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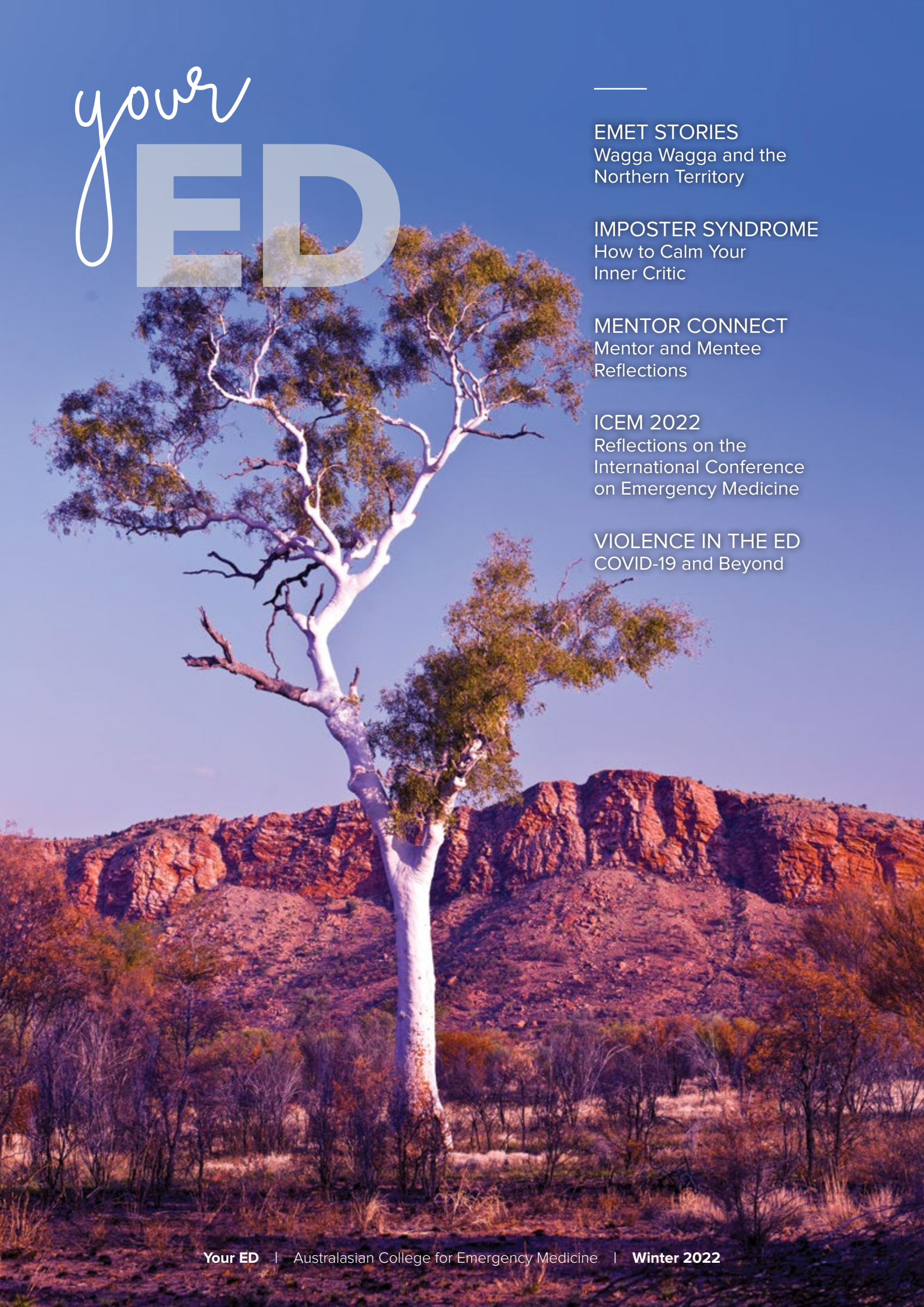

EMET STORIES
Wagga Wagga and the Northern Territory

IMPOSTER SYNDROME
How to Calm Your Inner Critic

MENTOR CONNECT
Mentor and Mentee Reflections

ICEM 2022
Reflections on the International Conference on Emergency Medicine

VIOLENCE IN THE ED
COVID-19 and Beyond

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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.

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Message from the Editor

Welcome to the 14th issue of *Your ED*. The College is again proud to showcase emergency medicine stories from across Australia, Aotearoa New Zealand and the globe.

In this issue we highlight work done by FACEMs in the Emergency Medicine Education and Training (EMET) program, with stories from Dr Jessica Mooney in the Northern Territory, and Dr Peter Chigwidden in Wagga Wagga.

We feature articles on imposter syndrome and how to calm your inner critic, and mentors and mentees share their experiences in mentorship through ACEM's Mentor Connect Program.

Dr Simon Judkins reflects on the International Conference on Emergency Medicine (ICEM) and ACEM's Global Emergency Care Committee showcases some of the experiences of the international scholars in attendance.

This issue also celebrates the release of *When Minutes Matter*, a collection of short stories, edited by FACEMs Dr Rob Mitchell and Dr Jennifer Jamieson, that highlight emergency care at its greatest and most tragic.

We hope you enjoy these perspectives on emergency medicine. Please take care of yourselves – and each other.

ACEM in the Media

In **May**, the College released a series of statements related to the Australian federal election, welcoming health-related pledges from both major political parties, and featured in a range of related media.

ACEM President Dr Clare Skinner said, 'Regardless of who forms government, we need to see the necessary reforms and improvements to healthcare systems. We stand ready to work collaboratively to achieve this.'

Throughout **May**, Dr Skinner featured heavily in the media nationwide discussing the national emergency in healthcare.

Dr Skinner said, 'I'm hearing from senior emergency physicians that the conditions are the worst they've experienced in their careers with very long waits for patients and desperate staff shortages.'

Dr Skinner said that some patients are 'waiting an unreasonable length of time for even basic treatment.'

Dr Skinner wrote a feature article for Croakey Health Media that examined the difficulties faced in the emergency medicine system, as well as the 'once-in-a-generation opportunity to create a better, fairer, safer health system.'

In **May**, Immediate Past President Dr John Bonning spoke with 1News on aggression directed at emergency department (ED) staff and the impact it has on morale.

Dr Bonning said longer wait times are contributing to negative behaviours and that 'there's no excuse for it and we really need, as a population, to try and do better.'

Dr Bonning called for 'more resources', 'more staffed inpatient ward beds' and 'more nurses' to help ease the pressure on the health system.

In **May**, the College issued a statement on the Northern Territory Government's $2 billion health investment in the 2022-23 budget.

The College urged the government to provide greater funding for public health facilities across the entire territory and to focus on workforce.

In **May**, Victorian Faculty Chair Dr Mya Cubitt featured in the *Sunday Age* discussing overcrowding and delays in EDs, where she warned, 'We're starting to see these 'never' events happening multiple times a day'.

In *The Guardian*, Dr Cubitt spoke about the 'national emergency' in healthcare and advocated for a state-wide dashboard to allow EDs to better work together.

Dr Cubitt said, 'In Victoria, we are working really blind, especially in the area of emergency medicine.'

Dr Cubitt was interviewed on Channel 7 News on the ramping crisis, warning that 'hospitals are over capacity and we have a perfect storm of burnt out staff… without the resources that they need to deliver the care that they would like to deliver.'

In **May**, the College released a statement attributable to Queensland Faculty Deputy Chair Dr Shantha Raghwan, who also appeared across various media including Channel 7, the *Courier Mail* and the ABC, warning that Queensland is facing a critical issue with its health workforce and that the system is in the worst state they have ever seen it.

Dr Raghwan said, 'We are fed up, we are broken, and we are exposed.'

In **May**, ACEM released a statement welcoming the focus on health in the 2022 Aotearoa New Zealand budget. ACEM stated that elements of the $11.1 billion investment could help reduce pressure on struggling hospital systems.

The College highlighted the need for a stronger focus on workforce.

ACEM Aotearoa New Zealand Faculty Chair Dr Kate Allan said, 'Right now, healthcare workers are burnt out, stressed and exposed, and we need an urgent focus on retaining senior staff, who are leaving the profession entirely.'

In **May**, ACEM released a statement offering its congratulations to Labor leader Anthony Albanese on becoming Australia's 31st Prime Minister.

Dr Skinner said, 'Mr Albanese and his team now have the opportunity to demonstrate the vision, collaboration and capacity needed to bring all parts of healthcare together to reimagine and deliver a better, more equitable system.'

In **June**, the College released a statement welcoming the new federal Minister for Health and Aged Care, the Honourable Mark Butler, and expressed its intentions to work with him and other healthcare stakeholders on an overhaul of Australia's health system.

In **June**, Dr Bonning featured extensively in the media discussing the pressure the COVID-19 pandemic was having on the health system, including how staff illness and isolation were having a flow-on effect across hospitals.

Dr Bonning said, 'We've kind of got a perfect storm of the beginning of winter, winter ailments, respiratory viruses that we have not been exposed to for a couple of years, the tail-end of COVID, although it's a pretty wicked tail in terms of number of cases.'

In **June**, Dr Cubitt was quoted on ABC News discussing the pressure the pandemic was having on Victorian EDs, warning that delays in being treated have an impact on mortality rates.

Dr Cubitt said, 'The problem is not people turning up at hospital feeling they need healthcare – it is because not enough people are leaving through the backdoor, so no one can get in.'

In *The Age*, Dr Cubitt warned, 'If we go into the winter without people being honest about the state of our emergency departments, we will continue to see an exodus of staff and more and more emergency departments will start to fall over.'

In **June**, ACEM released a statement welcoming the $2.4 billion investment into health in the 2022 South Australian state budget.

In **June**, the College released a statement announcing the 21st International Conference on Emergency Medicine (ICEM 2022). Croakey also published a suite of stories discussing the conference.

In **June**, the College released a statement welcoming the respective announcements by the Victorian and New South Wales state governments of policies and investments aimed at supporting healthcare workers.

Dr Skinner said, 'It is crucial that we support our highly specialised medical workforce, and other workers critical to the functioning of our health system, to remain in the sector.'

In **June**, the College released a statement, and Dr Allan also featured in media including TVNZ1 News, responding to misleading comments attributed to Health Minister Andrew Little and stood by Dr Bonning's assertion that EDs in Aotearoa New Zealand are under extreme and unprecedented pressure.

In **June**, Dr Skinner featured in media remarking on the increasing strain felt in Australia's emergency departments. Dr Skinner warned that COVID-19 and influenza cases were increasing admissions and that staff morale was 'low'.

In **June**, ACEM and South Australian Faculty Chair Dr Michael Edmonds were quoted in the media discussing the 'extreme pressure' in which South Australian EDs were operating under.

Dr Edmonds said that both short-term and 'longstanding, systemic issues that have been identified for many years' were impacting healthcare in the state.

In **June**, ACEM released a statement welcoming a study on the health impacts of ambulance ramping and urged all parts of the health system to collaborate on solutions for the systemic issues that cause ramping and overcrowding.

Dr Skinner said, 'This study verifies what emergency clinicians already know and what we have been drawing attention to for years: access block is dangerous and causes preventable patient harm.'

In **July**, the College released a statement welcoming the announcement of the establishment of specialised Aboriginal Health Practitioners in state-funded public health services in Western Australia.

Dr Skinner said, 'Australia's emergency doctors collectively envisage a future where Aboriginal and Torres Strait Islander peoples experience culturally safe emergency care that is self-determined, free from bias and racism, and enhances opportunities for quality health outcomes.'

In **July**, ACEM released a statement in support of all reasonable measures taken to ensure the Queensland health system can respond as effectively and safely as possible to high patient numbers.

The College warned that Queensland members were facing the worst conditions to date and urged all people presenting for care to remain patient.

In **July**, Dr Edmonds discussed the pressures facing the South Australian health system with InDaily, warning that 'the health system in South Australia is in crisis and it isn't safe, for either patients or staff.'

'ACEM will hold the government accountable for the delivery of crucial fixes and continues to offer clinician engagement in developing these solutions.'

In **July**, the College released a statement cautioning the Northern Territory Government over its plans for the large-scale removal of hospital department heads and senior NT Health leaders, without consultation.

In **July**, ACEM released a statement, attributable to Dr Skinner, responding to media queries over health system pressures and COVID-19 cases.

The statement encouraged Australians to receive the vaccines they are eligible for, and heed mask-wearing recommendations, and supported moves by governments to highlight risks and provide advice to the public amid the COVID-19 surge.

Dr Skinner told ABC News radio, 'this is not just due to COVID-19, it's actually been building for years. We don't have adequate staff. We've seen with any pressure on the health system that things start to fray at the seams.'

In **July**, Queensland Faculty Chair Dr Kim Hansen told ABC News radio about the 'huge' number of COVID-19 cases on top of the 'usual burden of chronic illness, mental illness and injuries' that are impacting the health system.

Dr Raghwan spoke with Channel 7 about the pressures on Queensland's EDs and said, 'emergency doctors across Queensland agree that this hospital state is the worst that we've ever seen' and that not all issues are due to COVID-19.

In **July**, the College released a statement responding to significant healthcare investment announcement by the Victorian Government.

The College voiced support to measures that may help address long-standing systemic issues and improve patient flow and safety.

ACEM Victorian Faculty Acting Chair Dr Belinda Hibble said, 'It is heartening to see a commitment to considering ongoing management of influenza and other respiratory illnesses, and evidence-based flow strategies, as we continue to emphasise the importance of investing throughout the system.'

PRESIDENT'S WELCOME

Welcome to the Winter edition of *Your ED*.

I'm enjoying watching the buds form on the Waratah in my front yard, the bright yellow wattle emerging, and the slowly warming weather.

After this truly hard winter of unprecedented virus presentations and staffing shortages, more than ever, it feels like a time for renewal, growth, and integration, and I can feel the collective energy lifting.

I am looking forward to the Spring Symposium in November, to be held in Ōtautahi, Christchurch, Aotearoa New Zealand. It feels like a privilege these days to hold an in-person event, not a given, and I know how much value we get from being with each other in person after years of screens.

Fittingly, the ACEM core value of this month is collaboration, the act of people coming together to work through a shared process towards a united goal.

For me, a music lover, this is a value that sits close to my heart.

Where would music be without iconic collaborations, like the song-writing partnership of Paul McCartney and John Lennon? Or closer to home, two of my favourite musical storytellers, Paul Kelly and Neil Finn, working together to record the fantastic trans-Tasman album, *Goin' Your Way*.

I could also posit that collaboration is the most obvious ACEM value of all, for collaboration is at the heart of our work.

In the emergency department, we work collaboratively across the system to support patients every shift. We collaborate with nurses, allied health professionals, paramedics, clerical and technical staff, and of course, inpatient and community-based specialist and trainee medical colleagues, to ensure that people receive safe and effective care in the smoothest possible way.

ACEM staff work collaboratively with FACEMs, members, trainees, community members and external bodies such as government, and other organisations and networks, to support and promote the needs of members, and to advocate for improvements to the systems we work in, and for the communities we serve.

We collaborate with the past and with the future, in a cyclical manner: Our Retired Fellows and former College leaders continue to contribute to shape ACEM today and support our present members. Our current members support trainees in their learning, training, and career journeys. And through the practise of mentorship, and reverse mentorship, trainees support and advise FACEMs and Retired Fellows.

We also collaborate with the past when we use our stories, our history, and experiences, to imagine and build a better future.

Most importantly, as patient-centred care is the heart of our work, we collaborate with the people who seek emergency treatment, for they are the experts on their bodies, and on their needs. We also collaborate with carers, and value their input, advice, and engagement.

Now, we must now collaborate on an even greater scale to heal and reform the health system. It is time for us to come together in a significant way, to partner with other stakeholders across the health system to solve the problems and create a health system that is fair, safe and meets the needs of all people.

Things are tough in emergency departments, and across the health system. It is important to remember that we are all in this together: we are aligned with the specialised general practitioners, we are aligned with the nurses, we are aligned with the paramedics, with governments, and with patients and carers. We are all facing the same problem: a lack of resources and good processes of coordination and integration in the health system. And it is only by working together against the problem that we will achieve what we all want.

Please know, the College is here working towards this, and we won't rest until we do.

Finally, as we look to the future, please join me in welcoming Emily Wooden to the role of College Chief Executive Officer. Emily brings a wealth of experience in the specialist medical education sector to ACEM, and we are excited to work with her as she contributes new ideas and energy to this key leadership role.

Until next time, thank you, for all that you do. And know that whatever the next month brings, we will get through it like we always do – together.

Dr Clare Skinner
ACEM President

CEO's Welcome

Emily Wooden

This is my first *CEO's Welcome* since I began at the College in late July.

I am honoured to take on this role supporting the College and its vital work, in a time of reimagination and integration. I offer my gratitude to Dr Peter White who, while leaving big shoes for me to step into, has left the College in excellent shape for the next stage of its evolution.

I have met many of you already and look forward to getting to know many more of you as time continues. For those I have not yet met, please let me use my first column to introduce myself, and my career that has led me here.

On a professional level, my 30-year career can be broken into thirds.

After my university studies where I became a CPA and Chartered Secretary, I began the first third of my career on a government graduate program in Canberra. I then moved into the commercial world of telecommunications and the finance industry.

This early experience and training in the corporate environment provided a useful foundation to my career. But I soon found myself wanting more purpose from and in my work.

For the second part of my career, I headed into the charity sector where I worked in the international development and childcare sectors. This gave me great understanding of the need for commercial expertise applied to the for-purpose sectors, and it gave me the purpose I was looking for.

But it was the final third – moving into member organisations – that led me to my niche, and, ultimately, to ACEM.

First, I supported the education and training spaces. Then I was appointed an Executive with the Royal Australian College of General Practitioners. Finally, for the last four years, I have been the Deputy Chief Executive Officer (CEO) at the Royal Australasian College of Surgeons.

It is an honour to work in specialist medical colleges, alongside specialist medical professionals.

I really value the more intimate relationships we have with members, compared to working with customers in corporate organisations, and I appreciate the opportunity to lead in collaboration with members, in responding to the needs of their profession.

As a leader, I aim to be highly affiliative, and for my leadership to be driven and led both by my personal values of compassion and integrity, and by firm business discipline.

I work to be empathetic, and to focus on the needs of others, led by a clear sense of accountability to the College.

Of course, I am human, and, as the new CEO of your College, I will make mistakes. But you can be assured that I will always make decisions that I believe are best for the College as a whole. At times, these decisions may not suit us as individuals, but my focus will always be on emergency medicine and the communities it serves.

On a personal level, I grew up in Wagga Wagga, in regional New South Wales, where I worked in my family's fast food chicken shop after school.

It is fitting that this edition of *Your ED* features stories of members who are living and working in Wagga Wagga, and it warmed me to read about the amazing people who will take care of my friends and family in an emergency.

I now live in Melbourne with my husband and our young family. When not at the College, I enjoy dressmaking and playing golf with my children. Like all families, we have had many visits to a local emergency department over the years and, every time, have received exceptional care, always delivered with kindness.

Now, I am honoured to have an opportunity to give back to the emergency clinicians who are there for people when they need it the most.

I know that every ACEM staff member is in awe of what our members do every day in the ED. And I know that this inspires and drives each of us to also give our best work, every day.

Yours in service,

Emily Wooden

ACEM CEO

Vale Associate Professor Joseph Epstein

Professor Anne-Maree Kelly

Professor Kelly is Director of the Joseph Epstein Centre for Emergency Medicine Research and a senior emergency physician at Western Health, Victoria.

Few people had such a varied and inspiring professional career as Joseph (Joe) Epstein: surgeon, emergency physician, one of the founding fathers of the Australasian College for Emergency Medicine (also later serving as its President), founding signatory of the International Federation for Emergency Medicine, director of the Retrieval Service in Victoria, advisor to ministers and governments, enthusiastic and generous teacher, academic mentor, inspirational leader, trusted advisor, force of nature, and a philosopher and raconteur, to name but a few of his guises.

Born and raised in Melbourne of Jewish immigrant parents, who narrowly escaped Poland before the War, Joe was intent on making the world a better place. He initially trained as a surgeon before shifting focus to emergency medicine. Joe was fascinated by its complex challenges and spent much of his professional life exploring them. He saw the opportunities to improve healthcare that working at this crossroads of the health system offered.

It may be hard to believe, but within living memory, care in what was then called 'casualty' was delivered for the most part by junior doctors, with little training, experience or supervision. Despite their best efforts, the term 'casualty' became associated with second-rate medical care. Joe and a small band of like-minded doctors in Australasia decided to change that. The road to establishing a specialist college for emergency medicine in Australasia was difficult, but ultimately successful. The College was not just about training a specialist workforce for emergency departments. It was about standard setting, monitoring quality and performance, advocating for system change, and being a voice for the vulnerable. The College we see today owes a lot to Joe's vision, energy and persistence.

Joe was a skilled influencer, but not in the social media sense. He used his charm, charisma and sharp intellect to open doors, inform and persuade those in positions of power on local and national issues. His intellectual agility, precise use of language, and careful preparation rarely saw him leave meetings without progressing his cause.

In addition to his work at state and national levels, Joe was an inspirational local leader and mentor at Footscray Hospital (and its later incarnation Western Health). For many years, the west of Melbourne was neglected. Its people were poor, working class, immigrant and of little political 'value'. They also had high rates of chronic and preventable illness and workplace injuries. Joe was a champion for them. He advocated for a greater share of health funding and more and better hospitals and services so that specialist care could be delivered where people lived.

At Footscray Hospital, Joe was a long-serving emergency department (ED) director and senior clinician. He established Western Health as a leader of Emergency Medicine practice and education for doctors and nurses. He also nurtured the diverse and dedicated team who work there. His mentorship has led to Western Health-trained clinicians taking up senior leadership positions throughout the health system, carrying on his legacy of providing the best care for all, no matter what their personal circumstances.

On his retirement in 2016, a booklet was produced that brought together recollections about Joe's career from some of the people his professional life touched. The diversity of the stories, and of the contributors, say a lot about the high esteem in which Joe was held by people from across many disciplines and around the world. The stories also speak of the enduring friendships that have been formed and nurtured.

It is no accident that there is a Joseph Epstein Centre for Emergency Medicine Research. Joe was a staunch believer that quality of care and research were inextricably linked. He also believed that to work effectively with, and influence, other specialist groups, emergency medicine had to establish its academic credibility. Through its ongoing and international research, the Centre carries on Joe's philosophy of rigorous inquiry and change driven by evidence.

Joe's concern for First Nations people, particularly expressed through the ACEM Foundation, has contributed to significant increases in awareness of health inequity in emergency care, and efforts to increase the number of emergency clinicians of First Nations heritage.

But above all, Joe was a doctor. He cared passionately about people – each individual's real-world struggles, their fears, their pain and their hopes. He would spend time and really listen to them. All those that worked with him know of a time when he went above and beyond. For example, one Christmas holiday period he found a place in detox for a young man whose father had brought him to ED distraught, not knowing what else to do. Then, after his shift had finished, he drove the young man there and saw him settled and safe.

Emergency medicine flowed through Joe's veins. His passion and energy for emergency medicine as a specialty and his care and advocacy for his patients were second to none.

Personally, he was an exceptional mentor and friend. There will never be another Joe.

How to Get the Right People in the Right Places and Keep Them There

My IRTP Experience

Dr Jess Mooney

Dr Jess Mooney is a FACEM working at Royal Darwin Hospital.
She has interests in rural and remote healthcare, palliative care and fishing.

'How long have you lived in Darwin?' asks the sun-wizened fisherman, as I suture his hand. A common question I get asked, given the temporary nature of Darwin's population and the suspicion of the locals that most doctors are just passing through.

'Eight years and counting,' I reply.

'Geez, a long stayer then,' he drawls, eyebrows raised and a smile on his lips.

'Yep, this is home now.' A smile creeps up behind my mask too.

This is a conversation I have fairly often with patients and each time I can feel how it changes the dynamic between us. A subtle shift in respect for someone who knows the land, the people and the culture here. I also feel a little buzz of pride and something akin to gratitude that I now feel this place is my home. It has taken many years, but somewhere along the way my love affair with Darwin turned into a committed relationship and now we are building a life together.

I've been able to make a life here thanks to the support of Integrated Rural Training Pipeline (IRTP) funding, which was delivered by ACEM and supported by the Federal Government from 2017-2020. IRTP enables funding for designated rural locations across Australia to help trainees complete at least two-thirds of their specialist training at that site. The aim of IRTP is to deliver 'a sustainable, Australian-trained future medical workforce for regional, rural and remote communities' by creating 'greater opportunities for graduates interested in rural careers to maintain connections to rural communities while they complete postgraduate training'.[1]

IRTP has been influential in providing access to emergency and non-emergency rotations for my training while I integrate into this community. If the proof is in the pudding, eight years on, I'm a newly qualified FACEM living and working in Darwin, about to have my second child. The paucity of specialists in rural and remote areas is not a new phenomenon, but one I have frequently been asked to ponder while being a rural trainee. Why did I stay? How do we get more people out there?

These questions don't have a simple answer, but reflecting on my rural training experiences helps to provide some points for contemplation as to why I've chosen to become a rural specialist. I'm originally from Adelaide and spent the first 25 years of my life there, including medical school. I'm a 'city kid' but grew up with a love of wide open spaces, so when it came to rural study opportunities in medical school, I took them.

During my six years at the University of Adelaide, I spent three months in Mount Gambier, a year in Port Lincoln, and participated in the John Flynn Placement Program, which took me to northern New South Wales for several weeks over four years. I realised quickly that the learning opportunities in these locations were fantastic and, in general, better than my experiences in the tertiary centres in Adelaide. I had more hands-on learning, access to specialists and unique clinical experiences.

These rural communities always offered lots of fun activities and places to explore. Weekends became filled with wine tastings, fishing trips, bingo nights at the local RSL, and exploration of sand dunes and endless coastlines.

I'm often left wondering, is it nature or nurture that led me here? Rural medicine certainly attracts and rewards those with a sense of adventure, but I also feel that once a trainee takes that first rural opportunity, it's likely to have a self-perpetuating positive impact on them. Each and every rural experience of mine has contributed to, and reinforced, my decision to become a specialist who practices in remote areas.

After my internship in Adelaide, I was ready for a change and headed north to Darwin. I arrived a fresh-faced resident and had a fantastic year of exploring the Territory and learning about tropical and Indigenous health. In my first year, I had opportunities to fly to remote communities and work alongside GPs, treat marine stings and, unfortunately, see my first of many cases of acute rheumatic fever.

Amongst some excellent learning experiences, I spent my time swimming in waterfalls, watching sunsets and enjoying local festivals. It seemed like a dream come true to find such interesting medicine in a beautiful and prosperous location.

Interestingly, I was surrounded by like-minded people and I made some great friends in my first year here. However, one by one they moved away and I realised getting them here was not the problem, keeping them here was. There are very few subspecialties where you can complete your training in Darwin, so many junior doctors move back to their home cities or bigger cities to follow their medical dreams.

Occasionally, I contemplate what it would be like to work in other states and cities, and an anxiety about being solely

Releasing turtles on Casuarina Beach, Darwin.

Territory-trained sneaks into my thoughts. But then I go to work and have a day where a stabbing with a tribal spear is flown in, a septic patient with gonococcal arthritis turns up, and we manage a tricky bronchiectasis exacerbation in a 20-year-old, and I can't imagine a more satisfying, varied and privileged job.

The rural and remote locations and populations in Australia offer rare and challenging medical problems, and I find this sentiment is well recognised amongst my peers, but it's equally important to have support for life outside of work to encourage a more stable rural workforce.

I started my emergency training in Darwin in 2016. With the help of IRTP allocated to Darwin in 2017, I was able to continue my training here. I completed placements in multiple remote Indigenous communities, Katherine and Alice Springs, and all of my critical care placements at Royal Darwin Hospital were supported, all the while continuing to build my life in the community of Darwin.

Many of us are in our late 20s and early 30s when we are training, which often coincides with other life milestones including marriage, partnerships and children, and these activities inevitably integrate you into the community you live in. I met my husband in Darwin and given the ability for me to train here, we continued to build our life, investing in the community and now raising our kids here, with an element of job security that's often rare in our hypercompetitive medical

Sunset on the Jatbula trail.

Flying to work in the Tiwi Islands, NT.

How to spend a weekend in the NT!

world. While facing the hurdles of specialist examinations, I was supported by an emergency department of consultants I knew, who guided me through without the additional stress trainees often face with managing multiple moves interstate and getting to know a new department.

The IRTP gave me professional security, but it also gave my community a specialist who knows the uniqueness of working in a place like Darwin. My training has given me experience in Aboriginal and Torres Strait Islander health, which is important given 70 per cent of our hospital population at Royal Darwin Hospital identify as Aboriginal and Torres Strait Islander.[2]

The challenges of our environment, including crocodile bites, heat illness and tropical diseases such as melioidosis, are familiar to me. There are immense flow-on effects for building these connections between medical officers and rural communities.[3] The IRTP has helped to support our family who now invest in property, day care and endless babycinos at the local cafes.

As we see the influence of the post-COVID sea or bush change[4] on our rural and remote health systems, there will be even more imperative to focus on building our remote workforce. Programs such as the IRTP will be important in capturing the rurally-minded trainee and supporting them to complete training while building their lives in Australia's rural and remote communities.

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EMET in Action in Wagga Wagga

Dr Peter Chigwidden

Dr Peter Chigwidden is a FACEM working at Wagga Wagga Base Hospital.

For the past 12 months, I've been the Emergency Medicine Education and Training (EMET) coordinator at Wagga Wagga Emergency Department (ED), where my main role is managing the WESTEND (Wagga Emergency Skills Training for EMC/EMD/EMAD/ENP and Non-emergency Doctors) program.

Wagga Wagga Base Hospital is an EMET training hub based in southern New South Wales, servicing 25 peripheral sites. The original EMET model began in 2014 under local FACEM Dr Shane Curran. Despite tremendous efforts from ED teaching staff, the standard peripheral site visits and education sessions involved a huge amount of travel and expense, providing, at best, patchy ED education to a large number of very small sites.

WESTEND, in its current form, began in 2017 as the brainchild of then-ED Director Dr Steve Wood. The idea was to streamline the education process by bringing staff from peripheral sites to Wagga on a fortnightly basis for full-day teaching sessions as part of a structured training program. This was part of a wider strategy aimed at increasing recruitment and retention of emergency service personnel to the region.

As a Staff Specialist and GP who has worked in ED for 20 years, Steve brought a unique perspective on the experience of ED Chief Medical Officers (CMOs) and the great value they offer. Most emergency care in Australia is not actually provided by FACEMs. This means that Rural Generalists, Nurse Practitioners and CMOs constitute an undertrained and overexposed resource for emergency care, particularly in rural and regional areas.

Despite some of Australia's best lamb prices and the ninth best beach in the country, for many years Wagga ED had been experiencing a significant shortage of senior and mid-grade doctors. A large proportion of the mid-grade roster (more than 50 per cent in 2016) was staffed by locums, with the associated increased financial and cultural costs to the department.

The WESTEND program was designed to provide an incentive for non-vocational mid-grade medical officers (in this case initially Rural Generalists and GP trainees) to come and work in Wagga, to help fill the roster shortfall from a lack of ACEM trainees. A driver for attracting CMOs to Wagga was to improve their experience and increase developmental opportunities while they were here.

Previously, despite extensive experience and local knowledge, non-vocational trainees consistently reported dissatisfaction with their ED experience. They disproportionately tended to work after-hours or low acuity shifts. The high acuity/resuscitation/procedural exposure they had hoped to experience in a busy mixed rural ED would preferentially be funnelled to ACEM trainees.

The WESTEND program was designed to improve the training experience and professional development for non-ED trainees, improving their confidence in assessing and managing emergency presentations. The program aspires to eventually entice more staff to form professional bonds and work long-term in our region.

The incentive for Rural Generalists to come and work in Wagga included funding to pay for the Emergency Medicine Certificate (EMC)/Emergency Medicine Diploma (EMD)/Emergency Medicine Advanced Diploma (EMAD) as well as a protected, formalised teaching program that would give them the broad skills and knowledge to allow them to manage emergency presentations more effectively in smaller sites. Additionally, these EMC/EMD/EMAD trainees would be employed as CMOs and have access to anaesthetics/ICU terms as needed in their curriculums. Upon completion, there would be opportunities to be employed as Senior Medical Officers in emergency medicine, either in Wagga or in smaller sites around the region.

WESTEND therefore represents a win-win situation: an opportunity to improve the CMO clinical experience; attract a mid-grade workforce to address staffing shortfalls in training hubs; and improve long-term provision of emergency care in our region by upskilling non-FACEM clinicians.

A key feature in getting WESTEND operational was the achievement of a critical mass of new FACEMs to Wagga. Dr Michael Davoren originally started the teaching sessions, followed by Dr Bridget Honan and then Dr Fiona Blackburn, who, as EMET coordinators, invested huge amounts of time and energy into providing engaging, practical educational materials at a high standard.

Through their work, WESTEND has evolved into its current structure. Assigned pre-reading complements an interactive four-hour morning session comprised of lectures, participant-led case discussions, and Journal Club evidence reviews. Following the provided lunch, the afternoon session consists of high-fidelity SIM and psychomotor skills stations. The latter is aided by SIM facilities from the attached University of New South Wales Rural Clinical School (coordinated by Mike Maw, a nurse practitioner with extensive ED, SIM and educational experience), and from the beginning the program has included the participation of local medical students. This has been beneficial over the years in retaining students in Wagga as they graduate, with several graduates applying to continue in the EMET program as junior doctors based on prior positive experiences.

Being a regional centre, we have also been able to provide subspecialty input into our WESTEND lectures from a range of inpatient colleagues including ophthalmology, paediatrics, and mental health services. We are able to tailor our program to more localised needs in addition to the core curriculum, such as our annual dental workshop. This gives participants perspectives and opportunities not previously available in EMET site visits.

The program was first implemented via buy-in from hospital executive through an understanding that this would save the hospital significant funds in decreased locum requirements. A lot of work was also done through Health Education and Training (HETI) and the Rural Generalist program to raise awareness among rural trainees.

From a funding point of view, EMET partially funds our wonderful Program Support Officer Diane Nilsen, who is invaluable in organising day-to-day administrative processes for the program. The WESTEND portfolio is funded through EMET, external to the ED funding model, which allows for additional time and resources for program preparation and delivery.

As our numbers grow, the participant skill level becomes more heterogeneous, from medical students through to GP CMOs with 40 years' experience. Fortunately, Michael Davoren has a dual role as a WESTEND presenter and Director of Emergency Medicine Training (DEMT), which has meant that some of our more experienced participants have been transitioned to the separate ACEM teaching program. Additionally, early phase FACEM Training Program trainees can gain an overview of EM practices by starting in the WESTEND program.

The pandemic has altered our practice, but in some ways it has actually increased the scope of the program. Our morning sessions have gone online, which has removed the travel requirement for clinicians in peripheral sites. This has allowed us to broaden our attendee list, with an increased participant list from diverse smaller sites like Finley, Deniliquin, Tumbarumba, and even Antarctica.

Over the past few years we have also included nurse practitioners from various sites in WESTEND, recognising

Photo by Megan Clark on Unsplash

the critical role they play in provision of EM care in smaller settings, and the gap they fall into from a clinical professional development perspective.

Central to WESTEND is assistance with the EMC/EMD/EMAD/ENP programs. Lectures are based on outcomes described in the respective curriculums, and SIM/skills sessions give ample opportunities for logbook skills acquisition, further experiential learning, and facilitated performance reflection.

As a result of the program, we have had four trainees attain EMC, two EMD, and one EMAD. Additionally, we have had three Australian College of Rural and Remote Medicine (ACCRM) trainees go through the Structured Assessment using Multiple Patient Scenarios (StAMPS) process.

We have recruited four more CMOs, two GP procedural trainees, and two Rural Generalist registrars to the region via WESTEND word of mouth or attendance.

This extra staff, plus additional ACEM trainee recruitment, has meant that our locum reliance in the ED mid-grade roster has decreased from 54 per cent in September 2016 to 17 per cent in April 2022, with an additional CMO currently seconded to ICU for six months. This has had obvious financial benefits for the hospital, but more importantly it's great for the department and the district.

Additional non-ACEM trainees provide a more stable workforce of long-term rural practitioners who have great knowledge of and commitment to the local area. It more effectively and efficiently utilises resources across a wide area, and it allows for a greater sense of collegiality among our clinicians.

Over time, it's hoped that the increased interactions between Wagga ED and referring staff from peripheral hospitals will improve communication and clinical handover. Increased exposure to our ED for doctors, who will ultimately work as rural GPs, means they get a clearer idea of the processes and specific services provided by the Wagga ED.

For the future, we are committed to improving the quality of our educational program, to reach a wider range of clinicians across the district. We remain open to the potential for this program to support other areas with more limited resources.

Specifically, we would be happy to be contacted by other training hubs who would like access to see or participate in our training program. The switch to remote sessions means that for four hours every fortnight we provide FACEM-led ED lectures to non-ED clinicians regardless of where they are, with the additional benefits of hands-on afternoon skills sessions for our local participants.

The WESTEND program has been successful in our region through improvements in the experience of a previously underutilised local medical workforce. It's potentially something that can be utilised in other sites to increase the efficiency of EMET resources and attract more clinicians to understaffed regional centres.

Governance and Leadership Inclusion Action Plan

In early 2022, ACEM launched it's inaugural Governance and Leadership Inclusion Action Plan. This plan represents the next phase of ACEM's efforts to promote positive cultural change within the College, and more broadly across emergency departments (EDs) as workplaces.

Since the implementation of ACEM's Discrimination, Bullying and Sexual Harassment (DBSH) Action Plan in 2018, the College has undertaken a number of initiatives to improve diversity across its activities. These include:

- A successful campaign to update the ACEM Constitution to ensure that, moving forward, diversity will always be present in the composition of the ACEM Board
- Introduction of a biannual Workforce Sustainability Survey
- Introduction of the ACEM Core Values
- Establishment of the Mentor Connect program
- Establishment of the ACEM Wellbeing Award and Diversity Award
- Production of an annual Governance and Leadership Diversity Report, reporting on the composition of ACEM entities
- Introduction of an Independent External Reviewer to provide oversight of the management of College complaints and decision review processes.

The membership of ACEM is diverse, yet there remain concerns that ACEM entities and governing roles or bodies are not representative of our membership. Although this has improved in recent years, particularly in relation to gender equity across key governance bodies, improving inclusion in College entities remains a priority. As part of this work, members and trainees have made it clear that there remain a number of barriers to increasing inclusivity amongst our membership, thereby preventing some members and trainees from participating in College activities.

Through the work of the initial DBSH project and the Expert Advisory Group (EAG) Action Plan (2018), and after further consultation with the ACEM membership, the College has identified four key areas to focus on:

- Increasing the inclusion of ACEM's diverse membership across College governance structures
- Improving members' educational capabilities
- Enhancing structures to support the needs of members and trainees
- Empowering ACEM trainees and members to lead positive behavioural change in EDs and hospitals.

The Governance and Leadership Inclusion Action Plan outlines a series of activities the College will undertake over the next three years that will: embed an inclusive approach to ACEM's governance structures; improve the support mechanisms available to members and trainees wishing to further their leadership goals; and increase educational resources on critical matters such as gender equity, unconscious bias and cultural safety.

Specific initiatives that will be implemented include:

- A Member and Trainee Diversity Survey to provide vital data that will enable the College to determine the cultural landscape of Australian and Aotearoa New Zealand members and trainees, to ensure ACEM better promotes inclusivity and properly represents all members and trainees.
- Develop and/or provide access to educational materials for all members and trainees on issues relating to diversity and inclusion.
- Develop and deliver appropriate training in inclusion, cultural safety and unconscious bias to all members and trainees.
- Develop and implement a range of inclusion indicators across diversity dimensions, to inform the future composition of ACEM's Court of Examiners.
- Establish a Committee Visitors Scheme to facilitate exposure to College activities. This scheme will allow members and trainees to attend some College entity meetings and experience the activities of College entities, before deciding to nominate for membership of a College entity.
- Develop a leadership program to assist all members and trainees with their leadership aspirations.

This work will be overseen and monitored by ACEM's Inclusion Committee, with regular reports provided to College members and trainees. This Action Plan is not intended to be a one-off document – it marks the College's renewed commitment to promoting inclusivity wherever possible, whether that be in the ED or College entities, so that when the membership looks at ACEM, they feel that their diversity is reflected.

Author: Fatima Mehmedbegovic, Manager, Workforce Planning and Inclusion

Dr Natasha McKay

Dr Mackay is a FACEM based in Aotearoa New Zealand, currently working in the sunny Hawkes Bay. She is interested in education, wellbeing and administration and is a former Director of Emergency Medicine Training (DEMT). She is involved in a number of ACEM committees – Deputy Chair of Selection into Fellowship Training and standard setting, and previously a member of the Aotearoa New Zealand Faculty Board and Examination Subcommittee.

Why emergency medicine?

I just couldn't see myself doing anything else after experiencing my first emergency department (ED) rotation as a PGY2. I tried a few other things – a bit of med reg-ing, a bit of O&G – but I just kept coming back to ED! I love the variety of the work, I love the excitement and drama of the cases, working in a team full of amazing clinical and non-clinical staff who have become my ED family and trying to solve the puzzle of the undifferentiated patient. I also love being the doctor who deals with patients on what may be one of the most challenging and difficult experiences for them, and to try and make that experience a little bit better, in any way that I can.

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

Communication. It is such an important part of our job, and can make or break your day. I love the interactions that I have with some patients – hearing their stories, helping them achieve optimal health and wellbeing, organising the best care that I can for them. On the flip side, difficult interactions with patients can be really unpleasant, and leave you wondering where it went wrong and how you could have managed things better.

It's the same with colleagues. I love coming to work each day and spending time with my colleagues, many are some of my closest friends, and it's great being able to share funny stories, challenges and successes with people who "get it." Conversely I really hate having challenging interactions with inpatient colleagues, and dealing with conflict is one of my least favourite things to do.

What do you do to maintain wellness/wellbeing?

One of the best things I ever did was get rid of work emails on my phone. It happened after an IT upgrade, and I could no longer work out how to do it, which probably speaks more to my IT ineptitude than my wellness journey! However, it ended up being a great way to really switch off and not worry about things on days off or during the evening. Nothing is really ever that urgent.

I also work hard to prioritise getting some exercise most days, and my favourite thing to do to relax is sitting in the sunshine with a coffee and a good book.

What do you consider your greatest achievement?

Outside of work – my two children are my greatest achievements. They remind me of what is truly important in life.

From a work perspective, I think my two greatest achievements were being accepted into medical school and then receiving my fellowship in emergency medicine. Obviously these two moments are not unique to me alone, but they represent a lot of hard work and sacrifice, and are moments that I am immensely proud of. I have had a lot of other great and memorable moments in my career (being a match doctor for the All Blacks is certainly a highlight!) and I am so lucky to have made some great connections and important relationships along the way.

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

Being told that I am a role model for trainees. It is incredibly humbling to hear feedback like this. I was lucky enough to have some amazing role models as a trainee, so it is a privilege to be able to pay this forward.

What inspires you to continue working in this field?

My trainees are the biggest motivation for me. They are some of the most talented, clever and driven young doctors, and they keep me honest and passionate about emergency medicine. I loved being a DEMT, and really enjoyed the relationships that I developed with my trainees. I really want to make emergency medicine an enjoyable, rewarding and fun place to work, and that is what drives me to make our workplace better, from an education, wellbeing and systems perspective.

Tell us a piece of advice that you would have liked to receive as a trainee or early on in your career? (Or advice I would like to give trainees or new FACEMS?)

There is no rush to get through training. All experience gained is useful experience for when you are a FACEM. Being a registrar is hard, but the reward is worth it at the end.

Always try and remember why we are here – for our patients. Doing the best for them and advocating for their care is what it is really all about. Being able to do our job is a privilege, hold onto the wins that happen every day, no matter how small. Decide what wellness looks like to you and make it a priority right from the start. Learn how to say no!

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

Finally solving access block!

Overcoming Imposter Syndrome: Calming Your Inner Critic

ACEM holds regular New Fellows webinars to assist new FACEMs with their transition to consultant life. In April 2022, the College held a webinar on overcoming imposter syndrome, which we knew was an important issue, often being ranked highly as an area of concern in the New FACEMs Early Career Survey Report.

South Australian Regional New Fellows Champion, Dr Amy Wilson, was joined by FACEMs Dr Andreas Tscharke and Dr Jenny Jamieson, who shared their own experiences of recognising imposter syndrome in themselves, and how they dealt with it. Webinar attendees appreciated the vulnerability and courage shown by the speakers, so we've asked them to share their stories with you here.

Dr Amy Wilson, Consultant at Flinders Medical Centre in South Australia, and FACEM since March 2022.

You might have seen imposter syndrome in some of your colleagues, and I suspect that most of you have felt it at some point in your medical journey, particularly when stepping into those new FACEM shoes.

For most of us, those first few days or weeks, from calling yourself a doctor, to referring over the phone as an emergency registrar, and then actually calling yourself a consultant, can be quite confronting and evoke feelings that you might be an imposter.

What is imposter syndrome? The definition may be very different for each of us. For a lot of people, it can feel like you don't deserve your accomplishments or your FACEM credential. You might be expecting the College to knock on your door and take your OSCE result away or say you need to complete one more In-Training Assessment (ITA) before you are officially a consultant. It's that nagging self-doubt that you are just not good enough, or simply feeling like you are out of your depth.

As someone who became a consultant in their early 30s, I felt like my colleagues thought I didn't have enough experience to be a consultant or didn't deserve to be a FACEM. Despite passing my exams, having a job, and completing all my requirements, there was still this niggling doubt there.

Imposter syndrome is extremely common and if you look around your consultant colleagues, you'll find that the majority of them have felt it, particularly in that new FACEM stage. You are not alone. Imposter syndrome can be experienced by anyone, but it's extremely common in high achievers, with a high prevalence in a specialty like emergency medicine. A lot of my colleagues admitted that, in hindsight, they can now recognise their own sense of feeling like an imposter.

The term 'syndrome' may lead you to believe there's something wrong with you; perhaps a form of anxiety, depression or poor self-esteem. In actual fact, imposter syndrome is completely normal and, in some ways, it can be a good thing.

I started my career in the UK where I graduated from medical school, worked for a year, and then moved to Australia around eight years ago. I very quickly decided that emergency medicine was for me and started the treadmill of training. Six years later, I became a FACEM.

My final year of training was exceptional. I was a Paediatric Emergency Fellow at Flinders and spent the nine months post-OSCE with fresh knowledge, enjoying a senior role, but with the safety net of a FACEM still behind me. I very much expected my transition to FACEM to be pretty seamless.

I was fortunate to get a job at the place where I worked. It was a mixed ED, so I found myself working in adult emergency medicine, which I hadn't spent much time in at that hospital. I found myself surrounded by older, wiser FACEMs, having not done an adult cannulae for 12 months, not being well-known in the world of adult medicine, and being frequently mistaken as a Resident Medical Officer (RMO) to inpatient colleagues because no one knew me in that aspect of the ED.

Being a young consultant and finishing my training in paediatrics made me feel very much like an imposter. I self-doubted a lot of what I thought, even when I checked it and was often right. I would take cases away and ruminate on them. I would look around the consultant group and see very confident and self-assured people, and think that wasn't how I felt.

I eventually sat down with my mentor, who's a very experienced, confident and comfortable emergency physician I have a lot of respect for, and discussed how I was feeling. It took me six months to talk to my mentor about it. I was embarrassed, having felt all through my training like I was ready to be a FACEM, but then coming across a stumbling block when I entered the consultant world.

My mentor gave me some interesting advice. His first words were, 'I'm really sorry to break it to you, but I actually still feel like that now', which was quite enlightening for me. He told me, 'The day you stop questioning yourself is the day you stop improving your clinical medicine, you stop making yourself better at procedures and giving feedback, and you stop being a better emergency physician. It definitely gets easier to handle, but it never fully goes away.'

That was a very powerful conversation and I realised a lot from it. I came to understand that imposter syndrome is completely normal and changed my outlook towards it. I started to see that the nerves and second guessing myself could be a good thing, keeping me accountable and engaged in reviewing my practice, and helping me become a really good consultant.

I did some reading to understand more about imposter syndrome, and found a book called Mindset by Carol Dweck, which was recommended by another inspiring FACEM colleague. The book enforced that imposter syndrome is simply a form of growth mindset; that you are someone who wants to learn, be better, and continuously improve yourself. This is opposed to someone who has a fixed mindset, who expects to be the final polished piece the first day they walk in as a FACEM, which no one else expects.

A few months after the session with my mentor, I noticed that these feelings had started to subside. I wasn't ending every shift second guessing what I was doing. I was taking away learning points and feeling comfortable admitting that I was enjoying learning things as I went. Every now and then, when I have a new challenge, or I'm asked to present at a webinar on imposter syndrome, those feelings come back, but I'm much more equipped now to enjoy the process and the challenge of it all.

I'm sure there will be many more lessons I'll have to learn with imposter syndrome, and many more periods of my life where it will come back. But I've learnt that it's normal. I'm proud that I have a growth mindset, and enjoy continuously learning and developing myself.

I would encourage you to look at your colleagues; those people who are in the first few weeks of being a registrar, or stepping into new consultant shoes. Reach out to them and share some of the feelings you had during those challenging times, because it may well just be what that person needs to hear to get past them.

Dr Andreas Tscharke, Emergency Consultant at Alfred Health in Melbourne, and FACEM since 2019.

It had been a long while since I'd felt such a great relief. Actually, I don't recall ever feeling a weight like this being lifted off my shoulders. After two years of studying for my Fellowship, punctuated by failure, regrouping, and significant soul-searching, I'd finally received my letters with ACEM. I was grateful for all the help from others along the way and had, through this journey, gained some self-confidence in my ability to overcome adversity. The hardest challenge was behind me, or so I thought.

Since I had a small fractional appointment at the hospital where I'd been working as a senior registrar, there was no great need for re-orientation or introductions. Everyone welcomed and congratulated me whole-heartedly. I wasn't given the challenging looks of 'yesterday you were a registrar, today you want to be a boss' by anyone. It was a smooth transition and a time of high-fives and hugs.

A second fractional appointment at another service gave me full-time clinical work and I felt I had now achieved all I'd been working towards. At no point did I have self-doubts or anxiety about my new role. I had worked independently and defended my clinical decision-making for years before, so what was different now?

What happened next is best described as a gradual deflation of all self-confidence I had cultivated up to that point. Around the two-month mark as a consultant, I began to develop this nagging feeling that I might make a medication error or fail at a procedure. I became increasingly aware of a voice whispering to me that I shouldn't be giving advice to juniors – I would likely be teaching them all the worst habits and imparting false facts with misplaced certainty.

It's important to understand that, despite all my training and experience in the hospital system in which I now worked, coupled with the reality that not a single adverse event had preceded these growing insecurities, there was nothing I could do reassure myself. I convinced myself that every time I made eye contact with the director of my department or other leadership personnel within the hospital, I'd be found out as a fraud and swiftly removed from my workplace.

As my imposter syndrome progressed, I became more and more despondent in anticipation of going to work. I began to dread all those aspects of my job in emergency medicine that, for years beforehand, I'd met with great pride and enthusiasm. While my insides were slowly withering away, I worked hard to maintain a façade of confidence and health. I kept telling myself that if I could just make it through this patch of newbie insecurity and self-doubt, I would become the clinician that everyone thought I was.

As more time passed, I started to realise that this self-doubt was intensifying rather than subsiding. I continued to manage the problem by ignoring and hiding my emotions from everyone. Though it seems obvious now, this strategy only made things worse, and I soon found myself avoiding all sick patients and potentially difficult decisions on shift.

Luckily, things did not continue like this for too long before I came across podcasts and books of various instrumental people, including the work of shame researcher Brené Brown. I found that her description of how shame manifests, evolves and festers in our lives was very similar to the imposter syndrome I was experiencing – an intrusive feeling of unworthiness that was eroding a crucial sense of belonging to my team, and hindering me in the job I had been assigned to do.

This is her insight about shame:

'If you put shame in a petri dish, it needs three ingredients to grow exponentially: secrecy, silence, and judgment. If you put the same amount of shame in the petri dish and douse it with empathy, it can't survive.'

Brené suggests three strategies to cultivate worthiness and, in so doing, combat shame:

1. Courage: Speak about the shame you feel with people you trust. This means being brave enough to show vulnerability and share your perceived imperfections with honesty.
2. Connection: Create an authentic exchange with someone where both people feel seen, valued, and heard, without judgement.
3. Self-compassion: Talk to yourself as you would talk to a loved one and remember that we all share a common humanity.

I discovered that her strategies were valuable in relinquishing my inner emotional turmoil. As I became more familiar with this new mindset, I became more comfortable in sharing my experience with a select few, and I noticed that, through this, my belief in my own ability began to shift.

I also found it helpful to appraise my perceived performance shortfalls more specifically by listing and problem-solving particular actions or inactions, rather than condemning my overall worth as a doctor.

I see now that by hiding my feelings of imposter syndrome, like shame, I intensified their effect on my life. As I'm usually a tremendous fan of the 'tough it out' philosophy, admitting out loud, even to people I trusted, that I was having a difficult a time, was a blow to my ego.

It's a stark paradigm shift to regard insecurities and vulnerabilities as true strength rather than weakness. I'm convinced now that respecting vulnerability is a key factor in becoming a more resilient human being and that faking authority will not expedite one's growth.

The challenge is to make space for vulnerability without losing a professional stance within your workplace. I regard this as an ongoing project. I can't say this approach will work for everyone, but it has certainly given me the chance to regain my enthusiasm and joy in my work.

Dr Jenny Jamieson, Trauma Specialist at Royal Hobart Hospital in Tasmania, and FACEM since November 2018.

I didn't have any obvious reasons to have imposter syndrome when I became a new consultant. I had a meandering training path, taking time off to work with Médecins Sans Frontières (MSF) in Afghanistan, in Tanzania for a year, and spending a lot of time doing rotations with the trauma unit. Towards the end of my training, I landed a trauma Fellow job, which led me to the job I was really after – trauma consultant.

Yet, once I was in the role, I started to have these feelings that I needed to validate my presence there. I continuously dismissed this job as luck rather than giving any real credit to the reasons why I might have been offered the role.

Being a System 1 thinker, I knew there had to be a solution. I thought that the most instantaneous way to solve these imposter feelings was to add another qualification to my name. If I did a Master in Trauma, all these feelings would magically disappear.

Of course, that was not the case. I flogged myself to get through this second Masters degree as quickly as possible, but realised towards the end that it was not as useful as the real-life experiences and lessons I was encountering in my job.

At the end of my Masters, I was still walking around the hospital introducing myself as 'the junior trauma consultant'.

I entered this spiral of trying to please, perform and perfect to cover up my self-imposed ideas of not being enough. You can find yourself in a spiral of resentment and exhaustion, pretending to your colleagues that you are someone you are not.

How do we get out of this spiral and overcome the feeling of imposter syndrome? Time? Wearing black scrubs? Faking it until we make it? As Brené Brown said, 'You can't get to courage without walking through vulnerability'.

Here are seven take-home messages that might help with overcoming imposter syndrome. They are not silver bullets that will instantaneously dissolve your imposter syndrome. All of them require work and training, the same way you would train for a run – the more you train, the better you get, the easier it becomes.

1. **Awareness.** Name the beast to tame the beast. Recognise that you have imposter syndrome and when it might be talking or acting through you. Take a moment to ask yourself if your imposter syndrome is getting in before you have a chance to process the opportunity or task you are being presented with.
2. **Dispute negative thinking.** Does your thinking actually fit with objective evidence, and are there cognitive distortions contributing to imposter feelings? Ask yourself if you are equipped to do the work. If you surround yourself with the right people, could this task be of interest and enjoyment to you?
   Pause and triangulate the data, as you would in your job as a clinician, and make sure you stand up to your inner critic. It can be a very harsh and dominant voice. What if you listened to the other voices? What would you say to your friend in a similar situation? Most likely, you would encourage them, act as their supporter, and ask what they needed to do to make it happen. We don't do this to ourselves enough.
3. **Adopt a growth mindset.** I completely misdirected my growth mindset by taking on the Master in Trauma, thinking this qualification would magic me into an expert trauma consultant, rather than adopting the view that it's okay to be a lifelong learner and learn from the incredible clinicians and patients around me. I needed to learn to reframe things and accept that there will always be challenges, embracing them rather than avoiding them. The ability to embrace challenges leads us back to the concept of being vulnerable, which is hard and scary.
4. **Grow positivity.** Visualise your successes and when they happen, celebrate them. Foster the relationships that are safe, and acknowledge yourself, like having your own cheer squad. Cultivate self-compassion, which takes genuine practice and discipline. It's not self-pity, self-indulgence or selfishness. Individuals who practise self-compassion are better able to cope with adverse or tough situations, engage better in healthier behaviours, and are more compassionate towards their patients and others, as well as themselves. It's a positive cycle.
5. **What if?** Most people's brains have a negative bias. When we think about dominant stories and beliefs about ourselves, the negative ones usually hold the most traction and currency in our minds. This doesn't necessarily make them true and doesn't make them the only possible story either. So even if you have a particular dominant story that might have a negative bias, ask if this story is serving you. It's important to step back and reframe your dominant stories. What if you gave that presentation you were asked to do? What if it was a great presentation? What if you got more people interested in the topic you are passionate about? What if the talk opened up new possibilities or opportunities? What if someone in the audience asked a question that you didn't know the answer to, but no one else did, and that paved the way for future research? Remember to take some of those dominant stories we tell ourselves and reframe them.
6. **Power poses.** The first time I heard about this, I must admit, I didn't think much of it. The more I read about it, the more I realised that Amy Cuddy is really on to something. Amy is an American researcher and studies non-verbal expressions of power and dominance. I encourage you to watch her TED Talk. Some of her research was about high power and low power poses. Low power poses are where we tend to close ourselves off and shrink into ourselves. High power poses can be equated to athletes when they win, arms in the air. At work, be aware of when you might be consciously closing yourself off.
7. **Cultivate your inner cheerleader.** Treat yourself like your best friend. Adopt a more compassionate and understanding voice and champion your own successes. We all have different beliefs about what self-care and self-compassion might look like.

Sometimes, it can feel like you have a finite compassion budget. A busy, stressful shift at work can deplete this budget, and by the time you get home to the people you care for, this budget can be running on empty, making self-care feel like the last thing you want to do or have energy for.

Read about the PERMAH model (Positive emotion, Engagement, Relationships, Meaning, Accomplishment and Health). It can help you construct your own self-compassion model, by pursuing and fostering positive emotions, being engaged in something you love doing, cultivating meaningful relationships, having meaning in your life, working towards something you want to achieve, and looking after your health.

Author: Alyssa Skylakis, Membership and Culture Officer

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i More information

If any of these experiences shared by our FACEMs resonated with you, we encourage you to reach out to friends, family and colleagues for support, or contact ACEM Assist, the College's free and confidential service, to get advice and help with strategies to overcome imposter syndrome. Visit acem.org.au/ACEM-Assist

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ACEM Mentor Connect

Dr Mark J. Sagarin

Dr Mark J. Sagarin is a FACEM and consultant at Taranaki Base Hospital in Aotearoa New Zealand. He has practised emergency medicine for 25 years.

Dr Sagarin shares his thoughts about mentoring, the positive impact it can have on mental health, and how each of us can continue to renew through learning.

I graduated from Harvard Medical School in the US in 1996. Harvard was late to the game of training emergency medicine specialists and so I was part of the inaugural class of trainees.

I trained and practised in Boston, Massachusetts, and then Albuquerque, New Mexico, before moving to Aotearoa New Zealand in 2014. I have recently become involved with ACEM as a Regional Wellbeing Champion. I think wellbeing and mentoring are linked and we can all benefit from guidance throughout our careers. I was lucky enough to have a mentor who guided me as a medical student and later became my first supervisor, but not everyone finds such a person early on in their career.

Teaching has always been part of what I do. While in university, I was a Big Brother, which, was a wonderful experience, and before I became a doctor, I worked for two years as an exam tutor and high school teacher.

There were times in medical school where I felt quite lost. At one point, in a state of deep sleep deprivation, I even considered quitting. I didn't really know who to turn to but did get some help from early mentors.

In the mid-1990s, emergency medicine was not fully accepted as a valid medical specialty, so I was lucky to have a few mentors who took pride and advocated for this field. Mentoring is essential to new doctors trying to find their own way. It enhances our own practice and confirms what we do.

So much of what we do, the style of our clinical practices and the ethics we follow, are found outside of any textbook. Each one of us eventually finds a practice style that suits us, which is usually an amalgam of our own personal values and ethics, and those of the people who guided us.

A mentor can reflect their own successes and failures as a physician. They can guide a younger colleague in the same way a parent or grandparent can guide a child. However, the mentees are adult physicians and often the person being mentored has a different approach. This can sometimes challenge the mentor, yet this interaction is one of the ways that our specialty – via thousands of such relationships – progresses and evolves.

There are many subtle aspects of our interactions with colleagues, nurses and patients that can only really be learned through repetition and experience, but I encourage younger colleagues to reflect on what goes well or poorly.

I had a junior doctor write something in the medical record that implied he had no confidence in my ability. This was the type of statement that should never be in a medical record. I had a discussion with him about this and the negative implications. I guided and asked the trainee to try to remember the details of this case in three to five years' time, and to reflect to see if he thought he would do the same thing again. I didn't feel I could allow my hard feelings about this incident to negatively affect my relationship with him, so I asked one of my colleagues to take him on, as an advisee.

These experiences teach us that we can continue to renew through learning and take pride in our work. Having support from a more experienced colleague, who sees you as the future of the specialty, is extremely meaningful.

I heard about the Mentor Connect program through ACEM communications and emails. I have only had the one contact with an Australian physician, which went very well. It could be a very meaningful and an important contribution to our specialty to have hundreds of quality mentors out there. We will all be doing ourselves a favour because the mentor usually gets as much out of the relationship as the mentee.

Mentoring Matters

Dr Cheryl Martin

Dr Cheryl Martin is an emergency physician in Hobart, Tasmania. Cheryl is a member of the ACEM Mentoring Reference Group and a local mentoring coordinator at Royal Hobart Hospital.

Dr Laura Scott

Dr Laura Scott is an emergency physician in Melbourne, Victoria.

The ACEM Mentor Connect program offers many reciprocal benefits to participants that go beyond specialised development, leadership skill building and professional networking. After speaking with Dr Cheryl Martin and Dr Laura Scott, it's clear that one of the most impressive things about this mentoring program is the ripple effect it has on everyone involved and how this positive momentum can trickle through the organisations and hospitals in which they work.

Cheryl and Laura have been part of ACEM Mentor Connect since October 2021. They talk about the mutual benefits and shared support and encouragement they each receive from each another, as well as the joy that comes from being part of a well-established, professional mentoring program.

They are yet to meet in person, but when Cheryl and Laura speak to me from their homes in Victoria and Tasmania over Zoom, it feels like I'm listening in on two friends who haven't seen each other in years and are finally getting a chance to catch up.

Together they laugh about the synchronicity of receiving introductory emails from each other – practically at the same time – and how, during one meeting, Cheryl was able to meet Laura's parents over Zoom when they arrived from overseas. They're looking forward to catching up in person now that restrictions have been lifted and travel is once again on the cards. Between the mirth and shared stories, it's easy to see that ACEM Mentor Connect is a valuable initiative with rewards that serve many College members and trainees in a multitude of ways.

Alyssa Skylakis, Membership and Culture Officer at ACEM, paired Laura and Cheryl after receiving their applications. Alyssa is committed to the program and says a lot of effort goes into making sure the right people connect in order to get the best out of the program.

She says, 'Even though it's only a two-page application, I find that the more detail candidates include, the more I have to work with and the better the fit. I feel excited about pairing a mentor and mentee together and knowing they will be a great match. It's wonderful that they'll have the extra support out there. There's lots to be gained, including engagement, connection and support'.

Alyssa tells me there are many reasons why people want to become a mentor and maintains that there are many professionals out there with lots of experience and knowledge who are willing and have the time to share.

She says, 'Ultimately, many of our applicants have had a mentor in their working career which they benefited immensely from. They're now grateful for the opportunity to share and pass on their experiences. They want to give back what they've learnt. They've picked up a lot of wisdom along the way and they want to pass it on. The feedback we get, is that it's rewarding for both the mentee and the mentor'.

The feedback we get, is that it's rewarding for both the mentee and the mentor

Cheryl says she first heard of the program when she saw it promoted to the Regional Wellbeing Champions, which she's also involved with. She was drawn to it for many reasons including the structure of the program. 'I'd heard that it was relaunched and was a revised program. I think that's what piqued my already growing interest in mentoring. I thought, oh this is novel, I'll sign up for it as I'm likely to get a lot of out if it. After that, I was so impressed I also joined the ACEM Mentoring Reference Group.'

Laura saw read about the program in the *ACEM Bulletin* and says, 'I had not long been a consultant when it came up and I thought, this could be really helpful'.

Mentoring is an important learning and development strategy for emergency physicians and an essential element, required for the accreditation process for training sites. Cheryl explains that the hospital mentor program and process can be different to ACEM Mentor Connect. 'I think it's beneficial to have a web, or even a network of mentors, from different environments, not just in the clinical space. I've mentored people through hospital processes and I thought it was informal and a little ad hoc. It's something that I've always wanted to get better at. Then I registered with ACEM. I did the ACEM Mentoring Course and I thought it was great.'

'I worked through the templates and I now use those. I recommend colleagues try it, but I also understand that many clinicians are time-poor. So, what I've started to do is just cherry pick some of the templates that I think might add value and I pepper them through our conversations. I say here is your mentor agreement, here is a mentee/mentor reflection kit, why don't you have a look? It's really well structured.'

Alyssa further explains how it all works. 'The actual toolkit on the website is user-friendly. You can dip in and out of it.

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If you are just getting started you might spend 20 minutes having a look. There are plenty of tools. You get to go through the modules in your own time and it's not linear; you can choose modules that are most relevant to you.'

The connection between mentoring and personal wellbeing go hand in hand as Laura points out: 'We're still going through a pandemic and it's a really busy time in emergency with a lot of challenges that we're facing. Having a support structure is key, now more than ever, and being part of a mentoring program provides an additional layer, not only of support and inspiration, but a reminder of the joy the specialty can bring'.

Cheryl adds that being a mentor or mentee in the Mentor Connect program has reciprocal benefits, especially in the wellbeing space. 'It's absolutely a two-way street. I get so much from mentoring Laura; mostly it's her enthusiasm, which really spurs me on. Even though I'm several years older, there's a bit of peer support in there as well. Because we're both consultant colleagues, we have very similar training experiences and so there's quite a bit of overlap. I think that's what I like about it most. I learn as much from her and I feel like I get mentored as well.'

Laura chuckles at hearing this. 'Cheryl, I'm not sure if I'm teaching you, but you are definitely helping me immensely. It's been a really fundamental experience. Cheryl has got wisdom and experience that she's lived, that as a consultant I haven't yet. It's good to have that sounding board and someone who's not part of my own hospital network to talk with. I don't think I realised how much this would be of benefit until I started the program.'

Cheryl is nodding and says, 'I have to agree with Laura. It's great to have people who are outside and external to your own immediate work environment'.

Laura responds enthusiastically and says, 'I think having that support structure in the Mentor Connect program has been a good way to debrief, discuss and talk about things that you've come across on a confidential platform. It has really been an invaluable resource during my first year as a consultant and no doubt will be ongoing'.

Laura goes on to say, 'I think it's also important to acknowledge during your training, you've got this structured program to train in, which is excellent, but when you become a consultant that structure dissipates and there's a sort of "part 3" arena that we acknowledge. Your clinical knowledge is there, but the reality of being the consultant on the floor, in terms of clinical leadership, is probably a bit more enhanced than it was when you were a registrar, even when completing shift reports. Having a mentor to discuss tips and approaches for the non-clinical components to being a consultant on the floor has been great'.

When I ask Laura what it is she looks for in a mentor, she tells me it's very simple. 'Just having an ear and a supportive colleague can be all a mentee is looking for and offering some pearls of wisdom provides an opportunity for the mentee to reflect. There's lots to be gained from this. It's also an opportunity to collaborate with other health networks and have space to share ideas and talk about career progressions and what comes next.'

'I also think Cheryl has got lots of tools in her pocket and I see that coming through. One of the things that has been really nice and, obviously, it depends on who you're paired with, but I think we've gelled quite well. We hadn't met each other before and our conversations on Zoom have been really relaxed from the get-go, a bit like having a chat with someone I've known for ages, which is nice.'

I ask Cheryl what some of the conversations might sound like. She says, 'There's been a couple of times when Laura has brought up a situation from her workspace, discussed her thoughts and approach, and asked me how I might have dealt with it. Then we chat through it. Over time, we've also talked about work-life integration and how you sustain it. I think we have still done a lot of things organically and we've certainly had lots to talk about'.

It's hard to imagine Cheryl and Laura coming across any challenges or roadblocks with Mentor Connect, but I still ask if it's been smooth sailing. I'm not surprised by Laura's answer: 'Just to get our rosters aligned to meet! That's about it. I think it's great that we're both invested in this. We're connected to it, we put the time into it, and we're getting so much back'.

Laura adds, 'I knew that having that opportunity was going to be really good for me but I was also aware it would depend on pairing, compatibility and mutual commitment. We've been given this opportunity and it's great to make the most of it'.

She also adds, 'I do want to say, first and foremost, that I think Cheryl is nurturing in her style and approach'. Cheryl says that she truly feels she gains peer support as well. 'In fact, I'm kind of reminded of my younger self. Laura excites me and gets me enthusiastic about different things again and she's doing some great things with her peers and trainees.'

Laura offers more insight. 'It's having the ear to bounce things off in a non-confrontational way. It's a safe space to have any conversations that you feel are important and necessary; the consultant role, leadership, teaching and supervision, and dealing with conflict. I'm really fortunate to have Cheryl who has a keen interest in wellbeing and has already done so much learning in that space. Everytime we meet, she sends me an article afterwards, so I also get to learn something that's completely related to medicine but not something I'd previously thought of. I have a chance to think about our exchanges and how we can navigate and translate it into our workplace, and how it can contribute to the culture of our department when I'm on shift.'

Cheryl is nodding, 'That's true Laura and I also think it's a valuable way to gain some extra support. Why wouldn't you take that opportunity? You have to be semi-interested and if being a mentee is not something you're interested in then you could be a mentor. Then you're building a relationship where you can potentially learn from each other, but you do have to be open and ready to be able to do that'.

I go back to Alyssa to find out some of the other reasons people may join Mentor Connect.

'Firstly, it's good to know that the relationship can be as long or as short as you want it to be. Once paired, I leave it up to the mentor and mentee to work it out or they work it out as they go along. Sometimes it's a trainee who wants to get through examinations, a new Fellow looking for advice on a career decision, a doctor who's interested in getting into research, an expecting parent or a new mother, or someone who's trying to juggle work and a family and simply wants to bounce ideas off someone.'

'Most recently, I paired someone who had trained overseas and wanted to understand the culture of working in a new country. Honestly, it can be anything.'

I ask Alyssa if it's important for the mentor and mentee to be in the same state or country. 'It depends. Sometimes mentees specifically request that the mentor is living in a different state because they want to discuss a career decision, so it's important for them to have that space of someone who is completely removed from their hospital or state.'

ACEM has embedded a culture of mentoring in emergency medicine and it has become clear why the program is growing rapidly, with a significant uptake by ACEM members and trainees. The reasons why are plentiful and when I ask Laura what she would tell someone who wanted to join Mentor Connect, she says pragmatically, 'I would simply say, why wouldn't you?!'

Author: Maha Sidaoui, Media and Publications Advisor

Dr Cheryl Martin

Dr Laura Scott

More information

ACEM Mentor Connect applications are currently being accepted from all ACEM trainees and members. For further information go to the website: acem.org.au/Mentoring or email us: MentorConnect@acem.org.au

ACEM Core Values

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

In this issue of *Your ED*, we sat down with Jen Morris and Dr Mim Scharkie to discuss Collaboration, the third of the four core values.

Collaboration

We partner with one another, with patients and with other health professionals. We unite to achieve better outcomes, to learn and to advance as a body, as a specialty, and as a practice.

Jen Morris

Jen Morris is a consumer representative and patient safety advocate from Melbourne, Victoria. She has a particular interest in preventing diagnostic error.

What are your current roles and titles?

That's always a tricky question. Across 10 years, I've trialled a dozen different ways to answer that question concisely without provoking confusion. None have quite hit the spot yet. I'm a healthcare consumer representative and patient safety advocate. I work with a variety of organisations, including ACEM, to bring patient perspectives into traditionally clinician-dominated forums – such as clinical governance, education, regulation, research and incident investigation.

What inspires you to keep working in this field?

By being 'unapologetically present' at the (now often figurative) table, I feel like I'm part of shifting attitudes. I enjoy watching my clinical colleagues, often by their own admission, sceptical at first, evolving into passionate advocates for the value of consumer voices in the work they do. I also enjoy the opportunity to really connect with clinicians as humans and equals. Better understanding their experiences makes me a better advocate for a health system that works for everybody.

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

Consumers are vital members of the emergency medicine team. The clinical team can't help who is not there. By the very act of calling an ambulance for a stranger, driving their child to hospital, or recognising they need help and fronting up, consumers are the indispensable first link in the chain of saving life and limb. They place the highest trust in strangers at critical moments in their lives. They provide vital information. They raise the alarm when things are going wrong. They endure the seemingly unendurable. Without collaboration between consumers and clinicians, the system would be untenable.

We know your role contributes to an important part of ACEM's work. Is there a memorable time that you have collaborated through your role as Community Member?

I find my role on the ACEM Pathway to Fellowship Review Committee to be one of my most meaningful and memorable. Making decisions that impact so significantly on the lives of others is a grave responsibility, which I never underestimate. The stories and decisions stay with me long after the meeting is over. I'm forever grateful to my colleagues on the committee for generously sharing their expertise and perspectives, for challenging my thinking, and being willing to disagree with grace and courage. It means we can make robust and fair decisions. Being afforded the respect of being genuinely heard and having an equal vote empowers me to do justice to the privilege and responsibility of the role.

How do you foster a collaborative work environment?

I recently learned about the simplicity and power of saying: 'Can you please tell me more about that?' We all experience that moment when our reflex is to disagree with somebody's analysis, conclusion or decision. In those moments, I benefit from asking the person to explain their perspective and reasoning further, before reaching my conclusion. I may change my mind, or not. But I will have open-mindedly assessed their ideas with more insight. I also find once people start trying to articulate their thinking, they often start re-assessing it too. It supports rigorous decision-making all round.

What advice would you offer someone in the workforce who may be new to a collaborative environment?

Have the courage to commit to voicing your limitations and asking for help shamelessly, readily and often. If you don't know, say so. If you don't understand, ask questions. If you're out of your depth, ask for help. It's liberating for you, safer for your patients, and better for the medical culture we need to create. People in our society generally, and doctors in particular, are so often cultured to 'fake it 'til you make it'. To be invincible, infallible and omniscient. It's not healthy and it's not safe. None of us are any of these things alone. But working together, we come to a reasonable approximation. No matter what you've been told about the primary importance of 'instilling confidence', your patient would rather you be assisted to do something right, than feign confidence while doing it wrong.

How do you feel a collaborative environment helps you to achieve your goals and/or participate more readily?

Being a consumer representative is a continuous process of learning new things. It's one of my favourite aspects of the job. All the joy of learning and discovering, with none of the exams and assignments. My role necessitates asking a lot of

questions, and requesting explanations of everything from acronyms (so many acronyms!) to surgical techniques. When people respond with grace, and are generous with their time and knowledge, it means I can do a better job. It means my perspectives and decisions are more informed, and I can frame them in a way that really resonates with others.

Dr Mim Scharkie

Dr Mim Scharkie is a FACEM Training Program trainee from Melbourne, based in Vila Central Hospital, Vanuatu. She has a particular interest in global emergency care, coffee and trail running.

What is your current role and title?

I am the Visiting Emergency Doctor at Vila Central Hospital in Vanuatu. This role is part of the Visiting Emergency Medicine Registrar Program (VEMRP) partnership with the Australian Volunteers Program, an Australian Government Initiative.

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

I used to joke that I picked emergency medicine because it meant I got to wear scrubs every day, but, in all seriousness, the scrubs are the icing on the cake! Emergency medicine is a place where you get to interact with people from every walk of life, and everyone has a different story to tell. You get to be with people at their most vulnerable time and support them on their journey.

No day is the same. You work in different teams, with different staff, and you can never predict how your day will turn out.

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

It's one of the most challenging but rewarding roles of my career to date. I'm working in a department that has no CT scanner, no access to most of the medications available in Australia, and limited resources. However, it's one of the most enjoyable places to work because of the patients and staff.

Yesterday, a little girl, whose brother was unwell, followed me around for half the day, checking the oxygen saturation of every patient in the department. She decided she would be the first person in her family to finish school and become a doctor. The day before, I met a woman who was the first female lawyer in Vanuatu. Prior to that, I met the first nurse practitioner of Vanuatu.

I'm currently helping four amazing doctors become the first emergency medicine practitioners in Vanuatu. It's these glimpses into people's lives that make working in emergency medicine so enjoyable.

What does work-life balance mean for you?

Work-life balance prior to coming to Vanuatu often meant that I had enough time each day to take the dog for a run! However, living in Vanuatu and being away from home has taught me the importance of having a solid work-life balance. It's so easy to not look after yourself, especially when you can see how much work there is for an emergency doctor to do and the lack of resources available. But I have realised that I can't help anyone unless I take care of myself. That means making sure I FaceTime my family and friends back home, turn off my phone when I'm not on call, leave work on time, and, most importantly, do the things I enjoy when I can, like snorkelling, running and surfing.

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

One of the most amazing experiences I had was working during the COVID outbreak in Vanuatu, managing our first unwell COVID-19 patients. I saw every person in the hospital work together to achieve fantastic results in the face of huge social stigma and fear. Fever tents were erected within hours and COVID training was given to everyone from the psychiatrist to the cleaner. Every doctor and nurse pitched in to care for the unwell, even when they too were unwell or faced backlash from the community for working with COVID patients.

Do you feel that working in an international context changed the way you collaborate?

Working in an international context has highlighted the importance of collaboration. Nothing can be achieved in isolation. Working in a country such as Vanuatu, where relationships are everything, has shown me the importance of partnership. In my role here, I've been fortunate to collaborate with everyone from the Australian Department for Foreign Affairs and Trade (DFAT), Australian Medical Assistance Teams (AusMAT), Aotearoa New Zealand Foreign Affairs and Trade (MFAT), Chiefs of villages, pre-hospital services and tiny village healthcare outposts, to huge organisations such as the World Health Organization (WHO), to achieve better emergency care in Vanuatu.

In the international context, collaboration means the sharing of ideas, values, experiences and knowledge. It's a two-way street in which I've been able to share my knowledge and training with the future emergency doctors of Vanuatu. I've also been privileged to learn amazing skills such as how to manage staff, tropical infections and common presentations without the resources I'm used to in Australia.

Mim's role, which concluded in July 2022, was funded by the VEMRP an ACEM and Australian Volunteers Program Partnership. The Australian Volunteers Program is an Australian Government initiative that is managed by AVI in a consortium with Cardno and Alinea International and provides an allowance and key safety, security and pastoral support to VEMRP volunteers. ACEM provides technical support and remote supervision for these roles.

Australian Volunteers | Australian Aid

More information

For more infomation on the ACEM Core Values visit: acem.org.au/corevalues

ICEM 2022 Reflections

Dr Simon Judkins

ACEM Past President Dr Simon Judkins was the Convenor of the 2022 International Conference on Emergency Medicine. He is the ED Director at Echuca Regional Health, and he works as an emergency physician at the Austin Hospital in Melbourne.

It's an odd feeling. After more than four years of preparations for the International Conference on Emergency Medicine (ICEM) 2022 – the angst around whether it would go ahead or not, delegate numbers, and the stress of confirmed speakers coming, then not coming – ICEM 2022 finally did go ahead, in June, in a wintery Melbourne, full of activity and interest.

Then the crowds went home or closed their virtual link. The Local Organising Committee (LOC) met on Sunday afternoon to reflect, high-five, hug, and shed a tear or two (well, I did).

It's now been several months and it's a good time to reflect on what we achieved, what the legacy of this meeting will be, and to ponder all the hard work many people put in.

It's an amazing achievement that the conference went ahead, with over 1,600 people attending from over 65 countries, with a fantastic program of inclusivity and diversity. Given that the world was coming out of a COVID wave and seemingly launching into another, we had to roll the dice when making the final decision to go with a hybrid event. I think we made the right choice.

The hybrid format was a new challenge that paid off. From feedback I've received, the virtual platform was a success. Although it has its challenges, having all events streamed, some dedicated virtual-only sessions, allowed broader speaker involvement and better access for many people. The option of being able to attend all presentations virtually enabled those who couldn't access funds or get the time off to participate at a high level.

This advertisement recognises support of ICEM 2022 by event sponsors.

We acknowledge the Djirri Djirri and Thoni as the welcoming ceremony performers at ICEM 2022.

Recording streamed presentations allowed those at the event to access all the materials post-meeting. It's also worth noting that a digital platform enabled speakers to present without the challenges of travel. This, in my view, was one of the great wins for this and future events. Even local speakers who became unavailable to attend due to changing circumstances were still able to present, so their hard preparation work was not in vain.

The enormous support we got through ACEM and the Global Emergency Care Committee, the Pacific community, Therapeutic Guidelines, ACEM Foundation, and others, as well as all those who donated extra funds through the registration process, changed the face of ICEM 2022. We were able to support over 150 delegates (I suspect much more than that when seeing 10 clinicians in Fiji gathered around a desktop watching the conference sessions), embracing the conference sub-themes of equity, inclusion and innovations in education. One of the big successes over all was the reach ICEM 2022 had across many regions, through the innovations and supports provided.

I hope you agree with me that living up to the conference theme of 'Better Care for a Better World', with the daily sub-themes of global health, equity, planetary health, and innovation and technology, delivered a meeting that was much-needed and different.

We, the LOC, came up with the conference theme before COVID-19 was a thing. In the four years since we dreamt up the theme, the issues of climate change and health, equity, innovation in health delivery, and access to healthcare, have grown in more ways than we could have predicted.

We wanted a conference, not just about how we practise medicine within the flexible walls of the ED, but about how we, as emergency care clinicians, can embrace our role as advocates, as leaders for change, and as leaders for access to global emergency care. We wanted a conference about how we address the existential challenges which face our communities, looming larger now than ever before.

We hope we achieved that. We hope we delivered a message that we are all connected, we all have similar challenges, and we need to continue to work together to strive for 'Better Care for a Better World'. That's what the world needs right now and we sincerely hope you've carried that message away from Melbourne to wherever you live and work. I hope this is our legacy.

Thank you for your contribution to our meeting. I hope to see you at ICEM 2023, where we can continue the conversations we have started.

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Dr Donagh MacMahon

Trainee Dr Donagh Mcmahon was born in Ireland and educated in Dublin. He moved to Aotearoa New Zealand in 2017 where he currently works at Dunedin Public Hospital. Donagh is Aotearoa New Zealand's trainee representative.

Why emergency medicine?

I was drawn early on to the potential of emergency department (ED), the excitement that it could provide, the satisfaction from managing complex and acutely unwell patients, and being able to manage anything and everything. In the ED I felt comfortable and at home. I did a house officer ED post in Dublin in my second year as a doctor. It was great when it was great but it was mostly exhausting and gruelling. When I moved to Aotearoa I started as a registrar in Middlemore ED. The FACEMs were friendly, enthusiastic and supportive. The job was enjoyable again and I don't think I've ever looked back from that point. It's getting harder, busier, more complex and strained in the years since I started in ED but there's still the enthusiastic and hardworking colleagues who make it an incredible job.

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

The hardest is inter-speciality interactions. I still often get some dread before lifting the phone with a complex referral. Most of our colleagues are great and helpful and we're all aware we're working in a strained system. However, a difficult interaction with a colleague who is dismissive or condescending still really hits my confidence and sticks with me longer that it should.

What do you do to maintain wellness/wellbeing?

I've always loved skiing. We moved to Ōtepoti last year. Being on the south island gave us way more opportunities to hit the mountains, which has been incredible. I've also taken up mountain biking down here, the hills and trails around the city are great and super accessible. But, to be honest, good food, beer and wine is my real go to. Can't beat smashing back a bottle of chilled red or a natty white with some friends over delicious food.

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

I published my first paper in the *EMA* last year. It was several years of work. My supervisor, Dr Eunicia Tan, was endlessly supportive and really got me over the finish line with it. I'm eternally grateful to her. I don't think I was as proud of it as I should have been at the time. I struggled with how difficult I found it to do. I've had some really nice feedback on it though and I am proud that I completed it.

What inspires you to continue working in this field?

The persistent potential of seeing something new, doing something new and doing something exciting. Every shift is a new shift. Every shift has the potential to have something exciting happen and to make a difference for someone. I always feel like there's something new to learn or get better at and that keeps me coming back.

Emergency medicine has always been at the forefront of change and can adapt and introduce new practices quickly and effectively.

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

The best advice I got early on was "don't miss what's going to kill them" and then work from there. It's a pretty solid starting point in emergency medicine. I've also been told it's harder to teach someone how to make a decision rather than what is the right decision. In ED one of our strengths is that we're quick and decisive. I think it's important for junior trainees to get really good at making a decision or plan. They can run it by a senior and should be open to being wrong and having to change the plan, but making a decision in the first place is the hardest part. You can then go learn the reason you were wrong.

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

Emergency medicine has always been at the forefront of change and can adapt and introduce new practices quickly and effectively. I'm excited that ACEM is recognising the importance of health inequity and Indigenous health, especially the work of Te Rautaki Manaaki Mana: Excellence in Emergency Care for Māori. Health inequity in Aotearoa and Australia is stark. In ED we often see the consequences of it. We're in a position where people come to us when they don't know where to go. We can be patient advocates and be at the forefront of trying to make systematic change. It's a massive issue that won't be easily solved but there are some incredible, hardworking people in Aotearoa behind the Manaaki Mana project who are inspiring change.

A Global Emergency Care Community Reunited

The recent International Conference on Emergency Medicine (ICEM) 2022 in Melbourne this year once again demonstrated the significance of engaging with our global emergency care community. The conference brought together 1,888 in-person and virtual attendees from around the world to discuss the overarching theme of "Better Care for a Better World".

Global Emergency Care Scholars

One hundred thousand dollars from the ACEM Foundation was put towards the provision of 11 global emergency (GEC) scholars, covering their travel and registration to ICEM. Scholars came from Botswana, the Cook Islands, Fiji, Papua New Guinea, Samoa, Solomon Islands, and Vanuatu. The ICEM academic program was enriched as scholars were invited to present on a range of topics pertinent to their individual contexts, allowing conference delegates to understand perspectives from all corners of the globe. Presentations incorporated topics such as leadership journeys, climate change in the Pacific, and the challenges of navigating the COVID-19 pandemic in resource-constrained environments. Scholars acknowledged the richness of the ICEM academic program, providing skills and knowledge that delegates could take back with them. Dr Nolan Fuamatu, emergency physician in Samoa remarked: 'I came from Samoa for the ICEM conference and I was terrible with ultrasound scans, but after the POCUS workshop, I will be returning to Samoa, still terrible with ultrasound scans, but at least I now know where to place the probe and what I'm meant to be looking for!'

The generosity of the ACEM Foundation must be acknowledged in facilitating these scholarships. The College

Above: The Global Emergency Care community comes together at ICEM 2022.

contributes $60 from the annual subscription fees of Fellows and the annual training fees of trainees to the ACEM Foundation to support its activities, allowing the College to provide these types of opportunities for global colleagues in low- and middle-income countries (LMIC).

LMIC Delegate Subsidisation Scheme

In addition to the global scholars, the LMIC Delegate Subsidisation Scheme (LDSS) created an opportunity for clinicians working in LMICs to apply through a centralised process for subsidised registrations and support at ICEM 2022. These subsidised registrations were funded by a range of different funding sources including Bolivia, Brazil, Cambodia, Colombia, Egypt, Ethiopia, Fiji, Haiti, India, Lebanon, Malawi, Malaysia, Mexico, Myanmar, Nepal, Nigeria, Papua New Guinea, the Philippines, Solomon Islands, Sri Lanka, Tanzania, Tonga, Tunisia, Tuvalu, Uganda, Yemen, and Zambia. There were 22 in-person registrations received and 81 virtual registrations.

We acknowledge the generous donor support from the Pacific Community, St Vincent's Pacific Health, Therapeutic Guidelines, Australian Volunteers Program, and ACEM Foundation.

Global Emergency Care Community Dinner

All GEC scholars and LDSS delegates came together on the Thursday evening of the conference to connect at the Global Emergency Care Community Dinner, hosted at the State Library of Victoria. This coincided with the launch of the book *When Minutes Matter*, and attendees were able to hear from writers who had contributed to the book. You can read more about this pivotal community event on page 28.

Australian Volunteers Program Breakfast

On the Friday morning of the conference, the Australian Volunteers Program, an Australian Government initiative, hosted a breakfast panel discussion led by Emma Hess with Dr Trina Sale, Dr Vincent Atua, Dr Georgina Phillips, and Mr John Foley discussing the importance of achieving systemic change in emergency care through long-term partnership. The session explored how volunteer programs and emergency health providers can work in partnership to contribute to the capacity of emergency departments (EDs), and to support institutional and systemic change. Dr Trina Sale from the National Referral Hospital, Honiara, Solomon Islands, and Dr Vincent Atua from the Vila Central Hospital, Vanuatu, highlighted how long-term partnerships with emergency care volunteer programs such as the partnership with ACEM can assist in the transformation of ED systems and processes.

When Minutes Matter

Dr Jenny Jamieson & Dr Rob Mitchell

Dr Jenny Jamieson and Dr Rob Mitchell are FACEMs and the co-editors of *When Minutes Matter*.

"Emergency departments are alive with stories, ours, and our patients'. When the razzle-dazzle and the adrenaline subside, the stories remain. Some are painful, some tender. Others are funny. And some we don't forget. We keep them with us, mixed up with our own stories until they become our stories too. They help us make sense of things and remind us of what it is to be human, and all the rewards and loss that entails. That is what emergency medicine is for me."

An extract from Dr Heidi Edmundson's 'The path to belonging', one of 27 short stories that feature in *When Minutes Matter*.

As Heidi's words attest, every patient who receives emergency care, no matter how briefly, leaves behind a story. *When Minutes Matter* recounts a small number of them, from within and beyond the emergency department. The product of a two-year project involving ACEM, the International Federation for Emergency Medicine (IFEM) and Hardie Grant, the book was recently launched at the International Conference on Emergency Medicine (ICEM) 2022 in Melbourne.

Stories

When Minutes Matter profiles emergency care at its greatest and at its most tragic. It is a moving compilation of stories and profiles from across the globe, with contributions from every continent. There are critical messages about the social determinants of health, the construct of humanitarian aid and the impending devastation of climate change. But the stories also convey a strong sense of optimism about global emergency care provision, and will inform and inspire those who read them.

The book was curated by an editorial committee with global representation. A key objective of the project was to amplify the voices of clinicians from low– and middle-income countries, providing insight into their work, humanity and the highs and lows of clinical practice on healthcare's frontline. These are the unsung heroes of global health; humble but deeply committed nurses and doctors working tirelessly to care for their communities.

When Minutes Matter also features a range of contributions from across Australia and Aotearoa New Zealand. For example:

- Dr Katrina Starmer, from the Royal Flying Doctor Service, describes a night flight across Far North Queensland to rescue a park ranger savaged by a crocodile. In her story, she reflects on the camaraderie that developed between the clinicians, patients and community members involved in a daunting rescue in the harsh Australian outback.

- Melbourne-based emergency physician Dr Amaali Lokuge beautifully describes the experience of emergency physicians providing compassionate care during the early stages of the pandemic, and the impact of that period on our colleagues and families.
- Ms Tileah Drahm-Butler, a social worker and narrative therapist in Cairns Hospital Emergency Department, delicately explores how she listens to the stories that patients bring with them, and helps them make meaning out of their situation.
- Dr Meg McKeown, a rural generalist from Tasmania, shares her reflections from the darkness of a winter spent in Antarctica. In her confronting story, she describes how her struggles to survive a lightless deployment led to a greater sense of self, and an enduring resilience.
- Newly qualified emergency physician Dr Evan O'Neill provides a moving account of his deployment to a refugee camp in Bangladesh. When he found himself laughing with some of his paediatric patients, he started to wonder: is it even right to smile, when surrounded by so much human tragedy?
- Dr Kelly Phelps, an emergency physician who worked during the Whakaari/White Island volcanic eruption in Aotearoa New Zealand, provides a powerful narrative exploring the profound impact of the event on Whakatane Hospital.

The stories come from a broad range of countries and contexts, and highlight the deep sense of solidarity and shared experience that comes with being an emergency clinician.

Launch

When Minutes Matter was launched at ICEM's Global Emergency Care Community Dinner, held at the exquisite State Library of Victoria. South Australian emergency physician Dr Rose Skalicky read an excerpt from her story about the arrival of emergency medicine in Myanmar. Following Rose's presentation, Dr Aloima Taufilo, Tuvalu's first emergency medicine trainee, and Dr Amy Neilson, a rural generalist with extensive experience in humanitarian response, were interviewed about their respective stories. Aloima described a terrifying obstetric retrieval from a remote Pacific island, while Amy reflected on the challenges for effective emergency care during conflict and crisis. Attendees then had an opportunity to mingle with the authors under the majestic dome of the Latrobe Reading Room.

Impact

We hope the book is a timely contribution. COVID-19 has exposed human suffering and hardship on an unprecedented scale, and highlighted entrenched inequities. It has also revealed the limitations of health systems and stretched healthcare capacity in almost every corner of the world.

As we look beyond the pandemic, it is critical to share the experiences of emergency patients and clinicians from across the place. Their stories – of trauma and survival – can help us imagine a different future, where quality healthcare is universal and emergency care is considered a right, not a privilege.

In highlighting the immense contribution of frontline healthcare workers, we hope that *When Minutes Matter* goes a small way to improving emergency care access and outcomes across the globe. We are grateful to all those who contributed to the project.

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i More information

When Minutes Matter is available for purchase via the ACEM website: https://acem.org.au/Content-Sources/About/Publications/When-Minutes-Matter. All proceeds received by ACEM from the sale of the book will be directed to ACEM emergency care development initiatives.

Stories contained within the book reflect the experiences and perspectives of the individual authors, and do not represent the College's formal views or positions.

Equity's Struggle, in Life, in Death.

Dr Michelle Johnston

Dr Johnston is a FACEM and author, trying to figure out how to get both jobs to play nicely.

The corpses are a trial. Four, yellowing out-of-towners. Four bodies, still now, still. Their veins are quiet, their eyeballs deflated – orbits without orbit, waxen and waned. They are the finest bodies, laid out on slabs, chosen for their corporeal integrity, yet they keen a cyclonic grief before I even place a gloved hand on their defrosting foreheads. Not their grief. Theirs was concluded years ago, faded now in some gloaming gloom. Neither is it the lament of their loved ones. Nobody is weeping at their sides, these sides preserved into thick, unbreathing hide. No it is mine, although the grief I feel will not out itself until I am at a dinner party later that night, unable to articulate why I feel so sad and wondering if I still smell of death.

The room is icy, as though crystals might form underfoot where I tread. I'm in before the others, those that I'm there, ostensibly, to teach. But as they say, it is the teacher who learns the most. I must plump up the eyeballs to create fidelity for the lateral canthotomies. I am alone in the lab while I do so. The cadavers are covered in white sheets, crisp and clean as the early morning, and I must steady my nerves to lift one, to meet the first of those heroic carcasses, those who've donated their companions for life – their bodies – to medical science.

The eyeballs are sunken white dwarfs. I inhale and pick up a syringe full of saline from a cold metal kidney dish situated on a precisely ordered table of instruments. I attach the needle, wondering if that's a shake I see in my fingers. Injecting the eyeball is a tiny miracle itself. It reinflates them so that they almost resemble their former ocular majesty. Oh, the eyeball, a structure to genuflect in front of. In life, a city – a metropolis of inputs and images and layers upon layers of marvel. In death, a stone. It wasn't so bad though, that hard, too terrible. I sigh, realising I'd been holding my breath the whole time. I move from cadaver to cadaver, resurrecting the architecture of orbits.

The day passes slowly in that silent, steely room. We teach. We learn. The facilitators, we relics who've tried to play the emergency medicine game for over three decades and today feel closer to those under our knives than those we are teaching, impart wisdom as though we are speaking in runes. The chill never lets up. We lay open the necks and the chests. We find the guitar string twang of the lateral canthal ligament. We show how to burr into the skull, demonstrating when to grunt and when to drill like you're carving your name on an eggshell. I wonder if it's warm outside and then bend to run a finger around the inside of a frigid chest, exploring where the soul might have been.

I find humour has deserted me. I do not understand why. Later, at that party, I am terrible company. Somebody has met someone vaguely famous and wants to gossip about them. I am disinterested. A bore. That evening I am neither articulate nor self-reflective enough to explain why. I feel there is an imbalance, that I had spent the day in the presence of unfathomable nobility, but I still don't quite nail my brief – of understanding. It takes me days to work through, to parse out these dissident feelings, this disquiet.

We are in troubling times. The worldly horrors are gathering at pace. At the heart of so many of them seems to be the throb of self-interest. This is what shocked me so greatly in the cadaver lab, I realised. That in this day and age people would still donate their bodies for us to make our educational mess inside; an act of generosity so mind-boggling the galaxies might bow to those who do so. A sacrifice so vast that evolution might stop and watch for a while, happy it got things right for a change. A covenant of trust, between those that chose donation as their parting gift, and we, the doctors who need to learn in order to perform our best on the patients next in line. The ultimate pay-it-forwards.

Such dedication, with the naked exposure of these transient temples, also takes death from the personal to the public. We talk a great deal about equity here – in this College, in this magazine, in this subset, AWE. Equity is a battle, an unending war to fight for those who are not the privileged few to have equal seating at the table. It's constant, this fight. One of the heart-breaking, infuriating consequences of this perpetual conflict is the energy it diverts from the issues (with perhaps the greatest issue bearing its furious climate-breakdown down upon us) that require collaboration from we global humans. Wearying, and often deadly diversions. Racism and ableism. Putin and Roe vs Wade. Robodebt and refugees. It is claimed Zeus decreed he would set humans against each other in eternal war so that they might never look towards Olympus in challenge, and it certainly, thus far, has come to pass. The pandemic is another example. Here we return to death being no longer personal.

The past two and a half years have been spent scrabbling for screenshots of numbers. How many cases? How many in ICU? How many deaths? We have oscillated between wanting it over, trying to predict the trajectory of this guerrilla virus, desperate to understand the messaging and mandates, and looking out for ourselves. Deaths became more than personal, they became political. Suddenly we were asking, how much is a life worth? Is it worth losing a business in the high street? Perhaps a cruise line, or a promotion? Then it became only *certain* deaths. Oh, it's OK because that person had *underlying conditions*, the rhetoric went. Underlying conditions felt

like we were saying *expendable*. Underlying conditions were the new minority group on the block. Disparity raised its serpent head again. It appeared as though different lives had different values. In emergency medicine, of course, we define ourselves by a commitment to saving lives, all lives, wherever possible. It's like a reflex. If those on the brink come through our doors, we'll give it a red hot try. We don't always make impeccable decisions, though.

But zooming out, as we can admit that medicine is imperfect, our western late-stage-capitalism-driven society is even more so. We, the general public, had a chance to establish what we were prepared to do to protect all human life during this novel bad-news-protein threat. As a society we fell short, just as we have done before. Deaths were transactional, commodified for some greater chess game.

Death is perhaps the great leveller.

If our deaths are not wholly our own, then who do they belong to? Perhaps in the same way our lives are, they are intricately bound to each other's. Our fates are communal, both responsibility and reward for our time here on this magnificent planet. I'm not sure I'll be courageous enough to leave my body, once I've grizzled it to the grave, for doctors to practice procedures on me, but I can admire those with this extraordinary dedication to humanity. I'm teaching on the cadaver course again next week. I shall go in with a greater reverence, be more eloquent in my teaching and gentler with my touch, and softly remind the participants of the heroes under their knives.

The struggle for equity will continue, in life as in death. How fortunate if we can see that, to have the chance to intervene, to dance before the dirge, be engaged prior to the requiem. To nurture respect, in the before, the now, the always. How fortunate are we, in emergency medicine.

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Violence in Emergency Departments – COVID-19 and Beyond

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Violence in emergency departments (EDs) has escalated in recent years, with a significant amount of stress being added on to the healthcare system due to the ongoing COVID-19 pandemic. The shortage of beds, the increase in patient demand, and the ongoing issue of infection control, has led to increased reports of verbal and physical violence against staff in these areas.[1]

ACEM members have seen first-hand the effects of the rise in violence in EDs during the COVID-19 pandemic. The College has updated P32: *Violence in Emergency Departments*, to ensure there is ongoing discussion and attention on this issue, with a focus on preventative measures as well as productive intervention measures.[2] The College believes that violence against healthcare workers and others receiving care should never be tolerated.

Violence in EDs is not an issue exclusive to Australia and Aotearoa New Zealand, and this increase in reports of verbal and physical have been reported worldwide.[3,4] The College has identified the need for early identification of risk factors that are associated with escalating violence in these areas and management of the risk of injury to patients and ED staff, as well as dealing with post-incident support and reporting.[2]

ACEM's position

The College recognises that no matter who the person is, a doctor, a nurse or another staff member, they deserve to come into a workplace where they feel safe.

ACEM's policy on Violence in Emergency Departments, developed under the leadership of ACEM's Public Health and Disaster Committee, highlights the need for hospital management to support staff through governance measures, preventative care such as early identification of risk factors, and post-incident management. It also includes recommendations for improved responses to reports of violence, whether physical or verbal, to ensure that individuals feel they are able to safely work and seek care within these spaces.[2]

Training on violence mitigation is important in ensuring that staff de-escalate issues and know how to safely respond to violent individuals. In addition to this, there is a need to recognise the importance of assessment rooms as low stimulus areas for patients suffering with behavioural disturbances, to minimise risk of injury to the patient.[2]

Current legal ramifications

Whilst hospitals have been attuned to workplace violence for some time, the ongoing COVID-19 pandemic has led to exacerbation of the problem. This includes reports of threats of violence, being spat at, and being abused, not just by patients, but by people who have family affected by COVID-19. Family's limited access to their loved ones during this time of uncertainty has resulted in an accumulation of frustration for staff, patients and family alike. In many cases this has led to increased security presence in hospitals, barring the offender from re-entering hospital premises, ongoing de-escalation training and pleas from staff for civility by the patients and their families.[2,3]

There have been attempts to use the legal system to address this issue. Currently, the punishment of offenders who assault health practitioners, anywhere they are providing support or care, varies by jurisdiction. The discrepancy in the

laws between different jurisdictions is indicative of different approaches and priorities in responding.

Reflections on violence in EDs during COVID-19

ED physicians remain well respected and trusted members of society, despite the increasing violence we are seeing within EDs. Globally, however, the association of the standard uniform of scrubs with COVID-19 has led to the idea that the staff that are battling coronavirus are likely the carriers of the disease. The wearing of scrubs make frontline healthcare workers easy target for violence from disgruntled members of the public. In Chicago last year, a nurse was punched in the face on the bus because she was wearing scrubs while travelling home after a shift and coughed.[3,4]

The pleas by staff that healthcare workers are there to help and not hurt the patients have not always been heeded, with there now being signs appearing across EDs globally, calling on patients and visitors to not hurt staff that are attempting to help patients.[5,6]

"Stop hurting us. We are here to help you"

Furthermore, the politisation of vaccines, social distancing and wearing a mask, all actions endorsed and symbolised by healthcare workers, have placed professionals on the frontline in the center of a fraught debate, where facts often take a backseat. When doctors, nurses and other medical professionals have advocated for the use of vaccines to halt the transmission of coronavirus, individuals firmly against vaccines have accused these healthcare workers of having agendas that may result in harm to the patient.[7,8] This has contributed to healthcare workers becoming burnt out, where they not only have to deal with an increasing load of patients that could be exposed to COVID-19, in addition to dealing with patients presenting with potential side-effects of the vaccines, in an overwhelmed system that was already dealing with access block and ambulance ramping, and now having to deal with more stress.[9,10]

Globally, cases of people vandalising COVID-19 wards, death threats being issued to staff and incidents of having liquids like coffee and bleach being thrown at them, have become commonplace. While this level of violence is rare in Australia and Aotearoa New Zealand, we need to ensure that violence never becomes an accepted part of the job, an occupational hazard that all members of the College, and beyond, have experienced.

Further action is required

Smart technology may play a significant role in reducing violence within these services. Features like panic buttons on desktop computers, mobile phones, and smart watches, that can alert 000, incident command centres and security could be simple to implement. For staff like paramedics, the escort feature can be used to activate when they set out for their vehicle and can be safely deactivated when they reach their destination. Furthermore, toolkits created by the Illinois Medical Professionals Action Collaborative Team (IMPRACT4HC), exist for health professionals to take action if they are facing cyber abuse, which too has escalated during the COVID-19 pandemic.[8]

Other initiatives to decrease violence include videos advising patients of the process of triage in EDs, wait times and patient liaison officer (PLO) who can de-escalate patient complaints in the waiting room and provide refreshments or explanation.

Action is required from institutions like hospitals, medical colleges and primary healthcare centres, to provide solidarity to healthcare staff that are advocating and fighting to work in safe workplaces. This can be done by leading conversations with the community on how violence against frontline staff is not acceptable and taking swift action when reports of violence are made.

It is imperative we not only recognise the issue of workplace related violence and take action against it but take into consideration the long-term effects of physician burn out and reduced retention rates of staff, that will further accumulate if this silent pandemic is not addressed. After all, every person, whether patient, visitor or staff member, deserves to feel safe in an ED.

ACEM will monitor emerging evidence about the impacts of violence during the pandemic, as well as sharing innovative programs and advocating on behalf of members to improve workplace safety.

Author: Arshdeep Cheema, Policy Officer

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Specialist Disability Accommodation and Hospital Patient Flow

People with disability have the right to a place to live that meets their specific needs and preferences.

Trevor was living in hospital after coming from supported accommodation where he was malnourished and abused. There was no way I was going to let him go back to that accommodation.

"Trevor had been approved for an apartment that was really appropriate for him and his needs, but he was at risk of losing that apartment while we waited for the NDIA.

The waiting time also had a huge impact on my physical and mental health and Trevor was becoming flat and depressed – not his usual bubbling self. I just felt so useless as a parent.

Since he moved into his apartment he's put on weight, his personality has come back … he's living the life of an average person … he's never been happier."

– Linda, Trevor's Mum, from downto10days.org.au

The introduction of the National Disability Insurance Scheme (NDIS) was the biggest reform in a generation for how support is provided to Australians with a significant disability.

Since commencing full operation in 2016, the NDIS has faced significant challenges. Over the last few years, a range of concerns have been raised about the way the NDIS is operating. This includes a drive towards 'sustainability' from the National Disability Insurance Agency (NDIA), which some people are concerned means it's more focused on counting pennies than providing funding packages that people with disability really need.

A recent prominent example was a move towards independent assessments, which meant the NDIA would no longer rely on doctors and other health professionals directly involved in a person's care, but utilise one-off assessments as part of the process. This change has since been discarded but highlights the ongoing tension between the needs of the individual and those who are responsible for the NDIS.

Inadequacies, gaps and lack of community-based care options mean that people requiring NDIS housing and services can't be discharged from hospital to continue their treatment or recovery in the community.

The Hon Bill Shorten is the current Minister for the National Disability Insurance Scheme. The elevation of a single scheme such as this to a Ministerial portfolio is unusual, reflecting the scale of change that's occurred and the work that's still required to make sure it runs appropriately.

Specialist disability accommodation

A key area of support for many people with disability is access to housing that meets their needs and preferences. Support to live as independently as possible is beneficial for the individual, as well as for the broader community. Given the incredible diversity in the disabled community, supports need to be tailored to the individual.

Specialist disability accommodation (SDA) is a type of housing developed for people with higher levels of disability. There are a range of organisations that develop SDA. Examples of the types of building specifications required include: enhanced physical access (for example, wheelchair accessible, adjustable sink heights); robustly built (high impact wall linings, secure windows with laminated glass); and design with a high level of physical access provision in mind (structural provision for ceiling hoists, minimum door widths, fittings to accommodate assistive technology). Access to this specialised housing allows people with disability to live more independent and normal lives.

Historically, group homes were a common form of accommodation, but there has been a strong push to diversify the type of SDAs available. People with disability, like everybody, deserve choice in where they live and who they live with.

According to the latest quarterly report from the NDIA[1], the two largest groups of enrolled SDA dwellings are villa/duplex/townhouse premises (2,157) and group homes (2,088), with apartments (1,211) and houses (1,012) the other major categories.

Over the last 12 months, the biggest increase in newly-enrolled dwellings has been for those that have a maximum of one resident, highlighting a drive to support higher degrees of independence where possible.

Challenges in accessing SDA

There can be significant delays in getting assessed for an NDIS package that includes SDA. Once a package has been approved there can be further delays.

Currently, the median waiting time for the NDIA to make an SDA determination is 94.5 days (up to 493 days), and the time taken to make a decision regarding funding for SDA support is 51 days (up to 63 days). This means some people are spending months, to over a year, in hospital unnecessarily due to delays processing their application for housing. This is despite more than 2,500 vacancies in disability housing around Australia.

While these delays are occurring, people with disability are waiting in potentially unsuitable housing, including hospital wards, nursing homes, or with family.

Impacts on patient flow

Data from the NDIA have shown there are 1,100 people with disability currently in hospital waiting for NDIS supports. Recent data collected by the Summer Foundation found that over 61 per cent of people who are stuck in hospital, despite being clinically ready to be discharged, are there because of a housing-related barrier. Nearly half of this cohort have inadequate funding for housing and supports that would allow a safe and effective discharge.

These delays are detrimental for the individuals, who spend months to years of their lives unnecessarily in hospital, and are costly to the health system in terms of finances, resources and patient flow. These delays represent a failure in the health and disability systems to ensure people receive the care and support they need in the most appropriate place for them. Surveyed hospital discharge professionals consistently express their frustration that, despite improving their processes and procedures, patients are being delayed for months in hospital due to the NDIA taking too long with funding decisions.

1,100 staffed beds are being used by people trapped in hospital due to poor bureaucracy. This has a major impact on the flow of patients through the hospital system and is a contributor to access block in the ED.

This, in turn, leads to lack of space to admit new patients to wards from ED, compounding the pressures and access block which EDs are already experiencing.

This is a prime example of where investment in community-based services will have a direct impact on patient flow in hospitals. Addressing this hidden crisis will benefit everyone involved.

Down to 10 Days campaign

ACEM is supporting a new campaign led by the Summer Foundation, Down to 10 Days.[2]

Along with dozens of other organisations, the College will be advocating for the lengthy bureaucratic delays for NDIS participants to be eliminated. ACEM believes that a hospital is no place for a person live. It takes just days for decisions around funding and supports to be made for older adults going into aged care, so it can be done for people with disability accessing age-appropriate housing and supports too. The 10-day time frame is in line with what the NDIA themselves think is achievable, yet evidence shows that the reality falls well short.

The campaign includes stories from people with disability who have experienced these delays, as well as tracking how the media has been responding. Head to the website to see more.

There are more than 2,500 vacancies in disability housing around Australia. This includes 800 new dwellings that have been specifically built for people with a disability and currently sit vacant. It isn't simply about availability of bricks and mortar. The NDIS is falling short with timely funding for adequate housing and supports.

Improving access to housing is a vital need, and will help ensure hospital beds are available for people requiring hospital care, including other people with disability.

Authors: Dr Lee Cubis, Senior Research Fellow and Research Team Manager, Summer Foundation
James Gray, Manager, Policy and Advocacy, ACEM.

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What Ails Us: Will a New Government Lead to More Health Reform?

After 10 years under a Liberal-National coalition, Australia has elected a new government, led by Labor's Anthony Albanese.

As the first Federal election since the beginning of the COVID-19 pandemic, it could have been expected that the health system would be front and centre of the campaign from the start. Major structural issues in health existed prior to the pandemic, but the impact of these was unmistakable when COVID-19 took such a heavy toll on the workforce that had been papering over the cracks in the system.

Initially, however, the opportunity to debate significant reform seemed to be off-limits as both the Government and the Opposition focused on running small, targeted election campaigns. It was not clear if there would be the opportunity to advocate for health reform, with parties and the media more focused on issues like integrity and past performance of the then government, rather than what was to come from the next government.

ACEM will always remain a non-partisan organisation that advocates on behalf of the profession of emergency medicine. The College does not support parties or individual candidates. Instead, ACEM encourages and supports the adoption of high-quality policies that will improve the provision of emergency care. In doing this, the College speaks out in support of policies that will have a positive impact, and conversely against policies that will have a detrimental impact. We also advocate proactively for evidence-based solutions to the challenges that face the health system.

ACEM connected with colleagues across the health sector to look for opportunities to engage and support each other's advocacy. The College had messages ready to go and began to actively hunt down opportunities to get those messages out to as many people as possible. After years of health being in the spotlight, voters and decision-makers needed to stay engaged, and to believe that improvements were possible.

Although neither party was providing leadership on significant reform, the reality of the experiences of medical professionals and patients became a central narrative in the campaign.

Overcrowded emergency departments, ambulance ramping, acute and chronic workforce shortages, and more, were consistently in the media. The consequences of this were also gaining greater traction, with increased morbidity and avoidable deaths casting a harsh light on the health system.

It was into this context that ACEM was able to play a central role in shifting the narrative about the health system. Building on direct engagement with parties and independent candidates, ACEM was able to become a prominent voice in calling for reform, pivoting the narrative from talking about the problems to demonstrating that they were fixable.

ACEM President Dr Clare Skinner was quoted in media that was seen, heard or read by well over one million Australians.


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A win for Labor but a messy one

So, what does the election result mean for the Australian health system? Health is traditionally seen as a strength of the Australian Labor Party, but it is not yet clear how far they will be willing to go to pursue major reforms.

This election was unusual in that large losses by the Coalition did not translate to a large majority for Labor, with significant gains to the Greens and independents. The new Labor Government holds 77 seats out of 151. This represents a slim majority, which could lead to a narrower agenda.

Meanwhile, in one of its worst results since the Second World War, the opposition Liberal-National coalition holds 58 seats. The loss of multiple inner-city seats to independents and the Greens has greatly reduced the moderate faction of the Liberals in what was historically considered their 'heartland'.

The Senate will have an important role in either constraining or facilitating the Albanese Government's agenda. Labor will need the support of the Greens and one other group to pass legislation. The Greens have increased their Senate representation to 12, alongside moving from one to four seats in the House of Representatives, making them a powerful third force in the Parliament.

It will be interesting to watch the impact of the teal independents. Although they do not hold the balance of power in the House of Representatives, they may still have an important role in driving public debates about key issues, including climate change.

Finally, an important difference in this Parliament that should signify a strengthening of our democracy is the increased diversity of MPs and Senators. There are record numbers of women, Indigenous Australians, and representatives from multicultural communities, bringing the Parliament closer to reflecting Australia's population.

Government commitments

The current composition of the Parliament provides a broad range of opportunities for engagement. ACEM will work with the Government, the Opposition, and the crossbench to seek improvements to emergency care in Australia.

During the campaign, the now Labor Government committed to five priority health areas that relate to emergency medicine:

- Establishment of the Strengthening Medicare Taskforce
- Development of Medicare Urgent Care Clinics
- Increased investment in aged care
- Review of the National Disability Insurance Scheme (NDIS)
- Investment in rural health workforce incentives.

Medicare Urgent Care Centres

ACEM will engage in different ways on these topics, but the priority will be the creation of what they are calling Medicare Urgent Care Clinics (MUCCs), which have the stated goal of reducing pressure on EDs.

There is limited information publicly available on the structure and governance of the planned MUCCs, which:

- will be based out of GP clinics or community health centres
- will be bulk billed
- are being framed with the distinction between urgent versus life-threatening care.

This commitment reflects a focus on expanded primary care rather than acute care. This will positively benefit consumers and structurally has the potential to alleviate some demand on emergency departments (EDs) in a limited way.

MUCCs will, however, have no impact on access block and they will be unlikely to achieve their stated goal of reducing pressure on EDs in any significant way. One of the biggest concerns is that these new services may represent a costly investment in low-value acute care, particularly if there are high rates of unnecessary referrals on to the ED, in which case they become a barrier to effective and efficient care.

ACEM will work with the Government to ensure that failed models are not repeated, and that this investment has the greatest positive impact for patients and EDs.

What next for the health system?

While the new Government didn't propose major reform during the campaign, they still have the opportunity to do so during this term of Parliament. Across Australia, there are still some politicians trying to maintain that the issues in the health system are solely or primarily related to COVID-19. This line is not sustainable, and the Federal Government may have an important role in shifting that narrative.

The National Cabinet has agreed to review funding and other health arrangements over the next three months, with Treasurer Dr Jim Chalmers tasked with providing advice on areas of joint funding responsibility by September 2022.

Major health reform is needed and ACEM will advocate to ensure that the Government steps up to the plate. Primary care remains a backbone of our health system, but it is in dire need of structural reform to improve integration. We need an appropriately trained workforce in areas of need. We need patients to be able to flow through the system to the most appropriate care, and not stuck in EDs awaiting admission, or on wards awaiting discharge.

New governments often mean new opportunities; let's make this time count.

Author: James Gray, Manager, Policy and Advocacy

Getting to Know You – ACEM's Inaugural Member and Trainee Diversity Survey

ACEM is committed to fostering and promoting the principles of diversity and inclusion amongst its members and trainees in the field of emergency medicine.

As the peak professional organisation for emergency medicine in Australia and Aotearoa New Zealand, ACEM has a duty to the emergency medicine profession and the wider community. Part of this entails training a sustainable emergency medicine workforce that provides high quality patient care and upholds the highest possible professional standards in emergency medicine.

ACEM's Governance and Leadership Inclusion Action Plan represents the next phase of the College's efforts to promote positive culture change within ACEM, and more broadly across Australian and Aotearoa New Zealand EDs. The College has made significant strides in ensuring that its governance structures have a more appropriate gender balance, but there is much more to be done.

A key activity is the establishment of a diversity data framework and as part of this the College undertook an inaugural Membership and Trainee Diversity Survey. The Inclusion Committee developed the survey utilising a framework from the Diversity Council Australia and Australian Bureau of Statistics, modified to reflect ACEM's context.

'It's two sides of the same coin: FACEMs are our College and our College is our FACEMs.'

– **Dr Shantha Raghwan**, member of the ACEM Inclusion Committee

Survey content and goals

The purpose of the survey was to gain an understanding of who College members and trainees are, in order to reflect on the diversity within ACEM. This information will be used to create initiatives that will improve inclusion across all College activities, including governance and leadership roles. The survey results will aid the development of better cultural competency training and is a means of ensuring increased resources and better engagement with members and based on their needs.

The domains of diversity included in the survey are age, sex, gender, variations of sex characteristics, sexual orientation, indigeneity, cultural identity, disability, and carer status. Questions also asked about people's experiences in their workplace and their engagement with ACEM.[1] These critical determinants are important in understanding the landscape of our membership, in order to '… [tap] into the success, the progress and the creativity that we know has been proven when we have diversity of thought and diversity of experience,' said FACEM and Inclusion Committee member, Dr Shantha Raghwan.

'Scientific first principles tell us that we make decisions based on data and we just don't have the data at the moment. … We have been making decisions for our membership and for the direction of the College, without actually knowing who our membership is. …. This [survey] is the first important step in our College getting to know who we are.'

Dr Clare Skinner, President of ACEM and Chair of the Inclusion Committee, stressed the importance of this survey by highlighting the benefits of diversity and inclusivity within healthcare. 'There is really good evidence that when we have diversity of leadership and diversity in decision-making, we make better decisions, and we provide better healthcare.'

Fellow Inclusion Committee member Dr Bhushan Joshi underlined this notion using a quote by Maria Popova: 'To understand and be understood, those are among life's greatest gifts, and every interaction is an opportunity to exchange them'. Dr Joshi said that through his own personal experience of being a gay, Indian doctor, he saw the importance of diversity and inclusion within his workplace. Diverse representation is vital for trainees who are working towards a career in the emergency department, and is also imperative for high quality patient care delivered by FACEMs.

'To understand and to be understood, those are among life's greatest gifts, and every interaction is an opportunity to exchange them.'

– **Maria Popova**

Dr Raghwan mirrored the sentiment, saying that diversity and inclusion for her is 'the ability of people to turn up, as their whole authentic selves, and they are not only recognised but appreciated. This means belonging … in the place that they work and within the College, which is something that we all deserve'.

How will ACEM use the data?

The College will use the results of this survey to inform change across the College's governance and activities. ACEM will undertake the following activities:

- A comprehensive analysis of the data, highlighting how the College can improve inclusion over time
- Publish and promote a summary report available to all members and trainees
- Utilise the results to reflect on how the College's leadership can provide greater commitment to inclusivity and diversity
- Improve training and education programs to build knowledge and skills on issues such as cultural competency.[2]

Ultimately, the goal is to ensure that ACEM reflects its membership and the communities that it serves. ACEM wants to be a leader in this space within specialist medical colleges and has taken on board the idea that creating change for everyone needs the input of everyone. Afterall, 'diversity is about all of us and about us having to figure out how to walk through this world together'.[3]

Authors: Arshdeep Cheema, Policy Officer and Nikita Swami, Project Officer

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ACEM Spring Symposium

Ōtautahi, Christchurch

Te Pae, The Christchurch Convention Centre

27–30 November, 2022

Join us at this year's Spring Symposium in Ōtautahi, Christchurch, New Zealand, the country whose COVID response is recognised by the WHO as one of the strongest on the planet, in the city that birthed HealthPathways and whose integrated health care system is internationally recognised.

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

In keeping with our theme Mahi Tahi – working together – we won't be having concurrent sessions – we will all be in the same auditorium, but with intimate and highly interactive sessions. These include evolving clinical scenarios supplemented with electronic polling, led by a diverse panel of clinical experts, and quick fire presentations presenting a rich potpourri of research updates from our international emergency medicine community. In addition, enjoy a fine selection of teamwork and wellness activities, social engagements and lectures from passionate leaders of the non-medical world.

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

Join us for education, exploration and inspiration.

Register Now

www.acemss2022.com

Feedback Provided to Candidates Sitting the ACEM Primary and Fellowship Examinations

ACEM Primary and Fellowship Examinations

The FACEM Training Program examinations comprise two Primary examinations, a written and a clinical, that are undertaken by candidates in the initial phase of training, and two Fellowship examinations, written and clinical, undertaken in the final stage of training. Each examination is scheduled to run twice yearly. A trainee must achieve a pass in each examination to proceed to the following one in the sequence below.

Trainees are allowed a maximum of three attempts for both Primary examinations and the Fellowship Written Examination, and a maximum of four attempts for the Fellowship Clinical Examiantion. Specialist International Medical Graduates (SIMGs) who are enrolled in the ACEM SIMG pathway may also be required to complete one or both Fellowship examinations.

Feedback provided to unsuccessful candidates

Feedback is provided to candidates who are unsuccessful at any of the examinations of the FACEM Training Program to assist them in preparing for a subsequent attempt. The following provides information about each of the examinations and the feedback provided.

1. Primary Written Examination (PEx Written)

The PEx Written consists of two Select Choice Question (SCQ) papers, which are completed over six hours; three hours in the morning and three hours in the afternoon of the examination day. The examinations are completed online.

Each paper has 180 Multiple Choice Questions (MCQs) that cover the four major medical sciences: Anatomy, Physiology, Pathology and Pharmacology. The questions are presented in MCQ format where candidates select the correct answer of the four options for each question.

To pass the examination a candidate must achieve:

- an overall score at or above the cut score plus one standard error of measurement (SEM), therefore the 'passing score'
- a minimum standard in all subject areas, where this is defined as scoring at or above the subject cut score minus one SEM.

*The application of the SEM is standard practice in high-stakes examinations and is applied as a quality assurance measure to ensure that the candidates deemed to have passed the examination have attained the minimum standard considered necessary.

Candidates who are unsuccessful in the PEx Written receive a feedback letter providing information about their performance that includes their overall score and a breakdown of the percentage items that were correct in each subject area. Additional information such as the subject cut score, their individual subject score, and whether they achieved the required standard in each subject is provided.

Candidates are referred to the relevant examination report that contains further information about the examination.

Your score*	Passing score*	Written result
213	219	Unsuccessful

Subject	Percentage of items correct*
Anatomy	60.9%
Pathology	64.8%
Physiology	52.7%
Pharmacology	62.5%

*Sample figures provided only.

Primary Clinical Examination (PEx Viva)

The PEx Viva comprises four scenario-led integrated Vivas, examined over one hour. Candidates move through the 10-minute stations with a five-minute break between each station.

Each Viva station includes topics from all four of the basic medical science subjects (Anatomy, Pathology, Physiology and Pharmacology) as well as a Clinical Building Block (CBB) section.

Each Viva station is scored out of a maximum of 30 marks with six marks available for each of the five sections. Candidates are required to obtain a score of 50 per cent or greater in at least two of the four integrated Vivas and achieve a total score of 60 or greater out of 120 to pass the PEx Viva.

Candidates who are unsuccessful in the PEx Viva are provided information about their performance in an personalised letter that includes their individual station scores and specific examiner comments. The formal examination report is also made available to all trainees and ACEM members.

A sample of the feedback provided in the individual letters is shown over page.

2. Fellowship Written Examination (FEx Written)

The FEx Written consists of two components, a Short Answer Question (SAQ) component, which is completed over three hours in the morning of the examination, and a Select Choice Question (SCQ) component, which is completed over three hours in the afternoon. Both examinations are completed online.

The SAQ examination incorporates approximately 27 questions of varying lengths but always totaling 360 marks. Each question has several parts. Candidates type answers into the spaces provided onscreen.

Your result in the 2021.2 Primary Viva Examination:
Viva result: Not successful

Viva A*	
Score/30	**10.5**
Examiner feedback	
Anatomy	Good answer in bone description but only at level for the other sections; insufficient detail, some wrong answers on extensors.
Pathology	Could not name the difference in pathology of gout and pseudogout; no knowledge of pseudogout.
Physiology	Could define and give accurate answer for glomerular filtration rate (GFR). Candidate could not describe the mesangial cell function.
Pharmacology	Poor knowledge in regard to colchicine and required significant prompting.
Clinical Building Blocks	Did not mention gout.

*Feedback is provided on all four Viva stations, A, B, C and D.

A breakdown of your mean scores per subject (across the examination), calculated as percentages, is shown below.

Anatomy	Pathology	Physiology	Pharmacology	Clinical Building Blocks
41.7%	54.2%	31.3%	47.9%	68.8%

This feedback is provided to assist you to reflect on your individual performance and identify areas for further development. It is provided to assist you in preparation for future attempts and cannot be used as an avenue to question or contest results awarded.

FEx Written Feedback continued

The SCQ examination consists of 120 multiple choice questions (MCQ). Candidates work through the questions selecting one correct option of the four options presented.

Candidates who receive a score equal to or greater than the passing score for each of the two component examinations at one sitting will be deemed to have passed the FEx Written. In addition, a candidate who passes either the SCQ or SAQ with a score which is larger than or equal to the passing score for that component plus one SEM (the raw cut score plus two SEM), but has failed the other examination by no more than half an SEM, will also be deemed to have passed the examination.

The passing score for each component is determined by standard setting, as is considered best practice for high-stakes examinations.

Candidates who are unsuccessful in the FEx Written receive feedback on their performance in a letter containing numerical data and examiner comments.

In addition to the numerical data provided, for candidates performing poorly in a question, examiners will indicate which of six 'generic' feedback statements contributed to the candidate's poor performance in the question. They may also add freehand comments. Where a Factor 6 (significant patient harm) is identified, examiners will write an explanatory comment. Samples are shown below.

Your individual performance: Select Choice Questions (SCQ)

Cohort pass rate	Total marks available	Cohort mean (marks)	Cohort median (marks)	Passing score (marks)	Your score (marks)	Your SCQ outcome
69.5%	116*	81.6	83	78	75	Unsuccessful

*Exclusive of items removed as part of the item quality review process.

Short Answer Questions (SAQ)

Cohort pass rate	Total marks available	Cohort mean (marks)	Cohort median (marks)	Passing score (marks)	Your score (marks)	Your SAQ outcome
79.3%	348*	222.5	227	206	172	Unsuccessful

*Exclusive of items removed as part of the item quality review process.

Overall written examination result: Unsuccessful
Description of Factors

Factors 1 to 5 As part of the marking process, examiners provided feedback on the factor(s) which contributed to a loss of marks for a question.

Factor 1	Parts of the SAQ had no answer.
Factor 2	A significant number of incorrect or irrelevant answers were provided.
Factor 3	The answer used vague or non-consultant level terminology.
Factor 4	Some of the mandatory answers were missing.
Factor 5	More than one answer on one line or answer/s in excess of the required number were not marked.

Factor 6 While Factors 1 to 5 referred to entire questions, Factor 6 applied to any sub-section of a question. If Factor 6 applied, the sub-section was given a zero score.
If the 'Short Answer Question Performance' table shows an 'x' in Factor 6 for any of your questions, this means that Factor 6 was applied to at least one sub-section in that question.

Factor 6	A response was provide or omitted which would cause significant harm to the patient, thus the zero score rule was applied to that sub-question.

Factor feedback — SAMPLE

Question number	Presentation – Scenario	Total marks available	Your question score	Factors applying to you					
				1	2	3	4	5	Factor 6
1	Pain management	12	8.25		x				
3	Child iron ingestion	12	4.25		x	x			
21	Carbon monoxide		4.75	x	x	x	x		Failed to give oxygen to patient who is symptomatic of CO

Examiner comments — SAMPLE

Question number	Presentation – Scenario	Additional feedback
16	Incessant crying/cyanosis	Incomplete/incorrect answers to management. Incorrect answers to test results.
17	Child with noisy breathing/ X-ray interpretation	Prop wrongly interpreted. Did not commit to a diagnosis/antibiotic choice. Inadequate no specific treatment for impending. obstruction.

A formal examination report that provides supplementary information is published on the ACEM website and is available to all trainees, SIMGs and ACEM members.

3. Fellowship Clinical Examination (OSCE)

The Fellowship Clinical Examination follows an Objective Structured Clinical Examination (OSCE) format in which candidates move through a series of clinical examination stations in a timed fashion.

To complete the OSCE, a candidate is required to undertake 12 OSCE stations over two days. Each of the stations is 11 minutes in duration, which includes four minutes of reading time followed by seven minutes of assessment. All stations assess competencies in two or three of the eight ACEM Curriculum Framework domains. All OSCE stations are assessed by two examiners marking independently.

Approximately four weeks after the publication of results, candidates who were not successful in passing the OSCE receive written feedback on their performance in each station related to the criteria being assessed, as well as a breakdown of their raw scores for all domains or sub-domains assessed.

If examiners reported that a candidate made an error during a station that had the potential to adversely affect a patient, department, hospital or community, the candidate will be advised of the error, regardless of whether they were successful in the examination or not. Unsuccessful candidates will receive this advice in their feedback letters and passing candidates will be emailed directly.
Samples of the information contained in the comprehensive feedback letters to unsuccessful candidates are shown over page.

In addition to the comprehensive feedback provided for the Fellowship OSCE, candidates who have been unsuccessful on their third attempt are permitted to review the station recordings of that attempt prior to their fourth and final attempt, with an experienced examiner organised by the College. Candidates may have their Director of Emergency Medicine Training (DEMT) or a FACEM support person at the review if they wish.

Candidate feedback – OSCE

General examination information provided:

To pass the examination, candidates are required to achieve a total score that is equal to or greater than the passing score for the examination that includes one Standard Error of Measurement (SEM).
For the purpose of candidate feedback only, OSCE examiners are asked to give an indication of whether or not they believe a candidate adequately addressed selected components of the domain marking criteria that a candidate at a 'minimum level of competence' would have been expected to address.
Additional examiner comments are not required for every station but are provided where examiners believed it was necessary to supplement the generated feedback.

Candidate specific information

The passing score for the Fellowship 2022.1 OSCE was 63 per cent. Your score was one to five per cent below the passing score.

Table of stations, domains and candidate scores		SAMPLE
Station descriptor	**Domain**	**Domain rating (1-7)**
1 SCBD: Threatened airway management	Medical Expertise: Assessment & management	5
	Prioritisation and Decision-making	4.5
	Leadership and Management	4
2 SCBD: Obstetrics/gynaecology	Medical Expertise: Assessment	3
	Medical Expertise: Management	5.5
	Health Advocacy	5.5

Individual feedback on each station – generic feedback and examiner comments	SAMPLE
OSCE Station 1	
Domain: Medical Expertise: Assessment & management	
Describe a safe approach to managing initial hypoxia	Adequately addressed
Describe a safe approach to managing airway/ventilation issues	Adequately addressed
Describe specific treatment of the complication	Adequately addressed
Outline a safe approach to urgent intubation in obese patients	Adequately addressed
Domain: Prioritisation and Decision-making	
Outline escalation of management techniques for laryngospasm	Adequately addressed
Identify high-risk features of intubation	Adequately addressed
Recognise that the patient is failing to improve	Adequately addressed
Domain: Leadership and Management	
Ensure ongoing safety of patient	Not adequately addressed
Describe support for registrar wellbeing and learning	Adequately addressed
Appropriately address management of adverse event	Adequately addressed
Examiners' additional comments	
Candidate failed to discuss post-intubation clinical care.	

Area of Concern feedback (sample)

In the following station(s) examiners reported that you made a serious error which, if made in actual practice, would have the potential to cause significant harm to the patient. The examiners' comments were:

Station 2

The Candidate lacked key investigations in their response.

In conclusion

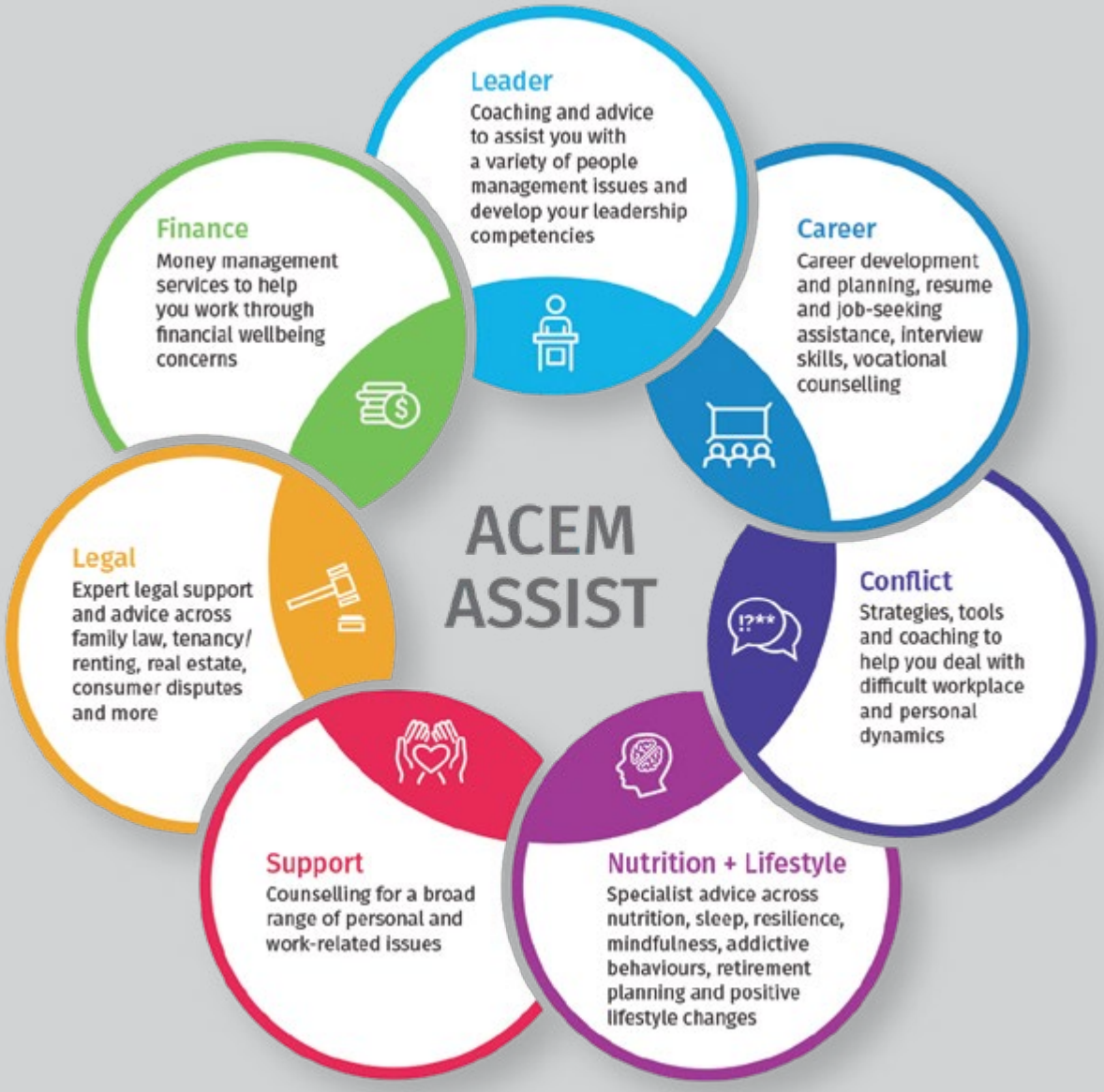
ACEM provides a comprehensive program of feedback that is provided primarily to unsuccessful candidates at the Primary and Fellowship examinations. Further information for the use of all trainees and SIMGs, and their DEMTs, supervisors and FACEM supporters, is provided in associated resources and publications such as the comprehensive reports produced for all examinations. The OSCE reports, for example, provide examiner comments on areas where candidates performed well and where they did not reach the required standard. As such, trends across the examinations, demonstrating optimal examination performance and pitfalls to avoid, are identified in each OSCE report.

Author: Lois Lowe, General Manager, Education Assessment

Assistance program

ACEM Assist

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



ACEM Assist does not replace Crisis/Trauma Counselling

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