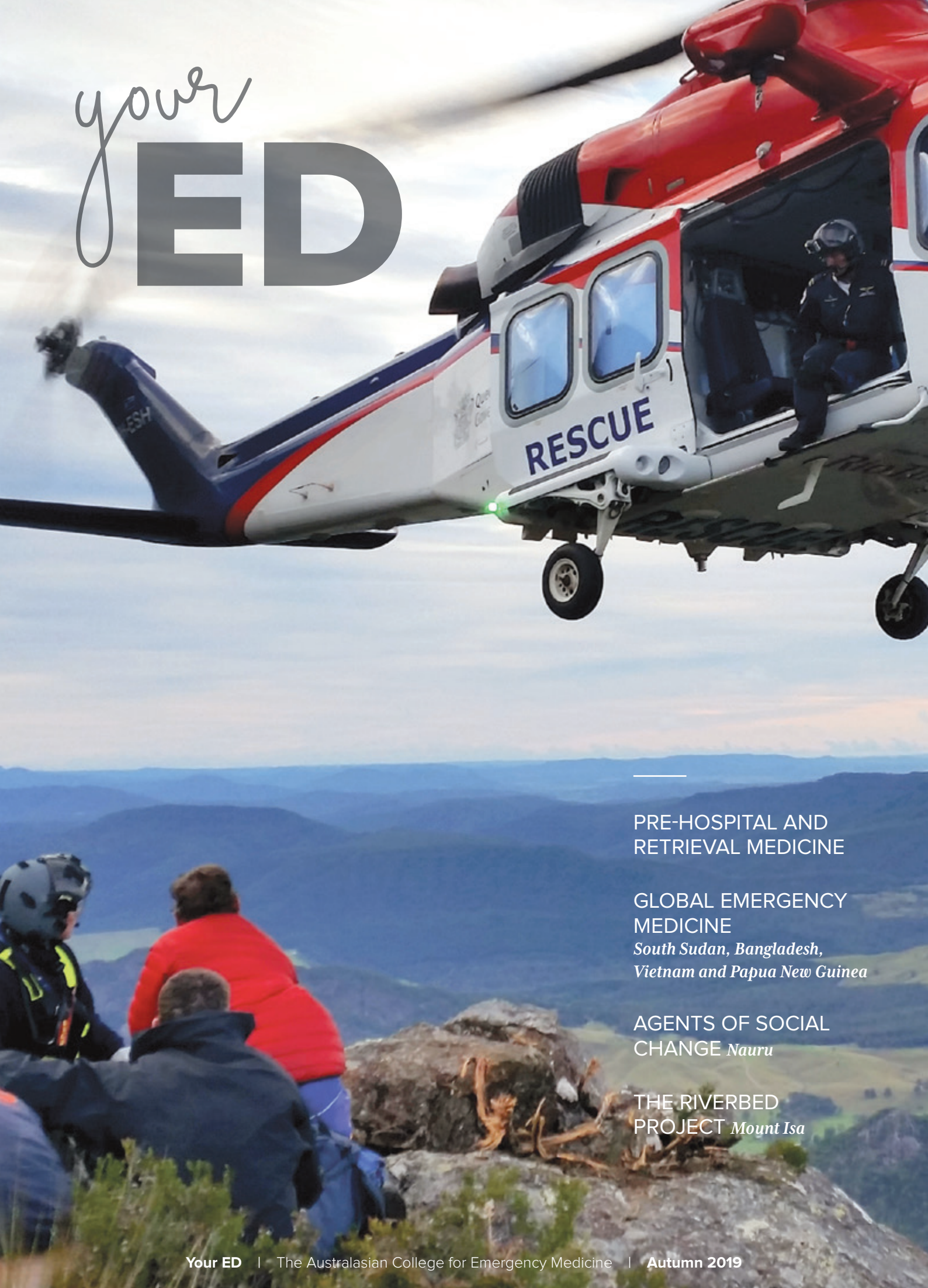
your ED



PRE-HOSPITAL AND RETRIEVAL MEDICINE

GLOBAL EMERGENCY MEDICINE
South Sudan, Bangladesh, Vietnam and Papua New Guinea

AGENTS OF SOCIAL CHANGE *Nauru*

THE RIVERBED PROJECT *Mount Isa*

QGAir image courtesy of the Queensland Government

Australasian College for Emergency Medicine

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Your ED

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Contents

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Message from the Editor

Welcome to the first issue of *Your ED*, ACEM's new quarterly magazine. We are thrilled to present this edition, filled with stories from emergency departments across Australia, New Zealand and the world. Within these pages we hope to highlight the many aspects of emergency medicine, the doctor–patient relationship and the clinical, advocacy and education works of the College, and so much more.

These narratives are real, they are written by your colleagues, by your peers and by you. They cross boundaries and show that wherever you are is *Your ED* – an inner city ED, a rural hospital, being winched from a helicopter, or under a tarpaulin in the middle of a foreign jungle.

We hope you enjoy these perspectives on emergency medicine.

your ED Sustainability Initiative

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ACEM in the Media

November 2018 saw ACEM's campaign to improve access to care for patients with acute mental and behavioural conditions in emergency departments dominate the news, following the College hosting its *Mental Health in the Emergency Department Summit* in October.

Media coverage was secured across Australia, covering TV, radio and online.

ACEM's key advocacy position, messages and solutions were covered, and were complemented with case studies.

ACEM President Dr Simon Judkins appeared on ABC TV News Victoria to talk about the crisis in mental healthcare in the lead up to that state's election in November. This followed the ABC's coverage of the issue on radio and online, both of which featured Dr Judkins. The ABC also published a story online detailing the emergency department experience of consumer Fiona Nguyen, who spoke at the Summit.

ACEM's 2018 Annual Scientific Meeting gained media coverage in Perth. ACEM President Dr Simon Judkins, a keynote speaker, and several other presenters featured in the news.

Coverage included:

- FACEM Dr Nick Taylor appeared on 10 News First talking about a study of first aid techniques following shark attacks. His study was also covered by *The West Australian.*
- FACEM Professor Drew Richardson gave an interview to ABC Radio in Perth on mental healthcare in Western Australia.
- In *The West Australian,* Dr Judkins called on the State Government to outlaw mental health patients being left in hospital emergency departments for more than 24 hours.

In **January 2019**, ACEM issued a statement in support of pill testing, gaining coverage in Nine mastheads across Australia.

ACEM aknowledged the discussion in the public, media and among politicians over pill testing, believing that, with its members assessing and treating patients attending an emergency department for suspected drug overdose, a pill-testing trial should be considered as part of a wider harm minimisation strategy.

In **February 2019**, FACEM Associate Professor Katie Walker spoke about how the use of medical scribes increased emergency doctors' productivity and reduced patients' length of stay.

'I can't understand how we have let ourselves become data entry clerks — we spend 50 per cent of our time entering computer data', Associate Professor Walker told the *Herald Sun*.

'Trained scribes can enter the data instead and then doctors can see 25 per cent more patients. Doctors and patients just want to see more of each other and this moves doctors away from filling in forms, back to patients' bedsides where patients need them.

'Now, having this rigorous evaluation, it is hard to imagine why we wouldn't proceed and start scribes.'

Dr Simon Judkins was featured in The Canberra Times in **February 2019**, commenting on the status of mental healthcare.

Figures had shown a sharp drop in the number of mental health patients at Canberra's emergency departments who are treated within an appropriate timeframe.

'We are mindful that it has taken years of neglect to get to this point, but we are encouraged that the minister is engaged in solving this critical issue', Dr Judkins told the paper.

'We are watching closely and have had meetings with the Minister and discussions with the CEO of Canberra Health Services.

'Our meetings have been positive and we will continue to work with ACT Health to improve the current situation.'

In **March 2019** ACEM welcomed the strengthening of gun laws in New Zealand.

Waikato-based ACEM President-Elect Dr John Bonning said, 'Strengthening gun control, registration and licencing makes people safer. We congratulate Prime Minister Jacinda Ardern and call on Parliament to pass these laws as quickly as possible'.

ACEM President Dr Simon Judkins said, 'Nothing like last week's terrorist attack on the Muslim community in Christchurch must be allowed to happen again. As the Prime Minister has stated, these moves are in everyone's interest'.

'We have seen how critical it is that emergency department teams are properly staffed, resourced and supported to ensure doctors can deliver the best critical care.'

In **March 2019**, FACEM Dr Vanessa Clayden was profiled in the *Melville Times* ahead of International Women's Day.

Dr Clayden is Head of Emergency Medicine at Fiona Stanley – WA's busiest emergency department.

Dr Clayden said she felt lucky to work in a field that valued the contribution of women and men equally.

'I think it's fantastic that 53 per cent of our senior medical staff are female', she told the paper.

'I'm grateful that men and women are equal contributors and I feel blessed to be in this industry.

'I also feel a responsibility to motivate the entire staff and continue delivering for the public.'

Dr Clayden said her work was split equally between administration and clinical work.

'We have 125 doctors, 45 of who are specialists and the rest are doctors in training so we need to make sure they are working cohesively', she said.

'We are one of the two busiest emergency departments in the country, we see about 110,000 people per year which works out to be just over 300 people per day.

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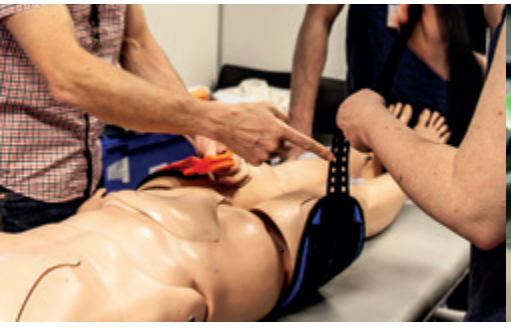

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ANZCA and FPM CPD program participants may claim the
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RACGP QI&CPD 40

'What motivates me is to be a benchmark department in Australia and to maintain staff cohesion and keep it as a collaborative environment.'

In **March 2019**, ACEM spoke out about conditions at Redland Hospital with about 90 people each month waiting longer than 24 hours in the emergency department.

Queensland Faculty Chair Dr Kim Hansen told the Redland City Bulletin emergency department staff were stressed about the wait times.

'They tell us they can't sleep at night after a difficult shift seeing those patients in the corridor, seeing all the patients in the waiting room that they haven't had a chance to see', Dr Hansen said.

Dr Hansen said Redland Hospital had a big emergency department but was a smaller hospital, transferring a significant number of patients to other hospitals.

'There's no intensive care here so the emergency doctors are doing intensive care not only for their own patients but everyone on the Redlands wards as well', she said.

In **March 2019**, FACEM Dr Peter Freeman spoke to the *Rotorua Daily Post* as the town in New Zealand hosted a mountain biking festival.

The paper noted an influx of mountain bike-related injuries, with local hospital staff saying this year's festival had been busier than usual.

Dr Freeman said injuries sustained during the event included spinal, spleen and a severe shoulder injury. Other injuries included grazes and painful wrists, arms and shoulders.

In **April 2019**, FACEMs Dr Katie Mills and Dr Sheree Conroy were featured in the media following an Emergency Medicine Education and Training (EMET) session at Toowoomba Hospital.

'We've travelled more than 46,000km to provide 215 EMET training sessions at 17 of our hospitals, with more than 2300 attendees', Dr Conroy told the *South Burnett Times*.

The paper reported that two emergency specialists from Toowoomba Hospital travel to a couple of rural hospitals every week to deliver training, and that they do separate training modules for topics such as airway management, paediatric and trauma which is seen weekly in Toowoomba, but less regularly in rural facilities.

'That's why it's so important to visit our rural hospitals and upskill and refresh our excellent rural staff on managing these less common emergencies in their own clinical setting', Dr Conroy said.

In **April 2019**, Tasmania Faculty Chair Dr Marielle Ruigrok wrote an opinion piece for the *Hobart Mercury*, calling for more effective and efficient health care.

'True change, culture change, takes time. And this involves engagement from hospital leadership who are inclusive in consulting with the skilled clinicians they have, utilising their knowledge to deliver a great service', Dr Ruigrok wrote.

'There are constant cries for more money and more beds. But, without evolution of our processes, without being more effective and efficient with our healthcare, we will be no better off.

'Clinicians must understand their roles as resource stewards for the system and be a conduit to effective and safe care.

'While we need more emergency department spaces at the RHH, most solutions lie outside the emergency department, both short-term and longer-term.

'It is about creating capacity on the wards and in the community.'

In **April 2019**, South Australia Faculty Chair Dr Thiru Govindan and Dr Judkins visited South Australia, calling for better patient care and improved work conditions for staff.

The two were featured in *the Adelaide Advertiser* following a tour of the Royal Adelaide Hospital.

'We can certainly say the situation here is as bad as it gets with mental health patients', Dr Judkins said of the hospital.

'When we look at the statistics the Royal Adelaide Hospital always stands out — but in a bad way.'

Dr Judkins said no Adelaide public emergency department, including Flinders Medical Centre, complies with the College staffing guidelines.

'We know from studies across the world that if you turn up to an ED that is under-resourced, overcrowded and without sufficient staff, your chances of spending longer in hospital, of adverse medical outcomes and your chances of actually dying are increased — this is directly related to patient morbidity and mortality', he told the paper.

In **April 2019**, FACEM Dr Jeremy Friend warned the Geelong community against turning to social media for medical diagnoses.

The advice came after a number of cases of people sustaining severe injuries after using home therapies came to light.

'In the case of burns, topical treatments applied immediately as first aid such as oils and creams may increase the damage caused by the burn', Dr Friend told the *Geelong Advertiser.*

'Home treatments such as toothpaste and egg whites can increase the risk of infection to skin already damaged by a burn.

'Any therapies that have not been subjected to appropriate rigorous medical research have the potential to cause more harm than good.'

In **May 2019,** FACEM Dr Mel Venn spoke about the need for commitment to health equity in Australia.

She stressed to *The Guardian* the importance of better funding for preventative health measures and primary healthcare.

'Every day we see people come to the emergency department, either because they can't afford to get into the GP or they can't get into the GP', Dr Venn said.

Her prescription for what would help her community's health and wellbeing includes wide-ranging action to address poverty, including through raising the Newstart allowance and more generally ensuring liveable incomes, as well as access to affordable fresh food, public transport and higher education, the website reported.

PRESIDENT'S WELCOME

Dr Simon Judkins

I am really proud to make a contribution to this first issue of Your ED. The magazine is the result of hard work, inspiration and collaboration, and the end product, I'm sure you will agree, is informative, entertaining and engaging. The aim of this magazine is to keep you up to date with the work of your peers and ACEM, and is for all members and trainees, as well as other health organisations. This first issue highlights the great work we – the College, its members, trainees and staff – are doing right around the world.

I have not spoken about it often, but my grandfather was a GP. He worked almost every day because he loved what he was doing. He was an old-school practitioner and relished the chance to care for his community and make a difference to their lives. My grandfather was a role model for me. He loved his job. Years ago when I was a medical student, and then as a junior doctor, I was never quite sure what to do or whether I would follow in his footsteps. I considered being a GP, I tried out surgery and anaesthetics, but when I got to the emergency department it felt right. It felt like my place. It still does.

All these years later, I love my job just as he did. I am privileged to be the President of ACEM, a role that has afforded me the opportunity to meet so many of my colleagues in emergency medicine, both locally and internationally. It has always been a very rewarding part of my role with the College to hear your stories and understand your perspectives.

As a specialty, as a College, and as a team, we can and are doing work that is incredibly valuable. Our work is life-saving for many of our patients, and life-changing for many more. I am proud of everyone who carries this responsibility so passionately as to do it every day, in face of all sorts of obstacles. Patient outcomes depend on what we do, and each day we step up and deliver our best. Sometimes it is hard and the world seems to rally against us, but we do what we do because our patients and our communities need us. I'm so proud of that. I hope you enjoy this first issue of *Your ED*.

CEO's Welcome

Dr Peter White

So, let's start with some simple mathematics. The sort where you get to a certain stage of life and are grateful that you can still do in your head, as your mind wanders randomly down inner-suburban lanes coming off the blocks that you have apparently been around more than once . . .

At the end of last year I reflected that I had had the privilege of being CEO for ACEM for about three-and-a-half years. Given that I started full-time work after university in 1983, there's some irony there that I had been in the professional workforce for as long as ACEM had been in existence as a College for a recognised specialist branch of medicine. That means I had spent around ten percent of my professional life at ACEM, and had been the CEO of ACEM for the corresponding proportion of its existence. In terms of my time spent in medical education and administration, similar number crunching reveals that I've spent just under half of my professional life in the sector, with about a fifth of that ACEM.

The point? All in all, I can now probably say I've seen a bit, and from a few perspectives. What is always impressive about working in this sector is the commitment of College memberships and other health professional colleagues to their professions and the communities they serve, and the commitment of College staff to ensuring the support of that work. ACEM is no different, though one of the things that I quickly became convinced of after I commenced here and decided we needed, was a way of communicating the huge amount of effort that goes into producing a range of positive outcomes for the benefit of the general community, in order to enable the College to celebrate the work and achievements of the organisation.

Sure, we have a website, we tweet, we post on Facebook, we're LinkedIn, and we put out e-bulletins and newsletters. But, unlike some other colleges and organisations, we seem to be lacking that regular summary of information and celebration of achievement that conveys a message about what ACEM is doing across its spectrum of activity, to those involved in the organisation and those outside. This is an organisation that can be proud of what it does and should not be afraid to showcase that.

So, here is the first edition of *Your ED*, a publication intended to do just that; to communicate the work the College does; for and by its members, in partnership with College staff and others that give of their time. Everyone involved has contributed much to produce a quality publication intended to have something of interest for everyone who works in emergency medicine or has an interest in the work of the College. Read it and take the time to let us know what you think. I genuinely hope you enjoy the first read, wherever your ED may be.

A Vote to Change the Constitution

Following consultations and member feedback, proposed revisions to the composition and structure of the ACEM Board have been put to a vote.

ACEM this month has invited Fellows of the College to vote on proposed revisions to the composition and structure of its Board. This follows more than a year of work by the Board and the Diversity and Inclusion Steering Group (DISG) to understand the perceived appropriateness of the composition of the Board, and to find practical solutions and approaches to redress any imbalances or barriers to participation.

Fellows have 30 days from May 6 to cast their vote on whether to accept the proposed changes to the Constitution that will remove two ex-officio positions from the Board and replace these with two positions open to FACEMs from the general membership. An ex-officio position is one held by a person because of a position they hold elsewhere. In the case of this vote, the ex-officio positions in question are held by the Deputy Chairs of the Council of Advocacy, Practice and Partnerships (CAPP) and the Council of Education (COE). The second resolution asks whether a community representative should be appointed to the Board.

The decision to hold this vote has not been taken lightly. In 2018 and early into 2019 the Board and DISG conducted two consultations that sought the feedback of members on the appropriateness of the composition of the Board, CAPP and COE, the barriers that exist to participation, and opportunities to rectify these issues.

'Only about 20 per cent of directors of emergency medicine (DEM) in Australia and New Zealand are women', says FACEM Dr Clare Skinner, director of the 'most female' ED in Australia.

Clare recognises that this vote is not simply about women, but is very clear that the visibility of women being on the Board is exceptionally powerful.

'The place that a lot of people start at is that you can't be what you can't see. I was lucky enough to see a lot of women in leadership roles in the start of my career and lucky enough also to overcome my own voices of doubt when I applied to be a DEM, but I know this is often not the case', she says.

The majority of respondents in the consultation phases indicated the view that the Board, as currently composed, does not accurately represent the diversity of the Fellowship and that there are barriers to participation.

More than half of respondents to the second consultation supported the removal of the ex-officio positions of the Deputy Chair of CAPP and COE, with most also agreeing that the incumbent Deputy Chairs should serve the remainder of their current term. Ninety per cent of respondents supported the creation of two new positions on the Board to be filled by FACEMs appointed from the general membership.

Fellows are asked in two resolutions whether to accept proposed changes to the Constitution that will:

1. remove two ex-officio positions from the Board and replace these with two positions open to FACEMs from the general membership; and
2. allow for a Community Representative to be appointed to the Board.

The vote – and the specific changes proposed – has the strong support of the Board and the DISG, both groups believing it is too important to delay or to disregard the fervent conversations happening informally on the ground and on social media. The latter is a platform frequently used by FACEMs such as Dr Kimberly Humphrey.

'I think sometimes (when I tweet) that I am preaching to the converted, but you do find people still talk about merit and that appointments to the Board should be strictly about merit, that changes like this will compromise the Board. But you have to take these proposed changes in the context of historical norms and social structures that have inhibited "minority" or "diverse" groups from necessarily obtaining these positions.'

FACEM Dr Ajith Thampi says that it is a chance we need to take.

'The College is all of us. We need to make a decision on what that means and what is best practice for our College, for us, to succeed.'

The voting period closes 4 June. All FACEMs are eligible to vote and are encouraged to do so via the ACEM website.

Fatima Mehmedbegovic *Strategic Priorities Implementation Manager*
Natasha Batten *Communications Advisor*

More information

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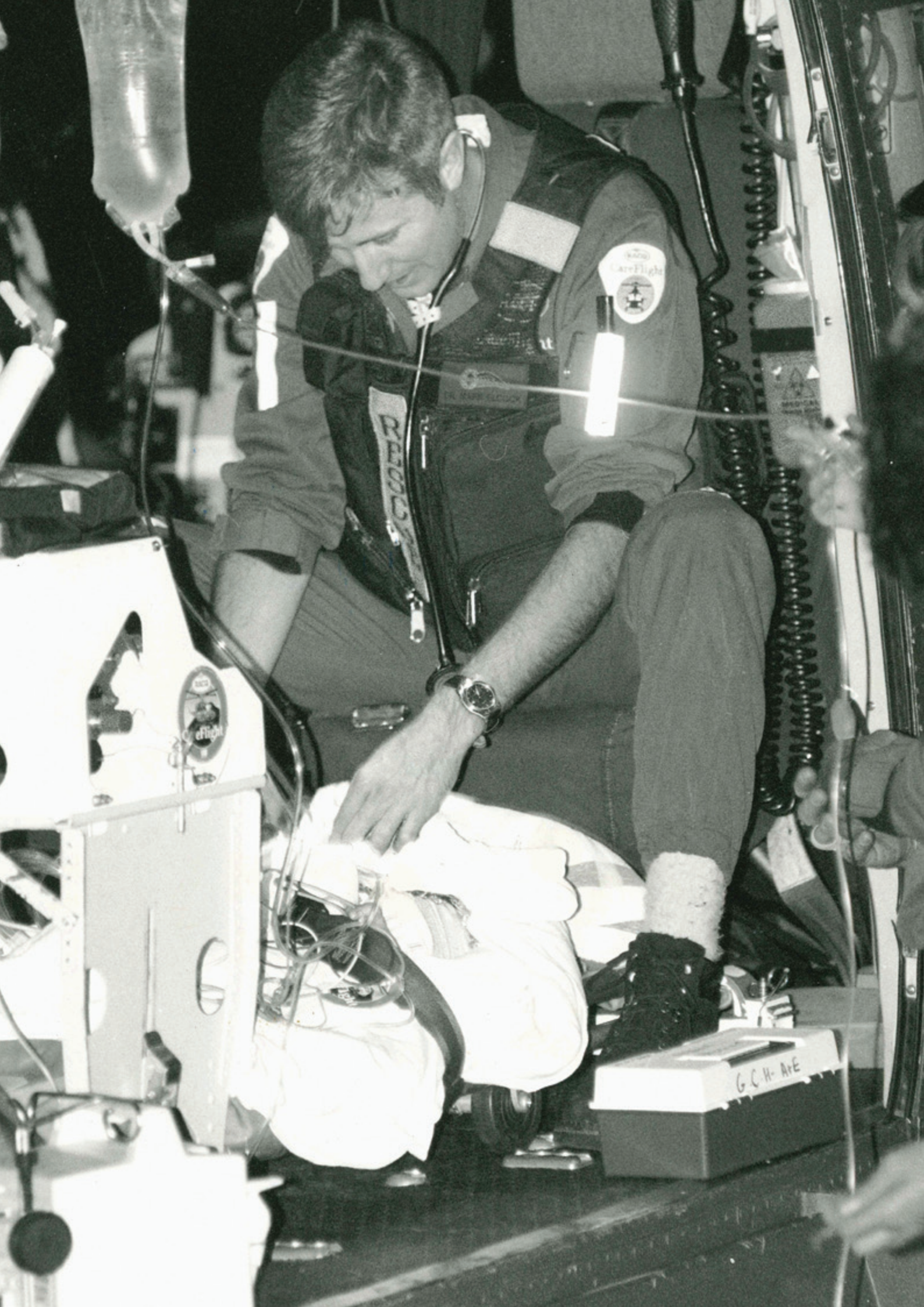
acem.org.au/vote
#getonBoard


CareFlight
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Spinning into Control

Dr Mark Elcock

When most people think about an ambulance, it's the distant sirens reverberating against the surrounding buildings, the flashing lights in their rearview mirror, but few would envision blue skies, vast green rainforests and golden beaches from 10,000 feet. The world of PHRM is just that, a bird's eye view of those in need.

Pre-hospital and Retrieval Medicine (PHRM) systems provide critical care medical services to safely manage and transport sick and injured patients to and between hospitals, specifically supporting communities in rural, regional and remote locations. There are now many well-developed PHRM services that respond to patients by road, helicopter and aeroplane across Australia and New Zealand.

FACEM Dr Mark Elcock started in PHRM almost 30 years ago on Queensland's Gold Coast. He was in his early twenties and newly arrived from his native Scotland.

'My experience of emergency medicine back in the UK was not great, but when I started at the Gold Coast Hospital Emergency Department in 1990, it was an awesome place to work and I was privileged to be given the opportunity by the Director, Dr David Green, to do PHRM. I jumped at the opportunity and I haven't looked back since.

'We used to fly in single engine helicopters with the doors open to get some fresh air and a reprieve from the stifling heat. We were available to go anywhere to rescue or retrieve sick and injured patients and I guess that was initially the attraction. To combine emergency medicine with flying was just so good!'

Today, Mark is Executive Director of the Aeromedical Retrieval and Disaster Management Branch at the Queensland Department of Health which oversees and tasks all aeromedical missions, statewide disaster management support and emergency telehealth models in Queensland.

Long haul

Mark recalls being enthralled from the very start by a job he says captivates you for the long term.

'In many ways it was incredible. Sometimes I couldn't believe that I was being paid to do this job.

'There was this amazing feeling of excitement you would get flying out over the ocean or hinterland. You were working with some of the best people you will ever know. Personally, and professionally, these were some of the best times of my career.'

Mark distinctly remembers helicopters being far smaller with minimal equipment and a general sense of improvising on the run.

'We didn't have any sort of robust governance or structure in place. Not clinically and not really from an aviation perspective either. Each PHRM service did its own thing.

'There was this frailty to the system. We went out as these young doctors or nurses or paramedics and landed in a lot of situations that clinically, physically and mentally we could have been better prepared for.'

There were days they went up in their jeans and runners, with very little protective gear.

'We would abseil out of these small aircraft without any standardised safety or clinical gear. You would drop into this forest and that was it. Off you go.

'Some of those early career moments are my most vivid memories and, in many ways, my drivers to pursue PHRM system change and integration', he says.

Team pursuit

A PHRM crew typically comprises of a doctor and a nurse or paramedic, supported by aircrew. Depending on the aircraft used this will typically involve a pilot and, in helicopter operations, an air crewman and a rescue crewman.

'You place absolute trust in everybody you work with and you are rewarded with this bond and camaraderie that I think is hard to match in medicine. We face some fairly extreme situations, but everybody performs and everybody looks after one another.

'During one mission over a mountain, I blacked out while being winched into the helicopter. I don't remember much, but I had got into a fierce spin on the winch wire due to the wind and turbulence. I had spun incredibly fast and really got knocked about.'

The air crewman was able to pull him in.

'It was one of the hairier moments I've had, I was so grateful. Pretty pale too I guess – I remember vomiting on the floor of the helicopter and was still shaky on our return. The patient was fine.

'I had absolute trust that the crew would be there to get me out. I am still good friends with that air crewman all these years later.'

Team effort

In 2013 Mark was recognised in the Australia Day Honours List and awarded a Public Service Medal for his 'outstanding public service in the development and delivery of integrated patient transport and retrieval services across Queensland'.

The award acknowledged almost ten years of leading the establishment of state-wide emergency medical system coordination centres in Brisbane and Townsville. In 2017/2018 those centres alone handled the clinical, tasking and operational governance of more than 24,000 retrievals and aeromedical transports.

He nods and smiles but shies from the accolade, particularly for him as an individual.

> *All these years later, we have robust systems in place to give structure to the care we provide and it has been wonderful personally for me to be involved in this side of things.*

'It was an honour, but this is a major team and whole of system effort. What motivates me to come to work every day is the people I work with and the sense that we are improving, changing and saving lives, specifically for those in rural, regional and remote Queensland. The award made me feel that I had repaid, in part, the opportunity that Australia had given me back in 1990.'

While the perception of PHRM might be led by the thrall and excitement of the adventure, Mark is still fundamentally drawn to the access to specialist medical care that PHRM provides. He considers the establishment and development of the coordination centres with their emergency telehealth services and the standardisation and integration of PHRM services in Queensland as some of his most important work.

'There is a lot of systems work that goes unknown and unnoticed by the broader community. You see the helicopters and the hairy moments on the news and so forth, but there is more to it than that.

'Robust systems and standards need to be in place to ensure that all patients who access these services are provided with the safest and highest quality care and aviation responses possible, irrespective of where they live.'

One component of this is that in 2005 an emergency retrieval telehealth videoconferencing system was established to give some of the sickest and most remotely located patients instantaneous access to specialist medical advice. 'The impact of this has been incredible', Mark says.

The service continues to expand its reach and is now available in 161 hospital emergency departments in Queensland.

Improving the support capability is a real impetus for Mark. 'Equity of access to PHRM is vital. We must not underestimate the human impact we can have on people's lives and families, particularly in rural, regional and remote Australia.

'There is one case that reinforced this to me from my time in North Queensland. We had been tasked on a pre-hospital mission by helicopter to a remote property 250km away, to a young man called John who had fallen four metres onto his head in a barn.

'As we were landing, we could see he was semi-conscious and agitated. We quickly initiated treatment and safely moved John in the back of a ute to the helicopter, provided a pre-hospital anaesthetic, explained things to his family and then retrieved him rapidly to our regional hospital where he subsequently underwent emergency neurosurgery for his traumatic head injury.

'In many ways this was not an unusual day, or a case that would have stood out. However, two years later while walking through Brisbane Airport, a stranger picked me out of the crowd, shook my hand vigorously and proceeded to thank me and tell me about how his best friend was getting on. He was John's brother.'

The majority of PHRM workload involves inter-hospital transfers. 'These tasks can be perceived as routine, sometimes mundane', Mark says. 'I can tell you, from experience, you will never see anyone more grateful for our system working than when a sick patient and their family, who live hundreds of kilometres from their nearest large hospital, see you and your team arrive.

'Our work in these moments means just as much as it does when we are hanging out of helicopters, winching someone off a ship at sea or caring for someone trapped inside a car wreck.'

Still, he says, he'd be pretty happy doing that too.

Future

Since 2016, Mark has chaired a collaborative PHRM working group with ACEM and other medical colleges (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 Australasian College of Physicians (RACP)), working with like-minded colleagues to develop a diploma and advanced diploma in PHRM. The programs will be administered by ACEM and will remedy the lack of formally recognised medical training in this field.

'PHRM is not an exclusive club', Mark says. 'We have to structure our medical training such that any doctor with the prerequisite medical skills, background and capability can be provided with a transparent pathway to attaining a bi-nationally recognised PHRM qualification.'

'For seven years we have been evolving our PHRM clinical and aviation systems and standards in Queensland.

'Over the past seven years, we have been working closely with senior PHRM colleagues in other states, territories and New Zealand to attempt to standardise how we provide PHRM care to patients. Governance can sound really tedious, but if our PHRM doctors and crews are skilled, well trained, well equipped and safe, then our patients will be well cared for and safe too. It has been wonderful for me personally to be involved in this side of things and, despite not flying much these days, the journey continues; onwards and upwards.'

Inga Vennell *Publications Specialist*

Diploma and Advanced Diploma in Pre-Hospital and Retrieval Medicine

In 2016, the ACEM Board endorsed a proposal to facilitate the development and award of a Pre-Hospital and Retrieval Medicine qualification.

In 2018, Australian College of Rural and Remote Medicine, Australia and New Zealand College of Anaesthetists and the College of Intensive Care Medicine and CICM formally signed a Memorandum of Understanding to commit to development of training programs in PHRM. These colleges are committed to improving access to rapid response medical care for seriously sick and injured people in Australia and New Zealand.

The development of these training programs is being overseen by a conjoint committee that represents the interests, specialties and expertise of each of those colleges. The Conjoint Committee of PHRM is developing a (bi)nationally recognised curriculum, qualifications, training and certification programs, and continuing professional development requirements for doctors intending to work in PHRM services in Australia and New Zealand.

Under the terms of the Conjoint Committee of PHRM, ACEM will administer all aspects of the program and take on all associated risks, including those associated with funding and legal risks, such as appeals. The Diploma and Advanced Diploma in Pre-Hospital and Retrieval Medicine are structured training programs aimed at appropriately experienced doctors who wish to work within PHRM services or clinical coordination.

This commitment recognises that PHRM services are provided by a range of medical practitioners who require specific clinical, academic, personal and professional attributes and expertise, to enable delivery of services with confidence and at a consistently high standard.

Launch

At time of writing, it is envisaged that both the Diploma and Advanced Diploma in Pre-Hospital and Retrieval Medicine will be available for prospective trainee enrolment in early 2020.

Jess Buchanan
Education Development Officer

Mental Health in Emergency Departments

ACEM is playing a central role in the major reform that is required to strengthen the primary care system. Access block for mental health patients is far higher than for any other patient, which can lead to negative effects on their immediate and long-term health outcomes.

In October 2018, 170 delegates to ACEM's Mental Health in the Emergency Department Summit heard how presenting to an emergency department with a mental health crisis too often means a long, distressing wait for care. These long waits, seemingly with no end, are harmful for patients and deeply frustrating for clinicians. The Summit put the urgent need for reforms to Australia's mental healthcare system on the agenda for state, territory and national governments.

In 2014, the Australian Department of the Prime Minister and Cabinet (PM&C) published a report on roles and responsibilities in health that noted the following:

> *There is in fact no such thing as a mental health 'system'; instead, this 'system' is shorthand for the many systems and services consumers and carers may encounter. For the most part, these services and systems are poorly integrated, overseen by different parts of government, based on widely differing organising principles, and not working towards a common goal … It is therefore no surprise that consumers find the system enormously difficult to navigate.*[1]

Background

ACEM's work to get mental health in the ED on the national policy agenda began with the report of findings from the snapshot survey of mental health access block in emergency departments in December 2017. Results from Australian emergency departments showed that while only four per cent were mental health presentations, this group of patients comprised 19 per cent of all patients waiting for beds and 28 per cent of those experiencing access block. The survey found 62 per cent of emergency departments reported patients had wait times of more than 24 hours, while 23 per cent reported patients waited more than 72 hours. The longest wait time in an ED for an inpatient bed was six days. Hospitals in rural and regional areas reported higher levels of access block than metropolitan hospitals, suggesting inequitable access to specialist mental health inpatient services across the country.

In the month before the Summit, ACEM released its analysis of data from the Australian Institute of Health and Welfare into mental health presentations to Australian emergency departments. *The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments* found that more than 250,000 Australians presented to emergency departments in 2016/2017 seeking help for acute mental and behavioural conditions. The vast majority (90 per cent) of people in this group waited in the ED for nearly 12 hours before being either discharged to a community mental health service, or admitted to a bed. For the remaining 10 per cent, their wait times far exceeded these already unacceptable standards and, not surprisingly, almost 7,000 people needing mental healthcare gave up and left the ED. These protracted and harmful delays in receiving timely access to urgently needed care undermine patients' health and recovery, place considerable stress and strain on emergency department teams, and waste limited health resources.

A systems issue

The Mental Health in the Emergency Department Summit recognised that these problems cannot be solved by emergency doctors alone; they reflect a sector under great stress and lack of a plan for system-wide development. In collaboration with the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Summit brought stakeholders into the same room to discuss gaps in community care prevention of patients having to attend EDs in crisis, how to ensure patients in EDs are managed in a therapeutic environment, and what can be done to ensure inpatient care can be accessed in a timely manner. To support engagement with the Summit and advocacy at a local level, each ACEM regional Faculty nominated mental health champions. Attendees at the Summit included patients, patient advocates, clinicians from diverse disciplines and specialties, community-based professionals, chief psychiatrists and policymakers.

With a program focused on the experience of presenting to and working in emergency departments, consumers spoke of crowding, noise, distress, long waiting times, and high use of restraint and seclusion. Together, consumers and clinicians shared experiences of good models of care, innovations in service delivery and structures that addressed the core elements needed to improve emergency care for people in mental health crisis. Stories from emergency departments highlighted the importance of social support services being available when needed, and the beneficial impact of respectful, culturally appropriate and compassionate responses to people in mental health crisis.

Summit communique

ACEM's communique from the Summit captured the commitment to action by delegates. Taking into account the discussions on the day and with the results from the survey of delegates, ACEM called on governments to act immediately on the following four priorities:

1. All Australian governments act urgently to engage people with lived experience in reforms that deliver timely access to appropriate mental healthcare, with an immediate focus on after hours care in the community.
2. When psychiatric admission is required, processes need to be timely and streamlined so that involuntary and acutely unwell people can access an appropriate inpatient bed at any time.
3. States and territory health departments enforce a maximum 12-hour length of stay in the ED by providing accessible, appropriate and resourced facilities to allow for ongoing care beyond the ED, with mandatory notification and review of all cases embedded in the key performance indicators of public hospital CEOs.
4. Incidents of a 24-hour wait in an ED should be immediately escalated to the Health Minister, alongside CEO intervention and mechanisms for incident review, as well as reporting of the findings to the Minister for Health.

Gaining consensus

At the conclusion of the Summit, ACEM was tasked by delegates with working with key people and organisations to develop a consensus statement with principles and priorities for action. The resulting consensus statement articulates the seven principles that underpin ACEM and other signatories' commitment to:

- respectful, patient-centred care;
- prevention and early intervention;
- timely access to appropriate care;
- safety and support in the ED;
- culturally safe care;
- a maximum length of stay in the ED; and
- increased community and inpatient capacity.

Stories from emergency departments highlighted the importance of social support, of services being available when needed.

Following the Summit, ACEM has worked collaboratively with members, consumers and their advocates, nurses and RANZCP, to develop the consensus statement, which was released in May 2019. A series of short mental health briefing papers will complement the principles and priorities in the consensus statement. These briefing papers address: the importance of an absolute limit on the length of stay for mental health patients in the ED and a mandatory reporting regime to support this; the use of restrictive practices in EDs; the role of peer workers in respectful mental healthcare in EDs; improving access to community-based prevention and early intervention services, especially after hours; and cultural safety in the ED.

Setting up for the future

In New Zealand, ACEM and RANZCP are working together to set the agenda for mental health policy development and advocacy, following the 2018 Inquiry into Mental Health and Addiction. ACEM is also working with RANZCP on a joint guideline for the physical assessment of people presenting to the ED with mental and behavioural disturbance.

Since the Summit, it has been pleasing to see greater attention being given to mental health, with a Royal Commission in Victoria and a national inquiry by the Productivity Commission. More jurisdictions in Australia are monitoring and reporting on 24-hour stays in emergency departments. The Summit has been a major step in a longer process of engagement and advocacy to set the agenda for policy reform that will improve the experiences of people needing mental healthcare and seeking help from emergency departments across Australia and New Zealand.

Reference

1. Department of the Prime Minister and Cabinet (AU). Roles and responsibilities in health: reform of the Federation White Paper, Issues paper 3. Commonwealth of Australia, 2014; 40. Available from https://apo.org.au/node/56123. Licensed from the Commonwealth of Australia under a Creative Commons Attribution 3.0 Australia Licence. The Commonwealth of Australia does not necessarily endorse the content of this publication.

Helena Maher *Manager Policy and Advocacy*

Spotlight on New Zealand Mental Health and Addiction

ACEM is calling for commitment and action to improve the care of people suffering mental health crisis across New Zealand, following the handing down of the Report of the Government Inquiry into Mental Health and Addiction.

Early in 2018, the New Zealand Government set up an inquiry to look at the mental health and addiction system.

The panel members for the Inquiry into Mental Health and Addiction were Professor Ron Paterson (Chair), Sir Mason Durie, Dr Barbara Disley, Dean Rangihuna, Dr Jemaima Tiatia-Seath and Josiah Tualamali'i.

Consultation was launched in April 2018 in Palmerston North and led to over 5,200 submissions. For several months, the panel travelled around New Zealand meeting with and listening to people at 26 public forums from Kaitaia to Invercargill and at hundreds of meetings, hearing from people with lived experience, whānau, service providers and community groups.

In its submission to the Inquiry, ACEM said people with mental health and addiction needs are presenting to emergency departments for services that would be more efficiently and effectively provided in the community, or as inpatient services.

'Major reform is required to strengthen the primary care system. People with mental health and addiction conditions need affordable access to General Practice services that are integrated with mental health and addiction assessment and early interventions, close to where they live', ACEM wrote in its submission.

'ACEM data shows that people needing mental health and addiction care comprise less than four per cent of emergency department presentations, but make up 25 per cent of those experiencing access block, when people have been admitted for care but are forced to wait in the emergency department for more than eight hours.

'Mental health patients wait longer than other patients to get treatment, putting their lives and future health at risk. Long waits in the emergency department are associated with excess morbidity and mortality and exacerbation of patient harm.'

> *"… people needing mental health and addiction care, comprise less than four per cent of emergency department presentations, but make up 25 per cent of those experiencing access block …*

Report handed down

On 28 November 2018 the Inquiry panel formally handed over to the Minister of Health, Hon Dr David Clark, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.*

The 200-page report was a substantial and considered piece of work.

On 4 December the Government publicly released the report of the Inquiry. 'Mental health and addiction are issues for all New Zealanders. Every community and just about every family has someone that has lived with a mental health or addiction challenge', Dr Clark said at the time.

'The Inquiry heard many stories of people who did not get the help they needed and deserved. We must listen to these voices of people with lived experience.

'The report charts a new direction for mental health and addiction in New Zealand, one that puts people at the centre of our approach.

'It is clear we need to do more to support people as they deal with these issues and do a lot more to intervene earlier and support wellbeing in our communities.'

The Inquiry panel delivered a set of recommendations covering everything from the social determinants of health and wellbeing, to expanding access to treatment services and taking strong action on alcohol and drugs.

Mental Health in the Emergency Department Summit

ACEM is preparing for a Summit on mental health in New Zealand emergency departments. The Summit will be held on 7 June following the New Zealand Government's response to the inquiry. The Summit will bring together stakeholders – consumers, the Government, District Health Boards and non-governmental organisations (NGO) – to help tackle New Zealand's mental health crisis.

ACEM President-Elect Dr John Bonning, a Waikato emergency doctor, said: 'The time for talk is over and we all now need to come together and work towards having the best mental health system we can possibly have'.

ACEM President Dr Simon Judkins says: 'Mental illness and addiction are major health and social policy issues'.

'We look forward to having a better functioning system that coordinates primary care, prevention and early interventions with acute care, so that people can access wrap around services when they need it in their community and are less likely to need crisis care in emergency departments.

'Particularly for Māori, Pasifika and young people, we welcome recommendations to strengthen the quality of the care, support and interventions available in the community and where necessary through emergency departments.'

The report's recommendations

1. Expand access and choice from the current target of three per cent of the population being able to access specialist services, to provide access to the 'missing middle' of people with mental illness or significant mental distress who cannot access the support and care they need. An indicative access target may be 20 per cent within the next five years.
2. Transform primary healthcare so people can get skilled help in their local communities, to prevent and respond to mental health and addiction problems.
3. Strengthen the NGO sector to support the significant role NGOs (including Kaupapa Māori services) will play with the shift to more community-based mental health and addiction services.
4. Take a whole-of-government approach to wellbeing, to tackle social determinants and support prevention activities that impact on multiple outcomes, not only mental health and addiction.
5. Place people at the centre to strengthen consumer voice and experience in mental health and addiction services.
6. Take strong action on alcohol and other drugs by enacting a stricter regulatory approach to the sale and supply of alcohol; replace criminal sanctions for the possession for personal use of controlled drugs, with civil responses; support that law change with a full range of treatment and detox services; and establish clear cross-sector leadership within central government for alcohol and other drug policy.
7. Prevent suicide. Urgently complete and implement a national suicide prevention strategy, with a target of a 20 per cent reduction in suicide rates by 2030.
8. Reform the Mental Health Act. Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992, to reflect a human rights approach, promote supported decision-making, align with a recovery and wellbeing model, and minimise compulsory or coercive treatment.
9. Establish a new Mental Health and Wellbeing Commission to act as a watchdog and provide leadership and oversight of mental health and wellbeing in New Zealand.
10. Establish a cross-party working group on mental health and wellbeing to reflect the shared commitment of different parties to improved mental health and wellbeing in New Zealand.

Next steps

The New Zealand Government had promised to respond to the Inquiry into Mental Health and Addiction Services in March 2019.

However, this timetable was pushed back to June due to the terror attack in Christchurch.

'My core priority as Minister of Health is improved equity of health outcomes for New Zealanders', Dr Clark said in late March. 'I want a health system that delivers the same high-quality health outcomes for all people, so they can reach their full potential no matter where they live, what they have or who they are.'

Andre Khoury *Public Affairs Manager*

Forces at Play in Shaping the Future of Emergency Medicine Workforce

Modelling by the Australian Government indicates that emergency medicine in Australia is facing an oversupply of specialist emergency medicine physicians, but the specialty continues to struggle to meet College recommended staffing levels, particularly in regional, rural and remote emergency departments. In New Zealand, the situation and the resultant pressures are no different.

The depth and breadth of the FACEM role is crucial to enhanced clinical decision-making and the delivery of safe, high-quality patient care. ACEM is committed to ensuring a sustainable workforce; one in which emergency physicians are able to maximise their health, professional satisfaction and career longevity, thereby delivering optimal care to patients across Australia and New Zealand. The benefits of such a workforce include retention of corporate knowledge, increased investment in hospital process development (both inside and outside the emergency department), reduced costs (through avoidance of repeated recruitment and reduced need for short-term/locum staffing), and the establishment of a culture of clinical excellence in both patient care and staff training.

A combination of factors has contributed to significant growth in the number of specialist emergency medicine physicians (FACEMs) in the past two decades; the emergency medicine specialty is relatively young, the number of medical students in the past decade has tripled, and entry into the FACEM Training Program has been relatively relaxed. Still, despite the significant number of trainees entering and completing the FACEM Training Program, the supply of emergency medicine specialists remains out of balance across Australia and New Zealand. Analysis of senior emergency department staffing against ACEM's *G23 Guidelines for constructing and retaining emergency medicine workforce* shows there are only a limited number of emergency departments with adequate on-the-floor coverage.

The pressure placed on emergency physicians by the lack of floor coverage is shown to be detrimental to the health, wellbeing and longevity of clinicians and may also explain the increasing interest by emergency physicians in part-time work, academic or research roles. Almost 30 per cent of FACEM respondents to *ACEM's 2016 Workforce Sustainability Survey* indicated they were likely to leave clinical practice within the next ten years, while 60 per cent of FACEM respondents and 71 per cent of trainee respondents also reported being likely to reduce their hours of clinical practice.

Clearly a diminishing clinical workforce is not suited to the growing demand for emergency department services. The Australian Institute of Health and Welfare estimates that in 2017/2018, more than eight million people attended emergency departments across Australia. This is a rise in presentations of 3.4 per cent.[1] Similar growth was experienced by New Zealand, where there were 2.8 per cent more presentations in 2017/2018 than in 2016/2017.[2,3] The demand for emergency department services has never been greater, and analysis suggests future growth is likely to exceed even these figures due to changing demographics, changes to health policy, the rising cost of private health insurance and the suitability of health infrastructure.

This situation is exacerbated in rural and regional areas, where there is a continued reliance on International Medical Graduates to staff emergency departments and the ability of 'market forces' to correct the persistent maldistribution of FACEMs and trainees. The 2017 *FACEM and Trainee Demographics and Workforce Report* shows just 19 per cent of FACEMs in Australia identified a rural or regional location as their primary workplace, with 41 per cent doing so in New Zealand.[4] The College is exploring mechanisms by which rural and regional training can be more robustly incorporated into the FACEM Training Program via a Council of Education review of the training program and the underlying *ACEM Curriculum Framework*, which describes the outcomes expected of training, however, for the moment, just 18 per cent of trainees in Australia report undertaking their placements in rural or regional locations, while in New Zealand, the figure is 37 per cent.

The College also is cognisant of its responsibility to ensure that within the emergency medicine workforce, senior clinical decision makers other than FACEMs have the appropriate skills to provide care to meet community need. For example, changing workforce models, such as the proposed national Rural Generalist Training pathways, are likely to see greater involvement of rural generalists and Career Medical Officers (CMOs) in emergency departments across rural and metropolitan areas.

The College has also commenced a review of its Emergency Medicine Certificate and Emergency Medicine Diploma training programs. This review will be used to ensure these qualifications remain appropriate to adequately upskill doctors to deliver services to communities where there are insufficient numbers of specialist emergency physicians available or where emergency departments are relying on increasing numbers of CMOs or other specialty doctors. ACEM's investment in this area is intended to ensure it remains a key stakeholder in the development of standards and programs in relation to the delivery of emergency medicine.

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Fatima Mehmedbegovic *Strategic Priorities Implementation Manager*

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Professor Diana Egerton-Warburton
Monash Health & Monash University, VIC

Dr Fiona Kerr
The NeuroTech Institute,
The University of Adelaide & SAHMRI, SA

KEY DATES

Registration opens	Call for abstracts opens	Call for abstracts closes	Early bird registration closes
18 March 2019	**5 April 2019**	**29 July 2019**	**16 August 2019**

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Global Emergency Care

Dr Jenny Jamieson and Dr Bishan Rajapakse

Dr Jamieson is an emergency physician and trauma specialist in Melbourne, Victoria, with an interest in public health and global emergency care.

Dr Rajapakse is an emergency physician and medical academic working in Sydney and Shellharbour, New South Wales, with a passion for global emergency care and physician wellbeing.

On behalf of the International Emergency Medicine Committee (IEMC), we welcome you to the Global Emergency Care (GEC) feature of the first issue of *Your ED*, the ACEM magazine. We hope that the stories will provide some insight into the interesting, inspiring and incredible work being done around the world by ACEM Fellows and trainees to progress the global development of emergency medicine.

While there have been a variety of names for the area of emergency medicine involving work in low-resource environments within developing countries, global health is defined as an area for study, research and practice that places a priority on improving health and achieving health equity for all people worldwide.

Around the world, acutely ill and injured people die every day due to a lack of timely emergency care. GEC is a subset of global health and is primarily concerned with the development and practice of emergency care in resource-limited environments. This includes direct clinical service provision, teaching and training, emergency health systems development, quality improvement, leadership, advocacy and research.

One of the many reasons behind a drive for GEC was beautifully stated at a recent World Health Organization (WHO) launch for the Global Emergency and Trauma Care Initiative (December 2018).

'No one should die for the lack of access to emergency care, an essential part of universal health coverage', said WHO Director-General Dr Tedros Adhanom Ghebreyesus. 'We have simple, affordable and proven interventions that save lives. This initiative will ensure that millions of people around the world have access to the timely, life-saving care they deserve.'

The IEMC has a long history within ACEM, with the International Emergency Medicine Special Interest Group originating in 2004. An integral component of this has included the newsletters, with correspondence and articles that highlight the involvement of FACEMs and trainees engaged in global emergency care work. With the launch of *Your ED*, we aim to bring you highlights of the inspirational work our members and colleagues participate in around the globe.

We hope you enjoy the Global Emergency Care feature. We welcome any submissions or recommendations for articles and interviews relating to global emergency care and look forward to sharing our stories.

Postcards from the Edge

Interviews with FACEMs and trainees returning from global emergency care work, highlighting their experiences and involvement in emergency medicine abroad.
This edition's Postcard comes from Dr Evan O'Neill.

Dr Evan O'Neill
Dr O'Neill is an ACEM and PEM dual trainee, currently working as a Retrieval Registrar at Alice Springs Hospital, while studying towards the ACEM Fellowship Examinations.

Tell us about your recent global health work/ projects.

In 2017, I made myself available for nine months of work with Médecins Sans Frontières (MSF). I had long aspired to work for MSF, admiring their fierce independence as a leading provider of humanitarian medical aid. They asked if I would work in South Sudan in a place I'd not heard of before – Old Fangak.

Old Fangak has become a population centre for Nuer people displaced by the dangers of civil war. The reasons for its relative security, isolated from roads and surrounded by swampy wetlands, were the same reasons that the local population suffered a multitude of health threats. We would intermittently receive an influx of war wounded, but day-to-day the most common afflictions reflected the conditions, namely malnutrition and infectious diseases.

We worked between tents and fixed structures, providing basic emergency, paediatric, maternal and medical care. Though technology was limited, we never wanted for basic supplies such as essential medicines. The profound effect that attention to detail, close monitoring and delivery of simple and relatively cheap interventions could have for the gravely ill children who presented, was a daily inspiration.

Come August 2017, the Rohingya crisis was evolving rapidly as scores of refugees fled ethnic cleansing in Myanmar, into the neighbouring Cox's Bazar Peninsular in Bangladesh. I was offered a role as Medical Activity Manager within a hastily organised team from MSF Barcelona. The humanitarian crisis was escalating daily on a massive scale and required endless late nights, bumpy travels and treks into dense and desperate camps.

We would visit camps and provide treatment with what medicines we could procure under bamboo and tarpaulin. These visits allowed us insight into where the greatest needs were as we planned to construct more definitive clinics, along with structures that would enable inpatient care.

The conditions the Rohingya endured brought malnutrition, pneumonia, watery diarrhoea, skin infections and sinister vaccine-preventable infectious disease outbreaks to our clinics. Side by side with the enthusiastic work of local Bangladeshi doctors we did all that we could every day. The initiatives of the logisticians to improve water and sanitation in the camps may not be what springs to mind when considering medical aid, but without their work our clinical activities would have been even further stretched.

What was one of the highlights from your time away?

The memories I have caring for one child in particular capture so much of what made my work with MSF special. While rounding on our ward I was called to a seizing child and found a tiny girl, reportedly two years of age, but with the frame of an infant. Hypothermic, hypoglycaemic and limp, even her initial resuscitation seemed improbable; I've not felt more fortunate for intraosseous access since.

The story emerged that a local woman had brought her to us, having taken her from the arms of her mentally ill mother who, thinking the child was dead, was on her way to bury her.

Surrounded by beds crowded with families in our ward, her otherwise lonely, skeletal figure was coddled in care as we cautiously fed her, treated her pneumonia, cellulitis, diarrhoea and kalar-azar. It was such a testament to the community spirit within that ward that other mothers or overworked nurses held her as she gradually gained nourishment. Ever so slowly, she regained tone and energy, and no longer looked like she was at imminent risk of demise. But still she would not gain weight, she had never walked.

Without advanced diagnostics, so much of what you do feels like educated guessing. I made the decision to treat her for tuberculosis after a month or so. The memory of her smile, with delightful weight gain evident on her belly and, eventually, her first steps, I will never forget.

What were some of the challenges you encountered?

To arrive in a place where our highest tech items were things like a sats probe and noisy oxygen concentrators was a shock to the system. But you soon realise that so much can be done with the basics. More kit at vastly more cost would have a sharply diminishing return for those you care for, when what was needed most was safe, reliable, basic care.

Coming from a healthcare system with the education and resources of Australia, I suddenly found my usual techniques of leadership and communication were way out at sea. Concepts such as closed loop communication and resuscitation algorithms were as foreign to my new colleagues as my accent. My internal sense of urgency, heightened by a mounting feeling of impotence, led to some frustration and exasperation.

I would find myself trying to force care forward through sheer will. The realisation of just how damaging my frustrations could be on that essential esprit de corps soon became apparent. I've always enjoyed working with people who don't have the training we are used to in Australia, but who work just as hard for their patients. Appreciating just how valuable that is and being gracious for the privilege to join them and help in some way, grounded me and taught me a great deal.

To take that step back directs frustration to a healthier place, to a more constructive, motivating place. I think that frustration is healthy. You want the best possible care for your patient, but your frustration needs a healthy outlet that's collaborative rather than corrosive.

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

It's a challenge to find the time to work abroad while dedicated to completing the rigours of training. Taking spells of dedicated time between training to work in the Developing emergency medicine context is my current method, but I don't think I've yet found how I'll sustainably maintain that balance. It's an ongoing aspiration.

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?

There is so much work to be done! The staircase we need to ascend in training won't be going anywhere, but the work, if mortgages and family commitments allow, is so incredibly rewarding and the perspective gained humbling and enriching.

I personally appreciate the efforts of ACEM to recognise more of this work as training time in Special Skills and admire all those who contribute to the growing community developing EM in Global Health.

Converge International Support Program

Converge International provides a comprehensive support program designed to assist ACEM members and trainees in meeting the challenges and demands of work and personal life.

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Emergency Medicine in Vietnam – Opportunities and Updates

Dr Megan Cox and Dr Hanh Pham
Dr Cox is a Emergency Medicine Specialist, NSW Ambulance and SEAHS, NSW Senior Lecturer, Sydney University Faculty of Medicine and Public Health

Dr Pham is a Emergency Medicine Staff Specialist and DEMT, The Prince Charles Hospital, Brisbane, QLD

Vietnam is a country of more than 95 million people and one of South East Asia's fastest growing economies. According to the 2016 census, aside from English, Vietnamese is the fourth most common language spoken at home in Australia; there are many established links between Vietnam and Australia in tourism, business, education and volunteering. Nearly 302,500 tourists visited Vietnam from Australia in 2017, no doubt enjoying the long coastlines, delicious cuisines and remarkable culture.

Emergency medicine development in Vietnam has also grown rapidly with Canadian, French, American, Japanese, Korean and Australian interests and involvement in the last decade. A significant emergency medicine consensus document was signed by the Vietnamese Ministry of Health in 2010 and the Vietnamese Society of Emergency Medicine has since held two international conferences, continually raising the profile of emergency medicine in Vietnam.

Internationally recognised short courses, such as advanced paediatric life support and basic life support (BLS), have been established in various sites in Vietnam through collaborations involving Australians and others. The first emergency medicine residency training program has recently commenced in Hue, central Vietnam, benefiting from American and Australian faculty support. This program continues to advertise for volunteer specialists for teaching and training opportunities, through programs at the University of Utah and Stony Brook University in the United States. Emergency medicine opportunities include onsite volunteering, collaborative curriculum development and interactive video and teleconferences.

ACEM has supported emergency medicine development in Vietnam through a number of initiatives in recent years. A Vietnamese medical practitioner from Saigon [Ho Chi Minh City] received ACEM sponsorship to attend a EM conference in Melbourne in 2013 and participated in a supervised exchange program at Royal Brisbane and Women's Hospital in 2016. Dr Hanh Pham, a FACEM working in Brisbane, has led three teams of FACEMs to southern Vietnam over the last three years, with ACEM support and funding.

> *An appreciation of karaoke and strong coffee would be an advantage.*

Dr Pham's first visit in 2016 was to Cho Ray Hospital, associated with Ho Chi Minh University Medical School. Cho Ray Hospital is the major referral hospital for 37 southern provinces, including Ho Chi Minh City, and serves a total population of 40 million. Dr Pham met with senior emergency medicine and intensive care unit (ICU) staff and developed a course introducing the principles of basic emergency care. The first course comprised two parts: 2.5 days for multiple medical emergencies, including some public health issues; and 1.5 days for basic trauma care with hands-on workshop interactions. Approximately 60 enthusiastic doctors from several hospitals around Saigon attended.

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The success of this visit lead to another visit in 2017 of eight FACEMs to Cho Ray Hospital and a large hospital further south in the Mekong Delta area, Can Tho.

The courses were repeated in 2018 at both sites, with 45 candidates attending the two-day basic course in Can Tho and over 100 candidates in Cho Ray for the one-day advanced course and 40 for the workshops. Translations were provided for lectures by Vietnamese emergency medicine and ICU senior staff with fluent English and previous involvement in these courses.

Lectures in 2018 for advanced and basic courses included the 'ABCDE' approach to the unwell patient; the trauma patient; principles of BLS and advanced life support (ALS); chest pain and sepsis; the sick neonate; and obstetric emergencies. Practical stations were provided to support these topics. The advanced course content included further lectures on sepsis, disaster preparedness, management and airway checklists, as well as workshops on ALS, electrocardiograms and arrhythmias.

All participants gave very appreciative and positive feedback and were highly motivated for more courses and further emergency medicine-related opportunities. Dr Pham successfully applied for an International Development Fund Grant with the IEMC in 2017 and uses the funds to continue these significant initiatives.

There is a fourth course already planned for 2019 in South Vietnam. Any FACEMs enthusiastic to visit Vietnam or become involved in future courses are encouraged to contact Dr Pham for further information.

An appreciation of karaoke and strong coffee would be an advantage.

More information

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The Road to Paradise
Developing Emergency Medicine in the Highlands of Papua New Guinea

Dr Rob Mitchell
Dr Mitchell is an emergency physician at the Alfred Emergency and Trauma Centre in Melbourne and Project Lead for the Mount Hagen Emergency Department Triage Development Initiative.

Australian Aid

The potholes are a blessing in disguise. They pepper the road between Kagamuga Airport and Mount Hagen town centre, moderating the speed of traffic snaking its way along the Highlands Highway. The drivers of public motor vehicles (PMVs) – minibuses ferrying locals in and out of town – are expert at pothole avoidance. It's an essential skill for motorists in this part of the world.

The potholes – some inconspicuous divots, others vacuous pits – may slow the traffic, but they don't completely mitigate the risk of road trauma. In November, an open truck carrying 26 passengers drove off an embankment 10 kilometres out of town. There were multiple casualties, including several women and children. In the absence of a pre-hospital care system, patients found their way to Mount Hagen Provincial Hospital (MHPH) by whatever means they could – some in other PMVs, many in the trays of utility vehicles incidentally passing the scene.

'It was early in the morning and I saw trauma casualties lying all over the place, some bleeding, some in respiratory distress, with an unknown number still to arrive', says Dr Scotty Kandelyo, Deputy Chief of Emergency Medicine for the Highlands Region of Papua New Guinea.

'It was a mass casualty incident and the day staff had not yet arrived. It was really chaotic. We were overwhelmed and we activated our mass casualty response.'

Scotty was the first emergency physician to be employed at MHPH – the first, in fact, of any public hospital in the lush and remote Highlands region. Having grown up in neighbouring Enga Province, he had a strong desire to return when he completed his specialty training in 2016 through the University of Papua New Guinea.

'Trauma is an area of interest of mine. In Enga and Western Highlands there is a lot of trauma.'

Although he has enjoyed his work with Western Highlands Provincial Health Authority, it has been challenging. His wife – a paediatrician – and his children live in Port Moresby, and the intermittent commute between Mount Hagen and the capital is not an easy one. There is no road connection and flight costs can be prohibitive. In a country with a gross national income per capita of AU$3306, $189 is an expensive starting point for a one-way ticket.

Scotty's new role will see him travel between Port Moresby, Mount Hagen and many of the smaller hospitals that litter the Highlands. He will have less time to work on the 'shop floor' in the MHPH ED, but he will be able to bring specialist expertise to other hospitals in the region, none of which has an emergency physician.

'I'm excited. It is easier to reach out and provide emergency services to hospitals that experience even more trauma and have even less resources, such as no proper emergency department and no emergency-trained staff.'

Fortunately for the Mount Hagen community, the void created through Scotty's promotion has been filled by another capable emergency physician. Dr John Junior McKup – known as 'JJ' to many – may have the figure of rugby player, but he is a softly spoken Highlander who cares deeply about improving healthcare in the region.

'I'm passionate about emergency medicine here, because I am from here', John says. 'I remember when the ED was staffed with the most junior doctors, the misfits and the renegades. There was no system. My people deserve better.'

John grew up in Mount Hagen and his return to the community has been eagerly awaited. Like Scotty, he has also faced barriers in his career. His wife and two of his children have, until recently, been living in Port Moresby, and he has still not been formally appointed (or paid) by the National Department of Health as a consultant, despite working as an emergency physician for 18 months.

John's circumstances are also unique for another reason: his mother is the Nurse Unit Manager of the ED. Although his family and professional lives are interconnected, he has quickly established his credibility as a capable and motivated emergency physician.

'My mum has been in the ED for my whole life. She actually said to me, "Why do you want to work here? Why not do surgery?" It is because here, I can make the most difference.'

Dr Colin Banks, Dr Scotty Kandelyo, Dr John Junior McKup and Dr Rob Mitchell outside Mount Hagen Provincial Hospital ED.

A lot has changed at MHPH since Scotty and John's arrival. In 2018, the ED was renovated to improve safety and functionality. The result is a more open department, with four dedicated resuscitation bays and a central fishbowl area. The pastel walls are stark, but, they signal a fresh, vibrant ED that is ready to embrace change. There's also a new short stay area, which is helping to improve flow through the department.

There are still plenty of challenges however. Staff shortages are chronic – the medical workforce consists of only three registrars, five health extension officers (HEOs) and five resident HEOs despite escalating demands for care (the department receives in excess of 150 patients per day). The casemix is diverse, from HIV-related presentations to exacerbations of non-communicable disease to trauma, compounded by a large burden of primary care patients who have nowhere else to turn. Equipment is limited – there is one cardiac monitor, the ultrasound machine is temperamental – and access block is the norm.

But the Executive is supportive and is keen to improve ED functioning however possible. As an indicator, the hospital has recently invested in additional clerical resources to register patients. This includes the use of biometric data – fingerprints – to record patient presentations. It is an inspired use of technology in an environment that is otherwise relatively free of it.

Overall, the signs are very positive for Mount Hagen ED. FACEM Dr Colin Banks, incoming Chair of the ACEM International Emergency Medicine Committee and long-standing supporter of EM training and development in Papua New Guinea, is impressed by the progress.

'I first came here in 2009 and there were no staff with emergency training, the department was poorly designed, and the result, not surprisingly, was chaotic. The transition now to a modern design, with trained staff and actual systems, is a huge leap forward.'

Among the long list of potential quality improvement projects, Scotty, John and their team have identified several key priorities. These include a triage system and a database of ED presentations that captures burden of disease and access block data. A small group of FACEMs has banded together to support MHPH ED with these activities.

> *My mum has been in the ED for my whole life. She actually said to me, 'Why do you want to work here? Why not do surgery?' It is because here, I can make the most difference.*

The project will see the world's first testing and implementation of the World Health Organization Triage Scale (a three-tier system developed in collaboration with the International Committee of the Red Cross), as well as a presenting complaint coding tool specifically designed for resource-limited settings. A team of Australian emergency physicians and nurses will deliver training in the new system, modelled on an education program developed for the National Referral Hospital in Honiara, Solomon Islands. The project is being supported by the ACEM Foundation (through the International Development Fund) and the Australian Government Department of Foreign Affairs and Trade through its Australian Aid: Friendship Grants program.

Colin considers it an important step forward, which will not only deliver meaningful improvements in ED functioning, but yield useful data on the value of triage in resource-limited settings. 'The introduction of a triage system into a department that doesn't have one has not really been studied in this way. It should provide insights into the effect that we just assume is there.'

It may be the 'land of the unexpected', but a lot of positive change can occur in a short amount of time in Papua New Guinea. In only three years, MHPH has gone from an ED lacking systems, leadership and direction, to a department with all of the foundations for a promising future. Success is never guaranteed in Papua New Guinea – the sociopolitical context is complex, institutions are fragile and the threat of natural disasters is enduring – but there are lots of positive signals emanating from Mount Hagen.

'The future is bright for EM in Papua New Guinea, especially with skilled and capable emergency physicians like Scotty Kandelyo and John McKup leading the way', says Colin Banks.

'And that's particularly the case for MHPH. The Western Highlands Provincial Health Authority is really setting an example that other Pacific health services will be able to follow.'

It's an exciting time for EM in Mount Hagen. The road ahead my be long, but hopefully the potholes will be few and far between.

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i Funding for the Mount Hagen Emergency Department Triage Development Initiative has been provided by a Friendship Grant from the Australian Government Department of Foreign Affairs and Trade and through the ACEM Foundation's International Development Fund.

Dr Suzi Hamilton

Dr Hamilton is an emergency physician in Christchurch, New Zealand, with specialist interests in toxicology, mentoring and expedition medicine. She was recently appointed to the Advancing Women in Emergency Section Executive. She hopes the section can highlight the issues that are specific to or disproportionately affect women working in emergency medicine.

Why emergency medicine?

I was one of those annoyingly enthusiastic first year docs who loved every rotation I did, but I quickly realised I didn't have the attention span for ward rounds, nor the patience for long clinics. Much as I loved the practical aspect of surgery, I couldn't see myself doing it long term. Emergency medicine was the only job I did where I saw consultants getting in amongst it with the rest of the team, with a horizontal hierarchy that seemed much more my style. I get bored easily, so the fact that it's different every day and constantly challenges me is perfect. It was also something I figured would lend itself to part-time work or time out, which was important to me to have options for travel, expedition work and having kids.

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

The people. Both colleagues and patients make it rewarding and also challenging. The medicine is the easy bit!

What do you do to maintain wellbeing?

The never-ending quest for work-life balance. You need to know what fills your bucket. For me it's getting outdoors – the exercise, the scenery, the peace, it's my happy place. I've dabbled in triathlons, adventure racing and multisport events. However, being short on cash and skill I've settled for just getting out in the hills however I can! A big part of why I chose to work in Christchurch is the fact that I've got hills full of trails on my doorstep just 5km from the hospital. I can surf and ski in the same day, I can head backcountry for a weekend hiking or ski touring with only an hour's drive, it's perfect for me. There's something incredibly refreshing about sitting somewhere beautiful feeling like a tiny human amongst the mountains or ocean.

What do you consider your greatest achievement?

Right now, managing to leave the house showered and fully dressed with my new baby! Achievements are relative – success is about how high you bounce when you hit the bottom. I'm proud of being a FACEM, I'm proud of being a mum. Winning the UK ladies national championships at laser sailing when I was 17 was pretty awesome. Resuscitating a 14-year-old porter with high-altitude pulmonary oedema in Nepal felt even better. Passing exams and getting articles published always calls for some bubbles, but there isn't a single achievement that I've done on my own. It takes a village.

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

Our department does annual registrar awards and during my training I was chuffed to bits to get the Registrar of the Year award twice. I never had any confidence and always thought I was pretty rubbish until then!

What inspires you to continue working in this field?

There's always something new to learn. The constant evolution of medicine is both exciting and scary – it's not a job where you can rest on your laurels. I like that challenge.

I have been fortunate to have some great role models – women in emergency medicine who balanced work and family and having a life too, doing cool stuff and also being bloody good at what they did. Now I find myself in a consultant position, I'm trying to figure out how to be that role model to the next generation. Anytime you see someone have that light-bulb moment as they learn a new skill or understand a new concept, it's such a buzz. I love teaching and mentoring. Both are essential for development and ACEM has really embraced the mentoring aspect recently. I set up a mentoring program in my department two years ago and although it's early days, it's awesome to see the benefits.

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

Impostor syndrome – it is real and it is ok. Everyone has it.

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

Solving access block, curing the common cold, organ donations being mandatory and emergency department nurses getting a pay rise!

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WILEY

Dr Marcus Yip

Dr Yip is an advanced trainee in the FACEM Training Program, with a special interest in nuclear disarmament and public health. He was part of the International Campaign to Abolish Nuclear Weapons (ICAN) which was awarded the 2017 Nobel Peace Prize.

Why emergency medicine?

Emergency medicine is great because of the variety that walks through the door! It can be anyone, with any story, with any problem that can range from minor to life-threatening. It's also one of the greatest equalisers in life – everyone at triage is treated the same and it doesn't matter who you are or if you're rich or poor; you're treated based on need and on the basis that healthcare is a basic human right.

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

Urgent critical care is probably the most challenging aspect of the job because it requires the ability to spring into action and work quickly as a team. But working in a team, banding together to treat and stabilise a patient, is one of the most satisfying aspects of the job!

What do you do to maintain wellbeing?

Just like in medicine, I believe balance is always key; to aim for that perfect in-between spot. I try to balance all aspects of life: time with friends and family as well as alone time; going for a walk or yoga vs. vegging out on the couch; eating healthily versus going out for extravagant meals (maybe this one could do with a bit more balancing); shopping versus Marie Kondo-ing my belongings; studying versus binge-watching the newest Netflix craze…

What do you consider your greatest achievement?

I don't think there are achievements, but lots of little achievements along the way that have brought you to where you are; and there's always the next achievement to strive for. Sometimes you're not even sure you're aiming for the next achievement; sometimes life just takes you there.

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

My biggest accomplishments have come from my involvement with the ICAN and the Nobel Peace Prize. I first got involved as a medical student with the peace group the Medical Association for Prevention of War. Being involved, I learned all about the uranium mining that Australia does, especially in South Australia (where I went to medical school), and about nuclear weapons as a global humanitarian and medical issue.

ICAN was launched in Melbourne. I stayed involved because it was an issue that I believed in and the amazing peace advocates in the group became my mentors. In 2017, ICAN was awarded the Nobel Peace Prize after we facilitated the negotiation of the Treaty on the Prohibition of Nuclear Weapons at the United Nations in New York. The Nobel celebrations later that year in Oslo were spectacular, but the real accomplishment for ICAN was the treaty – a framework to make nuclear weapons illegal under international humanitarian law, just like the other four weapons of mass destruction that have been made illegal. While 2017 was a big year for us, it was a decade of hard work and small accomplishments along the way; that began in Melbourne and led us to New York and the successful negotiation of an international treaty. The Nobel Peace Prize was the recognition of all that hard work from campaigners all around the world.

What inspires you to continue working in this field?

Emergency medicine is a great platform to advocate for equality and public health. We provide universal healthcare and serve our local communities. We educate the public like other primary health providers. And, as with larger issues like refugee health or kids on Nauru, we, as emergency doctors, are best placed to recognise an emergency and advocate for humanitarian solutions. As with all things in medicine, especially nukes, prevention (in the form of a treaty) is better than a non-existent cure!

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

The best piece of advice I actually got early on in my career was very practical: 'Before you ask a question, stop and think for five minutes about how you would solve this problem yourself'. It makes you think through the problem and possible solutions; a lot of the time you needn't get someone else involved, yet when you ask for help, it's clear you've thought it through and you don't make a fool of yourself.

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

I'm most looking forward to the innovative tech solutions of the future – probably stuff that we haven't even fathomed previously; like the mobile code stroke imaging team in the back of a truck, or portable ultrasound probes that connect to our phones to fully automated and integrated computer systems that make patient care safer and more efficient.

Agents of Social Change

Dr Akmez Latona
Dr Latona is an Emergency Medicine Specialist Registrar at Queensland Children's Hospital

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Recently, I have had cause to deeply reflect on the values around practising medicine, my values as a person and as a practitioner, as well as those of my community and humanity. I took the Hippocratic Oath six years ago and it was more than words to me. Its values guide me in serving others.

Retrieval medicine is enjoyable, exciting and worthwhile; fetching sick people and supporting practitioners in places that do not have all the resources of a tertiary hospital, so the best care can be accessed by all. Each case brings its challenges and this case was no different.

I was tasked to Nauru to care for a sick child. Nauru, a small island in the northeast of Papua New Guinea 4,500km from Australia, where hundreds of asylum seekers, including children, are held awaiting processing for as long as five years or more. Nauru is where vulnerable asylum seekers fleeing persecution, war and terror come to have their dreams perish alongside their physical and mental health.

Doctors are importantly placed as agents of social change. I urge us all to stand up for them, to contribute, to do what we can to improve their lives and live together in this world.

During the four-hour direct flight from Brisbane, I got to know the team. We performed our routine equipment checks – drugs, ventilators, lines, drains, critical care gadgets and more. I do not know what I was expecting. I have looked after plenty of sick kids, but they always manage to make me nervous. All I knew of Nauru was what is in the media and I had no real idea what to expect.

Upon arrival, I found myself attending to a child in demise in a makeshift medical camp inside a compound. It was surrounded by barbed wire fencing and watched by guards. The weather was cold and foggy. My patient was a nine-year-old boy named Reza*. He was so sick. Scarily sick.

He was severely dehydrated, had major electrolyte imbalances and sepsis without clear source ravaging his body. We had none of my usual resources to investigate further and not much time – Reza was dying in front of us – delirious, low blood pressure and thready fast pulse.

I found Reza's mother crying in the corner. I went to speak to her. She was surprised at my approach. She was grief stricken at the sight of her seriously ill son. She asked me if Reza would recover, her face reflecting the anguish of a mother with a dying child. Reza certainly looked like he had resigned from life, his eyes closed, body limp and appetite gone. I was not prepared for this question, so with my teary eyes fixated on my feet, I tried to sound reassuring: 'My team and I will do our best'.

Those were the last words I said to her before we left her and the compound behind.

I look around me … glimpses of lives, other children crowded into the medical tent. There was a young girl bleeding between the legs and the moment of connection I had with her haunts me as I think about what trauma she must have survived. I had to focus on Reza if he was going to have any chance of survival.

As we mobilised to the airport, initiating and planning further treatment for Reza, he worsened with malignant arrhythmias. The road was bumpy, long and pitch dark. The journey back to the airstrip through the dense bushland seemed to take forever. Backed into a corner, we had to decide whether to chance just using medications and fluids through drips or whether he would be sedated, paralysed and we would take control of his breathing and other vital organs. It sounds simple here, but although the better option for getting on the plane was to have him ventilated, the very real risk was that he would not survive the intervention.

We got to the work of resuscitation. Reza needed fluids and medications to increase his blood pressure. He was in circulatory shock and his veins were not accessible to give this treatment. I drilled a needle into the bone of his leg so we could start treatment. He didn't even flinch.

* Name has been changed to protect the anonymity of the patient.

We pumped fluids via the intraosseous needle while I performed a subclavian central line by inserting a needle under his collar bone and threading a wire and cannula into the vein going into the heart. This line is challenging to get right as it can cause the lung to collapse. I had the chest drain kit ready to handle the pneumothorax in case it happened, but to my relief it did not.

We started him on an adrenaline infusion, watching his heart's response vigilantly. We intubated him and now had control of his airway, breathing and circulation. He needed the pads on his chest and the regular electric currents of pacing to keep his heart coordinated and effective in pumping. I glanced up: chest drain kit opened on the airport tarmac, surgical airway equipment, ventilator, central lines, guide wires, needles … blood. All of a sudden I felt the adrenaline rush. I looked down again and focused on Reza's breathing.

My mobile children's ICU was the tarmac of the airport.

The next four hours passed like a blur as we transferred Reza to the intensive care unit of a major paediatric hospital in Australia. He remained in a coma for a week, but was able to be extubated and recover his physical health.

This experience enabled me not only to reflect on the values I hold as a human being, but also as a member of a profession that upholds medical ethics, principles of impartiality, independence and neutrality since time immemorial. We are best placed to recognise that people present to us in their most vulnerable states and Reza was one of the most vulnerable children I have ever met. I know that I work to do my best, to treat my patients like my loved family and friends. I know my colleagues and team do so too.

It hurts to see children suffering. My mind stayed with him as he fought for life in intensive care. Reza is one child alive today, recovering. I do not know his fate but I know he survived the almost unsurvivable. I know we transported him safely to Australian soil, but I do not know what became of him after that.

I cannot help but think of the thousands of children still suffering that we do not know about in places like Nauru. Doctors are importantly placed as agents of social change. I urge us all to stand up for them, to contribute, to do what we can to improve their lives and live together in this world.

We must never forget that things are much worse for the person on the cold end of the stethoscope.

“I looked down again and focused on Reza's breathing. My mobile children's ICU was the tarmac of the airport.

Excellence in Emergency Care for Māori

Some gains have been made over the past 30 years to improve health outcomes for Māori. Despite these gains, Māori continue to experience consistent and compelling disparities in health outcomes, exposure to the determinants of ill health, lack of health system responsiveness and the under-representation of Māori in the health workforce.

'Ngā Rau o Tāne Mahuta – The Leaves of Tāne Mahuta'

ACEM launched its strategy for excellence in emergency care for Māori at this year's Winter Symposium, held in Rotorua, in the North Island of Aotearoa New Zealand. The strategy is known as *Manaaki Mana* and is built upon the pillars of Pae Ora (healthy futures for whānau), Whānau Ora (healthy families), Wai Ora (healthy environments) and Mauri Ora (healthy individuals).

Manaaki Mana seeks to redress some of the imbalances and misunderstandings in culture and care for Māori that contribute to these disparate health outcomes.

'Everyone working in the emergency department wants to provide the best possible care, but to do this we need to get comfortable talking about equitable care delivered within an appropriate cultural framework', says ACEM President-Elect Dr John Bonning.

John is one of 12 members of the Manaaki Mana Steering Group and speaks fondly of the collaborative effort that has gone into the strategy.

'I have worked on this strategy with some really passionate people, in particular, some key Māori Fellows and trainees. It has been humbling to work with them, to listen to their journeys in healthcare and to hear stories from Māori, not only as emergency care providers, but also as patients.'

FACEM Dr Claire Manning says she was initially a little reluctant to take part in this group.

Claire grew up in a small, predominantly white New Zealand town. She is Māori, with iwi associations to Kai Tahu, Kati Mamoe and Waitaha.

'In my mind I didn't have the language, knowledge or skillset to contribute, but in the end it all made sense to me and I feel quite privileged to have been a part of it.'

Te Ao Māori

John, who will become the College's first New Zealand President at year's end, wants all staff in EDs to provide culturally sensitive care that is 'informed from Te Ao Māori (a Māori perspective)'.

'We should be providing excellent equitable care in a culturally sensitive way', he says.

Claire agrees and says that embedding Tikanga (customary Māori values and practices) is important, especially to improve healthcare and health outcomes for Māori.

'Bringing Tikanga into EDs will go a very long way towards making many Māori feel safe and respected', Claire says.

She acknowledges it might at first be an uncomfortable change for some practitioners, but envisions an end result where EDs throughout New Zealand and Australia are culturally safe places for Māori patients, whānau and staff.

Embedding Tikanga means taking the time to establish a connection with patients and their whānau.

Greeting your patients with 'kia ora' and taking time to acknowledge whānau in the room can make a big difference to getting a consultation off on a positive footing.

Tikanga also means following other protocols that guide social norms in Māori life (for example, being respectful of privacy needs, particularly for kaumātua – an elder or person of status within the whānau).

In high pressure moments within the ED it can be easy for staff to loose sight of Tikanga, however evidence shows that taking the time to put a patient and their whānau at ease, results in better relationships and long-term care.

Progress, Claire says, is notoriously difficult to measure objectively. She feels like change is in the air and is proud to see ACEM acknowledging the problem. Still, she hopes in five years' time if asked the same question, her response will be a definite 'yes'.

Ange Wadsworth *Project Lead*

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i The Manaaki Mana Implementation Steering Group will monitor the College's progress in implementing recommendations in the Manaaki Mana Strategy. You can follow this work on the ACEM website.

The Riverbed Project Mount Isa

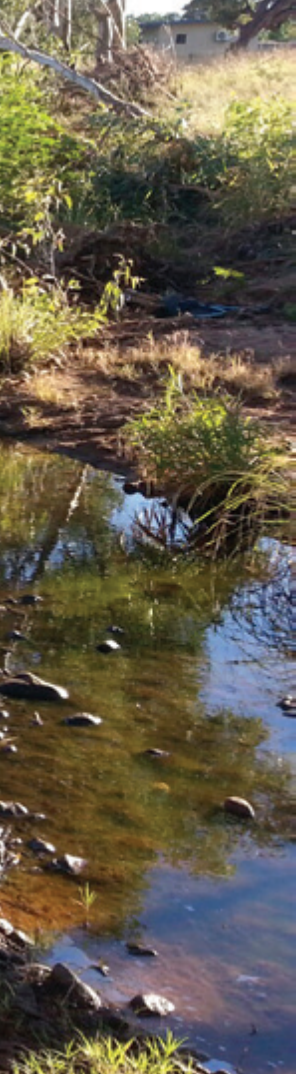
Dr Zafar Smith
Dr Smith is an Emergency Medicine Specialist in both Townsville and Mount Isa emergency departments and Senior Lecturer at James Cook University. Dr Smith is Samoan and Aotearoa New Zealander and was raised in Papua New Guinea.

Improving the indigenous cultural competence of emergency department staff through home visits to the homeless.

There is a population of Indigenous people that live in the riverbed of the Leichhardt River, Mount Isa. These people have no fixed abode. They often present to the Mount Isa Emergency Department, which is 40 metres across the road, with fractures, skin infections and alcohol intoxication. The staff of the emergency department have a limited understanding of the living conditions of this community. Emergency staff are reluctant to visit the people living in the riverbed, and the people in the riverbed are hesitant to visit the emergency department.

The Riverbed Project sees individual staff members from the Mount Isa Emergency Department organise voluntary informal home visits to the Riverbed in groups of two to four staff every month or two.

There are several aims of the project, most importantly, improving the cultural understanding of ED staff at Mount Isa Hospital. The project also attempts to break down barriers and build bonds of friendship between ED staff and the community living in the riverbed, while providing basic wound care and dressings.



Jim

When I first met Jim, he was covered in dust, could barely keep his head up and had a stench that was a combination of moist socks, stale sweat and Fat Lamb, a local brand of cheap wine. 'We found him up from the riverbed', the ambulance officer told me, 'his name is Jim. He was too drunk to stand, just lying in the street'.

It was 11.30pm and we had just finished the evening handover to the night shift team. Being the emergency physician on-call overnight, I was on my way out the door to get some much needed rest in case I got called back in the night. As I was leaving I heard one of the staff make a passing comment that stopped me in my tracks.

'He just wants a sandwich', she said. 'Don't worry, he'll be out before midnight.'

I was embarrassed and ashamed at our rush to clear the bed rather than offer the needed care. This man was clearly too intoxicated to hold his head up, let alone ask for a sandwich and walk out within the next half an hour.

I immediately arranged a short stay admission overnight and emphasised that he should only be discharged if he could walk, talk, eat and mobilise safely.

That night I would ask myself the following questions. How did we become more concerned about clearing the department beds than delivering compassionate healthcare? If we don't show compassion for this man, who else will? What can we do to help increase empathy and compassion for the Indigenous and vulnerable in our community?

The next morning I saw Jim sitting up in bed gobbling down his toast and Weetbix. As I walked passed he called out to me: 'Hey Doc, can you bring me some sugar please?' I smiled and threw him a couple of sachets of Bundaberg brown as he gave me a thumbs up. The Indigenous liaison officer was working on contacting Jim's aunt who lived on the other side of town, so that someone would be there to collect him when discharged.

A few days later I started wondering about this riverbed that Jim told me he was living at. I knew it was across the road from the hospital, only 40 metres away. I walked across the road by myself and saw a dusty dirt track winding its way down the riverbank. The grass was long and it was mid-afternoon. I passed the margin of the start of the long gras and I heard some people shouting and a dog barking. Nervous about what lay ahead, I quickly turned around and made my way back up the hill. I was hesitant to be alone and nervous that my intrusion may not be welcome. I needed to find a better way, a less intimidating way to get down to the riverbed to see exactly what life was like for Jim.

How did we become more concerned about clearing the department beds than delivering compassionate healthcare?

The visit

My first official visit to the riverbed was with Jamie from the Riverbed Action Group Outreach Support Service, along with two other ED staff. We walked through the long grass to an open clearing of round river rocks. There were about 12 people gathered in a circle, talking and laughing out loud, sitting on overturned plastic crates and wooden logs. I felt nervous about what they might think of us – doctors and nurses walking into the dusty riverbed with our hospital scrubs on.

I was apprehensive that they might feel threatened because we were walking through their turf. I had the urge to turn around and run back to the safety of the sealed road and buildings that I knew. I felt vulnerable and the feeling intensified the closer we got. There were several dogs barking in the distance and one of the nurses, who was terrified of dogs, said she did not feel safe. With all these fears running through my head, we walked slowly down towards the circle of people. I did not know what to say and was hoping that Jamie would be able to introduce us. At that moment, one of the people sitting in the circle stood up and said with a big grin and slurred speech: 'Hey Doc, I remember you. Remember me? From last week? You looked after me, remember?'

It was Jim. My fears immediately dissipated and I felt suddenly welcomed. A group that I thought was a blur of strange faces suddenly became a group of welcoming smiles. He started telling the others about me giving him the sugar. We were welcomed to sit down and hear stories about where each person was from. I asked each person's name. They went round the circle and the first two introduced themselves as Simba and Scarface. There was an uproar of laughter. I laughed out of politeness, unsure of the joke. The next person said his name was Pumba, which was followed by yet another roar of laughter. It was only when the last person said, 'and she is the hyena', that I finally realised they were role playing characters from The Lion King. We all had a good laugh and a yarn, and I learnt about the different groups of people that had travelled to the riverbed from places such as Lake Nash, Tennant Creek and Alice Springs.

The things I have learnt from visiting the Riverbed

Close to the earth, talking to the people in the riverbed, I asked them why they stayed there. My preconceived notion that they were there out of necessity was incorrect. Many of them replied, 'I like to be close to the earth', 'I want to be in the open with my people', 'I feel better when I am close to nature'.

This explained why many Indigenous patients do not like to wait inside the waiting room after being triaged. Many prefer to be outside in the open space and, often, hospital staff need to wander outside the waiting room to find Indigenous patients sitting under a tree or on a bench in front of the hospital entrance. Many Indigenous patients complain about the air conditioning being too cold and prefer to be in the warm outdoors.

I have heard that many of our Indigenous people feel alone and afraid when they come to hospital. They are worried that they will be harmed, that they will be treated disrespectfully and that hospitals are places you go to die. I never fully understood this fear until I went to the Riverbed. I was afraid to go to the Riverbed. I was afraid I did not belong there, that I would be judged or harmed.

I realised this is how Indigenous people may feel when they come to the hospital. Seeing it as a place where they do not belong, where there is another language spoken, where they are not welcomed. I was fortunate to have Jim there to welcome me during my first Riverbed encounter. I can only imagine how an Indigenous person would feel when they come to hospital, an unfamiliar and scary place, if they were met with a warm smile and kind gesture.

'Where are you from?' – The power of small talk before business. We are taught in medical school to take a history starting with the presenting complaint, then the history of the presenting complaint, then the past history. The last thing you ask about is the social history, about where the patient lives and their job. When talking to the people in the Riverbed, it was so much more important to start with the social history. Share a bit about yourself and show curiosity about the person in front of you. Asking the question 'Where are you from?' is much more important than the question asked in western culture of 'How are you?' Your parents' home town is more important than your occupation. People are defined by their ethnic and family origins, not by their job. We quickly learned that to connect with Indigenous patients, it helps to enquire about their place of origin. It is more important to ask 'Where you are going?' than 'How are you?' or 'What do you do?'

We don't need to change the people in the Riverbed, but we can change the attitude of our ED staff towards them; break down the barriers. We needed to see the people in the Riverbed as patients in need of equal care, no matter what the presentation, and, in some cases now, as our friends.

Not wanting for much, I asked the people in the Riverbed what things they needed. The list of things were: 'an Aboriginal hotel'; a swag; a beanie; a blanket; a mattress; paracetamol; and bandages. They didn't ask for anything that I had first assumed they wanted, like money or aid.

Moving forward

During the 12-month period that the project was running from July 2017 to July 2018, 25 ED staff members participated in eight home visits to the Riverbed, including 20 doctors, four nurses and one medical student.

There have been multiple skin wound dressings applied and a patient brought back to the ED for a cast to be changed. ED staff now know several Riverbed residents by name.

Staff have learnt more culturally appropriate ways of befriending Indigenous people, such as asking 'Where are you from?' and using non-verbal cues such as raising your eyebrows in greeting and twisting your hand like changing a lightbulb as a way of asking, 'Where are you from?' Small actions have been found to make an enormous difference with building patient relationships.

Hospital staff have started to visit the nearby Arthur Petersen's Diversionary Centre to gain an understanding of the services that the centre offers its clients experiencing homelessness.

There is a closer relationship and understanding between emergency staff and members of the Riverbed Action Group Outreach Support Service, who work to enhance the quality of life for Aboriginal and Torres Strait Islander people who are either homeless or at risk of homelessness.

ACEM Foundation

The ACEM Foundation was established in 2012 to consolidate the various philanthropic endeavours of the College. It exists to broaden the remit of the College's pursuits and further the objectives identified in the Constitution. The aim of the ACEM Foundation is to support practitioners working in emergency medicine by enabling them to deliver the highest possible level of quality healthcare and to contribute philanthropically towards the Foundation's three pillars:

- fostering emergency medicine research;
- encouraging and supporting Aboriginal, Torres Strait Islander and Māori doctors in undertaking emergency medicine training and to champion cultural safety; and
- building the capacity of emergency medicine programs in developing countries to deliver safe and effective emergency care.

The ACEM Foundation supports the three pillars through its awards, grants and scholarships.

Since 2012, it has given support to more than 100 Fellows and trainees, research projects, international scholarships and international emergency medicine programs in developing countries. The work of Dr Sarah Mikhail and Dr David McCutcheon are two examples of that which the ACEM Foundation enables across the globe.

The African Federation for Emergency Medicine

Dr Sarah Mikhail

The African Federation for Emergency Medicine (AFEM) works to ensure the development of collaborative and comprehensive emergency care systems in Africa. The Federation conducts several training and education programs throughout countries in Africa, and has developed an emergency care curriculum to facilitate the growth and sustainability of emergency medicine in African countries.

In 2018, FACEM Dr Sarah Mikhail, aided by the support of the ACEM Foundation, helped deliver a two-week program to the first emergency medicine residents at Uganda's Mbarara University of Science and Technology (MUST) and Makerere University. The universities launched their inaugural programs in emergency medicine in 2017 and 2018, respectively. With the support of the department head at MUST, Sarah and FACEM Dr Angela Harper, together with two emergency physicians from the University of Cape Town introduced 12 residents from those universities (the inaugural class at Makarere and the second intake of MUST) to concepts in emergency medicine through a series of hands-on, practical workshops and simulation sessions. Using the foundational AFEM Keystone module as its basis, the two-week program covered resuscitation, common presentations to emergency departments, clinical and diagnostic reasoning, communication and documentation.

'We used the AFEM Keystone course as it offered the most locally relevant content', Sarah says.

Sarah has been involved in the programs at MUST since their inception, and has travelled quarterly over this period to teach modules, including a local equivalency course in life support. She says the two-week program will now be repeated for future intakes, and the next program will be hosted by Makerere University.

'It is important for us and for Ugandans that the training programs are cohesive, and that the two cohorts of future physicians can develop strong relationships now to support them later on in practice.

'The residents in these programs are there through generous scholarships provided by government, but also with the support of ACEM's International Development Fund Grant. We've also had a lot of advice and support from other international bodies. It has really been a global emergency medicine experience and it's fantastic to know that there is such a community.'

2018 Al Spilman Early Career Researcher Grant

Dr David McCutcheon

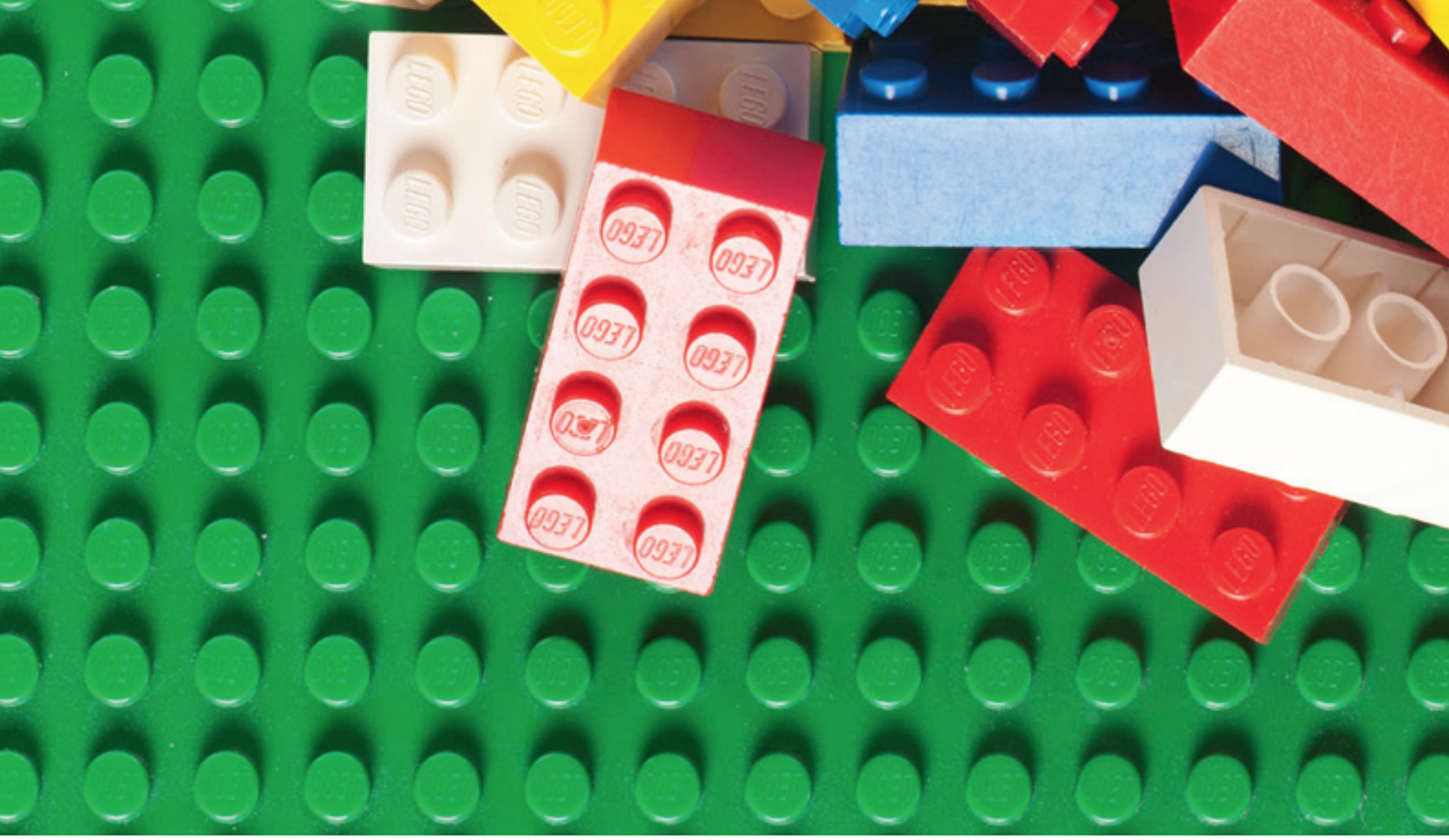
The Western Australian Illicit Substance Evaluation (WISE) study is exploring illicit drug presentations to the emergency department. There is an urgent need to understand more about novel psychoactive substances (NPS), which have been implicated in multiple deaths around Australia in recent years, as little is known about these drugs.

Patients can be included in the study based on clinician suspicion that the patient is significantly intoxicated with illicit drugs and requires IV access for routine care. In this circumstance, an additional blood sample is collected under waiver of consent. A unique de-identification regime is used, with a temporary two-week window where patient records are re-identifiable, allowing for high-quality clinical data to be collected and cross-checked, followed by permanent and irreversible de-identification of the sample prior to analysis.

More than 600 patients have been included in the study so far. Preliminary results indicate a significant proportion of patients with detectable NPS levels, including drugs such as 25C-NBOMe, 4-fluoroamphetamine, diphenidine, polymethyl methacrylate (paramethoxymethamphetamine), cumyl-pegaclone and alpha-pyrrolidinovalerophenon ('flakka').

The study methodology has recently been published in *Emergency Medicine Australasia*. The WISE study is generously supported by the ACEM Al Spilman Early Career Researcher Grant and the Royal Perth Hospital Medical Research Foundation. The study and methodology have been endorsed by the ACEM Clinical Trials Network.

Karen Eastwood *ACEM Foundation and IEMC Coordinator*



The Plastic Toy

Dr Andy Tagg
Dr Tagg is an emergency physician who works with both children and adults for Western Health in Melbourne. He is a co-founder of Don't Forget the Bubbles.

It has been said that it takes about 17 years for scientific knowledge to go from benchside to bedside. However sometimes, just sometimes, it can take less than a week.

One of the challenges of scientific research is just getting read. With more than 2.5 million new papers being published on an annual basis, it can be hard to stand out.

This is not a story about hard, evidence-based science, but about how we used a piece of yellow plastic to engage the lay public and medical community alike.

We founded our paediatric website – Don't Forget the Bubbles – in 2013. Originally it was as a means of collating our study notes. Since then it has morphed into something else. It's still an online repository of knowledge. We've written countless blog posts, been published in several peer-reviewed journals and, occasionally, we get asked to talk about paediatric medicine. As part of the founding collective, I was asked to give a talk at a tertiary paediatric hospital. The study day was a great success; my talk was not.

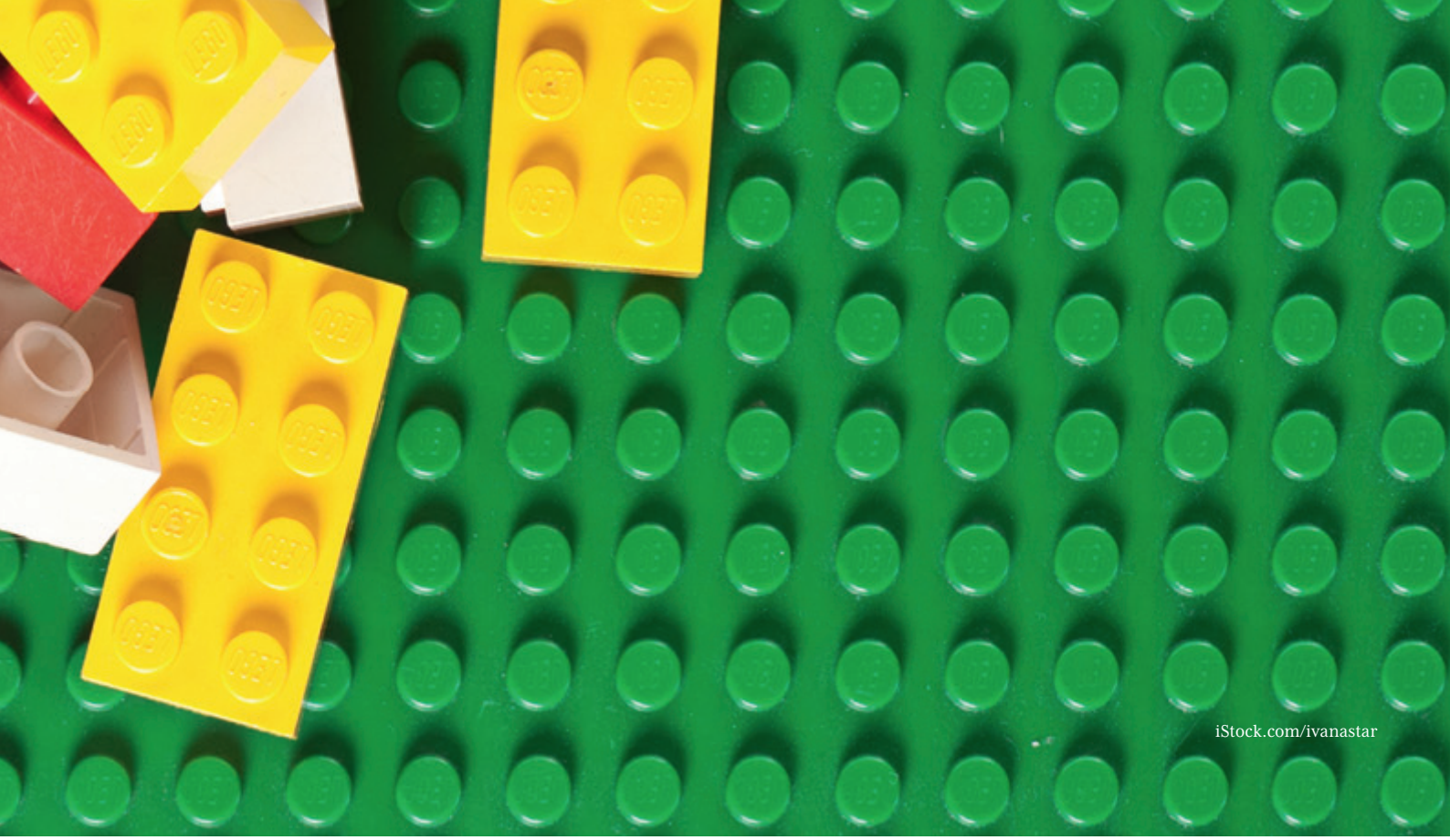
Perhaps it was the lure of adolescent medicine that dragged the audience out of my orbit. I had worked hard on my talk on ingested foreign bodies, complete with tales of tasty worms and not so tasty button batteries, but I could count the number of audience members on my fingers and toes. It is always disappointing when things don't go the way you expect, but I decided not to let my background reading go to waste.

We decided to change all that with a tongue-in-cheek study on the transit times of ingested foreign bodies. There was plenty of data out there around how long it might take a coin to pass through an unwitting diner, but I had discovered that there was no data surrounding the second most commonly ingested foreign body – the plastic toy.

The literature abounds with tales of self-experimenting physicians, from Barry Marshall drinking a flask of helicobacter pylori to Werner Forssmann performing his own cardiac catheterisation. While our pursuits were not quite so Nobel, we felt we couldn't ask anyone to do something we were not willing to undertake ourselves. The initial late night intercontinental phone conversations were first met with incredulity and then laughter as I described my far-fetched idea. Why don't we swallow a piece of Lego?

With a group of willing volunteers, collecting the preliminary data was easy. It was just a case of creating a stool diary, ingesting the golden piece of plastic, then watching and waiting.

The follow-up, or retrieval, was a little more challenging, but aided with plastic bags and chopstick, five of the six



iStock.com/ivanastar

heads were eventually found. With such a small group of participants we would never have a robust data set, but we had fun teasing out the statistics into something understandable.

The write-up process was just as collaborative, with ideas shared or squashed until we had the final document. With such a light experiment – in terms of both data and hard science – we targeted a journal that was known to have an entertaining Christmas edition. Unfortunately, we were met with the standard rejection email. In fact, we were met by another four rejections from other journals before the Editor of the *Journal of Paediatrics and Child Health* decided to take a punt.

Once accepted and published, we did what we do best, and publicised. How many regular journal articles – not just those game-changers in the *Lancet* or the *New England Journal of Medicine* – get their own press release? Through the help of Melbourne University Press we created a release and within hours had already scheduled interviews with every major radio station in Australia. No doubt bolstered by a need for a lighter read after a heavy week of politics, the Newswire then picked up the paper and it began to spread. First it was a filler in the local press, then it made it into the evening editions and by the next morning it had spread beyond our shores to America and Europe.

In crafting our press release, we made sure there was vision to go with the piece – we had recorded ourselves swallowing the little Lego heads – but we also made sure we used it to drive our agenda. While we spoke about swallowing toys, we also spoke about the dangers of button batteries in print, on the radio and on television.

By the second day of publication, we were getting phone calls at work; requests to speak on this radio show or to appear on that television program. We were careful to make sure we controlled the narrative. It would be easy to be a silly 'And finally…' piece but we did have a serious point to make.

We switched off the notifications on our phones for each mention on social media of swallowing, and so it took friends to point out that we had made it into the mainstream consciousness with mentions by Jimmy Fallon and James Corden in their late night shows. It had taken just three days for our paper to make it from toilet bowl to bedside.

So what did we learn from the experience? If I could take away just one thing it would be the power of perseverance. I had prepared hard for my talk and when nobody came I turned it into something else. When our paper was rejected, we didn't give up, we turned it into something else. And when it was finally published, we didn't just ignore it and add it to our resumes, we turned it into something else.

Work of the Council of Education

The work of the Council of Education (COE) and the Department of Education and Training, which supports COE, is complex and diverse. This is a brief synopsis of three new projects that have recently been developed and implemented.

Selection into FACEM Training

The new Selection into FACEM Training (SIFT) process for 2018 was developed by the SIFT Working Group and implemented by the Selection into Training Subcommittee.

Three tools were utilised in the SIFT process: a curriculum vitae/application form; selection references (maximum of four); and an institutional reference. Each had components and criteria that were aligned to the key selection criteria, with a focus on:

- capacity to learn and make decisions;
- strong communication skills; and
- professional characteristics that demonstrate capacity to thrive in an emergency department and add to the development of the speciality.

Of the 340 applicants received, 299 were invited to enrol in the FACEM Training Program, while unsuccessful candidates were provided with feedback specific to their application.

Review of the FACEM Training Program, Curriculum, and Hospital Accreditation Classifications

Throughout 2018, a comprehensive review of the FACEM Training Program and Curriculum continued. This has now been expanded with a working group appointed to develop several options to revise the hospital accreditation classification and delineation arrangements for consideration by COE.

The work from all three projects will be combined as a package for stakeholder feedback and approval by COE. Following this, regulation changes will need to be prepared, business rules developed, and IT specifications determined, built and tested. It is therefore envisaged that a revised FACEM Training Program will be implemented for 2021.

Selection into Training Applications

Australia

n=307

New Zealand

n=33

Fellowship Clinical Examination (OSCE) Preparation Program

In September and December 2018, the College introduced a program designed to assist trainees who have been unsuccessful at the OSCE on two or more occasions. The program covers:

- OSCE marking, standard-setting and key resources;
- Examination psychology – Resilience and the Growth Mindset or Emotional Intelligence and Communication;
- Hearing from new FACEMs who passed their OSCE after more than one attempt about the key things that made the difference for a successful attempt;
- OSCE essentials from an examiner perspective;
- OSCE station demonstrations – discussing candidate performance in small groups;
- OSCE station role-playing in two small groups (Communication and Teaching); and
- Examination preparation necessities – the checklist.

As participant feedback was very positive for all aspects of the program and, in particular, the examination psychology sessions, the College will continue to run an OSCE Preparation Program in 2019, with two courses scheduled for 29 May and 27 November 2019.

There will be two additional workshops in Melbourne held in the same months, titled 'Resilient Leadership' presented by Professor Jill Klein, Professorial Fellow in Medical Education, Melbourne Medical School.

The Education and Training team at ACEM look forward to sharing more of COE's work in future editions of *Your ED*.

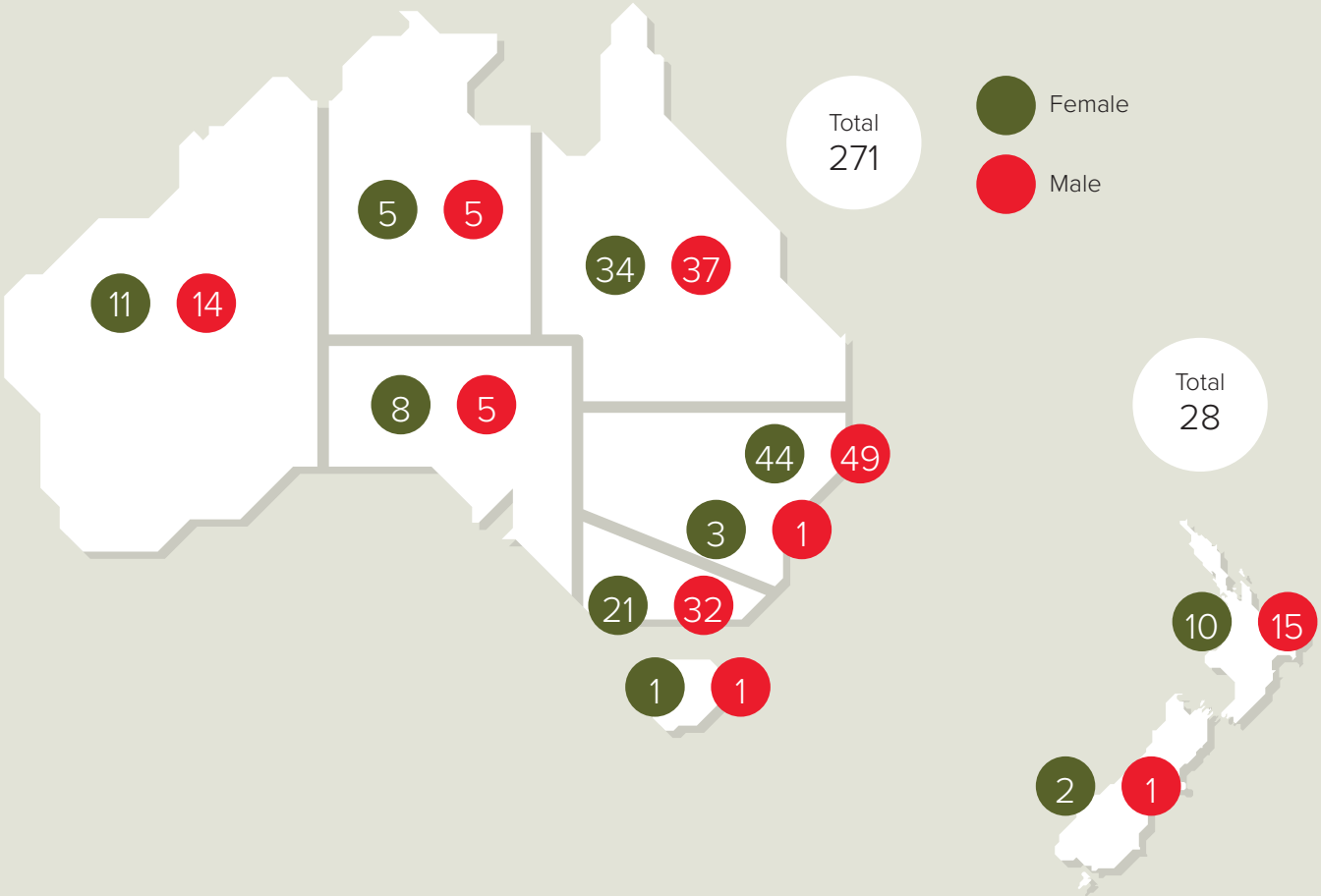
Lyn Johnson *Executive Director of Education and Training*

More information

Representatives

acem.org.au/COE

Successful SIFT applicants from Australia and New Zealand for 2018 by region



Calendar – Education and Training

Trainees

Fellows

JUNE			
3	2019.2 PE Written Examination	Applications open	
9	Training Term 2 Ends (New Zealand)		
10	Training Term 3 Commences (New Zealand)		
17	2019.2 FE Clinical OSCE	Applications open	
28	2019.2 PE Written Examination	Applications close	
JULY			
12	2019.2 FE Clinical OSCE	Applications close	
AUG			
2	2019.2 PE Written Examination	Examination date	*Various locations*
4	Training Term 2 Ends (Australia)		
5	Training Term 3 Commences (Australia)		
12	2019.2 PE Viva Examination	Applications open	
26	2019.2 FE Written Examination	Applications open	
SEP			
6	2019.2 PE Viva Examination	Applications close	
8	Training Term 3 Ends (New Zealand)		
9	Training Term 4 Commences (New Zealand)		
10-13	2019.2 FE Clinical OSCE	Examination date	*Melbourne*
16-17	2019.2 FE Clinical OSCE	Examination date	*Melbourne*
20	2019.2 FE Written Examination	Applications close	
OCT			
31 Oct-1 Nov	2019.2 PE Viva Examination	Examination date	*Melbourne*
NOV			
3	Training Term 3 Ends (Australia)		
4	Training Term 4 Commences (Australia)		
15	2019.2 FE Written Examination	Examination date	*Various locations*
26	Resilient Leadership Workshop		*Melbourne*
27	OSCE Preparation Program		*Melbourne*
DEC			
8	Training Term 4 Ends (New Zealand)		
JUNE			
6	EMCD Supervisor Workshop		*Launceston*
17	FE SCQ Writing & Review Workshop – Open to all FACEMs		*Sydney*
25	DEMT Workshop		*Sydney*
26	WBA Assessor Workshop		*Sydney*
JULY			
22	FE SCQ Writing & Review Workshop – Open to all FACEMs		*Brisbane*
24	DEMT Workshop		*Wellington*
25	WBA Assessor Workshop		*Wellington*
AUG			
19	FE SCQ Writing & Review Workshop – Open to all FACEMs		*Perth*
20	WBA Assessor Workshop		*Perth*
22	WBA Assessor Workshop		*Melbourne*
28	EMCD Supervisor Workshop		*Adelaide*
29	FE SCQ Writing & Review Workshop		*Darwin*
SEP			
16	EMCD Supervisor Workshop		*Auckland*
OCT			
22	DEMT Workshop		*Adelaide*
23	WBA Assessor Workshop		*Adelaide*
NOV			
25	FE SCQ Writing & Review Workshop – Open to all FACEMs		*Melbourne*

The Council of Advocacy, Practice and Partnerships

The Council of Advocacy, Practice and Partnerships leads ACEM activities in the areas of policy, the setting of clinical standards, research and advocacy.

Comprising regionally-elected FACEMs from each of the College's jurisdictions, as well as trainee and community representatives, the Council of Advocacy, Practice and Partnerships (CAPP) is committed to ensuring that emergency medicine in Australia and New Zealand is high-quality, safe and underpinned by professional standards founded upon an expanding body of specialist knowledge and evidence.

The establishment of robust standards entitles ACEM to be an authoritative source of advice on issues affecting the delivery of emergency medical care, and enables the College to advocate both for the interests of patients presenting to EDs, as well as members across their professional careers.

The activities of CAPP align closely with relevant areas of the College's Strategic Plan, focusing the work of its entities on matters of impact considered to be of most contemporary importance to members.

In November 2018, members were appointed to a range of new and ongoing committees under its purview. While recognising experience and expertise, an explicit commitment was made to appointing memberships that reflect the demographics of our diverse College. These committees will now dedicate themselves to a range of vital projects and programs.

The Standards and Endorsement Committee will maintain a contemporary up-to-date register of standards, ensuring they are embedded in practice and integrated within educational resources, training and curricula. It will bring a wider pool of members into the development of such standards.

The Health System Reform Committee will advocate on behalf of all patients, especially vulnerable and excluded groups, to improve timely access to appropriate care (including work on a new time-based target). It will build an evidence base to support advocacy activities in workforce planning, patient demand and presentations, and support system-wide initiatives aimed at achieving improvements to resource sustainability.

The Quality and Patient Safety Committee will enhance member and trainee expertise in quality improvement methodologies, human factors and patient safety. It will further implement the Quality Standards and Quality Framework in EDs, and encourage a culture of reporting and learning from adverse events and near misses.

The Rural, Regional and Remote Committee is supporting the development of an ACEM Rural Health Action Plan, the most important component of which is to develop a strategy on the future size and distribution of the emergency workforce, with particular focus on the needs of non-metropolitan communities.

The Indigenous Health Committee is continuing the College's commitment to Aboriginal, Torres Strait Islander and Māori health, which includes delivery of the Manaaki Mana/Equity for Māori in EDs Strategy and the second iteration of the ACEM Reconciliation Action Plan.

The Research Committee is working to strengthen the culture, profile and skills base of emergency medicine clinical research, develop models to enhance coordination of emergency medicine clinical networks, and enhance research opportunities and support for trainees.

The International Emergency Medicine Committee will expand ACEM's support to members of the International Emergency Network, and will continue to nurture strategic partnerships with Pacific Island jurisdictions and others as appropriate.

The Public Health and Disaster Committee will strengthen the public health approach in EDs to improve access for underserved populations, and continue its evidence-based advocacy on drug and alcohol harm in EDs. It will support the preparedness of EDs to respond to surges caused by disasters, pandemics and climate change.

The College has recently introduced a new type of entity, known as a Section. Formed by application, Sections represent a distinct area of practice and are open to all ACEM members. The Clinical Trials Network, the Emergency Department Epidemiology Network (EDEN), the Geriatric Emergency Medicine Section, and the Advancing Women in Emergency Section have each been formed as a section. This new 'resourced community of practice' model has great potential to engage members who are not attracted by mainstream committee work.

Finally, the term of office of elected FACEM members of CAPP concludes at the 2019 Annual General Meeting. Elections for those positions, as well as the Regional Faculty Boards, will be conducted in the second half of 2019. This is an opportunity for FACEMs interested in the continued improvement of the specialty to make a contribution. So why not consider nominating or encouraging someone you know?

Nicola Ballenden *Executive Director of Policy and Strategic Partnerships*

More information

Representatives

acem.org.au/CAPP

Election process

acem.org.au/Regulation-A

Workplace Wellbeing

Emergency medicine is a highly-rewarding yet challenging career. The constant exposure to patient ill health and injury and heavy physical and emotional demands can affect your wellbeing. ACEM supports the health and wellbeing of its members and trainees.

ACEM Wellbeing Award

The ACEM Wellbeing Award is one of a range of College initiatives aimed at empowering members and trainees to lead positive change in emergency departments, hospitals and the profession as a whole.

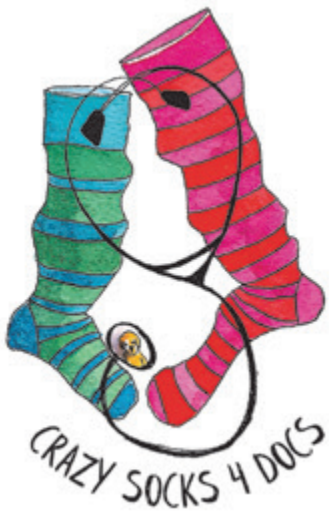
Launched in 2018, the annual award celebrates the initiatives of groups, individuals or whole emergency departments that have resulted in enhanced wellbeing for their emergency department colleagues.

The winners of the inaugural award were Dr Rachael Coutts (Northern Health, individual), Dr Ray-mund Siaw (Royal Hobart Hospital, individual), Sunshine Coast Hospital Emergency Department and St John of God Midlands Hospital Emergency Department.

The call for nominations for the 2019 Wellbeing Award will be advertised on the College website and wellbeing network.

Crazy Socks 4 Docs

Crazy Socks 4 Docs Day is the annual movement aimed at increasing awareness, removing stigma and reducing suicide rates in doctors with mental illness. So wear some crazy socks and join ambassador and founder Dr Geoff Toogood in the conversation on Friday 7 June 2019.



Recognising Burnout

FACEM Louise*, who found she was at high risk of burnout, thought she had a good balance in her life and says we should not take our personal resilience for granted.

'I had made conscious decisions that had allowed me to spend quality time with my family and explore other professional interests', Louise says. She decided to investigate her burnout risk after hearing a presentation by Dr Ken Milne at #ACEM18, finding herself worn unusually thin by her work and considering the viability of emergency medicine as a career.

'Given the way I was feeling, I was not surprised by my level of risk. Some of the questions focused on my personal behaviours and experiences, but it was also validating to see questions asked about workload and organisational issues', she says.

Louise spoke to her department and organisation managers and has been supported in her efforts to address issues affecting wellbeing in her ED.

Louise recommends WRaP EM, and the episode 'How to say no' on podcast *The Tim Ferris Show,* as resources to manage and strategise wellbeing. Other wellbeing resources are available on the ACEM website.

* Name has been changed at request of the FACEM.

More information

ACEM Wellbeing Award
acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Honours/Wellbeing-Award

acem.org.au/wellbeing

convergeinternational.com.au

Crazy Socks 4 Docs
#crazysocks4docs crazysocks4docs.com.au

Recognising Burnout
acem.org.au/News/March-2019/Beyond-burnout

wrapem.org

Workplace wellness, it's a thing!

Dr Shahina Braganza
Dr Braganza is an Emergency Physician at Gold Coast Health, Queensland. She strives to incorporate wellness into her workplace, for herself and for her team.

Emergency medicine is a team sport. Therefore, whether we are talking about performance, productivity or wellness, it behoves us to think about these things at a team level.

As clinicians, we know more about wellness and self-care than most people. Our challenge is not in the knowing – it's in the doing.

What gets in our way is simple: no time, no energy or volition, or even the stigma around struggle and being seen to have to pay attention to self-care.

It is a paradox that once we start to feel emotionally or physically fatigued, the first commitments that we jettison tend to be the ones that typically recharge us – exercise, attention to nutrition, socialising and staying connected. This triggers a downward spiral that can be dark and dangerous.

Thinking about wellness at a team level, and even as a workplace agenda, might help us to address some of these barriers. The five strategies below are just a few of the things you can look to implement in your ED, to improve overall wellness for yourself and staff alike.

1. Engage staff: cognition before emotion

When we reach out to a patient, we try to employ the strategy of 'emotion before cognition' – addressing their emotional concerns before our cognitive response.

So, for example:

Patient – 'I can't breathe'.

Clinician (emotional response) – 'I can see that it feels difficult for you. We have started our treatment and I'm hopeful you'll be feeling better in a short while'.

Clinician (cognitive response) – 'Well, your sats are 94% so you're doing just fine'.

When working to engage colleagues with some inherent scepticism and cynicism, we have found that putting a performance frame on our activity is met with more acceptance. Perhaps we are more comfortable talking about how we work than how we feel. Yet the goal remains the same; to start conversations by creating safe spaces for them within our workplace. Wellness by stealth!

Engaging medical and nursing leadership has been a vital first step. If a senior person in the room can start a busy handover by stating 'The day we feel we have no time for this [a brief wellness pause] is the day we need it the most', that makes a powerful statement regarding the department's attitude and value of our own wellbeing.

2. Keep the activity brief, simple and embeddable

It would be great if we had an allocated half hour each working day to sit quietly and meditate, but we don't. Even if we did, we'd probably spend it catching up on administrative tasks because that is how we are wired as emergency clinicians.

What we do have is brief periods in the day where we are literally forced to stand still – these are opportunities to, in fact, be still. While you're waiting for your blood gas to process, you could take a couple of deep and easy breaths. While you're logging into EMR, you can pay attention to the pressure of your feet against the floor.

Activity doesn't need to be long or sophisticated. Each time you slow down and drag your mind away from what just happened or what's going to happen next, and simply focus on the present moment, you can reset and recharge.

3. Make it fun, without making it cringey. What the heck – make it cringey

Our most warmly received activities have been the ones where we have taken the risk and tried to galvanise our team into some kind of connecting activity. Last year, we coordinated a flash mob to respond to our receipt of a hospital wellness award. On Valentine's Day, we allowed staff entering the handover room to choose how they would like to be greeted by a few of us: handshake, fist bump, hug or happy dance.

You may be surprised at how effective the cringey stuff can be. Those moments when we laugh with each other, even if our eyes are rolling, are the moments that build connection. Later, in the resus room, when you're feeling overwhelmed, you may feel just a bit more comfortable to ask your colleague for help.

4. Don't be discouraged by the negative voices

The negative voices tend to be the loudest, so it's likely that any air time will be occupied by those who feel strongly that these activities are silly/unnecessary/a waste of valuable time. For every one loud negative voice, I have had dozens of quiet voices who will approach me (and others) and share how the activity was valuable for them and why. From nursing students to veteran consultants, from the ED corridor to the tearoom to the clinical pod, colleagues have shared their stories and – I hope – they have felt validated and heard.

5. This is about nothing more than starting the conversation and building our community

Our efforts towards clinician wellness in the workplace will not fix depression or mental illness. They probably won't make more than a dent in burnout, compassion fatigue and vicarious trauma. What we hope our efforts will do, however, is start a conversation that may otherwise have gone unspoken, to enable the sharing of a story that may otherwise have gone unheard, and build a connection between people who work together, relentlessly, in challenging circumstances, and who may otherwise have felt isolated.

It doesn't really matter what your effort looks like. The most important thing is that you make one and that you start today.

ACEM Events

College staff work with Fellows, members and trainees to deliver high-quality events across Australia and New Zealand that support member professional development, member engagement and enhance ACEM's reputation as the leading provider of emergency medicine education, training, policy and research.

These events range in size and scope from our yearly Scientific Meeting, attended by more than 900 delegates, to the biannual Winter Symposium, workshops and networking events, featuring exceptional panellists and speakers from across Australia, New Zealand and the world, representing the best minds in emergency medicine.

These events are interspersed with a host of local, regional and national functions and Continuing Professional Development programs allowing members to learn and network with new friends and old.

MAY	Queensland Autumn Symposium, *Brisbane* | 23 to 24 May
JUNE	International Conference on Emergency Medicine 2019, *Seoul* | 12 to 15 June
JULY	Western Australia Faculty Networking Evening, *Perth* | 25 July
AUGUST	New South Wales Faculty Networking and Awards Evening, *Sydney* | 23 August
SEPTEMBER	Victorian Annual Conference, *Creswick* | 6 to 8 September
	Western Australia Annual Conference, *Bunbury* | 21 to 22 September
OCTOBER	New Zealand Emergency Department Conference, *Taupo* | 23 to 25 October
	South Australia Faculty Networking and Awards Evening, *Adelaide* | 25 October
NOVEMBER	ACEM Annual Scientific Meeting 2019, *Hobart* | 17 to 21 November

Our 35th Annual Scientific Meeting (ASM) was held in Perth, in November 2018. Celebrating the 35th year, ACEM was delighted to host record numbers in Western Australia with more than 930 participants. Delegates had the opportunity to hear from and share stories with some of ACEM's Foundation Fellows, gain key updates on College activities, hear from leading experts from across Australia, New Zealand and the world, and network with other colleagues, trainees and Fellows. The ASM is ACEM's annual signature event for the College and its members and we look forward to welcoming even more registrants to Hobart in November 2019.

A selection of photos from the Perth Annual Scientific Meeting.

My First Day on the Job

Dr Katherine Gridley

On my first night shift as an emergency registrar, I had to do a procedure that many FACEMs have yet to do in their career.

It was 2am and I had a patient present with facial trauma, who was noted to have excruciating eye pain. The patient had high intraocular pressure on examination, and a CT revealed a haematoma within the orbit. On discussion with our local tertiary ophthalmology service, we were advised to do an urgent lateral canthotomy.

You've got 10 minutes before I get there, so you'd better start Googling it.

My consultant had only just arrived home when she received the phone call from me.

'I hope you're not in your pyjamas yet, because I'm going to need you to come back in. I'm about to do a lateral canthotomy'. This was met with stunned silence.

I then sheepishly asked, 'Ah, so have you done one before?'

'No', she replied, 'but you've got 10 minutes before I get there, so you'd better start Googling it'.

It was akin to cutting a gristly piece of roast meat with a pair of scissors; but like most confronting procedures in ED, the hardest part was making the decision to do it. However, 20 minutes, one procedural sedation, and one cantholysis later, we had a patient with improving eye pain – and I had a rather unusual first ever DOPS assessment!

Dr Matthew Klan

My story's not from my first day, it's from my first night as a public health officer. It was New Year's Eve. It's a tradition in that hospital to wear a costume to work on the New Year's Eve night shift.

There's usually no particular theme ('60s tie-dye, zebra onesies, a Darth Vader watching the ventilated patient, etc.) It's a bad night to experience a ketamine emergence phenomenon. On this night I was extra help to two excellent (and much more senior) registrars, as NYE is always very busy.

Their costume inspiration was the fairy godmothers from *Sleeping Beauty*. We had enormous conical hats, big glittery fairy wings and magic wands in the colours of our scrubs – red, blue and green. Initially, I wasn't massively on board with this (I wanted to be taken seriously!) but was easily convinced.

We had enormous conical hats, big glittery fairy wings and magic wands in the colours of our scrubs …

Early in this shift a tox patient needed to be intubated and the consultant kindly let me take the airway. Obviously a bit nervous, I remembered to take the hat off but not the wings. As a result, on the first day of the year, the ICU nurses were still cleaning glitter off the patient's face well after extubation.

Perhaps being taken seriously isn't all that important.

Dr John Zorbas

Of course my swipe card doesn't work. They never do. There's always some form that hasn't been filled out properly, or needs to be sent to the Queen for Royal assent before it will function properly. So I do the time-honoured 'follow another person in and look like you belong' into the ICU at Royal Darwin Hospital. The Head of Department is on, and asks if I've worked in Darwin before, to which the answer is, 'no'. No uniform, no swipe card, no resident and no clue.

It's about halfway into the handover round that I realise why the question was pertinent. So far I've seen two intubated cryptococcal meningitis cases, a CRE patient with a small immigration fence around their bay and a renal patient with a dilated cardiomyopathy and pulmonary artery pressures suspiciously close to their systolic pressures … age 24. The look on my face must have said something because halfway through the round I get a chuckle, a pat on the shoulder and a 'welcome to Darwin!'

No uniform, no swipe card, no resident and no clue.

What has followed has been several years of unlearning and relearning of physiology textbooks, in one of the most glorious parts of Australia. If you want to relive your 'first day', no matter how senior you are, come north of the Tropic of Capricorn. Just don't stop to smell the Cryptococcus on the way.

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