your ED

COVID-19 UPDATE

AUSTRALIAN BUSHFIRES
Doctors on the front line

WHAKAARI/WHITE ISLAND
Volcano eruption

GLOBAL EMERGENCY CARE
Vanuatu, Syria and Papua New Guinea

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Australasian College for Emergency Medicine

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

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Message from the Editor

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

When we started this issue, the world was a very different place. We give you an update on the rapidly evolving situation that is COVID-19 and offer you support from the College during this difficult and stressful time. And we remind you all that there is no patient emergency that is more important than your own health.

Our lead feature in this issue follows the work of four FACEMs and their stories as they provided emergency care during the horrific bushfires that ravaged Australia. We hear a unique perspective on the Whakaari/White Island eruption and how a small hospital in Whakatane coped with the influx of critically ill patients.

The Global Emergency Care stories in this issue come from a resource-limited hospital in Vanuatu, the story of a trainee in Syria and training in Port Moresby, Papua New Guinea.

We hope you enjoy these perspectives on emergency medicine.

ACEM in the Media

In **December**, ACEM issued a media statement congratulating joint Buchanan Prize winners for the 2019.2 cohort, Dr Hussain Kadim from the Tweed Hospital in New South Wales, and Dr Andrew Crofton from Brisbane's Princess Alexandra Hospital in Queensland. 'I'm forever indebted to the countless people that dedicated their time and attention to help me become a better clinician through these exams and to win the Buchanan Prize', Dr Kadim said.

The Buchanan Prize is awarded to the candidate who achieves the highest mark in the Fellowship Clinical Examination and is named in honour of Dr Peter Buchanan, who was one of the founders of the College.

'I rang my wife straight away and couldn't wait to celebrate, given the huge amount of support she'd given me throughout my preparation', Dr Crofton said of receiving notification he had been awarded the Prize.

In **December**, ACEM President Dr John Bonning featured in *The Canberra Times* raising concerns about alcohol-related presentations to EDs, particularly on weekends. 'The harm caused by the abuse of alcohol represents not just threats to an individual patient's health but to other patients in the ED, as well as the broader public', Dr Bonning said.

In **December**, testimony from the Chair of ACEM's Geriatric Emergency Medicine Section, Dr Carolyn Hullick, to the Australian Royal Commission into Aged Care Quality and Safety was reported on by the Australian Associated Press (AAP) and syndicated widely across Australia. AAP also reported on elements of ACEM's formal submission to the Royal Commission, noting that, while the majority of transfers of aged care residents to EDs were appropriate, up to 40 per cent could have been avoided through the provision of appropriate care in the residential facility.

In **December**, Dr John Bonning featured extensively in New Zealand, Australian and global media, commenting on the response and aftermath of the Whakaari/White Island eruption.

In a media statement following the eruption and emergency response, Dr Bonning paid tribute to staff in multiple hospital EDs who provided critical treatment and care for the many injured patients.

'I'm also very mindful that Whakatane Hospital and staff, a small regional hospital, has dealt with the brunt of the acute injuries', Dr Bonning said.

'Whakatane rose valiantly to the unprecedented challenge, bearing the brunt of the acute injuries, and stabilising patients for transportation for definitive care.'

Dr Bonning also spoke of his experiences in the Waikato Hospital ED, which treated casualties from the eruption, and continued to advocate for staff at Whakatane Hospital who were still contending with the aftermath of the deeply traumatic event.

'They've had a challenging year with next to no staff, limited resources and not insignificant pressure, as all emergency departments around the country are under. It's just been possibly the straw that broke the camel's back, this particular incident', Dr Bonning told the media of the experience of staff at Whakatane.

'They did tremendously well in receiving up to 30 critical patients. It's just very, very tough on them.'

During **December**, ACEM's concerns about the public health emergency presented by climate change, smoke haze and the Australian bushfire crisis received widespread coverage in Australia and New Zealand.

Dr John Bonning told *The Sydney Morning Herald* that emergency physicians were treating firefighters with smoke inhalation and burn injuries, people with chronic respiratory and cardiac conditions, pregnant women, young children and babies. 'It is also an equity issue, as people without insulated homes, or who are unable to afford air conditioning, are at increased risk', said Dr Bonning.

Meanwhile, ACEM's role as a signatory to a joint statement from more than 22 health and community advocacy organisations urging governments to act on bushfire, smoke and climate change emergency was widely covered by media in Australia and internationally.

'It is logical and reasonable for us, as respiratory health professionals, to act on the strength of the evidence before us. And the evidence is clear: climate change is a medical emergency that is already impacting the health of our patients', said the Chair of ACEM's Public Health and Disaster Committee, Dr Lai Heng Foong, in a joint media release issued with the statement.

In **December**, ACEM Immediate Past President, Dr Simon Judkins, featured on ABC Radio in Brisbane to discuss the notion of delivering more care for patients in community settings. The conversation followed an opinion piece published by St Vincent's Health CEO, Toby Hall, which examined the idea of having fewer hospitals.

'From an emergency department perspective, we see a lot of patients coming to EDs who, if they had been able to access appropriate care in the community, may have been able to avoid that emergency department presentation', said Dr Judkins.

In **December**, Wellington-based FACEM Dr Paul Quigley featured in an article published by *Stuff* examining the prevalence of drinking and alcohol harm among young New Zealanders.

'It's the very heavy preloading at home and before going out that causes the problem. A significant amount of that young group come directly from parties, which are unsupervised, uncontrolled', Dr Quigley said.

In **December**, comment from Dr John Bonning featured in *The Age* in an article examining resourcing issues experienced at rural and regional hospitals.

Dr Bonning said measures were needed to lift the standard of care for patients in rural hospitals, particularly dangerously long wait times for mental health patients in EDs.

'One significant issue faced by many rural and regional hospitals is attracting and retaining specialist staff. This is essential to ensure clinical leadership and quality care for ED patients.'

In **December** and **January**, medical sector news organisation Croakey wrapped its coverage of the 2019 ACEM Annual Scientific Meeting, publishing stories from the conference on topics including: the complex interactions between political action, policy and evidence in the public sphere; the ongoing need for climate action; and embedding cultural safety in health services.

'This is about emergency medicine's role in achieving equity for First Nations people, and calling out racism in all its forms', said the Chair of ACEM's Indigenous Health Subcommittee, Dr Liz Mowatt, in the opening address to the cultural safety session.

In late **December** into early **January**, ACEM featured prominently in media coverage of capacity issues and overcrowding at Darwin hospitals.

In his capacity as Director of Emergency Medicine at Royal Darwin Hospital, ACEM Board member, Associate Professor Didier Palmer, raised concerns, saying more in-patient beds were needed to relieve pressure.

In a media statement on the issue, which was widely picked up by Northern Territory media, Dr John Bonning supported the call for more beds to improve the situation.

'More inpatient beds are the solution; it is not simply a question of managing the fluctuations. More patients are needing admission and we need more beds', said Dr Bonning.

In **January**, FACEMs Professor Diana Egerton-Warburton and Dr Donald Campbell were announced as recipients of the Medal of the Order of Australia (OAM) in the General Division in the Australia Day Honours List for service to emergency medicine and trauma medicine respectively.

Victoria-based Professor Egerton-Warburton said: 'I would like to acknowledge the role of ACEM and Monash Health and University team members in receiving my award. It's really a recognition of everybody I have worked with over the last two decades'.

Queensland-based Dr Campbell said: 'It is a great honour to receive this award, and I would like to acknowledge all of my colleagues who have contributed to the development of trauma services on the Gold Coast and in Queensland. It is extremely rewarding to see the improvement in care and outcomes for our patients that we have been able to achieve'.

In **January**, Croakey published an article by FACEM Dr Clare Skinner outlining a 'wish list' of health system improvements for 2020 and beyond.

'Coordinating change will be difficult – it requires cooperation and collaboration, putting aside differences to build a new system that puts the needs of patients at the centre. It needs clever strategy, political vision and courageous leadership', wrote Dr Skinner in the article.

In **February**, ACEM's call for a calm, unified and respectful approach to the ongoing novel coronavirus situation, in response to racist and xenophobic elements emerging in sections of the community and media, was covered by news outlets including the ABC and *The Guardian*.

'An area of significant concern which has been witnessed by physicians at the frontline of emergency medicine is misinformation, which has been spread among the public, as well as deeply distressing assumptions being made about "Chinese" or "Asian-looking" people, from some patients and families, as well as online, which amount to little more than racial profiling', said Dr Lai Heng Foong.

Dr John Bonning said: 'Any discrimination in the delivery of and access to healthcare is completely unacceptable and needs to be called out and stamped out to prevent healthcare inequity'.

'The coronavirus situation is cause for concern; it is cause not to be complacent, but it is not cause for panic and division.'

In **March**, ACEM continued to monitor the ongoing coronavirus situation, advocating publicly on issues of importance to members and trainees as needed. In a media statement, which was picked up by *The Guardian* and the Nine newspaper group in Australia, the College acknowledged hospital EDs and their staff have a crucial role to play in addressing the ongoing COVID-19 situation, and called on governments in Australia and Aotearoa New Zealand to do everything possible to support and sustain frontline efforts. 'The whole of our healthcare systems from primary care through to and beyond hospitals will have to rise to this challenge, with all healthcare professionals working within their scope to mitigate the surge', said Dr Bonning. 'To support the ongoing response to COVID-19, we are calling on all governments to provide the resources, policies and measures necessary to mitigate risks to the community and healthcare staff, and ensure frontline efforts are sustainable.' In Aotearoa New Zealand, Dr Bonning was interviewed by Newshub, encouraging a calm response to the situation and advising against panic buying.

'We need to be rational about this, and there's a lot of irrationality going on out in the community', said Dr Bonning.

PRESIDENT'S WELCOME

Kia ora koutou katoa

What a year 2020 is turning into, not quite what we expected, even as recently as February when this editorial was first written as were the bulk of the articles, some about critical life-changing events that occurred in December and January. Then in March the world changed. Although the changes had been building since December, I do not think many of us appreciated the enormity of the changes. Whilst COVID-19 is consuming every waking moment of every single one of us and will do for many months, we elected to not re-write the entire magazine; not in some sort of denial, but as an acknowledgment of what our world was like pre-COVID-19 and what it will return to when we have weathered this storm.

It has indeed been an extraordinary first few months of this year and this issue of *Your ED* contains some stories that really go to the heart of emergency medicine. For now our hearts and minds and lives are occupied by COVID-19, which has upended health systems and the world as we know it. Given this impact we've felt it crucial to include an update on coronavirus and how we are all being impacted at work and at home, and how the College is working to provide members and trainees with support in this fluid and rapidly changing time. We will have more stories about our emergency medicine people; their EDs and experiences in the thick of this pandemic crisis in our two counties in later editions of *Your ED*.

My wife and I have recently made a commitment to talk about our days as 'productive', rather than 'busy'. Everyone is busy – and maybe in emergency medicine more so than most, and busy can be interpreted as overwhelmed. But productivity echoes the fact that we're striving toward something, aiming to better ourselves, our workplaces and our patients' lives, putting some reward and positivity to the descriptor.

The results summary of the *2019 Sustainable Workforce Survey*, reiterates the stressors we face in access block, overcrowding and relations with inpatient teams. One thing that stays in my mind when I think productivity, is sustainability. This survey highlights clearly that the ways we are working now, our utilisation of healthcare resources, are not how we can continue to work. It's not sustainable.

We must find ways to reduce the high levels of burn out, to improve prospects of career longevity and reduce stress. Some of the key stressors include access block and ED over-crowding, where much of our (hospital) organisational risk is concentrated in the ED and not shared around the rest of the hospital. In this issue there is a piece profiling some members of our rural workforce. The article touches on the work of Dr Simon Judkins and the ACEM Workforce Planning Committee, which has been set up to oversee our existing policies on workforce and deliver long-term solutions to address some of the issues affecting workforce, including maldistribution.

The full survey report is on the College website, which I'd encourage you to read. These are issues we cannot confront in isolation – the more informed each of us is about the state of our workforce, the better prepared we are to advocate for change in the health system and the ways we can be productive.

This issue also sees members bravely recall their experiences of Australia's devastating bushfire crisis and the Whakaari / White Island eruption. Events such as this reinforce the potency of the natural world – and the precipice we find ourselves at as stewards of that natural world. I want to thank everyone who has been involved in the response to the bushfire crisis and the 2019 Whakaari/White Island catastrophe. Crisis rarely unites as it has for both these tragedies. I'm also aware of the quiet soul searching many go through after these horrific events. I encourage you to please seek support where you need it. Put your hand up. We're here.

In these extraordinary times I want to take this opportunity to remind everyone of the College's core values and the available training module for those values. A lot of hard work went into the development of both. It's easy to see the values – integrity, respect, collaboration and equity – and imagine they are in place and that they are embedded. Then a bushfire crisis happens, and these values come to the fore. Crisis brings out the best in us – but you never really know what anyone is going through. It is now more important than ever before to be kind to yourselves and to others.

The stories here are about people in emergency medicine. I hope in this unprecedented time you can find hope and renewal in these stories of all the positive work we do right around the globe

Be safe – as safe as you can be.

Kia hora te marino
Kia Whakapapa pounamu te moana
Hei haurahi mā tātou i te rangi nei
Aroha atu, aroha mai
Tātou i a tātou i nga wā katoa
Hui ē. tāiki ē.

Figurative Translation:
May peace be widespread
May the sea be smooth like greenstone
A pathway for us all today
Give love, receive love
Let us show respect for each other
Hui ē. Tāiki ē.

CEO's Welcome

Dr Peter White

Welcome to the fourth edition of Your ED, the first of the issues planned for 2020. Already this year appears to be passing quickly, and it is clearly one that will remain in our memories for a long time. The original version of this column was written in the middle of February when welcome rains were being delivered down the East Coast of Australia. This was, of course, in strong contrast to the catastrophic fire events that preceded them and combined with the tragic events of White Island, the transition from 2019 to 2020 was already a time that was not going to fade quickly from the memory of a significant number of people.

And then along came COVID-19, and how everything changed again. It is now early April; College staff are working from home, Zoom is a seemingly ever-present feature of people's lives and we are witnessing a situation that is testing the resourcefulness of all. From an ACEM staff perspective, there is always the appreciation that working at ACEM means the opportunity to make difference everyday supporting the people who deliver emergency care to the community. The appearance of COVID-19 has reinforced this and all ACEM members can be assure that College staff are doing their utmost to provide the best support they can in these uncertain and rapidly changing times.

Your ED was conceptualised and introduced as a way of highlighting to the ACEM membership and anyone else interested in the work of ACEM, the range of activities that the College, its members, trainees and staff undertake. Too often it is easy to become drawn into the things that may not be going as well as you would like, or rail against the observation that something desired deeply or believe in is either not being done, or not being done as it should. What Your ED is designed to demonstrate on a regular basis is the good that the College and the profession of emergency medicine is doing in all the communities that ACEM is able to make a difference and the way in which ACEM is working hard to better those communities, as well as make itself a better organisation.

A look through the contents of the editions to date and the contents of this fourth edition gives me faith that the magazine is doing that. Sure, we can, and we will, refine the sort of information being conveyed over time, and we can make sure that anyone who receives the magazine and makes us aware, receives it in e-copy, rather than hard copy, notwithstanding the efforts that go into ensuring the production and distribution process is best practice from a social responsibility perspective. But at the end of the day, if you are reading this as an ACEM member, a trainee or a member of the community, the intention is to make you aware of the work that is being done for you by an organisation committed to making a difference in a way that ensures it is seen as relevant, responsible and effective.

The ACEM Board has just had its first scheduled meeting for the year, as well as others since the COVID-19 pandemic has unfolded. It is satisfying as a CEO to work with a group of committed individuals who take their roles seriously and are willing to understand the issues facing organisations, such as decisions that need to be made in the face of a global pandemic, to future College accommodation needs and the ways in which the challenges of best approaching the future ICT needs of an organisation like ACEM can be met. These are not necessarily straightforward issues and the Board is cognisant of the need to balance all the considerations involved in these and other complex matters that require decisions.

I do hope you enjoy this edition of *Your ED*. As always, the College welcomes your views on the magazine, and my thanks to those of you who contributed your views already. These are difficult times and your college stands ready to do the best it can to support you all as a unique situation unfolds across the globe.

COVID-19

Latest updates
acem.org.au/covid-19

As emergency doctors we stand front and centre in the public health response to coronavirus. In this unprecedented environment our roles are more important than ever, and we must look to ourselves, our colleagues and our healthcare and hospital systems for the strength and support to prevail.

Dr John Bonning
ACEM President

The Australasian College for Emergency Medicine acknowledges the COVID-19 situation is evolving rapidly, with significant impacts on our lives, work, communities and families. We stand with all members, trainees and College staff at this difficult time.

The College is continuing to monitor the situation and is looking to provide as much information and support as possible as the situation develops. You can find the latest updates and resources from the College at our dedicated webpage below.

Thank you all for your efforts to date and those still to come.
There are many challenges ahead, but together we can meet them.

acem.org.au/covid-19

Update from the College President on COVID-19

Dr John Bonning
Dr Bonning is President of the Australiasian College for Emergency Medicine, Director of the Department of Emergency Medicine at Waikato Hospital in New Zealand until 2017 and Chair of the New Zealand Faculty of ACEM until 2018.

The coronavirus situation has rapidly evolved through early-2020 to become an all-consuming theme; and this will remain the case for the foreseeable future.

Perhaps more so than any single event in many of our lifetimes, the spread of this pandemic has had far reaching impacts on our lives, work, families, communities, nations and world.

We must in no way underestimate the gravity of the situation; there are already international examples of where political hubris, and lack of urgency, have contributed to some truly dire circumstances.

By the same token, we should have confidence that with the right approach, guidelines, policies, planning, responses, and support we can give ourselves the best possible chance of weathering this storm across our two countries.

Within this unique situation, we as emergency doctors are centrally placed at the frontline of the public health response.

There have already been many significant challenges, and in such a fast-moving situation there will be many more.

The pressures, stressors, concerns, and trepidation felt by many are of significant. We are only human, and to feel this way is completely natural.

But it is also important to remember what we have, and how we can use it.

Our roles as emergency doctors are more important than ever, and the fact that so many emergency physicians have been drawn into leadership roles in the planning and response effort to this pandemic stands as testament to that.

We can draw strength from that, but it is also important that we look after ourselves and preserve as much as possible the vital resource that is the frontline healthcare workforce.

We must continue to show support and compassion to ourselves, our colleagues and our patients in these most challenging of times.

This is what we train for as emergency physicians. It is up to us to continue doing our jobs; making the tough decisions about resource allocation, treatment and management options and the best way to care for patients while keeping ourselves and colleagues as safe as possible in life and death situations.

I know we are up to the task.

Support from your College

With so much to take on board and so many variables in the current environment, the College is eager to support you and help you navigate this fast-changing situation as best we can.

To that end, the College has been working hard to provide all members and trainees with a repository of the most current and useful resources, information and updates on College activity in relation to COVID-19.

A key component of this is the release of the *Clinical Guidelines for the management of COVID-19 in Australasian emergency departments*, which are the result of the intensive efforts of 20 FACEMs across Australia and New Zealand as well as College staff, in collaboration with Safer Care Victoria.

As the situation evolves, so too will this document. I encourage you to regularly familiarise yourself with it, as well as the other updated information, centrally housed on the College's dedicated coronavirus website – (acem.org.au/COVID-19).

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

On this website you will also find information and updates in relation to College events, activities and examinations, which have been necessary as a result of the evolving situation.

We remain particularly mindful of the inconveniences created for trainees by some recent decisions taken by the ACEM Board in relation to examinations. While these were deeply considered and necessary due to circumstances beyond any of our control, we remain committed to providing as much certainty and flexibility as possible to all members and trainees in the weeks and month ahead.

The College will also continue communicating with you, and providing as much notice as possible in relation to future developments and changes, should they occur. If there is something you need, then please let us know.

Preserving safety of the frontline workforce

Although there are many evolving variables in this fast-moving situation, there are certain components that must remain constant and are not up for negotiation.

Key among these is keeping our frontline medical workforce safe. As we have already seen internationally, as well as in Australia, where frontline medical staff have contracted COVID-19 (and we know we will see more of it), the risks to our personnel are significant.

This is deeply worrying, and once again reminds us that there is no patient emergency more important than the safety of our healthcare workforce.

The safety of the frontline healthcare workforce must be a key priority in the ongoing planning and response to COVID-19. We have put it in the strongest possible terms, both through official government and public media channels, that a key priority must be ensuring the ongoing adequate supply and security of Personal Protective Equipment (PPE) for frontline medical staff, as well as ongoing training in its effective use.

PPE must be used in accordance with clinical best practice to look after patients; and it is healthcare workers' PPE needs that must be the primary consideration here, rather than having their approach dictated by supply.

Our healthcare systems in Australia and New Zealand cannot function without healthcare workers, and preserving safety on the frontline will remain a key focus of the College.

Maintaining wellbeing

While protection from the virus must be a key consideration on the frontline, so too is preserving our mental and physical wellbeing in light of the significant additional pressures we, our families and communities are facing.

I know it can be difficult in the circumstances, but please do try to find some sometime for yourself; exercise, stay nourished and hydrated, and stay in contact with your friends, families and networks.

One key part of that network is the College, and I would like to remind members and trainees that the College has a Wellbeing Network from which you can access resources, a discussion forum and information regarding the Converge International assistance program for coaching and counselling. In addition, staff in the ACEM Membership and Culture unit can connect you with external resources, initiatives and advocates in your region.

At times like these, people want compassion, stability, trust and hope. By continuing to do our jobs as well as we do, and looking after ourselves and each other in the process, we can continue to provide precisely that.

Once again, thank you all for your ongoing efforts. I have faith we can continue meeting the challenges ahead.

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i More information

You can contact the ACEM Membership and Culture unit via wellbeing@acem.org.au or +61 3 8679 8860.

New Proposed Advanced Diploma to Address Emerging Needs

In 2008, ACEM's Council convened a Working Party to develop a proposal for the provision of emergency medicine education for the large group of non-ACEM Fellows and trainees working in Emergency Departments (EDs) across Australia and New Zealand. Led by FACEMs, including Associate Professor Tony Joseph, Dr Elizabeth Mowatt and Associate Professor Sally McCarthy, this work was to ensure the College's role in setting standards for emergency medicine training. Education extended to Career Medical Officers, Junior Medical Officers, General Practitioners and Rural Generalists involved in providing emergency care in hospitals across Australia and Aotearoa New Zealand. This work was realised in 2011 with the introduction of ACEM's Emergency Medicine Certificate (EMC) and in 2012 with the Emergency Medicine Diploma (EMD). These programs have proven to be very valuable initiatives, with over 1,200 doctors completing the EMC or EMD since their inception. With almost a decade since the launch of these programs, their review is timely, particularly with regard to their alignment with future workforce and training needs.

An EMC and EMD Review Working Group was established in 2018. This Working Group, coordinated by ACEM, includes representation from the Australian College of Rural and Remote Medicine (ACRRM), the Rural Faculty of the Royal Australian College of General Practitioners (RACGP), and the Division of Rural Hospital Medicine from the Royal New Zealand College of General Practitioners (RNZCGP).

Following a busy year of meetings, the Working Group has now developed a revised three-tiered nested structure, which, along with the EMC and EMD, will include a new Emergency Medicine Advanced Diploma (EMAD). Each of the three proposed competency-based training programs is designed to be completed in a minimum of six months Full Time Equivalent (FTE), such that the knowledge and skills progressively build upon each other from one training program to the next. The revised structure is intended to increase the flexibility and accessibility of the programs.

In reviewing the existing programs, the Working Group has considered future perceived workforce needs and forecasts, and the need to ensure robust training and associated programs are available for the many non-emergency medicine specialists who provide emergency care across Australia and Aotearoa New Zealand. The new EMAD provides a qualification that fits well within the advanced skills requirements of rural generalist training. The EMAD suits those wishing to lead and develop smaller non-ACEM-accredited EDs within a peer-supported ED network, with access to specialist emergency physicians. Within specialist-led ACEM-accredited EDs, changes to the supply of a trainee workforce are likely and need to be planned for. The proposed changes via the EMC, EMD and EMAD programs provide a pathway for the training and credentialing of Career Medical Officers in larger EDs in the future.

We have developed a revised set of qualifications, which I think will serve the College well over the coming years in its mission to ensure all communities across Australia and New Zealand have access to appropriately skilled doctors providing emergency care.

***Author: Associate Professor Didier Palmer**, Chair EMC and EMD Review Working Group*

Summary of the revised EMC and EMD and new EMAD

	Audience:	Will acquire knowledge and skills to:

EMC Minimum six months FTE	• Doctors working in a small ED with access to off-site advice and rapid access to on-site critical care
	AND/OR
	• Doctors working as part of an ED team with senior assistance available on the floor
		• Treat common emergency presentations relating to:
		  • Prioritisation
		  • Risk management
		  • Detecting red flags of serious illness
		  • Undifferentiated patients
		• Carry out initial focused assessment

EMD Minimum 12 months FTE	• Doctors working in a small ED with access to off-site support but *without* rapid access to on-site critical care support OR • Doctors working as part of an ED team where they are a senior decision-maker	• Stabilise critically ill and injured patients • Provide safe sedation for emergency procedures
EMAD Minimum 18 months FTE	• Directors of a non-accredited ED (not accredited for FACEM training) OR • Doctors working in an ED as senior decision-maker, involved in education and management	• Use ultrasound as appropriate • Use a wider variety of resuscitative and other emergency techniques • Improve their practice, practice of junior members, and practice of emergency medicine in their environment

Notes: The Working Group undertook a consultation process for the revised curricula and training programs between January and March 2020.

2019 Sustainable Workforce Survey Report

The findings of the latest Sustainable Workforce Survey have been released, with clinical work, teamwork and work variety reported as the most enjoyable aspects of emergency medicine (EM).

In February this year, the College released the *2019 Sustainable Workforce Survey Report*, the latest of a series of reports seeking to understand the issues that impact on the sustainability of the EM workforce, and the mechanisms that promote EM physician and trainee health and wellbeing.

For the purpose of the survey and report, a 'sustainable' workforce is one in which emergency doctors are able to maximise their health, professional satisfaction and career longevity, thereby optimising their ability to meet the EM care needs of Australia and Aotearoa New Zealand. The ability to meet the needs of a sustainable workforce can also contribute to improved work-life balance. This was identified by respondents as a key factor for reducing clinical hours.

There were 806 respondents, most (78 per cent) were FACEMs. A typical respondent to the survey averaged 44.2 hours of work per week, with 39.7 of those hours paid. Most (90 per cent) work in public hospital EDs and almost half (49 per cent) of FACEMs reported working in more than one workplace.

Conducted over six weeks in mid-2019, the survey's findings, in many ways, mirror its 2016 predecessor, the *ACEM Workforce Sustainability Survey Report*. Respondents to both surveys identified access block, overcrowding and conflicts with other clinical teams as their three greatest stressors at work.

Employee Assistance Programs (EAPs) were far more visible for respondents in the 2019 survey, with 399 respondents (50 per cent) reporting access to an EAP or counselling service, compared with 121 respondents (11 per cent of 1,187) in the 2016 survey. Respondents who obtained their primary medical degree in New Zealand were most likely to report their workplace offers an EAP or counselling – 80 per cent compared with 56 per cent who obtained their primary medical degree in the UK, 48 per cent who obtained their degree in Australia and 45 per cent in another country.

A holistic approach

The 2019 survey was designed to deliver a more holistic understanding of the state and sustainability of the specialist EM workforce, incorporating aspects of the *2017 Discrimination, Bullying and Sexual Harassment (DBSH) Survey*. These questions related to DBSH behaviours perpetrated by both professional colleagues and patients, with 41 per cent of respondents reporting experiencing DBSH behaviours by a patient in the past 12 months, and 39 per cent by a professional colleague. Bullying was the most heavily reported behaviour.

The percentage of female respondents who reported experiencing DBSH by a patient or carer in the past 12 months decreased steadily with age, but that percentage remained relatively constant for males across age groups.

Future plans

A significant number of respondents reported planning to reduce their clinical hours in the next 10 years, with many citing improved work-life balance or unsustainable workplace conditions, requirements or pressure, as their primary motivations. Twenty-five per cent reported being likely to leave clinical practice in the next 10 years, and 27 per cent reported being likely to leave EM in the next 10 years. More males responded this way than females.

Despite the smaller response rate compared with previous similar surveying activities, the findings from the *2019 Sustainable Workforce Survey* suggest that a significant number of our members and trainees continue to experience stress and personal and work-related burnout. However, the report also shows that a large number of members and trainees continue to find personal satisfaction with EM as a profession.

The College recognises, more than ever, the role that culture and civility are playing in the sustainability of the workforce. Its commitment to empowering positive culture is found in its 2018 introduction of the ACEM Wellbeing Award and the 2019 launch of ACEM Core Values (equity, respect, integrity and collaboration). These initiatives sit side by side with the College's continued commitment to advocate for health system reform and fixes to ramping, overcrowding, access block and other issues affecting the EM workforce.

The full 2019 S*ustainable Workforce Survey Report* may be accessed on the College website (ace.mn/sws19).

***Authors: Natasha Batten**, Campaign Advisor, and **Katie Moore**, Manager, Research*

More information

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This issue of *Your ED* also contains a feature on the rural workforce. Read more on page 12.

An online learning module about ACEM's Core Values is available on the College website: https://acem.org.au/corevalues

Rural Workforce: Practice as it's Preached

Is moving rural a solution to a sustainable future?

Immediate Past President, Dr Simon Judkins, is keenly aware that there are many regional and rural posts crying out for specialist emergency physicians.

Before he assumed the role of College President, Simon was a regular in the Emergency Department (ED) at Albury Wodonga Health. 'It's a different experience – a different role [to his role at Austin Health in Melbourne's north east]. I can be a lot more hands on.'

Despite significant growth in the overall number of FACEMs in the past decade – 93 per cent from 2011 to 2018[1] – just 21 per cent of FACEMs in 2018 reported working primarily in a regional centre, with another nine per cent dividing their time between regional and metropolitan workplaces.[2]

As he refocuses his role as an emergency physician, Simon is also commencing work as Chair of ACEM's new Workforce Planning Committee, designed to oversee the College's existing workforce policies and deliver long-term solutions that address significant workforce issues – including maldistribution.

The lack of FACEMs and trainees in rural and regional centres has significant impact – and one of the concerns Simon and his peers have is the adverse effect on the sustainability of the workforce, as well as ensuring regional and rural communities have access to high-level emergency care.

But there is a cohort of FACEMs who have moved to rural or regional locations and found the good life – an upside to their work-life balance and positive opportunities for career growth and development.

One FACEM who made the move is Dr Michael Davoren, who took up a position at Wagga Wagga, New South Wales within six months of completing his training in the Newcastle/Hunter network.

'Four years on and I have no regrets and no plans to move back.'

Michael says there have been opportunities in Wagga Wagga he doesn't think he would have received in metropolitan centres, including for his family.

'The way my family have been embraced by the community and so thoroughly integrated has really been critical, and it means we are all extremely happy here. It's not just me who is getting satisfaction from this move. It is something I think rural communities do really well; the family is as important as the clinician.'

Professionally, Michael works closely with the two university medical schools and has co-developed and led an ED skills training program for the region's rural generalists, GPs and GP trainees.

'I've also become a DEMT, all within a relatively short period of time post-Fellowship.'

Michael was attracted to working in Wagga Wagga by the opportunity to be a part of a growing department. He also sees the ED providing a higher level of care and management as patients may wait longer for specialist treatment or transfer to a metropolitan centre.

'Because of those waits, you have to provide more of the ongoing management for the seriously ill or injured patient', Michael says.

He has found that working in a rural ED often means also providing medical support to a large 'virtual' department.

'You provide remote and critical care support for the large number of surrounding hospitals – often run by GPs and nursing staff. We support the amazing work by those staff at smaller sites and then provide ongoing management when the patient arrives in our department.'

He says, although these situations are often incredibly challenging, they are also typically very rewarding.

'To be able to support those smaller sites and communities is something I really enjoy and appreciate.'

Michael also enjoys being so hands-on.

'I think you find in metropolitan areas that there are fewer hands-on opportunities. There is your patient load, but you also have other responsibilities and pressures that reduce your ability to do that hands-on clinical work. You really use all of your training here.'

His sentiments are echoed by FACEM Dr Jay Mueller, who has been working at Mt Isa, Queensland for the past six months following a three-year stint at Albury Wodonga.

'I fly in, fly out. I live in Brisbane but work at Mt Isa and I am really happy to do so. For me, it has really stripped back the experience of practising medicine to what I think we train for and find most satisfying – being clinicians.'

He says working at Mt Isa Base Hospital enables him to practise medicine imbued with clinical procedures, autonomy and patient interaction.

'It's a really elegant form of medicine that we learn. Working rurally, you do not necessarily have the resources of a city hospital, but you get these great opportunities to practise that really elegant medicine.'

Jay is from the US, where he worked and trained in tertiary centres in New York City and Boston, Massachusetts, serving largely indigent populations.

'There are a lot of pressures on productivity, it's about throughput and customer service.'

'I prefer working in a place where the work can be about the clinical outcomes and the clinical experience.'

Another FACEM who made the move is Dr Melanie Berry, a staff specialist at Orange, New South Wales.

Mel moved as she entered her last year of training – a move she thought was risky but has no regrets about.

'My son was about to enter school and we wanted to give him time to settle in before he started. I was a bit worried, but


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I went from being one of 30 trainees at a major metropolitan hospital, to one of two.'

She found considerable advantages completing her final year of training in Orange, including greater one-to-one teaching opportunities.

'There is a really vibrant community of FACEMs here; young and enthusiastic teachers.'

Mel says the FACEMs went to great lengths to ensure she didn't miss out on any opportunities.

Now a FACEM, Mel is keen to continue the positive teaching culture at Orange, but data shows that the likelihood of training rurally is also quite remote. The *2018 FACEM and Trainee Demographic and Workforce Report* shows only 17 per cent of trainees completing the FACEM Training Program in Australia reported their primary place of training was a rural or regional hospital. Eighty-one per cent were training at a metropolitan public hospital, and two per cent at a metropolitan private hospital.

Orange currently has six FACEM trainees and two Australian College of Rural and Remote Medicine trainees.

Mel recognises that as regional/rural services go, Orange is quite well-equipped. She accepts living in a small town has its downsides – opportunities for her husband's career progression have been harder to find, and familiarity walking down the street is a challenge to confidentiality.

She says balance can be hard to find at smaller sites. 'You have one or two FACEMs serving a town; that means when you are on-call you are always heading into the hospital. You never really get a break.'

Mel says there are opportunities for change in the culture of working rurally – that once a few people make the move and have a positive experience (good rostering, varied work, options and opportunities for families), others will follow suit.

'Set up correctly, it could really be a self-fulfilling prophecy.'

Certainly, that is the case for Simon, who is soon to resume working shifts at Albury.

'They seem to need me, want me to come back (I hope!). I certainly need them.'

He's been invited to spend time in other regional EDs as well and hopes to make his way to as many as possible.

'There are often a lot of opportunities available through locum agencies, but it's great to use your networks or make connections directly with the department.'

'Tap someone on the shoulder. Go down and make yourself useful. Make a long-term commitment. The community you find and the experience you have will reward you. You will not regret it.'

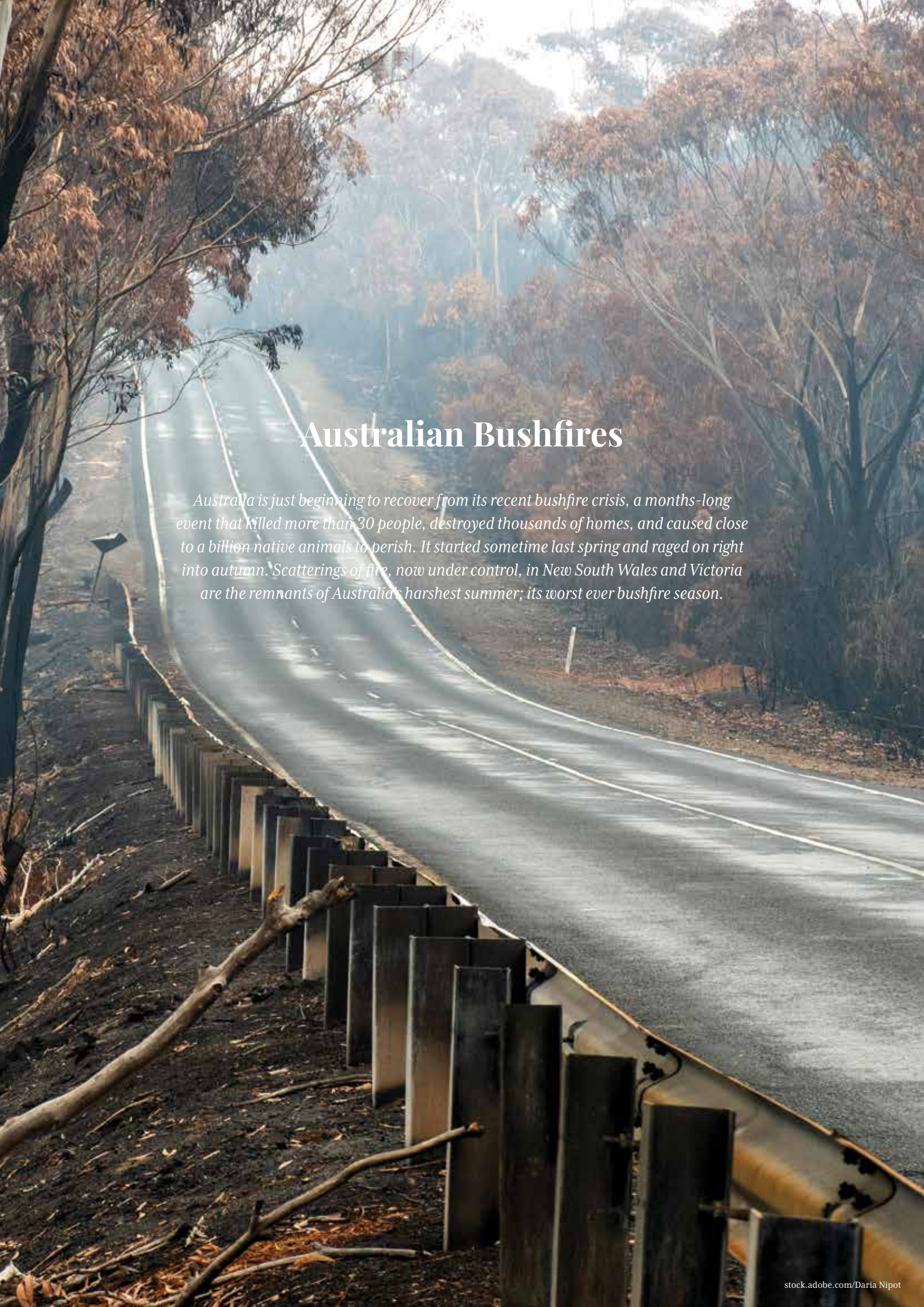
***Author: Natasha Batten**, Campaign Advisor*

More information

2019 Sustainable Workforce Survey Report: ace.mn/sws19

References

1. 2018 FACEM and Trainee Demographic and Workforce Report. ACEM, Melbourne.
2. 2019 FACEM and Trainee Demographic and Workforce Report. ACEM, Melbourne.



Australian Bushfires

Australia is just beginning to recover from its recent bushfire crisis, a months-long event that killed more than 30 people, destroyed thousands of homes, and caused close to a billion native animals to perish. It started sometime last spring and raged on right into autumn. Scatterings of fire, now under control, in New South Wales and Victoria are the remnants of Australia's harshest summer; its worst ever bushfire season.

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Dr Michael Hall

Dr Hall is a Senior ED Specialist and DPET at Canberra Health Services. He has a keen interest in clinical leadership, toxicology and searching out the grey among the black and white.

Dr Hall spoke to us about his experience in the Australian Capital Territory during the recent fire season. This is his firsthand account.

November 2019

Emergency Department (ED) life is normal. That is, it's a cluster of unwellness and undifferentiated problems, cloaked in the wrapping of National Emergency Access Targets (NEAT), Australasian Triage Scale (ATS) performance, did-not-wait (DNW) rates, access block and admission processes. It's hard to sort what matters to us, to the patients, and to the hospital. So … normal.

December 2019

The east coast is on fire. Fires in Queensland, fires in New Soulth Wales. I find myself fascinated and horrified all at once. The scale of the flames, the tireless efforts of the firefighters, the disruption to communities. But it's abstract, distant. Normal life in Canberra ED is unchanged. The ground is brown and dry, the garden is parched, and the creeks are empty, but life is normal. Patients everywhere, flow challenges, teaching sessions, Christmas parties. Most people seem unaffected by the flames around Braidwood on the distant horizon. We sympathise with our registrar who has a property there and sends us pictures from his deck. We listen as the firefighters work to save Bawley Point. For some of us, there's this little niggle. A feeling that maybe this summer is different. A tipping point.

The smoke has come. The mountains have vanished. The sunsets are beautiful, but everything is covered in a mild haze. The hot northwesterly wind will blow it away, but the normally restorative sea breeze brings it back every afternoon. We think it's bad, but we don't know what the next month will bring. There's discussion about air purifiers and the safety of exercise, but most people shrug and continue.

We travel to Tasmania. It's green and beautiful, and the air is so clean. We sleep deeply and imagine we live in a time when smoke and fire weren't part of summertime life. We see the forecast of multiple 40 degree-plus days in Canberra, and wonder whether our clean, beautiful city can manage this. We get home to baking heat, relatively immune to the smoke haze due to the winds. Canberra's hottest day, twice in a row, and the fires creep closer, and time passes.

It's Christmas Day. We go for a picnic at Honeysuckle Creek in Namadgi National Park. It was closed for the heatwave, but it's cooler now, although still surrounded daily by dense smoke blown from the coast. All campgrounds are closed but we sit in the picnic area as the only visitors that day wondering again, if something's changed. This place housed the telescope that beamed the pictures of the moon landings, but now it's all about the curing levels of the grasslands, the prevailing winds and the air quality. We get used to barely being able to see the local hills, but life continues, still unchanged. The hospital is quiet, with Canberrans escaping to the coast, or to the mountains.

It's New Year's Eve. The warnings are off the scale. There are catastrophic fire warnings for the coast, and the mountains, and in a lot of places. There are no fires near Canberra, but people start to prepare. Queues at the petrol station, bottled water being sold by the pallet. And it starts. Reports from Bateman's Bay, Mallacoota and the Snowy Mountains. A cacophony of noise, with traditional media lagging way behind social media sites. It's impossible to take your mind off it. We hear, read and watch, as peaceful, relaxing communities become chaotic places battling for survival. We wonder and worry for our rural colleagues, and find ourselves looking for something we can do, while struggling to do the often mundane daily things we must do.

In Canberra, it's extreme heat, but a relatively clear sky. New Year's Eve fireworks are cancelled, like much of the east coast, and people are staying in a bit more. There is a cool change forecast, with warnings that the smoke may be stronger. A bit thicker. The change comes. The clouds of thick smoke roll across the city like dust storms in the desert. For five minutes, there is a cool breeze with a towering wall behind it, then it sweeps across. It is thick and acrid, and smells of ancient forest and climate calamity. Eyes water, throat burns, and driving home is like the thickest winter fog, punctuated by eerily silhouetted kangaroos desperately trying to find green grass. In the morning, the city is uniformly grey, and almost silent, except for the queues of people trying to visit a shop for the long sold out air purifiers that most people didn't think they could ever need.

The hospital smells. There is smoke everywhere, even in resus. This is NOT normal. The hospital should be a refuge, a place of sanctuary, but although there is no direct threat, nothing in Canberra feels like that anymore. There is confusion. Some staff wear masks, patients request them, the public present to triage asking for them, or taking them from the bench and leaving. The calls start to come. Transfers, advice, a slight sense of desperation. Knowing that there is a much bigger story than ISBAR (clinical handover tool) can hope to convey.

Structured handover somehow doesn't seem enough anymore. You feel as though you must open the conversation to enable them to share the experience. Logistics of moving patients through fire zones and closed roads means long waits and incredible work done by rural communities. One of our consultants needs a police escort to get his coastal ED to work. We put together emergency burn and dressing supplies for a rural hospital that's run out.

The world calms. Smoke, closed roads, local stories of crisis and drama, without specific challenges. Life becomes a cycle of smoky days and tracking air quality measures. Everyone seems to have a story; a need to tell, to share and just be there with each other. Normal patient care happens, but other things seem somehow less important. The pub is busy, the walking trails almost deserted. It's a warm afternoon, but not crazy. I sit in an office on Level 10, the mountains sunburnt but beautiful on the horizon. It's clear for a rare change.

The world changes. A puff of smoke, frail initially, then bigger. Within two hours, there's a billowing column filling part of the sky. The wind picks up. The inferno that will destroy the natural wonders of the ACT cannot be stopped. We pause, with an inner gasp, and a sense of foreboding. The fire has come to us. For some, the weeks of smoke and fire smells has slowly built to a sense of overwhelming anxiety. For some, this has happened before.

January 2003

A younger version of myself drives over a hill. In the distance, you can see the billowing smoke in the mountains. A huge fire front about 30km long sits in the distance. It's been there for days. The city watches and barely notices as day-to-day things happen. This is scary, but it cannot affect us. The wind howls. It feels wrong, but we don't yet know what the day will bring.

My family and I go to the movies. When we leave, the world is different. It's pitch black at 2:00 pm. There are flames on top of the local hill, in the middle of the city. There is a gasp from the crowd, no one seems to know what to do. I ring the hospital to see if they need help. No, it's fine they say. I head home, constantly scanning the darkening sky. The air is full of sparks and ash. There is no power to our suburb and a mere trickle of water from the taps and hoses.

We grab our most precious possessions (and argue about whether the extended edition of Lord of the Rings and new DVD player can really count) and leave for the only place of safety we can think of, the hospital. The traffic lights are out. There are fires in the suburb, but we escape to the same Level 10 office that I will sit in 17 years later, watching the world explode again. The code brown goes off — external disaster — and I head down to the ED to help. It's chaos, yet amazingly calm.

The sickest patients arrive in the first five minutes by private car, and then we just have what seems to be suburbs full of people with sore eyes, breathing problems and minor fall injuries. I have a cast on my wrist, yet somehow think it's fine to be attempting one-handed femoral stabs on the 'undrippable' patient. It's that kind of day. I call Sydney to try and organise a transport out for a patient with paracetamol toxicity and established hepatic failure. The Sydney call centre states, perhaps ironically, 'You do know that Canberra is on fire, right?'.

The 2003 fire was sudden, dramatic and entirely unexpected … but it was quick, and it came and left. The 2019/2020 fires just festered, and grew, and inexorably expanded until lives were filled, resilience sapped, and normality was rewritten. 2003 was more dramatic for Canberra itself, but somehow, for the hospital at least, infinitely more manageable.

January 2020

The Orroral fires have only been burning for hours. We sit on the ridge behind our house, watching towering columns of smoke. The darkening sky reveals the extent of the flames on the local hills. So close, yet just out of reach. We watch the tiny firefighting aerial team, seemingly powerless against the monster. For days, we see the ebb and flow of the smoke and the flames, as it expands, and crawls along the ridge, seemingly in all directions at once. Could it reach into the city again? Are we more prepared than last time? The inattention of 2003 has been replaced with an obsession with detail; fire updates and endless management briefings. We have plans, and subplans, and master plans, but who knows. A simple look at the horizon tells us the power of this thing. If it comes into the city, is a plan going to stop anything?

Late February 2020

The Orroral fire is declared out! Such a simple word, but so powerful. For now, the fire has gone. But more than 50 per cent of Namadgi National Park is destroyed and it will be months before it reopens. The majority of the historical and tourist sites have been protected, but the bush itself, the animals, and the water catchments, are damaged to a degree that would never have been thought possible.

The hospital smells. There is smoke everywhere, even in resus. This is NOT normal. The hospital should be a refuge, a place of sanctuary, but although there is no direct threat, nothing in Canberra feels like that anymore.

This event has been unprecedented for us. As a city, and a department, we have survived pretty much entirely unscathed. While thousands around the country have lost homes, and countless families have lost loved ones, we have sat in our modern city, with power, air conditioning and running water. But we have also lost, and we are changed. The feeling is tiredness, exhaustion and perhaps resentment at a summer stolen. There is the feeling that this can, and will, happen again, and that we have to consider our place and our practices in this changing world. I think it has drawn the ED community, the hospital and the city closer together. This is not just a place of work, but a place of safety, fellowship and sanctuary for us, and for the people and patients from the surrounding region. It has shown again that emergency medicine is more than KPIs; it is a collection of stories. Our stories, our patients' stories and our families' stories.

March 2020

ED is again a cluster of unwellness and undifferentiated problems, cloaked in the wrapping of NEAT targets, ATS performance, DNW rates, access block and admission processes. So … normal?!?

Dr Simon Judkins

Dr Judkins, Immediate Past President of ACEM, is an emergency physician at Austin Health in Melbourne, Victoria.

Dr Judkins is a member of the Field Emergency Medical Officer (FEMO) program, run out of St Vincent's Hospital Melbourne. The program is aimed at responding to any disaster, assisting with the coordination of health resources, and providing support and advice to any in-field health personnel or other agencies. It was created to provide advanced medical and clinical advice to ambulance services, provide medical care to patients, liaise with the Health Commander to determine the appropriate casualty-receiving hospital(s), and refer casualties to alternative care options (such as GPs). FEMO is usually based close to the scene of the disaster, with

Picture taken from Dr Michael Hall's backyard

more than one officer deployed for large, protracted, or multi-site incidents. The Victorian bushfires fit that bill.

Simon was called on New Year's Day and asked to assist in Mallacoota. He started his trip early the next morning. He was keen to offer any support he could to the local community and in the field. Knowing about the devastating fire that isolated the town of Mallacoota, being one of the defining moments of the summer fire season, he was unsure about what he would face.

On Boxing Day, authorities urged holidaymakers to reconsider their plans. As the area continued to fill with campers and beachgoers, the call out for everyone to turn around and go home was made by Emergency Management Commissioner, Andrew Crisp. Within hours of that warning, a fire 30km west of Mallacoota started to spiral out of control, generating its own weather. Those who had not heeded the initial warnings would find themselves trapped, with no way out, within a matter of hours. Four thousand people clambered onto the beach in pitch darkness, only listening to the sound of the roaring fire around them. Authorities warned that if the fire engines sounded their sirens, everyone was to get under water, as the strong winds started to push the blaze into town.

Simon arrived by boat, after a very long day of changing travel arrangements, just before midnight, with a menacing orange glow surrounding the landscape, and immediately made his way to the GP clinic. From there, he would assist with the management of patients, sourcing supplies and liaising with staff. He assisted in triaging people who required more urgent evacuations by boat or, when possible, by air. On the radio, for the first time in Victoria's history, Simon heard that Premier Daniel Andrews had declared a state of disaster. Looking around at the town he had found himself in, it was easy to understand why.

'I spent four days in the area, based at the GP clinic, with the command centre just down the road', says Simon. 'Provisions were picked up en route to help with supplies at the clinic. But thankfully, more resources from the Navy, who arrived on day two, included ventilation equipment and some critical care medications etc.'

Working from the GP clinic, Simon was available for any acutely unwell patients. All medical staff liaised closely with ambulance staff to provide much needed support. Simon met ambulances at the clinic as they arrived with patients who required acute emergency care. The communication within local emergency service teams was invaluable, enabling everyone to work together to provide the best possible care in difficult circumstances.

It is this collaborative approach with local resources, hospitals, doctors and paramedics in the disaster response that is so crucial. The approach needs to be joint and inclusive, and the local expertise must be tapped into for successful relief support.

'Adapting to working in an unfamiliar environment was the most logistically challenging aspect', says Simon. 'Providing the usual medical support you are used to delivering becomes that much more difficult when you're in an unfamiliar place, under-resourced and attempting to work through how different disaster scenarios will be managed.'

One of the most difficult aspects of those four days was being pragmatic about what could and could not be achieved as different scenarios arose. 'Being mentally prepared and having plans for those scenarios was incredibly difficult.' Simon reflects, 'For example, we faced questions of how to care for a critical patient without the access to usual evacuation methods. With both road and air cut off, we faced situations that would never arise in our usual emergency departments in metropolitan hospitals. Fortunately for all involved, the arrival of the Navy offshore gave us much needed support and the option of using their facilities, if needed.'

Outside on the streets of Mallacoota, a line of people snaked from the registration hut set up by the Commander of the HMAS Choules. Stranded people putting down their names, desperate to be evacuated as soon as possible. Only 1,000 people at a time were able to be transported on the 16 -17-hour sea journey to the nearest port.

'Mainly respiratory and mental health', Simon says of the most common presentations. 'Many people became understandably anxious and stressed being cut off from their families and care providers. It was the not knowing, the uncertainty, which affected so many, being unable to go home, to contact loved ones, to find their pets and so much more. The feeling of being isolated weighed very heavily on many.'

The mental impact from this ongoing crisis will be the greatest challenge as these communities try and move forward. People have lost houses, possessions, businesses, income and stability. 'Those who sheltered on the beach for hours in darkness, traumatised by the sounds of exploding gas canisters and falling ash and embers, will take some time to recover from that kind of life-threatening experience', Simon says sadly.

'Being able to rebuild these communities will be the largest test. Many towns will take years to recover. Part of the recovery will be trusting that the government will respond to the climate crisis and see that long-term risk is addressed through climate change mitigation and action. Having trust in the political leaders will help recovery. Having investment back into communities to help the rebuild is imperative.'

'The main lessons need to be learnt at a government level. Clearly, the climate change denialism is impacting the capacity of communities to recover', Simon says. 'Those impacted understand the ferocity of the fires, the impact the drought and heat had on the bush surrounding them. The fear will be that this could all happen again if we don't address our changing, heating world. How can a community recover when the same threat is still ever-present and is not being managed? Our government needs to learn from this. They cannot continue to ignore the science and the facts.'

When looking toward the future, Simon says, 'If this isn't managed, regional and rural communities will remain under constant threat. Eventually, people will move, and these communities that are such a valuable part of Australian history and culture, our future and our national identity, will cease to exist'.

Dr Scott Squires

Dr Squires is an Emergency Physician, Royal Australian Navy, Maritime Operational Health Unit, HMAS Penguin, and Emergency Physician, The Tweed Hospital, New South Wales.

Dr Squires spoke to us about his experience providing emergency care during the devastating Australian bushfires. This is his firsthand account.

I was working the late shift and on call at The Tweed Hospital ED (in Far Northern New South Wales (NSW)) on New Year's Eve. After a busy night, I went home the next morning. My head had just hit the pillow when, at 10:00 am on New Year's Day, I received a call from my Navy boss saying that I had four hours to get to Sydney. HMAS Choules was sailing south at 2:00 pm to assist with bushfire relief and evacuate the Victorian town of Mallacoota.

I had seen footage of the fires surrounding the coastal town, including the picture of a child driving a dinghy across the lagoon to escape the fires, with the burnt orange sky enveloping him. I had heard that the bushfires destroyed multiple buildings.

Mallacoota has a population of 1,000, which swells to 3,000-4,000 over the Christmas/New Year period. The fires had extended down towards the waterline, with some people getting on boats or into the water to escape the flames. The one road into town was closed and dense smoke was preventing flights in or out. Mallacoota was isolated, with the sea being the only means for transporting supplies, providing medical support and evacuation.

I flew to Sydney and joined the HMAS Choules via Navy helicopter, flying onto the ship halfway down the NSW South Coast, as she was already making her way to Mallacoota. HMAS Choules is an amphibious landing ship. She had 170 personnel, five amphibious landing craft, one MRH-90 helicopter, medical supplies – including AusAID disaster response supplies, and an augmented medical team (two emergency physicians and aeromedical retrieval teams). We anchored off Mallacoota on the evening of 1 January, preparing to head ashore early the next morning.

We (myself, the Commanding Officer of HMAS Choules and a Logistics Officer) departed the ship on a small craft bound for the Mallacoota jetty. Due to the smoke, visibility was reduced to less than 100m. There were several people at the jetty to meet us and members of the public enquiring about how they can get out of town. I recall a young family there, the parents distressed as they were concerned their infant was struggling to breathe due to the dense smoke.

We were the first Australian Defence Force (ADF) personnel on the ground in Mallacoota. The drive from the jetty to the town was a surreal experience. The land was still

smouldering and there were several small fires. I was taken aback by the fact that fire can ravage some houses on a given street and leave others completely untouched.

We attended an emergency services meeting that morning with the local police, Country Fire Authority (CFA) and the Ambulance Victoria Commander. We discussed the situation in Mallacoota and how the ADF could assist. We also discussed the logistics of evacuating people utilising HMAS Choules and ADF fixed and rotary wing aircraft (once the smoke cleared).

From the outset, a great relationship was established between local emergency services and the ADF. The teams worked seamlessly together.

The town of Mallacoota has a medical centre (two GPs), a pharmacy and a community health centre, all of which were still functional. Holidaying GPs, nurses and administration people volunteered their services to assist the clinic. On the day of our arrival, the medical centre was working well beyond its capacity, with the waiting room spilling over into the car park. The practice did not have any triage capacity, nor could it hold patients or manage those that were critically unwell.

In the first 24 hours of our arrival, the ADF medical team achieved a great deal. We organised supplies from the ship to be provided to the medical centre, including medications, medical consumables, and equipment for managing critically unwell patients, such as a ventilator, oxygen regulators and syringe drivers.

2,000 people were evacuated from Mallacoota over the first five days

We liaised with the medical centre to set up their treatment room as an acute care room, capable of managing more unwell patients, and to provide the centre with a holding capacity in the event that an unwell patient could not be evacuated and had to be managed on-site.

We established a casualty control point/triage at the front of the medical centre. In the first day, 150 people were triaged and those that required further treatment were managed in the centre. Those that just needed respite from the smoke were directed to the community health centre. We provided medical personnel to augment the medical centre staff, including after-hours cover.

The ADF coordinated opportunistic rotary wing evacuation of medically vulnerable people in town. On the first afternoon 45 people were evacuated. We also provided aeromedical evacuation of a septic child with pneumonia.

The majority of the injuries were related to smoke inhalation. Most people had mild effects, however, there were multiple presentations for exacerbations of asthma and chronic obstructive pulmonary disease (COPD). There were also minor burn cases and minor musculoskeletal injuries.

Other members of HMAS Choules repaired key infrastructure in Mallacoota, such as generators, showering and toileting facilities, and provided supplies, including fuel.

Over the next 24 hours, town meetings were held to discuss the evacuation of Mallacoota and, on the afternoon of 2 January, it commenced. That evening 1,100 people were evacuated. HMAS Choules departed Mallacoota bound for Westernport. Also on the journey were 160 dogs, 20 cats, one rabbit and a cockatiel. During the 20-hour transit, medical staff provided 230 consults to the evacuees.

With 1,100 extra people on board, as you can imagine, things were a little cramped. I shared my cabin with a group of 14! A mother and her two children (aged 23 and 18) had been camping with 11 other 18-year-old friends for her son's birthday. They told me that on the night the bushfire came to their campsite, they had to wade across the lagoon to escape the flames. Everyone had a story of survival to tell. It is fortunate that no lives were lost in Mallacoota.

After delivering people in Westernport, the HMAS Choules returned to Mallacoota and evacuated another 280 members of the public. ADF rotary and fixed wing aircraft were able to evacuate a further 450 people from town.

During the second visit, further supplies were provided to the medical centre. By this time, the centre was well supported by two emergency physicians (Field Emergency Medical Officers) and medical staff from a private company. Over the next few days, the ADF predominantly played a role in bringing medical supplies to the town.

Around 2,000 people were evacuated from Mallacoota over the first five days, including the most medically vulnerable. The focus was then recovery for the town, and enabling the medical centre and local ambulance services to run as close to 'business as usual' as they could.

There are many valuable lessons to be learnt about the emergency medical response to a disaster such as the Mallacoota bushfires. Early engagement with all the relevant service providers is essential. Identifying the needs of the community and tailoring support services to those needs is also essential. Having a clear chain of command, with all information and requests for tasks going through the Emergency Management Commissioner, is essential to ensure that the allocation of resources and services is timely and appropriate. The combined ADF and Emergency Management Victoria response to the Mallacoota bushfires is a great example of how the ADF can assist state government services and the Australian community in times of crisis.

As Mallacoota moves towards recovery and rebuilding, ongoing mental health support for the community will be essential; as it will be for the tourists who were holidaying at Mallacoota and have returned home to assume their day-to-day lives, with enduring memories of their traumatic experience.

I will have lasting memories of the amazing locals of Mallacoota: their strength, resilience and spirit. I feel privileged to have worked with some tremendous people from Emergency Management Victoria. Friendships born in times of hardship are often enduring and I look forward to seeing those people again, to sit down and reflect on our experiences, perhaps over a cold beer or two.

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

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Whakaari/ White Island

For non-locals, the area around Whakatane in the Eastern Bay of Plenty on Aotearoa New Zealand's North Island is perhaps best known as an idyllic and spectacular tourism destination. For many others, parts of the surrounding country are recognised around the world as part of the dramatic natural backdrop to Peter Jackson's film adaptation of the Lord of the Rings Trilogy.

On Monday 9 December 2019 the postcard-perfect, film-set beauty was shattered as the natural world reinforced its potency, when the Whakaari/White Island volcano erupted. The consequences for the dozens of tourists and guides nearby at the time were devastating. In the resulting mass casualty event, which would go on to claim more than 20 lives, it was staff at the small regional hospital at Whakatane who bore the brunt of the acute presentations, battling bravely to stabilise patients for transportation for definitive care, and doing what they could to ease the suffering of those for whom little more could be done.

Just a few months on, Whakatane Hospital Emergency Department FACEM Dr Kelly Phelps, who was on duty that day, draws on the courage and strength of staff and patients and an enduring and shared love of the Lord of the Rings mythology, to reflect on the devastating event. We hope you will find some comfort, solace and inspiration in these words as the recovery from the terrible trauma, for staff patients, their families and communities continues.

Whakaari/White Island

Dr Kelly Phelps
Dr Phelps is an Emergency Physician living and working in the Whakatane area of Aotearoa New Zealand.

Eleven hours 22 minutes. That is an estimated amount of time it takes to re-watch Peter Jackson's extended version of the Lord of the Rings (LOTR) Trilogy.

Twenty-one hours. That is an estimated amount of time that Whakatane Hospital was engaged in its own epic battle with a volcano. Fast forward several months and our community is still battling, but more about that later.

We enjoy J.R.R. Tolkien's LOTR for its climactic drama, heroes, battles, tears and sorrow. It is man versus nature; but it is fantasy.

Whakaari/White Island is real.

Our tale begins just east of the Shire on a seemingly normal Monday afternoon in a place called Whakatane, New Zealand. Being summer holidays, I'd imagine vacationing hobbits would be surfing on boogie boards, elves would be exploring Toi's track native flora and fauna, and dwarves would be quenching their thirst at the local watering hole. Old wizards would be puffing Longbottom Leaf with community elders and learning about the local legends. Legends of moving mountains in the night, jealousy and heartbreak, brave ancestral men and women, and the transfer of fire that makes up New Zealand's geothermal volcanic landscapes.

At 2:11 pm a burst of ash and steam exploded out of Whakaari. This volcano, that you can see from the beach or from Toi's track, had erupted.

Whakatane Hospital Emergency Department (ED) got the call: Whakaari/White Island has erupted with tourists ashore. Expect to receive casualties, number not yet known.

The shift duty doctor and ED team activated our mass casualty plan. Light the beacons of Gondor! Just like in Peter Jackson's depiction, swiftly, the call for help was heard across the hospital and the community (and eventually across the North Island, then beacons hopped the Cook Strait and over the Southern Alps to the South Island, across the Tasman Sea to Australia, and even across the Pacific to North America, and just kept going and going).

Fortify the keep. Preparation of the hospital: empty the ED of current patients, empty the waiting room, make room in ICU, make room in surgical theatre.

Ready yourselves. Grab coloured vests, protective gear, medications, syringes and bandages.

Prepare your legions. Triage to station at the front doors; resuscitation teams formed and assigned bed spaces; security to line the perimeter; get an Incident Command assembled.

Insert director's scene in the ED: Shoulder to shoulder, actors and volunteered extras stand at attention, all eyes and ears towards the leaders awaiting instruction and an update. First responders will soon be meeting the boat of casualties, just 4km away at the wharf.

Our Fellowship was as varied as Frodo's. He had a wizard, a dwarf, an elf, hobbit friends and brave men. They each brought unique gifts to the table, all willing to work for the common goal.

We had ED doctors, junior doctors, surgeons, ED nurses, nurses from other wards, anaesthetists, pharmacists, radiologists, security, orderlies, Māori health services, social workers, administrative support staff, physio and occupational therapists, GPs, paediatricians, obstetricians, internists, lab technicians, victim support, cleaners, biomedical and site engineers, and so many more, it is impossible to name them all. Our St John Ambulance officers, all in green uniforms, arrived like the Riders of Rohan. We all had a common goal: to do the best that we could possibly do.

Prepare your legions. Triage to station at the front doors; resuscitation teams formed and assigned bed spaces; security to line the perimeter; get an Incident Command assembled.

Our first patients arrived. While Peter Jackson depicts chaos on the silver screen, to the actors, each movement was known, practised and organised. The hospital may have only prepared for mass casualty on paper and in drills, and on a much smaller scale; the real life depiction kept rolling. Everyone had a job to do. Organised chaos; seemingly an oxymoron, but a way to describe what was happening.

Patients arrived three or four at a time via ambulance or from our helipad. The severity and critical conditions of our patients were quickly recognised. Analgesics, airways, stabilisation and comforting words were our main priority. Every room in our ED became a resuscitation bay.

Our ED books tell us to 'reassess airways' frequently during burns, but our staff weren't just thinking like a clinical

handbook; they were also thinking 'keep them talking' and 'keep them comforted'. Staff and patients swapped stories about where they were from, family, hobbies and where else they had visited in New Zealand.

Patients were transferred to surgical theatres or ICU. Everyone was working together. The moment when the cavalry arrived happened just like in the movies. Help from our big sister hospital Tauranga (90km away) brought more doctors, resuscitation equipment and controlled drugs. The Great Eagles of Middle Earth arrived in the form of medical transport aircraft and transfer teams from around the country.

But the initial stabilisation was not enough; not in a small, provincial hospital. The logistics of who goes where and when kept critically injured patients alive after this initial scene. The quick thinking and comprehensive airlift was an amazing feat for all of New Zealand. The patients were transferred to tertiary centres, to be in the best place for their conditions.

Cut to behind the scenes: often not talked about in mass casualty planning is the major contributions of our non-medical personnel. Support from our social workers and mental health workers was a massive undertaking, especially when the majority of patients were from overseas. Their skills were truly valuable and heroic.

Now, remember how I mentioned 21 hours earlier? Twenty-one hours is from the time the hospital was notified of the event to when our last patient was transferred from our campus. A stillness settled over the hospital, for a brief moment, before media and politicians arrived. In that time, supplies were restocked. Ash was vacuumed from the air vents. The first support activities began. Activity continued around Whakaari/White Island, but the hospital had no further part in that. We needed to prepare for business as usual, for the next casualties of another normal day.

Epilogue

At the eleventh hour, Frodo had destroyed the ring with help from his loyal friends; hugs and tears for those they had lost along the way. Congratulations were given for a job well done. But who remembers the scene at the end, when Frodo starts rubbing at the scar on his shoulder inflicted by the Dark Rider in the first movie? Some scars take a long time to heal.

We may still have some elven magic here in New Zealand, but it can take many forms. Some elven magic may be in the form of our specialists in the burn centres who continue the intensive care for patients. Some magic comes from dedicated and tireless mental crisis workers who are working with us to debrief from this event. Some magic is from our family and friends who recognise our needs and continue to reach out and support us. That beacon that spread across the globe? Colleagues from around New Zealand, Australia and Canada came to help us – to give our staff a chance to debrief, recover and help our tertiary colleagues continue caring for the patients.

How do you recover from an event such as Whakaari/White Island? It has affected our patients, our patients' loved ones, ourselves, our loved ones, our whole hospital staff, our community, our nation.

I've been asked that question and I very much wish I knew the answer. Perhaps we will bulk up our MC plan under the Recovery Heading. What things have we tried? We fed hungry staff snacks and pizza during the event. We gathered the night of the event to let staff know this is really hard, and it is going to affect you individually somehow or another, and that is okay. Prayer times initiated by our Māori community. Reminder emails and texts with offerings of free counselling. Bringing in kittens and puppies to cuddle. Arranging for a safe, protected place at the local watering hole for all involved in our community: first responders, police, fire brigade, civil defence, Māori community workers, and hospital staff. Hugs and tears in the hallways. Are-you-okay check-in by text or email. Diligence on who is safe to continue to work and who needs some time off, if possible. Awareness of post-traumatic stress disorder (PTSD) symptoms in ourselves and in our staff. Planned debriefs for individual departments, the hospital as a whole, the District Health Board and Civil Defence inter-agency, and New Zealand as a nation.

It is too early to tell if our recovery efforts have helped, but I surely hope so. I am so proud to be a part of Whakatane Hospital and our community. May we all continue to heal and support each other. Our hearts go out to our courageous patients still fighting the good fight, as well as to those mourning the people we have lost. We thank the individuals and communities that have supported us, through chocolates or coffee vouchers, words of support, or warm bodies of staff for some reprieve. Again, some scars take a long time to heal.

These are the personal views and reflections of one of the Emergency Doctors who responded to the Whakaari/White Island eruption, Dr Kelly Phelps FACEM Whakatane Hospital

Dr Andy Churchman

Andy is an Emergency Physician and co-DEMT at the Princess Alexandra Hospital in Brisbane, with interests in education and training.

Why emergency medicine?

As a junior doctor, I found emergency medicine to be exciting, diverse and challenging. What stood out most to me was how relatable and approachable the registrars and consultants were – I felt like an important part of the team. As a consultant, I now face the challenge of being an approachable, supportive leader on the floor.

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

We have the responsibility to reassure, connect with and care for patients during what can be a scary and uncertain time in the ED. While there is satisfaction in the clinical challenges, such as making a diagnosis, breaking bad news and leading complex resuscitations, for me, the most enjoyment comes from the teachable moments with juniors and trainees on the floor.

As a part of the Director of Emergency Medicine Training (DEMT) team, I am fortunate to spend time talking about emergency medicine with motivated and enthusiastic trainees. Knowing you have been a small part of their progression through training to become excellent emergency physicians is highly rewarding.

What do you do to maintain wellbeing?

Having a supportive, close-knit consultant group makes it easy to maintain perspective. For me, balance is key. Emergency medicine may be my job, but it doesn't define me. Keeping my energy balanced, through time with my family and maintaining non-medical interests, allows me to feel in control and I can turn up to work with energy to give.

What do you consider your greatest achievement?

I have been fortunate to have many great mentors and coaches through my career. One of the most integral lessons has been to remain focused on the process. If I keep turning up and putting in the hard work, the outcomes will take care of themselves. While individual achievements and recognition are nice, keeping the longer term process in focus keeps me inspired to do my best.

What inspires you to continue working in this field?

I am inspired by the opportunity to work with and train new junior doctors and help trainees progress through their specialty training. They force me to stay current with my knowledge, and to explain my reasoning.

Getting involved with the College as an examiner, OSCE writer and standard setter has given me the chance to get involved in ways that keep me engaged and learning.

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

A mentor told me during my training: 'As a leader, everything you say will be repeated and every behaviour you model will be magnified'. Hearing this challenged me to reassess my own behaviours when acting as a leader in the ED. When the department is busy or the workload appears overwhelming, maintaining positivity and engagement has a clear impact on everyone else. Being optimistic and 'can do' is infectious.

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

Emergency medicine departments seem to be getting busier everywhere. We have contributed to this by always being the helpful specialty that walks towards a problem and gets involved, with the patient outcome at the forefront of our minds. However, for sustainability, we need to look at how we can focus our skills and time on the patient cohorts where we can provide the most benefit. To me, this will mean strategies whereby stable patients with chronic disease known to inpatient teams can access them directly, allowing the emergency physician to focus on the undifferentiated, acutely unwell patients.

Dr Harriet Jennings

Dr Jennings is a FACEM Training Program Advanced Trainee in Christchurch, New Zealand, with special interests in paediatrics and trainee advocacy. She has recently been appointed Chair of ACEM's Trainee Committee after working as the New Zealand Trainee Representative for two years.

Why emergency medicine?

As a medical student I was fixated on the idea that I wanted to be a surgeon. As a doctor, I realised I didn't actually enjoy standing for hours under hot theatre lights twiddling with laparoscopic devices or coming in on my days off to do ward rounds. I moved to Christchurch and began working in the emergency department. For the first time, I felt like I was part of a team, not just with other doctors, but with the nurses and allied health, too. I love that I'm not restricted to one field of medicine. In one shift, I can see newborns and 100-year-olds, suture wounds and intubate people. I enjoy the diversity of my job.

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

The shifts. While I enjoy having midweek weekends and the out of hours work, at times, I find changing from nights to days to evenings challenging, particularly when studying.

What do you do to maintain wellbeing?

I like to escape into nature and head to the mountains whenever I can. Since studying for my Fellowship exams and moving to a lifestyle/life-sentence block in rural Canterbury, I haven't been able to go hiking as much as I'd like, however, I do spend every opportunity in the garden. My current greatest achievement is managing to grow my own aubergines despite having to constantly chase the chickens, goats and sheep out of my vegetable patch.

What inspires you to continue working in this field?

The people. They keep the job interesting and varied. I work with some inspiring colleagues and feel fortunate to be part of a great team. Currently, I am close to light at the end of the tunnel with Fellowship exams and I am excited to see what the future brings.

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

Don't take things personally. We often meet people on the worst day of their lives. They might be in pain, frightened or upset, and their behaviour may not be the best. This is also often the case with our inpatient colleagues, as the most challenging ones are usually the most inexperienced, and they are worried about getting into trouble with their bosses. I try to keep this in mind when I bear the brunt of their emotional distress and, while it doesn't excuse bad behaviour, I find it makes it easier to deal with and de-escalate issues.

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

Emergency departments with windows – I have yet to work in one.

This article was written before I had ever heard of COVID and now it is all most people talk about. In these challenging and uncertain times the Trainee Committee is dedicated to advocating for you. Please contact your local trainee representative or myself at traineecommitteechair@acem.org.au for help and support. Kia kaha – kia haumaru. Be strong – stay safe.

The Leadership Role of Emergency Directors – a College Partnership

Whether you are responsible for the overall running of an organisation like ACEM, or a hospital, or part of an organisation like an emergency department (ED), the ethereal concept of leadership is never far away from a conversation about the highs or lows that go with the responsibilities involved.

Recognising the importance of leadership in emergency medicine in delivering high quality care to patients in EDs and the wider healthcare setting, ACEM has partnered with the Business School of Swinburne University to provide leadership opportunities for current and aspiring Directors of Emergency Medicine (DEMs), with the aim of raising the awareness of DEMs about what leadership looks like for them and the ways in which they can harness opportunities to address the sometimes complex issues that they encounter in their roles.

The partnership began with a literature review on the leadership role of DEMs (soon to be submitted for publishing), as well as an empirical (Delphi-based) study of DEMs involving in excess of fifty DEMs from Australia and New Zealand, with participants stratified into groups based on 'Experienced' or 'New' and 'Metropolitan' or 'Rural'. Feedback from participants in the study was positive, with the findings from this work recently published in EMA.

To harness the outcomes of activities associated with the research and expand the educational opportunities offered by ACEM for Fellows and trainees, the ACEM Board has agreed to extend the partnership with the Swinburne Business School through two avenues:

- The development and delivery of a Leadership Development Action Research Project, tackling the research question of, 'How does Action Learning enable DEM's thinking and acting on Access Block in their hospitals and emergency departments?'
- The offer of up to two full-time 3.5-year PhD awards, running in parallel with the Leadership Development Action Research Project.

Applications for the PhD awards were invited from FACEMs and trainees enrolled in the FACEM Training Program, with interviews for short-listed applicants held in January. More will be written about the successful applicants and their projects in future editions of *Your ED*.

The Leadership Development Action Research Project has been designed around a program of interactive workshops and action learning projects. The program has attracted in excess of 30 DEMs from Australia and New Zealand. Due to the evolving COVID-19 situation, the program, which was initially structured as an 18-month program scheduled to commence in March 2020, has now been revised to a 12-month program that will commence in the second half of the year. In the lead-in to the program, Dr Clare Skinner, DEM at Hornsby Ku-ring-gai Hospital offers her perspectives about her leadership pathway in the DEM role.

Dr Peter White, *ACEM Chief Executive Officer*

Dr Clare Skinner

Dr Skinner is Director of Emergency Medicine at Hornsby Ku-ring-gai Hospital in Sydney and Deputy Chair of the ACEM Council of Advocacy, Practice and Partnerships.

I remember day one of internship as if it was yesterday. There I was, proud but apprehensive. Only slightly more comfortable in my new clothes than my new role. There were more firsts to come. First day as a trainee, first night in-charge of ED, and eventually my first shift as a consultant. Each step-up involved a leap of faith. Increasing responsibility came with a subtle shift of identity.

I was appointed DEM at Hornsby Ku-ring-gai Hospital, on the northern perimeter of Sydney, in 2015. I had applied because I was curious. I have a longstanding, deep interest in people and systems – I'm the sort of person who reads health policy for fun. I also love writing and speaking. The job seemed like a good fit. An adventure and a challenge.

When I started as Director, I had a baby and a two year-old. I had been a FACEM for nearly four years.

'Do you really think I'm grown up enough?' I remember asking anyone who would listen. Bemused expressions revealed that becoming a Director didn't appeal to everyone. 'Are you really sure you want to do it?' my colleagues asked back.

Nothing prepared me for the enormity of this first day. After a career of shared lockers, I suddenly had my own office. The sign on the door said 'Director'. There was no shying away – I was Impostor-in-Chief. I spent the day rearranging the furniture, hoping no-one would notice how ill-equipped I was for the job.

I asked other Directors for advice. 'Don't go looking for work', I was told. 'It will come looking for you.' That proved true very quickly. 'Always know where your next holiday is coming from' another Director suggested. I'm still working on that, five years later.

One of the best things about Emergency Medicine is visibility. Taxi drivers and dinner party guests know what we do. We're television stars – romantic leads in hospital dramas and regular interviewees on the nightly news. We interact with everyone and anyone. Yet the ED Director role is cloaked in mystery.

A slice of the Director job translates directly from any modern managerial position description. There are obvious tasks, like writing rosters and coordinating recruitment. Working through incidents and complaints. Reviewing documents, signing forms and attending countless meetings.

Despite a steep learning curve, I found these managerial responsibilities relatively easy to grasp. There were courses to do, modules to complete and helpful people willing to answer questions along the way.

But then there was leadership.

What does leadership really mean? What training is required? There was far less to guide me with this crucial aspect of the Director role.

The internet overflows with leadership advice. Expensive courses with catchy-names and subscriber-only newsfeeds. As an emergency doctor, up to my ears in real-life, none of these really clicked.

When I reflected on my own experiences of being led, I quickly discovered that it's complicated.

A thank-you note after a busy shift. Feels great when you have a connection with the boss but comes across as a cynical exercise if the delivery is less than perfect. Honest feedback is cherished from someone you respect but can easily cross the line when a working relationship is uncomfortable. Personal questions are welcome from some people but intrusive or inappropriate from others. Favouritism never feels good, even when unfairness is more perception than reality.

What should happen when things go wrong? I remember times when I was grateful that the boss fixed it on my behalf, but on other occasions I wanted an opportunity to tell my side of the story.

I had more questions than answers.

To what extent should I feel responsible for the actions of others? I have only limited influence over who is on the team, and emergency clinicians tend to have strong personalities and even stronger opinions. Is it possible to be both liked and respected? And still get the job done?

How much of myself should I give? Had I forsaken my right to complain about the everyday frustrations of life in ED? Should I own up to hiccups in my personal life or periods of low motivation? Would sharing my true feelings impact negatively on the team? How would I look after my own wellbeing?

There was a lot to learn.

The first step was a deep reckoning with myself. My biases, motivations and fears. My perceptions and projections. Personality traits likely to rub people the wrong way. My values and my needs.

I'm physiologically incapable of pretence, so the only real option was to be myself. A human being – replete with flaws.

I decided to always be honest. Open about things I could and could not achieve – personally and professionally. This requires humility. Willingness to listen to others and change my mind. Courage to own up to mistakes. Vulnerability to show how much I care. Integrity – always.

I fell into a strategy I describe as 'emotionally engaged leadership'.

Lots of effort goes into getting to know my colleagues personally, so I can be flexible in my interactions with them, based on their individual preferences and style. I aim to channel positive emotion, motivating the team through praise and encouragement. I try to validate the impacts of negative emotion, by allowing time and space for processing, recovery and re-connection.

I soon learned to trust my instincts. I'm guided by my values and feelings, testing each decision with the question 'will I be able to sleep tonight?' And I try to always treat others as I would like to be treated myself.

So – as Director, what do I actually do?

I look after people. It's my job to know the strengths of each clinician and help them perform at their best by assigning them tasks that match their aptitude and interests. To link them with opportunities for professional development. To make sure they stay home when they are sick, take meal breaks, go on holidays and get paid properly.

Psychological safety is enormously important. Creating conditions in which people can talk about problems without fear of reprisal. Managing change with consideration and care. Making sure procedural fairness is observed – especially when things don't go to plan. Striving to make the ED culturally safe – a truly diverse and inclusive space, for clinicians and patients. Promoting emotional safety through civility, kindness and respect – and by understanding the negative effects of shame.

As Director, it is important to take on difficult conversations and handle them with care. The team needs to know that wrongs will be put right.

I connect with people. Seeing, talking and above all, listening. Nuanced communication is paramount. Primarily, I act as interpreter between ED and hospital management. I have become fluent in 'exec-speak' and know how to translate a request for clinical resources into strategic priorities and KPIs. I'm also the main point of contact between ED and other clinical services – an advocate and defender of our work. I aim to build relationships and ensure that communication is constructive – because teamwork is fundamental to improving patient care.

I make decisions. Understanding data is very important – patient flow statistics, quality measures, clinical outcomes, staffing and the budget. I read widely about ED practice and stay up-to-date with policy and guidelines. I go looking for ideas and innovations. Ideally, all big decisions are collaborative and multidisciplinary. Close partnership with nursing leadership is vital.

I'm liberal with credit and congratulations when things go well. I hold myself accountable when they don't.

I inspire people. It's my job to create shared purpose and meaning – to encourage people to engage, do their best and want to come to work, even on the bad days. Our department has a strong sense of family – a culture of love and belonging. Doctors, nurses and other staff members work together. We know each other well, look out for each other and celebrate our successes. I make sure everyone knows that what we do is special. A little bit of magic goes a long way.

The most rewarding part of my job is helping people grow – especially junior medical officers and trainees. I love being able to use the skills, experience and network I have built as Director to help people take on new challenges. In return, colleagues at all career stages support, encourage and look after me too. Everyone benefits from mentoring.

My heart bursts with pride as I watch doctors from our department graduate as Fellows at the College Ceremony each year – one of my favourite moments.

Five years on and I do feel more grown-up. But deep down I'm still me. I have been able to do things my own way. I can honestly say that I love my job.

I feel privileged to lead a team of dedicated clinicians providing excellent care to our community. I have agency to make meaningful change, which has been enhanced by my increasing engagement with ACEM over the last few years. And I'm a much better clinician because of insights gained as Director too.

There have been highs and lows, achievements and set-backs, moments of exhilaration and extreme vulnerability. Being an ED Director is challenging and rewarding.

Guess what? It's also really fun.

PHRM

Dr Eleanor MacDougall
Dr MacDougall is an ED and Retrieval Consultant in Adelaide, South Australia who has recently returned from working in Central Australia.

My colleague hung up the phone. 'That was a call from a station. They have just found an elderly couple who have been lost in the bush for five days after their car got bogged.' The pair had been driving, taken a wrong turn onto a disused track and were worried they would not be found so left their car. They ended up walking 40km across rough ground, drinking from cattle troughs and sleeping amongst the rocks. They were eventually found when they got close to some remote cattle yards where station workers just happened to be working that day. They were dehydrated and exhausted but otherwise physically unharmed. The workers took them to the station where the family fed them, gave them water and then drove them two hours to the nearest remote clinic. From there it was a two-hour flight to Alice Springs, where they could recover from their acute renal failure and exhaustion. They were very aware how lucky they were that it was early winter, the nights were not too cold and that they were found at all. This story is a common but stark reminder of how far from help you can be in outback Australia and how reliant we are on the kindness of strangers who look after each other round here.

I work as a consultant in the Alice Springs Emergency Department (ED) and the Central Australian Retrieval Service (CARS). I am amazed every day by the differences between practising medicine in metropolitan Adelaide (thinking about my old life in the UK is just too surreal to even contemplate) and Central Australia. The patients here are younger and have more co-morbidities. Many more are Indigenous (75 per cent of ED presentations) and survive social challenges, poverty and illnesses of a severity that we would never imagine in the city. It can be sobering to see adolescents with uncontrolled type 2 diabetes, 25-year-olds on dialysis and having STEMIs, children developing rheumatic fever, and neonates with widespread scabies. A neck of femur fracture here is a once a month novelty. The local population and those living in communities and stations serviced by Alice Springs are resourceful, resilient and hardy, and the local remote area nurses (RANs) and remote medical practitioners (RMPs) go above and beyond to care for them. I rarely get to meet any of these people, but frequently talk to them on the phone. Through them I am learning about what life is like working out bush and I am hopefully providing essential support and advice when things are stressful.

This is not the 'sexy' retrieval medicine of helicopters, REBOA and thoracotomies. It is the dash to the floppy, shut down six-week-old with pneumonia and a respiratory rate of 80, in a community 90 minutes flight away, being cared for by a clinic nurse who is struggling to find a vein to give antibiotics or fluids. It is making the decision as a coordinating retrieval consultant whether to take a critically unwell patient to Adelaide out of hours, which will leave the whole of Central Australia without retrieval capability for the entire night. It is deciding whether to leave a child who has borderline observations in a community at 11:00 pm because there is no night strip and the long drive down a dirt road in the dark is just too dangerous.

Despite the medical challenges of treating highly complex patients with combinations of immunosuppression, end-stage renal failure and severe right-sided heart failure, and the emotional challenges from seeing rates of alcohol abuse, poverty and domestic violence that are not found in most of the hospitals we work in, Alice Springs holds a charm that nowhere else could quite meet. I had been told by numerous friends who previously worked here that it would capture my heart and, especially in winter, now that the flies and heat have abated, they were right. Flying past Uluru at sunset would be enough to make most people fairly satisfied with their lot in life, but that is merely a small part of my wonderful job. I feel genuinely privileged to treat the patients I see, ranging from the gorgeous tiny children running amok barefoot around the ED, to the hardy 'elderly' patients in their 60s who have lived their whole life out bush, and the men from stations who have been bumped two hours down a dirt road with rib fractures without so much as a paracetamol after getting between an angry bull and a fence.

Anyone who has worked in a rural area would be likely to agree that the differences in their work can be refreshing. It is wonderful to see a group of talented and dedicated unit directors work in a focused team, striving to improve the experience and outcomes of their patients. General medicine here truly is general and the renal team are the busiest in Australia, with huge numbers of admissions. Access block rears its ugly head here as much as anywhere else, but a well-designed department and a 'can do' attitude from the whole hospital makes it more bearable. With the next nearest FACEM-staffed hospital in Adelaide or Darwin (both 1500km away), we can't go on diversion, and ramping isn't an option even if we needed to. There are only two ambulances to cover 40,000 people in a 150km radius. The patient ping-pong between sub-specialty teams that can make practising emergency medicine incredibly frustrating in a large hospital just doesn't happen here. Almost without fail the inpatient doctors, from intern to consultant, are friendly and willing to give their time and advice. The hospital is small enough that the faces are familiar and within a few months I have got to 'waving in the corridor terms' with everyone from the orderlies to the Executive Director.

As a consultant, it feels such a treat to spend my days actually talking to patients and having time to think about their individual medical and social needs. Many of our patients make decisions about their health that we may not understand or agree with, but instead of being frustrated by this, there is time to explore their reasons and educate myself about culture and community. I can then try to provide the medical care that a patient wants and needs rather than forcing on them the model of care we feel is 'right'. Even the most tenacious repeat presenters, who miss more sessions of dialysis than they attend, can be supported to live their life in the way that allows them to do what matters most to them. It would be very hard to see a patient in terms of KPIs and NEAT targets when you have been able to develop such a relationship. It also brings sharply into focus how small we are as individuals in being able to stem the tide of inequality in rural and Indigenous health, and it is very good for keeping the ego in check.

This is not the 'sexy' retrieval medicine of helicopters, REBOA and thoracotomies. It is the dash to the floppy, shut down six-week-old with pneumonia and a respiratory rate of 80, in a community 90 minutes flight away

As well as working in ED, being a co-Director of Emergency Medicine Training (DEMT), providing Emergency Medicine Education and Training (EMET) support to Tennant Creek and working in CARS, there is the opportunity to assist with medical cover at a variety of events. These range from the (frankly insane I think) West Macs Monster trail running event to the famous Finke Desert Race and the Harts Range Rodeo. The medical needs at these events vary, but they are all a lot of fun and give me the chance to get out and see the area in a different way and meet more of the population we serve.

Instead of focused wellness activities to keep us sane, there is a flexible roster, extra leave allowance, team dinners and lots of support for the whole team from motivated and caring directors who show me how I want to be when I grow up (both in ED and CARS). The priority here is compassion for each other and for our patients. Self-care involves sunrise hikes up Mount Gillen, swimming in the waterholes at Ormiston Gorge and Glen Helen, and camping in swags under the shockingly bright stars of the Milky Way. Every day, I wake up to blue skies and sunshine, and every night the sunset is the most beautiful I have ever seen with a half hour light show of greens, purples, oranges and pinks lighting up the red dirt and the mountain ranges. The red dust around here gets everywhere but especially into your heart.

More information

centralaustralianretrieval.com.au
jobs.acem.org.au/job/196/staff-specialist-or-fellow-in-retrieval-medicine-alice-springs/
jobs.acem.org.au/job/70/pre-hospital-retrieval-registrars-alice-springs-hospital/
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Partnerships and Improvisation in a Resource-Limited Paradise

Dr Jonathan Henry
Dr Henry is an emergency physician working at Peninsula Health and Bass Coast Health in Victoria, with special interests in global emergency care and point-of-care ultrasound.

Each year, the Australian Government spends, on average, a whopping $7,500 per citizen on health. Next door in Vanuatu, this figure comes out roughly at $210, and the bulk of that is allocated to staff salaries. With just a few dollars left over to spend on resources, what can realistically be achieved? We hear the term a lot, but what is it like to practice emergency medicine in a resource-limited setting? While working for six months on a local doctor contract at Northern Provincial Hospital (NPH) Emergency Department (ED) in Vanuatu, I had the privilege of finding out.

Imagine a 60-year-old woman is wheeled in by ambulance to an average ED in Queensland — we'll call her Marie. She's short of breath and in rapid atrial fibrillation (AF). Treatment has been started en route and she's already improving. In ED, her vitals are done while an ECG is printed, and you obtain intravenous access. The non-invasive ventilation machine is wheeled in and fired up. A blister-pack reveals precisely the medications taken and missed. Within minutes your clerical team have her loaded onto the computer system, and you flick up the old notes on the computer — old ECGs, labs, x-rays and admission notes. Your portable x-ray machine arrives, and a chest x-ray flashes up at the bedside for you to interpret. Diffuse infiltrate, big heart — looks like pulmonary oedema. You scratch your head for a minute, then select from a smorgasbord of treatment options — maybe some IV meds and some electricity. All the drugs are on hand and given within minutes.

A couple of hours east in Vanuatu, the pathology presenting to ED is surprisingly similar, but on a sliver of the budget. How does the experience change?

Marie might arrive lying in the back of a ute, which isn't helping her shortness of breath. She's been driven all day across potholed roads, a dozen family members huddled around her on the ute tray. Pre-hospital care is severely lacking throughout the Pacific. Uniquely, in Vanuatu, a high-calibre ambulance service, ProMedical, operates on Santo and Efate, but access and cost issues mean they're heavily under-utilised at present. Most sick patients are driven by family or taxi into hospital.

The family carry Marie in by her armpits through the open ambulance door and take the initiative to choose a spare bed. They lay her on a bare mattress just cleaned by one of the nurses; sheets are in short supply as usual. Her sudden appearance in our seven-bed ED reminds me of our absent triage system. Thankfully, at the larger Vila Central Hospital, plans are afoot to implement a triage research project, supported by an ACEM Foundation International Development Fund Grant, which we hope will provide a major boost for timely patient care and departmental organisation.

Marie still looks short of breath lying flat. 'Guys, this bed is the broken one. Let's go over to bed one.' The bed wheels don't seem to lock, but the strong hands of her sons gripping the frame do the job when some stability is needed.

A strong family unit is a prominent feature of Ni-Vanuatu culture. In my first few months, I was stricter about expelling the crowds of well-meaning relatives cramming the ED. Currently, there is room and they're providing useful collateral history, so they're staying for the moment. I've realised they're a vital part of this whole process, and I've learned a lot about caring for patients as well as families. In fact, the families of our Ni-Vanuatu patients sometimes seem more passive than I'm accustomed to, quietly waiting their turn for hours, hesitant to advocate for their deteriorating loved ones. I hope they aren't too intimidated by the new white doctor. I trust that they'd alert the nurses if their relative really was worsening.

Marie's finally on a better bed, propped up on pillows. My diligent Ni-Van intern has arrived at the bed ahead of me and is asking for a brief history while checking the patient's pulse. 'Dr Jono, she's very tachycardic.'

Vital signs are an issue, as always, and I learn to trust basic clinical skills above any of our technology. Cyanosis and work of breathing become more important than the temperamental number on a pulse oximeter. I learn to trust a history of fevers and chills and the back of my hand on the forehead ahead of our thermometer. Our old friend the respiratory rate really comes to the fore here, and a palpated pulse is usually more reliable than the pulse oximeter trace. Today, Marie is hypoxic and her blood pressure is elevated, all of which we note with a bit of skepticism.

'Nurse, could we please get a 12-lead?' 'Sorry Dr Jono, we ran out of sticky dots.' 'OK, let me text the private clinic Medical Santo down the road, I think they had some spare.' 'Hmm, I don't know. The ECG paper has run out, too, and anyway, the nurse overnight said the machine is broken.'

That doesn't sound good. We have one trusty workhorse that acts as defibrillator and ECG machine for the whole department. My mind wanders to the half-dozen dusty ECG machines I found buried in the back room last week, the covers of each inscribed with various foreign languages. The room is a crowded museum of antique medical devices, all donated by well-meaning visitors and organisations. I've realised that when resources are so limited, staff are hesitant to throw something out that might provide value.

The nurses have placed a small IV line on the back of Marie's hand with ease. Their skill with access is legendary, often slotting in a 25-gauge cannula in a crashing neonate without fanfare.

'Does anyone know Marie's past history?' 'Dr Jono, remember it's Saturday. Medical records are closed for the weekend.' Computerisation is filtering into some parts of the health system here, but patients' medical records are still kept in a paper folder. Older patients usually aren't sure of their date of birth and alternate between several different first and last names, with a spread of possible spellings. I marvel at the ability of clerical staff to locate patients' files.

We check with the family. Marie has a heart problem of some kind, but that's all they know. What medications is she on? They're not sure … the doctor prescribed some a while back, but she ran out a few months ago.

What's her history today? The language barrier looms large. Urban Ni-Vanuatu patients usually speak decent English or French, in addition to the creole language Bislama. I feel a pang of guilt for not learning basic Bislama properly before arriving. Thankfully, it is an easy language to pick up, with most words having an English origin. Unfortunately, Bislama doesn't sync well with the biomedical paradigm of health, and I've learned some key pitfalls. 'Numb' is used to describe both sensory and motor deficits. 'Shot-wind' refers to both the verb 'dyspnoea' and the noun 'asthma' — perhaps a factor in our liberal use of salbutamol nebulisers for all-comers with dyspnoea. Body cavities are probably the easiest terms to learn — basket blong bebe (uterus), basket blong pispis (bladder), basket blong bol (scrotum) and basket blong sitsit (bowel).

If an intern or nurse isn't around to guide my bumbling efforts in Bislama, a neighbouring patient or their family usually chimes in to clarify things. Lowered voices and thin curtains don't achieve the patient privacy we'd like. Patients in neighbouring beds rapidly bond. There's much to discuss — some not-so-distant family connection, one's favourite kava bar, whether the next government might end the era of zero income tax, the increasing numbers of passports for sale, or China's growing influence with the largest wharf in the entire Pacific having just opened right here in Luganville.

It turns out Marie's been short of breath for two weeks. Delayed presentations are multi-factorial, but much of it seems due to kastom medicine being the dominant paradigm. Some people propose a culture of acceptance, and even collaboration, with the local alternative health practitioners. Others speak with contempt when a patient comes in with extensive cellulitis, which has been incised with shards of broken bottles, or children with herbs applied to fractured limbs for weeks on end. As an outsider, I keep silent on these matters and try to focus my efforts on emergency medicine public relations; doing my best to improve the reputation of Western-style emergency care.

I know we don't have a mobile x-ray machine, but can we get her around to radiology for a film? Oh, that's right, the main radiology x-ray has been broken for months. Has anyone heard when that spare part's arriving from Vila? Not only do supply chains break down out here in the peripheries, but Vanuatu has only one medical technician. His flight bill must be enormous, constantly roving around the many islands in perpetual crisis mode, maintaining ageing equipment. Resource limits inspire improvisation though. I've enjoyed learning some useful tricks — an 18-gauge needle works brilliantly as a tibial intraosseous line in children, and a soldering iron cuts a snug hole for an inhaler in a 600ml Vanuatu Water bottle base to create a superb spacer.

One saving grace this Saturday morning is the portable ultrasound machine, which was first loaned to me for six months, then on my departure generously donated by SonoSite. It's been a lifesaver and I scan everyone in the ED from head to toe. Today we find diffuse lung B-lines, and an anterior mitral valve leaflet bent into the hockey stick shape that is becoming depressingly familiar here. Did you ever have rheumatic fever as a child, asks the intern? Not that we know of. Rheumatic heart disease is widespread in Vanuatu, as elsewhere in the Pacific, and outpatient staff are liberal these days with their penicillin prescribing for sore throats.

Ultrasound has been a lifesaver here and, as a point-of-care ultrasound (POCUS) enthusiast, that suits me just fine. I try to pass on knowledge to the 10 junior doctors currently on placement at NPH, keeping it relevant and practical to the setting. Here in Melanesia, the usual ED obsession with our old foe, the aorta, is less pressing. Without an operative solution, aneurysms and dissections are diagnoses sometimes better left to fate.

The next step of training for these junior doctors is one to two years at a small rural hospital, and the lucky ones might have an ultrasound machine to use. With ongoing partnership, plummeting costs of portable machines, and innovative programs for remote training and support, I hope that ultrasound will become more accessible for all staff providing emergency care in the far reaches of Vanuatu.

Pulmonary oedema is tricky to manage here without non-invasive ventilation. Thankfully, Marie's saturations rise just with oxygen via Hudson mask. Do we have any GTN (nitroglycerin) in stock? Only patches today, doctor, there are no sublingual or IV options around.

Next, a urinary catheter. I hunt for an appropriate size, eventually finding one on the medical ward. We only have the standard gel, no lignocaine. Luckily, most Ni-Van patients are stoic, and both women and men seem to cope with catherisation without outward signs of distress. We don't have disposable packs of sterile gear either, making do with iodine and a fresh pillowcase.

Alright, it's time to call the intern on the ward about this admission. 'But Dr Jono, remember they're having salary issues, and haven't renewed their contracts since last month — so technically, they actually aren't allowed to work.' Ah, I forgot. OK, I'll call the senior doctor, Dr Lawrence. He's been here for a few years now and covered the service 24/7 for much of that time. The poor fellow is a newlywed, but he rarely seems to take a day off from ward rounds, not to mention all the administrative duties that come with being one of only several senior doctors running a hospital.

I'm always glad when Dr Lawrence stops by to play soccer out the back of the hospital, along with some interns and medical students. Unfortunately, our turf is only a stone's throw from the makeshift morgue and some days the cries of the mourners filter over the pitch. Humid football games under a purple and orange sunset accompanied by the cries of our patients' grieving families is a vivid memory that won't fade easily.

Dr Lawrence doesn't pick up on my first call, so I communicate with him electronically. Smartphones and knowing all the staff mean referrals go remarkably smoothly here — that is, when the networks aren't down. As a blessing, they are in good order this sunny morning.

I'm also thankful that bed block rarely impacts our work at NPH ED. We often speculate why NPH's 120 beds are rarely as full as you'd expect when we are the regional referral hospital for over 160,000 Ni-Vanuatu. Access must be the primary reason. Vanuatu consists of 83 islands and, even on our own island of Santo Espiritu, some patients will take days to travel from deep in the west coast bush. A preference for the kastom healers is another problem. During periods when word spreads that no surgeon is currently working at NPH, some wonder whether patients with surgical pathology are simply staying at home. My colleague, Dr Vincent Atua, a Papua New Guinea emergency physician at Vila Central Hospital (VCH), does struggle with access block, with length of stay in his ED frequently exceeding 24 hours.

In our ED, with our trivial three per cent resources, what have we managed to do for Marie? An intern trained on a scholarship in Cuba used their clinical skills to diagnose rapid AF. We gave a GTN patch and frusemide, and some tank oxygen bridged her for a few hours until her lungs dried out. Although we didn't have the fanciest IV calcium channel blockers on hand, I expect we'll achieve rate control by this afternoon with digoxin. A donated ultrasound machine gave us a window into her cardiac function and lung oedema. Out here on the edge, I've realised that in emergency medicine three per cent goes a long way, and the sense of achievement I get from stabilising patients with our limited toolbox is really rather satisfying.

Vanuatu consists of 83 islands and, even on our own island of Santo Espiritu, some patients will take days to travel from deep in the west coast bush.

Vanuatu's emergency care development has been on a slow burn for many years, with scoping reports a decade back from FACEM Dr Brady Tassicker and others, a new ED built at VCH, the Ni-Van ED registrar Dr Trelly Patunvanu in training overseas, and more registrars now queuing up to follow behind him. Coming into 2020, many of these seeds of change are bearing fruit, and progress at VCH ED is palpable, largely due to the work of Dr Vincent Atua on the ground, and FACEM Dr Leanne Cameron and ACEM Global Emergency Care Committee, Country Liaison Representative for Vanuatu.

In a tropical paradise, just a few hours flight away from you, many opportunities are emerging for involvement: ACEM supported EM Advanced Trainee placements with the Australian Volunteers Program; visiting short courses such as ELSi ultrasound training; private and hospital ambulance staff education; ED registrar mentorship; implementation and research of a triage system by FACEM Dr Rob Mitchell; emergency nursing courses; and more. Recent work from FACEM Dr Georgina Phillips has outlined universal priorities and pathways for development throughout the Pacific. I encourage emergency care clinicians with an interest in global health to join the continuum of growth of global emergency care in Vanuatu or one of their many neighbours. You too will discover that with some basic drugs and equipment, strategic partnerships, some ingenious problem solving, the few dollars allocated to emergency care can go further than you might imagine.

More information

If you're interested in learning more about ACEM supported activities in Vanuatu, please contact the Global Emergency Care Desk at GEC.Network@aecm.org.au and Vanuatu Country Liaison Representative Dr Leanne Cameron at Leanne.Cameron@waitematadhb.govt.nz

A Trainee in Syria

Dr Aurelia Stapleton
Dr Stapleton holds a Graduate Certificate in Disaster Health and Humanitarian Assistance (James Cook University), Diploma Tropical Medicine and Hygiene (London School of Hygiene and Tropical Medicine) and is an ACEM Advanced Trainee. She is returning to work at Liverpool Hospital Emergency Department, Sydney, New South Wales.

Tell us about your recent global health work

I was based in a Médecins Sans Frontières (MSF) project in a town in north east Syria. I worked at the local hospital.

What were some of the highlights from your time away?

Can I say food and eating? Watching one of my patients, a 13-year-old girl with 50 per cent body surface area (BSA) burns, sitting in a wheelchair in the courtyard with the sun on her face, eating an ice cream, smiling, after six weeks in the high dependency unit. Getting accustomed to sharing our translator's mum's homemade makdous (fermented baby eggplant stuffed with nuts and chilli) for morning tea. Listening to stories from our Syrian staff of life under ISIS while sipping 3-in-1 sachet coffee at the 'cafe' across from the hospital under a tree. Frying up Friday morning breakfast pancakes for the whole team on our one day a week off. Celebrating when our babies with severe acute malnutrition reach stabilisation on F-100 formula, or when the three-year-old with severe envenomation from scorpion bite starts eating again, despite being critically unwell just 24 hours earlier. I could think of many more highlights of my time there …

What were some of the challenges you encountered?

Isolation. On arrival to the hospital one morning, I was urgently called to assist with the resuscitation of a ten-month-old boy. He was blue. The team had been trying to resuscitate him for 20 minutes. We tried everything we could, but he died, and the family bundled him up and took him away. Afterwards, in that room full of people, the red zone of our ED, I felt so isolated. I couldn't quite process what had just happened. I have been involved in plenty of resuscitations, but nothing like that.

There were endless challenges — medicines, equipment, staff, skills, language, culture, social circumstances — and usually several going on all at once. But the feeling of isolation is what had the most impact on me. Under normal circumstances, there is always someone around I can ask for help or advice, or a shoulder to lean on, and they will understand and appreciate what I'm going through because the situation bears similarity to something they have experienced themselves. However, here, everything was so different that it felt almost impossible to describe to anyone else. My expat colleagues all had different jobs. I was the only expat doctor in the hospital.

With the long, complicated, frustrating days, it would have been easy to shut down, but I made a real effort to stay connected, both with my colleagues in the project and with family and friends back home. It was definitely worth the time and effort in the long run. I still felt isolated, but those connections gave me the strength and courage to keep going.

How do you balance your work in global emergency medicine with other competing demands in your life?

I always knew I wanted to work in global emergency care and I finally felt I was at a point in my career where I had enough skills and knowledge to make a meaningful contribution, so I did it. I took a whole year out of training and ultimately only had three months working in this project!

Things happened that were out of my control.

As I was finishing up my last job, in the final week, my dad had a large stroke. There were complications and, ultimately, he passed away. It was so unexpected. I hadn't even had a chance to talk to him about this year, about how I finally achieved my dream of working for MSF. I had been avoiding this conversation because I knew he would worry about me travelling to somewhere remote or dangerous. In retrospect, I wish I'd had that talk with him. He would have been worried, but he also would have been happy for me. When I finally left for my mission, it was my mum worrying about me and worrying alone. This weighed heavily on me, thinking of mum now by herself.

I was waiting to get a mission and picking up some locum work. It was taking ages, as there was a reduction in positions this year — just my luck. Due to my lack of a job, I could go away for an entire Easter long weekend. We went hiking along the Green Gully track in New South Wales. It was a great adventure until I fell on wet rock with a full 15kg pack, sustained a distal radius fracture, and had to hike two days, then drive seven hours back to Sydney to have it fixed. At that point, I had to surrender to my worst nightmare — becoming a patient.

With too much time on my hands while my wrist healed, I reflected on my choices and the issues in front of me. I only just got married the year before. We bought our first apartment and, suddenly, paying the mortgage became a real issue. I had resigned from my regular job. I was not yet being paid by MSF, as I was not yet on a mission, and my back-up plan of locuming also went out the window for at least six weeks until the cast came off my wrist. More issues kept coming up. I caught up with a friend who had recently




struggled to get maternity leave and found myself belatedly considering the benefits and entitlements that I forfeited when I resigned. I was seriously wondering if I had made a mistake taking the year off.

Then, not long after the cast came off, the email finally arrived that I had a mission, and I found myself in Syria. The war had been in the news for a long time and it felt strange to actually be there. It was weird for family and friends to be following the news from the outside. I certainly underestimated how difficult it would be for my husband and mum, with ongoing news reports of terrible things happening in Syria. For me, insulated in our compound and at the hospital, the wider security concerns seemed a distant distraction. One day, though, everything changed. We were evacuated and I finally felt the reality of being in a war zone. As Turkish forces invaded north east Syria, news reports showed roads and water being cut off, towns and villages under fire, and people fleeing their homes. I had an influx of messages from back home checking that I was ok. I felt very sad for our Syrian staff, patients, neighbours and friends who were left behind.

I returned to Sydney a couple of weeks before Christmas. I went to a local supermarket with my husband. There were Christmas carols playing as we wandered up and down the aisles. I felt so lucky. I was home for Christmas, with my husband, shopping in complete safety, while the community I had cared for and grown to love in Syria were under fire yet again in a civil war that has been going on for many years, and now without even a medical service. I started sobbing in the middle of the bakery goods and my husband held me until I could stop long enough to get through the check out and go home.

I feel very happy that I finally achieved my dream of working in global emergency care, but I also feel relieved to have made it home for Christmas, even though it was our first without my dad. There will always be many competing demands in life — that will never change. Finding balance is just finding what works for each of us as individuals, with all the unique circumstances of our lives. Next year, I hope to sit my Fellowship exams and maybe the year after that we will start a family. I still want to work in global emergency care in the future. I don't know how that will work or what that will look like, but I am confident I will find a way with the support of my family and friends.

If you could pass on one piece of advice to trainees or FACEMs looking to become involved in global emergency medicine work, what would this be?

Be open-minded and flexible. Things won't always go to plan — if there even is a plan to begin with! But that's ok. You will find your balance and you won't regret the experience, memories and relationships that will stay with you for a lifetime.

ACEM encourages those considering undertaking independently sourced Global Emergency Care opportunities in complex emergency contexts to partner with reputable organisations such as Médecins Sans Frontières (MSF) who provide comprehensive safety and security support and training.

EM Abroad: Papua New Guinea

Dr Duncan Sengiromo

Dr Sengiromo is an emergency medicine specialist at Port Moresby General Hospital, Papua New Guinea.

istockphoto.com/PietroPazzi

Tell us about Emergency Medicine in Papua New Guinea

Emergency Medicine (EM) in Papua New Guinea (PNG) is a new specialty, having its first intake into the post-graduate arena with the University of Papua New Guinea (UPNG) in 2002. EM training has had strong support from the Australasian College for Emergency Medicine (ACEM) since its establishment.

The UPNG and Port Moresby General Hospital (PMGH) have also trained many Pacific Islanders to become emergency physicians, including doctors from Solomon Islands, Timor-Leste and Vanuatu. There is a tremendous need for EM in the city and country. With the growing population and diverse medical and trauma presentations, there is a need for EM to provide urgent and organised treatment to stabilise patients. Furthermore, we pride ourselves as being the front-liners in resuscitation (CPR, etc) and mass incident hospital responses, which can extend to national levels. An extension of EM in PNG is its pre-hospital care, we have emergency physicians attached with the St John Ambulance to provide medical advice as needed. Moreover, EM training involves rotations to major disciplines like surgery, medicine, pediatrics and obstetrics and gynaecology (O&G). In the peripheral hospitals in our county, in the absence of surgeons or O&G doctors, we can perform basic emergency laparotomies as in appendectomies, Caesarean Sections and laparotomies for ectopic pregnancies. Therefore, as noted, we can perform multiple clinical roles but with patient best interests and best outcome in mind.

The PMGH Emergency Department (ED) is the largest functioning ED in Port Moresby with only 29 beds. The ED sees only Australasian Triage Scale (ATS) Category 1, 2 and 3s. The Category 4 and 5 with stable reviews are seen at the Ambulatory Clinic (only open during the day). Thus, the daily attendance to the ED averages more than 70 patients per day.

What does an average working day look like?

The PMGH ED was newly built/renovated with full utilisation by 2013. With much assistance from management, the facility continues to be maintained adequately. For me, it's a beautiful place to work.

Length of Stay (LoS) continues to be a problem. However, much improvement has been done since December 2018 with management, especially our CEO and Director or Medical Services (DMS), driving changes in processes to ensure patients are seen and sorted quickly.

On an average day, there are many illnesses and injuries encountered. This includes Tuberculosis (TB), which remains a leading cause of patients being admitted. This is followed closely by other acute exacerbations of respiratory illnesses such as asthma, pneumonia and COPD. Other non-communicable diseases include acute coronary syndrome, hypertensive emergencies and diabetes with metabolic complications. Trauma patients are seen daily with injuries that are often due to physical violence (with use of weapons, especially bush knives, stones), as well as road traffic accidents. These commonly results in limb fractures, chest injuries, abdominal injuries and traumatic brain injuries.

What are your biggest day-to-day challenges when working as an emergency doctor?

The number of patients attending the ED! Our bed occupancy rates are near 100 percent with each shift. With great assistance from the current hospital managers, changes to system have been occurring since December 2018, as well as improved data collection around ED overcrowding, ED bed occupancy rates, and hospital length of stays.

PMGH has increased its bed capacity to about a thousand to cater for the patient load. It caters for nearly a million people. The demand for its services are huge. It is a challenge to continue to support the numbers with its current capacity. Furthermore, this is worsened when other health facilities (clinics/ hospitals) are unable to open or provide certain services.

If you could make any changes in emergency medicine in your country, what would this be?

I would allow movement of emergency physicians to rotate from Port Moresby to other provinces and hospitals on a weekly basis to support emergency departments that have no emergency physicians, in order to train staff and provide clinical and human resource support.

I would also love to build a huge seminar room to allow for telemedicine. This can improve standards and clinical knowledge of EM across the country.

Lastly, I would also create a better pathway for "health and wellbeing" for doctors and other health practitioners as well. Personally, it has been difficult for me to take care of my own health and wellbeing. For a long time, the ED and my family were more important than my own wellbeing. This issue continues to be a struggle for me. However, I have improved over the year in terms of time management, physical exercise and healthy diet choices.

What do you love most about your job?

Resuscitation of patients from Basic Life Support measures and Advanced Cardiac Life Support measures remains a highlight of my job.

Australia's Aged Care System: an Optimistic Outlook?

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Cruel, harmful, discriminatory, and neglectful. This is how Australia's aged care system has been described in the interim report by the Royal Commission into Aged Care Quality and Safety released on 31 October 2019.

In the damning 800-page report, the Commissioners concluded that the aged care system is characterised by a 'sector-wide focus on the need to increase funding, a culture of apathy about care essentials, and a lack of curiosity about the potential of aged care to provide restorative and loving care – all of which is underpinned by an ageist mindset'.[1]

While only being mid-way into their investigation, the Royal Commissioners have been told of 112,000 instances of substandard clinical care and 69,000 instances of substandard medication management, amongst many other situations where an older person has been denied dignity and fundamental human rights. Alongside this, the report details harrowing personal accounts from older people, their families and carers, in many circumstances leading to an ambulance call out and an Emergency Department (ED) presentation.

Unfortunately, this is seen all too often, with older people being transferred to an ED for something that could have been managed in a residential aged care facility, had there been an appropriate level of staffing, skill mix and access to GPs, specialists and allied health professionals. In many cases, the risks and benefits of an ED transfer are not assessed or communicated to the older person or their families, despite exposing them to an increased risk of pressure sores, falls, delirium, medication errors and extended delays. This led ACEM's Geriatric Emergency Medicine Section Executive to provide a detailed submission to the Royal Commission and propose 16 recommendations to ensure that older people have equity of access to acute healthcare.

In recognising that Australia's population is ageing and that the need for high quality aged care services will only increase, the Royal Commission was tasked with an inquiry into the quality of the aged care system; how with increased demand, aged care can be delivered in a sustainable and person-centred way. To date, the Royal Commission has received 7,485 submissions and 5,217 calls to the information line. It has also held 14 witness hearings, including a hearing in Canberra in December 2019 focusing on the interface between aged care and the health system.

At this hearing, the Commissioners heard from Mr MacLeod, a resident of an aged care facility, who detailed how he was sent to an ED for fluid build-up in his legs. He was required to wait in the ED for eight hours before he was admitted, but due to insufficient movement while he waited, he developed a pressure injury in that time. When Mr MacLeod was discharged from the inpatient ward, staff at the aged care facility had to contact the hospital to understand his medication needs and treatment. On top of this, he was told that his medical records had been sent to another hospital rather than the facility.

Similarly, Ms Walton gave evidence about her mother's experience of multiple transfers to the ED. Ms Walton stated that some of her mother's transfers could have been avoided. In one particular instance, Ms Walton described how the treating health professional may not have understood

how her mother's dementia presented or how to ease her agitation, leading them to initiate an ED transfer which she considered unnecessary and distressing to both her mother and herself.

Tess Oxley, a paramedic from New South Wales (NSW), recounted her experiences where she thought aged care facilities often feared litigation and initiated ED transfers. She described how, despite the presence of Advance Care Directives, facility staff or relatives regularly urge for the resident to be transferred. She said, 'I think if it's deemed to be almost any form of risk, if there's any concern, we're immediately called and expected to transport … Generally, I find that there are no other options'.

Exploring the solutions

While it can be easy to focus on the problems of a broken system, the Royal Commission is also interested in solutions. Over the course of the week, a number of ACEM Fellows, including Dr Carolyn Hullick, Dr Ellen Burkett, Dr Terry Nash and Dr Clare Skinner, as well as other specialists, health professionals and service managers, gave evidence to the Royal Commission.

Dr Hullick and Dr Burkett framed their recommendations around the need to improve the quality of care and choices available to residents across care settings. As emergency physicians are well aware, key performance indicators (KPIs) – if implemented without a focus on improving patient outcomes – can be used punitively or be subject to gaming. Dr Hullick similarly noted that an ED presentation and hospital admission is not always in the best interests of the patient, as residents may be exposed to a number of risks, leading to a further deterioration in their health. As Dr Skinner stated, 'it's not that we don't want people there, but there's actually research evidence that there are safer ways to provide care to people'.

In considering ways to deliver care to older people, the Commission explored the option of multidisciplinary outreach (or in-reach depending on the jurisdiction) services. Such models have been piloted and delivered, however, as Dr Burkett highlighted, '… the need for these models of care inherently is because there are weaknesses across the whole system of care. If we had a perfect and unified care system, there may, in fact, not be as much of a need for this sort of system'. The Commission discussed the need to improve resident access to GPs, registered nurses and other specialists such as geriatricians.

Alongside this, there was acknowledgement that processes could be improved. There was substantial discussion about patient handovers from residential aged care facilities to hospitals and vice versa. As Dr Skinner described, resident transfers could be improved in the level of detail that is provided to the hospital. She recommended the introduction of electronic clinical templates to ensure that comprehensive detail about the patient and the reason for their presentation is provided. The discussion also highlighted that discharge summaries and clinical handover could be substantially improved. As Dr Hullick highlighted, 'we're handing them over from one health care provider to another', and as a result, it should be mandated that discharge summaries be provided to residential aged care facilities as well as a resident's GP.

Behind these issues is inadequate data. Dr Burkett raised that, 'the primary issue from an aged care facility resident perspective at the moment is that hospital systems across Australia don't have the ability to accurately identify aged care facility residents'. Similarly, if we want to be able to measure and track any change, interfaces between My Aged Care, My Health Record and the jurisdictional health system need to be improved. Dr Hullick stated that '… for us to be able to monitor and show diligence to the recommendations, we have to understand the data, and at the moment that data is actually very difficult to see in the state health system. So, I think at a systems level, an evaluation level, a research level, we need good access to the data'.

There was much discussion about the need to improve the standard of Advance Care Planning and Advance Care Directives, and the stage at which these are completed. Dr Skinner emphasised that, 'end-of-life planning conversation[s] need to be pragmatic and realistic and guided by senior clinicians with experience in end-of-life care, and not be something that patients and their families can do without that level of guidance … it's setting up clinicians and the families themselves for disappointment and failure when they encounter the acute hospital environment'. Dr Burkett also said, 'ideally, bringing the process forward so that it's occurring at a point where people are cognitively able to document their own wishes would be an ideal scenario, but I would certainly support the provision of Advance Care Planning discussions and facilitation of those in aged care environments'.

The Royal Commission follows 18 other inquiries and reviews into aged care. However, it is clear from the interim report that the Royal Commission is no longer interested in patch-ups to the system. Instead, the Royal Commission has called for an overhaul of the design, objectives, regulation and funding of aged care – a system which values older people and ensures that they receive quality clinical care. We look forward to the Royal Commission's final recommendations in November 2020 and await the changes this will bring.

Author: Freya Saich, *Policy Officer*

More information

If you are interested in becoming a member of the Geriatric Emergency Medicine Section, you can sign up here: acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Geriatric-Emergency-Medicine

Reference

Royal Commission into Aged Care Quality and Safety (2020) Interim Report: Neglect, available online at: agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-report-volume-1.pdf

Learnings from the Coroner: Snakebite and the SNAKE Study – How Many Vials is Enough?

In the spring of 2014, 27-year-old Shane Tatti was removing wild radish weed from the banks of the Snowy River when he was bitten vigorously by a 1.5 metre tiger snake. Co-workers applied immediate first aid, and he was taken to a local hospital where he received one vial of tiger snake antivenom. He arrived at Austin Hospital in Melbourne later that day but continued to deteriorate despite further treatment. Two days later, he died of hyperkalaemia from rhabdomyolysis and renal failure, together with refractory shock.

On a hot night in the summer of 2015 – only two months later – 70-year-old Mrs Z was asleep in her bedroom in a rural area of outer western Melbourne. Her partner awoke around 1:00 am to find her gurgling and appearing limp. There was a live tiger snake in the doorway. On examination, she was observed to have three double fang bite marks on her left big toe. She was treated by ambulance officers and taken to Royal Melbourne Hospital, where she received an initial two vials of tiger snake antivenom, later followed by a third vial. Despite this and other treatment, she suffered a cardiac arrest in the afternoon of the same day and died that evening.

Death from snakebite is rare. Concerned by these two cases in quick succession, Victorian Coroner Caitlin English consulted a number of experts on whether national guidelines advising the sufficiency of one vial of antivenom for all cases remained valid – but the experts were unable to agree. In late 2018, noting that her concerns remained unresolved, she recommended her findings be circulated to ACEM Fellows to highlight the evidence, guidelines and potential issues in the management of snakebite. ACEM's primary mechanism for review of Coroners' recommendations is its Quality and Patient Safety (QPS) Committee.

From these cases came the Survey of National Attitudes and Knowledge in Envenomation (SNAKE Study). QPS Committee member and FACEM, Professor George Braitberg, and FACEM Associate Professor Vasilios Nimorakiotakis (Bill Nimo), are the Principal Investigators. The study surveys Australian clinician knowledge, attitudes and practices in envenoming and antivenom use, and highlights the rich opportunities for potentially life-saving research that exist in the ED environment.

Our interviewee, Professor Braitberg (AM OStJ MBBS FACEM FACMT FRACMA MBioethics MHlthServMt Dip Epi Biostats), is the Executive Director of Strategy, Quality and Improvement at Melbourne Health, the Deputy Director and Head of the Emergency Medicine Program at the Centre for Integrated Critical Care (CICC) at the University of Melbourne, and an Adjunct Professor of the Health Sciences Unit at Monash University. He received the ACEM Service Award in 2018.

Professor Braitberg, thanks for agreeing to talk to us about the SNAKE Study. We know you are a FACEM with a long and distinguished career, and a member of the College's QPS Committee. Could you tell us a bit more about your background, especially the history of your interest in toxicology?

I have been a Fellow of ACEM since 1988 and director of a number of metropolitan emergency departments since then. I have been a toxicologist since 1995 when I completed my Medical Toxicology Fellowship at the Good Samaritan Regional Medical Center in Phoenix, Arizona, under Dr Steve Curry. I became Board-certified in emergency medicine and medical toxicology and was elected as a Fellow of the American College of Medical Toxicology in 2005. I started the Austin Toxicology Service and the Monash Toxicology Service (with Andis Graudins) and have been on the Victorian Poisons Information Centre roster almost continuously over this time. I have been very fortunate to combine my love of emergency medicine and toxicology, which has been fundamental to the development of my academic career.

In late 2018, the College received two Victorian Coroner's Reports concerning the deaths of patients – the first, 27-year-old Shane Tatti in 2014, and the second, 70-year-old Mrs Z in 2015 – both of whom received emergency care after a tiger snake bite. The recommendations were sent to the QPS Committee for consideration and action. What are the key issues for clinicians that these cases raise?

The key issues are:

1. Patients still die from snakebite.
2. Our current protocols may not adequately treat 'outliers' — patients who have increased susceptibility to venom (genetic or otherwise) or who receive a larger venom load.
3. Emergency physicians manage snakebite in a background of uncertainty and controversy.
4. We do not know if current guidelines are adhered to.
5. We do not know how clinicians seek help when managing a snake bite.

Were these Coroner's cases the main impetus for the SNAKE Study, or were there others?

The Coroner's cases were the main impetus as they challenged the concept that 'one vial treats all'[1] and highlighted the lack of agreement amongst the three expert witnesses called to provide an opinion. One of the expert witnesses introduced the concept of outliers and we were interested to explore this further. A review by Greene[2] suggested that the 'one vial treats all' recommendation was based on median venom concentrations and interquartile

ranges, thereby minimising the influence of outliers. We wanted to know what other clinicians thought and how that influenced their practice.

Who else is involved with the SNAKE Study? What previous research does it build on, if any?

The SNAKE Study is being coordinated by the Centre for Integrated Critical Care at the University of Melbourne. The Centre has been recently formed to promote academic research and teaching in the critical care disciplines. My principal co-investigator is Associate Professor Bill Nimo. Seqirus Australia (the sole manufacturer of specific-to-Australia antivenoms) has provided funding for the project. There are a number of associate investigators involved in the project. While there has been considerable research undertaken over the past decade about the pathophysiology of venom and envenomation, to date, there has not been a study that has looked at how this knowledge has been translated into practice or whether there is consistency in the application of clinical practice guidelines incorporating antivenom usage. The SNAKE Study aims to add to our understanding by asking doctors directly involved in patient care about envenomation management and where, when, and how advice is sought.

How is the SNAKE Study going so far? What stage are things at?

We have completed the recruitment. Preliminary results show 217 snake envenoming cases were reported, with all Australian states and territories represented. 65 per cent (n=142) of patients were not treated with antivenom, 30 per cent (n=44) received one vial, and 14 per cent (n=31) were treated with two or more vials. In 11 per cent of cases (n=9), adverse reactions after the use of antivenom were described. Hence, there is wide variation in the use of antivenom, and deeper analysis of the results should enable us to determine why this is so and make recommendations for the future.

On a lighter note, everyone loves a good acronym in research, and SNAKE must be among the most aptly named studies of all time. Who deserves credit for the name?

While I would like to say this was a result of 'group think', I suspect our study coordinator, Dr Ronelle Welton, came up with the name.

Australia is famed for its poisonous snakes, but what can you tell us about the true incidence of snakebite? What is the incidence of mortality? How worried should the public be?

In a study of Coronial deaths, conducted between 2000 and 2018, the average fatality rate was 2.2 deaths per year.[3] As per the SNAKE Study, only 30 per cent of snakebite received antivenom, so the public should not be worried. Clinically significant snakebite is uncommon and death is rare.

What is the best way for clinicians to be confident they are offering the right treatment to patients with known or suspected snakebite?

My advice at the moment is to follow your jurisdictions guidelines. Following a recommendation made by the Coroner, an expert working party convened in Victoria to review the guidelines emphasised the importance of seeking advice from a toxicologist. I think this is sound advice.

How can people track the progress of the SNAKE Study or find out more?

For people who would like to know more about the Study, please contact myself or Bill directly or via the Centre for Integrated Critical Care (https://medicine.unimelb.edu.au/school-structure/medicine-and-radiology/about-us/department-sections/critcare).

ACEM encourages members to subscribe to the Victorian Institute of Forensic Medicine's Communiqués, an electronic publication containing narrative case reports about lessons learned from the Coroner's investigations into preventable deaths – subscribe at https://www.thecommuniques.com/

The cases referred to in this article are available by searching for Case IDs #569614 and #4815 on the Coroners Court of Victoria website (www.coronerscourt.vic.gov.au/inquests-findings/findings).

***Author: Belinda Rule**, Committee Administrator*

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Continuing Professional Development

Doctors complete a rigorous training program to become emergency physicians, to ensure that the public receive the best possible care.

As learning doesn't stop when training is completed, all doctors, including emergency physicians, are expected to continue to learn new skills and enhance and refresh their knowledge through Continuing Professional Development (CPD).

The Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ), as the key medical registration authorities, determine minimum CPD standards for doctors in Australia and New Zealand respectively. The two authorities have very similar CPD standards, with many requirements the same. Medical colleges are required to develop CPD programs that meet these standards and are tailored to suit the scope of practice of their members.

ACEM's CPD Program is recognised by both authorities as the appropriate program for certifying that emergency physicians are meeting the CPD requirements for continued medical registration in both Australia and New Zealand.

Change is coming

Both the MBA and the MCNZ have recently reviewed, revised and announced changes to their respective registration and recertification requirements regarding CPD standards.

In order to derive more value from CPD activities, the MBA and the MCNZ will now require a mix of activities from three CPD categories:

1. Educational activities
2. Reviewing performance
3. Measuring outcomes

Within these three categories, all doctors will be required to undertake educational activities that are useful to them and their scope of practice, and be involved in regular feedback about their own performance and their clinical outcomes.

The MBA requires CPD programs to operate on a calendar year. To accommodate this, ACEM's new CPD Program will move from the current July to June cycle to a January to December cycle. This change will take place in 2021, allowing CPD participants

to begin accumulating CPD hours from July 2020, effectively extending the 2021 year to 18 months.

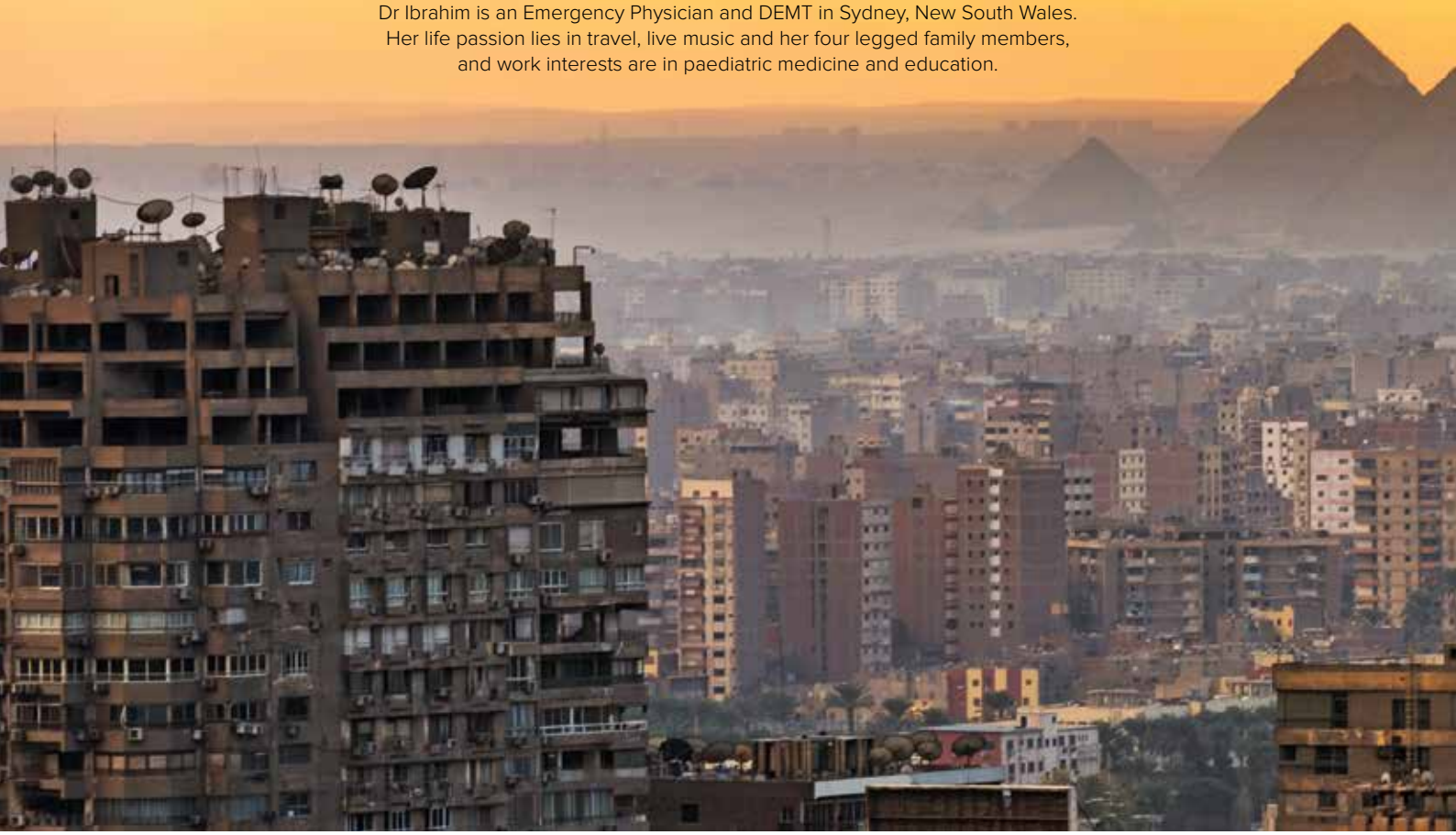
ACEM has responded to the changed standards on both sides of the Tasman with a revised CPD Program that will be introduced in July 2020.

The table below illustrates the key changes that will be introduced in the new CPD Program

CPD element	MBA requirement	MCNZ requirement	Explanations
CPD categories	• Educational Activities • Performance Review • Measuring Outcomes	• Educational Activities • Performance Review • Measuring Outcomes	Eamples of educational activities include lectures, conferences, reading the literature. Performance review examples include participating in a multi-source feedback exercise, peer reviews and formal staff review processes. Examples of measuring outcomes include, Morbidity and Mortality meetings, formal evaluations of clinical outcomes for particular groups of patients, and benchmarking of adverse outcomes against peer services.
Minimum annual requirement	50 hours of activity (at least 12.5 hours in each of the three CPD categories above and the remaining 12.5 hours allocated to any of the three categories.	Hours not specified by MCNZ. To be consistent with Australian peers, ACEM has decided to apply the same requirements as for Australia.	There are effectively two requirements for minimum hours: • no less than 50 hours overall for the year; and • no less than 12.5 hours in each of the three categories.
Professional Development Plan (PDP)	Developed at the end of a previous CPD year for the following CPD year. Reviewed at end of CPD year.	Developed at the end of a previous CPD year for the following CPD year. Reviewed at end of CPD year.	The annual PDP will require the development of a plan that will guide the participant's annual CPD activities and will incorporate professional development goals for the year. Reflection of the PDP at the conclusion of each CPD year will inform PDP goals for the following year, perpetuating a cycle of learning.
Conversation addressing professional development	Not required.	At least one structured conversation with a peer or colleague during the CPD year.	ACEM will require evidence that the conversation has occurred, but will not require participants to submit notes from the conversation.
Cultural competency activity	No MBA requirement (please refer to explanation).	Integrated into CPD activities.	ACEM has introduced this requirement to reflect their commitment to the integration of cultural competency. ACEM has pre-approved numerous cultural competence activities and participants may apply to have additional activities recognised. One activity every three years (as part of CPD cycle).
Procedural skills (annually)	No MBA requirement (please refer to explanation).	No MCNZ requirement (please refer to explanation).	ACEM has included procedural skills in its CPD Program to reflect the strong procedural nature of Emergency Medicine. One each of airway, breathing and circulation skills (by performance, teaching or supervision.
Procedural skills (three-year cycle)	No MBA requirement (please refer to explanation).	No MCNZ requirement (please refer to explanation).	ACEM has included procedural skills in its CPD Program to reflect the strong procedural nature of Emergency Medicine. At least 12 scope of practice procedural skills (by performance, teaching, supervision). One each of airway, breathing and circulation by performance.

Life After the OSCE: a Journey to Find Myself

Dr Mary Ibrahim
Dr Ibrahim is an Emergency Physician and DEMT in Sydney, New South Wales. Her life passion lies in travel, live music and her four legged family members, and work interests are in paediatric medicine and education.



I remember the day I got my Fellowship OSCE results telling me that I had now completed my final requirement for ACEM training. It was magical, momentous, historic! In my mind fireworks were going off, bottles of champagne were being popped everywhere — heck, they were even popping themselves — and there was going to be a gigantic celebration! This marked the moment life was suddenly going to become filled with rainbows, birdsong, butterflies and unicorns.

That's the story I'd like to tell. That is the story we would all like our trainees to believe. But it is far from the truth. And I believe that the truth remains unspoken, like a dirty secret that is, at most, whispered in darkened hospital corridors and behind closed doors.

Let me start again. Let me tell the real story of becoming a Fellow and the truth that followed for me.

For as long as I remember, becoming a doctor was all that I was ever going to be. I do not come from a medical family, but I was adamant from my early childhood. I fought hard to get into medical school, after being rejected by universities in Australia, the UK and Egypt. When I finally got into medical school at the University of Western Australia, it dawned on me that this drive was rather persistent and inflexible. After much self-evaluation, I discovered that my need to do medicine came from repressed and traumatic memories of witnessed violence and loss, an inevitable part of growing up a member of a minority group in Egypt. My family were loving, supportive and did their best to protect us. But I heard the news. I saw the fear. I remember watching from our balcony in Cairo as Anwar el-Sadat was assassinated and the chaos that ensued, hearing the gun shots and being ushered inside by my mum. I remember the child that died in the street below after being struck by a car. I remember watching a screaming neighbour across the street on fire on his balcony as the apartment block burned. I remember hearing the anguish in my parents' voices as they talked of the violence toward people they loved, the mass killings at churches and villages. At a very young age, I discovered that people — all people — including those that I love, would one day die. It sent me into a panicked subconscious frenzy. Enough so that I redirected the entire course of my life to build a career at the forefront of trying to prevent people from dying – emergency medicine.

My pursuit of medicine was not about the prevention of death. I know I can't do that. For me, as time passed, it genuinely became about service to others, a vocation that I could practise with love. None of us would choose this career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if we didn't truly care about others. I walked through my training with passion, motivation to be the best I could be for my patients, and the desire to serve with humility. Every patient to me was my own – my family, friend, partner, child. I treated them with love, with kindness.

I remember watching from our balcony in Cairo as Anwar el-Sadat was assassinated and the chaos that ensued

I had this false belief that once I got my golden ticket, everything would be a little more magical. I thought I would feel more equipped to do my job and that the grind of work would get easier. That I would have more time for my patients. Time to sit and listen to the 83-year-old widower who misses the love of his life after 62 blissful years of marriage. More time to support my colleagues and pass my passion and motivation on to trainees. I thought I would always feel in control of my choices. I thought there was no clinical situation I would not be able to handle. I believed that all this hard work would result in financial stability, a better quality of life, and the time to rediscover myself.

This is what actually happened.

The day the exam results came out I was at home trying to clean and organise my house. I had Fellowship material everywhere to remind me of the year that I lost me. I had ten missed calls and messages from friends asking how I'd gone.

I looked. I had passed.

I casually told those in my life that needed to know, and then I felt nothing. So, I kept cleaning. The following night I went out for celebratory drinks with a few close friends (all non-medical). They were ecstatic for me – maybe they would get their Mary back. I once again felt nothing but I recognised their love.

It was only a matter of weeks before I was offered my first staff specialist job, then a couple more job offers within a month. I was wanted! By getting joint training in paediatrics, I had secured my position in emergency medicine as someone that would be in demand. Before I knew it, I got swallowed up in the machine. The version of myself that loved live music, travelling and socialising over dinner was fading into someone I didn't recognise. I didn't even feel a need to attend my Fellowship ceremony.

In your first year or two as a staff specialist, you are perceived as potential by your department. You are young, enthusiastic and can help lighten the load, as well as bring

new life to a department under the stress of a public hospital ED. I spent my time saying yes to everything I was asked to do. I was not just working my full-time position. I was enthusiastically spending as much time at home every week doing non-clinical work as I did in the lead-up to my Fellowship exams.

Then there is the clinical time. Becoming a staff specialist doesn't suddenly mean you can deal with anything that gets wheeled through the door, it just means that everything stops with you. You have no one more senior to turn to. Even when there is a more senior colleague around, there is a pressure to prove you are worthy, to not ask for help. It is now you that has to speak with the parent whose child has died, it is you that has to manage the junior medical officer who has just been assaulted, it is you that runs the debrief after that 25-year-old successfully suicides, and you that holds it together for those who look to you for help. It is also you that carries the legal responsibility for what happens to patients who you often don't even know exist, even if you are home asleep in bed.

Of course, my life went on. Personal losses, life-changing events, everything continued. About three years after receiving my Fellowship, I found myself feeling blank. Who on earth was I? What was I doing? Everything I had done to this point was aimed at becoming that kind and competent clinician and I was there now — well on paper anyway – and all to the detriment of my personal life. There were many victims of my devotion and passion for work — my neglected family, loved ones and friends, personal joy, physical health and peace. In the process, I lost my clinician self that I had worked so hard to be. I was tired. I didn't love my job anymore. I didn't love that vocation I had worked so hard for since the age of three. I found myself getting annoyed at the lonely elderly patient that wanted a chat. I was irritated that my patient died because it increased my workload. I lost everything humane about my love of medicine and my love of people.

All that sacrifice, all that hard work, to get to this point in my career and now I wasn't even the clinician I wanted to be. I felt dis-eased.

That word intrigues me. Disease. The lack of ease. In medicine we learn it represents a physical ailment. Or at least something listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). To me, the word represents a lack of peace, an absence of internal ease. I wasn't depressed. I was still quite a happy person. I just didn't feel at peace or at ease.

I made several life-altering changes that helped me find my peace again. I went on a course called Simulation as a Teaching Tool run by the Center for Medical Simulation. This course was incredible. Not just in the way it was intended. It taught me to reconnect with parts of me I'd lost. It taught me to stop and listen to others, practise non-judgement and, in a sense, see a reflection of myself in those around me. It also taught me the art of communication. I had gotten so busy in my mind and my life that conversation became a process, a job – I was listening to others to respond, not to understand. I left this course realising that the non-judgemental me, the person who cared enough about others to really listen had

disappeared during my time as a doctor. Who on earth was I? What was I doing? I needed to find me again.

I attended a Paediatric Acute Care (PAC) Conference held by Advanced Paediatric Life Support (APLS). One of my recently retired mentors gave a talk. He was, to me, the superman of paediatric medicine, a mentor who always spoke and practised with love and wisdom. He always had a smile on his face. He could achieve anything and had changed healthcare in Australia as we knew it. He talked about his career and achievements over the years. He then spoke of his path with depression and how he thought of ending his life. He shocked the crowd – you could hear a pin drop. I was shattered and felt very vulnerable. If he felt like this, then what hope did any of us have? He spoke with honesty and courage. His voice shook on stage as all those who looked up to him sat with mouths open, eyes moist. He spoke of the impact of depression and burnout in medicine. The statistics were devastating. Then he spoke of his path, what he had personally done, and what we could all do to prevent and manage this reality. I left the conference and took a long walk on my own. I needed to process what I had just heard. Who on earth am I? What am I doing?

Another remarkable moment occurred as I sat on my own at my 12-seater expensive teak dining table, where I ate lunch for one. As I ate my microwaved frozen meal, I realised I had surrounded myself with ornaments that symbolised my progress and achievements. In doing so, I had also surrounded myself with symbols of my sacrifices, losses and dis-ease. When was the last time I had 11 friends over for dinner? I couldn't remember. I finished my lunch, cleaned the table, took photos of it and put it on Gumtree for $100. It sold within the hour. That evening, I also sold my outdoor dining set, a display cabinet and my two dogs' houses. Each time I removed an item of furniture, I gained a little bit of crazy joy and freedom, like an invisible weight was being taken off my hunched shoulders. Over the next two weeks, I sold or gave away most of my belongings. I was left with about

eight changes of clothing, a fridge, washing machine, bed, Fellowship notes, computer, camera and my car (which I was trying to get rid of). And I felt free. I guess this was my midlife crisis. Who on earth was I? What was I doing?

This loss of self I felt, my blankness, my dis-ease, and the encouragement of a close friend, led me to my boss' office. Despite the difficulty of it all, let me say this, my workplace was blessed with a director who was kind, protective, diplomatic and caring. She was the final element that allowed me time to ask questions to find my peace. I initially walked into her office to ask for three weeks off to travel overseas. While I was talking to her, without warning, I felt a little voice saying 'admit it to her – you are burning out. Three weeks isn't going to cut it'. So, I did. I exposed my vulnerability and asked for an additional six months off. (Six months?? Where the hell did I even pull this from?) She diplomatically listened, holding her position of authority, but with clear compassion in her eyes. She told me she'd think about it. A week later, my leave was granted. She just wanted me back, happy and ready, before Christmas. Just like that, a new phase of my life started.

I travelled for seven and a half months. I sold my belongings and arranged dog-sitting. I packed one backpack, purchased a one-way ticket out of the country, and left with my camera in hand. I had three changes of clothing, one pair of walking shoes and some toiletries. All I knew was I had lost me. In doing so, I had neglected family and friends. My motivation was to reconnect with those I had lost, to tell them I am sorry and that I love them. What I got was so much more.

People may think that this sort of gluttony and self-pampering sounds amazing and exciting. It was at times, but I also had some very dark moments. I had spent decades of my life running away from me and avoiding every truth that mattered by being too busy to deal with it. There was study before my Fellowship, then a mountain of responsibilities that followed. With all this leave and travel, despite where I went, when I looked in the mirror to do my makeup or brush my teeth – there I was! There I was with all my repressed truths, cracks and issues in my 'deal with it later' pile. I couldn't distract myself with work responsibilities anymore. I chased myself through every country, hotel room, friend's house, museum, through jungles in Central America, deserts of Arizona and Utah, the WWII trail of Europe, tropical paradises, and retreats. This is when I had my true breakdown – when I was faced with me. I couldn't escape nor recognise the person looking back at me from the mirror.

What did I learn from these experiences? They have completely changed me. I have learned self-compassion. I have learned to care for myself the way I care for others. I eat better food, I meditate, I have facials and massages, I see friends and spend more time with family. I am comfortable saying I love you and just as comfortable saying I am sorry. I have also become exceptionally talented at saying 'no' to things and people that are not good for me.

I have become less arrogant in understanding the place of medicine in the world. We as medical practitioners are a very small part of the wellbeing world. Our profession unfortunately teaches arrogance that keeps us vulnerable and keeps our patients at arm's length. There is much to be said for alternative and traditional health practices, community, exercise, yoga, nutrition, osteopathy, physiotherapy and psychological therapy.

The importance of green therapy (hiking, camping, enjoying natural light, taking a walk) and the appreciation of music and the arts has become a truth to me, as it allows me to reconnect with my humanity.

I have learned, deeply, that we are all equal as humans. We have the same needs (kindness, love, compassion, purpose, food, water and shelter) and the same vulnerabilities (disease, sorrow, death, loss and financial struggles). This was something my travels showed me. I was able to sit with people who looked, dressed and ate differently, practised a different religion and spoke other languages – we could truly connect, laugh and cry.

The importance of green therapy (hiking, camping, enjoying natural light, taking a walk) and the appreciation of music and the arts has become a truth to me

I have learned to pay attention to the small things and be grateful for the opportunity to work, eat and live. It has taught me more compassion for my patients.

I am more aware and respectful of the beautiful world I live in. I burn incense every morning, as is done in many other countries around the world, as a symbol of gratitude for the new day.

More importantly, I have brought this new lease on life back home with me. I am now privileged to be a Director of Emergency Medicine Training (DEMT). I talk to all my new trainees about how to weave wellbeing and self-care with the demands of efficient work and study. I have regular sit-downs with them about life planning, not just work planning. I am by no means an expert, but I have found a way to straddle the fine line between the machine that is medicine and the truth that is life. I tell trainees the honest truth about what happens when you first become a FACEM. The path post-Fellowship exam is littered with traps and poisonous arrows. The mirrors that line this path have been altered to reflect an untrue version of yourself. As you continue life as a FACEM, it is easy to miss ageing lines, fatigue, unhappiness, and the neglect of yourself and loved ones. I encourage trainees to treat their patients like family, their colleagues like brothers and sisters, and to practise self-care and communication in their life.

I feel that only by losing myself completely, I was able to regain my truth and peace, not just in my personal life, but as a clinician. It has left me kinder, more compassionate and more patient at work. I now look again at my patients and see the faces of those of my loved ones looking back.

Infusing Cultural Competency: A Supervisors' Guide to Resuscitate their Workplace

Dr Elizabeth Mowatt
Dr Mowatt is an emergency physician in Cairns, Queensland, with an interest in Indigenous health and medical education. She enjoys working with many passionate people in the space of cultural safety training.

Shells. An integral part of cultural practice for the Palawa and Muwinina Peoples of Lutruwita (Tasmania). Tiny, teeny-weeny shells, the size of a grain of rice. Strung together patiently over many hours while sharing stories, talking, learning, in silence. Connecting with each other, connected to Country and the waters of Lutruwita that will always connect mountain to river, to sea, to sky, to mountain. Fingers busy stringing and weaving stories, weaving the very DNA of these strong women into necklaces. Thousands of years of health and wellbeing practice … in shells.

Post-workshop reflection: Dr Nicole Liesis. FACEM and Workshop Facilitator

The Infusing Cultural Competency: A Supervisors' Guide to Resuscitate their Workplace workshop was held at the ACEM Annual Scientific Meeting (ASM) 2019 in Nipaluna (Hobart). The workshop was opened by Theresa Sainty, Palawa Elder, with a Welcome to Country. Theresa shared local cultural knowledge with a group of 30 FACEMs. Participants and facilitators will always remember Dr Ryan Dashwood kneeling over the fire in his possum skin cloak during a cleansing smoking ceremony involving new Aboriginal Fellows of the College. Grounding all the participants in local cultural practices and hearing Tasmanian Aboriginal perspectives was a powerful way to engage everyone in a shared learning experience, encouraging them to progress from merely observing, to embracing traditional Aboriginal protocols, practices, and ways of being. From the onset, there was a shift in perspectives, and deeper learning evolved.

The workshop allowed Directors of Emergency Medicine Training (DEMTs) and others to explore Cultural Safety and Cultural Competence; it relates to us all as practitioners, supervisors, role models and educators. The idea of the workshop was to address a number of challenges:

- Cultural Competence is explicitly included in the ACEM Curriculum, yet trainee learning happens mostly in local EDs.
- Most FACEMs and DEMTs have received minimal Cultural Safety Training, yet are responsible for what trainees learn in their departments.
- Cultural safety skills are essential when treating culturally diverse patients *and* supervising culturally diverse trainees.
- One size does not fit all, because local education should be developed in partnership with local communities.

FACEMs Dr Liz Mowatt and Dr Nicole Liesis led the facilitator team that came from far and wide – Cairns, Perth, Sydney and Auckland. There were many meetings to bring the workshop together, including invaluable contributions from people who were not able to be there in person. Most of the preparation work was done via teleconference and email. 'The journey of development for this workshop involved wide consultation and new friendships were made along the way. Meeting Associate Professor Peter Shine, Director of Aboriginal Health, Northern Sydney Local Health District, and getting that elder education was amazing. That man put me on the spot, made me think, and made me understand me and my purpose. That meeting was one of the highlights for me.' Dr Ryan Dashwood, new FACEM, Facilitator, Budawang man.

It was a challenge to know what to include in the four-hour workshop. It needed to be experiential, not didactic. Activities needed to engage the participants in theory that

could translate into practice and expose them to new ways to facilitate learning in their departments.

'Teaching cultural competencies in healthcare provision is not a train-the-trainer model. It is far more complex than that.' Dr Nicole Liesis.

Self-reflection is always the starting point in cultural training, as our personal perspectives influence how we perceive those around us. The workshop introduced concepts that are central to cultural safety and cultural competence, with activities designed to stimulate the participants to reflect on their own cultural values and views of the world. 'Without cultural competence, doctors are unable to obtain a complete history, and may not receive important information. That can lead to patient harm. To do our best for the patient, we must understand their main complaints and concerns; this is the ethical principle of beneficence. If cultural barriers impede health literacy and understanding, it compromises a patient's autonomy to make the best decision for themselves. Patients will not access services where they feel culturally unsafe, which creates inequity. This is why cultural competency should be considered as the fifth pillar of medical ethics, as it underpins all the other principles of ethical medical practice.' Dr Lai Heng Foong, FACEM and Facilitator.

Shared reflection and facilitated discussion were critical components of the workshop. Activities based on role play and storytelling were devised to encourage participants to explore the opinions and perspectives of others, not just their own. The workshop's success depended on creating a community within the room where people would feel safe to explore uncomfortable topics, including conscious and unconscious bias, discrimination and racism. Discomfort is essential if there is to be self-reflection, critical thinking and transformative learning. There was some definite awkward squirming noted in chairs at the start, followed by facial expressions confirming a 'lightbulb moment' of understanding.

Strong relationships are integral to Aboriginal, Torres Strait Islander and Māori communities, and the workshop structure drew on this construct. Working closely with Palawa Elder, Theresa Sainty, was fundamental to the success of the workshop. Members of the facilitator team travelled to Lutruwita to meet with Theresa in person. Through sharing stories and providing context around the workshop, ideas slowly emerged on how local cultural knowledge could translate into health practices relevant for 'our mob' (FACEMs). Mutual understanding and respect took time to develop, while Theresa got to know the facilitator group. This was an important foundation to create a setting where Theresa could feel safe in the group environment.

'Creating the Infusing Cultural Competency workshop was almost as much fun as delivering it. It was definitely a learning journey for me. It is part of the reason I am so drawn to the topic of Cultural Competency. It challenges me to think and reflect on a deep and personal level and learn more about the human experience'. Dr Liz Mowatt, FACEM and Facilitator.

The impact on the facilitators of designing and delivering the workshop was another highlight. Each brought a unique story to the table. Some have experienced discrimination and racism in their lives and training, while others strive to acknowledge their privilege, and to de-assemble the systems that advantage them. These are hard conversations to have, to hear, and contribute to. A safe space for facilitators to discuss their own positions and perspectives was critical and challenging to achieve through email and teleconferences. Everyone learnt more about themselves and each other through this journey, picking up new skills and ideas on how to continue championing the need for change in health care across Aotearoa New Zealand and Australia.

'The Infusing Cultural Competency workshop was a great success for all involved. It provided a unique opportunity for Fellows and trainees to reflect, communicate and expand skills in a safe, welcoming surrounding. Starting predominantly with DEMTs and managers is a critical first step in improving cultural awareness bi-nationally, but I emphasise it is the first step. My hope is that we can take this workshop (and others) to a broader audience and slowly diffuse all emergency departments with the skills taught. Part of this diffusion process should, in particular, include increasing the numbers of, and supporting, Indigenous and culturally diverse trainees and Fellows. We have all been called to action, so let's make a start.' Dr Angela La Macchia, new FACEM, Facilitator, Gumbaynggirr woman.

Transformative learning requires meaningful engagement with your peers as you explore novel ideas and practices. Face-to-face learning is ideal, but not always feasible. Cultural safety skills enhance everyone's practice and are good for all patients. They will become increasingly important and not just because the regulating bodies insist on it. An online community for emergency medicine practitioners can facilitate learning, offering more than a tick the box exercise to complete mandatory CPD requirements.

We want to hear what you do locally, what you need to continue learning, and what you feel about this topic. Providing and accessing a list of resources is easy; engaging in change and talking about its impact is harder, especially if only talking to yourself. So please, contact us at; educationalresources@acem.org.au and be a part of what comes next.

'It is *your* responsibility to go out and learn about Aboriginal peoples. You must find out about things and educate yourselves, meet the local people where you work. You shouldn't wait for that to come to you. Seek it out.' Theresa Sainty, Palawa Elder.

Council of Advocacy, Practice and Partnerships

The new Council of Advocacy, Practice and Partnerships (CAPP) term began with its first meeting on 27 March 2020. Members have been regionally elected to champion the cause for ED doctors locally and nationally.

CAPP has oversight of ACEM's policy, advocacy and research agenda, coordinating the work of a large number of entities. Members are elected to CAPP to make a positive difference. They are proud of their profession, but recognise the current system as unsustainable. New Chair, Associate Professor Didier Palmer, and Deputy Chair, Dr Clare Skinner, share a priority list of improvement issues that will be pursued by CAPP in 2020 and beyond.

ED role

Emergency Departments (EDs) are designed to provide urgent acute episodic care. As presentations grow, so does the complexity of the patients who present. Role creep is extreme, and the time has come to examine the role of EDs in the health system – designing, resourcing and supporting them accordingly.

Workforce

We need EDs that are specialist-run, not just specialist-led. This requires redesign of the workforce to allow specialists to do rewarding work at the top of their scope of practice, and to do so in all locations. We need quality emergency care that is accessible not just by wealthy people in cities. Future workforce modelling is the key strategic priority for the College in 2020 and beyond, led by the College's Workforce Planning Committee.

Referral options

Most EDs/hospitals have entirely predictable presentation and admission rates, but capacity is overwhelmed by minor demand fluctuations. More available hospital beds are required immediately. In the longer term, we need to build genuine capacity for out-of-hospital care. In 2020, we will be looking at alternative service models and advocating for those that are proven to work.

Patient-centred hours

The rest of the health system needs to operate patient-centred hours. The ED is an inappropriate setting for many patients. There will be no genuine alternative until senior clinical decision-making and diagnostic testing are available outside business hours in other settings. This is particularly true for mental health services. In 2020, a new ACEM Mental Health Working Group will be developing mental health action plans for Australia and Aotearoa New Zealand .

Physical infrastructure

ED design must reflect presentation numbers, throughput, models of care and wellbeing. Efficient EDs do not need to be large, they need lay-outs that allow clinicians to work effectively and safely, while providing privacy, space for carers, and orientation cues. In 2020, we will be reviewing our G15 ED Design Guidelines.

Health-promoting structures

We need KPIs that prioritise quality and safety, use resources efficiently, and promote health rather than disease management. Time-based targets must drive patient flow through the entire hospital and system, not just the ED. In 2020, we will consult with members on new access measures that reflect this need, and start work to secure buy-in at the highest levels bi-nationally.

Workplace culture

We need to care for people who care for patients. This requires training health leaders in people management, realistic and patient-focused targets, and engagement of clinicians and patients in decision-making. It requires attention to workplace design, team relationships and rostering – to allow meal breaks, education and research, adequate sleep and connection. It requires genuine support for diversity and inclusion. It requires compassion and care.

Global emergency care

We need to share our expertise in mutual partnership with our neighbours in the Indo-Pacific region. Our Global Emergency Care Committee is forging links with emergency medicine providers globally, and cultivating international opportunities for members. This enriches careers and raises the global excellence of our profession.

Sustainable resourcing

We must support health professionals to allocate scarce healthcare resources appropriately. Patients need to partner clinicians in 'Choosing Wisely', avoiding futile, unnecessary and harmful over-diagnosis, and over-treatment.

This article is based on a Croakey article published on 29 January 2020.

Diploma of Pre-Hospital and Retrieval Medicine – Landing Soon at a Training Site Near You

Over the past couple of years, the College – in collaboration with the Australian College of Rural and Remote Medicine (ACRRM), the Australian and New Zealand College of Anaesthetists (ANZCA), the College of Intensive Care Medicine of Australia and New Zealand (CICM), and the Royal Australian College of General Practitioners (RACGP) – has been working towards the launch of the Diploma of Pre-Hospital and Retrieval Medicine (DipPHRM). It is the first formally recognised qualification in pre-hospital and retrieval medicine in Australia and New Zealand.

The DipPHRM is a six-month training program and will entail training at a site in Australia or Aotearoa New Zealand accredited for training, workplace-based assessments, a written examination and an Objective Structured Practical Examination (OSPE). Due to the nature of PHRM practice, DipPHRM trainees will be expected to have a high level of functional independence. There is expectation of a significant degree of advanced knowledge and suitable critical care experience in base specialty training prior to applying for the DipPHRM.

The DipPHRM was due to launch in term three of the 2020 medical year, however the impact of COVID-19 has necessitated a delay in implementation. Keep an eye on the ACEM website for additional information as it is released or contact PHRM Coordinator Jess Buchanan (at jess.buchanan@acem.org.au).

More information

Additional information, including details regarding eligibility, can be found on the DipPHRM page of the ACEM website (acem.org.au/PHRM).

My First Day on the Job

Dr David McGreachan

I was obviously a bit anxious, who wouldn't be, starting a new job in a new department and in a new city.
I was surprised by how nice everyone was, they all went out of their way to introduce themselves and make me feel

they all went out of their way to introduce themselves and make me feel welcome

welcome. I quickly realised that this was a supportive and accomodating environment and it didn't take me long to know I wanted to be here long term. I enjoyed it so much I decided to stay and train here!

Dr Peter Carter

In my previous life, I was a rural procedural GP doing obstetrics and anaesthetics. On my first day as an obstetrics registrar in a regional hospital, I was covering the previous registrar on the Sunday night before my official start the next morning. I hadn't delivered a baby since medical school.

just in time to see the midwife smiling at me as she handed the mother her new daughter

The midwife called me at 11:00 pm to attend my first delivery. When I ran in, I could see baby's bottom on view — a breech! My reaction was to run back out to the doctors' desk to call the consultant, whose advice was unprintable but valid. I went back in to assist, just in time to see the midwife smiling at me as she handed the mother her new daughter.

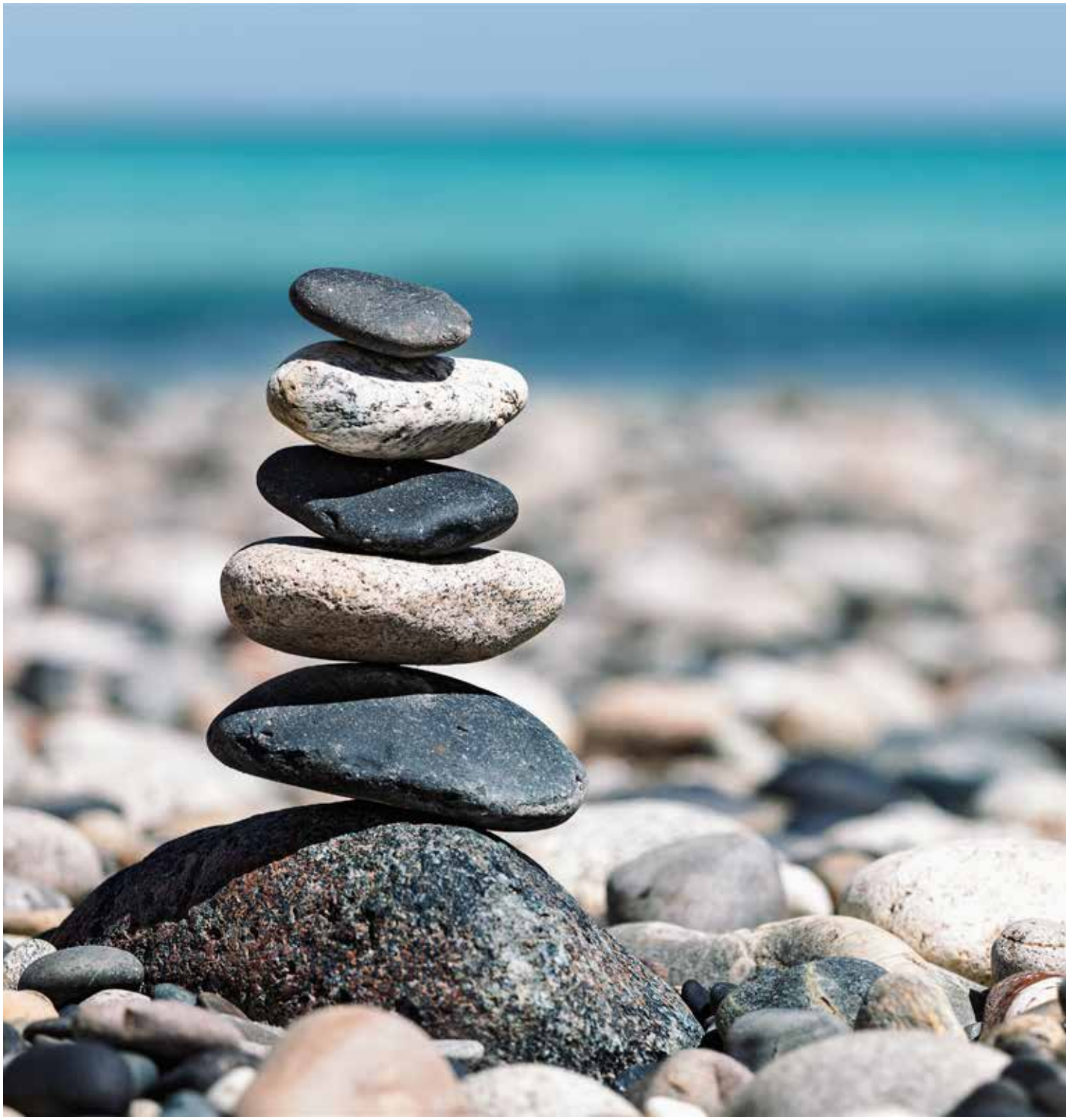
I grew to love GP obstetrics and practised for 15 or so years, but it was a very humble beginning.

Dr Thomas van Dantzig

The bat phone sung out across the floor and I craned over the registrar's shoulder to read his scribble: 'snake bite to the eye, ETA five mins'. Crikey! My student years in city hospitals had not prepared me for this. I recall asking myself, 'How do I pressure-bandage an eye?'

The patient was wheeled in and casually hopped off the trolley onto our resuscitation bed. 'Hey bra, sorry it's taken me so long. We were having lunch out bush after going hunting.' It turns out he was hunting snake for bush tucker. After the catch, he kindled a fire and roasted the snake for dinner. By now, it was four hours post-bite. I remember feeling grateful he was alive and then wondering what roasted snake tasted like. Such were my scattered thoughts as an intern at Alice Springs Hospital Emergency Department.

Given the vast size of most cattle stations in the Northern Territory, stockmen often fly small helicopters to herd stock and transport supplies. One jackaroo was a little too eager to alight his aircraft and received a spinning rotor blade to the head. He was bleeding from his ear, still breathing, but needed airway security and scanning. I managed to stop my hands from shaking for 30 seconds to plumb a cannula and then retreated to write the imaging request form. He went swiftly up to ICU with a base of skull fracture and a contrecoup injury.



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

–Sadhguru

Need tips for managing competing demands?

Speak in total confidence to a Converge International consultant.
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