your ED

ACEM AND COVID-19

OUTBREAK
Measles in Samoa

RESEARCH
Supporting Productive Culture

EMET
Rural and Regional Health During Coronavirus

Flinders Street Station in Melbourne's CBD stands eerily empty during the coronavirus crisis.

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Australasian College for Emergency Medicine

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

Cover: iStock.com/ FiledIMAGE

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Message from the Editor

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

This issue was written during a changed world, so different from previous issues. As we move forward during these uncertain times, we endeavour to give you a clear understanding of what the College has done, and continues to do, during the time of COVID-19.

Faculty Chairs from across Australia and New Zealand address what's happening in their region and how coronavirus is affecting them, and we hear from Dr Roberto Cosentini in Bergamo, Italy on the initial stages of the pandemic in his city and beyond.

We follow the story of another outbreak, this time measles in Samoa, written when a novel coronavirus in Wuhan was something we were watching on the horizon, and how the measles epidemic stimulated a rush of outbreak preparedness and training in other Pacific countries.

The Global Emergency Care stories in this issue come from tropical pre-monsoon season in Sri Lanka, emergency life support training in Vanuatu and tales of violent electrical storms in Zambia.

We hope you enjoy these perspectives on emergency medicine and take care of yourselves.

ACEM in the Media

In **March**, ACEM continued to feature prominently in media coverage of the ongoing COVID-19 situation. A College media release calling for improved community testing and screening options for coronavirus received widespread national coverage across Australia, including in print in *The Australian* and *The Sydney Morning Herald* and on ABC radio, television and online.

ACEM President Dr John Bonning told *The Australian* large crowds lining up outside hospitals and emergency departments were potentially increasing the risk of infections.

'We need to urgently set up fever clinics in the community, particularly for the worried well and those with possibly mild illness for testing this disease.'

In **March**, Dr Bonning and ACEM Immediate Past President Dr Simon Judkins featured in media coverage canvassing the type of treatment decisions doctors may have to make should COVID-19 cases escalate in Australia to the extent being experienced in Italy at the time.

Dr Judkins told *The Sydney Morning Herald* and *The Age* that if the number of COVID-19 infections increased rapidly, there might not be enough intensive care beds.

'The reason we try to put in mitigation strategies and slow the spread of the disease down is to avoid that, to flatten the spike and spread the sick people out so that it's less likely they won't be able to cope', said Dr Judkins.

'But if there is a surge, it's a very tough situation. Like any triage situation, you triage according to who is the most likely person to benefit from the intervention — the person who is most likely to survive.'

Dr Bonning also spoke about the issue in a radio interview with the ABC in Melbourne.

'We do have what's called disaster triage and we plan for this sort of thing, in general, if you have a disaster at a football stadium or an earthquake or what have you. You have to change the way you do things ever so slightly and have a utilitarian approach of the greatest good for the most people.'

'We need to plan for this but I am keen that it's not felt that we're in the war zone yet.'

In **March**, ACEM featured in media coverage of *Emergency Medicine Education and Training (EMET)* sessions held in a number of health services in the Western New South Wales (NSW) Local Health District — including Mudgee, Gulgong and Rylstone.

'The days are full on, these smaller facilities are so grateful that we can tend to their health service to provide this education and training', FACEM Dr Randall Greenberg, Director of Critical Services for Dubbo Health Service Emergency Department, told the *Mudgee Guardian & Gulgong Advertiser.*

In **March**, Dr Bonning featured in *The Daily Telegraph* commenting on new statistics issued by the NSW Bureau of Health Information on the increasing pressures on Emergency Departments (EDs) in the state, prior to the emergence of COVID-19.

'In light of the coronavirus situation, this highlights the crucial importance of robust and ongoing planning, and a whole-of-healthcare-system response to meet the significant new and ongoing challenges and ensure the sustainability of frontline efforts', said Dr Bonning.

In **March**, Dr Judkins participated in a panel discussion on Dr Sally Cockburn's nationally syndicated radio show on 3AW, discussing information and myths pertaining to COVID-19.

Dr Judkins was one of several representatives of specialist medical colleges who appeared on the program to discuss the response to the coronavirus.

In **March**, Dr Bonning featured prominently in Australian and New Zealand media discussing the crucial importance of personal protective equipment (PPE) supply, security and training to keep frontline healthcare workers safe.

'PPE must be used in accordance with clinical best practice to look after patients and it is healthcare workers' PPE needs, which must be the primary consideration here rather than having their approach dictated by supply', Dr Bonning told *The Age*.

In a further interview with TVNZ, Dr Bonning spoke of the urgent need to protect frontline medical workers, and paid tribute to the work of emergency doctors.

'We've got a phrase that we use, that there is no patient emergency that is more important than the safety of our healthcare workforce, and that might sound a little bit harsh, but in fact we've got guidelines around if somebody collapses and needs CPR. We need to make sure that the people there that are going to resuscitate those people in hospital are fully protected with personal protective equipment', said Dr Bonning.

'Our people, I'm amazed at how they are lifting themselves into leadership positions and really organising themselves. It's amazing, it takes a crisis like this to see people say "right, you know, let's do this".'

In **March**, a Tweet by Dr Judkins was featured in *The Monthly* as part of a compilation of key quotes of the coronavirus pandemic to date.

'Part of the pandemic plan is "hospitals opening their surge capacity". Now, I don't want to alarm anyone, but there is no surge capacity … We've been saying this for years', read the Tweet, which featured alongside quotes from US President Donald Trump, Iranian Deputy Health Minister Iraj Harirchi, Australia's Deputy Chief Medical Officer Professor Paul Kelly and Australian Prime Minster Scott Morrison, among others.

In **March**, an article by members of ACEM's Public Health and Disaster Committee, Dr Laksmi

Govindasamy, Dr Kimberly Humphrey and Dr Lai Heng Foong, explaining why climate change is a public health emergency, was featured in the National Rural Health Alliance's *Partyline* publication.

'The climate crisis is a health emergency because it poses an existential threat to the systems upon which our society and our lives depend', the article began.

In **April**, FACEM Professor Diana Egerton-Warburton featured in print, television and radio media in Victoria as part of a crowdsourcing drive to have businesses donate unused stocks of non-medical grade PPE for use in training frontline medical staff.

'This is an unprecedented opportunity for different industries to rally together and strengthen the frontline of our health system', Professor Egerton-Warburton told *The Age*, of the initiative, which was also backed by ACEM.

In **April**, ACEM Tasmania Faculty Chair Dr Juan Carlos Ascencio-Lane participated in a number of ABC radio interviews to discuss the COVID-19 situation, and, in particular, to show support for frontline medical staff in the northwest of the state, where a significant outbreak caused the closure of local hospital facilities.

'It's not just staff, it's the whole population. Within Tasmania, and across Australia and the world, we need to support and we need to be there for each other', said Dr Ascencio-Lane.

'From the Australasian College for Emergency Medicine, we unreservedly support our colleagues up in the northwest. They've been doing a fantastic job and they've been put in a really difficult situation.'

During **April**, ACEM's call for members of the community not to neglect urgent medical needs and to continue seeking medical care as required received widespread media coverage in print, online and on radio and television across Australia and New Zealand. An ACEM media release on the topic was picked up by ABC radio news, *The Guardian* and the Australian Associated Press, and widely syndicated across the country. Meanwhile, Dr Bonning conducted several media interviews on the topic in New Zealand.

ACEM Victoria Faculty Chair Dr Mya Cubitt echoed the sentiments in comments made to *The Age* in Melbourne.

'By delaying seeking medical attention for severe illness or health issues, such as heart attacks, asthma or abdominal conditions such as appendicitis, patients risk making their situations much worse, and in extreme cases this can be life threatening', Dr Cubitt warned.

In **April**, Dr Cubitt was featured in a *Croakey* article discussing her personal, professional and family experiences of COVID-19.

Dr Cubitt said, despite the challenges of contending with coronavirus, she saw room for optimism in the pandemic planning and unprecedented levels of collaboration, which may assist not just in weathering coronavirus, but also in addressing ongoing systemic issues.

'I hope that on the other side of this, there are lasting system changes and improvements', said Dr Cubitt.

Dr Cubitt also featured in online publication *Kidspot* to discuss the impact of working on the coronavirus response on family life.

'I have an awesome team of people around me who are working really hard to care for others. I don't think my kids get a vibe that I'm unsafe. I'm not afraid, so they aren't afraid', said Dr Cubitt.

Meanwhile, FACEM Dr Bishan Rajapakse featured in an ABC online story, speaking of his experiences being a new dad and working at the hospital frontlines during coronavirus.

In **April**, EMET activities in regional Queensland aimed at preparing local hospitals for COVID-19 received coverage in local media.

'In the last few weeks, we've ramped up efforts and tailored the training in light of the current pandemic, so we've been able to deliver a COVID-19 module to our rural teams', said FACEM and Darling Downs Health Director of Clinical Training Dr Sheree Conroy.

The EMET activity was covered in the *Balonne Beacon, Dalby Herald, Chinchilla News, Stanthorpe Border Post, South Burnett Times* and *Oakey Champion*.

In **April**, FACEM Dr Shahina Braganza was featured in *The Gold Coast Bulletin* paying tribute to the team effort underway to address COVID-19 on the Gold Coast.

'We have been so humbled by the response from the community, both in tangible ways and their moral support, but we want to make sure that this support is felt by every worker at Gold Coast Hospital', said Dr Braganza.

'Doctors and nurses are always recognised but there are so many less visible workers like cleaners, wards people and catering services, whose roles are equally as vital.'

'It all contributes to delivering the best patient care. Everyone has stepped up and everyone is essential.'

In **April**, Dr Bonning was featured on ABC radio's AM program discussing access issues faced by fly-in-fly-out healthcare workers at some regional and rural hospitals, which the College had raised with the Australian Government.

'It really is both the restriction in travel and the drastic reduction in flights that's caused this issue', said Dr Bonning.

'I'm always in awe of the teams who often work there, and people who are in these location who stay and work longer.'

In **April**, ACEM issued media releases as part of the Driving Change project, highlighting the high prevalence of takeaway alcohol consumption among patients requiring hospital treatment after drinking in Melbourne and Canberra.

'Despite lockdown conditions, emergency clinicians are still seeing tragic cases of alcohol-related harm presenting to EDs. People are stressed and anxious, and what we don't want to see is people using excessive amounts of alcohol, often delivered straight to their doors, to try and relieve that stress', said Dr Bonning.

PRESIDENT'S WELCOME

Once again, the COVID-19 roller-coaster has proceeded at speed in the few months since the last edition of *Your ED*. In Australia, Aotearoa New Zealand and around the world, the escalation of and response to the pandemic has had a massive impact on our lives, work and communities.

The sheer speed and scope of developments and changes has presented momentous challenges, and plenty of anxiety, uncertainty and stress. We've all had to make major ongoing changes to almost everything we do. We certainly know more than we did in March but much uncertainty still remains.

While the threat isn't over, it's important to search for positives and cause for optimism. Some of that can stem from the observation that, compared to even just a few weeks ago, the path forward is looking a little bit clearer, and there can be silver linings and learnings from a crisis like this.

Our thoughts and sympathies remain with colleagues, internationally and across our two nations, experiencing ongoing challenges as a result of COVID-19. Relative to the rest of the world, however, Australia and New Zealand, at the time of writing, were on track to avoid the overwhelming surge of cases that have been experienced further abroad. We've got ourselves onto a life raft, just uncertain which way to paddle it, unlike colleagues in the UK, Europe and US who are still floundering in the water.

Clearly, the stringent public health measures, including community lockdown and physical distancing, put in place by our governments have had an impact. Remember whilst we must be physically distant we must remain socially close. Such measures have been beneficial in terms of flattening the curve, however, there is of course the flipside of the social and economic impacts of the pandemic and response to consider. There has been a tremendous amount of work carried out behind the scenes and at the frontline, particularly by emergency physicians.

In this edition of *Your ED*, we reflect on some of that work; the tremendous efforts of our colleagues in emergency departments (EDs) in Australia and New Zealand, and internationally, as well as the College's efforts in supporting its members and trainees during these unprecedented times.

I trust that you will be as impressed as I have by the volume and quality of what has been achieved, with our focus on a common goal as part of whole-of-health-system responses to COVID-19. Achievements due in no small part to the leadership our members and College staff have shown.

While we remain hopeful of avoiding a second wave of COVID-19 cases, we brace for further challenges, such as the potentially unmet acute and chronic healthcare needs that may be simmering under the surface during the pandemic.

As the impacts of COVID-19 continue, we are mindful of the pressures this can place on mental health, and the need for dedicated services and resources, for the patients we treat, and the medical professionals who continue to work so hard over the course of this pandemic.

As we acclimatise to our new normal, we must learn from the lessons and experiences we have gained, particularly the cooperation that has flourished across our health systems. Looking ahead, a priority for our advocacy efforts must be avoiding a return to the chronic access block and ED overcrowding so common prior to COVID-19, and which we see re-emerging in some locations.

Our journey in this pandemic continues and uncertainty persists, but I hope this edition of *Your ED* gives you cause to reflect on how far we have come, that we are in a better place than we could have been, had we not reacted as we did, and I hope you will take some heart from that.

'Our thoughts and sympathies remain with colleagues, internationally and across our two nations, experiencing ongoing challenges as a result of COVID-19'

CEO's Welcome

Dr Peter White

In the article Managing Wellness During COVID-19 contained in this edition of *Your ED*, Dr Charley Greenstone opens with the question, 'When was the last time that the world you knew changed profoundly?'. The article goes on to point out that, recently, millions of people are experiencing that feeling of profound change at the same time as a result of the COVID-19 pandemic, and that for this region of the world, we are reminded that COVID-19 arrived shortly after the extraordinary bushfire season in Australia. We are also aware that the White Island eruption was in December just last year.

The last few months has indeed been a time that can be described as unprecedented for the vast majority of us, and which will almost certainly leave a legacy of long-term change and lesson learning. The health systems in Australia and Aotearoa New Zealand have experienced preparedness assessment that only a threat to public health such as COVID-19 can provide and we have seen how important decisive action with clear objectives and messaging can be in averting widespread poor medical and social outcomes. Similarly, in other countries with supposedly well-resourced healthcare systems, we have seen how a lack of decisive action, and unclear objectives and messaging can have medical and social outcomes that leave members of those societies wondering what could have been had things been done differently.

The last few months have certainly been unique in my lifetime; never before have social controls been enacted that were seen as necessary to avert illness and death on a widespread scale, probably not seen since the time of my grandparents. This issue of *Your ED* gives some indication of what has been required of the profession of emergency medicine during this time, from dealing with the need for supplies of PPE to the need for guidelines to guide practice at a time when the status of patients coming through the ED doors from an infection perspective was frequently unknown. Rightly so, healthcare workers across the hospital and primary care sector have been recognised as critical during this time and ED doctors and other staff have been at the forefront of the efforts that have kept the system working.

As CEO of ACEM I have seen first-hand the efforts of ACEM members, trainees and staff in responding to the pandemic and the needs of the profession in Australia and New Zealand. What has been satisfying from a College perspective is the ability of all involved to focus on the tasks at hand and recognise the importance of getting things done within timeframes where delays in responding can have potentially widespread negative implications at both a professional and a general societal level. Indeed, it may have taken a global viral pandemic, but after close on two decades I can now reflect on how a specialist medical college can actually be described to me as 'agile' by a Fellow, with all the positive associations implicit in the contemporary use of that term.

The past few months have indeed been many things; unique, extraordinary, unprecedented, etc. Part of the purpose of implementing a communications tool like *Your ED* was to try and develop a mechanism that enabled a widespread dissemination of the positive things that ACEM does. It is times like this that there are, indeed, many positive things that the College does and the hope is that *Your ED* aids in communicating that. This is the half-way point of a two-year trial period for the magazine. When the opportunity to assess its usefulness arises in the near future, please give us your views.

It would be remiss of me to finish without acknowledging the members and trainees who have worked over and above their ED shifts to ensure that ACEM could rise to the challenges presented by COVID-19. It would also be remiss not to acknowledge the efforts of the ACEM staff, who have adjusted to the requirements of the situation and who have worked in partnership with members and trainees for the good of the College and the populations who depend on the medical care provided by EDs.

Finally, while recognising the inherent dangers always present in singling out individuals, I would like to use the privileged position I have of writing this column to acknowledge the contributions of the College President, Dr John Bonning. As College CEO I work closely with the College President and John's commitment to both ACEM and the profession has been on display every day during the COVID-19 situation. Leadership is easy when times are stable and straightforward. When times are as they have been for the past few months it is not such an easy thing and it requires qualities that John has demonstrated in considerable quantities. The organisation known as ACEM has been fortunate to be in such committed, capable hands.

New Object Proposed for Constitution

In mid-2020, the College will seek support from FACEMs on a special resolution to include a new object in the ACEM Constitution. The object will explicitly state the College's commitment to equity and excellence in emergency care for Aboriginal, Torres Strait Islander and Māori communities.

FACEM Dr Max Raos (Te Atiawa/Te Arawa) says the change will underpin equity as a core business at the College.

'The addition of this object is written affirmation that equity for our College is not lip service – it is of value and something we must strive for.'

'Its inclusion gives a signal to Aboriginal and Torres Strait Islander Peoples and Māori from Australia and Aotearoa that we count, our views should be regarded and included in guiding College policy.'

New Fellow Dr Ryan Dashwood – a Budawang man, part of the Yuin Nation – says a constitution represents the values and beliefs of a group at the time it is authored. 'Now is the time for an upgrade [to the College Constitution]. We cannot remedy the cultural devastation [that has occurred], but we can move forward to improve the current inequities.'

'By ACEM taking a stance and acknowledging Aboriginal and Torres Strait Islander Peoples and Māori People in our Constitution, our College is recognising the health inequalities we suffer.'

'It means we – the College – not only accept, but also promote the vital role emergency physicians play in holistically improving health outcomes.'

The proposed object makes explicit the College's commitment to the principles of Te Tiriti o Waitangi (the Treaty of Waitangi), the process of reconciliation in Australia and the intent of the United Nations Declaration on the Rights of Indigenous Peoples. If successful, it would be the first object of its kind among medical colleges in Australia.

Similar to the vote on two special resolutions in 2019, this vote will be voluntary, but 75 per cent of those Fellows who choose to vote must support the resolution for the object to be passed into the Constitution. The wording of the object has been worked on by members of the Reconciliation Action Plan Steering Group and Manaaki Mana Steering Group.

Retired Fellow Associate Professor Geoff Hughes, Editor-in-Chief of Emergency Medicine Australasia, says as a member of the Manaaki Mana Steering Group he has had several 'lightbulb' moments that have altered his perspective.

'I've realised what I thought I knew was wrong. It has been an educational and very reflective experience, which I have truly learnt from. The subtlety in it for me, as a white person of European descent, is understanding what equity really and properly means for Māori, Aboriginal and Torres Strait Islander Peoples. I regret not having had these lightbulb moments earlier in my career.'

He thinks health outcomes have the potential – in time – to be broadly changed by the inclusion of such an object.

'Rome wasn't built in a day. In time, I do think that improvements will be seen in most health outcomes – be they acute illness and injury, chronic disease, social health or wellbeing and mental health.'

FACEM Dr Liz Mowatt says the statement is simple in intent and hard to disagree with.

'Inclusion in the Constitution will be very powerful, both as an action and as a symbol. The action is work we are already doing. It is work that enriches all aspects of emergency medicine for all staff, patients, family and whānau.'

'In many ways, the symbolism is even more important than the action. By actively including this object, we are standing up as a College and saying proudly to anyone who looks that these things are something that ACEM values, something that we prioritise, and we welcome the challenge to live up to those commitments.'

For Ryan, it's simple. 'The College is not pretending it has all the answers. It is saying we are taking a journey. We are striving to get somewhere, to achieve equity.'

Your vote counts. When you receive the ballot, cast your vote to make a positive difference at the College.

Author: Fatima Mehmedbegovic, Strategic Priorities Implementation Manager

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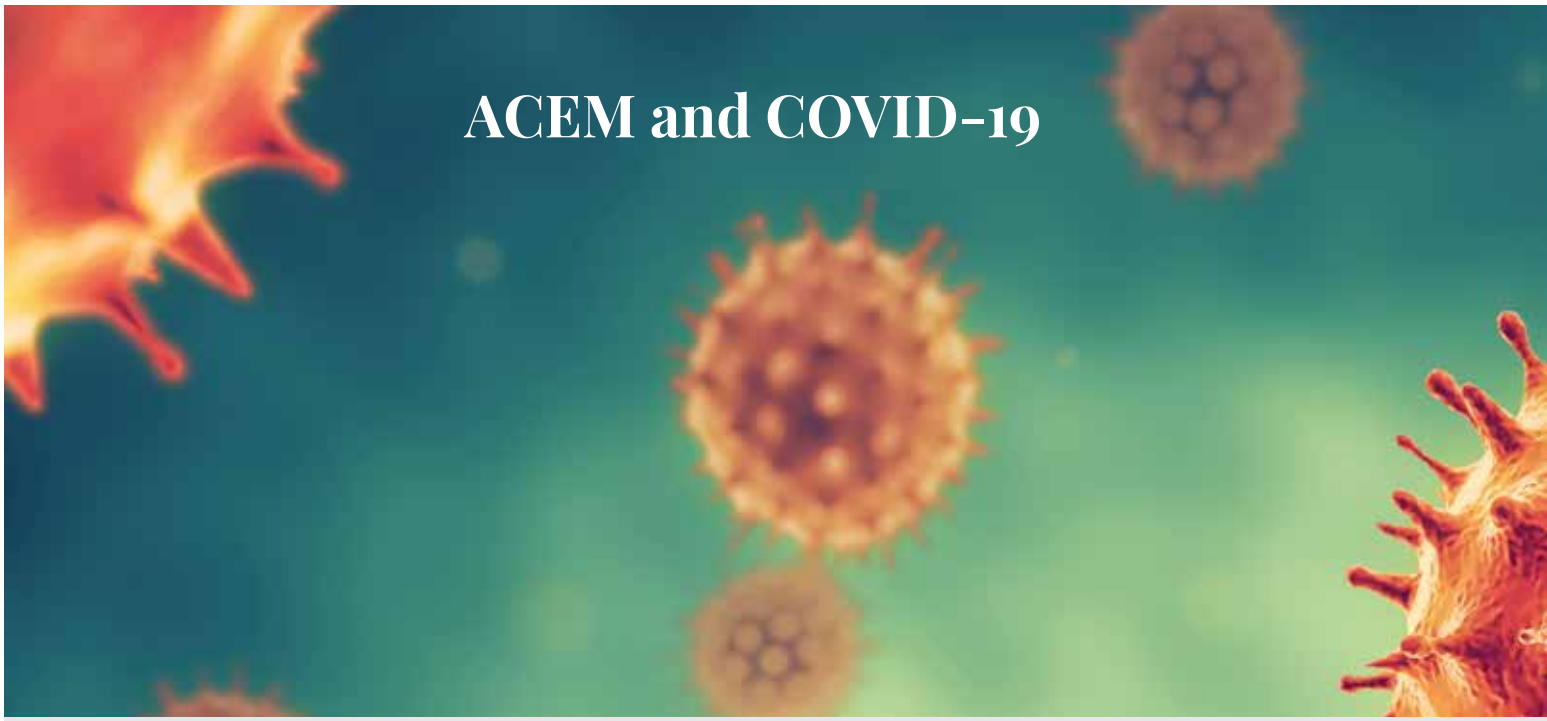
More information

acem.org.au/vote



ACEM and COVID-19

Clinical Guidelines – Planning for the Worst, Hoping for the Best

'There is no patient emergency more important than the safety of our healthcare workforce.'

As the narrative of overwhelmed hospitals and appalling human tragedy began to unfold in the media in late February 2020, creating waves of anticipatory fear and anxiety in medical communities across the globe, another phenomenon threatened to hamper efforts to respond effectively to COVID-19 – information overload.

FACEMs were quickly deluged with information, trying to make sense of a torrent of rapid review articles, expert (and non-expert) opinion and guidance, and homegrown protocols and algorithms shared peer-to-peer through multiple channels. While this represented an amazing outpouring of goodwill, it was clear that the receipt of discrete, often overlapping or contradictory pieces of unevaluated information was contributing to general feelings of helplessness. Afterall, at the best of times, the breadth and volume of information required by emergency clinicians in treating a large volume of undifferentiated physical and behavioural conditions is a challenge to cognitive retention.

Mark Twain once apologised that, 'I didn't have time to write a short letter, so I wrote a long one instead'. This quote acknowledges that selectivity is the cornerstone of quality, recognising that comparison and distillation creates value. The College quickly realised that it needed to 'shorten the letter', through truncating its normal governance processes without sacrificing quality, authenticity and provenance. Perfect should not be the enemy of good, but 'good' needed the safeguards provided by method, expertise and hard work.

Luckily, help was at hand when a team from Safer Care Victoria, led by FACEM Professor Peter Cameron, approached ACEM suggesting collaboration in developing a set of 'meta' guidelines, or a 'straw man' framework that could be used to integrate existing advice across the various clinical domains of the emergency department (ED) in managing COVID-19. Answering the clarion call, an authoring group of around 20 FACEMs and FACEM Training Program trainees from across Australia and New Zealand was mobilised, working tirelessly to populate the domains with new and existing content. Authors were allocated to chapters based on their expertise, and all content was agreed by consensus of the full authoring group.

'Just finished reading through this brilliant set of guidelines. Thank you, thank you to everyone involved. Clear and measured recommendations covering system and patient issues. A must-read for everyone working on the front line.'

The *ACEM COVID-19 Clinical Guidelines* were published on 26 March 2020. ACEM staff, working with the authors and in line with the urgency of the situation, ensured that the online product had the publication values required of such an important resource. The Guidelines are a living document based on the best information known at the time, and represent a framework of general principles of COVID-19 and non-COVID-19 emergency care that apply to all workplaces. They provide clear recommendations across the domains of

response planning, patient flow, transport, infection control, personal protective equipment (PPE), treatment, care of specific patient cohorts, rural and remote EDs, ethics, and staff wellbeing.

Since that first version, new evidence identified by routine scanning, or provided by College members via a dedicated structured feedback form, has been evaluated by the authoring group on a weekly basis. Several further iterations of the Guidelines have been published, reflecting the growing and changing evidence base, particularly around the safe use of PPE and treatment efficacy. Work has also been undertaken to distil relevant aspects of the Guidelines into a *COVID-19 Toolkit for Rural and Remote EDs*, with publication imminent at the time of writing. The authoring group has also collaborated in developing the Guideline's CPR recommendations into a journal article, with the hope that it will be published in the MJA. Over the last few weeks, aspects of the Guidelines have been featured in well-attended ACEM webinars presented by members of the authoring team and other experts.

One encouraging aspect of the response has been the focus on clinician welfare, with many initiatives and tools developed to help staff cope with the real and apparent danger to their patients, themselves and their families. ACEM has evaluated and made available to members an online peer-reviewed collection of these resources.

At the time of writing, this pandemic has not, in Australia and New Zealand thankfully, turned into the public health catastrophe that many predicted. However, the dread of what might have come or might still be coming, the exhausting daily rituals of PPE and other infection control measures, the concern of a time-lag of patients who are inappropriately self-managing their non-COVID problems, and the unavailability of many of the usual 'reset' mechanisms, will take their toll. We cannot forget that, for many FACEMs and trainees, this pandemic closely follows the trauma of the Australian bushfires and White Island disaster.

In response, the College will continue to consider the best ways to support its members and trainees, particularly in the aftermath of the pandemic, as they attempt to re-establish business as usual while many are simultaneously 'running on empty'. The College is grateful for the ingenuity, resourcefulness and commitment of all those involved in the development of the Guidelines, and all those using them in 'planning for the worst, while hoping for the best'.

Richard Whittome, ACEM Staff

Council of Education – Responses to COVID-19

The impacts of COVID-19 in the community have been significant, not least for our members and trainees working on the front line.

The Council of Education (COE), the ACEM Board and staff in the Education and Training Department have been meeting regularly since preparations for COVID-19 began, to ensure that any impacts on training could be minimised as much as possible and that no trainee would be unfairly disadvantaged by the uncertainty of the events unfolding at the time. This has meant monitoring and responding to issues as they have arisen and exploring flexible and pragmatic initiatives and options along the way. Each decision that has been made was in response to the best information available at that time, and so many decisions had to be revisited as the circumstances evolved, particularly in the first four to six weeks after COVID-19 was declared a pandemic.

Unlike some specialist colleges, ACEM made the decision early on to not suspend training requirements completely, for a period of time, but to introduce concessions and adjustments incrementally to help retain flexibility where it could. The College was very cognisant that applying blanket rules had the potential to disadvantage some trainees much more than others, and particularly those nearing the completion of their training.

Some difficult decisions had to be made early on, including the cancellation of the Primary Viva and the Fellowship Written Examination. Knowing that many months, sometimes years, are spent studying and sacrificing family and free time for examinations, the decision to cancel these was extremely difficult. All involved in this decision were acutely aware of the consequences and acknowledge the stress and disappointment that this decision may have brought to affected trainees. Behind the scenes, the College has been working hard to explore options, alternative dates and venues to try and ensure that when restrictions are eased and things become more certain, the examinations can be run and that all who are eligible can be accommodated.

At the time of writing this update, the predicted number of COVID-19 patients had not eventuated and so the expected impact on several training components, including the completion of WBAs and structured education sessions, has been much less than originally anticipated. Completion rates of Workplace-Based Assessments (WBAs) have been the same or higher than in comparable periods and education sessions have continued to be held in many sites, albeit in a different format and using different technology.

The College would like to thank all of our trainees and Fellows for earnestly trying to meet training program requirements and obligations, whilst also rearranging their workplaces, rosters and schedules to ensure hospitals everywhere were in a position to meet the expected challenges that our overseas colleagues were encountering.

COE and the ACEM Board will continue to monitor, review and reassess circumstances in the coming months.

We encourage you to visit the College's COVID-19 webpage (www.acem.org.au/COVID-19), which provides links to ACEM Board and COE Communiqués detailing all decisions made to date, as well as a wealth of other resources.

As always, if you have questions or concerns, please contact the relevant College staff directly. Staff may be working from home, but they are working harder than ever to support you.

Lyn Johnson, Executive Director of Education & Training

ACEM Media and Public Advocacy in Times of COVID-19

Few, if any, global events in recent memory have dominated the media's attention as much as the COVID-19 pandemic. Throughout 2020, the global creep and escalation of this virus has generated countless media stories and near blanket coverage of developments and impacts in Australia, Aotearoa New Zealand and globally.

With emergency physicians standing front and centre within public health responses to the coronavirus, the situation has generated numerous opportunities to engage in the media; to advocate publicly for, and tell the stories of, ACEM members and trainees at the front line. The protracted and intense media focus on the public healthcare systems of Australia and Aotearoa New Zealand has allowed for important contributions to the public health narrative in unprecedented times, and chances to highlight the crucial roles and work of emergency physicians.

Despite the abundance of opportunities for media engagement, the College has walked a delicate path; we are mindful of the need to advocate for the best interests of emergency doctors and our communities, while also promoting public calm and supporting proportionate and evidence-based responses, amid heightened community anxiety and an, at times, frenzied media environment.

As with ACEM's response to all aspects of COVID-19, the College's approach to public advocacy has prioritised the need to support members and trainees contending with the planning and response to the virus at the front lines.

This has included calling for a calm and unified response to COVID-19, and a condemnation of discrimination, in response to reports of hospital staff and members of the community being subjected to racial profiling and racism during the early stages of the virus outbreak in Australia.

Meanwhile, in early March, the College led the way with advocacy for a cooperative response to COVID-19, acknowledging the crucial role emergency physicians have to play within whole-of-health-system efforts.

ACEM media engagements and public comments over this time have supplemented and complemented formal advocacy efforts to governments and national, jurisdictional and local health authorities.

This has included: calls from the College for improved coronavirus screening in the community to alleviate pressure on EDs; the need for additional hospital capacity; the importance of keeping frontline healthcare workers safe, including security of supply, and training in the proper use of, personal protective equipment; the workforce needs and difficulties being experienced by hospitals in rural and regional areas; and a call for patients not to neglect their urgent and primary healthcare needs during the pandemic amid concerns of a looming surge in unmet need, and catch up demand in the community once the COVID situation eases.

Amid all of this, the stories of individual emergency physicians, speaking of their professional, personal and family experiences of COVID-19, have featured prominently in the media. Such stories have recognised the sacrifices being made and the valuable, stressful and demanding work being carried out.

While the profile of emergency medicine and emergency physicians has unquestionably been raised during this pandemic, the ongoing challenge of College media and public advocacy efforts will be ensuring that long-term systemic improvements for our members, trainees and the communities they serve, are secured and cemented in place.

This will be an ongoing priority for the remainder of the COVID-19 response and into the future as we all confront our 'new normal'.

Andrew MacDonald, Media Relations Manager

A Snapshot of COVID-19 Across Australia and Aotearoa New Zealand

John Bonning, ACEM President (Chair of the Faculty Chairs group)

When I commenced my role as the ACEM President, responding to a global pandemic was not on my 'things to do' list. While all the crystal balls were smashed in March, there is perhaps a little more future clarity in May compared to then, and we are now in a unique position to influence our ongoing response to these challenging circumstances by drawing on our training, experience and expertise, as well as our experiences of the last few months.

I continue to be impressed and inspired by the leadership roles and actions undertaken by our members and trainees in response to this slow-moving disaster. Looking back at what I promised to promote through my presidency – equity, our personal and professional sustainability, resource stewardship amongst others – there has never been a better opportunity to look at our future, a new normal, through the lens of these issues.

I take this opportunity to thank each Faculty Board for representing the concerns and challenges of their colleagues and patients, for their support in working with the College to our common goals and values, for their opinions on what the next weeks and months holds for us, and their vision and leadership in what we need to strive for as we continue to navigate the uncharted waters of this pandemic.

The Faculty Chairs group would normally meet three times a year … we had met three times by 1 May! We've discussed the latest developments in Australia and New Zealand, and how the College can best support our members and trainees. I hope I can reassure you that we continue to engage with ministers, Chief Medical Officers and health departments in all jurisdictions on issues, including Personal Protective Equipment (PPE) use and supply, workforce needs in regional areas, emergency department (ED) design to manage COVID-19 patients, wellbeing initiatives, and our desires for a new normal where access block and crowded EDs are a thing of the past.

Enough from me, what better way to hear about these issues than from each Faculty directly – I welcome the following updates from Faculty Chairs on a snapshot of their experiences.

Michael Edmonds, Acting Chair, South Australia (SA) Faculty

- In the space of two meetings, I've been promoted to Acting Faculty Chair as Mark Morphett (the new Chair) has accepted a role within SA Health throughout the pandemic. This degree of influence is a great outcome for the Faculty and I believe will better assist SA's management of this challenge.
- We have had a lower degree of impact from the pandemic than initially feared. Fortunately, the Royal Adelaide Hospital's design has greatly assisted managing patients suspected of having COVID-19, or those who are COVID-positive.
- Planning and resources across regional and rural SA remain a concern.

Didier Palmer, Chair, Northern Territory (NT) Faculty

- We have been extremely fortunate to have had no community-based transmissions and no cases in our Indigenous communities.
- Closing our borders, good leadership from the Health Department and across the Territory, and community support in following restrictions has placed NT in a good position to face the months ahead.
- The challenge now is sustaining the community message that COVID has not 'gone' and that we still need to be cautious in opening up restrictions and maintaining physical distancing.
- We also have to remain vigilant in hospital as we re-open services.

Peter Allely, Chair, Western Australia (WA) Faculty

- WA has been managing this crisis well. Our EDs are working effectively to support both COVID and non-COVID patients.
- Closing the state border and minimising intrastate travel appears to have been effective in controlling cases.
- The COVID impact on the airline industry has led to significant difficulties with regional hospital staffing, with fly-in-fly-out out FACEMs no longer able to get to some centres.
- The difficulties in recruiting overseas doctors at the moment is likely to start impacting all departments in the state by mid-year, with some departments facing shortages of 50 per cent in their junior medical workforce.
- PPE stocks are good and transparency from the Department of Health has reassured staff.

Trevor Chan, Chair, New South Wales (NSW) Faculty

- At the start of 2020, NSW was significantly impacted by the terrible bushfires that affected large parts of Australia. Our communities and regional EDs were under significant pressure due to the immediate threat of the fires, while many other areas struggled through the haze and resultant respiratory issues patients presented with.

- We then moved straight into a pandemic, with the highest numbers across Australia and New Zealand. Hospitals and EDs rapidly moved to update and develop pandemic pathways reflecting issues such as testing, PPE, managing COVID presentations of low and high acuity, and managing ED workforce and flow. What began as informal discussion and coordination amongst FACEMs became more formalised via the ED Community of Practice, with the assistance of the Emergency Care Institute/Agency for Clinical Innovation, with regular teleconference meetings on multiple topics and the development of guidelines, pathways and procedures. This was supported by regular NSW Faculty meetings.
- EDs across the state liaised with colleagues from intensive care, anaesthetics, medicine, in particular respiratory medicine, infectious disease and public health, to establish direct and regular communication pathways.
- Specific case clusters, such as passengers and crew from the Ruby Princess cruise ship, and residents and workers at Anglicare Newmarch House, reminded everyone of the dangers associated with transmission and acuity of COVID-19. There are ongoing system lessons to be learnt from both clusters.
- I've been impressed by how quickly different services have pulled together to make some pretty significant changes to the ways we operate:
  - The Community of Practice has been a useful and innovative collaboration between the Ministry of Health and frontline clinical staff, and might be of use for other jurisdictions for future major challenges or crises.
  - New models of care have been established, for example, secondary triage of residential aged care facility patients, access to telehealth, and ED diversion streams.
- Now is our time to reflect on which parts of this 'new world' we want to keep, and what our 'new normal' will look like. We've proven that our systems can be agile, innovative and resilient in response to unprecedented need — this is worth celebrating.
- COVID-19 has highlighted the longer term supports required for staff. Wellbeing efforts were welcomed from the College; they are needed and will be needed as we continue to manage this pandemic.

Mya Cubitt, Chair, Victoria Faculty

- I thank all members of the Victoria Faculty for their support. Taking on the role of Faculty Chair in a time of pandemic has been interesting, challenging and engaging – it's been really pleasing to see so many faces during our Zoom meetings ('the new normal') and on Microsoft Teams. It really does help!
- Victoria felt the significant impacts of the bushfires early in the year. Immediate Past President Simon Judkins travelled to bushfire-affected communities to lend a hand, seeing first-hand the devastating impacts of the conditions. Smoke haze hit our communities with a vengeance, impacting many people with respiratory issues. We know members of the College had to make changes to their daily lives to manage their health during this time as well.
- As COVID-19 hit, Victoria was presented with new challenges, including processes to better manage resources and supports across the state. This included engaging broadly with external stakeholders (Chief Health Officers, Department of Health and Human Services Deputy Secretaries, Ambulance Victoria), to improve communication and better align planning arrangements. We're also working hard to better engage our members and DEMs.
- I'm particularly pleased we've been able to improve visibility and engagement with our rural and regional workforce colleagues through increased collaboration with the College of Intensive Care Medicine of Australia and New Zealand (CICM), the Australian College of Rural and Remote Medicine (ACRRM), and the Rural Doctors Association of Victoria (RDAV, through a Regional/Rural Critical Care Network. This has also provided an opportunity for an unprecedented level of resource sharing among EDs, no better example than in the ACEM COVID-19 Clinical Guidelines, to improve efficiency in our response and shared learning.
- Victoria has had the second highest levels of infection and deaths in Australia, and we remain concerned for the impacts on non-COVID patients, those presenting late, those with mental health issues, and people vulnerable to domestic violence.
- We're not out of this yet but we are giving ourselves some room to breathe – let's hope it continues!

Kim Hansen, Chair, Queensland Faculty

- There have been challenges with the fly-in-fly-out (FIFO) workforce to some regional centres due to the drop off in domestic flights.
- Queensland has had moderate numbers of COVID patients in the hospital system compared with other states, but most are diagnosed through 'fever clinics' that are separate to the EDs. Once diagnosed as COVID-positive, patients are admitted to a 'virtual ward' and hospitalised if they deteriorate. This means admissions through ED with known COVID-positive patients have been largely avoided.
- Virtual wards have been set up across Queensland as a type of hospital in the home (HITH) ward. All COVID-positive patients who are well enough to be at home are admitted as inpatients remotely, and then have structured telephone or video reviews twice daily, more if needed. There is a dedicated nursing and medical team to meet their needs. There has also been a virtual ED set up in north Brisbane for COVID and non-COVID patients, for clinicians in the community to talk to a FACEM for advice.
- The development of ACEM COVID-19 Clinical Guidelines has greatly helped with better certainty of how to prepare and plan for patient care in EDs.

Suzanne Smallbane, Chair, Australian Capital Territory Faculty

- In Canberra, we were also affected by the bushfires early in the year, with the city covered in smoke haze. We all saw very clearly the impacts of the climate crisis and hoped our representatives in Parliament took this message on board as well.
- COVID-19 planning started before we had much time to catch our breaths. Our hospitals worked well to put procedures in place, managing not only the needs of our Territory residents, but those that come to our hospitals from NSW.
- We have a short-term hospital being built to manage the COVID-19 caseload.

Juan Carlos Ascencio-Lane, Chair, Tasmania Faculty

- I took over as Faculty Chair from the steady hand of Marielle Ruigrok early in the year, as she started planning for long service leave. It has certainly been an experience taking over this role in a time of crisis.
- COVID-19 led to not just a crisis, but a show of solidarity among the EDs in Tasmania. We all stood together, supporting and developing strategies to move through this crisis.
- PPE and protocols were on everyone's mind, but together we developed protocols and methods to ensure we had adequate equipment. While mistakes were made, we quickly learnt and improved, leading the country in certain practices that improved our approach.
- The North West (NW) Tasmanian experience has been on the national radar – it resulted in both NW EDs being closed. It was a turbulent time for the NW, but we worked hard to support them. We watched on as our colleagues were all put into two weeks quarantine and had their department run by Australian Medical Assistance Teams (AUSMAT) and the Australian Defence Force (ADF), a great example of the support being offered when required. Life is slowly getting back to normal up in the NW. The experience showed us all how quickly this infection can spread and the impact it can have, particularly on a small community.
- The impact of the NW was felt in the rest of the state, as Launceston ED took up the challenge to look after the entire north of the state and the south had staff at the ready to send. We saw just how strong our emergency medicine family is in Tasmania and how supportive it is as care packages were sent from and to all departments.
- We now have better engagement with the health department and are working hard to support our members and trainees during these challenging times. We will use this to carry a great relationship forwards.
- A great side effect of the virus has been the ability of teams across departments in some of our hospitals to work more collaboratively. The whole-of-hospital approach has had a significant impact on access block, particularly in the Royal Hobart Hospital. We have proven that effective flow and teamwork can work.

Andre Cromhout, Chair, Aotearoa New Zealand (NZ) Faculty

- NZ has now had more than six weeks of quarantine, which has had an important impact on the spread of COVID-19, with a significant decrease in the number of cases reported. At this stage, there has been almost three weeks of single digit daily new cases with multiple days of no new cases.
- As of 11 May, there were only 123 active cases across the whole country.
- NZ did see a Minister (incidentally the Minister of Health) demoted for going to the beach, against the government's stay at home order. This is a strong reminder that we must all be accountable for our actions and keeping our country safe. We have been interested to see such a positive international lens on our Prime Minister!
- We almost had an ED closed due to widespread staff exposure in the very early phase of the pandemic, however, the situation was well managed and has now been resolved.
- There is now a significant emphasis on keeping staff and residents in Residential Aged Care Facilities (RACF) safe as outbreaks of the virus in two RACF contributed to almost 90 per cent of all COVID-19 related deaths in NZ.
- The NZ Government is planning to ease some of the restrictions and increase the ability to socialise, although with some restrictions still in place.
- It is hoped an increase in health spending announced in the 14 May NZ budget will contribute to overcoming decades of underspending laid bare by COVID-19.

The Indo-Pacific Region

Colin Banks, Chair, Global Emergency Care Committee (GECCo)

- This is not a faculty report but the challenges for our neighbours in the Indo-Pacific are worth considering.
- Thankfully, the region has been spared the worst of the pandemic, at least thus far. With few or even no recorded cases, many Pacific countries are in the preparation or containment phase. The impact though has been immense. Common issues are fragile health infrastructure, insufficient PPE and minimal or no testing capability. Many Pacific countries face economic devastation with the border closures and the ability to respond is limited. As if this wasn't enough, severe tropical Cyclone Harold wreaked havoc resulting in the loss of many lives in the Solomon Islands.
- Emergency physicians have taken key roles in the national response in many countries, demonstrating leadership and resilience in areas outside the traditional scope of our specialty.
- While it is a challenge from afar, GECCo is supporting emergency care providers in the region with the development of guidelines for EDs in low and middle-income countries (LMICs), as well as hosting regular online meetings to share ideas, strategies and concerns. We are working with our partner organisations, including the Pacific Community (SPC), to assist where we can.

COVID-19: The Italy Experience

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On 20 March 2020, ACEM hosted its first webinar (*COVID-19 – an ED Focus*). In a matter of days, there were more than a thousand registrations, and almost as many attended on the day. The webinar was presented by FACEMs Associate Professor Didier Palmer OAM Chair of the Northern Territory Faculty Board, and Queensland Faculty Chair Dr Kim Hansen, and infectious disease physician Dr Alex Chaudhuri. It ran for more than an hour.

It was not without its glitches, but it is the first of many pivots the College will undertake to confront this pandemic. The priority is to support members and trainees – to facilitate safe practice, advocate for adequate resourcing, and ensure trainees can continue their training, even as examinations are postponed and training opportunities are cancelled.

On 27 March, the College hosted a second webinar – an account from Italy by emergency physician Dr Roberto Cosentini, presented by FACEMs Dr Martin Than, Dr Jan Bone and ACEM President Dr John Bonning.

This webinar was conducted when Italy was the epicentre of the COVID-19 pandemic.

An account from Bergamo

Dr Roberto Cosentini is Director of Emergency Medicine at a hospital in the small town of Bergamo, northeast of Milan, in Italy's Lombardi region.

'Bergamo is a town of 100,000 people, but we're the biggest facility in the area – 900 beds. We [the hospital] serve about a million people each year', Dr Cosentini said.

'Our outbreak started on 21 February, so now it's day 35. Until now, we saw 1,600 suspected COVID patients. We have admitted more than 900 patients with pneumonia.'

The initial wave of patients were 60 to 80 years old. Dr Cosentini said after those first couple of weeks, they saw a shift to younger patients – 40 to 60 years of age.

They had three positive healthcare workers in the ED from a staff of 32, with an infection rate of 10 to 15 per cent across the hospital, which he found 'not too bad'.

'We used typical PPE. Visors, glasses, masks (N95), gowns, overshoes.'

Dr Cosentini's hospital was fortunate not to experience PPE shortages.

'The relationship between the patient and us changed dramatically during the epidemic. No patient asks about their disease or their future. They have complete faith in us.'

'We received many masks – either surgical or N95 – from other hospitals or even from other countries. A group of doctors visiting from China left several boxes of masks for us.'

The hospital started with 80 regular ICU beds as a big hospital. Gradually, these were converted into COVID-19 ICU beds. After expanding into the recovery room, they had 90 COVID-19 ICU beds, with patients kept in cohorts. Clean (non-COVID) patients were transferred to other hospitals to ensure access for COVID-19 patients to ICU beds.

Nonetheless, Dr Cosentini said Italy – Bergamo – made mistakes early.

'We started late with social distancing and lockdown. We'd had the virus for three weeks already. By the time people started distancing, we had already seen a high surge.'

Some of that surge was attributed to a football match on 19 February that was attended in Milan by more than 40,000 people.

'Lots of people who attended – the vast majority – went to Milan by bus. 50 people to a bus. I think that – the travel and the football match – contributed significantly to the spread of infection before the onset.'

It was not until images of the devastation were shared that people began to take the distancing and lockdown measures seriously.

'Figures don't speak to the heart, images do', Dr Cosentini said.

'We read the numbers from China, but we didn't understand until we saw it for ourselves.'

Dr Cosentini said his hospital initially had success with hot (dirty)/cold (clean) zones, but, very quickly, they were swamped and the whole department was a hot zone.

The system required flexibility.

'The dirty area in the first few days was very small. Only upper respiratory patients, but then we had to enlarge it because the number of people steeply increased, and people were much sicker.'

The clean area saw a dramatic drop in patients, with just four beds allocated to it in late March. Ninety per cent of patients were COVID-19.

In the ED, the COVID-19 area was split into zones to help to manage severity and space.

Red: six beds – intubated patients
Orange: 16 beds – NIV + awaiting admission (started with eight patients, but peaked at 16)
Green: 22 beds – O2 but OK

Elsewhere in the department, the waiting area and hallways had been turned into bed space, with a total capacity for 100 patients.

'We also rapidly doubled beds in the infectious disease unit in the hospital. We now have 350 COVID-19 beds around the hospital.'

One of their methods to manage patients was to re-purpose beds and under-utilised staff from other areas of the hospital.

'We organised rapid education courses about acute respiratory failure and CPAP application. Each ward was supervised by an intensivist, an immunologist or infectious disease doctor.'

Each patient receiving oxygen was given a mask, regardless of oxygen type.

To protect staff and their families, Dr Cosentini said many staff stayed near the hospital. He slept in the hospital, but others were able to sleep in hotels nearby or accommodation lent by those living locally.

'Since the relatives are not allowed to go to hospital when he or she is dying, I see that sometimes they prefer to stay at home with their elderly relatives.

'Most of the older patients, older than 80, with CPAP or intubation, died.'

Dr Cosentini said he'd had a friend at the centre of Italy's initial outbreak – in a town named Lodi – and he'd been able to give advice in Bergamo to prepare for what was to come. This helped their response, but also enabled them to take some care of mental health.

'We were prepared. We had only three to four days, but we were mentally prepared for this.'

Dr Cosentini gave daily updates via email to the rest of the hospital. The hospital started providing psychological support within a week of the outbreak, which helped to deal with the daily tragedy.

'The relationship between the patient and us changed dramatically during the epidemic. No patient asks about their disease or their future. They have complete faith in us and they are somewhat relaxed.'

'The trouble for them is that they are away from their family and communication is difficult. This has been tough, but we have a strong relationship with the relatives.'

More information

All College resources relating to COVID-19, including the full video and audio recording of this webinar, may be accessed at acem.org.au/covid-19

Measles in Samoa

Dr Mark Little
Dr Little is an emergency physician and clinical toxicologist in Cairns Hospital, Queensland. He is one of the AUSMAT Mission Leads.

Samoa has the same population (roughly 200,000), climate and vegetation as Cairns, where I live. It is a country where religion and family are paramount; children are their future.

Sadly, Samoa's entire health system was overwhelmed with a measles epidemic, and I, as leader of an Australian Medical Assistance Team (AUSMAT) was deployed twice in November and December 2019.

As you read this, look at your hospital. Imagine double the usual number of presentations to your emergency department (ED) for weeks on end and having to use a clinic area to see all cases of measles. Imagine that every corridor, room and space has a chair or bed with someone (usually a child under age five) who has measles. Your waiting room now has nine beds (full) and your side rooms all have cases in them. Some patients have been in your ED for 24 hours.

A state of emergency exists. All schools and universities are closed. Sports events and gatherings are cancelled. Children and visitors are banned from hospitals and dissuaded to go to church, and, for two days, the entire country closes while mandatory vaccinations occur.

Your 120-bed hospital has up to 190 cases of measles, plus your usual workload. Your seven-bed ICU has 11 patients, all children ventilated, and two adults are ventilated in recovery. There are another 10 children, critically ill, being managed either in a high dependency unit in the paediatric ward or the AUSMAT ICU tent. You have converted your dental and physio clinics into wards that now house nearly 70 children, all with measles, all miserable. Your paediatric ward is 35 per cent over capacity.

Since early October, your nursing staff have been working 12-hour shifts and your medical staff often work more than 24 hours straight. Family members of your staff are likely to have measles. All pregnant staff have been sent home.

All over the hospital, your staff are resuscitating sick children daily, usually with pneumonia who rapidly deteriorate.

You need an extra 180 nurses, dozens more medical staff, cleaners, laboratory, pharmacy and biomedical staff, orderlies and many others. Every part of your health system is overstretched. Your country's oxygen production system, which produces 30 G cylinders per day, is unable to supply the 80 G cylinders being used, and is just hanging on. The oxygen supply fails twice in a day in the ICU. You have literally run out of beds and Rotary is building wooden beds for you. All clinics are shut, and only emergency cases go to theatre.

Today there have been seven deaths and it is highly likely you know someone who has died.

This was the incredible crisis that confronted the Samoan health system.

For two months, more than 120 AUSMAT staff were deployed to Samoa to work alongside other international health teams to support this crisis. Our aim was not to take over, but to stand next to the Samoans and do what they needed or wanted to get through this. Our team worked in the national referral hospital, Tupua Tamasese Meaole Hospital (TTM), and in the

Health Emergency Operation Centre (HEOC), as well as setting up and running a tented eight-bed ICU and a 20-bed ward. Midway during the deployment, UK-Med, a UK medical team, was deployed for four weeks and worked alongside AUSMAT, adding to the skills and support we could provide.

Clinically, this was mainly a paediatric pneumonia crisis. Microbiology data showed that 50 per cent of the pneumonia cases were due to staph aureus and roughly 50 per cent of these were MRSA (methicillin-resistant staph aureus). Many children we managed with high-flow oxygen, while others were ventilated. Seventy-six children died. The World Health Organization (WHO) estimated that would be equivalent to 10,500 children dying in Australia in a 10 week period.

There was only one portable x-ray machine, so we deployed the AUSMAT machine and radiographer. Working with the Samoans and NZMAT team, we helped to solve the oxygen crisis. New Zealand helped fix and improve the machine; Australia brought out extra G cylinders and portable oxygen generators from the Australian Defence Force.

Our public health team helped improve data collection and analysis; our infectious disease physicians were microbiologists and strengthened the laboratory services, as well as helping better rationalise antibiotic management. Our emergency physicians and nurses worked alongside Samoan staff deployed to the ED. It would not be unusual to have clinic nurses, radiologists, ophthalmologists and GPs working together in an overwhelmed emergency system. Our paediatricians worked closely with the paediatric teams, as they often admitted up to 45 children a day, having over 110 inpatients. Our intensivists worked in the overwhelmed ICUs. And our amazing nurses worked everywhere, being at the bedside day and night alongside Samoan nurses.

We created systems and protocols, standardised care and used WhatsApp to create a medical emergency team (MET) service, share radiology and laboratory results, and as a mode to communicate to all relevant clinicians about plans for each child. The team created an ICU transfer trolley using a large 'tea' trolley with an auxiliary power unit, a high-flow unit and an oxygen cylinder, to transfer the sickest around the hospital. We shared the successes and grieved the deaths. Tears were shed nearly every day.

I led and supported this amazing team. I worked closely with the Samoan Director General of Health, the leadership team at TTM Hospital, the Australian Government and other governments' representatives, WHO, and leaders of other Medical Assistance Teams (MATs), to help strategise and collectively support the Samoans.

Officially, 83 people died (more than 90 per cent were children under age five); 1,868 cases were admitted to hospitals and 5,707 cases were notified. On 20 January 2020, the Samoan Government announced there were no inpatients with measles.

It is difficult to put into words what we all went through. If ever you needed proof of how important vaccinations are, this was it. The days were long, the nights longer. This was the largest and longest AUSMAT deployment and the hardest I have responded to. When I got home, friends and colleagues kept asking if I was ok. They later told me I looked pale, exhausted and 'haunted'. I was hypervigilant around any child with a fever presenting to the ED.

With some apprehension, I returned to Samoa just before Christmas. To see the numbers dropping, be able to give the Samoan staff time off, and see the ending of the crisis was extraordinary. Wandering around the hospital in early January to see healthy children and a normal hospital system was so therapeutic.

As AUSMAT was leaving in the first week of January, we received much gratitude from everyone, ranging from the Prime Minister of Samoa and the Director General, to hospital staff and the public. We all knew we could not have done this without the Samoan health staff and I feel they are the most amazing group of people I have ever met. I have the utmost admiration for them and how they dealt with this crisis. They were the true heroes and 2019 was rightly deemed the Year of the Health Worker by the local media.

But Samoa and its people will grieve for a long time.

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Dr Emma Lawrey

Dr Lawrey is an Emergency Physician at Auckland City Hospital, the clinical director for NZMAT and until recently a WHO consultant for the Emergency Medical Team Initiative. She is the Head of Foundation at MAS Foundation, a newly formed health philanthropy foundation that aims to improve health of New Zealanders by making systematic change.

For many emergency physicians, 2019 will be a memorable year, though possibly not for the right reasons. For some, it is the year of smoke and fires, the Christchurch mosque shooting and the White Island eruption, but for me, 2019 will be the year of measles.

The New Zealand Government Emergency Medical Assistance Team (NZMAT) is a trained group of physicians, nurses and urban search and rescue (fire personnel) who can deploy into austere environments with a fully self-sufficient tented medical facility — think MASH, but with blue scrubs instead of green camo. We deployed teams to Samoa in November 2019 for six weeks as part of the global support to the Samoan Ministry of Health (MOH). I initially deployed in November in the forward planning team to discuss with the Samoan MOH how NZMAT may be able to assist, and then subsequently in December as the Mission Clinical Lead for Team Bravo.

New Zealand and the Pacific are a hotbed for natural disasters. Oceania has the dubious honour of having five of the top 12 most natural disaster-prone countries according to the 2019 World Risk Index, including Vanuatu, that tops the list. But we find ourselves in a changing environment, where deployment scenarios for natural disasters are rivalled by outbreaks, and climate change and globalisation increase the risk.

All disasters cause a surge of patients, but in an outbreak the surge creeps up on a health system and can be sustained or increasing for weeks to months. There isn't that defining moment when it begins. When does it constitute a disaster? When do regions or countries ask for help? And given the recent developments with coronavirus, will that international support be available as all countries respond to or prepare for an internal surge?

We have tools to calculate the likely number of injured in an earthquake based on the estimated number of dead and the peak workload is predictably within the first few days. But in Samoa, each day we watched the data, looking for the top of the curve, tentatively hoping that the epidemiologists would look into their crystal ball and tell us that a small downturn in case presentations might just be the peak.

Since 2011, NZMAT has predominantly deployed within the Pacific for trauma and for national response we are focused on preparedness for earthquake and tsunami. That means we usually deploy with our own facility in an area where health infrastructure has been damaged and destruction is visibly evident. We live in tents, eat ration packs, roads are blocked, wharves destroyed, and buildings are down. Physical hardship and visible destruction creates a sense of urgency, helps formulate team cohesion and gives people resilience to work long, hard hours for a two-week deployment. But outbreaks are a different type of disaster; where five children die in your emergency department (ED) today, you can still walk down the road and buy an ice cream, or go to a restaurant for dinner after a shift.

What the numbers of sick and dead also don't convey is the clinical complexity of many of the cases and the challenge of managing health facilities full of highly infectious patients. Tupua Tamasese Meaole (TTM) Hospital in Apia opened a 'measles ED' in a separate building across the carpark from the main ED. Wards were designated suspected measles, confirmed measles or non-measles in order to group patients. All clinics were shut down and staff redeployed to the response. Well children were banned from hospital grounds.

Each morning, the hospital clinical staff would meet to report on the whiteboard how many patients their department had — measles, non-measles, adults and children, deaths in the last 24 hours. For many weeks, it was a sobering meeting without many highlights. Although the international response was focused on measles, as an emergency physician, I felt for the hospital ED as they shouldered most of the burden of non-measles work for the country and reported presentation numbers rivalling a tertiary hospital in New Zealand.

NZMAT is just one of many international teams that offered assistance for this unprecedented event in our region. As of early December 2019, more than 19 non-governmental organisations and governments had contributed surge support; many planned to send multiple rotations. This truly was a global response to a request for help in the South Pacific. Teams came from Australia, Norway, UK, French Polynesia, Solomon Islands, Papua New Guinea, USA, Japan, Israel, Médecins Sans Frontières, the Red Cross and Save the Children. It takes more than doctors and nurses to staff a response — assistance included clinicians, vaccinators, biomedical technicians, logisticians, oxygen supply specialists and public health specialists.

Although external support was welcomed, it comes with its own challenges. During this stressful period for the Samoan health staff, both personally and professionally, the Samoan MOH and its clinicians now had to integrate hundreds of new foreign staff, and they did so with patience and dedication. Imagine this in your own hospital — registrar turnover week is hard enough! Even with the best intentions and training, differences in language, culture, expectation, clinical decision-making and even ambient temperatures play their part in the dynamics of the response.

NZMAT deployed three rotations of doctors, nurses and logisticians to support the staff of Leulumoega (LLM) District Hospital and Faleolo Medical Center, which lies an hours' drive west of Apia. LLM, as it became known to staff, is a 10-12 bed district hospital located near Faleolo Airport on the main island of Upolu. It had been designated a measles-only assessment and inpatient facility. On my initial deployment, 21 children filled two small wards. All consulting rooms and the hallway were full, with numerous patients waiting to be seen. Local staff had been working at 200-300 per cent capacity for weeks with no days off and no end in sight.

Our staff embedded with local staff at LLM, bolstering numbers to assist with triage, resuscitation, assessment, and admission or transfer of measles cases. As in any disaster, regular community healthcare needs continue, so we also had a clinical team at a non-measles outpatient clinic to ensure that care of non-communicable diseases (NCDs), trauma and reproductive health continued. The delivery of a few babies by the NZMAT midwife allowed the team some happy memories among the sad. While the clinicians focused on patient care, the logisticians secured clean water, assisted with safe systems and management of oxygen, sourced supplies, improved infection prevention and control (IPC) in the small wards, and became famous for their rehydration solution ice block supply chain (among many other tasks).

Unfortunately, our team regularly had presentations of critically unwell children, many of whom didn't survive. Although EMTs ensure they send very experienced clinicians, the severity of illness and steadily climbing number of deaths hit all teams very hard.

NZMAT handed over the LLM support to a smaller Japanese team as presentation numbers were falling. There was a lot of angst within the New Zealand team when we

withdrew from Samoa. Was it the right time, would case numbers continue to fall, had the mass vaccination campaign been sufficient? I saw recently that TTM Hospital had discharged their last measles case. In retrospect, it was the right time for our team to withdraw, but the recovery for Samoa is only just beginning.

The majority of the 83 deaths were under the age of five — that's three classrooms of children who will never start school, sing in church, play in sports teams, get married and have children of their own. So many families left psychologically bereft, sometimes two or three children in a family having succumbed. Some of those who survived will have medical complications that will continue to affect them throughout their lifetime. These increased needs combined with the effects of three to four months of cancelled outpatient clinics and elective surgeries will have implications for the Samoan communities and health system for the foreseeable future.

Deployments highlight to me that medicine is so much more than a science. Without good relationships it is hard to achieve good outcomes. Delivering quality coordinated care takes good communication and a desire to find common ground.

Samoan culture places huge importance on relationships, faith, community and family, and the relationships we developed were many.

The Samoan community was incredibly welcoming to all these foreigners in their midst. Every taxi I took, coffee I ordered or shop I went into, Samoans took the time to talk and thank the international community for coming to support them.

When I see Samoan patients in the ED, I take a little extra time, chat a little longer, ask about their families and which village they are from, and check in on whether they have been affected directly by measles. We all have patients that touch our souls; I have a country.

Hesitancy to Vaccinate: The Case of Measles

No one needs to tell the medical community how deadly measles can be. For many people in Australia and New Zealand, they are fortunately unaware of the devastating effects of the disease. The irony is that this can lead to complacency and a belief from parents that their child will be fine even if they are not vaccinated. Today, countries which have previously eliminated measles are experiencing outbreaks and a resurgence of the disease. This resurgence has been attributed to vaccine hesitancy, incomplete or inadequate access to vaccination, and the increasing numbers of unvaccinated travellers visiting countries where measles is endemic or where outbreaks are occurring.

What is measles

Measles is a highly contagious virus spread through droplets from coughing or sneezing. It has a relatively long incubation period (10-14 days), which means that people can be moving around the community spreading the disease unwittingly before they develop symptoms. For most people, measles causes a high fever, runny nose, cough and watery eyes followed by a distinctive rash that can spread over the body.[1] Children under five and people who are immunocompromised are at risk of serious complications such as blindness, encephalitis, pneumonia and even death.

Prior to 1963, measles accounted for 2.6 million deaths worldwide every year.[2] While deaths have substantially decreased, it is still considered to be the leading preventable cause of death among children.[3]

Through the development of a vaccine and sustained vaccination programs, in 2014, the World Health Organization deemed that Australia had eliminated measles (transmission had been halted for 12 months and sustained over 36 months).[4] Three years later, in 2017, New Zealand was also awarded this status.[5] However, just a few years on, both Australia and New Zealand have experienced outbreaks of measles, the worst of which has occurred in New Zealand. Between 1 January 2019 and 29 January 2020, there were 2,193 confirmed cases across New Zealand, with 80 per cent occurring in the Auckland region alone.[6] Although there is evidence to suggest that transmission rates are slowing, New Zealand's measles free status will be reviewed again in March 2020.

Vaccine hesitancy

To prevent the spread of measles, more than 95 per cent of the population needs to be inoculated with two doses of the vaccine. In Australia, 94.78 per cent of children aged five years old in December 2019 were immunised.[7] However, in New Zealand, only 88 per cent of five-year-old children were immunised, with five per cent declining at least one vaccination.[8] Hesitancy to vaccinate reflects a growing concern to the ongoing prevention of measles. So much so that the World Health Organization considers vaccine hesitancy, that is, the delay or refusal to vaccinate, one of the top 10 global health threats. People's hesitancy may come from cultural or religious beliefs about vaccines, mistrust in their safety, fear that their child may have an adverse reaction, belief that vaccines are ineffective, or a general mistrust in the medical community.

Unfortunately, the Measles, Mumps and Rubella (MMR) vaccine has had its fair share of controversy. The MMR vaccine was first shrouded in controversy in 1998 when falsified data was published in the highly reputable journal *Lancet* linking the MMR vaccine with autism and inflammatory bowel disease. Despite the journal retracting the article and no evidence to suggest causation (including a *Cochrane* review), this myth continues to circulate and even has its own hashtag.

Antivaccination sentiment is a powerful and growing movement. Prominent celebrities and social media are increasingly blamed as sources of misinformation or disinformation. In addition, trolls and bots are pervasive problems in social media, which serve to intensify the divide through the posting of both positive and negative messages about vaccines.[9] One US study showed that people who relied on social media for their source of information about vaccines were more likely to be misinformed compared to people who relied on traditional forms of media.[10]

Organisations have made efforts to monitor their platforms to ensure that misinformation and disinformation is removed and prevent misleading hashtags from being circulated. For example, Pinterest only allows credible sources of vaccine-related content, while Facebook and YouTube have banned advertising for anti-vaccination content.[11] Facebook has not gone as far as to ban anti-vaccination content, but ensures that credible content appears at the top of a search.[12] Increasingly, there are calls for organisations and health departments to utilise social media to a greater extent to ensure that there is a greater body of credible content circulating social media.

Countering misinformation and disinformation is not purely about the amount of content that is available to questioning parents and individuals, it is also about the way in which this message is conveyed. There is evidence to suggest that myth-busting strategies serve to only reinforce ideology,

even when people are presented with evidence to the contrary. The reason – people are more likely to remember the myth rather than the fact.[13] While it can be tempting and the 'fact versus myth' format is frequently used to present information, it is important to maintain positive, evidence-based messaging rather than seeking to dispel myths. This can convey that the issue is 'up for debate'.[14] Rather than saying 'the MMR vaccine does not cause autism', the consistent message should be 'vaccinations are safe and effective'.

Travellers

Vaccine hesitancy is only one aspect to the resurgence of measles. Prior to 1990, only one dose of the measles vaccine was administered. This was changed in 1992 to two doses. Consequently, people born between 1966 and 1994 may not be fully immunised (it is considered that, due to the prevalence of measles prior to 1966, people born before this year contracted measles and are immune).

Unvaccinated travellers pose a threat to the ongoing spread of measles and outbreaks. Measles is common in parts of Africa and Asia where weaker health systems mean that children do not receive the vaccinations they require. Travel to these parts of the world is increasingly popular. When unvaccinated travellers visit these parts of the world, they then have the possibility of spreading it when they return, which not only exposes people who have intentionally chosen not to vaccinate, but also those who are unable to be vaccinated or have not had the complete dose. Unvaccinated travellers may also import measles into other countries, which was seen in the case of Samoa.

Samoa

Samoa has recently seen the devastating effects of when vaccine hesitancy, unvaccinated travellers and low vaccination coverage converge. In 2018, two infant deaths were attributed to measles vaccines being incorrectly mixed and administered.[15] The deaths caused distrust and fear, leading to a sharp decline of measles vaccination rates on top of already declining rates in the years prior. It is likely that measles was spread from a New Zealand tourist, where there is currently an outbreak, primarily in the Auckland region. The outbreak in Samoa led to a state of emergency being called in October 2019. By the end of December, when the state of emergency was lifted, more than 5,600 people had been infected and 81 deaths were attributed to the disease, with most among infants and young children. The vaccination rate has been increased to 95 per cent and Samoa now requires travellers to present evidence of their vaccination or immunity to measles before they are permitted to enter the country.

Conclusion

The resurgence of measles is a concerning trend and vaccine hesitancy could potentially reduce the gains that have been achieved through vaccination campaigns. It is important to engage with people who are vaccine hesitant in positive ways through the channels they rely on. There is also a need to ensure people are vaccinated, particularly if they are planning on travelling to areas where measles is endemic.

Author: Freya Saich, Policy Officer

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A Research Culture Supports a Learning Health System

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

In 2012, the US National Academy of Medicine described an aspirational view of the healthcare system of the future as being a learning health system. It's an inspiring definition: A system in which science, informatics, incentives and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process, patients and families as active participants in all elements, and new knowledge captured as an integral by-product of the delivery experience.

This dovetails perfectly with clause 1.1.1 of the ACEM Constitution, which states: 'The objects for which the College is established, are to: promote and encourage the study, research and advancement of the science and practice of emergency medicine'. Research is therefore a fundamental and integral component of our work. Developing a culture of research to achieve a learning health system and to advance emergency medicine requires constant effort and organisational support. Much of this effort is driven by passionate individuals.

The Centre for Clinical Research in Emergency Medicine (CCREM) was established in 2008. Our research involves collaboration between academic emergency physicians, research nurses recruiting patients in the emergency department (ED) with acute illness, and scientists analysing samples in the laboratory using immunological and molecular biological techniques. Our aim is to improve clinical care with a focus on patient-oriented outcomes. We endeavour to integrate laboratory and clinical research, using laboratory studies, to help us understand the results of clinical trials.

Having a research team embedded in the ED has helped us develop a culture of research. We have found that ED staff are keen to support research, but this can only be done by having a supporting infrastructure. Clinical staff are typically so busy, they don't have time to do the research as well. One of the perpetual problems of research is that it is viewed as a costly add-on on activity. My view is that it needs to be integrated into everyday practice.

My vision is that every patient who attends an ED is given the opportunity to participate in some form of clinical research. The term 'clinical research' refers to studies that address questions on treatment, prevention, diagnosis/screening, prognosis, or enhancement and maintenance of health. Useful clinical research means that it can lead to a favourable change in decision-making, therefore, it enhances our ability to make clinical judgements.

A great recent example of this is Simon Brown's clinical trial of conservative versus interventional treatment of spontaneous pneumothorax, published in the *The New England Journal of Medicine (NEJM)*. Simon developed this trial as Founding Head of CCREM and I need to give him a shout out for establishing a great research group. The collaboration included emergency and respiratory physicians from 39 hospitals around Australia and New Zealand working together to address a simple question that is important to patients – can I get a better or similar result by doing nothing to treat a spontaneous pneumothorax?

The study found that the timeframe for resolution of the underlying pneumothorax was longer without standard intervention, but not having standard intervention meant less time in hospital, less time off work, fewer complications, less surgery, lower risk of recurrence, and no difference in the time to complete symptom recovery (a median of two weeks in both groups). Eighty-five per cent of patients did extremely well with no intervention at all.

The importance of this type of research is that it is simple bedside clinical research focused on outcomes that are important to the patient, challenging the medical status quo, and saving the health system millions of dollars. The study is a great example of the need for more research in emergency situations where many of the treatments used 'routinely' do not have strong evidence to support them.

Remarkably, on the day of publication, we had a patient attend our ED with a spontaneous pneumothorax. The treating staff spoke to him about the study and proactively provided him with a copy of the paper and the one page infographic. The patient later gave a TV interview on his experience. This episode reflects well on ED staff: they appreciate the value of this kind of work, as do patients. Staff tell me that they walk taller, knowing that they work in an ED that is at the forefront of advancing emergency care.

Developing a Productive Research Culture in Emergency Medicine

As a specialty, emergency medicine (EM) has been good at training people, educating them about processes, delivering best care, and advocating for EM. 'What we haven't been so good at,' says Associate Professor Ed Oakley, Acting Chair of ACEM's Research Committee, 'is acknowledging that we actually need to know what the best thing is for our patients and staff'. Indeed, a recent collaboration between Australian and New Zealand researchers, co-authored by several FACEMs and published in the *The New England Journal of Medicine (NEJM)*,[1] found that medical intervention is not always in a patients' best interests; in some instances, if doctors step back and do less, patients can actually do better.

Findings such as these often cause major shifts in EM patient care, and clearly show how evidence-based research can be incorporated into our training programs, as well as departmental clinical care programs. Unfortunately, when it comes to obtaining funding to undertake this and other EM research projects, results are not so good. Over the last five years, Australian emergency departments (EDs) received 0.4 per cent of national health funding and 0.006 per cent of funding available through philanthropic organisations, despite managing 10 per cent of clinical encounters.[2] 'To truly advocate for emergency medicine, we need to develop a cycle of continuous improvement in our specialty', says Associate Professor Oakley. As one of the most evidence-based medical specialties, evaluating new research is vital; furthermore, no one has the insight to undertake research in our specialty better than ourselves.

Research is one of six strategic priorities that guide College activities, which are key to ensuring that the culture, profile, skills base and capacity of EM research is informed and strengthened by high-quality data analysis and evaluation. Since the restructuring of Council of Advocacy, Practice and Partnerships (CAPP) entities in 2018, the ACEM Research Committee has been actively working to achieve these objectives. There are now an additional two research-focused sections within the College – the Clinical Trials Network (CTN) and the Emergency Department Epidemiology Network (EDEN) – which work to enhance coordination of research networks in EM to facilitate multi-site research and increase funding opportunities.

The CTN, previously operating as a clinical trials group, aims to bring together researchers across Australia and New Zealand with an interest in clinical research to facilitate high-quality, multi-site trials. Currently chaired by Dr Gina Watkins, the CTN aims to harness collaboration and the power of a shared track record to unite EM researchers and further raise the profile of ED-based interventional research. The CTN seeks to increase the share of competitive funding that EM research attracts and, most importantly, improve outcomes for our patients by answering those research questions that are most relevant to their quality of care. To achieve these objectives, the CTN undertakes several activities, including endorsement of clinical research studies and full membership of the Australian Clinical Trials Alliance, giving ACEM a voice in decisions affecting EM research.

In conjunction with multi-site clinical trials, 'big data' and clinical epidemiology provides important insight into individual patient-centric care at a granular level. However, aside from certain areas such as serious trauma and paediatrics, EDs have very little information on the nine million people who present annually across Australia and New Zealand. Enter EDEN, currently chaired by Associate Professor Paul Middleton, whose overarching aims focus on: gaining epidemiological insights from ED data and observational studies; linkage of routinely collected ED data to other datasets; building predictive models to develop decision rules; complex adaptive system modelling; and utilising large-scale data collection to establish variations in quality of care and interventional outcomes.

There are also dedicated opportunities for networking and capacity building – aside from the College Annual Scientific Meeting, the inaugural ACEM Research Network Symposium was also held in 2019, with the 2020 Research Network Symposium to be held online in August.

For Associate Professor Oakley, research is a vital part of practising emergency medicine, as, 'if we want to be able to do the right things for our patients and our staff, we need to be part of the worldwide emergency medicine research movement'.

'It is also vitally important for our EDs to be involved in research because it provides an opportunity for staff to participate in activities that put those departments in a different sphere internationally. Even though the clinical care they give might be world class, what people see from the outside isn't the clinical care you give to your patients, it's your involvement in improving what the specialty does, the care the specialty can give.'

Authors:
Dr Robert Lee, General Manager, Research and Policy
Associate Professor Ed Oakley, Acting Chair, ACEM Research Committee
Dr Gina Watkins, Chair, ACEM Clinical Trials Network
Associate Professor Paul Middleton, Chair, ACEM Emergency Department Epidemiology Network

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CAPP

The Council of Advocacy, Practice and Partnerships (CAPP) met on 27 March 2020 by videoconference – the first time the Council has met remotely.

All members were welcomed to the first meeting of the new CAPP term, and specific congratulations extended to new members on their appointment, namely Rhiannon Browne (NSW); Ellen Meyns (NSW); Kimberly Humphrey (SA); Belinda Hibble (VIC); George Braitberg (VIC); and Harriet Jennings (Trainee Representative). It was also the first meeting for Didier Palmer and Clare Skinner in their respective roles of Chair and Deputy Chair.

COVID-19 Jurisdictional Roundtable

Due to the rapid upheaval in business as normal, the meeting was focused on a COVID-19 roundtable, with jurisdictional representatives describing the current situation in their area, including perceptions of preparedness and priority issues for College advocacy. The following themes arose:

- In most areas Ministries of Health were working closely and collaboratively with FACEMs – for instance in establishing emergency department (ED) task forces or reference groups directly led by clinicians.
- Clinicians were quickly overwhelmed by multiple overlapping sources of advice. Devolved systems have sometimes contributed to duplication of effort in developing local guidelines. Therefore, the ACEM COVID-19 Clinical Guidelines have been instrumental in providing unified and authoritative advice.
- The College can play a role in direct public health messaging via the media, in terms of the importance of following official advice around prevention, and the possible societal consequences of not doing so.
- Information on the location, quantity and use protocols for personal protective equipment (PPE), including rationing and safe reuse, was inconsistent. PPE supplies were reported as generally inadequate at the start of the response, and some clinicians personally sourced supplies from other sectors, such as from the food preparation industry.
- The slowdown in patient number in the ED had been useful during the preparation stage, but there is mounting concern on the future impact of ED-appropriate presentations being self-managed.
- In smaller states with lower numbers of large metropolitan hospitals, the concept of hot and cold facilities was trialled, with all testing for COVID-19 occurring at the 'hot' hospital. Some smaller EDs struggled initially with operationalising hot and cold zones. In one state, a team of expert clinicians undertook a gap analysis of hospitals in terms of their level of preparation.
- Some rural hospitals in proximity to state borders experienced frontline staff being marooned on the other side of the now closed state boundary. FIFO health workers were fearful of being stranded in remote areas.
- The 24-hour rostering of critical care teams (including FACEMs) was a part of contingency planning in some states and territories, while others are looked at other non-traditional shift patterns to raise consultant capacity in a surge scenario. The trigger point for rolling out these phases was a key discussion in jurisdictions, as was the process for supporting and protecting vulnerable healthcare workers.

Immediate advocacy priorities coming out of the discussions were as follows:

1. Personal Protective Equipment

CAPP agreed that, even just one day after the publication of the ACEM COVID-19 Clinical Guidelines, within the confines of pragmatism College recommendations on PPE needed to be strengthened. It was agreed that the Guidelines should advocate for a phased response according to specific trigger points.

2. ACEM Communications

Members agreed that weekly webinars, either based on particular aspects of the ACEM Clinical Guidelines, or on the experiences of overseas colleagues who were ahead of Australia on the pandemic trajectory, were the most useful form of communication between the College and its members and trainees at this time.

3. Ethics

Members discussed how to support College members and trainees in end-of-life care if the system became overwhelmed, and rapid 'least-worst' decision-making necessary. Discussion centred on the potential establishment of an ACEM-moderated mentoring group, an expert online 'debriefing room', with senior ED doctors, psychiatrists and ethicists combining to give multi-disciplinary support as required.

Faculty Support

Members noted that during the pandemic response, and proportionate to the nature of the crisis in each region, ACEM was boosting its support to Faculties. Initially, New South Wales and Victoria would have weekly facilitated faculty videoconferences, with Queensland biweekly, and the other states and territories sharing a combined weekly meeting, with the situation changing according to need. Engagement of faculty members has been higher than usual.

Events Advisory Committee

Members noted the importance of the new Events Advisory Committee in meeting the scheduling challenges caused by the necessary hiatus in all such College activities. Council endorsed the draft Events Advisory Committee Terms of Reference and established membership of this body.

Paediatric Paediatric Emergency Care Section

CAPP endorsed a recommendation to the ACEM Board that the Paediatric Emergency Care Section be established. Following subsequent Board approval, membership recruitment will now be undertaken, and a Section Executive formed.

Mental Health Working Group (MHWG)

CAPP approved the draft Terms of Reference for the MHWG, which will be developing Mental Health Action Plans for Australia and New Zealand.

Author: Richard Whittome, Policy and Research Administrator

Education and Training Updates

Examinations – Recording of OSCE Stations

In February 2019, the Council of Education (COE) approved the *Policy and Procedure for the Recording of Stations at the Fellowship Clinical Examination (OSCE)* and the implementation of recording all OSCE stations from the 2019.1 sitting.

The Policy does not authorise general candidate access to recordings but access only under the approved uses as specified:

1. As a resource for training purposes
2. For quality assurance and continuous improvement
3. For review of results of borderline candidates
4. For review for candidate feedback after a third unsuccessful attempt
5. For review in the event of a candidate complaint about the conduct of a station
6. For use in reconsideration, review and appeals.

In accordance with the allowed use for training purposes, in January 2020, the College released two recordings from the 2019.1 OSCE onto the ACEM Fellowship Examination Resources webpage. The recordings show two candidates, each undertaking one station during their examination. The College acknowledges the generosity of the candidates, examiners and role players involved in the recordings, in giving their permission for the publication of this material.

The recordings were released to enable candidates to familiarise themselves with the structure and context of two OSCE stations and to provide an opportunity for them to review the conduct of the station using the previously published materials from those stations. To gain the most out of viewing the recordings, trainees are encouraged to read the previously released station documentation and the Guidelines for trainees viewing the recordings, prior to accessing the recordings.

Specialist International Medical Graduate (SIMG) Assessment

Each year, the College undertakes the assessment of some 50 internationally qualified emergency medicine specialists for their suitability to enter the pathway to Fellowship of the College and to gain medical registration to practise in Australia or New Zealand.

Applicants with primary or secondary medical qualifications from the following countries were assessed in 2019: Canada, Egypt, Iran, Jordan, Malaysia, Pakistan, Qatar, South Africa, Sudan, United Arab Emirates, UK (includes England, Scotland, Wales and Northern Ireland) and the USA.

Eligible applicants attend an interview with trained members of the SIMG Assessor Panel and/or SIMG Assessment Committee, including a community representative. After the interview assessment, the SIMGs whose training and experience is deemed 'comparable' to an Australasian-trained FACEM will undertake prescribed pathway requirements before being eligible to apply for election to Fellowship.

The College has robust processes around all SIMG assessments, which comply with requirements of the Australian Medical Council, the Medical Board of Australia and the Medical Council of New Zealand.

The duration of the SIMG pathway can be up to four years, depending on the degree of comparability of the SIMG.

Vignettes of recently-elected Fellows from the SIMG pathway

Vignette 1: Anne Smith, FACEM

Tell us about your background training and experience overseas.

I completed my undergraduate medical training at the University of Pretoria, South Africa, in 2005 and embarked on my internship and 'community service' (compulsory Resident Medical Officer year) at a small regional hospital in the Cape Winelands, an hour outside of Cape Town. Thrown in the deep end with regards to decision-making, procedures and dealing with extremely sick patients, this was an ideal place to learn the art of clinical gestalt and how to work efficiently. In 2007, I took some time out from medicine to travel largely around the Middle East, as my now husband was living in Egypt at the time.

I moved to Ireland and worked for a year in geriatrics and emergency medicine. It was there that I met a South African emergency medicine (ED) consultant who told me all about the relatively new emergency medicine training program in Cape Town, which I had never heard of. By then, I had realised that ED was where I was meant to be. After a few long distance phone calls and interviews, I found myself back in South Africa, in Cape Town, and started my emergency medicine training in 2009.

I loved my time as a registrar and had the opportunity to work with some truly inspiring leaders and teachers, most of whom I now count as friends as well as colleagues. I trained in many different hospitals in Cape Town, including Groote Schuur Hospital (site of the world's first heart transplant) and the Red Cross War Memorial Children's Hospital (at that time, the only dedicated paediatric hospital in South Africa). In 2013, I was elected to Fellowship of the College of Emergency Medicine of South Africa and dived head-first into my first consultant job.

I was Head of Department in a regional ED (about five hours outside of Cape Town) and had amazing opportunities during this time to hone my skills and work on projects in the region that had never been done before. I started an outreach program to neighbouring towns, developed a mock OSCE for Diploma candidates, set up a short-stay ward, and introduced the hospital to the magical world of POCUS (Point-of-Care Ultrasound).

Unfortunately, the ongoing political and economic instability in South Africa led us to start looking for options overseas and Australia came out on top due to the well-established emergency medicine systems, as well as the desirable lifestyle. I initiated the SIMG assessment process and pathway after I was offered a position in New South Wales (NSW).

After my period of supervised training, as mandated by ACEM's SIMG Assessment Committee, I was elected to Fellowship to the Australasian College for Emergency Medicine (ACEM) in January 2018. I am extremely grateful and proud to belong to ACEM and to the wider emergency medicine community in Australia.

What were your experiences of the SIMG assessment processes and pathway?

The words I would use to describe the process are rigorous, efficient, thorough and transparent. There was absolute clarity from day one as to what was required from me and the support team were extremely helpful with my many queries. The structured interview was stressful (of course), but I felt that the questions were all appropriate and of extremely high standard. Having now worked in Australia, I can see how the process is set up to ensure that the SIMG has appropriate medical expertise as well as the communication, social and leadership skills required.

I was well supported during my supervision period and I found this time invaluable to make the adjustment to the Australian system, medical culture and patient profile — all of which are quite different to South Africa.

Would you recommend the SIMG pathway to others?

Yes, absolutely. It opens the door to the amazing experience of working in Australia and joining ACEM.

What's happening for you now?

I work part-time as a Staff Specialist at Shoalhaven District Memorial Hospital, in NSW's Illawarra Shoalhaven district. This is a regional site with an interesting and sometimes challenging patient population, and a huge seasonal influx during school holidays. I also work as a VMO at Prince of Wales Hospital, which is a fantastic Sydney hospital with an amazing ED team. I enjoy the clinical work at these sites, as well as the opportunity to mentor and teach junior doctors. I feel more settled in both of these roles now and am looking forward, I hope, to getting more involved with the College in terms of registrar training, and hopefully becoming an examiner. I was elected to the SIMG Assessment Committee this year and am really looking forward to working with this team.

My family and I are settled in a small town on the South Coast, where we spend most of our days on the beach or exploring the beautiful region. We love Vegemite and sausage sizzles (but still cheered for the Springboks in the Rugby World Cup).

Vignette 2: Simon Tucker, FACEM

Tell us about your background training and experience overseas.

My medical training in the UK was unique. Having lived in Northern Ireland, I moved to Scotland to complete my pre-clinical training at the University of St Andrews before moving to the University of Manchester to complete my clinical training. This is a totally unique program and the only example in the UK where medical training is provided across two university institutions. Famed as the home of golf and the university attended by Prince William, St Andrews is a small coastal town with only a cottage hospital. Such facilities could not support clinical training, and after two years of pre-clinical training, medical students relocated to Manchester to complete their studies.

Upon graduation, I remained in the North West of England to complete my pre-registration and senior house officer posts – the equivalent of an Australian internship. Originally, I had always considered a career in orthopaedic surgery, so following my intern years, I applied for a surgical training rotation. This training program provided me with opportunities not only in orthopaedic surgery, but also placements in general surgery, cardiothoracic surgery, ear, nose and throat (ENT) medicine, vascular surgery and intensive care medicine. But it was my six months in emergency medicine that changed my career focus. I realised that, with all my surgical rotations, what I enjoyed most was the on-calls and managing the acutely unwell and critically ill.

Having completed my surgical membership examinations, I declared my intention to move toward a career in emergency medicine. I completed six months paediatrics and a further six months of emergency medicine before being encouraged to apply for registrar training, despite having no middle grade experience in emergency medicine. I interviewed successfully for the West Yorkshire specialist registrar training program – at that time (and probably still today) regarded as the best training program for emergency medicine in the UK.

During my final Fellowship examinations, I was approached by an ED consultant examiner who had mentored me in my junior doctor years and invited me to return to the unit. After careful consideration, I decided to decline the opportunities offered to me in West Yorkshire following my Fellowship and specialist registration. I returned to the North West of England to start my consultant career in emergency medicine in the hospital where I had completed my surgical training.

I worked as a consultant at Blackpool NHS Foundation Trust for eight years. This large teaching hospital has more than 900 beds with 92,000 ED attendances a year. During this time, I developed an interest in systems to improve and standardise patient care to comply with best practice and linking to ED key performance indicators. These Better Care Now Pathways initially focused on ED delivery of care and compliance with best practice guidelines. Later, they were expanded beyond ED care to encompass better use of resources and smarter ways of managing patients efficiently, with improved patient safety, improved morbidity and mortality indices, and a reduction in length of stay.

I still maintained those guidelines five years after I was appointed at Blackpool as a consultant. I took on roles in trauma care and research before being appointed the Clinical Director for Emergency Medicine — a role I held for two years until I moved to Australia.

Unlike many who moved from the UK, I was not unhappy where I was working. I really enjoyed working with the team and our successes in implementing improvements in emergency care. I also enjoyed my responsibilities as an educator, with roles in simulation, and an appointment as an examiner for the Royal College of Emergency Medicine. However, I had grave concerns about my ability to keep working with such intensity in my later years. All of these successes were only achievable because of the amount of time invested outside of work to progress the projects. With a young family, I was becoming increasingly aware of work-life balance and my responsibilities as a parent.

I met with the medical director to discuss my interest in working in Australia. After careful consideration, I was permitted to take up to two years unpaid leave with my post secure, should I decide to return to work in the UK. I registered with an agency who sent me frequent advertisements for opportunities in Australia. I wasn't prepared to give up everything I had worked so hard to achieve for any job in Australia. Many posts offered were remote or central. I wanted a coastal location within 90 minutes of a major city such as Brisbane or Sydney. After 12 months, an advertisement for Shoalhaven Hospital, NSW, was forwarded to me and eight months after accepting the position, we made the move to Australia.

What were your experiences of the SIMG assessment processes and pathway?

The College requirements alongside the AHPRA performance reports provided plenty of opportunity for me to meet with supervisors for feedback on my progress and integration. Although I would consider myself an ED senior doctor with a good level of experience, these meetings provided opportunity for me to discuss differences in practice between the two systems, and opportunities for my supervisors to give feedback to me on my progress and practice. When you are trying to establish yourself as a senior doctor within the team, this feedback is extremely valuable.

Like every interview I've ever done, I always come away focusing on the things I wish I had said and wondering if I had done enough to meet the requirements. Anybody going through the SIMG assessment process will have already made the decision to stay in Australia. This in turn brings about a certain amount of pressure. I've done lots of interviews before, but while sitting in the waiting area at ACEM in Melbourne, a little voice in the back of my head was reminding me that my ability to remain in Australia as a senior medical officer in the job I love is entirely dependent on the next 60 minutes. And in case you need reminding, you've sold your house in the UK and your kids are now settled in their new school and tell you every day how much they love living in Australia. So, good luck and no pressure!!

The interview process, I felt, was fair and appropriate. The clinical questions were relevant to the practice of emergency medicine. I certainly felt that the three months practising in the Australian healthcare system before the interview were beneficial, as it gave me the opportunity to discuss differences in practice and the 'unanticipated' challenges of working in the same job, but in a different country with a different healthcare system.

Would you recommend the SIMG pathway to others?

Yes.

What's happening for you now?

Lots!!

Professional

I am now the Clinical Director of Emergency Medicine at Shoalhaven Hospital and have been in the post for almost one year. It has been a very exciting period of development within the department.

Immediate

Much of my focus to date has been on medical workforce. Business cases submitted for staffing uplifts have been agreed on by the executive and I am currently in the process of recruiting for these new positions.

Short term

Following a review on the use of the over-census unit adjacent to the ED, we have executive support and agreement to utilise this area as a clinical decisions/short stay unit as part of the ED Winter Pressures Strategy. I hope to see an improvement in non-admitted breach compliance and an opportunity for income generation to support further medical and nursing staff enhancements.

Long term

$434 million funding has been secured for development of the hospital. A new ED will be built with a portion of the funds. I am currently in discussions regarding resourcing and configuration.

Personal

The hospital has been extremely supportive of my appointment and assisted with my 186 application for permanent residency. Submitted just before Christmas, it was granted earlier this week!

My advice for anybody considering the move:

1) Despite the droughts and recent bushfires, the grass is definitely greener in Australia.
2) In the UK, College concerns are resilience and sustainable practice. The system in Australia is more supportive of work-life balance.
3) The application process is long and, at times, you will question if it is really worth it. I used an agency — they proofed everything for my AHPRA registration and visa applications. As clinical director, I am more aware now of the obstacles to these processes. I am learning from my current IMGs, who have not had an agent, that having an experienced agent to assist with these applications is a huge benefit.
4) I moved from a large teaching hospital with every specialty immediately available to me on site to a small district general hospital with limited specialty on site support. I have to use the skills and knowledge from my training more than I ever had to in the UK, which provides amazing job satisfaction.
5) There will always be questions about pay. I worked full time in the UK as a consultant and my wife worked 20 hours a week as a band 6 nurse. Moving to Australia, I work full time and my wife has taken a career break. We have more disposable income than we had with both of us working in the UK. As a consequence, we have enjoyed more time as a family doing the things we want to do. I work four 10-hour shifts a week. The shifts are longer than in the UK and it does take a bit of getting used to, however, 18 months down the line, we have had more holidays and done more as a family than we ever did when we lived in the UK. With such dependable weather, it is easier to make plans for the days off and have quality time.

Author: ACEM Education and Training Team

Sri Lanka

Dr Sanj Fernando
Dr Fernando is an emergency physician and retrievalist working in Sydney, New South Wales. He has an interest in the international development of acute care medicine and is the Co-Director of DevelopingEM.


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Tropical pre-monsoon heat hangs over a small island in the Indian Ocean. Its rocky coastline greets the angry waves with a strong unbreakable jaw resulting in a turbulent spray that coats the coastal road. It is relatively quiet at 2.30 am with only a few people wandering around. In Sri Lanka, which is slightly larger than Tasmania, but with just under the population of Australia, there are always people around.

The wet road glistens. The streetlights are intermittently working and infrequently serviced. A sparkling clean, new model SUV surges down the road. The driver didn't even see the young man who had slipped while crossing the road until he looked in his rear vision mirror. The only indication of an accident were the two thumps he had felt through the steering wheel. The first when the car's bumper bar collided with the young man's head and the second when the front wheels had gone over what felt like a large bump in the road.

The driver screeched to a halt, immediately aware of what had just happened. Getting out of the vehicle, he realised that the young man lying unconscious on the road was seriously hurt. The overwhelming emotion was of helplessness. Who could he call for help? A drunk old man staggered over and started yelling at him but would not assist. There was no help and he didn't know what to do. The ground was very wet, and his car was a long way from the young man. He couldn't get anyone to help carry the man to his car, so he returned to his vehicle to drive it back to the injured young man. As he got back in his car an angry crowd started to assemble, alerted by the yells of the drunk man who was now throwing stones at the previously pristine vehicle.

The man was faced with indecision. To get out of the car would be dangerous. He wasn't even sure if he could lift the injured man or if he should be moved at all. His car was expensive, and it had taken him many years to save for it. The options were stark and obvious.

Surprisingly, he braved the crowd who hampered him at every turn. Some tried to move him in one direction, some tried to sit him up, most refused to help until his intensions to help the injured man had become obvious to all. The bleeding man was destroying the upholstery of his rear seats. He drove faster. He could hear the man grunt. As he raced to Colombo General Hospital, he heard the grunts become softer. The SUV skidded around a roundabout, clipping a parked car on the way.

He pulled up at the Emergency Treatment Unit (ETU) and ran in to get assistance. An orderly with a wheelchair accompanied him to his car several minutes later to transport an obviously dead young man to the doctor, whose only duty would be to confirm the time of death.

A problem

Prior to 2015, Sri Lanka did not have a cohesive public ambulance service. Most patients arrived at hospitals via personal or public transport with no pre-hospital care. This resulted in significant but unreported pre-hospital mortality. Small scope private ambulance services did run for varying periods of time but did not provide comprehensive care throughout the island.

The 2004 Boxing Day tsunami highlighted the need for a more robust approach to emergency care in Sri Lanka. A partnership between the Sri Lankan Government and the Victorian State Government established the model ED at Karapitiya Hospital in Galle. Emergency medicine (EM) training commenced in Sri Lanka in 2005. Sri Lanka

currently has 166 EM trainees with three fully qualified and board certified EM Specialists. However, a formal ambulance service providing coordinated pick up, transport and pre-hospital medical care did not commence until 2016.

Efforts to address this pre-hospital area of need began before the Developing EM conference in 2016, held in Colombo. The conference provided a forum to discuss the challenges of operating and maintaining this service. Harsha de Silva (an economist and Sri Lankan Deputy Minister for Foreign Affairs at the time) participated in some discussions and was the driving force behind the establishment of a Sri Lankan ambulance service.

The Sri Lankan Government, via an aid grant from the Indian Government, purchased control and communication systems, medical equipment and ambulances, and organised training for emergency medicine technicians (EMTs) to staff the newly formed ambulance system (known as '1990' as this is the emergency contact number for the public to call). EMTs were predominately advanced level examination school graduates and did not have training or experience in medicine or pre-hospital healthcare. The initial training was provided in India by GVK Emergency Management and Research Institute (GVK EMRI). Their training program included 54 days of classroom-style teaching and some practical components. GVK EMRI also assisted in the training of ambulance control coordinators, who would take calls and task ambulances.

While the EMTs had basic knowledge of pre-hospital care from their training in India, they required advice on more complex situations, so a support and control structure was set up. This entailed a roster of senior EMTs who were on duty 24 hours a day to take calls and provide clinical advice for junior EMTs who were with a patient.

On 4 July 2018, the Government of Sri Lanka established the 1990 Suwa Seriya Foundation and the 1990 Suwaseriya Foundation Act in order to ensure the continuity of the pre-hospital care service.

There has been exponential growth of the 1990 service, which started from the coverage of just one province and 80 EMTs in 2017. By 2019, there were just under 900 EMTs working across the island, and the Sri Lankan ambulance service increased its coverage to every corner of the country (all nine provinces). Currently, 297 ambulances cover an area of 65,610 square kilometres and cater to a population of 21.4 million people. The service attends more than 1,000 incidents a day, with a national average response time of 11 minutes and 52 seconds. The response time within Colombo, the business district where the population density is highest, is around eight minutes and 32 seconds.

The rapid expansion of the service meant that the on-call doctor was frequently swamped with calls and EMTs were often unable to get through for advice. It was recognised that EMTs needed to operate using protocols that allowed them to independently perform interventions (such as giving nebulised bronchodilators, placing an intravenous canula, stemming blood loss, splinting limbs and providing basic analgesia). While life-saving interventions were applied prior to attempting to contact the on-call doctor, decision-making after this point was often delayed until the conversation with the doctor.

It was clear that the Sri Lankan ambulance service needed a structured, standardised method of providing education and accreditation to EMTs.

A solution

Collaboration was established between the Sri Lankan ambulance service (1990), the Sri Lankan Society of Critical Care and Emergency Medicine (SSCCEM) and the Australasian College of Paramedicine (ACP) to support the development of a standardised education program. In addition, there was a need to have processes for EMT accreditation as a clinical governance tool.

Basic EMT Skills Training (BEST), a one-day course, was designed. A one-day program supported by online learning was the preferred format, as this would have the least impact on on-duty staff and ambulance availability. This was also the lowest cost option, as the course was run in Colombo and EMTs had to travel from all over the island and be accommodated at 1990's expense.

Curriculum development was aimed at supporting protocols and procedures for the recognition and early management of serious illness and injury. All material was created in three languages: Sinhala, Tamil and English. Online lectures and recorded demonstrations of scenarios were also available.

The program design was guided by theories from adult education and cognitive psychology. The pre-course written and online material maximised opportunities for flexible learning. The interactive face-to-face program was designed to focus on the practice, recall and synthesis of relevant knowledge, as well as providing opportunities for small group learning.

A testing component was included to fulfil the need for performance accreditation. Testing spanned knowledge (gained from online resources and initial training), the practical application of this knowledge (assessed by simulation), and skills acquisition and mastery (assessed by continuous repetitive assessment).

The end result was a robust educational experience with the ability to assess candidates' performance. However, judgements based on a new and, as yet, unvalidated course could be disputed. Rather than have the candidates assessed based on pass/fail criteria, it was more prudent to assess them into three colour groups. If the candidate did not meet the expected standard in one of the three assessment domains (multiple choice questions, Basic Life Support (BLS), airway and Advanced Life Support (ALS) skills, or simulation scenario), they were assigned a red colour and prioritised for re-enrolment in the course with additional support. If the candidate performed to the expected standard in all three domains, then they were accredited for a two-year period (orange group), after which they would have to re-enrol in the course again to maintain currency. If the candidate reached an advanced level in a minimum of two out of three domains, they were assigned green and selected for enrolment into an advanced skills course.

If candidates in the green or orange group were identified as having the potential to be a good educator, they would be enrolled into the Generic Instructor Course (GIC). This program is already well established and is used to train Advanced Paediatric Life Support (APLS), Early Management of Severe Trauma (EMST) and ALS instructors.

Training saves lives

The initial four courses were delivered by Australian and Sri Lankan faculty who had been through the GIC and were identified for their commitment to service development and educational expertise. A further six courses have been undertaken by Sri Lankan local faculty. Each course can take 24 candidates and, to date, 245 candidates have been trained and accredited (some courses were oversubscribed). No candidate assigned a red colour designation has not achieved orange or green on their second enrolment in the course.

While EMTs may need to treat patients who speak Tamil, Singhala or English, testing was carried out in the language of their choice. This maximised the course's ability to assess their knowledge and skills rather than their language fluency.

Only 27 per cent of EMTs reported that they were 'very comfortable' managing critical cases prior to the course, and this grew to 72 per cent following completion of the course. In addition, call volumes to the on-call doctor prior to treatment have dropped significantly. This suggests that early treatment is not being delayed and that there is confidence for the EMT service in instituting and following its own protocols.

On an individual level, the confidence and belief in their own skills has been paramount to the growth of the service and the competent delivery of care. As one EMT reported, 'This course has given me the strength to do what I need to do to save people's lives'.

The future

There are many challenges that remain for a fledgling pre-hospital service. 1990, with international support, is boldly addressing most of these.

The general population, being unaware of the role of a coordinated pre-hospital response, may be hesitant to call an ambulance or move out of the way when they see an ambulance with flashing beacons. Programs about the ambulance service have been run in schools to educate children. Not only will the next generation be fully aware of the importance of 1990, the children can advise adults what to do in a medical emergency, as well as guide adults to move aside for an ambulance with beacons flashing. Other promotional activities have been undertaken at sporting events, mass gatherings and through conventional advertising.

An Advanced EMT Skills (AEMS) course is being designed to provide a cohort of motorcycle-based first responders with an extended skills base and extended formulary. The first of these courses was due to run in July 2020, prior to the outbreak of COVID-19. This pandemic brings new challenges with policies about transportation and personal protective equipment, and limitations of care needing to be formulated, tested and implemented.

NSW Ambulance has taken over 200 years to arrive at the robust service we enjoy today. The remarkable commitment and vision of 1990 has seen incredible strides forward in just the last five years. There is no doubt that this will be an enormous benefit for a small tropical country like Sri Lanka with a very large population.

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i More information

If you would like to assist in program development or direct teaching activities, please contact Sanj Fernando – nipuna.fernando@health.nsw.gov.au

Emergency Life Support Training for Vanuatu

Ms Laura Bland, Dr Jamie Hendrie and Dr Vincent Atua

Ms Bland is a medical student from the University of Melbourne, Victoria, with a keen interest in global and emergency care.

Dr Hendrie is an emergency physician working at Austin Health, Victoria, with a special interest in working and teaching in resource-limited settings.

Dr Atua is an emergency physician who is currently the Director of the Vila Central Hospital Emergency Department, Vanuatu, whose current interest is in developing EM systems in Vanuatu.

The islands of Vanuatu are filled with volcanoes, villages and deep blue lagoons. Surrounded by sandy beaches and bright blue oceans, they are home to many locals and to a vibrant, unique culture. When delivering emergency care to this Pacific Nation, healthcare professionals face many challenges. In April 2020, Cyclone Harold, a category five storm, ripped through Vanuatu's Northern Islands causing devastation and damaging villages. Situated in the earthquake and volcanic eruption prone 'Ring of Fire' and at the centre of the Pacific Cyclone Belt, Vanuatu frequently experiences natural disasters. Pacific countries are also particularly vulnerable to the effects of climate change, which is causing sea levels to rise, extreme weather events to increase in frequency and severity, and is having a negative impact on food and water security.

The country's population of approximately 300,000 is spread across 63 islands, meaning many communities are geographically isolated and have poor access to healthcare. The incidence of non-communicable disease is also on the rise. Together, these factors put a strain on the country's developing emergency care system, which is operated by nurses, interns and one emergency registrar, under the guidance of the country's only emergency consultant, Dr Vincent Atua.

In resource-limited settings, such as those found in Vanuatu, effective emergency care has been shown to substantially reduce preventable morbidity and mortality. The World Health Organization has identified improving and standardising the education of healthcare professionals in Vanuatu as an area of need. However, this is easier said than done. Due to geographical isolation, a lack of funding, and a shortage of trained personnel to act as teachers, emergency training programs are difficult to access.

To help bridge this gap, a team of Australian health practitioners from Austin Health and Box Hill Hospital in Melbourne travelled to Vanuatu to teach an Emergency Life Support international (ELSi) course at the country's two major hospitals, Port Vila Central Hospital (VCH) and Luganville's Northern Provincial Hospital (NPH). Our enthusiastic teaching team was composed of emergency consultants and registrars, emergency nurses and nurse practitioners and science students. We worked closely with the Vanuatu–based Dr Atua, Dr Henry and the charity Presbyterian Church of Vanuatu Health (PCV Health), who were integral to organising the course delivery and recruiting

participants. In 2018, we ran a five-day course at VCH and in 2019, we ran a four-day course at VCH and a two-day course at NPH.

The course aimed to improve the delivery and outcomes of ELSi by teaching relevant, evidence-based clinical practices to a range of healthcare professionals. In Vanuatu, it is routine for doctors and nurses to work independently or in small groups in rural communities. Here, they lack a variety of resources and the guidance of more experienced colleagues from a variety of specialisations. Therefore, the course was designed to cater for a range of skill and knowledge levels. Nurses, midwives and doctors at varying points of their training could all participate, as they are all required to be proficient in ELSi techniques.

The curriculum included a variety of topics relevant to ELSi and was taught by dedicating half of the sessions to theoretical lectures and half to workshops, which reinforced the lecture information and provided practical skills training. We thank ELSi Inc. and the course organisers for the course material.

Training in basic, advanced, trauma and paediatric life support, airway management, shock, seizures, and plastering, provided knowledge and skills that could immediately be applied in the workplace. Topics such as triage and asthma management were included to help support emerging changes in treatment plans and hospital systems. Vanuatu utilises a basic triage system during mass disasters, however, it is not routinely used to prioritise patients presenting to the emergency department. Additionally, many patients present to the emergency department with asthma that could potentially be managed at home using an inhaler and a spacer. Providing education in these two key areas was therefore prioritised and identified as important to improving patient care.

So far, 43 participants have completed the program, including graduate nurses, midwives, medical interns and one emergency registrar. To gain an idea of participant perceptions of the course and its utility, an anonymous survey was distributed to the participants who were present at the final session of each course. Over the three courses that were run, 20 responses were received.

The survey covered four key themes – the use of group work, the facilitators, the course's relevance and the participant's understanding of the content. From the information collected, individual responses to questions exploring the same theme were collated to determine overall participant perception of each theme.

The results of the survey are shown over the page. Two of the statements explored whether working in groups was a comfortable and effective way to learn. Three statements explored if the facilitators were organised, engaging and professional. Three statements explored if the course content was relevant, insightful and applicable to the participant's work. For each lecture and practical session, participants indicated whether a concept 'was explained to me clearly and I am confident to apply it in my area of work'. A majority of participants 'strongly agreed' or 'agreed' with each of

these statements. This indicated that there was positive perception of the course and its facilitators, and that participants felt confident applying the theoretical and practical knowledge they had gained from the course.

These results were supported by statements made in the 'further comments' section, which were almost all positive. These included: 'The course was magnificent. Hopefully, I will be able to do effectively what I have learnt', 'This training helps me a lot as a new graduate nurse. I have learnt a lot from it', and 'It was excellent refresher training for me. Looking forward to more training like this in the future'.

Beyond this positive feedback, the questionnaire also gave some insight into what the participants thought was the optimal time length for the course. Three of the 10 participants who completed the two-day course in Santo stated that the course 'needs more time' and should be run over five days as opposed to two. Following this, in the future we will aim for the full five days.

The majority of participants had positive perceptions of the course's structure and its facilitators, and felt confident in applying the knowledge and skills they acquired. This, in conjunction with the improvement in knowledge and skills that facilitators observed throughout the program, suggests that the ELSi Course was a success. It is currently unknown if this knowledge has translated into clinical practice. This is an area we have highlighted for future research.

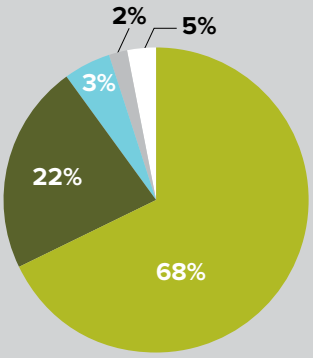
Before the COVID-19 pandemic, organisation for the 2020 course was underway. Now, like many things, it will be postponed until international travel is feasible and the teaching team are able to take leave from work. Future courses will promote local faculty members with the view that, eventually, they will take over and run the course independently. To facilitate this, manikins and other resources have been donated to VCH and NPH. Local faculty will run the course and refresher courses regularly, while further developing the clinical, communication, and teaching skills of Vanuatu's health care professionals. They will also provide an avenue for the repetition and reinforcement of information after the course has ended.

This ELSi Course is one of the many steps that must be taken to build and strengthen emergency medicine in Vanuatu, with the end goal being improved patient care and outcomes for this beautiful, friendly nation.

i More information

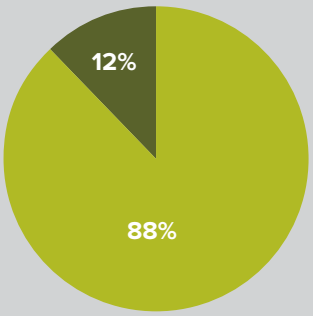
Fellows working independently in the Field are known affectionally to us at FiFs. Are you a FiF working in the field to support GEC? We would love to hear from you at the GEC.Network@acem.org.au

The survey covered four key themes – the use of group work, the facilitators, the course's relevance and the participant's understanding of the content. Individual responses were collated to pie charts displaying survey responses to four aspects of the ELSi course.



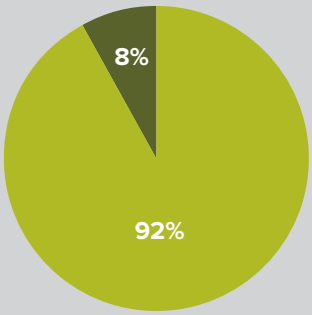
A

Working in small groups was a comfortable and effective way to learn.



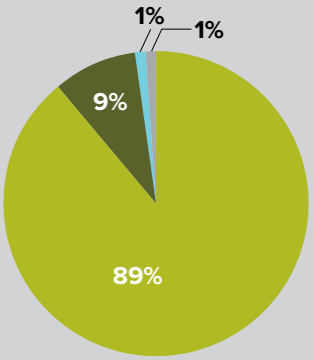
B

The facilitators were organised, engaging and professional.



C

The course was relevant and applicable to my work.



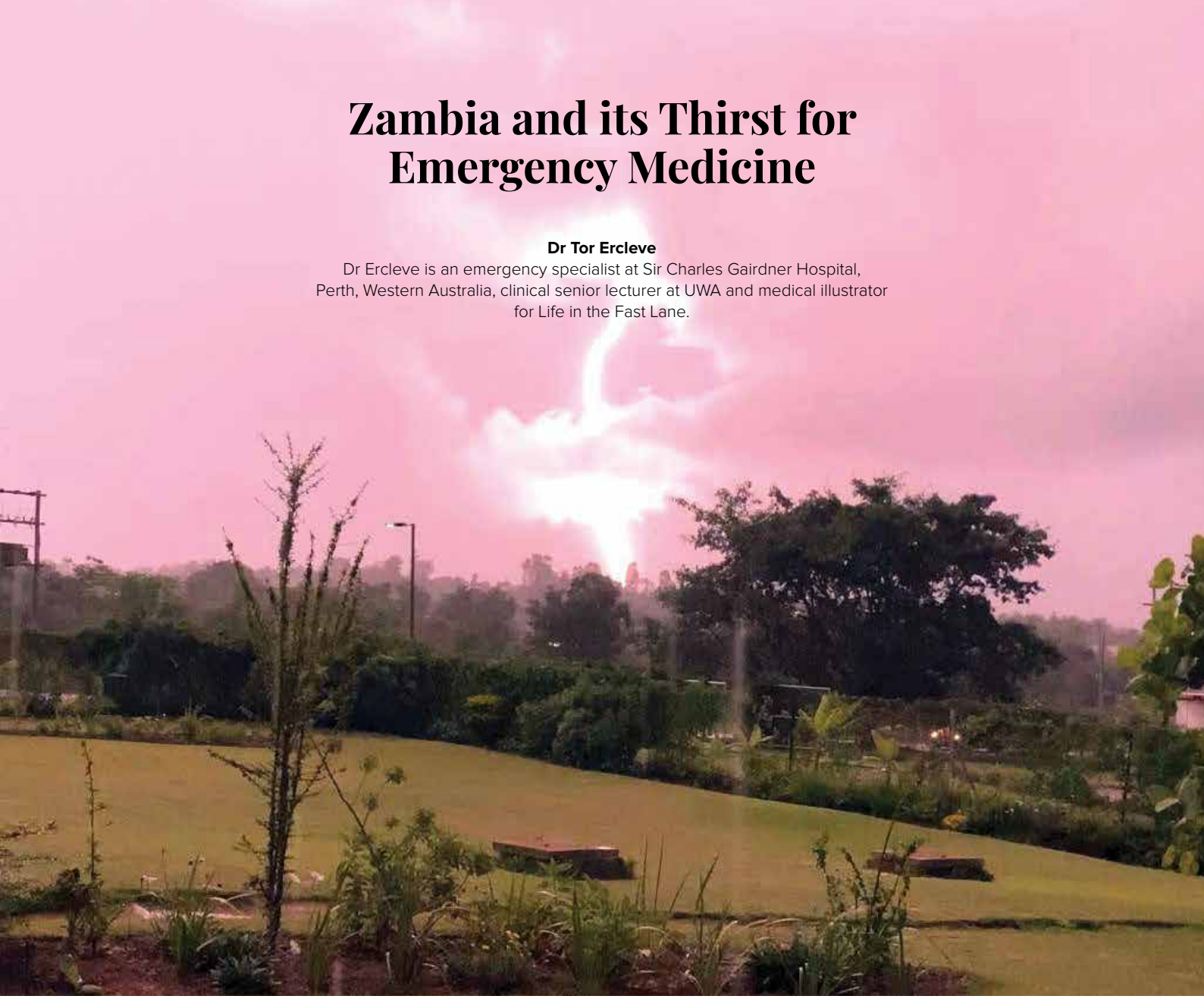
D

Concepts were explained to me clearly and I am confident applying them in my area of work.

- Do not agree
- Partly agree
- Mostly agree
- Strongly agree
- No response

Zambia and its Thirst for Emergency Medicine

Dr Tor Ercleve
Dr Ercleve is an emergency specialist at Sir Charles Gairdner Hospital, Perth, Western Australia, clinical senior lecturer at UWA and medical illustrator for Life in the Fast Lane.



They say the sky is bigger in Africa and the same can be said for its thunder.

It was an early afternoon in March when we heard the almighty crack. I was presenting to the board of Mary Begg Health Service when my deferential distance was instinctively broken, as if briefly huddling together would provide us with protection. In Kansanshi, Zambia, sirens warn of approaching thunderstorms, followed by a flurry of people rushing for shelter. But this bolt had come unannounced.

Solwezi is a bustling town in the North Western Province of Zambia, 20km from the border to the Democratic Republic of Congo. It first became popular as the final destination of Western missionaries from all across Africa. As a result, it has one of the highest concentrations of Christian denominational diversity in the world. With the discovery of large copper reserves in 1898, it once again attracted the attention of the western world. The population boomed, with people seeking work at the local mine in Kansanshi. Despite the influx of 30,000 miners and their families, little infrastructure exists to support such a large population.

During the dry season, Solwezi town is without electricity for between six to 10 hours a day. Rolling blackouts are so prevalent at this time of year that people's activities are heavily influenced with the rise and setting of the sun. TVs, mobile phones and radios remain silent much of the day because of the starved Kafue Gorge hydroelectric dam on the Zambesi River. This year would be worse than other years. The stifling heat and humidity is broken with the arrival of the rainy season in November and, with it, clouds and dust burst to life. Violent electrical storms herald the floods that quench the marshland and restore the scorched grass to its lush magnificence.

Kansanshi Mine Hospital had just invested a large amount of money in a Laerdal SimMan 3G for their 2030 training program. It was Zambia's only high-fidelity SIM facility and I rushed to unplug the invaluable simulator from the wall.

It took about 15 minutes before I heard the siren. Not the alarm warning us of another strike, but the rising pitch of a siren from one of the mine's ambulances. A young man had been hit by the lightning. I scurried off

to the small emergency department (ED) to help prepare for his arrival. The ED's resus room was an improvement on previous set-ups, but equipment lay in boxes along the wall, organised by convenience of unpacking rather than for the purpose of a sequenced critical care process. The ventilator and defibrillator were unintuitively placed and the resus medications were locked in a cupboard across the hallway. Unconfident team members scrambled for roles that required them to leave the bedside to get something, or someone from somewhere else. It was going to take time to replicate and implement our changes from the SIM lab to where they were needed, saving lives in the hospital.

'I had not seen a person hit by lightning before. Like a naïve medical student opening their first pathology textbook, I looked for the fine print details of Lichtenberg figures and barotrauma. But he revealed only a charred excoriated chest wound and a knotted grey exit burn to his ankle.'

Lying peacefully in a high vis uniform, his body showed few signs that he had been a victim of mother nature's violence. I had not seen a person hit by lightning before. Like a naïve medical student opening their first pathology textbook, I looked for the fine print details of Lichtenberg figures and barotrauma. But he revealed only a charred excoriated chest wound and a knotted grey exit burn to his ankle.

The doctors and nurses at Kansanshi Mine Hospital fought valiantly to save the young man's life. Despite the anxieties of the team, the level of care that could be provided at Kansanshi was far higher than what could be delivered by the local public hospital, not that the commitment of their staff was any less. On the contrary, doctors at the public hospital worked long hours in extremely difficult conditions, many of them with long lapses to their pay. Resources in the public system were scarce and demands exceptionally high. Only a few weeks earlier, the roof of the public maternity wing had been torn off during a storm, and in a few months they were to lose their entire water supply for several weeks. Our patient would have had to make do with a solitary automated external defibrillator (AED), with only one set of pads and an old ventilator, for which he would have had to fight for a place. But our patient was destined elsewhere.

The patient was caringly packaged in a retired St John's ambulance — the legacy of a health system from another world. This old workhorse's life was far from over. Expectations of its performance were much higher than its former demands in Perth. The four-hour drive from Solwezi to Ndola Airport greatly exceeded the ambulance's designed operational range. We sat on a large untethered oxygen cylinder, listening to the gentle rasping of the paraPAC ventilator, as the driver navigated Kitwe's potholes with the skill of Buzz Aldrin over a pocked lunar surface. Out of the window, you could just make out the straw-roofed rondavels (traditional circular African dwellings) where young children were selling umbrella-sized mushrooms on the side of the road. There were men pushing rickety bicycles overladen

Simulation training in burns resuscitation using a burns mannequin / SimMan

with charcoal. I had travelled down this road many times before and I wondered if I would see the old man and his goat. The last time I caught his eye, we connected and, for a brief second, he thought we may just stop to buy his cloven-hoofed friend.

'This year, dark storm clouds of another nature are gathering over Solwezi. They carry with them a sinister threat, the likes of which few of us have ever seen. It will test our seven doctors' skills beyond the scope of any emergency training they have received so far.'

It was night as we approached the airport. I could see the medevac plane shining in the runway lights. This was the farthest the medical arm of South Africa could reach. It had taken us eight hours to get to this point, to hand over the responsibility of this young man's care to another group of doctors, another health system, another country.

This reluctant abdication is not the future of emergency medicine in Zambia. The small cottage hospital in Solwezi, led by their medical director Dr Vernon Julius, made an affirmative step in 2019 to develop the foundations of a diploma-level training program for seven of its practitioners. In January, a small group of pioneering doctors led by Dr Mwiche Chiluba FCEM(SA) established the Zambian Emergency Medicine Society (ZEMS). Many Zambian emergency consultants, who have been trained in South Africa, are looking to return to their homeland to set up a grass-roots specialist training program. With growing political strength and support from the University Teaching Hospital, Levy Mwanawasa Medical University, and teaching hospitals in Ndola and Solwezi, Zambia will recognise emergency medicine as a specialty and realise its ambitious goals for universal health coverage in 2020.

I look back to that fateful day when the emergency doctors and nurses rallied together to try and save the young man's life. This year, dark storm clouds of another nature are gathering over Solwezi. They carry with them a sinister threat, the likes of which few of us have ever seen. It will test our seven doctors' skills beyond the scope of any emergency training they have received so far. But this time, they will find light, not by banding together, but by how effectively their team can work apart.

Dr Tor N Ercleve, FACEM, EM Consultant, Sir Charles Gairdner Hospital, Perth, Western Australia

SMO Mary Begg Health Service, Kansanshi Mine Hospital, Solwezi, Zambia (2019)

Medical Illustrator @ZambiaEMS @Ercleve

Dr Suzanne Moran

Dr Moran is an emergency physician in New Zealand and Head of Department for Rotorua Emergency Department. Her interest is in clinical leadership and workplace wellbeing.

Why emergency medicine?

I've always felt like I belong in an ED. I first went to the ED as a medical student and I knew I had found my people. I've worked in EDs in many parts of the UK and subsequently two since my move to New Zealand, and they have the same core qualities. Everybody enjoys the variety, the highs and lows of the clinical work, the opportunity to perform under pressure. I really love the ED mentality and the particular type of nurse that seems to gravitate to ED – they are my tribe.

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

I find letting go of the job the hardest – I've been a doctor for 21 years and I still struggle to leave the job at work sometimes. Difficult cases or people can occupy my brain for far more time than they should. I'm still learning to deal with it but I'm getting better – I'll have it mastered by the time I retire. It's the little things that are most enjoyable. I love it when a child and parent have a really positive experience of care. I love chatting with an elderly patient and finding that they have the most amazing backstory. I remember looking after a fabulous old lady once with a fractured NOF (neck of femur). While I was putting her block in, she told me the story of how she escaped from a concentration camp during World War II. We are so privileged to care for people at their most vulnerable and they reward us with their trust and a glimpse into some really interesting lives.

What do you do to maintain wellbeing?

I'd say I was on a continuous journey of improvement with regard to wellbeing. I'm fully aware of what I should be doing but I sometimes struggle with the practical application. I've learned to turn my phone off and disconnect from my email when it's my day off – that's a simple thing but really important. We went on a holiday last year to somewhere with no Wi-Fi or mobile reception – it was absolute heaven and I've booked to go again. I'm not good at mindfulness but I'm trying to get better at separating work from non-work time. I suppose I am learning to be present in the moment. I enjoy/endure exercise and I appreciate the benefits of living in a beautiful place by the sea. My dog is a good sounding board when I need to vent and I genuinely believe that being able to have a really good laugh is good medicine.

What do you consider your greatest achievement?

I'd like to think that the best is yet to come, so I'm hopeful that I have a great achievement waiting in my future. My greatest non-work achievement is that I have two happy and kind-hearted children who I am very proud of. I can't top that one.

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

Passing my Fellowship. It was 12 months of blood, sweat and tears. I still have nightmares and I'm sure my husband does, too.

What inspires you to continue working in this field?

I can't imagine doing anything else. However, I think it's important that you know when to stop. We all need a strategy to ease out of our careers and approach retirement in a healthy and pro-active manner. I want to glide out gracefully rather than burn out and I recognise that I need to find ways to keep myself invigorated, up to date and interested in my work, until I reach the point when I'm ready to embrace the next phase of my journey.

Tell us some advice you would have liked to receive as a trainee or early in your career.

Do not just focus on your career goal. Becoming a specialist is NOT the be all and end all. Life is about so much more than that. Take time, take opportunities, have experiences and smell the roses. You will still get the specialist job in the end, but your life will be a lot richer for a slower and more elaborate journey.

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

The day that a radiologist comes to ED because they've seen a patients presenting problem on the screen and thought we might want them to arrange a CT. One day it will come. You've got to have a dream.

Dr Michael Hale

Dr Hale is an FACEM Training Program trainee, currently working at Royal Perth Hospital in Western Australia, with an interest in medical education and wellness in the ED.

Why emergency medicine?

Emergency medicine wasn't on my radar when we arrived in Australia, then as a resident medical officer in a busy tertiary ED, I saw the organised (sometimes!) carnage and loved it. A resus in that corner, chemical sedation in the other, a red phone ringing … it went on and on. And right in the mixer were the ED trainees and FACEMs moving from here to there, problem solving, tweaking, working together and always ready for the next challenge.

Someone once said to me 'Teamwork makes the dream work!' and I thought this is for me. The team dynamics are my favourite part of the job — learning from great bosses on the shop floor, teaching and guiding juniors through their cases, as well as working alongside awesome ED nurses who've seen so many of us pass through the ED doors. The fact that we have a job with such variety, acuity and a sense of family is pretty special.

What do you do to maintain wellbeing?

Plenty of exercise keeps me ticking over outside of work — lots of running around Perth's King Park and river loops. I'll aim to check off the Rottnest Channel Swim in the next few years. I feel it is a right of passage in Western Australia. Trips to Margaret River with the missus and the pup (+/- family/friends/visitors) always help maintain a sense of wellness and keep the wine stores well stocked. At home, I like to bake, mainly bread, and cook for friends, while trying to take note of the time difference and keep abreast of the goings on with UK-based friends and family.

What do you consider your greatest achievement?

It took me five goes to get into medical school, so that has definitely got to be up there on the wall of achievements, along with actually finding someone to walk down the aisle with and get a ring on their finger. Thanks, Loz!

Setting up the peer support program at medical school, a group that is still loud and proud, and teaching and providing moral support to students at the medical school nine years after it started. The opportunity to present at the World Health Summit in Berlin, as a medical student, was an amazing experience, too.

In 2018, I was a crew member for the Liverpool 2018 team as part of the Clipper Round the World Yacht Race. Leg 5 (my leg!) sailed from Airlie Beach to Qingdao, China, and was crazy good fun. We saw some huge seas, fantastic storms, got very wet and had lots of laughs, not to mention the view from the top of the 90ft mast (yes, I volunteered to climb up there!). Hurtling along at 16 knots was unbelievable. As a proud Scouser, a podium finish at Liverpool 2018 in Qingdao was the icing on the cake!

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

It's early days for me but, obviously, getting through primaries written (unfortunately the Viva got COVID) was a huge scalp. Advocating for a sick croupy kid as a junior registrar and getting them a tube, via anaesthetics, was one of the scariest but most rewarding clinical cases I've managed and still stands out for me as one of the most rewarding night shifts I've worked.

What inspires you to continue working in this field?

The people – teamwork makes the dream work!

Every patient is a person – ED is non-judgemental – it is a real privilege to try and make the patient and family feel we have treated them individually.

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

A piece of advice I was given when I graduated was: There are three things that'll kill you … Hurry, worry and curry!

I particularly like this nugget. It makes me laugh to think of it, but, practically, it helps me to slow down when things pick up pace, gives me some clarity of thought and drives me away from stressing out when carnage seems imminent, while also reminding me to eat. Last thing anybody wants is their Reg to croak it on a night shift. The amount of paperwork would be huge.

Be yourself and don't be afraid to ask questions, no matter how stupid they may feel. Every day is a school day.

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

I'm excited by the space for medical education in the ED, whether that be POCUS/SIM/WBA development or procedural skills work. As the Wellness Registrar (@MikeyBrul23ED on Twitter) at Royal Perth Hospital, I'm keen to advocate for wellness and wellbeing for all ACEM trainees, along with our junior medical officers and colleagues who work beside us day in day out. Hopefully, this is an area where I can really add some value.

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EMET at Tennant Creek Hospital

How a small investment transformed a health service

Dr Stephen Gourley
Dr Gourley is the Director of Emergency Medicine at Alice Springs Hospital, Northern Territory, and has an interest in Indigenous health and rural health.

Tennant Creek is located 500km north of Alice Springs and has a local population of about 3,000. The town also provides services to the Barkly Region, which has some of the most remote Aboriginal communities in Australia. The hospital has 36 beds and the emergency department (ED) currently has about 18,000 presentations a year. Tennant Creek Hospital (TCH) and Alice Springs Hospital (ASH) form the Central Australian Health Service. I am the Director of Emergency Medicine (DEM) at ASH and I started there in 2009. While I do not have direct responsibility for TCH, Alice Springs is the referral centre for them, and I have a close working relationship with the TCH ED.

Prior to 2012, TCH struggled to recruit medical staff. There was a GP in the lead role of Director of Clinical Medical Services (DCMS) who lived locally, but all the other medical staff were short-term locums. Due to the remote location and poor reputation of the hospital, it was difficult to recruit appropriately trained and experienced doctors to work in TCH. There was no training program in place, poor retention and recruitment of permanent staff was challenging. Even locums were difficult to attract and, often, the positions were filled with very junior (although enthusiastic) doctors. Nursing retention was similarly poor, so the usual safety mechanism provided by senior nurses was also missing. The

local community were wary of going to the hospital because of the high turnover of staff. People often stayed away when they were ill, resulting in late presentations in extremis, which always has a poorer outcome than if the problem was caught earlier. This served only to exacerbate the negative perception of the hospital.

There were numerous significant clinical incidents during this time. In my role at ASH, I was involved in several root cause analysis (RCA) committees, which were convened in response to incidents resulting in significant harm to a patient. One particular incident resulted in the death of a patient – the worst outcome imaginable. It was an 18-year-old Aboriginal woman, with a full life ahead of her, who I firmly believe would still be alive today if there had been appropriate training and support available. The poor junior doctor involved in the case was also damaged by this unfortunate chain of events and I am sure they will carry the scars of that night for the rest of their life. It was a tragedy for the family and the local community, and traumatic for the acute care staff. Eventually, the DCMS resigned, leaving no permanent medical staff at TCH.

Something had to be done.

In late 2012, after this particular case, funding was announced for the Emergency Medicine Education and Training (EMET) program, which is a grant provided by the Commonwealth Government and administered by the Australasian College for Emergency Medicine (ACEM). I applied for this on behalf of ASH, with the idea of using it to develop a training program at TCH. The evidence seemed clear to me. Care improves where there is training. All I had to do was somehow turn TCH into a training hub.

I was successful in obtaining the grant. At the same time, I was in discussion with Dr Sam Goodwin, who was the DCMS at ASH and a rural GP with the Australian College of Rural and Remote Medicine. He felt he could convince five GPs to join him in a consortium to cover TCH; however, in the first meeting, it became clear that the group was not entirely comfortable dealing with the severely ill or injured, which resulted in a reluctance to go to TCH.

Fortunately, I had EMET and the support of the FACEMs at ASH. I promised they could call the consultants at ASH ED for advice any time, day or night, no questions asked. This is the same for any other rural hospital and received a lukewarm reception, but I had an ace up my sleeve. Through EMET, one of the permanent ED consultants (a FACEM) would physically be in TCH providing education and training in emergency medicine. This was the turning point that convinced consultants to come to TCH, which later proved to be a decision that transformed the hospital.

The EMET grant is very flexible in the way it can be used. I have attended ACEM meetings where hospitals showcase how they have used the funding and there are some spectacular projects happening in Australia. I have used it in a slightly unique way, but I believe the outcome has been tremendous and fits within the spirit of the agreement. Our project sends a permanent FACEM from Alice Springs to Tennant Creek for a week (Monday to Friday) every second week and backfills the position in ASH ED with a locum. That way, TCH is getting someone who knows the area and the specific local health needs of the population extremely well and is able to provide the nuanced support required to work effectively in Central Australia. FACEMs also develop a relationship with GPs working at TCH and this has greatly improved communication between the two hospitals. Importantly, the EMET FACEM is not on TCH's working roster. This is purely an education, training and support role.

The EMET program started in July 2013. At that time, there were five senior rural generalists who worked a rotating roster of two weeks each and the rest of the roster was filled with locums. It was a start. At least there were five GPs who committed to work at TCH on a regular basis and established the beginning of continued care. EMET provided education sessions for all the hospital staff – even the pathology staff turned up! There was a renewed enthusiasm for TCH and it was obvious that change was in the air.

By August 2014, the idea of turning TCH into a medical training hub was beginning to mature and pay off. There were now four GP registrars employed and while there was still the need for locums, it was much less. There were two rotating medical students and a position was developed for a Resident Medical Officer (RMO) from ASH to rotate at TCH. The Emergency Medicine Certificate (EMC) and Diploma (EMD) were offered through support provided by EMET. This provided specific training in emergency medicine to the doctors working at TCH.

By 2016, TCH had six GP registrars, four RMOs and two medical students. The Postgraduate Medical Council accredited it for intern training and there were two positions established, which were filled in 2017. TCH was also accredited by ACEM for training ED registrars in Rural and Remote Medicine and several registrars have participated. We have successfully trained more than 14 doctors through the EMC, including the first local Indigenous doctor, born and now working in Tennant Creek.

In 2020, TCH is oversubscribed for registrars. We had to turn doctors away. There are very few remote hospitals that can say they had more applications for places than were available. It is a far cry from the desperate position we were in a few years ago.

Why is this important? The care improved immensely. Significant clinical incident plummeted; no more unexpected patient deaths. Community confidence in the hospital has improved and there are compliments rather than complaints. People are more comfortable coming to the hospital for help before they get so unwell that they are in dire straits. TCH is able to provide safe care closer to home, so more Indigenous patients can receive the care they need earlier and in Country. There are fewer locums being used, which saves money. Morale in the hospital has improved and has led to better staff retention.

Training and education is key. It is now a sought-after training job for rural GP registrars seeking experience in Indigenous health and acute care. By turning TCH into an education hub, it has been transformed, benefiting the community it serves.

This was all made possible by a modest injection of funds and the foresight to use it in a way that embraces local innovation. The EMET program.

Emergency Medicine Education and Training

Rapid multi-professional training for COVID-19 in rural hospitals

Dr Sheree Conroy
Dr Conroy is an emergency physician in Toowoomba, Queensland, with an interest in medical education and training.

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Contribution: Project conception; data acquisition and interpretation; manuscript drafting and revising
Funding: None
Conflict of Interest: None
Ethical approval: This project was submitted to the Darling Downs Human Research Ethics Committee, who deemed it 'Not Requiring Ethical Review'.

What problem was addressed

With rapid worldwide spread of the COVID-19 pandemic, a training solution was required to quickly educate doctors, nurses and transport staff in a health service comprising a large regional hospital and 19 smaller rural hospitals. The health service cares for a total catchment population of almost 300,000 spread across a sizeable geographical portion of southern Queensland, Australia.

The regional hospital sees approximately 60,000 emergency department (ED) presentations a year with 14 emergency physicians (EPs), while the smaller centres see more than 100,000 presentations between them with no on site EPs. Delivery of on site training was thought to be very important despite the extensive road travel required.

What was tried

An existing Emergency Medicine Education and Training (EMET) program formed the basis for the new training. A four-hour face-to-face training package was developed, comprising four main parts. An initial slideshow explained clinical information about SARS-Cov-2 and COVID-19, including transmission, symptoms and the importance of staff safety. The second part covered personal protective equipment (PPE) training, with practical demonstration and participant practice of donning and doffing (where stocks allowed). The third section included discussion around important changes in management of respiratory presentations with COVID-19, in particular, aerosol-generating treatments. The final part involved simulated inter-professional practical scenarios with facilitated feedback.

The first COVID-19 EMET session was delivered at a rural hospital five days after the new module was conceived. Communication and planning were made easier by calling on existing network relationships throughout the health service.

Originally scheduled weekly, EMET training sessions were all changed to deliver the new module and were advertised widely to all staff, including those in adjacent towns, to increase attendance. Two additional sessions per week were also scheduled. Due to the increased number of training sessions, additional facilitators were sourced and trained. Usual EMET sessions are delivered by two EPs, and alternatives included an ED nurse practitioner, a medical education registrar (ED-trained), and a specialist anaesthetist.

Permission was sought and granted from the EMET funding provider, the Australasian College for Emergency Medicine, through the Australian Federal Government, to cover this additional training. No new equipment resources were required, as previous EMET modules contained the required equipment.

Lessons learned

It is possible to rapidly develop and deliver crucial emergency medicine preparedness training to rural hospitals in anticipation of the influx of patients expected due to community transmission of COVID-19. The prior existence of a network training program and established relationships in the health service were very helpful in allowing quick implementation.

The EMET COVID-19 training sessions have been well received, with excellent feedback from rural doctors and nurses. Eleven visits were undertaken, with over 200 doctors, nurses and other staff attending.

Darling Downs Health is now much better placed to cope with peak presentations during this pandemic, particularly with staff safety considerations, and individual staff have greater confidence treating COVID-19 positive patients.

EMET in the Time of Corona

Dr Elizabeth Mowatt
Dr Mowatt in an emergency physician and the EMET Clinical Lead in Cairns, Queensland. She aspires to add value through education for the staff and patients in rural emergency departments.

QUESTION

How do you manage an education program, delivered by more than 15 people to 11 separate and unique sites, across 273 119^2 kms, covering a broad curriculum via six different educational modalities?

ANSWER

With great difficulty!!

QUESTION

Will there be much impact from a global pandemic?

ANSWER

#@@***!!!!!

I had no idea how hard the job I love as Clinical Lead for the Emergency Medicine Training and Education Hub in Cairns (EMET FNQ) would become with the emergence of the COVID-19 global pandemic.

2020 was the final year of funding for this EMET cycle and everything seemed to be coming together for the team in Far North Queensland. Most exciting of all was the opportunity to take on site simulation to the remote sites. Every FACEM facilitator in our EMET Hub wants to go to Thursday Island! It is the jewel in the EMET FNQ crown, and there are only two visits a year. These three-day trips are resource-intensive and logistically challenging.

Schedules must align for staff in the rural facility and the facilitators, and the extra resources required impact on other activities we cram into the program. The visit includes a side trip to Bamaga on the mainland by ferry, and flights to these remote locations are limited. The Onsite Sim Team also needed to visit Weipa.

I call them the Onsite Sim Team, but they are really just two Cairns FACEMs who, in 2016, undertook the week-long course to become Sim-Cos and certified to operate high fidelity equipment. Simulation on site was something

identified from the very start of EMET FNQ as desirable by every rural facility, but despite many other achievements, we were yet to deliver on that request.

Four years and 22 Onsite Simulation workshops later, 326 participants have now attended one of these workshops in FNQ. It remains the most popular education modality we deliver. We had been to Cooktown twice but were yet to crack the truly remote sites. As we began to plan the 2020 EMET calendar, it seemed that we might make this happen. However, resourcing would be tight, other activities might need to be reduced and, most importantly, numerous schedules would need to align (rosters, holidays and family commitments for multiple people each visit, plus plane and ferry timetables). Preparations needed to start months in advance to clear all necessary approvals. If we did not try, it would not happen, and we wanted to honor the Remote Equity Package in our funding submission for EMET 2018-2020.

As obstacles started to evaporate, we locked in dates for separate trips to Thursday Island and Bamaga, to allow for extra set up time and avoid the challenging ferry ride. Weipa could not accommodate us until after August, so we identified potential future dates. We discussed a unique format for course content on Thursday Island, to allow training for more staff. Finally, rosters were written.

And then the world changed.

Suddenly, nothing was certain, although it quickly became clear we could not visit the Cape and Torres. Even before these communities closed their borders, we realised our staff should not fly in.

Could we even visit the nearby sites? Maybe change to video conferencing (VC) rather than onsite education? Would the audience be able to physically distance around the VC equipment? Is there a process for them to dial-in individually?

Will staff in the rural facilities be too busy to attend?

Will Cairns ED need to cancel all non-clinical duties to staff the floor because of pandemic surge or staff absences?

Will what we think today be what is happening next week? Next month?

Can people be focused on anything other than COVID-19 at the moment?

This last question was probably the most important to consider. The cognitive load of being a health worker in the time of a pandemic is overwhelming and all-consuming. But it was this question that found us a way through the turmoil.

After cancelling all remote travel, we looked at the scheduled local visits. We had three onsite visits planned for the next two weeks. In this lull before the storm, we decided to go ahead while we could. In fact, a request from one of the sites to focus on COVID-19 and personal protective equipment (PPE) drills prompted us to change the focus for all onsite visits in this time.

EMET FNQ knows that every rural facility in the program is unique. The success of the program has relied on the ability to tailor education to individual situations and requests from each site. So, we asked our networks what they needed. Most wanted PPE drills, although one site was already doing that. Some wanted to know all about complex respiratory failure, others an intubation refresher. What we were doing in Cairns was important to one site, while others wanted us to review their local processes. No one size ever fits all for EMET FNQ.

Before the scheduled break for school holidays, EMET delivered onsite education focused on PPE to four of the seven rural sites within driving range. The facilitators adapted their workshops in a matter of days. A fifth site we visited were drilling PPE protocols already, allowing the planned workshop on Procedural Sedation and Fracture Reduction to go ahead, focusing on skills to treat patients locally and avoid transfer to Cairns. There are now plans in place to visit the two remaining sites in the next month to drill their COVID-19 protocols.

We did cancel the two booked High Fidelity Simulation Courses that run monthly, due to travel restrictions, physical distancing requirements and uncertainty about staff availability.

We are staying connected within our networks and sharing resources developed by the Cairns ED team, such as the Streamlined COVID Intubation Protocols. It took a little while to realise that, even though pandemic planning was well established at executive level, clinical staff still value clinicians providing tools and advice, and that this granular detail is not something command centres are (understandably) focusing on. EMET FNQ's strength continues to be its grassroots approach and strong networks.

The combination of being guided by the educational needs of rural facilities and having a facilitator group who can lithely respond to a dynamic environment has been the backbone of our program since its inception. Now more than ever. Importantly, within a month, rural facilities are telling us they are comfortable with their pandemic preparedness and returning their focus to everything non-COVID. The stuff that EMET is made for. We are planning to do that next. Fingers crossed. The challenge is, we usually roster EMET months in advance and, currently, our world is changing daily.

In reality, our EMET time is not as productive as before COVID. In all honesty, I don't think anything I do is as productive anymore. Receiving news of an extension of funding into 2021 is very welcome. We know that the time we invest in developing new resources will pay dividends when things return to normal … whatever the new normal is.

ACEM Goes Online

As we moved into 2020, the world quickly changed, affecting all work at the College significantly, including events and conferences. COVID-19 created widespread cancellations of all face-to-face conferences, meetings, symposiums and other events. As the ACEM Events Team and various organising committees move to cancel and postpone activities, we are shifting to digital platforms to explore the virtual world of sharing information.

The Events Team have been fortunate to connect via webinars, with emergency physicians working on the front line across the globe in places like Italy, Israel, UK, South Pacific, as well as colleagues in Australia and New Zealand. We are working hard to provide resources and information and ensure that all members and trainees can maintain their continuing professional development requirements during this time.

On 20 March, ACEM hosted its first webinar: COVID-19 – an ED Focus. There were more than a thousand registrations. The webinar was presented by FACEMs Associate Professor Didier Palmer OAM, Chair of the Northern Territory Faculty Board, and Queensland Faculty Chair Dr Kim Hansen, and infectious diseases physician Dr Alex Chaudhuri.

It was not without its glitches, but it is the first of many pivots to digital that the College will undertake to confront this pandemic.

Following the success of the first webinar, ACEM held the next one in early April: COVID-19 – Personal Protective Equipment (PPE). This webinar was presented by infectious diseases physician Dr Rhonda Stuart, FACEM Professor Peter Cameron, FACEM Associate Professor Sally McCarthy, Nurse Unit Manager Sue Cowling, and a representative from Ambulance Victoria, Adjunct Associate Professor Mick Stephenson. The webinar was moderated by FACEMs Dr Gabriel Blecher and Dr Simon Judkins and joined by more than 400 attendees.

ACEM recently hosted its third webinar: COVID-19 – Ethical Decision-Making. It focused on the challenges of ethical decision-making during a pandemic with resource limitations. It was presented by ACEM President Dr John Bonning, FACEM Professor George Braitberg and Australian Health Care Ethicist, Associate Professor Sarah Winch.

In the coming months, the ACEM Events Team looks forward to hosting more webinars on a range of key topics to support College members and trainees during these difficult times. As we complete the shift to a digital platform, we thank you for your patience and understanding.

If you have any questions, please do not hesitate to email the Events Team at events@acem.org.au

Managing Wellness During COVID-19

Dr Charley Greentree
Dr Greentree is an emergency physician in Queensland and one of the founding members of WRAPEM.org

When was the last time that the world you knew changed profoundly? Was it a birth? A death? Personal illness, injury or that of a loved one? 9/11? The HIV pandemic? Experience of racism or bullying? You know, that feeling, deep and jarring, the one that may not have appropriate words to describe it properly just yet, but your lens on life is different, your actions are influenced and your intent or values may be modified or reinforced. How do you go forward from this change, as going back is impossible? What will your impact be on the situation? What is the impact on you?

In a pandemic, millions of us are experiencing this profound sense of change, all at the same time.

Within this last year, we have had the horror of bushfires, destroying massive amounts of land, human life and lifestyle, native vegetation and wildlife in unimaginable amounts. The smoke and sorrow of one continent reaching New Zealand and beyond. At the same time, before any chance of resolution of the effects of the fires, we were and are faced with COVID-19.

Initially watching and learning from other countries' experiences, from scientists and public health clinicians, we plunged into preparations for handling the potentially disastrous surge of cases that threatened to overwhelm New Zealand and Australian health services, as people with the infection and illness hit our shores and the inevitable community transmission occurs. To date, health and political leadership and, especially, the actions of community in Australia and New Zealand have delivered us from the heartbreak we have seen in Asia, Europe and the US. We are not in the clear yet though.

The health community and, in particular, emergency medicine clinicians have shown courage, wisdom, intellect and pragmatism in preparing for and dealing with care of our patients, and the systems within which we work with flexibility and accountability. The larger community has, in the main, complied with physical distancing, handwashing, self-isolation and other mitigation strategies at the hefty expense to relationships, livelihood, income and industry. There is collateral physical, mental and economic injury and illness as a consequence of defending our community against COVID. We can't actually measure the cost because we are still within the foray.

We all have decisions to make as we exist in our current circumstances. In this sea of uncertainty, disconnection and massive changes in work practice and lifestyle, how do you grow your resilience, endure troubles and distress, and even potentially thrive or flourish? How do you empower yourself and others to do so? We often need space and time to consider these decisions.

Social isolation gives opportunity for reflection. What are your personal strengths? What are your strengths as an emergency clinician? What are your department's and community's strengths? How will these strengths work for you, your family, your colleagues, your community?

We have resources and guidelines to support us, to make sense of, to apply and evaluate in our practice, to share, develop and respond to.[1,2,3] There are multiple communications and publications flooding our consciousness daily — multiple elements that we need a framework to be able to assimilate and use fully.

There are a number of conceptual frameworks to use if you are feeling lost or overwhelmed. One such framework is the Cynefin (sense-making) framework – offering us a sense of place to consider our situation from. Cynefin is Welsh for habitat. The closest term in Māori is tūrangawaewae (a place to stand) and in Bundjalung the most appropriate term would be yahnalal ngumbinya (sitting or staying home). In this framework are five domains. (**Figure 1**)

'Disorder' is that state of disorientation and transience, which the scientific mind can find exciting in the right context, but usually evokes fear and anxiety. Our only actions are to identify we have 'lost' our place and gather any information we can to move into one of the other domains. In the state of this new existence with a novel virus we have been disoriented. We did have information to gather – SARS, MERS, HIV, influenza. In the state of personal isolation and disconnection, there was less information and experience to gather. By now, most of us have either moved or been moved to another domain. If you are not sure, you could be here or in the Chaos domain.

'Chaos' is where cause and effect is not evident at all and there is a compulsion or instinct to act first and survive. Your limbic system is driving the decision-making, you are prone to error, and the way forward is to establish any sort of sensibility, then respond by getting yourself into another domain, usually 'Complex' or 'Complicated'.

The Complex domain of unknown unknowns is challenging. Cause and effect can be established – but in hindsight, and working within a righteous paradigm is futile in real time. We have seen this in variable political leadership responses globally. A seemingly infinite loop of experimentation and evaluation can appear until courage to pursue the next step with resolve and progress to another domain – usually the Complicated. In a community context, will physical distancing flatten the curve? What level of social restrictions are needed? In a personal context, this is where self-compassion and kindness is most needed.

The Complicated domain is actually comforting for emergency physicians, as our practice deals with lots of

'known unknowns' on a daily basis. We gather and assess facts, analyse and formulate possible solutions, and evaluate their success and worth. We use consensus and expertise for evidence, looking at a range of 'right' answers. Our current emergency medicine practice in Australia and New Zealand would largely align with this domain, but, importantly, we still have colleagues and places in the Complex domain to be aware of and possibly assist.

When will we know what we know? When will it become Simple? Best practice? Compare this to conscious competence or refining expertise. We continue to aim for best practice. Even though we don't know what this is yet (in our evidence-based paradigm of practice), we do know of the concept we are heading for. The danger we have is forcing ourselves to go into this domain by oversimplifying, complacency or being blinkered to new ways of thinking. We can be encouraged by recognising smaller pools of 'known knowns' in this situation that we bring into COVID times and beyond (neoCOVID).

So why bother with contemplating this or any other framework? Why think about professional and personal wellbeing as context for these frameworks? Well, because that domain of Disorder, or the element of it, of remaining 'lost' or uncertain, can lead to Moral Distress – the experience of being seriously compromised as a moral agent in practising in accordance with accepted professional values and standards; a relational experience shaped by multiple contexts.[4] From such distress, Moral Injury can occur. This is when there is an act or perception of betrayal of what's right, by our self or our leaders or colleagues, with a loss of trust, in a high stakes situation.[5] Moral Injury is associated with intense feelings of guilt and shame. Tools to assess the occurrence of Moral Injury, such as the Trauma-Related Guilt Inventory or Trauma-Related Shame Inventory, are not specific for the health context, but do provide some understanding.[6,7] There is a developing body of work postulating a spectrum, including Moral Injury and Post Traumatic Stress Disorder (PTSD). The current situation has potential for harm, short and long-term, and in many modalities. We have the opportunity to proactively mitigate and protect against Moral Injury and possible PTSD. It is important to reflect, to have insight into any possible occurrence of Moral Injury. We are facing many unknowns with lots of support and resources. Colleagues elsewhere in the world face a much different and, at present, more threatening situation. I have had conversations with colleagues recently who have some distortion of 'survivor guilt' because we are not London, New York or Italy. These are some of the important conversations for our mental health, as speaking to the guilt or shame is the most effective treatment. If there is perception of betrayal, guilt and shame in yourself or others, I would urge you to speak up and seek help (your GP, Workplace EAP, ACEM EAP)[8]. As emergency physicians, we become experts in clinical decision-making, in team-based and system-based decision-making. These and decisions we make around our self-care and wellbeing in this current unknown, high stakes environment will endure into all of our futures.

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My First Day on the Job

Dr Sandy Inglis

As a more mature FACEM, a first day on the job should be a very remote and vague memory. But thanks to having a somewhat itinerant existence and a French wife, I seem to have had my fair share of first days of late. We said farewell to South Africa at the end of 2018, relocating to a small village in the south-west of France, and I've had a hotchpot of jobs since then, waiting for the next perfect challenge.

So, I won't talk about my first day on the job working for the amazing telemedicine group My Emergency Doctor on Christmas Day, which was an IT extravaganza with multiple screens and platforms and anxious patients being placated from nearly 20,000km away.

Nor will I talk about my first day on the job in the ED in Reykjavik, Iceland. I was employed on a 0.5 post in 2019 and got to experience a very high tech and well-staffed ED, where I was assigned a medical student on every shift as my scribe, who not only wrote all my notes, but translated for me, chased results, made referrals and often my coffee too!

And I won't talk about my first day on the job in the ED at The Indus Hospital in Karachi, Pakistan, where I volunteered for a month in October 2019 as visiting faculty for their Certificate program in emergency medicine, and where I saw what it was like to have 700 patients a day through the ED in a hospital with 150 beds and a dengue epidemic.

Yes, and I won't talk about my first days on the job at my 2020 locums. My first job was at beautiful Bunbury where I worked with a wonderful international team and got to cycle to work along the seafront every day. Then I went to Letterkenny Hospital in the west of Ireland, where we were warming up for COVID-19 as continuous showers lashed the coast, and I took refuge in warm pubs with Guinness and friendly locals, and then escaped back to France as lockdown set in.

No, I think that I'll talk about my first day on the job working in France.

I don't need to remind you that France is different and that it isn't all about baguettes, croissants and red wine. The French emergency medicine scene is very different to ours. Where we have a paramedic-led 'scoop and run' strategy, they have an EM doctor-led 'stay and play' approach, and boy, do they stay and play. Lines, tubes, ultrasounds, syringe pumps, ventilators, etc. But the interesting thing is that this same ED doctor then brings the patient to ED and continues with the management in the ED, so no fuss with trauma teams, overzealous anaesthetists and in-patient team fussing. But I digress, my first day on the job!

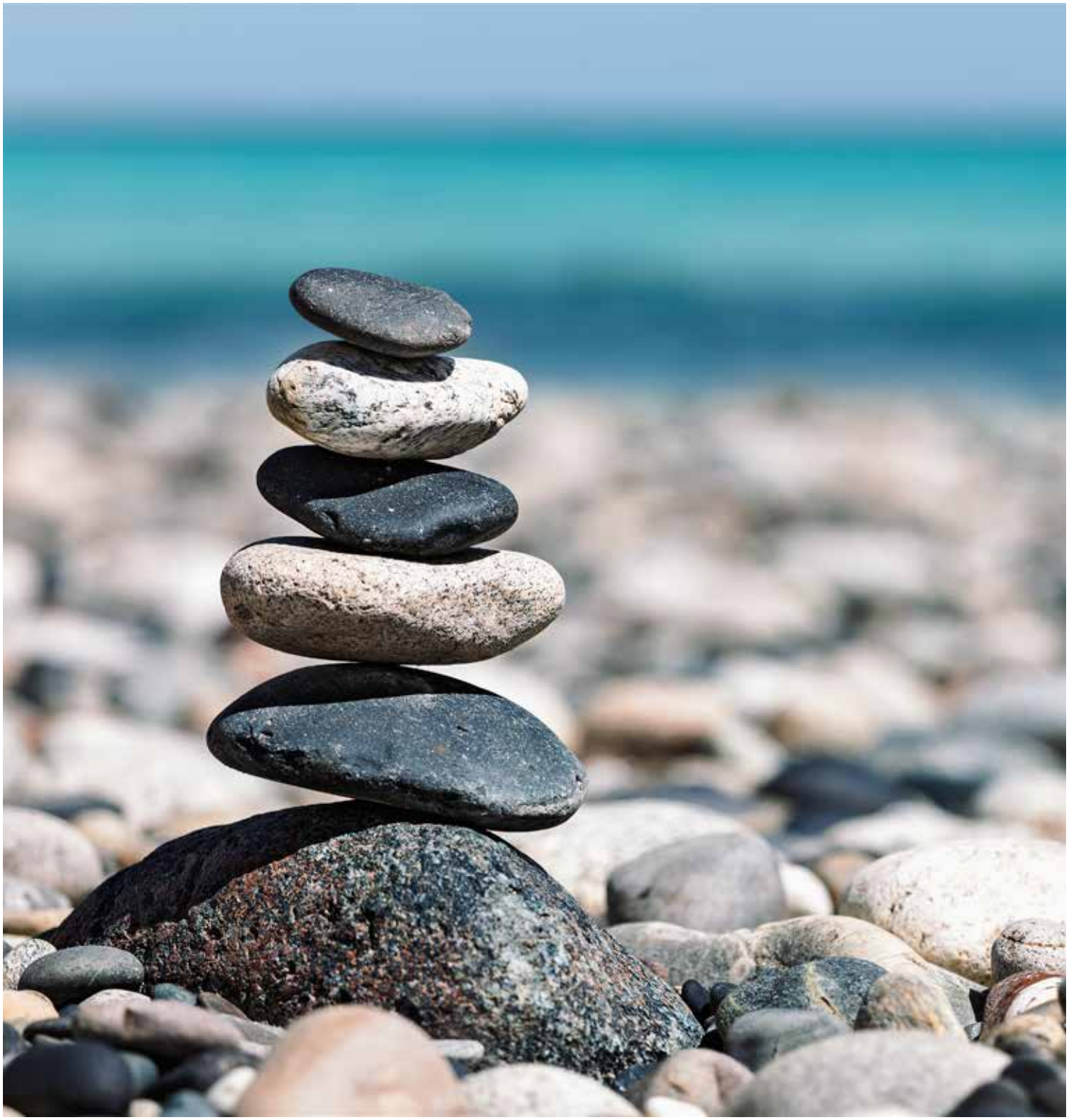
I just need to add here, that the FACEM Fellowship exam counts for squat in France. Twenty years as an EM specialist and being registered in New Zealand, Australia, South Africa, UK, Iceland and Ireland, all count for ZERO! I have been fighting with the CNG (French AHPRA) for about 18 months and they want 36 months' European experience AND they want me to write an EM exam in French. So it was with my tail between my legs and the COVID-19 lockdown, that I accepted a position in our local ED as a 'medicine attaché', which basically means that I am under the supervision of the clinical director and that they can pay me really badly. But hey, at least I get to work locally and, best of all, get to ride the magical 15km to work through Tour de France-like countryside while the COVID crackdown is on.

So, the first day on the job. Imagine. New uniform, new ED, new hospital, new system, new computer programs, new language, new country, new disease! But thankfully, the same old ED problems. My French is passable but medical French is a completely new dictionary. All our abbreviations (SOB, ACS, PND, BLS, RTA, MRI, FBC, etc) are completely different and need to be learnt from scratch. The French keyboard is weird. QWERTY is gone and accents and uppercase buttons abound. And then there is the usual, 'So who takes GI bleeds?' and 'Do you do CT or MRI for strokes?', and so on. It was with some trepidation that I stepped out onto the floor introducing myself as 'Sandy', although my name badge advertised me as Alexander, and explaining that I was in fact South African, but Australasian-trained, and normally work in Iceland and Ireland, and live nearby in a little village of 5,000 inhabitants called La Crèche. By this stage, the locals seemed to have glazed over and lost interest and we followed the medical migration to the ED canteen, where copious cups of coffee were proffered and mountains of croissants, cake and chocolates, donated by the adoring and grateful public, adorned the table.

With the COVID-19 deluge imminent and horror stories from the east of France, we are fully mobilised here with the ED totally reorganised into a (predominantly) COVID-19 ward, including all the resus and monitored bays, and a smaller 'normal' ED upstairs. Staffing has been hugely augmented so that we are somewhat falling over each other and scratching for things to do. Copious COVID conferences and meetings, scrupulous persistent handwashing, permanent masks (removed only to slurp down a coffee or the boeuf bourguignon at lunch time), and lots of idle banter, have made for a good milieu to orientate and manage my first day on the job.

What did I see on that first day on the job? Nothing dramatic, I'm afraid. The middle-aged man with renal colic, who explained in beautiful detail the excruciatingly painful migration of his pain from loin to penis tip, relieved by the passage of 'granules of sand'; the young lady with the recurrence of her pilonidal abscess from which I drained a disgusting 50ml of putrid pus; the otherwise fit 60-year-old car renovator who presented well with melena, whom I referred on to gastro; and the lovely 85-year-old lady who had spent a day on the floor with her broken hip, having never ever been in hospital before.

So, 'same old, same old' but definitely with a twist. It is quite something to have to call on the interns to check that my notes make sense, allowing them to add e's and accents, and watching them squirm at my annihilation of their mother tongue. The second day was better than the first, and each day, my vocabulary, grammar, abbreviations and understanding grow. Next week, I graduate to COVID care.



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

–Sadhguru

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