, but they have been able to manage it, not with more beds necessarily', ACEM Tasmania Faculty Chair Dr Marielle Ruigrok told WIN News. 'They have different processes in place to manage that flow better.' The College welcomed a commitment to find solutions to the issues following the meeting with the Health Minister, but vowed to continue advocating for improvements.

In **November**, ACEM issued a media release announcing the commencement of Dr John Bonning's term as College President, and noting Dr Simon Judkins had assumed the role of Immediate Past President at the conclusion of ACEM's Annual General Meeting in Tasmania. The news was noted in Tasmanian media, and received follow up interest from New Zealand media.

In **November**, the College's Annual Scientific Meeting (ASM), held in Hobart, was the subject of significant media interest. Proceedings were covered extensively on medical sector news website Croakey, and generated local and national interest, with emergency consultant Associate Professor David Caldicott and Dr Simon Judkins appearing on local ABC Radio. A climate march organised by delegates on the final morning of the ASM, as well the College's declaration that climate change represents a medical emergency, received national media coverage, with President Dr John Bonning featuring on ABC Radio's PM program. Croakey's comprehensive coverage of the ASM included: an event preview; the call for climate action from 16-year-old Tasmanian high school student Caitlin Ross during the opening plenary; Dr Bob Brown's ACEM Foundation Lecture; the climate action march and subsequent climate emergency declaration by the College; the first-hand account from the frontline of climate change from Dr Aloima Taufilo Teatu, who originally hails from Tuvalu; the screening of the *Against Our Oath* documentary, which investigates the ethical issues confronting doctors and other health professionals in caring for asylum seekers when governments are involved in clinical decision making; and reflections and lessons from the Christchurch shootings from Dr Dominic Fleischer, who was on duty in the Christchurch Hospital on the day of the attacks.

In **November**, ACEM issued a media statement in response to new figures indicating acts of aggression against Queensland Health staff, particularly in the southeast of the state, had increased. 'Emergency departments need to be resourced and supported so that they can respond properly to complex community health needs in an appropriate way, while also ensuring staff, patients and visitors are safe', said Dr Kim Hansen.

In **November** and **December** ACEM's focus on mental health services continued, with the College issuing separate media statements in response to the draft Productivity Commission report in to mental health, and the interim report of the Royal Commission into Mental Health Services in Victoria. In both, the College highlighted the need to relieve pressure on EDs and to ensure patients suffering from mental health issues are appropriately cared for.

In **November** FACEM Dr Shima Ghedia featured in an article in the *Sydney Morning Herald* and *The Age* discussing the decision to pursue emergency medicine as a career. 'What I like about my job, besides the fact that I am able to help people in crisis, is that it's a bit like being a detective', Dr Ghedia said. 'You have to gather all the clues by asking questions and doing tests in order to make a diagnosis.'

# PRESIDENT'S WELCOME

## Dr John Bonning

*Kia ora katoa. This is my first issue of* Your ED *since commencing as College President in November, and I want to say how pleased I am to be involved with the publication.*

Before I elaborate though, I want to convey what an honour it is to have been elected by my peers as the first President of this College from Aotearoa New Zealand. I am relishing the opportunity to promote, represent and advocate for our bi-national College, and all of our members on both sides of the Tasman. I want also to pay tribute to those who have gone before me; particularly my predecessor Dr Simon Judkins, who has now assumed the role of College Immediate Past President.

Simon's tireless work and advocacy would be well known to you all, and he has certainly left big shoes to fill. Simon has connected with everyone, from those of us at the coalface in EDs through to state, federal and national politicians and ministers. He has also been a tremendous champion of promoting, celebrating and telling our stories, through outlets such as this magazine. I will do my utmost to build on his legacy, and the legacies of all of my predecessors.

I would also like to acknowledge what a rare and humbling privilege it was to have the Māori King's representative, Waikato Tainui Kaumātua Mr Taki Turner and his wife Kuia Mrs Ratau Turner, representing Waikato Tainui iwi (tribe) and the Waikato District Health Board, present in Hobart to lead the President's handover ceremony, as part of the College's Annual General Meeting.

Waikato being the region of Aotearoa in which I live and work, I was immensely grateful for their presence and their tikanga (protocol) support. It was an amazing experience to be enveloped in the traditional Māori feather cloak, the korowai, symbolising aroha (love) and protection.

Commencing as President in November in the midst of this year's Annual Scientific Meeting in Hobart was inspiring and a big congratulations must go to the Convenor, Associate Professor Geoff Couser, and the entire Organising Committee for such a successful conference. Delegates were challenged, entertained, engrossed and treated to the very best our specialty has to offer, as we considered the conference theme *The Changing Climate of Emergency Medicine*.

Powerful scientific sessions; reflections on equity – gender, privilege and bias; cutting edge research; sustainability of our people, profession and planet; Choosing Wisely; reflections on climate change and mental and planetary health; moving accounts from those who have experienced harrowing mass casualty events and terrorist attacks were just some of the of the complex, diverse, controversial, and not so controversial topics covered.

It was also incredibly invigorating to participate in a march of emergency doctors from the Royal Hobart Hospital through the middle of the city, to call for action on climate change. This impressive statement preceded the declaration from the College later that day that climate change, and its associated impacts on public health and hospital emergency departments, represents a medical emergency.

This intersection of advocacy, expertise, evidence and the science, provided real insight into the influence we, as a College, as a profession, as doctors, can have.

A key part of that is telling our stories; the stories of emergency doctors at the frontlines, the work we do and the things we care about. That's why publications like this are important; so we can continue sharing those stories, to educate, enlighten and advocate.

On that note, I hope you enjoy this third issue of *Your ED*, as much as I have enjoyed previous issues.

Until next time…

# CEO's Welcome

**Dr Peter White**

Well, here we are again in December. Another year coming to an end and many people seemingly having thoughts along the lines of, 'Where did the time go? The last time I looked it was only . . .'. In a sense, the College has a cycle marked by events that repeat across the year and serve to remind you of many things, depending on the event in question. The most recent event, of course, in the College calendar, was the Annual Scientific Meeting (ASM) held in Hobart in late November. From the perspective of those involved in the planning, I do hope there was a sense of satisfaction at the end of the meeting. This applies to all College members and trainees involved in the formal planning through to the Organising Committee, led by Associate Professor Geoff Couser, as well as the College staff, led by Rebecca Thompson, and our Professional Conference Organiser, Encanta. While there are always lessons to be learned from events of such complexity for taking to the next iteration, all involved are to be congratulated on what was reportedly a very successful event with a terrific attendance, a varied program and well-attended and enjoyed social events.

I wrote in the previous issue of *Your ED* about the contributions of the now Immediate Past President, Dr Simon Judkins to the College and it was pleasing to see the appreciation of those attending the ASM for Simon's contributions. It was particularly pleasing that Simon's family were able to be present in Hobart to share in this appreciation and gain an insight into the respect and admiration that the College membership and staff have for Simon, and I look forward to continuing the work commenced with him in relation to emergency medicine workforce and leadership over the next 12 months.

The 'new' College President, Dr John Bonning, has already chaired his first meeting of the ACEM Board in that role and it is heartening to see how smoothly the momentum developed over the past few years is able to continue following the transition that, on this occasion, will be remembered by many due to the ceremonial aspects that occurred at the College Annual General Meeting (AGM), which was held following the College Ceremony and prior to the official opening of the ASM. As I have said previously, the College is in good hands going forward as we continue the work committed to in our current *Business Plan* and underpinned by the *Strategic Plan 2019 – 2021; The Next Phase*.

On the day of writing this welcome, the College received its response from the Australian Medical Council (AMC) in regard to its 2019 Progress Report that was submitted in August. In summary, the College has met all Conditions required to this time; the seven (7) due for completion by 2018 and the eight (8) due for completion by 2019. It is noted that the AMC has assessed three (3) of the nine (9) Conditions required to be completed by the 2020 Progress Report as being 'Satisfied and Closed', as well as three (3) of the ten (10) Conditions required to be completed by the review due in 2021. Thus, of the original 34 Conditions, there are now 13 remaining, with six (6) due for completion by the 2020 Progress Report.

So, now attention turns to ensuring the requirements necessary for the Conditions due for completion in 2020 are able to be completed and the Conditions judged to be 'Satisfied and Closed' by the AMC when the next Progress Report is submitted in August 2020. The work required for this does not, of course, start now, but has already been commenced. What the need to meet conditions does is focus attention, it is not the prerequisite for initiating attention. Again, the cycle commences and again the partnership between College members and staff will be relied upon to continue to progress ACEM as a robust organisation that is relevant and which meets contemporary expectations.

Again, I hope you enjoy this issue of *Your Ed*. I look forward to working with you in 2020 and take this opportunity to wish you a safe and happy Festive Season.

# Workforce Planning – Reshaping the EM Workforce for the Future

The past two decades have seen significant growth in the number of emergency physicians (FACEMs) in Australia and New Zealand. The specialty now faces the serious issue of workforce oversupply, with a maldistribution of workforce across rural and regional areas. While this scenario is supported by data collated through projections from the Australian Government Department of Health, the general understanding is that the situation is replicated in Aotearoa New Zealand.

The expansion of the EM specialist workforce is due to the coupling of specialty training needs with the necessity for a dedicated and skilled workforce. This has led to a large number of trainees enrolled in the FACEM Training Program. There has been a 93 per cent increase in the number of FACEMs between 2011 and 2018.[1] The College recognises the significance of these challenges to the specialty and to the community more broadly. While there are regions in both Australia and New Zealand with shortages of emergency physicians, largely in rural and regional areas, there are also many EDs still falling well short of ACEM staffing recommendations outlined in G23 *Guidelines on constructing and retaining a senior emergency medicine workforce*. There are significant concerns that the system cannot absorb the number of trainees coming through the specialist training pipeline.

*'We need to embrace and find roles for ACEM Diplomates and Certificants across our EDs and look at the significant roles for other craft groups.'*

*'While I don't want to pre-empt any outcomes, I think we will see more FACEMs in more EDs for more of the time.'*

ACEM has had a significant role over the last decade in setting and advocating for workforce staffing standards across Australian and New Zealand EDs. The College acknowledges that the time has now come for a more direct and substantial role in determining what the future emergency medicine workforce will look like. The ACEM Board approved establishment of the Workforce Planning Committee[2] in August. The Committee reports directly to the ACEM Board, and is chaired by Immediate Past President, Dr Simon Judkins. Its role will be to oversee the College's existing workforce-related policies and, importantly, deliver long-term solutions to address significant workforce issues.

Development of solutions will require confronting the unique challenges the EM specialty faces – the interaction between the FACEM Training Program, with jurisdictional workforce needs and a resource constrained health system. While aspects of developing solutions may be uncomfortable, the College recognises that it must take the lead and clearly define the distinction between the needs of trainees with the needs of the broader workforce, and develop solutions and models that contribute to both.

This work will require vision and, importantly, conversation and collaboration with the membership and trainees about what EDs need to look like in the future. The College will work with other specialist groups and jurisdictions, particularly in matters relating to rural emergency care, to ensure that all communities have access to senior clinical decision-makers, and receive the right care, at the right time, in the right place.

Dr Judkins is clear in his assessment of the College's role – 'This will be tricky. We don't need just one plan; we need quite a few for different regions, but this work needs clear leadership. This is where the College needs to step in'.

The Workforce Planning Committee comprises representation from key College entities, including the Specialist Training and Assessment Committee, Standards and Endorsement Committee, and Rural, Regional and Remote Committee, and commenced its work in December 2019.

In speaking to the work ahead Dr Judkins has said, 'The Committee and I look forward to getting out and talking to people, testing out some ideas, and working together to ensure our profession is sustainable, leads from the front when planning the emergency care needs of Australasian communities, and delivers the best care possible'.

***Author: Fatima Mehmedbegovic**, Strategic Priorities Implementation Manager*

References and notes

1. Australasian College for Emergency Medicine. (2019). FACEM and Trainee Demographic and Workforce 2018 Report. ACEM Report: Melbourne.
2. In 2017, the Trainee Selection and Workforce Planning Reference Group was established to advise the Board on policy matters relating to FACEM trainee selection and workforce planning. This group has now been revised to primarily focus on workforce planning matters.

# Finance Update

*Changes to accounting standards*

In 2019 the College adopted the Australian Accounting Standard Board (AASB) new income recognition requirements for non-profit entities. The AASB is an agency of the Australian Government under the *Australian Securities and Investment Commission Act 2001*. The agency develops and maintains financial reporting standards that are equivalent to International Financial Reporting Standards (IFRSs) for all profit and non-profit Australian entities.

Accounting Standards AASB 15 Revenue from Contracts with Customers and AASB 1058 Income of Not-for-Profit Entities ensures that international and Australian financial reporting guidelines are interchangeable, and revenue is recognised in a consistent manner across both standards.

This article highlights some of the implementation issues that were faced by the College and the direct impact the new standards have had on ACEM's Balance Sheet and 2019 Profit and Loss Statement.

### What has changed?

Under AASB 15 and AASB 1058, the timing of income recognition for certain College fees will depend on whether a transaction gave rise to a performance obligation, liability or contribution by the College's trainees and members. In short, the new accounting standards require an assessment of the College's performance obligations to its trainees and members. The core principle of the new accounting standards is to recognise revenue when the College satisfies a performance obligation by transferring a promised good or service to College trainees and members.

### Which fees are impacted?

As you will be aware, when submitting their application for FACEM training, prospective trainees pay an Entrance Registration Fee and, if successful, pay an Annual Training Fee. The Entrance Registration Fee is paid once, while the Annual Training Fee is paid for each year of training. Likewise, prospective Fellows pay a Fellowship Application Fee and, thereafter, an Annual Subscription Fee. The Fellowship Application Fee is paid once while the Annual Subscription Fee is paid annually for the life of membership. The changes to accounting standards affect the Entrance Registration Fee and Fellowship Application Fee only. There is no impact on Annual FACEM Training or Annual Subscription Fees.

### What does this mean in simple terms?

Before 2019, the College was able to recognise FACEM Trainee Entrance Registration and Fellowship Application Fees in the year the fees were charged. Under the new accounting standards, Trainee Entrance Registration Fees and Fellowship Application Fees (noting the standards do not change Annual FACEM Training or Annual Fellowship Subscription Fees) are to be recognised across the life of FACEM training and Fellowship respectively. In order to meet the new standards, the College was required to estimate the average period of training and the average period of active membership of Fellows. The average length of training was estimated at seven years, while the average length of Fellowship was estimated at 25 years. This means, going forward, FACEM Trainee Entrance Registration Fees are to be recognised over a seven-year period while Fellowship Application Fees are to be recognised over a 25-year period.

To illustrate the example if, in 2019, the College received $10,000 in Fellowship Application Fees, it was previously able to recognise the full $10,000 in the 2019 accounting period. Under the new standards, the College is required to apportion the $10,000 over 25 years and only recognise $400 ($10,000/25 years) in the 2019 accounting period.

The principle of AASB 15 and AASB 1058 is that income recognised as goods or services (performance obligations) are transferred to the customer. As trainees and Fellows receive the benefit over the entire period of training and membership for the initial Entrance (trainees) and Application (Fellows), the income is recognised over the period the benefit is provided. As indicated above, this period is seven years for trainees and 25 years for Fellows.

### How does this impact the College finances?

There are two major impacts on the College's finances. Firstly, income received in 2019 is now apportioned over the life of training and membership. This resulted in less than expected revenue recognition in the 2019 accounting period.

Secondly, the College was required to apply the new accounting standards retrospectively. That is, the College was required to implement the change as though it had always existed. As a result, the College had to adjust all previous amounts presented in prior financial statements for each prior period presented. For Trainee Entrance Registration

Fees, the College not only adjusted the amount received in 2019, but for all previous six accounting periods. For Fellowship Application Fees, the College was required to adjust not only the amount received in 2019, but for all previous 24 accounting periods.

Changes to income recognition for the 2019 accounting period is reflected in lower income received in the 2019 Profit and Loss Statement. Retrospective changes for previous periods are reflected in lower Total Equity, as a proportion of previous income must now be assessed as income in advance, thus increasing the College's liabilities. This is reflected in the College's Balance Sheet.

It is important to note that the changes have impacted the College's Profit and Loss Statement and Balance Sheet only. There was no change in the College's Cash Flow Statement, as the income was still received but not yet recognised.

**Does this mean the College was doing something wrong?**

No. Prior to 2019, the College was abiding by existing standards. The new requirements result in a different method for matching of income and related expenses as income recognition will now be deferred due to the College's ongoing performance obligation in relation to trainees and Fellows initial fees.

***Author: George Kadmos**, Executive Director, Corporate Services*

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**More information**

Please visit the below link to read the ACEM Financial Report https://acem.org.au/Content-Sources/About/Publications


# A Day in the Life of a Major Trauma Centre

*The Royal Melbourne Hospital (RMH), located in Parkville on the cusp of Melbourne's CBD, is one of Australia's leading public hospitals.*

**Dr Mark Putland**

RMH is one of the busiest emergency departments in one of the busiest hospitals in Australia. Director of ED Dr Putland spoke to us about a day in the RMH ED.

The ED is truly the front door of the RMH. We've seen over 80,000 patients in the last 12 months and will see 85,000 over the coming 12. We receive up to 100 ambulances and two helicopters most days. There are two trauma and six resus cubicles, 24 other cubicles, eight fast track/ambulatory spaces, a 20-bed short stay unit and a six-bed behavioural assessment unit. We have our own satellite radiology department with two plain X-ray rooms, an OPG, a CT scanner (it is one of the busiest scanners in the country and rarely stops spinning) and five point-of-care ultrasound machines. We have a consultant and registrar-dominated medical workforce with a very much hands-on approach from our senior staff, and a really strong team of nursing, allied health and mental health staff including one of the biggest cohorts of post-graduate trained nurses around.

We are finally building a nurse practitioner model of care, which is the one place we have probably lagged behind until now and are really hoping to see them fully operational early next year.

As well as our Major Trauma Service role, we are the state obstetric trauma service, one of two Emergency Clot Retrieval centres for Victoria and our hospital runs the Victorian Infectious Diseases Service. We are the receiving hospital for Ebola and other highly virulent pathogens. We are part of the Parkville biomedical precinct with the Peter Mac Cancer Centre (PMCC), the Royal Womens Hospital (RWH) and Royal Children's Hospital and the various research institutes associated with Melbourne University, which means we have significant responsibilities to the precinct as well as our state service and local ED responsibilities. Our local community has some very complex needs. We're in a 'growth corridor' that has a big mental healthcare demand and ED has been providing a lot of buffer capacity for that for a while. Our local population is really diverse with hundreds of languages spoken, a large inner city homeless and transient population, a lot of overseas students, and everybody who works in the inner city. This place just has to work - there is too much that depends on it.

We are building a mental health /alcohol and other drug crisis hub at the moment, which will add six PECC beds to the current six BAU beds and will represent the biggest change to our way of providing ED care since the institution of the trauma system. We are building a master's degree in emergency mental health nursing for post-graduate certificate qualified ED nurses and a fellowship position in emergency psychiatry and observation medicine for ACEM trainees. We hope to take advantage of this opportunity to make emergency physicians and emergency nurses as proud

of their care of psychiatric disease and of complications of addiction as they are of their care of trauma, sepsis and cardiovascular catastrophes.

The ED has spent this year spearheading the implementation of the Epic EMR system, with the rest of the hospital, as well as RWH and PMCC all due to switch it on in May 2020. This has been a huge body of work for everyone in the ED and we are very proud of what we have achieved with it.

What's it like being director of an ED? It's like being Dumbledore but without the beard, magic, wisdom or answers.

My clinical shifts? Like everyone's I suppose, they tend to be pretty frantic. Check who has called in sick? Can we replace them? What's the team look like? Reshuffle things. seventeen waiting to be seen - must have been an ugly night. Then meet my intern and registrar for the morning. Send the intern to see the elderly patient with breathlessness and go see the failed renal transplant patient with fever, sent from nocturnal dialysis, see the intern's patient. The registrar has one who belongs to another hospital but she's struggling to get hold of people to talk to there - help out with that, intern has gone to see another, good on her. 'Bat Phone', ped struck by car, seizing, two minutes away... and so it goes on.

The ED itself is a labyrinth with very few sight lines, so a lot can be going on without people actually knowing about it. I get a big step count up on my clinical shifts.

The most difficult part of my shift that day? Another young woman murdered by her partner today. It gets you down. It gets everyone down. It's rotten and sometimes it is hard to bear.

The best part of my day today? Late in the day I supervised the intern to do an LP for a possible meningitis. I gave the phone to the registrar. It was quiet and peaceful in the infectious isolation room, the intern nailed the LP on her first attempt and learned some new tricks and was thrilled. The patient was grateful, the CSF was clear. They even got to Short Stay in four hours to await the result. The simple act of taking care of a patient, or helping a junior member of staff to take a step along their career path, is still the most rewarding part of my day, even now.

### Dr Sarah Whitelaw

Dr Whitelaw is an emergency medicine consultant working part time at RMH. Her shifts vary with day shifts starting at 8:00am and evening shifts that start at 3:30pm.

Sometimes, as she drives towards the hospital, the whir of a helicopter overhead makes her pulse race. When parking her car, if she spies one landing on the hospital helipad her pace quickens, knowing it could be a patient coming to her ED.

The 'Bat Phone' ringing lets her know that the ambulance clinician is calling to tell them of a major trauma. She can hear it all the way down the halls and there's a spike of adrenaline every time.

There's no adjustment time when you walk into the ED. Sarah takes the opportunity to check who's working and meet the team. A registrar or two and sometimes a resident have a huddle, discuss who's who and what's what, and then it's straight in. The first patient is there and there's no time to ease in to your day.

Sarah describes the ED at RMH as, 'an incredibly civilised department'. They are lucky enough to have no corridor patients and very few patients sitting on chairs. 'It's so divided as it can feel so organised and quiet, but so much is happening behind the scenes', Sarah describes. 'It's a bit of a rabbit warren in there, even nine years later I occasionally find myself taking a wrong turn, it's one of its great quirks.'

'RMH is a very well established hospital', Sarah says. Things are done the Royal Melbourne way, for those who have only ever worked there, it's the norm, but for someone new it takes time to adjust. 'Learning by doing', Sarah says. 'There are super specialists here, normally for atypical seizures you'd consult neurology, here they have specialists for different types of epilepsy. It's pretty incredible, and it means there is the ability to deliver international best practice standard of care.'

Coming from Queensland, Sarah says it can take time as a newbie to understand the Royal Melbourne way and the Victorian way (i.e. complex coffee preferences, dressing in black, frequent weather and 'liveability' discussions etc.). 'The Royal Melbourne can be a very 'serious' place, but it's generally because they take their role as a state trauma, neurology and infectious diseases clinical practice and research centre very seriously, and this is reflected in their emphasis on best practice patient care.'

Sarah remembers a time when a patient presented with a very unusual periorbital tumour during a night shift at 2:30am. Both an endocrinologist and an ophthalmologist attended the ED for her patient, they were both willing and interested to assist. 'We are so lucky to be able to access their expertise 24/7', Sarah says. 'That and our anaesthetics and trauma service back-up are luxuries that I don't take for granted.'

'There is so much research going on', she says. 'We often have the opportunity to hear about results and incorporate them into patient care well before it becomes part of an international guideline.'

'By far, the most difficult part of my job are system errors, they defeat us all', Sarah says. She talks often about this with medical students, trying to emphasise the impact this has on patient care. It's not the patients or their families or the clinical care she finds difficult, but navigating the healthcare system, IT and communication issues. 'You sometimes feel as though you are being thwarted by the system in your efforts to give the best possible care', Sarah says. She describes mental health patients as particularly difficult to assist due to system failures and the 'missing middle'.

The non-clinical aspects of the job are also so important, Sarah highlights, reflecting on a recent patient who homed in on this for her. An elderly man from rural Victoria was brought in following a severe car accident. His injuries were acute and as he left for the operating room, Sarah notified his family. 'It's so difficult to tell someone that their able-bodied independent relative has lost all of that that and so suddenly', Sarah reflects. 'It is one of the hardest parts of the job.' This task was particularly difficult, with multiple contact numbers and relatives based in different locations. They arrived at different times, all needing to hear the same story face-to-face.

This patient ultimately died, but weeks and months later Sarah received cards from the family, thanking her for the care she had given.

'It wasn't thanking me for the resuscitation or the clinical care, it was thanking me for telling them tragic news about their father. It really surprised me and was a good reminder of the importance of that aspect of the job.'

During resuscitations, when Sarah was a junior doctor, her pulse rate used to speed up and everything went into overdrive. Now further into her career, it feels as though time actually slows down in these situations and distractions fade away. 'The real heart-sinking moments now come when you walk into shift, there's a handover of 30 patients, no beds, 10 ambulances on the way and a helicopter about to land and you're in charge. However, I know that we're lucky here at RMH, for many places this scenario is much more extreme.'

Occasionally there will be a patient who makes your heart sink, someone you want to do more for, or someone whose clinical work will stay in your mind for a while. A woman came exsanguinating from an av fistula after an outpatient angiogram the day before. 'We had a nurse sitting on her leg to compress the femoral artery as a tourniquet wasn't possible, and we needed a vascular surgeon to take her to theatre', Sarah says. 'It is difficult to have the sensation that, this is someone we should be able to fix and we're coming very close to that not happening.' It is the back-up and support at RMH that is generally so accessible that Sarah says you can largely go home knowing the patient was given the best chance.

The case mix at RMH, like many EDs, can be fascinating. A woman recently came through the ambulatory care pathway of RMH, ideally designed to deal with quick simple issues – sprained ankles, small cuts etc. English was her third language, and she was complaining of an unsettled stomach and feeling nauseous after eating weetbix. 'We put her in our short stay unit, as it initially seemed likely she would be able to go home', Sarah says. 'Her diagnosis ended up being spinal tuberculosis. You just never know what is going to come through which door.'

The most rewarding part of her job? Being able to tell her children what she does for a living. 'I can say to them, we try to make people better', she says. 'We get the opportunity to make people better and to make things better for them – to treat their illnesses and injuries but also their pain and distress, and sometimes to get them better before our very eyes.' She describes her work as enormously rewarding being able to do this for people over and over again.

'I've been lucky not to have to go through the mid-life career crisis that many of my non-medical friends have. I learn something almost every shift, time passes so quickly at work and people are endlessly fascinating in the way that they behave. I feel that our constant glimpses into the fickle nature of life are a privilege that can't help influencing how we live our own lives to some extent.'

The most difficult part? 'Burnout is real', Sarah says. The schism between what you think is your job in terms of delivering quality efficient and cost-effective medical care, as well as education and training, the differing pressures and perceptions of what that means to other people in the hospital and healthcare system, can be extremely dispiriting. 'From the minute you walk in the door to the minute you leave, the work is absorbing, constant, challenging, and exhausting. Shift work is the added X factor. That exhaustion takes away from everything else you want to be doing with life, and from your interactions with family and friends', Sarah says. Her tip for dealing with it all, is to try and make a difference, even if it's small, 'I try and walk home when I can, and I often tend not to take my clinical work home with me, but I do find myself answering more and more emails and doing more and more non-clinical work at home, which is not good for preventing burnout. The expectation on all of our departments to do 'more' with less time and money is ever increasing.'

To deal with the biggest frustrations within her work, Sarah says; 'It's important for me to try to fix the system issues that bother me. I have benefited enormously from mentors, who have shown me what's possible in terms of using an emergency medicine background for effecting enormous change and benefiting so many people beyond our direct patient care, as well as being involved in the Australian Medical Association (AMA) and the College and in advocacy on policy and medico-political issues. I have realised that no one is necessarily more responsible, more qualified or more able to fix the system issues that bother us than ourselves as emergency physicians. If you have the time – and that's the kicker – to be involved at multiple levels to directly tackle the bigger problems that we see every day – I highly recommend the benefit of feeling proactive in a situation you may otherwise feel helpless and so frustrated in'.

### Dr Jasmine Poonian

Dr Poonian is an emergency registrar at RMH. She describes her work as entailing patient care, leadership and working as part of a multi-disciplinary team.

Jasmine started her day shift at 8:00am, checked her allocated role within the department and met with her team.

Below is a summary of her first patient of the day.

A 98-year-old lady was admitted to the ED. She suffered from dementia and was non-English speaking. There was no contactable family. 'The patient presented overnight via AV with a suspected fall', Jasmine says. 'We were unable to elicit history from the patient, but there was no obvious evidence of external trauma. The ECG indicated pacemaker failure to pace, evidenced by a prolonged sinus pause.'

As the day progressed, it was this first patient that remained in her mind. 'It can be difficult to manage your own frustrations', Jasmine says. 'Being unable to communicate with my first patient to elicit their symptoms was challenging. Additionally, being unable to contact next of kin, despite extensive efforts, can significantly impact my decision-making process for patient care.'

RMH has a behavioural assessment unit (BAU), which enables the ED team to effectively manage patients presenting with the acute sequalae of alcohol, drug and mental crises. 'As this unit is part of the emergency department, we have been able to continue to provide high acuity treatments to such patients should the need arise, even ECPR', Jasmine says.

This unit will soon to be expanded into the Crisis Hub, which will enable all to work more closely with mental health colleagues. 'This will assist with the management of patients who present with mental health concerns.'

The sheer size of RMH means that the majority of the time you are working in larger teams with multifaceted specialists and teams coming in. 'Watching the ED, trauma, ICU, obstetric and neonatal teams work together through a resuscitative hysterotomy was the highlight of my shift'. Jasmine says. 'It shows the real value of the exceptional teamwork that we work so hard to achieve.'

The most heart racing moment of her shift that day? 'Seeing the neonatal team caring for the approximately 26/40 neonate, post resuscitative hysterotomy,' she says.

'Whilst my colleagues were managing the neonate and obstetric trauma patients, I received a pre-notification phone call advising we were about to receive two patients who had allegedly been stabbed,' Jasmine says. On informing the in-charge consultant, it was agreed that one patient would come to RMH and one would be taken to The Alfred. The in-charge consultant asked if Jasmine would like to take the case and team lead, to which she agreed.

'On pre-notification we were advised that the patient had arrested, but regained ROSC and they were 15 minutes away', Jasmine says. 'In this time the team receiving the patient were assimilated, some of whom had been/were still involved in the resuscitative hysterotomy case.'

The team was briefed in preparation, roles allocated, and the patient arrived. 'On arrival the patient was in cardiac arrest with the LUCAS device in situ, once this was removed the team worked together to resuscitate the patient', Jasmine says. 'From the end of the bed I watched nursing and medical staff work together to restore circulating blood volume, decompress the chest and perform a lateral thoracotomy with repair of ventricular lacerations and internal defibrillation.'

'I was given a great training opportunity to lead the team for the second trauma call, with consultant support as required. I felt proud to be part of such a high functioning, adaptable team.'

This teamwork comes with its own challenges. Working within a large team in a big department can result in communication difficulties, which can lead to frustrations. Communication is key between colleagues and departments, which can be difficult when a department is so physically spaced out.

When walking out of RMH at the end of her shift at 5:30pm Jasmine was exhausted but said 'I felt extremely honoured to be part of such an exceptional team'.

### Dr Amaali Lokuge

Dr Lokuge spoke to us about a day in the emergency department at RMH. This is her first-hand account.

I'm early for my shift so I brake as the light changes to amber instead of racing through. It gives me time to watch the enormous Australian flag at the roundabout unfurl and undulate in the breeze; drawing me in and pushing me away, pride swells and releases. A siren sounds in the distance on Royal Parade. The clock on the dash still shows 20 minutes until I have to start. A signal one will be sorted by then. Theatre or death. A life hangs in the balance.

I glance to the left as I walk towards the admin area. The curtains hang open on Trauma 2 like an abandoned stage. Debris and blood, bits of cut-off clothing, a motor bike helmet tell the story of the trauma that has just been. The cleaner slowly drags the mop and bucket into the centre of the bay. Maybe the resuscitation hadn't gone so well. I quicken my pace as I pass the worried family congregated at the relatives' room.

As I take the handovers, the young registrar is ebullient. He delivered the motorcyclist alive to theatre despite 20 units of blood and products, bilateral chest tubes and a near arrest in emergency. His eyes sparkle as he describes the resuscitation. It's not far from the sparkle of tears glistening in the young girl's eyes as she leans against the wall, waiting for news.

The department seems to exhale after holding its breath for too long. The nurses bustle and laugh, another shift has begun with a bang, four ambulances arrive at once and two of them will need a resus bay. It's still early and nerves haven't yet started to fray. We begin the game of emergency with a smile.

I like the in-charge shift; it's one of the few times I can cherry pick the patients.

A young girl, suicidal, considering jumping from a building. She's been here before. I book her for BAU before I even see her.

She's small and pale with a pixie haircut, a nose ring and torn black jeans. The room stills around us as I close the door. Defiant and aggressive, she sits on the bed, arms folded, jaw thrust forward, challenging me to alleviate her pain. I wouldn't usually try, but something makes me delve deeper, struggling to comprehend. I parry her hopelessness with words my mum would say when I was sad. The enormity of her isolation makes me want to cry. That wouldn't help either of us. I think twice about mentioning the quote about 'if it is not a happy ending it is not yet the end'. But I say it anyway. She snorts and looks away. I seem to have lost her, so I turn to the computer and order a valium. I wish I could take it back.

An orderly comes to escort the patient to BAU. I'm released.

The charge nurse asks me to come to Trauma 1, they're having issues with a patient. It must be the prisoner who had slashed his throat with a box cutter. His doctors have been called away to another trauma. The prisoner is stable. I can see his intact larynx move up and down as he yells at the surgeon to leave him alone. His neck is strangely bloodless, as if the wound edges had been cauterized. The trauma surgeon walks towards me shaking his head in frustration. The patient is competent, he only cut his throat to be taken out of prison. The junior trauma doctors throw up their hands. I don't have time to have a multidisciplinary team discussion about patient competence.

The charge nurse calls again to say that we're getting an intubated overdose and an Acute Pulmonary Oedema. Clearing Trauma 1 becomes even more vital.

The patient is cheerful enough when I introduce myself. I smile a lot and I think I have good rapport. The answer is still no. No surgery today, no to moving, no to assistance. I almost turn away. Is there really anymore I can do right now? But then I give it one more shot. I put on my most 'ocker' Aussie accent. Why? Do I think they'll believe me more if I sound like I was born here?

'Look mate', I say, sounding more confident than I feel. 'I'll film your neck on my phone as you talk and you can watch your own voice box moving up and down, how about that?'

'Holy shit!' He exclaims, watching the video. I doubt whether he is competent after all. The trauma surgeon slides the consent form across the bed. We get the patient to theatre in ten minutes.

The room is cleaned, the bed is made, the IV set up and the drugs drawn. Another consultant comes in with his registrar just as we hear the sirens closing in outside. We exchange nonverbal 'are you ok?' and 'yes I'm fine' looks.

I leave resus and go back to the computer to calculate the damage in my absence. There are 20 patients waiting to be seen. It's that time in the shift when we're hungry and tired and there's still two hours until the evening doctors arrive.

The shift ends with a whimper.

As I take off my stethoscope from around my neck, I realise I haven't used it once today. I'm exhausted.

I walk past the BAU on my way to the car park. Something compels me to look in on the patient I saw earlier.

'Are you ok? Have you seen the psychiatrists?'

'Yes, they were here. Thank you.' She doesn't seem to know who I am, so I turn to leave. I wonder how I could have felt such a connection when there obviously was none.

But then the she says, almost in passing, almost to herself, 'Hey, what was that quote you said before? I liked it'.

## Dr Emma West

Dr Emma West spoke to us about a day in the emergency department at RMH. This is her first-hand account.

I am an Emergency Physician. I am also co-DEMT (Director Emergency Medicine Training) at RMH. My DEMT role entails supervision of my registrar group on the floor (I say my group as you really invest in your trainees as DEMT, i.e. you want to give them the best training and have them get the most out of their time at RMH), running weekly teaching sessions and intensive examination support. There is also a significant welfare role, which can be challenging but is also extremely rewarding. I love engaging with passionate junior doctors who want to be the best ED doctor they can be.

I have four children aged four, eight, ten and 13. I work evenings and weekends mostly as it allows me to manage the kids and work. My day starts when they are awake - from 6:00am, and then its madness until they are out the door at their various schools and kindergartens. I start my paid work at around lunchtime. I do my DEMT role for the first part of the afternoon and then head to the ED floor for clinical work until approx 1:00am (and often later). And then back to kids again at wake-up time - usually 6:00am!

My work as a clinician is a labour of love! Really, I love it! I love helping people in their time of need when they present at a vulnerable moment in their life to ED. Patients really don't want to come to ED, and I love having a role making their experience as good as it can be. I know people have fears and concern over what is wrong with them and I try to let them know I will work hard for them as I care about them and what they have presented with.

I love the comradery of the ED. Our staff work as a team and the working relationship is really something very special to me. I enjoy seeing others do a fantastic job and caring about what they do and their dedication to the sick.

I do enjoy spending time with the elderly. They have a different view on life and offer so much wisdom. Recently a 94 year old offered me a kiss in exchange for a neurological examination! He was cheeky but respectful and really made me laugh a lot! Patients like this brighten up your day.

One of the most difficult parts of my job is breaking bad news. It might be a serious and likely bad outcome for trauma (usually speaking with a family), or letting a young person know their cancer is likely to result in death in a short period of time. These conversations are emotionally charged, and I want my patients to know I care for them and will go to any lengths to support them.

This can take a toll.

Leaving work late at night I drive home and run through the patients I have seen and critique how I did as a doctor. It is a therapeutic wind down process for me. Twenty minutes later I arrive home, tiptoe into bed trying not to wake anyone and cross my fingers hoping I don't get woken up by either a need to head back to work or a kid needing a cuddle!

***Author: Inga Vennell**, Editor*

# Thunderstorm Asthma

On 21 November 2016, Melbourne experienced the most severe thunderstorm asthma event recorded anywhere in the world. A deadly mixture of grass pollens, heat and high winds combined to hit communities across the city, resulting in extremely high numbers of patients presenting to EDs with asthma symptoms. Although uncertain of the triggers, our members and trainees, with strong support from their hospital and retrieval colleagues, responded in the only way they knew how.

Three years have passed since this event. It is timely to reflect on what happened and what has been learned.

### What is a thunderstorm asthma event?

We all know what a thunderstorm is, with storms experienced in most Australian and New Zealand cities each and every summer. What differs for a thunderstorm asthma event is how the storm forms, and the impact this has on people who are at risk of breathing difficulties (for example, people who suffer from hay fever or asthma).

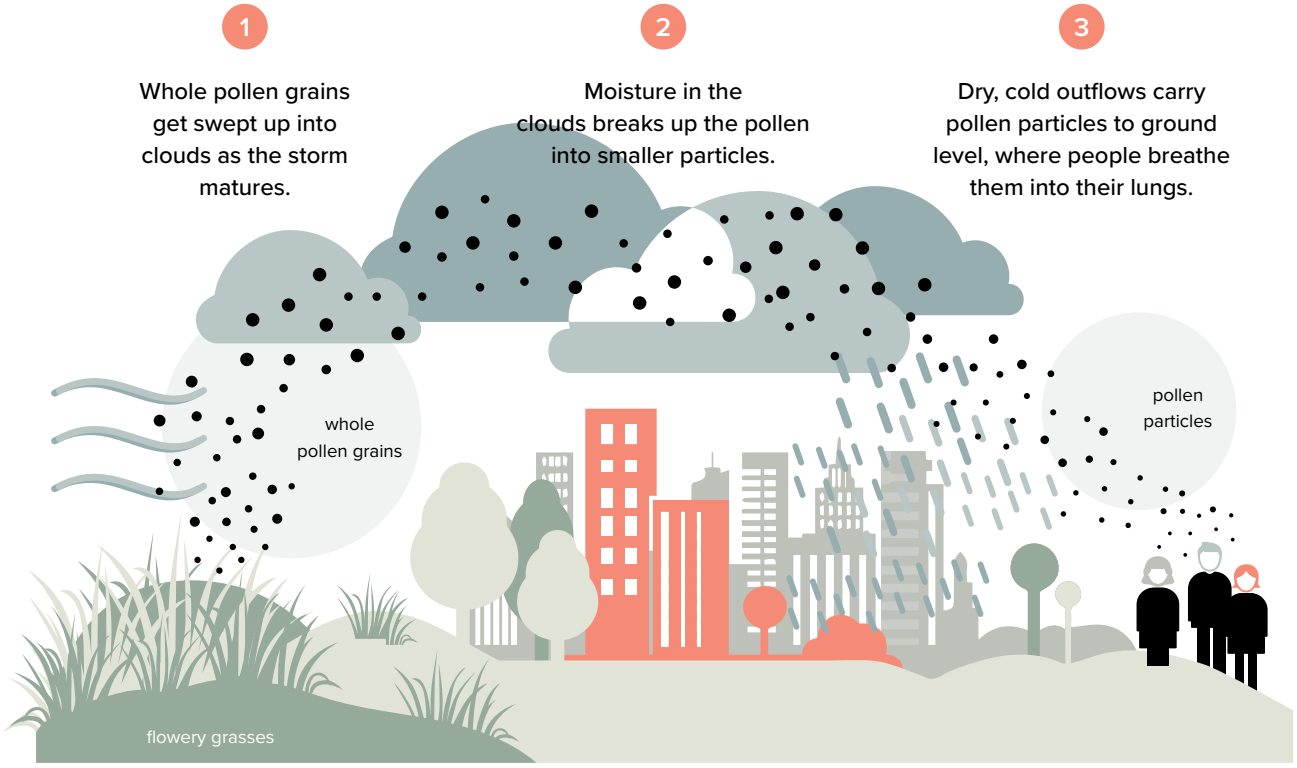
A visual description of thunderstorm asthma[1] is provided below:

### What happened on 21 November 2016

There is widespread consensus that Monday 21 November 2016 was a very hot spring day. The day was identified as a 'high' fire danger risk, as there was a strong and gusty wind, and it was highly likely that a thunderstorm would occur that afternoon or evening. At the time, there was no alert system to rank the risk of, or outline any impact from, a thunderstorm asthma event.

Leading asthma expert, Professor Jo Douglass, highlights, 'There were several unique elements contributing to this event. Firstly, 2016 had experienced good rain and in Victoria this resulted in high flowering of crops and grasses. Secondly, the days leading up to 21 November were hot, dry and associated with high pollen counts, providing a lot of "fuel" for a thunderstorm asthma event. Finally, the weather conditions on the day provided a 'perfect storm' for grass pollen particles to be swept into the thunderstorm clouds, break down into inhalable particles, sweep across heavily populated areas, and hit at a time when people were either going about their day-to-day business, or heading home for the weekend'.

## What is thunderstorm asthma?



## STATS[2]

**Thunderstorm asthma has occurred before, both in Australia and around the world:**

**Melbourne, VIC**
1984 – 85 patients and 16 admissions
1987 – 154 ED attendances and 26 admissions
1989 – 277 ED attendances and 47 admissions

**Wagga Wagga, NSW**
1997 – 215 ED attendances and 41 admissions

**Tamworth, NSW,** in 1990

**Canberra, ACT** in 2010

**Birmingham, UK,** in 1983

**Canada, Italy** and **Iran**

**2016 event – loss of life**

## 10 deaths

Thunderstorm asthma contributed to the death of 10 people

**2016 event – impact on EDs**

## 12,723 presentations

There were 12,723 presentations across 21 and 22 November 2016 to Victorian public hospitals

## 9,909 presentations

There were 9,909 presentations across 21 and 22 November 2016 to public hospital EDs in Melbourne and Geelong (3,643 [58 per cent] more than expected, based on the three-year average)

## 672% increase

This resulted in a 672 per cent increase in respiratory-related presentations to Melbourne and Geelong public hospital EDs in the 30 hours from 6:00pm on 21 November 2016 (3,365 more presentations than expected based on the three-year average)[3]

Dr Mya Cubitt was on shift at the Royal Melbourne Hospital that day and recalls what happened.

'I was only a year and a half into my first consultant position and in charge of the ED that evening. Fairly early into the shift, several calls came through from our ambulance colleagues, highlighting they were receiving an unusual number of calls from people with asthma-like symptoms. We were yet to see any patients present, but I made some calls to colleagues across the hospital as an FYI. This quickly escalated to a call for immediate help!'

'Our ED was flooded with patients, each affected by severe or life-threatening asthma symptoms. We quickly ran out of space (we have six resus bays, two trauma bays, three critical care step-down beds). It rapidly became hard to keep track of where our patients were within our ED. We set up multiple teams within teams to cope.

'One of our consultants set up chairs down the ambulatory care corridor to treat those with less severe symptoms who could manage their own care needs with some close oversight. Our inpatient colleagues responded brilliantly and got on with the job of getting patients out of the ED as soon as possible and bringing in extra supplies, including ventilators and critical care-trained staff. Although we never ended up calling a 'code brown', the hospital-wide response effectively saw the resources and supports provided to the ED as if one had been called.

'I left the ED about 5:00am after a 14-hour shift that I will never forget. Although the initial surge was over, we felt the effects of the event over that week. So many staff stepped up – it was an amazing team response and I'm proud of the care we provided to our patients.'

### Response to the thunderstorm asthma event

Following the event, the Victorian Government quickly moved to review what action was taken to learn from what went right, and what could be improved. ACEM submitted a response to the official review run by the Inspector-General for Emergency Management across the following themes:

1. A lack of rapid responsive communication for clinicians
2. A lack of escalation policies and resources
3. Under-utilised resources due to a failure to recognise the event as a state-wide emergency
4. A lack of community engagement.

Reviews undertaken by the Victorian Government confirmed the issues raised by ACEM. In essence, the systems to manage and respond to disaster events were not activated, nor applied as needed, to the thunderstorm asthma event.

### What would help frontline ED staff in a thunderstorm asthma event?

**Dr Mya Cubitt**

- The 2016 event showed a need for frontline clinicians, in the ED and across the network, to have the ability to access 'real time' information.
- With unforeseen events such as this, we need to be able to communicate in real time with colleagues across our own networks to get a better handle on what is happening, and also to scale up successful 'in the moment' innovations, flexibility and responsiveness that allow us to safely

support those parts of the emergency network that are struggling.
- Disaster planning traditionally focuses on 'command and control', but as with any pressured system, the weak links in our day-to-day frontline will become the gaping holes in a surge – it's our frontline that will see that.
- Our siloed healthcare communication systems, with fax machines and individual organisation electronic systems, are huge barriers. They are poorly integrated and offer limited collaboration with each other on any given workday, let alone when the system is under pressure.
- Even if we can't yet do it in real time, the 2016 event offered a unique opportunity for collaboration and debrief, to share our experiences, to learn from each other.
- Emergency medicine is full of people well versed in the 'get in and fix it' mentality – we're used to leading from the front. But sometimes it's important to pause, reflect, seek expert input, build community and move forward with new relationships and solutions that will support us to do our job to the best of our ability!

### Professor Jo Douglass

- I think we've seen some good progress in learning from this event, with the establishment of more sites across Victoria to forecast grass pollens as just one example.
- More should be done to ensure the literacy of the health sector is improved on thunderstorm asthma events, and asthma more generally.
  - Asthma guidelines have recently changed and this requires us all to understand the roles for treating patients, particularly when they present with low-level symptoms.
  - There is a risk of system inertia in the corporate memory of the healthcare sector, particularly if frontline workers aren't supported through educational activities and testing exercises.
  - We need to research and consider the impact of fungus spores in the severity of thunderstorm asthma. The conversation on grass pollens is absolutely warranted, but fungus spores do play a role in this space and we don't know enough about this relationship.
- It is highly likely that we will experience another thunderstorm asthma event. It is hard to predict what year that may occur, but we do know that late spring is particularly likely given how thunderstorm asthma comes to be.

### What do we have in place to better alert us to another thunderstorm asthma event?

The Victorian Government has worked with stakeholders across the health system to ensure communities and members of the public are better supported.[4] This has included:
- developing an alert system based on an expanded pollen monitoring network
- targeted research
- public health campaigns
- education programs [5]
- revised emergency response plans.

Two apps have been developed to assist the public and frontline clinicians better understand and prepare for at risk days of high pollen or thunderstorm activity:
- Melbourne Pollen Count Mobile App
- VicEmergency app, available via the VIC Emergency website.[6]

The Melbourne Pollen App and the VicEmergency app will carry thunderstorm asthma alerts when given by the Bureau of Meteorology.

### What can I do, as a clinician, to help my patients?

Desiderius Erasmus once said that 'Prevention is better than cure'[7] and this is certainly applicable to helping patients manage the risks from a future thunderstorm asthma event. Awareness of the preventative steps available to people at higher risk from asthma will help to reduce the likelihood of effects.

*The Australian Asthma Handbook* recommends:
- Prescribe regular inhaled corticosteroids for continuous use if indicated (most adults and older adolescents with asthma)
- For patients for whom preventer therapy is not otherwise indicated, prescribe regular inhaled corticosteroids for at least two weeks before and throughout the pollen season (for example, in Victoria, 1 September – 31 December)
- Provide training in correct inhaler technique, and check technique and adherence regularly
- Advise patients to carry a reliever inhaler and replace it before the expiry date
- Provide an up-to-date written asthma action plan that includes thunderstorm advice and instructs the person to increase doses of both inhaled preventer and reliever (as well as starting oral corticosteroids, if indicated) in response to flare-ups
- Check grass pollen counts for their region during spring and early summer (if available)
- On high grass pollen days, avoid exposure to outdoor air when a thunderstorm is approaching, especially during wind gusts just before the rain front hits (for example, by going indoors with windows closed and air conditioner off or on recirculation mode, or shutting car windows and recirculating air).[8]

***Author: Lee Moskwa**, Manager Faculties and Foundation*

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# Professor Diana Egerton-Warburton

Professor Diana Egerton Warburton is an emergency physician, past Chair of the ACEM Public Health Committee, current Director of Emergency Medicine Research at Monash Medical Centre and a keen community advocate.

### Why emergency medicine?

I've always been passionate about emergency medicine and one of the things I love is the equity aspect. Patients don't generally pay to attend an emergency department; so there's not a transaction between you and patient. You are there for your patients, as their advocate and as an advocate for their families and the community. Emergency medicine is like a magnet, it draws people who are passionate about public health, the public health system, equity and advocacy.

I love the depth and breath of emergency medicine, the warp and weave of it. As a speciality EM requires a broad range of skills and knowledge that are applied to an almost limitless aray of challenges that people and communities might have. It also provides an opportunity to interact with many other clinicians both within the hospital system and in the community.

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

I don't think anyone would argue that access block is the most challenging. Often I arrive at work and there's the equivalent of two wards worth of patients waiting to be admitted, which makes things really challenging.

In terms of the most enjoyable parts, it would be the patient advocacy. One of my favourite things is talking to the elderly, frail people who come in to the ED. It's one of the most stressful things they will have done, so to take them by their hand, call them by their name and help them is very rewarding.

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

I definitely think that the idea of being resilient is overrated. Like everything else, you need systems and structures in place for it to work. A golden rule is I have my family time and I don't let work encroach on that, so after 6:00pm and on weekends, I generally don't reply to emails. I think it's important to set boundaries.

Another way I have maintained wellness is by getting involved in research, advocacy and public health. I find it both very rewarding and energising.

### What do you consider your greatest achievement?

The public health research that I have done and, through that, to influence national and international policy. One of my proudest moments that I recall is being described in a media article as a 'community advocate'.

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

Giving the Tom Hamilton Oration to new graduates. Tom Hamilton was my first director at Sir Charles Gairdner Hospital, so to give to the Oration in Perth at the College ceremony with Tom present is something I was honoured to do. The title was "One From The Heart" and it was.

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

The patients; young, old, fit, frail, vulnerable, outspoken, the people that I see every day and the amazing team of clinicians I work with.

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

One of the most use useful things I did, was when I received an ACEM leadership scholarship, was do a business leadership course and read the work of the leadership guru Peter Drucker. His quote "The best way to predict your future is to create it" could be a call to ACEM trainees and Fellows to get involved in College activities.

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

The opportunity to see patients and do research.

# Dr Nicholas Lelos

Dr Nicholas Lelos is an ACEM Advanced Trainee and has trainee wellbeing and advocacy as some of his main foci. Bankstown Hospital is his base, whilst also training in Liverpool and Royal Prince Alfred hospitals.

### Why emergency medicine?

Believe it or not, I actually started as a neuroscientist before medicine. I missed the people interaction, so after medical school I applied for neurosurgery, got offered a job and turned it down for internal medicine. I fell in love with accident & emergency as a resident, working in it on and off for years. But practising EM in Australia converted me fully – the depth and range of acute medicine, with the diversity of trauma, surgery and paediatrics thrown in the mix, sprinkled liberally with procedures, resuscitation and intubations. What is there not to like?

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

The variety, the shifting intensity of effort and the lack of routine. It could be a calm day, or it could be blazing mayhem. Then you put down your tools and walk away. The troubleshooting is what I enjoy the most – I like facing challenges and needing to find solutions. And sometimes outside the box.

### What do you do to maintain wellbeing?

I think maintaining interests outside of medicine is key – sports and hobbies. I do regular yoga and enjoy swimming in the ocean as often as I can. Surviving the massive waves adds an element of increased hilarity. Friends outside of medicine are essential as well, although having to field the inevitable 'what is the worst thing you ever saw' questions once in a while is the price to pay.

### What do you consider your greatest achievement?

Teaching medical students as well as my juniors and peers, and helping foster enthusiasm in EM. Recently, a junior registrar saw me at a conference and said, 'I remember you! You are the reason I chose emergency medicine after being a medical student in your department'. That alone is worth all the nightshifts, difficult end-of-life conversations and missed breaks.

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

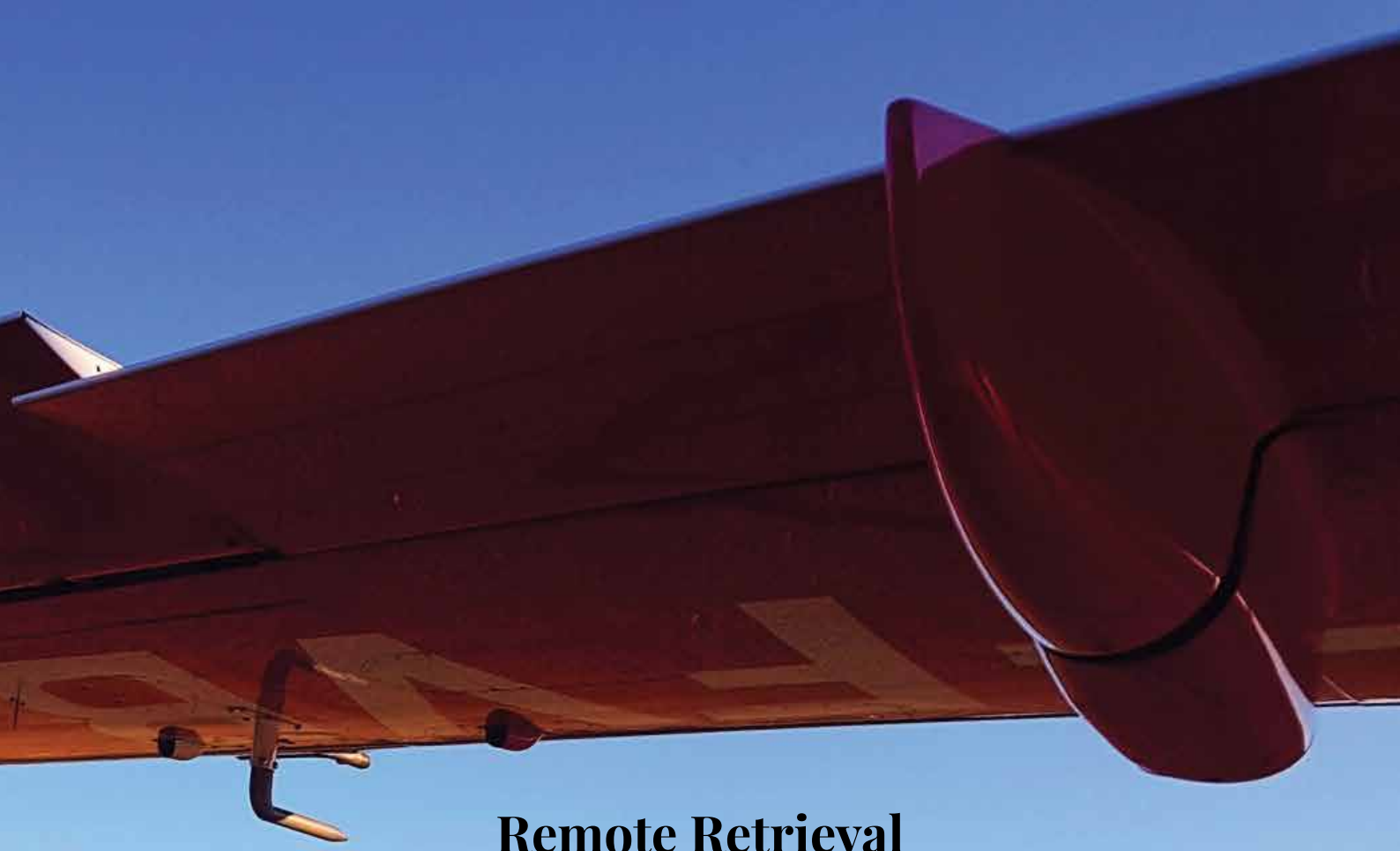
The frontline feel of it. The skills and competencies acquired to know that I can deal with most things that are brought to me and, if not immediately sort out, keep patients alive until further management can be instituted. Working in a field that has constant improvements and innovations in technology as well as cutting-edge evidence base. The feeling of working in a team with a horizontal hierarchy, knowing that we are all working together towards the same goal and share the same burdens. It is mostly looking forward to coming to work and being with my colleagues that motivates me daily.

### What advice would you have liked to receive as a trainee or early in your career?

There is a tendency in medicine to push towards speedy completion of training programs, and putting a lot of pressure on doctors to finish their training quickly. Getting more experience by doing a few more terms in different departments and specialties to acquire knowledge and skills can make the next 30 or 40 years of work much easier and less stressful.

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

The ability to extend the reach of our specialty and improve what we can physically do to relieve suffering in more remote locations, with even more advanced technology at our disposal. The exciting new prospects for telehealth and retrieval medicine. The sky is the limit.



# Remote Retrieval

**Dr Richard Johnson**

Dr Johnson is a father, husband and emergency physician in Alice Springs, Northern Territory. He was the Central Australian Retrieval Service director between 2012 and 2018 and has interests in Indigenous and remote medicine but, above all, equality and equity of access to healthcare for all.

I was asked by *Your ED* to write on what it means to be a specialist retrieval doctor. It is an amazing experience to go to places that few others get to see; the beauty, contrasts and challenges of Australia's great outback. I feel privileged to impact positively on the outcomes of critically unwell patients in some of the remotest communities imaginable. I am passionate about Indigenous medicine, equity and equality of access to healthcare, and remote environments – the more remote and rugged the better.

I want to describe the life journey that has led me to where I am now, illustrated by a few cases that have had lasting effects on how I approach medicine and life more broadly.

I moved from the faded industrial heartland of North East England to Alice Springs. I blame the mountains. As a medical student and junior doctor in the UK, I got dragged out hill walking, which, gradually over the years, evolved into mountaineering and rock and ice climbing in an attempt to tackle more remote and technically challenging mountains. I became involved in the Northumberland National Park Mountain Rescue Team and from that stirred the primeval awakenings of an interest in pre-hospital medicine, search and rescue. At that point, I was a surgical trainee on the pathway to becoming an oesophago-gastric cancer surgeon and finding it increasingly difficult to reconcile the two parts of my life. My solution was to leave the training program without an exit strategy and spend the next couple of years working in developing countries for expedition companies and a Rwandan mission hospital. That time, chaotic as it was, was life-changing and key in developing my interest in Indigenous medicine and access equality.

*I moved from the faded industrial heartland of North East England to Alice Springs.*

The first case I want to talk about is not a retrieval case from Alice Springs. As this case was one of the most formative events of my life, it is fundamental in understanding why I believe what we do is so important. This story is the sliding doors moment of my life. The hospital I worked at in Rwanda was remote; access for most of the surrounding villages was by foot. It was a 100-bed facility staffed by me and two other doctors. I did daily ward rounds but spent most of my time operating. One morning, out of routine, I passed through the baby nursery for no other reason than for a change. I had very rarely, if ever, needed to see a patient in there. I found a baby in the incubator (which only worked for the roughly 50 per cent of the time that mains electricity was on). She had been left on the steps of the hospital, her mother having died at home giving birth to her. She weighed 900g and was being given sugar solution as comfort measures in the expectation that her condition was non-survivable. Much to the amusement of the Rwandan nursing staff (I am not sure they knew what to think of this eccentric Englishman), I kangaroo nursed her for the next four months. She was too weak to suckle so I fed her naso-gastrically. We had no neonatal formula so I made some with soya milk powder, olive oil, sugar and water from a recipe on the World Health Organization website. We had no IV equipment small enough, so when she had skin infections or became oedematous, I titrated tiny doses of antibiotics and frusemide and gave them sub-cutaneously. Slowly she grew and when, after six weeks, she was finally strong enough to cry (in the middle of a ward round), I cried too. I named her Rebecca but many of the nurses called her Good-Luck and both names stuck. She is now 14 years old, has already lived an incredible journey, and is the centre-point of a not-for-profit organisation that my wife and I run with the mission to empower and enable access to education for orphans in Rwanda.

In Rwanda I dealt with typhoid, malaria, gastro, trauma, obstructed labour and many more pathologies with little resources. It was largely the medicine of disadvantage, poor health literacy and grinding poverty, and often a last resort, as most treatment was out of the price bracket that subsistence farmers can afford. Presentation was late and children died of diseases that are easily treatable in early stages or preventable. I had little or no options available in terms of critical care support for patients. I was single-handed in many things; often anaesthetist and surgeon, obstetrician and paediatrician. I learnt a lot about how robust humans (and myself) can be. I also learnt time and again what it means to make a difference to an individual and a community, and I mean a REAL difference to individuals and those around them, not applying band aids to a broken system.

It wasn't until I returned to the UK, having avoided working in an ED like the plague as a surgical trainee, that I fell into a job in emergency medicine. Having surprised myself by loving it, I joined the training program. After a few years' experience I had the opportunity to work for the Great North Air Ambulance Service, the Helicopter Emergency Medical Service (HEMS) that covers a large swathe of Northern England, including remote and mountainous regions.

In 2008 I stumbled across an advertisement for a retrieval job in Alice Springs, applied and got the job. I had been to Alice before as a medical student on an overseas elective placement, so I knew what I was letting myself in for, but I am not sure my wife did! As we left after the end of my 12-month contract, I had a feeling we would return. And I did, in early 2012, to take on the Director of Retrieval role. At that stage it was me and two registrars. The referral and coordination process was complicated, convoluted and chaotic. The majority of patients that we retrieve come from remote Aboriginal communities and have a very similar demographic and clinical pathology profile to the patients who present to the ED in Alice Springs. Yet they were treated quite differently. Often, the nearest ED (Alice Springs) is hundreds of kilometres away, up to 750km! They had no access to emergency specialist care and oversight of the retrieval system was by primary care rural practitioners. As I built up the service through a series of changes in improved staffing, governance and clinical oversight, the system slowly transformed into one with emergency physician oversight for emergency patients and then, with the launch of the Medical Retrieval and Consultation Centre (MRaCC) in February 2018, we finally had direct specialist contact with 24/7 medical retrieval consultants taking calls, giving advice and supervising the retrieval registrars. There is telemedicine

support for remote clinicians (mainly remote area nursing [RAN] staff). Now, patients presenting to remote clinics can have the same (or better) timely access to FACEM advice as those who are brought to ED by ambulance.

Having achieved the goal of equitable access, robust governance, and retrieval physician oversight and coordination, I stepped back from the managerial role last year, and can now enjoy the reason I am here – the clinical work — and I will use a couple of cases to illustrate why I have the best job.

Three hundred kilometres away a teenage jackaroo has come off his motorbike while mustering cattle. He is in the soft sand of the dry river bed. The nearest airstrip is on a neighbouring cattle station 1.5 hours' drive across rough ground and deep sand and we have no rotary wing. A RAN has been sent from a nearby Aboriginal community clinic but won't arrive for at least an hour. The only clinical information is he is conscious but in a lot of pain from his back and abdomen. Our crew consists of myself, a critical care-trained flight nurse and a pilot with first aid training. We are met at the airstrip by the cattle station manager's wife and a station hand with a ute to transport us to the scene. We get a situation report from the RAN who has just arrived on scene that the patient is in too much pain to move although his physiology is okay. The manager arrives with a mustering chopper and offers to take me and limited equipment directly to the scene so I can start assessment and packaging while the rest of my team are on the way. When I arrive, the patient is under a hastily erected temporary shelter but is already badly sunburnt, dehydrated and hyperthermic. Although his obs are 'normal' he has a tense abdomen and screams in pain from his back every time he is moved. He is still lying in the hot, deep river sand and it is around four hours since his injury. Given the environment and team complexity, I elect to manage him with conscious sedation, analgesia, fluids and a vacuum mattress. The next three hours across rough terrain to the cattle station airstrip were a physical and cognitive stamina test. Despite drinking several litres, I was dehydrated. The patient had T12, L1, 2 and 3 fractures and traumatic pancreatitis. I have often looked back on this case critically and thought I should have intubated him; that would have meant an easier three hours for me cognitively compared to the 4WD adventure and maybe more comfortable for him. But I also look back on the moments of personal connection with a scared young man, where he would look at me and ask for a hug, as a real and unique experience few get in clinical medicine. I followed him up a few days later – one of the advantages of working in a system with a single receiving hospital from which the retrieval service is based — and he was so grateful.

*As a reformed surgeon, I always assumed that it would be trauma in emergency medicine that was the big ticket item for me, but as my training progressed, I found the critical aspects of really sick medical patients much more fascinating.*

The final case I present describes the variety of situations we see, as well as the cognitive flexibility required to be a 'retrievalist', where there is no other help available. I had been tasked to a routine adult case of acute pulmonary oedema in a bariatric patient in Tennant Creek Hospital, 500km north of Alice Springs, and we had tailored our equipment to match the size and weight of the patient. While on the ground assessing the patient, we received an urgent re-task and were diverted to a nearby remote community clinic for an ex-premature neonatal respiratory arrest on the background of respiratory sepsis. The baby needed IO access, intubation and ventilation, and inotropes. The challenges were many. We had not taken the neonatal ventilator to an adult bariatric job. I had to hand bag the baby for three hours; it was winter, the temperature was eight degrees and we did not have the cot. We had to change our planning for one extreme of patient group to the opposite extreme. The clinic staff, although performing admirably, were well out of their comfort zone and required significant input from a team management perspective. The child's mother, as you can imagine, required significant support. Things did not go entirely smoothly for the whole retrieval – mucous plugging made for interesting ventilation, maintaining body temperature proved impossible, and she had a temperature of 33 degrees at handover. There was a brief requirement for chest compressions and boluses of adrenaline during descent into Alice Springs Airport. The baby did, however, do well enough and after treatment for pneumonia in PICU in Adelaide, she came back to Central Australia. I have seen her several more times in retrieval and in ED, growing and thriving.

As a reformed surgeon, I always assumed that it would be trauma in emergency medicine that was the big ticket item for me, but as my training progressed, I found the critical aspects of really sick medical patients much more fascinating. Don't get me wrong – I look back on trudging for several hours in crampons to pluck a guy with an open femur off an ice fall on the north face of the Cheviot, or tubing someone with a severe head injury on a roundabout in central Leeds with relish – but give me a sepsis on the background of CKD5, RhD and cardiomyopathy in Ampilatwatja, Northern Territory, any day. There is an excitement and va va voom about jumping in and out of helicopters and dangling on winches for dramatic rescues and juicy trauma. But the romance and raw beauty, married with complex critical care medicine in a population who are truly disadvantaged, isolated and marginalised, gives central Australian retrieval medicine the best overall experience. For me, it is the complex and varied critical care cases, the truly spectacular and remote places, and interesting Indigenous medicine, with the high tech critical care resources of a modern retrieval service.

# Making a difference

**Dr Michael Ben-Meir**

Dr Ben-Meir is the Director of Emergency Medicine at Cabrini Malvern in Melbourne, Victoria and a member of the ACEM Health System Reform Committee.

In February 2019, the Australian Parliament passed the Medevac Bill, which empowers medical doctors to recommend whether it is necessary to remove refugees and asylum seekers from Nauru or Papua New Guinea (PNG) for medical or psychiatric assessment or treatment.

FACEM Dr Michael Ben-Meir volunteers as part of the team assessing refugees and asylum seekers for medical transfer. He was motivated by his concern for our political and humanitarian approach to asylum seekers.

'Decisions on medical needs were obscure and overly politicised, and often not in the best interests of the patients involved', says Michael. 'With the passing of the Medevac Bill there was an opportunity to get involved and allow medical and psychiatric need to be paramount in the care of these patients.'

Michael believes that '… all people under the care of our state (as these patients are) should be cared for in a safe and humane way'. As he proudly says, '… to be part of a team of professionals advocating for and, at times, enforcing delivery of appropriate care is a great privilege'.

Michael has been involved in four remote assessments, which he undertakes from his home office after work or on weekends. This involves a briefing from the asylum seeker's legal team and a review of their discovered medical notes, hospital admission notes, investigation reports, prescriptions and other relevant documentation.

As part of his assessment, Michael takes into consideration whether the patient is receiving appropriate assessment or treatment on Nauru or PNG. He then compiles a set of questions for a pre-arranged teleconference with the asylum seeker, with the support of an interpreter.

Michael is then tasked with forming an opinion on whether the patient's medical or psychiatric problems can be managed based on the above, and a report is produced 'outlining the specifics of each case, the treatment received, the investigations and treatment required, and an opinion (with justifications) as to whether this can be provided on Nauru or PNG'.

'[There] are a complex mix of psychiatric and medical conditions, with suicidality, pain management issues, chronic infection and inflammatory conditions, and trauma', he says. 'All the cases with which I've been involved have revealed difficult medical, investigative and management problems that require multidisciplinary input at tertiary centres.'

While this process presents challenges, such as the limitations of remote phone conversations with asylum seekers through interpreters, Michael describes the experience of supporting these patients as rewarding work.

'The experience has been hugely gratifying, as well as concerning to me. The stories of these peoples' travels, detention and current medical and psychiatric issues are harrowing. The situations they are in would generate illness and psychiatric issues in most people; the language and cultural difficulties compound this. To be able to make a positive difference to such a vulnerable group of people is very satisfying.'

Michael encourages others to become involved and believes that, 'as FACEMs we have a very broad understanding of hospital and community-based medicine. This makes our opinion in these cases quite valuable, in that we are generalist specialists'.

His most memorable experiences are learning the outcome of the cases he has been involved in and helping four critically unwell men get off Manus Island.

'The complexity of the political and legal situation around immigration and seeking asylum is significant', he says. 'I am grateful that my professional skills give me the ability to contribute meaningfully to people seeking asylum, often from war-torn countries.'

The experience of working with colleagues and legal teams who are dedicated to a just and humane approach to asylum seekers has inspired Michael. 'I'm constantly impressed by the discipline and determination of the various not-for-profit legal organisations, like Refugee Legal, who fight these battles daily on behalf of their clients. It has been a great honour to observe and support their skill, passion and expertise.'

Since the Federal election in May 2019, the majority Coalition Government has sought to abolish the Medevac process by repealing the legislation. In July, the then ACEM President and ACEM's General Manager of Strategic Partnerships joined the Royal Australasian College of Physicians in a series of meetings in Canberra with ministers and representatives from all political parties to advocate to retain the bill.

Michael strongly supports medical colleges advocating for the Medevac process. 'From a moral and humanitarian perspective, it is wrong to effectively torture the existing arrivals as a means to discourage future arrivals – especially when it is legal both in Australian and international law to seek asylum as they have', he says. 'As medical professionals, we must advocate for the appropriate medical care of all people.'

In October, ACEM joined 10 other medical colleges in advocating to retain the Medevac process.

***Author: Allison Roper,*** *Committee Administrator*

**Editor's note:** At the time of publication in early December, ACEM was disappointed with the news that the Coalition Government had secured the necessary Senate votes to repeal the Medevac Bill.

# The Price we Pay

**Dr Simon Judkins**

Dr Simon Judkins, Immediate Past President of ACEM, is an emergency physician at Austin Health in Melbourne, Victoria. He has interests in Choosing Wisely, mental health care, access block and emergency medicine workforce planning.

There are strange moments, odd times, which get you, make you stop and reflect; make you think about your job, your staff, patients and, ultimately, your own values and sense of purpose. There will be a trigger. It may be that you are stressed, tired and wondering how you are going to go to work today. It may be a story you read, or a conversation with friends and colleagues.

I wasn't feeling great. The last 18 months have been very, very busy; lots of hours, lots of problems to solve, and trying to balance work, family, me … trying to find my ikigai hasn't been an easy task.

This Saturday seemed no different — a normal, busy morning and facing an evening shift in the ED. Working the pm shift in winter, with two medical staff down, was not something I was looking forward to. I don't usually mind a challenge, but the depths of winter, bed block, staff illness … it all adds up. You all know the feeling.

As I was loading one of my kids in the car to take to school sports, I grabbed my computer. I thought I'd run through the radiology reports from yesterday while watching the game; clear the decks early so the staff could concentrate on seeing patients. This is usually tasked to someone each day, but I thought I'd save them the trouble. I know, I shouldn't be doing this, it's not my job today, but all the little things help out sometimes.

As the game started, I kept an eye on the developments (a couple of shots up early, a few points and a nice assist, so good news) and began to work through 200 or so reports.

The usual process is we review the report findings, access the medical notes and ensure that the ED staff haven't missed anything important. It's pretty rare that we do, but there is an occasional lung nodule or subtle fracture which needs review. I've done this many times before, usually at work, or over a morning coffee.

I settle in a corner, separated off from the throngs, my laptop on my lap, with games of basketball on either side of me. I paused as I read the first report and then the patient's ED notes.

' … acute left temporal intraparenchymal blood with associated subdural …'.

I look at the medical notes. A 30-year-old man assaulted. He was out with his fiancée. According to the brief notes, there was an altercation outside a bar. Nothing much it seems. But, as they stood and waited for their taxi, he was coward punched. The assailant ran. The patient collapsed to the ground, hitting his head.

*Dealing with this grief, with the tragic stories, can eat away at your defences. Your ability to absorb the traumas, the grief and the heartache has its limitations.*

He was intubated at the scene … his life has changed forever. Many people's lives have changed forever.

A few reports with normal findings, including 'no aortic dissection seen', but a few reports later, 'type-B aortic dissection from the aortic arch to the infrarenal aorta'. I looked at the notes. I know the team would know this, but I wanted to see who this person was. Pretty well, about 75,

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with a history of hypertension. At home with his wife, who he cared for. He died …

His wife was with him, but she may not remember what happened. Her dementia is severe, but he looked after her in their home. Their home will not be their home anymore.

We need to track down the family. We're not sure what we are going to do with his wife, who is now our patient. She needs our care as there is no one else who can care for her right now.

CT scans for headaches, CT scans for pulmonary embolism, CT scans for trauma.

'No intracranial pathology identified. Fracture or left orbital as described and comminuted nasal fracture …'.

Domestic violence. A 34-year-old with two kids. She had been with us before, with broken toes. Looking at the old notes, she said she had dropped a heavy plant pot; when revisited, she admitted that her husband had stomped on her foot. She had been to another ED not far from us after a fall down some stairs; it turns out she was pushed. Prior to that, her ED presentations had been in another state.

This time the husband has been charged. Uses ice (crystal meth) and alcohol a lot. The kids are being cared for by a friend. Our social workers are trying to find accommodation. The rental is under his name. She wants out this time. But she has no income, no close family. Another broken home. The children will be affected. Social determinants of healthcare. How do we break that cycle?

Abdo CT … 'two areas of colonic thickening. The area in the transverse colon is highly suspicious for colonic malignancy. The liver lesions are consistent with metastases. The limited lung views reveal a number of lesions …'.

The pain had been there for some time. Vague pain, with some change in appetite and bowels. She is in her 60s and has a son at home who needs care. His requirements are significant; intellectually disabled with behavioural issues (meaning he can get quite angry and aggressive at times). He is okay when mum is around. She hesitated about coming to hospital, but the blood in her bowel action forced her hand.

She discharged herself to try to get her son sorted and will come back to outpatients. The NDIS is lagging a long way behind, so she will need a few days.

'The ETT is in the correct position. There is evidence of aspiration ….' 19 years old. Overdose two days after being discharged from hospital. Living between friends' places, couch surfing. Apparently, she had a job interview, but they wouldn't take her on because she didn't have a permanent address. She was found cold and unresponsive in a park. The team weren't really sure what she had taken, but it seems like a mix of alcohol, antidepressants and 'oxy'. It's not hard to get this 'prescribed' medication on the streets. The toxicology was all survivable if she had someone to tell before it was too late … but not now.

And the list goes on.

Another life changed.

And another …

And another …

This, all of this, was just one day in one ED …

Dealing with this grief, with the tragic stories, can eat away at your defences. Your ability to absorb the traumas, the grief and the heartache has its limitations. We need to be able to step away, to make sense of it all. We must realise that for every tragic story, there is a life saved, a life changed for the better. It is not always easy to walk away from a shift with a feeling that you've done good. Sometimes the sheer volume of the work, the density of the decision-making, the constant demand, the 24/7 nature of the work, is overwhelming. But, amongst all of this, we do good. We care, we comfort, we are there for those grieving, to tell them that their loved one didn't suffer, that the grieving will end, that they will be okay. A smile, a touch on the arm, a moment of silence sitting with a family … it all makes a difference.

A lot of the time, it doesn't feel like enough – it can make you feel empty. It's hard to brush off. But, sometimes, thinking about those moments, moving from words on a radiology report to a story of a person who needed our help … sometimes that is enough to make you realise that you are doing a job, which means something; a job so, so important to so many people each and every day.

Another life changed … for the better.

And, so the game ended. We won.

I took my son home and got ready to change some more lives in my ED, with my colleagues, doing my job. A job which, despite all the stresses, all the struggles and frustrations, has changed me, is part of who I am, and I still love to do.

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# The Emergence of GECCo and the Global Emergency Care Desk

There have been important developments in the establishment of Global Emergency Care (GEC) as a key pillar of ACEM's body of work. The International Emergency Medicine Committee (IEMC) has been renamed the Global Emergency Care Committee (GECCo), and the IEM Network will now be known as the GEC Network. This rebranding is to better align with the broader scope of work undertaken by ACEM in GEC and shifting terminology in the Global Health sector. The Committee's key objectives are to; advocate for global health; improve the GEC Network, FACEM and trainee engagement in GEC; support capacity building for emergency care in Low and Middle-Income Countries (LMICs); and promote and facilitate GEC research.

Following the appointment of a GEC Manager, ACEM has established the GEC Desk as a key focal point for Fellows and trainees interested in learning more about or getting involved in GEC. The GEC Desk will manage the portfolio of ACEM Supported Projects in GEC and be responsible for establishing partnerships that support locally-led, capacity development of emergency care in LMICs. The GEC Desk will become a repository of resources and guidance, for those interested in engaging responsibly in GEC capacity development and volunteering.

In this issue of *Your ED*, we will focus on emergency care development in the Indo-Pacific Region and the signing of a memorandum of understanding between ACEM and the University of Papua New Guinea (UPNG). The following stories from Bhutan, Samoa and Tuvalu have been submitted by Fellows in the field (affectionately known to us as FIFs) and their GEC colleagues working independently in the field.

### More information

If you would like to learn more about GEC or ACEM's GEC activities and projects or share with us a story from the field we would love to hear from you at gecnetwork@acem.org.au.

# Papua New Guinea
# ACEM MoU Signing with UPNG

**Dr Colin Banks**

Dr Banks is an emergency physician from Townsville, Queensland, and Chair of ACEM Global Emergency Care Committee. He is passionate about global emergency care, particularly in the Pacific Region.

A key determinant of the development of healthcare provision in Papua New Guinea (PNG) is related to medical specialty training and this is governed solely by the University of Papua New Guinea (UPNG). Emergency medicine has become the most popular field of training, with the first UPNG emergency physician graduating in 2007, and there are now UPNG-trained emergency physicians throughout PNG and the Pacific.

This progression has been supported by various FACEMs. ACEM has contributed with the provision of a needs analysis, the International Scholarship Program to support PNG emergency physicians to attend Annual Scientific Meetings, and assisting triage implementation with support from the Australian Government through an Australian Aid: Friendship Grant and an ACEM Foundation International Development Fund Grant.

ACEM aims to support emergency care development in PNG, so it is natural that UPNG and ACEM should partner together. During the Medical Symposium in Port Moresby in September 2019, a ceremony to sign a memorandum of understanding (MoU) between UPNG and ACEM was held. It was not only a celebration of what has been achieved, but a path forward for cooperation between the two institutions. The evening was well attended by local emergency physicians and trainees, as well as a good number of FACEMs.

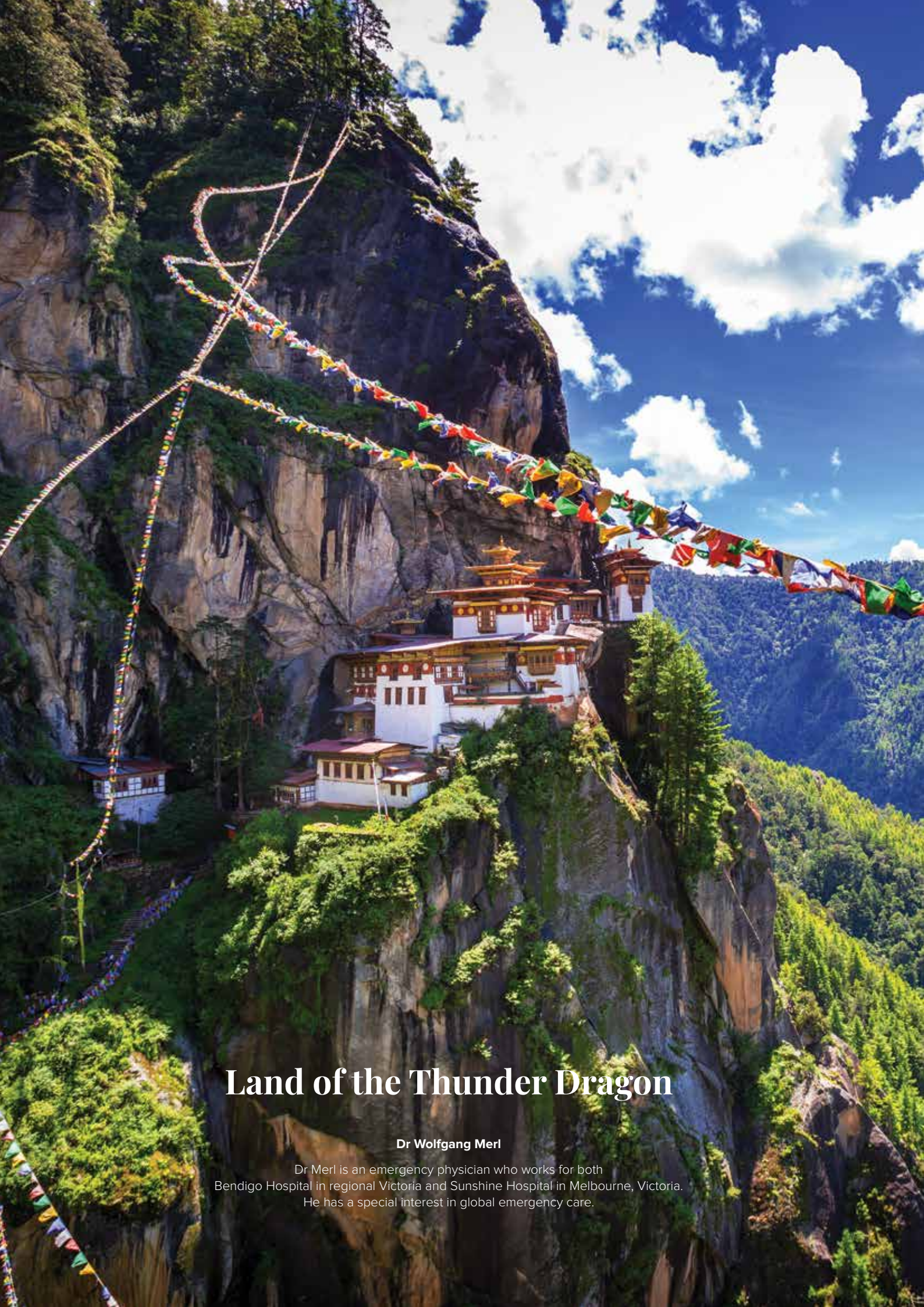
Signing the document on ACEM's behalf was then President Dr Simon Judkins, who also took the opportunity to visit the two public EDs in the capital, Port Moresby General Hospital and Gerehu General Hospital. He met local leaders and saw first-hand the progress that has been made. 'The visit demonstrated the impacts of this great work but also showed how much we can assist with …'. He was impressed by the long-term relationships and commitments between FACEMs and local emergency physicians and how this is '… needed to see sustainable change and allow the local experts to lead further development'.

*The signing of the MoU between ACEM and UPNG marks the beginning of a new and promising chapter in the unfolding journey of emergency medicine in PNG and the Pacific.*

In addition to the MoU signing, there was the presentation of a new award, the ACEM-sponsored Chris Curry Medal, for the highest performing candidate in the UPNG emergency medicine final examinations. The senior members of the emergency medical community chose this name to reflect the pivotal contribution that Associate Professor Chris Curry has made in establishing the specialty in PNG. Dr Carl Kingston was the inaugural recipient of this Medal and stated, 'this award recognises a commitment to high standards in training. The signing of the MoU between ACEM and UPNG marks the beginning of a new and promising chapter in the unfolding journey of emergency medicine in PNG and the Pacific'.

This was a landmark event for emergency medicine in PNG and reflects the growing stature of the specialty. At this point in time, ACEM is the only specialist medical college to have signed a MoU with UPNG. Dr Sam Yockopua, the Chief of Emergency Medicine, acknowledged that, '… it is a great step forward to have ACEM formally involved to support the ongoing development of emergency medicine in PNG'.

Following on from the Medical Symposium was the Emergency Medicine Specialty Meeting, which showcased the progress that is being made throughout PNG. The future for emergency care in PNG is bright, although a lot of hard work will be required to maximise the opportunities, and for ACEM and UPNG to deliver on the MoU.



# Land of the Thunder Dragon

**Dr Wolfgang Merl**

Dr Merl is an emergency physician who works for both Bendigo Hospital in regional Victoria and Sunshine Hospital in Melbourne, Victoria. He has a special interest in global emergency care.

Flying into Paro Airport, Bhutan, is probably one of the most exhilarating descents that one can experience in a large commercial aircraft. Paro is often named one of the most dangerous airports in the world. As the snow-covered peaks of the Himalayan mountains disappear from view, the plane weaves its way through a narrow valley with several turns, often so close that the wings seem to touch the mountain slopes. Luckily they didn't and so this breathtaking experience marked the start of my time in one of the most remote, least accessible and beautiful countries in the world.

This journey started almost a year earlier when a successful interview with Health Volunteers Overseas (HVO) opened the opportunity to work for two months as a volunteer in the ED of the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) in Thimphu, Bhutan's capital.

Bhutan is a small Himalayan kingdom roughly the size of Switzerland. It lies between two powerful neighbours, China to the north and India to the south. For many centuries, the country was virtually cut off from its neighbours, fearing that outside influences would undermine its monarchy and culture. It was only in the 1970s that Bhutan, or Druk Yul in Dzongkha language, the Land of the Thunder Dragon, opened to the outside world. Since then, it has allowed in some aspects of the world, while strongly guarding its ancient traditions. Radio broadcasting began in 1973, with television and the internet only arriving in 1999.

This political autonomy has led to the development of a rich and distinctive culture. Perhaps the single most important factor is the strong grounding in a long tradition of Buddhist teachings and influences.

For a small country with two of the most populous nations in the world as neighbours, this preservation and promotion of Bhutan's distinct cultural identity is an important means for its survival as an independent and sovereign kingdom.

Nowadays, Thimphu feels like a booming modern city with widespread construction of new housing estates, where mobile phone shops happily co-exist with traditional weaving or cobbler workshops.

Thimphu is situated in the central-west region of Bhutan. The city lies at an altitude of 2,300 metres, which makes it the third highest capital in the world. Thimphu has an estimated population of 98,000 out of a national population of 730,000 (in 2017), with an average life expectancy of 76 years for women and 71 for men.

Travelling to Bhutan as a tourist entails rigorous restrictions. The country is closed to casual travellers and visiting is possible only via pre-arranged government-controlled travel packages.

The country has some of the world's most rugged mountainous terrain, with many remote agrarian communities connected by dirt or paved roads, which often makes timely access to emergency care difficult. Particularly in the monsoon or winter seasons, it can take patients several days to reach a major hospital.

To help address this challenge, Bhutan has set up a tiered system of healthcare starting with basic health units (BHUs) that are generally staffed by community health workers. The next tier is the district hospitals, which are staffed by medical officers who have completed a medical degree, followed by an intern year. Lastly, there are three regional referral hospitals and one national referral hospital, JDWNRH, a 350-bed facility where the majority of specialised consultants are based.

*Thimphu feels like a booming modern city with widespread construction of new housing estates, where mobile phone shops happily co-exist with traditional weaving or cobbler workshops.*

Of the regional hospitals, only Central Regional Referral Hospital (CRRH) has one certified emergency physician working in an ED outside of Thimphu.

JDWNRH currently has four consultant staff in the ED. Dr Sona Pradhan and Dr Ugyen Tshering are local doctors who specialised in emergency medicine on a government scholarship in Malaysia before returning to Bhutan. Two US-trained emergency physicians, Dr Melanie Watts and Dr Shankar Levine, complete the team of resident physicians. HVO provides a regular flow of visiting emergency physicians.

The ED at JDWNRH sees 40,000 patients a year. It is the major referral centre for trauma. To improve access to the national hospital, the Bhutan Emergency Aeromedical Retrieval (BEAR) service was established in 2015 and went into full operation as a Helicopter Emergency Medical Service (HEMS) in 2017. BEAR comprises a team of six flight doctors and five flight nurses, and performs 150 retrievals a year in often challenging conditions.

In 2018, the first local trainees entered the Emergency Medicine Residency program. It is a four-year training program organised under the patronage of Khesar Gyalpo

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University of Medical Sciences of Bhutan. The course currently has four residents; two in their second year and two in their first year of training.

Training junior doctors is a large part of the workload of the ED. The consultants and residents teach the intern physicians during their one-month posting. They learn the necessary basic emergency medicine skills for their posts in rural areas after their internship.

Only three years ago, Bhutan's medical university launched an Emergency Medical Responder (EMR) program, which is delivered by the ED. Other teaching commitments include a week-long workshop for new residents and regular advanced cardiac life support (ACLS) courses for hospital staff.

Training junior staff is the main duty of a visiting emergency consultant. This will take shape through regular formal lectures, bedside teaching, workshops, simulation and procedural teaching. It is a very rewarding job and an experience in which the teaching is often reciprocated, with many patient presentations uncommon to our practice in Australia, ranging from aconite-induced cardiac toxicity, to seizure induced by cerebral echinococcosis, trauma due to bear mauling, and archery-related penetrating injuries.

Many of the challenges faced by the ED at JDWNRH will sound very familiar to an Australian physician. Access block and overcrowding is a common problem. Radiology department operating hours from 9:00am-3:00pm on weekdays are unique to Thimphu. Challenges resulting from difficulties in acquiring equipment are common to healthcare providers in resource-poor environments and no different here.

*Many of the challenges faced by the ED at JDWNRH will sound very familiar to an Australian physician. Access block and overcrowding is a common problem.*

No formal relationship has been established between the emergency medicine faculty in Bhutan and ACEM. Only a very small number of FACEMs have visited JDWNRH, with Dr Tom Morton, a New Zealand-based emergency physician, leaving the strongest legacy. Hopefully, the future will bring stronger collaboration and possible exchange between the two faculties.

Despite a five-day week in a busy tertiary ED, there is still time to explore this wonderfully unique country with its beautiful natural sites, to experience the rich culture and the generous hospitality of the people of Bhutan.

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DEVELOPING EM

# Medical Support for the Pacific Games in Samoa

**Dr Anne Creaton**

Dr Creaton is an emergency medicine specialist who has spent four years teaching in Fiji. She enjoys taking emergency care outside of the hospital.

Emergency care systems are complex. Catering for mass gatherings and potential surges in activity provides a valuable opportunity to evaluate the system as a whole.

The Pacific Games is a multi-sport event, similar to the Olympics, held every four years. It is a celebration of sport, community and the shared culture and geography of the Pacific region. Samoa is made up of nine islands and has a population of 196,000. The capital, Apia, and the international airport are located on the island of Upolu. This small nation was to host an event featuring 24 countries and 26 events across ten venues. Extra flights were scheduled, accommodation was full to bursting and a festive atmosphere pervaded the country with flags and bunting lining every road. The emergency care systems needed to cope with an influx of 4,000 athletes, 2,500 support staff and an opening ceremony with 14,000 spectators and 3,000 performers.

Dr Pai Enosa and Dr Agape Amituanai are the only two doctors in Samoa formally qualified in emergency medicine, having completed the postgraduate diploma in Fiji, and work at the Tupua Tamasese Meaole Hospital in Apia. Pre-hospital care is accessed by calling a national toll free number and is the responsibility of the Samoa Fire and Emergency Services Authority (SFESA). Personnel receive basic training, but there are no clinical guidelines and no formal communication procedures with the emergency departments, so clinical assessment and management is limited. Support for such a large-scale decentralised event requires multi-disciplinary, multi-agency collaboration. What occurred was comprehensive, innovative and built relationships and capacity, which are likely to result in benefits for Samoa long into the future.

## VFR Fiji and Fiji-Samoan collaboration

Mr Lemeki Lenoa founded the Volunteer First Responder group in Fiji (VFR Fiji) in 2009. With a passion for emergency care and an IT background, he has set up the Fiji Navy Search and Rescue Coordination Centre, responded to mass casualty events, and signed a memorandum of understanding with Fiji National University to assist with the delivery of the Certificate of Pre-hospital Care. Teaming up with emergency doctors and nurses, VFR Fiji has provided training to members of the National Fire Authority, Fiji Police, St John Ambulance, the Ministry of Health and Medical Services, and the Fiji Navy. He has also represented Fiji in the Pacific Games in Karate and won gold. Clearly well qualified for the job, he was approached by the Oceania National Olympic Committee to assist with coordination of the pre-hospital medical response for the 2019 Games.

During the lead up to the Games, VFR Fiji conducted first responder training workshops, and the National Critical Care and Trauma Response Centre (NCCTRC) in Darwin ran




a Hospital Major Incident Medical Management and Support (HMIMMS) course. Many of the Samoan doctors studied medicine in Fiji, and the NCCTRC has provided disaster training for Pacific Island doctors since 2013, with the first HMIMMS course held in Fiji. Five of the instructors delivering the course in Samoa were Fijian and members of VFR Fiji. These relationships helped bring people together and provided the glue for the Fiji-Samoan collaboration.

## Operations

Samoa provided the medical command and response, with the Fiji team fulfilling a coordination role. A pre-hospital emergency care coordination cell was set up, which housed senior members of each agency, who communicated directly with members of their respective teams. Daily briefings were held and communications were logged. Screens displayed venue maps with marked access and exit routes, current weather conditions and a de-identified updated case log. The case type, location, response and disposition was captured within a smartphone app designed by Mr Lenoa. Each sporting venue had a medical post with doctors and nurses assisted by personnel from the SFESA and the Red Cross. Three 'polyclinics' staffed by doctors, nurses and physiotherapists were set up within the games village and in sporting venues.

## Learnings

Building capacity in emergency care requires investment in multiple interdependent areas, in relationships and at interfaces. A high profile event can be a catalyst for development, to break down communication barriers, incubate new ideas and find ways of working better together. People from different backgrounds have diverse skills and can bring fresh energy and approaches to old problems. Training together allows personnel to better understand the roles of others, creating mutual respect and improving communication. Patients benefit from having well-coordinated pre-hospital and hospital care with clinical and logistical oversight. We hope that the investment made in providing a comprehensive high-quality medical response during the Pacific Games will result in an enhanced response to all emergencies in Samoa.

## Acknowledgement

I would like to thank everyone who contributed to the medical support of the Pacific Games in Samoa.

# Developing Emergency Care in Tuvalu: Pacific Emergency Nurse Training Program

**Angie Gittus and Bronwen Griffiths**

Angie Gittus and Bronwen Griffiths are clinical nurse specialists in Australia, both with Master's in Public Health and a variety of international health experience.

Tuvalu, a tiny nation of 12,000 people spread along nine remote and beautiful atolls in the Western Pacific, has become famous as the face of climate change in 2019. A visit by United Nations Secretary António Guterres and the hosting of the Pacific Islands Forum have shone a compelling spotlight on the extreme vulnerability of small Pacific countries to rising sea levels.

Early impacts of climate change on health can already be seen tangentially here. Capacity for local food production in Tuvalu has always been minimal due to limited soil build up in its low-lying atolls. Now, rising salinity in the groundwater pits traditionally used to grow pulaka (swamp taro) and unpredictable rainfall have added food insecurity to the many implications of climate change facing the community. Aside from fish, most food is now imported, with the most affordable products high in fats and sugars. The rising burden of non-communicable diseases (NCDs) is already felt acutely in Tuvalu. The World Health Organization (WHO) estimates nearly a quarter of the adult population has Type 2 diabetes and two-thirds of the population is overweight or obese.[1]

Nurses form the backbone of the health service in Tuvalu, as they do throughout most of the Pacific, but here capacity issues are further complicated by the small population. There is not enough workload for more than one specialist anaesthetist, surgeon or obstetrician, and yet these services are required 24/7. Combine this with a chronic shortage of trained doctors and the health service becomes dependant on locums and nurses. Services away from the capital, Funafuti, are remote and resource-poor, so nurses in these areas must diagnose, treat and transfer to the main referral hospital, Princess Margaret Hospital (PMH), using only the most basic equipment. Transfer can be a protracted and dangerous business as unwell patients, including high-risk maternity cases, arrive in Funafuti by boat.

As is the case regionally, emergency care is a newly developing specialty in Tuvalu. New training programs have seen a welcome increase in numbers of local medical graduates across the Pacific, and scholarships for advanced training are enabling these doctors to gradually move into specialty areas. Tuvaluan graduate Dr Aloima Taufilo has a Diploma of Emergency Medicine and is now partway through her master's degree at Colonial War Memorial Hospital in Suva, Fiji. Her eventual return, with strong links to ACEM and regional networks, will boost the development of emergency care at PMH, but highlights the need for the parallel development of emergency nursing.

Pacific nurses are adaptable generalists, rotating throughout their careers across a wide spectrum of environments encompassing community clinics, hospitals and remote outer islands. While this system creates a nursing culture that is impressively flexible, healthcare in the Pacific is changing rapidly and a new skill set is needed in the frontline of care. The traditional burden of tropical

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and regional diseases has been joined by a rapidly increasing burden of NCDs, and developments in medicine mean that expectations and capacity for treatment are changing.

While change is welcome, this highlights the increasing disparity between the capacity for care in remote clinics and treatment available in main referral centres. In recognition of the changing landscape, the New Zealand Ministry of Foreign Affairs and Trade (NZMFAT) supported the Pacific Emergency Nurse Training Program (PENTP) in Funafuti in May this year, providing the first step towards specialty emergency training for frontline Tuvaluan nurses.

The PENTP is usually run as a blend of nurse-focused emergency topics and WHO material. In Tuvalu, the program was separated into two components so that the basic emergency care (BEC) material could be delivered to medical staff alongside the nurses undertaking the full two-week course. Dr Brady Tassicker, an Australian FACEM and GECCo Country Liaison Representative for Tuvalu, has been involved with PENTP since its inception in Kiribati. He visits Tuvalu as part of a regular support program for Cuban graduates via the Kiribati Internship Training Program (KITP). With support from NZMFAT, Dr Tassicker added four doctors to the 18 nurses attending the training and assisted with delivering the BEC component of the material.

*Frontline nurses in the Pacific are the gatekeepers of the health of their communities. Whether they are in remote clinics or in emergency departments, on atolls or islands, their strength going forward lies in developing a sense of regional identity and collegiality.*

In contrast to many regional facilities, PMH has a permanent emergency nursing team, led by senior nurse Mamaha Viliamu, however, the service is only staffed from 8:00am - 4:00pm. This leaves nurses on the wards to respond to after-hours emergency presentations when staffing is poor and medical cover at its most scarce. This is a source of ongoing concern to the nurses at PMH.

The hospital is a well-constructed and maintained facility where staff work with a high level of engagement and a strong sense of community. The nurses recognise that education is needed to keep abreast of the changing health landscape and they have proven to be highly focused course participants. Two were unable to change their roster and attended the course while on night shift, miraculously staying awake for the lectures and participating enthusiastically in the afternoon simulation sessions. All participants passed the written and practical assessments and, outer islands nurses in particular, spoke of the difference that a systematic emergency structure would add to their practice. The responsibility that comes from being a sole practitioner in a small close-knit community cannot be overestimated. Giving nurses tools to assess their patients in a structured way and communicate their concerns effectively seems the most fundamental of necessities for safe practice.

Frontline nurses in the Pacific are the gatekeepers of the health of their communities. Whether they are in remote clinics or in emergency departments, on atolls or islands, their strength going forward lies in developing a sense of regional identity and collegiality. The nature of medical training has seen graduates form supportive networks that help disseminate change and allow areas like emergency care to develop with strong regional links. It is hoped that a future emergency nursing diploma would allow nurses to develop similar networks and a stronger regional voice.

**Acknowledgments**

We acknowledge the support of the Australasian College for Emergency Medicine, the College of Emergency Nursing Australasia and the Pacific nursing team at Counties Manukau Health (NZMFAT) for supporting the development and implementation of the Pacific Emergency Nurse Training Program.

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# Climate and Health: What Can an Individual do?

**Dr Marianne Cannon**

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

In late 2016, I represented ACEM at a climate and health roundtable meeting in Canberra. Senior bureaucrats politely told us — despite the well-documented heat-related deaths in Victoria in 2014 – that global warming was not on their radar as affecting the health of Australians, and that it only crossed their desks as a Pacific Island issue. My own experience is that during heat waves, and other disasters, hospital resources are often overwhelmed by surges of patient presentations. As it is obvious that these events are on the increase, this is clearly a health issue for FACEMs to get involved in. I realised I needed to learn more about the implications of climate change on human health and our national healthcare system, having read the Lancet statement that climate change was the greatest health threat this century.[1] Vulnerable populations such as the elderly, Indigenous people, chronically ill people, outdoor workers and children will be worst affected, even in our own communities.

In my work for the ACEM Public Health Committee I drafted a sustainability framework for the College, but hastened my personal journey after an impassioned conversation with (read a shellacking from) my adult children, who reassured me that people of my generation have much more power than we choose to exercise. Initially, I looked to my personal consumption choices, such as choosing low food and wine miles, eating less meat, using active transport (bikes and buses), driving a smaller/low emissions car, reducing flights and holidaying closer to home. Train travel is a great way of seeing the country too, better than flying or driving. Installing solar panels can reduce our carbon footprint and energy costs as well, or we pay a little extra to purchase 'green energy'.

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I have a long way to go. Living sustainably is virtuous and role models the fact that sustainable lives are fulfilling, but it does not change the economic system built on ever increasing rates of consumption. Historically, 90 companies are responsible for 60 per cent of emissions. So, while individual choices may save emissions and may even be making us healthier, they may not be where we have most impact.

We can make significant inroads by insisting our money is invested, both directly and via superannuation, in ethical or sustainable companies. Collectively, as consumers and shareholders, we can effectively drive change. We can ask our bank if they fund fossil fuel projects,[2] and go elsewhere if they do. Likewise, as donors we can legitimately impact the climate policy of third sector organisations, which often champion marginalised populations. I looked at every organisation I support, am a customer or member of, and made it my business to work my way through the list, starting close to home, and asked questions that reflected my intention to support elsewhere if they didn't act responsibly. I wrote articles for mainstream media, where the information gap seemed to be, and donated more to environmental organisations. Late last year, when I saw the great work they do behind the scenes, I joined Doctors for the Environment Australia (DEA). After some encouragement, I ran for the Australian Medical Association Queensland (AMAQ) and have introduced the idea of a sustainability action plan there. Watch this space.

Healthcare is responsible for seven per cent of overall Australian emissions,[3] mostly hospital and purchasing-based. As clinicians, we can encourage and support environmentally sustainable initiatives, which have been shown (for example, in the National Health Service[4]) to lead to cost savings as well.

As healthcare providers we dispense preventive population health messaging and interventions on a daily basis. Collectively, we make our voices heard when things such as overcrowding, anti-vaccination movements or tobacco marketing threaten our patients' health, or it is undermined by commercial or political forces. As doctors, we can leverage our impartiality, gravitas and high community respect to support and drive good population health interventions. As a respected profession, we can educate and advocate for mitigation and adaptation to the health impacts of climate change. Recently, the Australian Medical Association (AMA) announced a climate health emergency, although this is just the beginning of what needs doing. Already, doctors are being accused of being politically motivated, or persuaded by groupthink in the national media, albeit by people with non-scientific backgrounds. As professionals who see biosystem failure on a daily basis and know its non-linear trajectory, we need to claim this ground and persuade others to join us.

We are particularly vulnerable to climate disruption in Queensland.[5,6] Recent uprecedented fires and associated smoke events here and in New South Wales have confirmed that a population health emergency exists. From a disaster management perspective climate change is a risk multiplier for natural disasters in Australia. Many vulnerable groups exist. By raising the scenarios particular to your region, and the known solutions, with patients, colleagues, professional associations and leaders, we can make a difference. DEA and the AMA have strong policy in this area and can play an important role as a non-partisan voice for the health implications of a changing climate. Member-run organisations like ACEM need doctors to step up and support leaders who want to do the right thing, and who hear from naysayers loud and clear. Trainees have a role to play through their representatives and as individuals if they choose to do so. Many strategies to reduce emissions have health co-benefits, such as diet and active transport, reducing air pollution and obesity; green spaces are aesthetic environments for children to thrive and grow, and have been shown to improve wellbeing.

Speak to your elders, colleagues, state faculty and hospital administration. Meet your local members, contact your super fund. Let our local, state and federal leaders know the facts regarding global warming and health. Demand their attention and their efforts toward local practical solutions, from local heat pockets, to land clearing and legislation around emissions. It is our business, and it feels better than being a powerless bystander, as I know from experience. Then perhaps we can look our young people in the eye and honestly say we did everything in our power.

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# ACEM and Malpa

The gap between health outcomes for Indigenous and non-Indigenous Australians is sadly a well-established fact. The gap of an Indigenous male's life expectancy is 10.8 years less than non-Indigenous and 10.6 years less for females.[1]

ACEM's Reconciliation Action Plan (RAP) Steering Group has been working for three years on initiatives to help address this gap. One of the key actions in the RAP is to encourage and support Aboriginal and Torres Strait Islander medical students and graduates to pursue emergency medicine as a career. However, we know we need to identify and support Aboriginal and Torres Strait Islander students much earlier than medical school if we want to make a genuine impact on the number of Indigenous FACEMs in years to come. But how can ACEM do that? Where should we be engaging our efforts? Our focus is and needs to be on graduates and trainees, right, not kids?

Welcome Malpa! An organisation supporting young Indigenous people all over Australia to become 'Young Doctors'.

What is a Young Doctor and what is Malpa? The organisation works with young people aged between nine and 12, creating educational programs embedded within the school curriculum, teaching Indigenous and non-Indigenous children bush medicine, western medicine and wellbeing concepts. The young people become doctors in their school and communities, teaching their families and friends the things they have learnt.

ACEM Immediate Past President Dr Simon Judkins and I were lucky enough to visit a young doctors' program in action at Thornbury Primary School in Melbourne. We saw the kids having concepts like exercise, diet, and ear, nose and mouth hygiene reinforced in the songs and games they played at the beginning of the class, before engaging in a wellbeing activity. Helping young people to think about mood, emotions and ways to process negative emotions is a core component of the program.

'Watching the kids engage with each other, learn techniques to look after their mental health and be excited about education was an absolute privilege', said Dr Judkins. 'The work that Malpa is doing to support these communities is inspirational. I'm really excited about how ACEM can support them.'

There are now 1,200 Graduate Young Doctors bringing this knowledge to their communities. One school principal working with the program said, 'when it is Young Doctors

day, we get 100% attendance – even on Fridays!' The program instils a sense of pride and ownership in young people, while learning simple hygiene tricks like nose-blowing and face washing (which can prevent a raft of chronic disease later in life). The children also get to participate in sessions to encourage future careers.

'I was holding a heart in my hand!' exclaimed one Young Doctor with a mixture of fascination and surprise. 'And then a kidney!' Down in East Gippsland, forty Dala Mala Malung Doctors attended a weekend camp to encourage careers in medicine. Lead by Dr Jane Greacen and Aunty Doris Paton, and supported by Elders, doctors and paramedics, the young people became certified practitioners of CPR and learnt about diabetes and much more. It was a weekend to remember.

Malpa programs have been shown to help young people gain confidence, increase their school attendance rates, help their communities by having a group of young people telling their families all of the things they are learning. Really importantly for ACEM, young Indigenous children get to meet a range of health professionals who can encourage and inspire them to consider a career in health.

So how can ACEM contribute to Malpa? Improving health literacy is a really important goal for Malpa. By identifying FACEMs who want to partner with local Malpa projects, doctors and project leads can work together to design projects to address local health needs. Project leads and the Young Doctors have a lot to learn from our Fellows. From simple things like how to navigate the ED if you need to go with a family member, how to clean a wound and put a bandage on, to supporting project leads to identify ways to navigate local health systems and ensuring the children in the project are getting the healthcare they need. ACEM has also offered to support Malpa to develop an educational framework to include health literacy in all the projects across Australia.

FACEMs working with Malpa can be part of supporting young Indigenous Australians to be our future doctors, emergency specialists and leaders.

***Author: Amelia Howard**, General Manager, Strategic Partnerships*

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**What are MALPA's outcomes?**

Results have shown:

**87-98%**
school attendance (Excluding Sorry Business)

**100%**
of Young Doctors reported thinking about working in a job after completing school

**98%**
reported feeling happy to come to school since becoming Young Doctors

**100%**
reported they are happy to see a doctor since participating in Young Doctors

**100%**
reported sharing their new learning with other children and families

**100%**
reported knowing more about Aboriginal culture

**100%**
of parents reported that their child's school was more supportive since they offered Young Doctors

**99%**
were able to identify 1-3 people within their community to ask about healing (they mentioned Elders, parents, health professionals and teachers)

**3 in 5**
highlighted that they most enjoyed learning from Elders and Aboriginal community leaders

*'My child grew in confidence since doing Young Doctors. She is now fascinated with cures and medicines. She has more of an appreciation, respect and understanding of her heritage and of Aboriginal culture. I saw a significant difference in my child's empathy and compassion and now she says she wants to be a doctor.'*

**A parent's comment**

*https://www.malpa.org.au/why-this-works*

# Staff Wellbeing

**Dr Anil Nair and Dr Mike Nicholls**

Dr Nair is the ED Director at Auckland City Hospital, New Zealand and has an interest in improving patient experience and staff wellbeing.

Dr Nicholls has an interest in workplace wellbeing and believes that improving this requires attention to efficiency of practice, the culture of the department, as well as individual resilience. Supported by funding from the 2019 ACEM Morson Taylor Award Grant, he and his team will be researching workplace wellbeing in emergency departments throughout New Zealand in 2020.

In the busy and sometimes chaotic environment of the ED, it is rare for emergency clinicians to focus on their health and wellbeing. We are expected to be at our best 24/7 and not be affected by the physical and psychological trauma that we see in our daily work. Like most hospitals, we have improved the flexibility of clinical rosters and tried to maximise leave. Most of our clinicians work part-time, and this seems to give a better work-life balance.

We are fortunate at Auckland City Hospital to have clinicians who are passionate about addressing this critical issue. Initially led by Dr Lynn Theron and now Dr Mike Nicholls, our multidisciplinary Healthy Workplace Group focuses on the improvement of staff wellbeing. Our department has seen several attempts at improving staff wellbeing through focus on the system, culture and personal resilience, as outlined by Bonham and others.[1] Each of these three domains will impact on the others. Improvement in workplace wellbeing, in theory, can be achieved using an evidence-based approach to quality improvement as advocated by the Institute for Healthcare Improvement framework.[2]

The Healthy Workplace Group did a survey of staff wellbeing in our department (n=270, 71% response rate).[3] Given that our most valuable resource is our people, it was encouraging that most respondents (80.7%) found their work meaningful, and one of four major themes gleaned from our qualitative results was the desire to provide high-quality patient care. Respondents thought that increasing staffing and improving IT would make the most positive difference to the system. We have had small increases in medical, nursing and clerical staff over the years, but this often lags behind an ever-increasing acute demand. We have attempted to improve aspects of our IT system, with some successes, for example, we now have ready access to new keyboards and computer mice when old ones malfunction, and have several new printers in our department. There remain many areas for improvement in the system.

In terms of staff culture, teamwork, respect for one another and open communication were the most frequently cited areas for improvement. One example in our department is an email project that has not yet gained the required traction. Communication, in particular, staff feeling well informed of important decisions (only 42% agreed with this), remains an area that requires attention.

We also focused on staff safety at work. ED staff are at high risk of exposure to violence. We used a three-pronged approach: environment; deterrence (increased security presence); and team training. Significant changes in the environment were made, including securing areas with instant 'lockdown', duress alarms and improved CCTV coverage. A dedicated behavioural assessment and mental health area is also planned. To enable staff to report violence easily, occupational violence (OV) readers have been installed. Security presence was increased with the employment of 30 security guards. Head security officers (HSOs) undergo intensive induction training that emphasises soft skills not usual in security, including values, ethical decision-making, teamwork and emotional intelligence. Another innovative practice is intentional rounding, where HSOs spend more time interacting in friendly, supportive ways with patients and whānau identified as being at higher risk of escalating violence. Security values and practice are aligned with clinical values and practice. This has made the most noticeable difference in creating a safe environment for staff.

*ED staff are at high risk of exposure to violence. We used a three-pronged approach: environment, deterrence (increased security presence) and team training.*

Staff training included *in situ* simulations with security staff to manage aggressive behaviours. Security and nursing staff have undertaken a recognised course — Management of Actual or Potential Aggression (MAPA). This course emphasises verbal de-escalation and safe (pain-free) restraint, and has been highly effective at reducing the number and intensity of physical interventions. A modified module for medical and clerical staff is being rolled out. Since July 2019, incidents of verbal and physical abuse of staff have


decreased, and staff report significantly improved feelings of safety. This has been much appreciated by staff.

Projects that focus on improving personal resilience, if ill-considered, can reasonably be perceived as papering over cracks in the system, subtle attempts to blame staff for not managing stressful environments, and an obfuscation of responsibility of leaders to provide resources whereby workers can reasonably be expected to survive (and ideally thrive) at work. We trialled four four-week meditation workshops attended by 60 staff in response to 83.1% of survey respondents expressing interest. A nurse peer-support program, focused on new staff, is growing in response to 86.3% of nurse respondents indicating interest. Debriefing was identified as an idea to improve personal resilience. We have started a 'hot debrief' project that is challenged by time constraints staff face on a busy work floor, however it is evolving with use. Another program underway in November 2019, is the presence of a psychologist for staff in our department for six hours a week.

One of our clinicians, Dr James Le Fevre, has been looking at the impact of training on reducing stress at work and thereby improving resilience. It is well documented that austerity can result in adverse health outcomes for populations.[4] A qualitative investigation involving our UK colleagues eloquently articulates the effects on frontline staff:

'Feelings of detachment and powerlessness in the face of the conditions created by austerity policies were common among those interviewed. The longer one is confronted with situations where their professional integrity and ethos is compromised regularly, the more likely they are to suffer from moral and psychological effects such as detachments, low morale and burnout.'[5]

A deliberate focus on workplace wellbeing that is adequately resourced, using well-documented quality improvement methodology, and overseen by strong leadership, will ensure that we optimise our finite resources for the benefit of staff, the health system and, most importantly, our patients and their whānau. Despite our deficiencies, we have many strengths. We hope we can learn from our failures, build upon our achievements, and ensure our staff can thrive while doing significant work.

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# Education and Training

*Aboriginal, Torres Strait Islander and Māori recruitment, engagement, and support of trainees and Fellows*

### AIDA Conference 2019

Members of ACEM's Education Development team, along with some Indigenous Health Committee (IHC) members, attended the Australian Indigenous Doctors' Association (AIDA) 2019 Conference in Darwin, from 2 - 4 October.

The team took the opportunity to meet some of the Aboriginal and Torres Strait Islander doctors of the future, those currently exploring their specialist training options and those already working in their specialist field of choice. The conference program, which was packed with inspirational presentations, yarning circles and cultural activities, was a wonderful and highly memorable experience.

The highlights of the Gala evening were celebrating AIDA's recognition of Dr Ryan Dashwood's recent conferral of ACEM Fellowship, and Dr Elizabeth Mowatt (FACEM) receiving the AIDA Associate Member of the Year award in recognition of her exemplary dedication to improving health outcomes for Aboriginal and Torres Strait Islander peoples. Dr Mowatt, Chair of ACEM's IHC and Co-Chair of the Reconciliation Action Plan (RAP) Steering Group, has long advocated for Aboriginal, Torres Strait Islander and Māori patients and whānau, as well as supporting Aboriginal, Torres Strait Islander and Māori doctors, particularly those with a desire to pursue emergency medicine. Dr Mowatt has a keen eye for spotting future FACEMs in her workplace and is tireless in her support of them.

Dr Glenn Harrison (FACEM), Dr Dashwood (FACEM) and trainee Dr John Zorbas, with the support of Anna Kaider (General Manager, Education Program Development) and members of the IHC, conducted an interactive workshop for Indigenous medical students to support them in preparing their applications for the Selection into FACEM Training process. The workshop was very well attended and highly regarded by participants.

### Yarns with our Indigenous trainees and Fellows, kōrero with our Māori trainees and Fellows

Following the launch of Manaaki Mana and the development of ACEM's second RAP, conversations have continued with ACEM's Indigenous trainees and Fellows to glean their views on barriers to selection into FACEM training, existing and potential support for Indigenous trainees and Fellows, and involvement in ACEM committees. Once all yarns and kōrero have been conducted, a de-identified report with recommended actions will be prepared for consideration by the IHC, Council of Education (COE) and other ACEM entities.

### LIME Connections VIII

Dr Max Raos (FACEM) and Anna Kaider of ACEM's Education Development Unit, delivered a presentation on the reasoning, design and implementation of selection into FACEM training, and ACEM's plans for continuing engagement with, and support of, prospective and current Aboriginal, Torres Strait Islander and Māori trainees and Fellows, at the LIME Connections VIII conference in Christchurch on 5 - 8 November.

LIME has established a network for specialist medical colleges, of which ACEM is a founding member. The network affords Fellows and College staff the opportunity to share success stories and lessons learned, and to further explore strategies to optimise education and training initiatives for Indigenous trainees and Fellows.

### The future

Education and Training are excited about what the future holds as we focus on recruitment, engagement, and support of Indigenous trainees and Fellows, including:

- Continuing yarns and kōrero
- Actioning the Education and Training deliverables of the Manaaki Mana and RAP
- Further developing networking and mentoring opportunities
- Exploring ACEM's involvement in the activities of Malpa and its Young Doctors for Life program, and the Melbourne Indigenous Transition School
- Continuing to develop programmatic assessment of cultural competence and safety for ACEM training programs
- Encouraging and supporting existing and developing Indigenous Health Special Skills Placements
- Continuing active engagement with AIDA and the LIME Network for Specialist Medical Colleges.

ACEM's dedicated contact for Indigenous, Torres Strait Islander and Māori trainees is Elisa Carbone, who is readily available to answer questions and provide support to our trainees.

Queries and conversations related to recruitment, engagement and support of Indigenous, Torres Strait Islander and Māori trainees and Fellows can be directed to Alicia Hewes, ACEM's Education Development Coordinator.

# Calendar – Education and Training

## Trainees

| FEB | | | |
|---|---|---|---|
| 3 | Training Term 1 (2020 Training Year) Commences (Australia) | | |
| 7 | 2020.1 PE Written Examination | Examination date | *Various locations* |
| 10 | 2020.1 PE Viva Examination | Applications open | |
| 24 | 2020.1 FE Written Examination | Applications open | |

| MAR | | | |
|---|---|---|---|
| 6 | 2020.1 PE Viva Examination | Applications close | |
| 8 | Training Term 1 Ends (New Zealand) | | |
| 9 | Training Term 2 Starts (New Zealand) | | |
| 10-13 | 2020.1 FE Clinical OSCE | Examination date | *Melbourne* |
| 16-17 | 2020.1 FE Clinical OSCE | Examination date | *Melbourne* |
| 20 | 2020.1 FE Written Examination | Applications close | |

| MAY | | | |
|---|---|---|---|
| 3 | Training Term 1 Ends (Australia) | | |
| 4 | Training Term 2 Starts (Australia) | | |
| 7-8 | 2020.1 PE Viva Examination | Examination date | *Melbourne* |
| 15 | 2020.1 FE Written Examination | Examination date | *Various Locations* |

# CAPP

The Council of Advocacy, Practice and Partnerships (CAPP) had their final meeting for 2019 immediately prior to the College Annual Scientific Meeting (ASM) in November. As this was the final meeting for the current CAPP term, those members who were leaving the Council: Dr Peter Allely; Dr Suzanne Doherty; Dr Alan Tankel; Dr Sara MacKenzie; and Dr Tom Soulsby, were thanked for their contributions. As Chair, Dr Yusuf Nagree was also thanked for his dedicated and expert leadership of CAPP since its inception in 2014. Several achievements for 2019 were discussed, including:

### Mental health campaign

The impact of the College's two-year Mental Health in the ED campaign, including ongoing plans for 2020 with respect to the Australian and New Zealand health systems, was discussed. ACEM President at the time, Dr Simon Judkins, emphasised the College's success in reframing the narrative around the issue of long stays in the ED, with 12- and 24-hour stays now adopted by external organisations as a tangible measure of system success or failure. Moving forward, CAPP endorsed plans for the establishment of a mental health working group (subsequently approved by the ACEM Board) for the development of Australian and New Zealand Mental Health Plans.

### Rethinking of time-based targets

The Chair of the Health System Reform (HSR) Committee reported on outcomes from the most recent meeting, where three key access measures were agreed upon. In conjunction with an expert working group, a draft paper outlining a final position on time-based targets will be prepared ahead of consultation with the College membership. Following consultation with ACEM members the position paper will be reviewed by the Standards and Endorsement Committee ahead of consideration by CAPP.

### Supporting EM research

Councilors noted that the inaugural ACEM Research Network Symposium, held immediately following the 2019 ASM, was fully subscribed. CAPP also noted that the Emergency Department Epidemiology Network (EDEN) is progressing work to secure National Health and Medical Research Council (NHMRC) funding in order to procure linked data from the Australian Institute of Health and Welfare (AIHW) Non-admitted Patient ED Care and Admitted Patient Care National Minimum Datasets.

# Vale Dr Yusuf Nagree

It is with great sadness that Friday 22 November 2019 saw the passing of our dear friend and colleague, Dr Yusuf Nagree. Throughout his life Yusuf inspired so many of us with his dignity, humility and generosity. Yusuf was one of the world's true gentlemen. Those of us privileged enough to have worked with Yusuf knew that we could approach him for help at any time, which he would always willingly give and yet never ask anything in return. Yusuf reminds us that the only reason you really need to help others, is because you can.

Yusuf never promoted his own achievements, however, he embodied the ethos of what it meant to be an emergency physician and there is little doubt he is among the most influential emergency physicians of our generation in Australia and we have a great deal to thank him for.

He was an active advocate for Emergency Medicine in International and College forums, Western Australian health services, and held pivotal roles in the College as well as in and around Perth, including the Fiona Stanley Hospital.

Yusuf had a long-standing involvement with and commitment to ACEM and served on a range of Committees most recently as the Chair of CAPP, a member of the Governance Committee and a member of the Board.

We feel privileged to have worked alongside Yusuf and will miss him enormously both as a friend and a colleague. Yusuf is survived by his mother, father and two brothers all of whom were by his side during his final illness.

We grieve Yusuf's loss; we are humbled to have known him and we celebrate the difference he has made to our lives.

*Dr John Bonning*

# New Zealand Emergency Department Conference

The New Zealand Emergency Department (ED) Conference marked its 11th year with a focus on Māori equity and the newly developed Manaaki Mana strategy. A diverse spectrum of distinguished speakers kept everyone on the edge of their seats. Held in Taupō, on the edge of the lake, the conference is a great opportunity for nurses, doctors and management staff to get together and focus on non-clinical issues that affect our EDs. The meeting is preceded by separate meetings for the Directors of Emergency Medicine and Charge Nurse Managers from EDs across the country. It is also an opportunity for the whole of the New Zealand ACEM Faculty to meet at the Faculty meeting and to discuss issues specifically pertinent to New Zealand FACEMs. With plenty of time to network, it is the ideal place to catch up with friends and colleagues one seldom sees. This year the conference launched the 'Peter Freeman Making a Difference Award' and will be seeking nominees for this prestigious award in 2020.

We wish to thank the organisers for the hard work and time they put into organising the most important and well-attended meetings affecting New Zealand EDs. Everyone in New Zealand EDs simply refer to this as the 'Taupō conference', illustrating how well it is embedded across Aotearoa.

***Author: Dr André Cromhout**, New Zealand Faculty Chair*

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# ACEM 2019 Annual Scientific Meeting

**17-21 November 2019, Hobart, Tasmania**

2019 saw yet another successful ACEM Annual Scientific Meeting (ASM). The event, held at Hobart's scenic harbour side, in the Hotel Grand Chancellor, attracted more than 900 delegates from Australia, New Zealand, America, South Korea, Singapore, Japan, Fiji and many other countries. The theme of the Meeting *The Changing Climate of Emergency Medicine* was a particularly relevant and timely one for emergency medicine.

Congratulations and thank you to the Convenor of the event, Associate Professor Geoff Couser, and the Organising Committee. Congratulations also to the staff that ably supported them.

In keeping with the theme of the Meeting, from the outset of this event the Organising Committee sought to deliver a more sustainable conference, which was achieved by purchasing carbon offsets, reducing the amount of printable material, using digital platforms to deliver key information onsite, vegetarian catering and offering collapsible, reusable and biodegradable cups.

Having farewelled Hobart after a fun and busy event, work is already well underway for the 37th ASM. The College looks forward to welcoming you all again to the next Meeting in Canberra in 2020.

A selection of photos from the Hobart ASM





### College Ceremony

The College Ceremony was a great opportunity to welcome and recognise many new Fellows and to wish them well in the next phase of their journey. A record number of 124 new Fellows attended the Ceremony and collected their Fellowship certificates, in front of their family, friends and colleagues. A number of outstanding Fellows were also recognised at the Ceremony, with several worthy recipients receiving awards and commendations for their contributions to emergency medicine and to the College.

### Program

One of the biggest drawcards of the ASM has always been the unique gathering of Fellows, members, trainees, international visitors and presenters from all over Australia and New Zealand, and the globe, covering a myriad of different topics. The theme for the week was reflected throughout the presentations.

Highlights included former Tasmanian and Federal Greens leader, medical doctor and life-long activist, Dr Bob Brown, delivering this year's ACEM Foundation Lecture.

### Social Functions

Hobart is known for its culture and cuisine, as well as for its many bars and restaurants. Many of these locations provided lovely settings for the various social functions and dinners held throughout the week. After a quick ferry ride across the Derwent, the Welcome Reception took place at MONA, where nothing was as it seemed, and delegates were welcome to explore the many interesting and sometimes bewildering exhibits. The ASM Dinner was held at The Goods Shed; an unconventional venue for some unconventional Tasmanian Gothic outfits. The Global Emergency Care Network Dinner was held at Annapurna restaurant, where the signing of the Memorandum of Understanding with the Secretariat for the Pacific Community took place, formalising efforts between ACEM and the Pacific Region.


# My First Day on the Job

### Dr Emma Batistich

I was PGY2 and wanted to train in anaesthesia/ICU. An ED rotation became available so I took it thinking it would be useful for anaesthesia/ICU training. My first shift in ED changed the trajectory of my career and life. I loved the fast pace, the variety and the tangible difference I could make. One patient came in with urinary retention and

*'My first shift in ED changed the trajectory of my career and life.'*

was in agony - I put in an IDC and he cried with relief and gratitude. Fifteen years later and I still remember that patient. Needless to say - I was hooked from day one in the ED. I signed up for EM training and I've never looked back.

### Dr Natasha McKay

I started working in ED as a PGY2 and my first shift was a night shift (I guess someone has to do it!). The senior registrar on looked unimpressed at having to deal with a newbie and sent me off to make the coffee.

*'I have never forgotten this case nearly 15 years on, and also take handlebar injuries VERY seriously!'*

The first patient I saw was a 12-year-old boy who had come off his bike and had a handlebar injury to his upper abdomen. I didn't realise the significance of this, and thought that as he didn't seem too sore, I would send him home. Luckily the registrar reviewed the child and advised me to refer him to the surgeons for observation. Turned out he had a pancreatic injury and required surgery the following day. I have never forgotten this case nearly 15 years on, and also take handlebar injuries VERY seriously!!

### Dr Charley Greentree

It was the Monday after medical school graduation. Poverty dictated starting 6 weeks before my peers. I didn't know where I fit, if I belonged. I had no identity as a doctor, but I told myself I could work hard, listen and learn. My first day as a doctor was in the emergency department. I walked into the office, hoping not to be noticed and dreading seeing my first patient. The Director of ED stepped forward.

'I'm Pat. You're new. Pick up that chart and see that patient. Ask lots. Come and tell me in ten minutes what you know.'

A few years later I'm walking into that same emergency department as a day one registrar. I had been tempted to start training in another specialty but after six months, the culture of 'eating your own young' had enlightened me. I remembered this other workplace that included everyone, saw everyone, even when it wasn't in the textbook, and returned.

*'A few years later I'm walking into that same emergency department as a day one registrar.'*

They saw humanity on all of its days, in all of its ways. The bosses smiled, spoke to you, took interest in you.

No photograph supplied.

### Dr Clare Skinner

It's not my first day ever in ED that has stuck in my memory. It's my first day back, after a year out to study, teach and work out what to do with myself.

I was at a loose end. Broken. I had been scared off clinical medicine. Time away helped, but I missed the sense of purpose and identity that came with being a 'real' doctor.

I arrived early. Dressed in plain clothes. The butterflies in my stomach fluttered so hard I thought they might escape through my mouth.

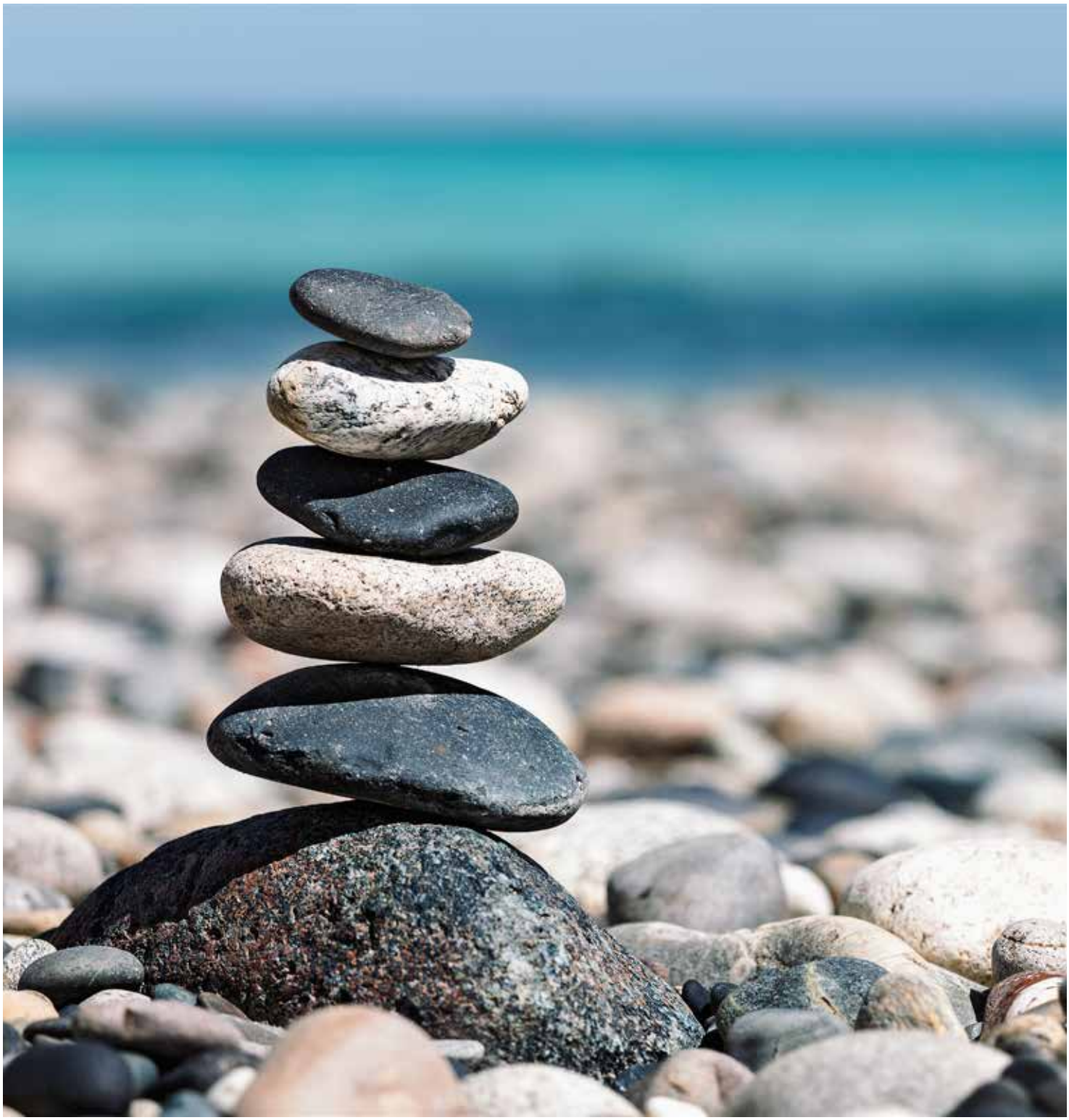
I timidly joined the ward round, led by a woman with presence. She had curly blonde hair and intense eyes. She scribbled on a piece of paper towel as we moved around the department.

'Who are you?' she asked. 'Clare', I replied. '@%#*!' she said. 'Not another Clare.' We paused for introductions. There were five Clares on the round.

'Pick up a patient', she suggested. I hesitated. 'You'll be right, pet', she said. 'I'll help.'

Later, she overheard me getting a grilling. Calcium gluconate versus calcium chloride. She sidled up. 'Ignore him', she whispered.

An extraordinary role-model had entered my life. Caring, intelligent, thorough, hard-working and as direct as they come. I felt safe. I knew instantly that I wanted to be just like her when I grew up.



"There is no such thing as work-life balance – it is all life. The balance has to be within you."

**–Sadhguru**

## Need tips for managing competing demands?

Speak in total confidence to a Converge International consultant.
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