your ED

PRE-HOSPITAL AND RETRIEVAL MEDICINE
in Aotearoa New Zealand

ACEM RECONCILIATION JOURNEY

ENOUGH IS ENOUGH:
Assessing the Impact of Alcohol-Fuelled Violence in Australasian Emergency Departments

LESSONS FROM THE FRONTLINE:
Pacific Emergency Care Clinicians Respond to the COVID-19 Pandemic

Icebergs and snow mountains during dusk in Aotearoa New Zealand

Cover: iStock.com/Skyimages

Australasian College for Emergency Medicine

Editor	Inga Vennell
Design	Studio Elevenses
Printing	Printgraphics Printgreen
Mailing	D&D Mailing Services

Your ED

34 Jeffcott Street, West Melbourne, VIC 3003, AUSTRALIA
t +61 3 9320 0444 | f +61 3 9320 0400 | admin@acem.org.au

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

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

Contents

Inga Vennell

inga.vennell@acem.org.au
+61 3 8679 8855

Message from the Editor

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

In this issue we feature stories of Pre-Hospital Retrieval Medicine (PHRM) from Aotearoa New Zealand, Australian Football League (AFL) concussion management and alcohol-fuelled violence in emergency departments. We also take a look at ACEM's reconciliation journey, Rural Health Action Plan and Environmental Strategy.

We highlight Global Emergency Care stories from the Solomon Islands and we hear from ACEM's Global Emergency Care Desk about lessons from the frontline, as we document the shared experiences of Pacific emergency care clinicians as they respond to the COVID-19 pandemic.

This issue also introduces the members of ACEM's Regional Wellbeing Committee, Regional New Fellows Committee and Diversity and Inclusion Committee.

As this will be Dr John Bonning's final magazine as President of the College, I would like to personally thank him for his hard work and support. Faced with a pandemic, it has been a difficult two years to say the least, and throughout it all, it has been a pleasure to work with John.

We hope you enjoy these perspectives on emergency medicine. In these unpredictable times, please take care of yourselves – and each other.

ACEM in the Media

In **May**, ACEM President Dr John Bonning featured in Aotearoa New Zealand media raising concerns about access block and emergency department (ED) crowding and the need to implement system-wide solutions as winter approached.

'We are looking down the barrel this winter of ambulance ramping, where every single space in the emergency department is full', Dr Bonning told *Stuff*.

In **May**, ACEM Western Australia Faculty Chair Dr Peter Allely featured in local media raising concerns about major capacity issues in the state's hospitals leading to access block, emergency department crowding and ambulance ramping.

'The whole health system just doesn't have the capacity to physically look after people at the moment', Dr Allely told *The Sunday Times*.

'Heaven forbid we get a COVID outbreak because we just wouldn't cope'.

In **May**, the College's South Australia Faculty Chair Dr Mark Morphett provided an interview to ABC radio in Adelaide, discussing the major access block issues being experienced by the state's EDs.

'In many ways we have an acute healthcare system, that isn't set up to run seven days a week as it needs to', said Dr Morphett.

'It still runs, primarily on a five-day a week model. So we have these periods where we fall behind over weekends and we need to catch up early in the week, and we just can't afford to do that anymore.'

In **May**, Dr Bonning featured on ABC television news in Victoria discussing major pressures and access block, as a result of widespread systemic issues being faced by the state's hospitals and emergency departments.

'We've hit the ceiling in terms of resources', said Dr Bonning. 'The whole system is full and backed up.'

In **May**, ACEM's Queensland Faculty Chair Dr Kim Hansen featured in local media commenting on the significant pressures facing the state's emergency departments.

'Emergency departments are the canary in the coalmine', Dr Hansen told the state's News Corp publications. 'They bear the burden when other parts of the health system are over capacity.'

In **May**, the College's concerns over the South Australian Government's failure to truly understand and address key underlying factors contributing to hospital access block featured in local media. Dr Morphett also featured in *The Adelaide Advertiser,* raising concerns about the fact too many people needing mental health support were continuing to face 'dangerous and unacceptably long waits' for definitive psychiatric care following their initial treatment and stabilisation in emergency departments.

In **May**, the College's calls for a more collaborative and cooperative approach between the Commonwealth and state/territory governments to address Australia's acute hospital access crisis received significant media coverage.

Dr Bonning conducted a range of high-profile media interviews on the topic with ABC radio and television, as well as Channel 10's The Project and radio 5AA in Adelaide.

'This crisis is caused by systemic issues and pressures that have been growing for years', said Dr Bonning.

'These issues are causing sick and seriously injured patients to face major delays in being admitted to hospital inpatient beds or other healthcare services following their initial treatment and assessment in EDs. This is not a new problem. Presentation numbers have continued to climb steadily for the past decade, and systems are failing to meet that ongoing demand. This has been predictable and should have been planned for.'

ACEM President-Elect Dr Clare Skinner also provided an interview to ABC radio's AM program, to discuss the issue and potential solutions.

In **May**, Dr Bonning was interviewed by *The Sydney Morning Herald* and ABC online to discuss the results of an emergency department patient satisfaction survey released by the New South Wales Bureau of Health Information.

'There are a lot of positives in the results but as lockdowns have lifted patients are filling emergency departments and doctors and nurses are all under the pump, morale is low and burn out is high', said Dr Bonning.

'The acute hospital access crisis is not just a post pandemic blip. This has been coming for a decade or more.'

In **May**, Dr Bonning featured in media in Aotearoa New Zealand discussing the impacts of a cyber attack affecting computer systems at Waikato Hospital.

'We've gone back to whiteboards, we're able to use some non-networked computers, everybody is rolling their sleeves up and working together', Dr Bonning told Radio New Zealand.

'Everybody's impacted and we'll deal with this crisis.'

In **May**, Dr Bonning spoke to *Stuff* about the major demand pressures being faced by Aotearoa New Zealand emergency departments.

'We are spending 25 per cent of our time treating patients who should be admitted to hospital, but there is no space to move them through', said Dr Bonning.

'We need more beds to take acute patients, extended hours of operating theatres, more nurses to staff the wards.'

In **May**, the College featured in Western Australian and national media highlighting the need for focus on fixing

a broken system rather than blaming individuals following the release of a report into the tragic death of a child at the Perth Children's Hospital earlier this year. Dr Allely spoke to the major systemic issues confronting the state's healthcare system in interviews with *WA Today, The West Australian* and the ABC's 7.30.

In **May**, following the announcement of a snap COVID-19 lockdown in Melbourne, ACEM Victoria Faculty Chair Dr Mya Cubitt featured in *The Guardian* discussing concerns about emergency department crowding, healthcare system capacity and staff wellbeing.

'Whether we have a COVID outbreak or not, emergency clinicians, and all of the many colleagues that we intersect with in the healthcare system, are under extreme pressure', said Dr Cubitt.

In **June**, Dr Allely featured on Perth's 6PR in response to claims from the state government that a decision to postpone some elective surgeries was primarily due to a surge in mental health presentations to emergency departments.

'The beds in our emergency departments are full of people needing to go to wards, and mental health patients make up maybe 15 per cent of those patients', said Dr Allely.

'So the other 85 per cent of patients are non-mental health presentations, so I'm not sure you can blame it all entirely on an increase in mental health presentations.'

In **June**, the College issued a media statement, and co-signed a joint statement with other specialist medical colleges, calling for the Murugappan family of four who had been held in immigration detention on Christmas Island to be released into the community. The call followed the transfer of the family's youngest daughter, accompanied by her mother, to Perth for treatment for sepsis. The joint statement featured in national media, and the family were subsequently re-united and released into community detention in Perth.

In **June**, the *Medical Journal of Australia* published an article, co-authored by Drs Bonning, Skinner, and former ACEM President Dr Simon Judkins, calling for whole-of-system reform to address Australia's acute hospital access crisis.

The piece generated a follow up article in *The Guardian* and Dr Bonning also provided an interview to ABC radio in Adelaide.

'This is a hospital wide, or health system wide issue, manifest in the emergency department', said Dr Bonning.

'We're trying to engage with the politicians, trying to engage with health management, but we need to be brave and we need to change a bit of the way we do things to try and rectify this.'

In **June**, Dr Skinner featured in the *Sydney Morning Herald* commenting on the serious pressures facing New South Wales EDs, highlighted by the release of new quarterly figures from the Bureau of Health Information.

'There was a slight pause during 2020 but now we are back to pre-pandemic levels with older patients, people with mental health conditions and children needing the most care', said Dr Skinner.

'But it's not just the pandemic it's the result of an ageing population and the end product of years of dysfunction in the health system.'

In **June**, Dr Hansen featured across a range of high-profile media outlets in Queensland discussing the ongoing pressures on the state's health system resulting in ED access block, overcrowding and ambulance ramping.

'It is a desperate and complex situation and we need the government to listen and take action', said Dr Hansen.

In **June**, Dr Morphett featured on ABC radio in Adelaide to once again discuss the state's acute hospital access crisis and the impact on patients and frontline staff.

'What we've seen in the last two years is increasingly our emergency departments starting to move not only to code white, but we've seen two of our biggest emergency departments move in to code yellow this year. What we talk about when we talk about code yellow is a situation that is just manifestly dangerous and unsafe, and I think we need to acknowledge that. And it's not about blame and it's not about politics. It's about how do we fix that problem.'

In **June** the College's response to the South Australian budget, welcoming investment in mental health but raising concerns over the government's continuing failure to understand, and address, the systemic issues that lead to dangerous bottlenecks in emergency departments and ambulance ramping was featured on Channel Nine News.

In **June**, ACEM issued a further public statement calling for the safe release of medical professionals detained in Myanmar, including Professor Maw Maw Oo, the Emergency Clinical Lead for Myanmar's national and regional COVID-19 response.

In **July**, Dr Bonning and Tasmania Faculty Chair Dr Juan Carlos Ascencio-Lane featured in local media amid concerns of the potential impact of a proposed elective surgery blitz on the state's already struggling emergency departments.

While the government must deliver on their election promises, without an immediate increase in sustainable in-patient capacity across the hospital system, which includes completed staff hires, not just planned, the increase in elective surgery will put pressure on our acute health system that is already struggling beyond anything we have seen before', said Dr Ascencio-Lane.

PRESIDENT'S WELCOME

Kia ora katoa.

Welcome to the latest edition of *Your ED*. As we continue to confront the uncertainties of the COVID-19 pandemic, this will also be my final welcome message to you as ACEM President in this magazine – though I have some time yet and more still to do in the job.

It seems like only yesterday, as well as many eons ago, that my first greeting appeared in these pages. Following our Annual Scientific Meeting, Annual General Meeting and College Ceremony in Hobart in 2019, the last time we gathered en masse in person, I was, and remain, honoured, humbled and proud to have been elected the first President of our wonderful College from Aotearoa New Zealand.

After our landmark climate march through the streets of Hobart, coupled with the College's declaration of a climate emergency, I was struck by the sense of vigour and appetite to confront and address the challenges of our time, both within our work, and at a societal level. The best of our dynamic, caring and compassionate specialty was on display.

Just a few months later, our world was turned on its head, due to what we would soon know as the all-pervasive COVID-19 pandemic. It has ultimately impacted almost every facet of our work and lives – and will no doubt continue to do so for some time to come.

That energy, innovation and dedication, so palpable in Hobart, was channelled into our collective efforts to respond to this global crisis. We are, after all, trained to deal with emergencies, uncertainty and unknowns. So what better stage for emergency clinicians to come to the fore than a global health emergency?

From our rapid development of living guidelines to advocacy at national and jurisdictional levels, to emergency physician colleagues being seconded into senior roles in government responses, to the painstaking efforts of our College councils, committees, members, trainees and staff to maintain business as close to usual as possible – what we can achieve when we work together is so clearly on display.

It hasn't been easy, but when reflecting on the past two years, we must acknowledge how much we have collectively achieved. Amid the new paradigm and significant pressures of our COVID-19 reality, old and new challenges, and issues with our work have emerged. Among the most wicked is access block and major systemic pressures being felt in emergency departments across our two countries. Work is progressing to find solutions – our proposed new Hospital Access Targets are just one example – and our commitment to improving the situation on the ground for our members, trainees, and patients remains unwavering.

Though this is my final message in *Your ED* as President, my commitment is that I will continue to push for resolutions to the crucial issues that affect us all, for my remaining time in the role, and beyond. While education and training, and science and research are at the heart of what we do as a College, I hope we will continue to advocate for social justice, equity in healthcare, rational resource stewardship, and the health of our planet.

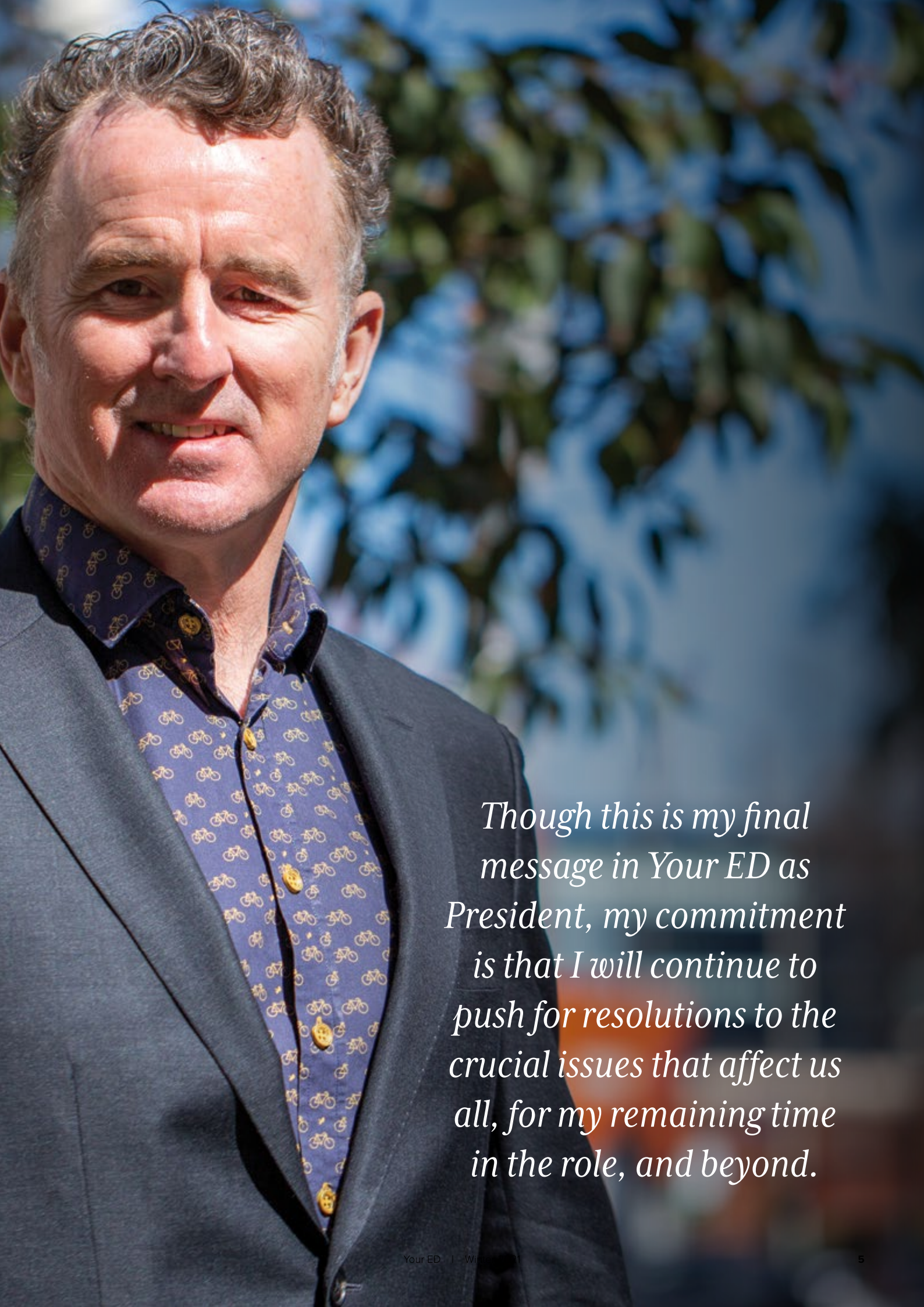
In signing off, I would once again implore you to remember kindness to our patients, our colleagues, and ourselves.

I humbly thank our team of 6,000 College members and trainees, for all of your extraordinary efforts. Thank you to those who have come before me and those who will follow, and thank you for the honour and the opportunity to represent you all as the President of the Australasian College for Emergency Medicine.

Kia kaha,

Dr John Bonning

ACEM President



Though this is my final message in Your ED as President, my commitment is that I will continue to push for resolutions to the crucial issues that affect us all, for my remaining time in the role, and beyond.

CEO's Welcome

Dr Peter White

Once again, I write this column as the COVID-19 pandemic continues to challenge the ability to deliver care through our health systems, as well as the ability of organisations, such as ACEM, to conduct their functions that support this delivery. Indeed, the demand for emergency care has not diminished during these times, nor has the demand for ACEM to conduct its functions. Nevertheless, whether by being 'agile', or simply by being determined and committed, delivery by healthcare professionals continues, as do the services of the College.

There is no doubt that these are difficult and trying times. Such times call for commitment and leadership, and I am grateful that over the duration of the COVID-19 pandemic to date I have had the opportunity to work with Dr John Bonning who has provided that commitment and leadership to ACEM in his role as President. As John indicates in his introduction to this edition of *Your ED*, this is his final welcome message as ACEM President, his term concluding at the College's Annual General Meeting (AGM) to be held in November. On behalf of the ACEM staff, I thank John for his absolute commitment to the role of President. He has accomplished much in difficult times, and I am sure that he will continue to contribute to ACEM and the specialty after his term as President formally concludes.

Along with all other necessary business that is required to be transacted, the handover of the ACEM Presidency at the AGM in November comes toward the end of the calendar year. Dr Clare Skinner will assume the ACEM President role at a time when the College is nearing the end of the period covered by its current strategic plan. The Strategic Plan 2019 – 2021 is based around six Strategic Priorities, and much has been achieved against the key objectives and work associated with these priorities.

Work is now underway to develop the ACEM Strategic Plan for the period 2022 – 2024. Having assessed the current priorities of the College and the environment in which it is operating, the ACEM Board has taken the decision to develop this plan around the same six Strategic Priorities contained in the 2019 – 2021 document. An initial draft of the plan is under development and, as always, wide consultation will be undertaken as the document is developed before consideration by the ACEM Board of a final version in early 2022. It is anticipated that the ACEM membership will be invited to contribute to the process of developing the Strategic Plan 2022 - 2024 in the near future and I would encourage all members to do that when the opportunity arises.

The most recent meeting of the ACEM Board considered recommendations in relation to the awarding of Distinguished Service Awards (DSAs). These awards are made on an annual basis at the discretion of the Board in recognition of significant high-level service, over and above that of other individuals, demonstrating a commitment to the work of the College. Two of the recipients acknowledged through the award of a DSA this year for their contribution to the College are ACEM staff members; Leonie Tatt and Lyn Johnson. Both have made significant contributions to the College and I congratulate Leonie and Lyn on their awards.

As I write this column we are about to embark on another round of Fellowship clinical examinations for the year. Enabling all trainees to progress through training during the COVID-19 pandemic has been a priority for the College and one that has not been without its challenges. Indeed, the College has recently been forced to make the reluctant decision to postpone the clinical examinations scheduled to be held in New South Wales and Aotearoa New Zealand, due to factors associated with local circumstances resulting from the latest Delta variant outbreaks, and we have become aware of the cancellation of examinations by the Royal Australasian College of Surgeons for the remainder of this year. That said, ACEM has enabled more than 2,000 examination attempts by FACEM trainees since September 2020 during the pandemic. This is a significant accomplishment that has required enormous commitment from a number of College members and staff and is one example of the capacities of the College to deliver outcomes in difficult times.

In closing, I thank all College members and staff for their ongoing commitment to the work of the College and enabling the provision of emergency care to all who need it during these trying times.

The Morson Taylor Research Grant Drives COVID-19 Research in Emergency Care

Associate Professor Gerard O'Reilly (FACEM) is perhaps as enamoured with emergency medicine as the day he started. The 2020 Morson Taylor Research Grant winner presented at ACEM's annual Research Network Symposium and was also an Event Faculty Member for the Global Emergency Care Conference 2021 held from 8-10 September – a collaboration between Alfred Health Monash University and ACEM.

In some ways, Associate Professor O'Reilly has been preparing for these events his whole career. About 20 years ago, he helped provide disaster relief in Afghanistan and Kenya, which led him to pursue a Master of Public Health, and, ultimately, a Master of Biostatistics.

'I hadn't really dabbled in mathematics since school, but during the Master of Public Health we had to complete a compulsory biostatistics unit. I rediscovered my love of mathematics from that one unit and so decided to complete the Master of Biostatistics too.'

He followed his two Master's degrees with a PhD in global trauma epidemiology and registry development.

'It combined my passion for global health and statistics with trauma and emergency medicine.'

Registries, he says, are datasets for improving care. They exist for many conditions but are often disease and diagnosis-specific.

'Until now [the pandemic], there have been very few registries established for emergency care.

'It has a unique setting. We deliver life-saving care, often before a diagnosis can be confirmed, which isn't generally how a registry works.'

Associate Professor O'Reilly says COVID-19 has driven great strides in research and registries.

'COVID-19 generated fear, anxiety and, I think, a strong desire to act.

'We've seen this energy really quite pervasively in the emergency medicine community and it has led to many COVID-19-related research activities trying to fill the abyss of knowledge.'

He says he has felt lucky to be part of that community.

'The pandemic has forced research to be more relevant, timely and clinically focused. It has brought together public health and emergency care, and integrated the approach to health system improvement, surveillance, emergency care, advocacy, health promotion and research.

'In 2020, I had the wonderful privilege of leading a collaboration of emergency medicine researchers across Australia to develop the COVED Registry; a registry specific to COVID-19 in the emergency department.'

'What we found is the COVID-19 pandemic affects all patients in the emergency department.'

This caused Associate Professor O'Reilly and his peers to pivot – to embark on a new project, which underpins his Morson Taylor Research Grant.

'We're trying to progress the establishment of a Registry for Emergency Care for Australia and New Zealand (ANZ-REC).

'But first we want to understand what data would be useful for improving care in the emergency department. Our project is titled *A binational survey of emergency physicians using Delph methodology.*

'The Morson Taylor Research Grant is helping us to develop this dataset.'

Associate Professor O'Reilly says the grant – first established in 1999 – has profound value for emergency medicine research.

'It supports activities that will inform emergency care binationally for years to come.

'It sends a strong message to the emergency medicine community that ACEM is a lead partner in emergency care system improvement and advocacy.

'And it allows emergency clinicians in Australia and New Zealand to be engaged in the future of their own specialty and emergency department.'

That future, he hopes, will be helped too by the Research Network Symposium. A staple of the College's Clinical Trials Network and ED Epidemiology Network (EDEN), the symposium (now in its third year) fostered multi-centre research across emergency departments in Australia and Aotearoa New Zealand.

'The symposium is an important vehicle for achieving all the many things multi-centre research contributes.

'It's valuable in so many ways, including the value of the research outputs, the collaboration, the advocacy, and the increase in capacity for everyone to be involved and benefit.

'In the past year, I've taken the lesson that anything can be achieved, as long as people come together.

'This is as true for emergency care research as it is for other aspects of emergency care system improvement. Research is about people; it's about patients, carers, clinicians and researchers. It's not about the statistical software program in isolation.'

Author: Natasha Batten, Communications Advisor

More information

Entries for the 2021 Morson Taylor Research Grant closed in August. Keep an eye on the awards page for future opportunities. acem.org.au/awards

ACEM Reconciliation Journey

Acknowledgement of Country

Let us take this moment to acknowledge the Traditional Custodians of the lands across Australia on which we live and work, and to pay our respects to their Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples.

In recognition that we are a bi-national College, let us also take this opportunity to acknowledge Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

Reconciliation is an important process in the journey within Australia to strengthen relationships between Aboriginal and Torres Strait Islander peoples and non-Indigenous people.

'Aboriginal and Torres Strait Islander peoples, despite the dispossession, violence and repressive racist policies they have endured, have shown a generosity towards the new arrivals; and since 1788 have repeatedly called for reconciliation and a coming together.' – Reconciliation Australia, 2021.[1]

To help define and recognise when reconciliation has been achieved, Reconciliation Australia has identified five dimensions to measure reconciliation: race relations; equality and equity; institutional integrity; unity; and historical acceptance. They are interrelated and must all be progressed together to achieve reconciliation as defined by Reconciliation Australia.[2] For example, greater historical acceptance of the wrongs done to Aboriginal and Torres Strait Islander peoples can lead to improved race relations, which in turn leads to greater equality and equity.

Progress, although slow, has been made in the past few decades in Australia in building relationships between Aboriginal and Torres Strait Islander peoples and the wider Australian community, to work together to achieve a shared sense of fairness and justice.

Reconciliation Action Plans (RAPs) provide a framework for organisations to support the national reconciliation movement. No matter where an organisation is on its reconciliation journey, there is a RAP that can guide the organisation through the journey. RAPs can, and are, making a difference across Australian workplaces, universities, schools, government, and community organisations.

ACEM's vision for reconciliation is that emergency departments (EDs) deliver quality, acute healthcare that is culturally safe, resulting in health equity for Aboriginal and Torres Strait Islander peoples.

On the eve of the launch of ACEM's third RAP, the Policy and Advocacy Team sat down with RAP Working Group Co-Chair Dr Elizabeth Mowatt to discuss the College's reconciliation journey.

While the College is approaching the release of its third RAP, Dr Mowatt emphasised that ACEM's reconciliation journey started a long time ago before the RAP came along. There are several important milestones that preceded the launch of the first RAP.

On 10 May 2012, the Indigenous Health Working Group met for the first time as part of the College's Public Health Summit. In 2013, the Indigenous Health Subcommittee was formed to provide leadership on Aboriginal, Torres Strait Islander and Māori health equity and cultural safety in emergency departments (EDs) in Australia and Aotearoa New Zealand. In 2020, the Subcommittee became a Committee, reporting directly to the ACEM Board.

Also, in 2013, the ACEM Foundation established the Joseph Epstein Scholarship for Aboriginal, Torres Strait Islander and Māori Advanced Trainees, to encourage and support the undertaking of advanced training in emergency medicine

through ACEM. This scholarship aims to increase the number of Aboriginal, Torres Strait Islander and Māori emergency medicine specialists. Applications can be submitted anytime and anyone who fits the eligibility criteria will receive a scholarship, which covers annual training fees and the cost of one attempt of the Fellowship exam.

ACEM has actively participated in the National Close the Gap Day since 2014 by donating to this initiative through the ACEM Foundation, which was pivotal in establishing a College connection to the Close the Gap Campaign. In December 2018, the College joined public calls for the Closing the Gap Health Strategy to be rebuilt. In 2020, ACEM was accepted as a member of the Close the Gap Campaign Steering Committee.

Dr Mowatt proudly states that, ‘It’s an incredible honour for us as a non-Indigenous organisation to be invited to join that group’.

Of all the formative actions, Dr Mowatt points to the Indigenous Health and Cultural Competency Program launched by ACEM in 2015 as one of the College’s achievements to be proud of and to continue to promote. This online resource received an Australian and New Zealand Internet Award for Diversity in 2015 and is freely available to the public.

Comprised of podcasts and eLearning modules for doctors and other healthcare professionals, the Indigenous Health and Cultural Competency Program was informed by literature reviews, and participatory research with Aboriginal and Torres Strait Islander health staff, emergency medicine physicians and nurses. The reference group was made up of representatives from the Australian Indigenous Doctors Association (AIDA), the Leaders in Indigenous Medical Education (LIME) Network, cultural educators, academics, and emergency medicine doctors.

On the process of developing this Program, Dr Mowatt states, ‘That was the first time that ACEM looked beyond its own walls with the diverse reference group that brought this together. It wouldn’t be the great resource it is if we hadn’t brought in external experts to guide us and lead us in the work’.

These modules are mandatory for trainees in the first stage of the FACEM Training Program. Cultural competency has also been mandated for Fellows participating in the ACEM Continuing Professional Development (CPD) Program.

Dr Mowatt highlights that, ‘This is important because we are a training organisation. The fact that we are embedding Indigenous health and cultural safety training in the lives and learnings of our trainees and Fellows is one of our greatest achievements’.

On 21 March 2017, the College launched its inaugural Innovate RAP 2017-2018 with a smoking ceremony. The responsibility for implementation and operation of ACEM’s RAP is delegated to the RAP Working Group, which reports to the ACEM Indigenous Health Committee.

Reflecting on the inaugural ACEM RAP, Dr Mowatt notes that, ‘ACEM, as an organisation, is embarking on a unique RAP journey in the sense that if you did a RAP in a traditional way, it would be about the staff at ACEM headquarters. We’ve always had a vision that our RAP is a way to actually influence emergency medicine care as it’s delivered to Aboriginal and Torres Strait Islander peoples when they present to Australian emergency departments across the diaspora, which are our training sites. And so, that’s a real challenge for us to ensure that we keep the essence of what Reconciliation Australia wants us to do, and yet interpret it through the lens of what we understand is emergency medicine, emergency medicine training and emergency departments’.

The College has made good progress to embed reconciliation in the business of the College. ACEM staff are engaged in reconciliation through regular training and reflection sessions, and by marking National Reconciliation Week and NAIDOC (National Aborigines and Islanders Day Observance Committee)

Week. The College regularly reviews processes and policies to ensure there are no barriers to the recruitment and retention of Aboriginal and Torres Strait Islander staff.

Visible signs of inclusion and respect are important. At the entrance of ACEM head office, you will find a plaque recognising the Wurundjeri people as the Traditional Owners of the land upon which the office is located. Aboriginal and Torres Strait Islander flags, Aboriginal artwork and copies of our Innovate RAP 2019-2020 document are visible throughout the building.

To this end, Dr Mowatt says, 'We have to absolutely shout from the rooftops that we have managed to embed all the RAP-mandated actions that referred to ACEM headquarters'.

Engagement with Aboriginal and Torres Strait Islander people and organisations is a core part of any RAP. Dr Mowatt reflected on the significance of the collaborative relationships that the RAP Working Group and Indigenous Health Committee have established at a national level. 'ACEM is a national body, as are the peaks that we engage with. We've had some fabulous relationships come out of that, including our sponsorships of LIME, AIDA, and the Lowitja Institute conferences, with members, trainees and staff attending those events – our engagement with the National Aboriginal Community Controlled Health Organisation (NACCHO), and the advocacy work we partnered with them around the Close the Gap (CTG) scripts (pharmaceutical benefits scheme co-payment program). The rules just changed on 1 July so scripts written in the ED are eligible for the CTG co-payment.'

While ACEM is a bi-national body, emergency care is happening on a local level. Dr Mowatt regards the local level as an area where, 'We've got a lot more work to do in how we encourage people to engage locally and at a state and territory-based level through RAP champions, etc. We have the support structures in place, but it has not yet really happened'.

The importance of relationships can't be understated, as Dr Mowatt points out. 'There's a reason why relationship is a domain on its own within the reconciliation process, because relationship is the cornerstone of working with Aboriginal and Torres Strait Islander peoples – you must invest in developing relationship first.'

Dr Mowatt reflected on some of the challenges along the journey. An area where less progress has been made is the translation of accreditation standards into ED language. The original RAP had hoped to take the National Safety and Quality Health Service Standards as they relate to Aboriginal and Torres Strait Islander peoples and turn that into a toolbox for EDs.

Additionally, the impact of COVID-19 has unsurprisingly interrupted the momentum of some reconciliation activities, noting the importance of engagement and building relationships in a face-to-face setting.

Dr Mowatt ponders how the third RAP would look had it not been for the impact of COVID-19. 'I wonder if COVID hadn't come along and we hadn't been derailed off our second RAP – I wonder whether we would not have been looking for a "Stretch RAP". I think that's where we need to be aiming next time around.'

Another area Dr Mowatt would like to see improve is the uptake on applications for the Al Spilman Award for Culturally Safe Emergency Departments. It recognises the efforts of ACEM-accredited EDs to ensure cultural safety for Aboriginal, Torres Strait Islander and Māori patients, visitors and staff. The award highlights the importance of cultural safety to improve health outcomes for Aboriginal and Torres Strait Islander peoples in Australia, and Māori in Aotearoa New Zealand. It consists of an Aboriginal, Torres Strait Islander or Māori artwork to be displayed in the ED.

To be eligible for the Al Spilman Award, there is just a single mandatory criterion – you work in collaboration with Aboriginal or Torres Strait Islander peoples, or Māori. You must truly be in partnership with the people who received the service in one way or another. That can be working with staff, patients and/or working with community or community organisations. The award is about reflecting on your department's actions for creating cultural safety; each department will have a different starting point and a unique journey. More information about the Al Spilman Award can be found on the ACEM website.

ACEM's third RAP is expected to be endorsed by Reconciliation Australia and made publicly available by the end of 2021.

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Making a Difference in Emergency Departments in Aotearoa New Zealand

Dr Ruth Large
Dr Large is an emergency physician at Middlemore Hospital and Chief Clinical Officer for Whakarongorau Aotearoa.

In 2007, as a young FACEM joining the Thames Hospital team, I managed to find myself on the Regional Emergency Department (RED) group for our area. This group was one of many up and down the country created to support regional conversations around the management of our emergency departments (EDs) in Aotearoa New Zealand. Gatherings of this nature highlighted the need for a national forum where the community of ED staff, doctors, nurses and managers could come together. The New Zealand Emergency Department (NZED) Conference was born with the intention that a core organising committee was to form out of each REDs group and it would move throughout the country. More than a decade later the principal culprits for kicking the event off were still running the conference at the same place with a similar format each time. The only way to break the bond of these organisers was obviously to step down and to stop doing it!

Over the past decade the conference has become somewhat of an institution, known simply as the Taupō Conference, with active participation up and down the Motu and featuring a special prize for best costume at the annual dinner. This year it was the committees, delight to both tender a mass resignation and to award the annual Peter Freeman "Making a Difference" Award for the first time. The Award was dreamed up in 2018 when the conference's fearless leader Dr Peter Freeman stepped down from the committee. Wanting both a way to recognise Peter's long contribution to emergency medicine in the country (he has after all been Clinical Director of three emergency departments and the Chair of the ACEM Aotearoa New Zealand Faculty) and to provide an opportunity to recognise individuals who are making a difference to staff and patients in the ED, the Award is a monetary prize associated with the conference with the mana of recognition attached to the recipient.

The inaugural recipient Dr Marysha Gardner's nomination came with this statement: "Currently I am the CNM at Whangarei Emergency Department and I am privileged to work alongside Marysha Gardner as Clinical Director and SMO. As we all know the COVID-19 pandemic has faced EDs all across New Zealand with extraordinary circumstances and challenges. Marysha has shown on-going initiative, leadership and dedication. What makes her different from others are her selflessness and her ability to accommodate changes - so staff feel supported within an unpredictable environment whatever role they have. Marysha is not only a SMO and CD but a mother of four with huge drive to making a difference. Marysha has taken on the lead for implementing 'Manaaki Mana' within our ED, which has involved public speaking and at times has been uncomfortable, which she has undertaken with such professionalism. As an SMO Marysha

has enriched the lives of many within our community especially those that are vulnerable. Unfortunately Northland has seen a rise in family violence cases, and Marysha will go that extra mile to ensure their safety. 'Marysha is unique' - she always shows a personal interest in others and has an open door policy. Marysha has had a huge impact on our ED from her accomplishments, and the obstacles she has had to overcome to 'make a difference' to the working environment within ED. Marysha truly is a role model who we all admire and respect."

The NZED conference committee members will now be taking a break from conference organising and instead step into the role of stewards of the Peter Freeman 'Making a Difference' Award. We will be seeking nominations for next year's recipient in time to award the prize at the yet to be announced 2022 NZED conference, which will proudly not be hosted by us at a yet to be named destination.

Author: Dr Ruth Large on behalf of the 2021 NZED Taupō conference organising committee Matthew Valentine, John Bonning, Mariska Lambert Marama Tauranga, Stephanie Watson and Colleen McGregor.

The Diploma of Pre-Hospital and Retrieval Medicine (DipPHRM) Training Program in Aotearoa New Zealand

Dr Christopher Denny
Dr Denny is an emergency physician at the Auckland City Hospital and Medical Director for the Northern Rescue Helicopter Limited (NRHL). He is a Clinical Team Lead for the New Zealand Medical Assistance Team (NZMAT).

The Diploma of Pre-Hospital and Retrieval Medicine (DipPHRM) Training Program was launched in February 2021. The DipPHRM requires satisfactory completion of a minimum of a six-month 1.0 full-time equivalent (FTE) placement within a CCPHRM-accredited site, formal structured workplace-based assessments, and examinations.

The Auckland Rescue Helicopter Trust (ARHT), established in 1970, is the first service accredited to offer this program in Aotearoa New Zealand. The ARHT is part of the regional entity known as Northern Rescue Helicopter Limited (NRHL). Auckland Helicopter Emergency Medical Services (HEMS), established in 2011, refers to the PHRM Doctor and Flight Intensive Care Paramedic (ICP) clinical crew configuration used at the accredited training site. The Northland Emergency Services Trust (NEST), established in 1988, is also included in the NRHL, operating from Whangarei, Northland.

In Auckland, we are fortunate to have a partnership between the Auckland District Health Board (ADHB) and the NRHL. Our PHRM senior advanced trainees are employed by the ADHB, which provides vital clinical administrative support. During their PHRM training, they alternate between PHRM and emergency medicine (EM) clinical duties. This allows for immersion within both our pre-hospital and hospital systems. Our PHRM trainees also provide introductory training in pre-hospital and retrieval medicine for the regional EM trainees.

The NRHL currently has two trainees undertaking the DipPHRM at their Auckland base. Trainees are exposed to pre-hospital and retrieval tasks, a comprehensive training and orientation program, and a wellness and mentoring program.

We asked the team for a glimpse into their world:

- In relation to clinical **education and training**, the Training Supervisors provide an overview of their experiences as they went through the accreditation process, and how they overcame some of the challenges.
- The PHRM **trainees** give us insight into their **experiences** as they transitioned into the new program and how they find the program so far.
- In terms of operations, the management team discusses safety and quality from a different lens.
- Their Manaaki Mana kaikōkiri (Champion) and wellness champion explain how **cultural safety**, **wellness and resilience** are built into the program.

Education and training

Dr Emma Batistich and Dr Chris Duncan, FACEMs and DipPHRM Training Supervisors

Applying for DipPHRM Training Site Accreditation was a comprehensive process. Even though rewarding, anyone who has been through an emergency department (ED) accreditation will appreciate how long it takes to collect all the relevant information for the application. This process required us to take a deep dive into our entire service – examining each aspect of the many different facets of our work, including mission profiles, supervision models, education, and clinical governance. Once the information was collated, it was reviewed. This was followed with interviews by the accreditation assessment team, who left no stone unturned.

We were elated and felt immensely privileged when we learned that we were the first site to be accredited for DipPHRM training in Aotearoa New Zealand. As pioneers venturing into uncharted territory, we were absolutely up for the challenge of getting our trainees through the rigours of the DipPHRM.

The NRHL clinical mission profile includes a majority of pre-hospital taskings. Spending time with our colleagues at Garden City Helicopters from the Southern Aeromedical Region in Christchurch was an amazing opportunity for our trainees to gain more exposure to the retrieval side of PHRM. We ran an intensive three-day workshop incorporating fixed-wing simulation, a base visit, and expert tutelage from their experienced retrieval crew. It was an incredible opportunity to tap into this knowledge base – not only for our trainees but also for our education team, who travelled to Christchurch to help facilitate the workshop. We plan to reciprocate in future by hosting a team from Christchurch to visit our Auckland base for a pre-hospital workshop.

Trainee experiences

Dr Sue Johnson (ACEM DipPHRM trainee and CICM trainee) and Dr Kate St Louis (ACEM trainee)

A different perspective

No matter where in the world you practise EM, nothing can really prepare you for the very different perspective gained by working in a pre-hospital setting. As EM trainees rotating through the Auckland region, there were times where we noticed the occasional raised eyebrow for our ambulance colleagues. More often than not, questions would be posed as to why certain decisions were made and interventions performed by our paramedic colleagues.

We are probably all guilty of wondering why the patient has only one IV access, or why the crew has not done a full 12-lead electrocardiogram (ECG). Until you've walked in their boots up to the second-floor bedroom and extricated the patient who's wedged between the bed and the wardrobe, we implore you to withhold judgement and recognise the challenges these crews face.

The NRHL DipPHRM trainees are fortunate to spend a year working in Auckland, alongside a truly remarkable group of intensive care paramedics, PHRM doctors, pilots, and air crew officers. This gives us a huge insight into the different challenges facing pre-hospital services and an appreciation of

the amazing care that is provided.

The 2021 DipPHRM

Once NRHL gained accreditation as a DipPHRM training site, we collaborated with the retrieval and intensive care teams in Christchurch and Whangarei to broaden the experience of providing safe interhospital transfers (IHTs), alongside the primary pre-hospital work. We are involved in regular education sessions in Auckland and the wider Australasian pre-hospital network to meet the curriculum objectives for the DipPHRM.

A typical day

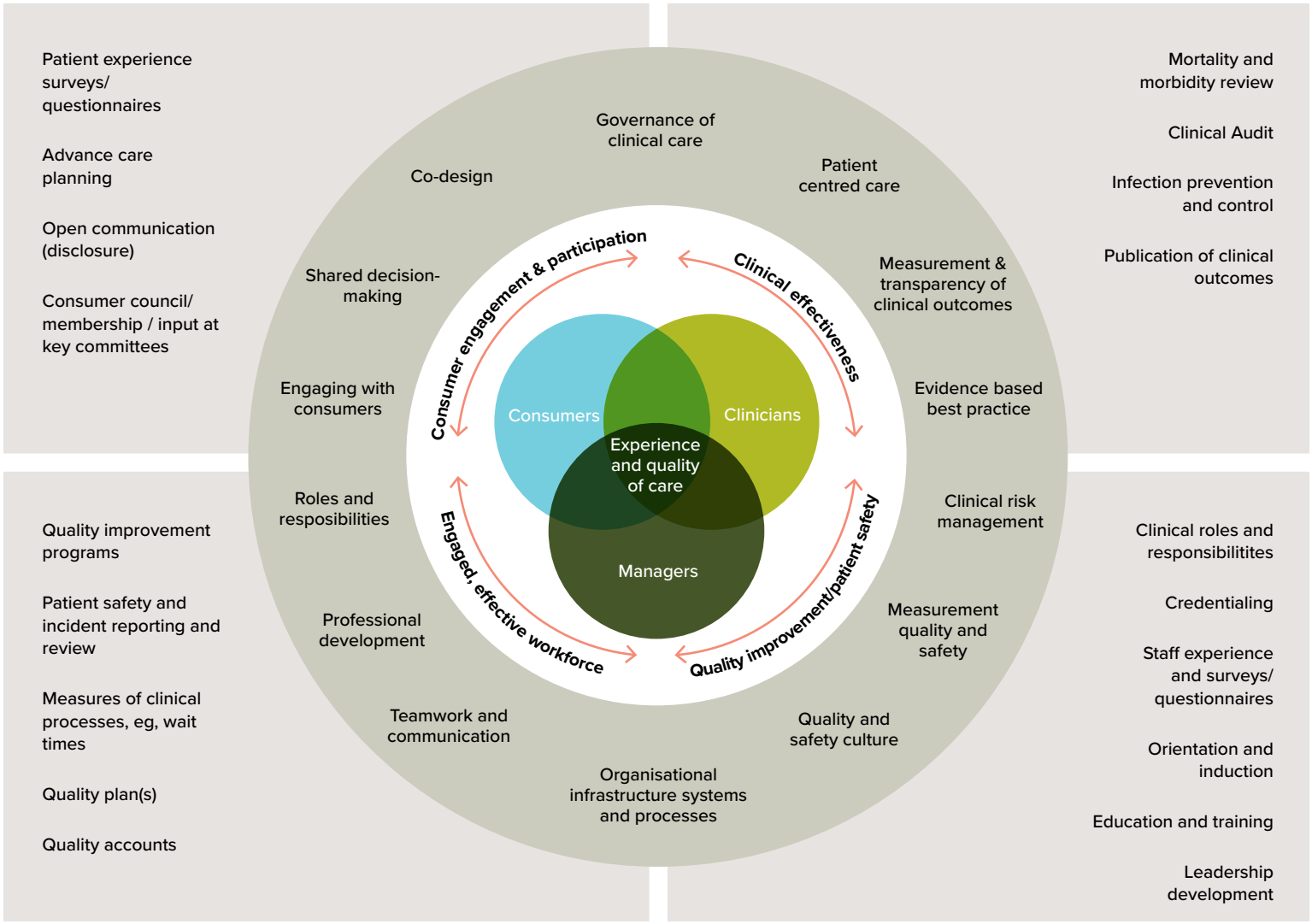
What does a typical workday look like for a DipPHRM trainee? Well, first and foremost, there's no 'typical' day. NRHL DipPHRM trainees begin their placement with a rigorous two-week induction program. This provides orientation to the helicopters and rapid response road vehicles, the base, various equipment and safety gear, the team dynamics, and a rather impressive coffee machine! We are also put through our paces with a set of high-fidelity simulations to help prepare us for working in the pre-hospital sphere. This isn't a workplace where you ask someone to do an ECG and one appears. The simulations involve hands-on real-time preparation for doing the job. The helicopter underwater escape training (HUET) is another challenging aspect of the induction and vitally important given that most missions in New Zealand end up being over a body of water in some part.

Once the 'real work' starts, you work in partnership with the intensive care paramedic to perform daily checks of the aircraft, road vehicle and equipment for the day. There are checklists detailing what should be where in the aircraft, vehicle and clinical packs. The pilot leads a morning briefing for the four-person team (pilot, air crew officer, intensive care paramedic and PHRM doctor). A full weather report, known potential hazards, any safety concerns, and planned training for the day are all discussed.

The strength of this service comes from the exceptional teamwork and comradery among the people who work here. When a 'tasking' occurs, a shrill alarm will sound over the tannoy and the hairs on the back of your neck stand up as you know that the National Air Desk has requested the team to attend a job. The whole crew will listen to the brief of the job and discuss any aircraft reconfiguration or special considerations needed prior to departure.

We have a designated 'ready room' where we'll check the correct fitting of one another's safety harness, life jacket and helmet. The melded worlds of aviation and medicine make everyone a stickler for running through checklists to ensure nothing is overlooked or left behind before embarking on a mission. There is an appreciation for the possibility of oversight when your mind is racing ten steps ahead to imagine the scene you are about to confront and the potential treatments and interventions that may be required.

In stark contrast to the relentless multi-tasking merry-go-round that a typical ED shift consists of, there are frequently periods of down time on base when we await a tasking. This is the aspect of the work we've found most challenging. We are



fortunate to have monthly learning themes, a clinical 'dojo' for refreshing clinical skills or procedures, and a willingness from all team members to be involved in simulations.

Monthly clinical governance meetings ensure quality and safety initiatives are upheld. A more informal 'coffee and cases' allows crews to share learning points from jobs we've attended.

No two scenes are the same. The scope of things to consider when approaching a pre-hospital scene goes far beyond the medical care that needs to be delivered to individual patients. There's a myriad of hazards, personnel management issues and general crowd control to consider. It can be chaotic and confronting, making the importance of keeping your team together and working to the same goal a vital aspect of the job.

In the ED, a packaged patient is wheeled in on a stretcher to a pre-briefed team in the resuscitation room. In PHRM, we go to the patient with limited information, work with other services to extricate the patient, administer lifesaving treatments, package the patient, transport them to hospital, and provide a succinct handover to our colleagues. This isn't a career for a solo operator or someone who is not willing to embrace a dynamic leadership model.

The experiences from our time at NRHL have certainly fueled a passion to continue working in pre-hospital medicine and help ensure that shared knowledge and methodology from services around the world continues to drive positive change for patients. We are privileged to be part of a small, highly trained team encountering people facing what is generally one of the most traumatic days they'll ever experience.

If you've ever considered pushing yourself and your scope of practice to something beyond the four walls of the hospital, we would recommend that you get in touch. Good starting points are a doctor already working in PHRM, the ACEM website, your local Director of Emergency Medicine Training (DEMT), or your local ambulance service.

Safety and quality for all

Dr Chris Denny and Dr Alana Harper

Safety first

Our PHRM service relies upon the New Zealand Health Quality and Safety Commission (HQSC) Clinical Governance Framework, which underpins our clinical priorities:

- Clinical effectiveness
- Quality improvement
- Patient safety
- An engaged, effective workforce
- Consumer engagement and participation.

A step in the right direction

We believe our diversity is our strength. During the decade since we were established, our service has grown through the contributions of clinicians from different backgrounds, specialties and perspectives. Historically, medicine and paramedicine have been male-dominated careers. Dr Alana Harper has seen an encouraging shift in the number of

women pursuing their dreams of a career in PHRM. Ten years ago, she was the first female PHRM doctor to join the ARHT. She's also a FACEM at Auckland City Hospital, the NRHL lead for clinical safety and quality, and a mum of two boys.

Dr Harper set up the Women in PHRM Network New Zealand when she became involved in sponsoring and mentoring women in PHRM, including ACEM and DipPHRM trainees. This deepened her interest in workplace diversity and gender diversity in general. The network is a source of advice and support clinically and professionally for women in PHRM careers, where they can share common experiences and challenges. It currently includes paramedics, air crew, and doctors working primarily on rescue helicopters, but also ground ambulance staff in New Zealand. We have several NZ DipPHRM trainees in the network and we have DipPHRM trainee representation in the Women in PHRM Network committee.

'Our vision is to provide early, safe, optimal patient care'

The inclusion of more women in PHRM and a focus on the diversity of our workforce is vital. The phrase 'anyone, anywhere, anytime' accurately describes PHRM work. By creating a workforce, leadership and governance structure that accurately reflects the diversity of patients we look after, we ensure a better standard of care. The PHRM workforce needs to be clinically adept and socially empathetic to serve our increasingly diverse communities' needs and build strong community links.

Gender diversity enhances innovation, engagement, and cultural safety and competency, as well as attracting existing and prospective talent. This has had a very positive impact on our workplace culture.

Some recent achievements for the Women in PHRM Network:

1. We have opened a conversation to equip women with the right equipment to be more comfortable and perform better in the PHRM setting. Most of the personal protective equipment (PPE) available is designed for men, thus lacking the same safety profile for women. Even 'unisex' PPE is designed to a standardised European male default. This has been starkly highlighted during the COVID-19 pandemic. One-size-fits-all just doesn't work.
2. We are encouraging young women to consider a career in PHRM through presentations at science, technology, engineering and mathematics (STEM) events, careers day talks, and school visits. As a network, we are very aware that you can't be what you can't see. The visibility of women working in these roles is really important for young women thinking about their futures.
3. We are supporting women in PHRM while pregnant or returning to PHRM careers after having children, and ensuring there are breastfeeding-friendly workplaces for them.

The main benefit of the network, however, has been the shared experiences, wisdom and support. Research has shown that belonging to women's professional networks is advantageous to their career progression, improving their prospects for promotion and leadership opportunities. This is amplified in male-dominated workplaces where opportunities may not be as visible or feasible.

The Women in PHRM Network's future focus is leadership. Diversity must be driven by leadership. We don't just want women represented in this network, but others from diverse cultures and backgrounds as well, so everyone can enjoy the exciting career opportunities in the aeromedical and PHRM space.

Cultural safety, wellness and resilience

Dr Louise Park, FACEM

Cultural safety

The NRHL is working hard at becoming a more culturally safe organisation. The past six months have seen important and promising progress in this area. Along with a set of cultural safety documents, which have been developed in consultation with the New Zealand Paramedic Council and the Medical Council of New Zealand, we have attempted to align our strategy with ACEM's Manaaki Mana strategy, *Te Rautaki Manaaki Mana: Excellence in Emergency Care for Māori.*

We have also recognised that the foundational steps in becoming a more culturally safe organisation include developing a meaningful relationship with your local communities. We are delighted to be building ties with the incredible team from Papakura Marae. Our inaugural crew visited the marae in March 2021. We were treated to a pōwhiri (welcoming ceremony) and hāngi (feast cooked in an earth oven), followed by a Te Ao Māori (Māori world view) program, which included education around rituals of engagement, tikanga (customs and etiquette), learning a basic karakia (prayer) and waiata (songs), and establishing support networks. We hope to hold more of these meetings in the future and support the marae in other ways, such as serving at their community dinners.

Wellness and Resilience

We recognise the significant challenges our trainees face during their time with NRHL. Our ACEM DipPHRM trainees are often balancing Fellowship examination study, while trying to adjust to the new world of pre-hospital and retrieval medicine. We have developed a mentoring program for our PHRM trainees, which aims to provide additional support through a traditional one-to-one mentoring model. We believe this offers benefits not only to mentees, but to mentors and our organisation, in terms of workplace culture, relationships, and dissemination of knowledge and experience of the pre-hospital landscape. Further support is provided, not only to trainees, but all of our crew members, through a small peer support network made up of operational crew members. Our peer support team has undergone training and operates under the guidance of a clinical psychologist.

Maintaining peak physical and mental fitness is crucial to the optimal performance and safety of our crews, as well as having positive effects on mental health and wellbeing. We are incredibly fortunate to have an on-site gym for functional training, and crews are encouraged to utilise this space prior to, after, and sometimes during a shift if we have downtime. Over the last year, we have been working with local experts on fitness, nutrition and performance under pressure, to provide our team with a variety of tools to optimise physical and mental health, and performance.

More information

For more information on the Diploma of Pre-Hospital and Retrieval Medicine, please visit the:

- ACEM webpage or contact the ACEM PHRM Coordinator at PHRM@acem.org.au. Alternatively, contact the ACEM Office in Aotearoa New Zealand at acemnz@org.au
- Auckland HEMS website
- Auckland Rescue Helicopter Trust (ARHT) website: rescuehelicopter.org.nz
- Find out more about the Women in PHRM Network Aotearoa on their website womenphrmnetworknz.org.

Enough is Enough: Evidence 2.0. Action and Advocacy, Assessing the Impact of Alcohol-Fuelled Violence in Australasian Emergency Departments

Professor Diana Egerton-Warburton
Professor Egerton-Warburton is Director of Emergency Medicine Research at Monash Medical Centre, Melbourne, Victoria. She is an adjunct professor at Monash University in the School of Clinical Sciences at Monash Health and Monash Art, Design and Architecture (MADA).

Alcohol has never been cheaper, more heavily promoted, or more readily available, and alcohol harm is the biggest preventable public health issue facing emergency departments (EDs).[1] Harmful use of alcohol is also a major cause of preventable, non-communicable disease and injury. In 2017-2018, almost half of Australians (42.1 per cent) over the age of 18 had consumed more than four standard drinks on one occasion in the past year, putting them at an increased risk of acute injury. In Aotearoa New Zealand, four in five adults had consumed alcohol in 2017-2018, while one in four had drunk hazardously in a way that could harm themselves or others.

ED presentations relating to alcohol and other drug (AOD) harm represent significant challenges for the acute health system, particularly in the context of rising patient demand, hospital access block, overcrowding, and limitations to ED capacity and resourcing. However, inconsistent collection of routine AOD-related ED data means the impacts of AOD-related harm are underestimated in EDs, and the acute health system is under-resourced to properly care for affected populations. Demand for community-based generalist and specialist AOD treatment services also outstrips supply.

The ACEM Alcohol Harm in EDs (AHED) Project[2] found that, in 2019, 13 per cent of ED presentations were alcohol-related in Australia, while 16 per cent of ED presentations were alcohol-related in Aotearoa New Zealand. In Australia, alcohol-related ED presentations have remained relatively consistent from 2016-19, whereas they have varied in Aotearoa New Zealand, ranging from 23 per cent to 12 per cent across this period.

EDs represent the first point of contact for individuals affected by AOD and emergency physicians are at the forefront of responding to and treating the consequences of alcohol-related harm. This ranges from treating alcohol intoxication and drug overdoses, to severe injuries sustained as a direct result of intoxication, and managing acute complications of chronic alcohol conditions. There are also the indirect effects of alcohol harm such as the 'innocent bystander', family violence, and the contribution that the harmful use of alcohol makes to homelessness and mental health issues.

In 2014, the College undertook the largest survey (over 2,000 ED clinicians) of alcohol harm in EDs across Australia and Aotearoa New Zealand, finding that alcohol-related verbal and physical aggression from patients (a) had been experienced by almost all ED clinical staff in the past 12 months, and (b) negatively impacted on the care of other patients.[3] As a result of these findings, ACEM led a community campaign (Enough is Enough) with high media and policy maker impact. However, the scale of adverse impacts of alcohol on ED staff and patient safety has not been re-examined since 2014.

Likewise, our position statement on alcohol harm[4] recommends alcohol-related harm data to be routinely collected in EDs as part of a minimum data set. However, the type(s) of screening questions currently being used across Australasia for this purpose is unknown.

Enough is Enough 2.0

This year, the College received funding from the Australian Rechabite Foundation to obtain qualitative and quantitative data from ED clinicians in Australia and Aotearoa New Zealand on their experiences of the effect of alcohol-related presentations on ED staff and ED function. This data will be used to:

- quantify the scale of alcohol-related violence experienced by ED staff in EDs in Australian and Aotearoa New Zealand in 2021 and compare to data obtained in 2014
- determine how ED clinical staff perceptions of alcohol-related presentations have changed in EDs in Australia and Aotearoa New Zealand since 2014
- assess the type of screening questions used in EDs in Australia and Aotearoa New Zealand when assessing a patient for risky drinking to inform recommendations to policy makers about alcohol screening questions.

Currently, the Australian National Minimum Data Set (NMDS) doesn't capture data associated with alcohol-related ED presentations. For example, in New South Wales alone, it has been shown that only one per cent of alcohol-related ED presentations are identified as having a primary diagnosis related to alcohol.[5] Aotearoa New Zealand is ahead of Australia and most of the world in collecting an alcohol harm element on all ED presentations. ACEM is working with the Commonwealth Department of Health to progress this issue.

Of equal importance, obtaining a better understanding of inter- and intra-jurisdictional variation in Screening, Brief Intervention and Referral to Treatment (SBIRT) models, and any other interventions that are being used within the ED, will provide essential information. SBIRT models have been developed for healthcare settings to identify, reduce and prevent problematic use and abuse of, and dependence on, AODs. SBIRT involves a healthcare professional:

- assessing a patient for risky drinking and/or drug-taking using a standardised screening tool

Alcohol Harm in EDs (AHED) Project[2] found that, in 2019, 13 per cent of ED presentations were alcohol-related in Australia

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- conducting a structured conversation about risky alcohol and/or drug use
- providing feedback and advice
- referring the patient to a brief therapy or additional treatment, if appropriate, while in the ED (mechanisms should also exist to refer at-risk patients to an appropriate community resource for culturally sensitive and appropriate education/intervention).[6]

ACEM's *Position Statement on Alcohol Harm*[4] and *Statement on Harm Minimisation Related to Drug Use*[7] both acknowledge that the ED setting provides valuable opportunities to identify AOD-related problems in presenting patients. While the use of brief interventions originated in the ED, evidence of the success of SBIRT models in these settings is largely observational, with limited controlled trials conducted and mixed findings depending on the severity of patients' drug use.[8]

Some EDs have reported difficulties in implementing SBIRT, particularly without appropriately trained personnel and time constraints.[9] Further evidence is needed to examine the feasibility and effectiveness of these interventions in the ED. Where possible, EDs should contribute to the ongoing assessment of efficacy and quality improvement of SBIRT programs. As screening and early intervention are specialised skills, the success of brief interventions will depend on EDs being appropriately resourced with dedicated AOD staff who possess the skills and knowledge to accurately use SBIRT models.

What will success look like?

The primary indicator of success will be increased community awareness of alcohol-related harm and its impact on EDs, as evidenced by informed community discussions. By using the same survey questions from 2014, this project will also be the first to quantify ED staffs' perceptions of alcohol-related presentations over time. Obtaining data on the type(s) of interventions used in Australian and New Zealand EDs when assessing a patient for risky drinking will, in and of itself, be a successful outcome. It will also provide a new data set that will inform the NMDS, facilitating early engagement, appropriate treatment, and minimising complications arising from alcohol and drug use. This will enable governments and stakeholders to gain a better understanding of the true burden of alcohol-related harm across the Australian and New Zealand health systems, thus enhancing the safety, clinical outcomes, quality, and efficiency of services for patients with alcohol-use disorders.

AOD-related ED presentations can be complex, of high acuity, and require significant resources to keep themselves and other patients safe, and ensure effective care. There is a clear need to collect prospective and reliable data and understand the impact on healthcare workers. This will inform and enhance the College's understanding of AOD-related presentations to hospital EDs in Australia and New Zealand and ignite the policy debate.

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AFL Concussion Management

Sport is one of the few universally spoken languages around the world. Australia and Aotearoa New Zealand are no exception, with both countries regarded as sporting nations with a proud history of achievements on the world stage. When you step outside your home, all around you, people can be observed playing sport or exercising – at gyms, cycling on the roads, or flocking to recreational reserves, just to name a few.

And why wouldn't we? Participation in sport is widely recognised in research literature as having a direct positive impact on physical, mental and social health outcomes,[1,2] underscoring why government support for sports at all levels is a popular choice for policymakers, and often a key target for health promotion activities.

Every week, across both nations, children and adults gear up for community, semi-professional and professional competitions in their hundreds of thousands. The participation rates are so high, in fact, that 81 per cent of Australians (over 15 years old) participated in sport and/or physical activity at least once per week, while 68 per cent of children (under 15 years old) participated in some form of organised sport or activity outside of school hours at least once per week.[3]

In Aotearoa New Zealand, 72 per cent of the adult population (over 18 years) participated in sports and/or

physical activity at least once per week, and 94 per cent of children (aged 5-17) participated in play, active recreation and sport.[4]

While the health benefits of sports or physical activity are evident, playing sport has its own associated set of risks. The Australian Institute of Health and Welfare (AIHW)[5] reported that almost 60,000 people were hospitalised for sports injuries in 2016-2017, noting this was almost at parity with the number of people hospitalised due to transport crashes.

The cases presented in the report reflect only those cases that were serious enough to require hospitalisation. It does not include information on people who may have sought treatment at hospital emergency departments (EDs), general practitioner clinics, sports medicine centres, or from allied health practitioners such as physiotherapists. The true prevalence of sports-related injuries remains somewhat unknown.

In April 2021, the AFL released an updated set of guidelines, The Management of Sport-Related Concussion in Australian Football.

The AIHW report makes it clear that there are risks to safety when participating in all forms of sport, and that contact sports such as Australian football and the rugby codes involve risks of head and neck injuries.

There was historically a much more cavalier attitude towards head knocks and concussion in contact sports. This was partly due to the 'warrior' mentality and media focus on high intensity, spectacular hits. It reflected a lack of understanding and research on the cause and effect of head trauma and concussion in sports.

To this day, notwithstanding advances in research and concussion management, it's suspected that there are still instances of concussion that go unseen, unrecognised and undiagnosed, particularly at levels below professional sports. A lack of reliable, objective biomarker of injury and recovery add to the challenges in recognition and diagnosis.

The issue of sports-related concussion is not limited to Australia and Aotearoa New Zealand, nor does it apply only to Australian football and the rugby codes. Across a range of sporting codes, there's anecdotally an increasing number of professional athletes who have prematurely called time in their careers following repeated bouts of concussion, with symptoms persisting for weeks to months in what is known as post-concussion syndrome.

Although the science is not settled, there's a growing body of research being undertaken internationally and in Australia that supports an association between concussion and neurogenerative conditions such as chronic traumatic encephalopathy (CTE), which can only be definitively diagnosed after death.[6,7] Symptoms of CTE include cognitive impairment, impulsive behaviour, short-term memory loss and mood disorders. The relationship between concussion and CTE is complex, so one can't simply deduce that concussion equals CTE.

It's not known why some people experience concussion symptoms more severely and have longer recovery times than others. This uncertainty is a reasonable consideration for an athlete, whether professional or amateur, in assessing the implications of repeated head injuries and the potential impact on their life.

Professional sporting codes around the globe, in particular full contact sports, are addressing the challenges of concussion and the safety of athletes. In recent years, they have made substantial investments into research and technology to further our understanding of sports-related concussion and its management.

This has resulted in new approaches to the assessment and treatment of athletes with suspected concussions: changes to rules; use of technology (such as Hawk-Eye video review) to allow identification of head trauma and recognition of early, often subtle, signs of concussion (such as balance disturbance); sideline spotters; and league-imposed recovery periods before return to play for athletes who have sustained a concussion in training or in competition.

The Australian Football League (AFL) is an example of a professional sporting code displaying leadership in prioritising the health and safety of its players across all levels of competition. Efforts made by the AFL have led to significant changes in the way that assessment and treatment of concussion are managed at the elite level. Of equal importance, there has been work in this area for players at the grassroots level.

In April 2021, the AFL released an updated set of guidelines, *The Management of Sport-Related Concussion in Australian Football.* The current Guidelines contain specific provisions for children and adolescents (aged 5-17 years) and reflect the most conservative set of guidelines to date regarding important aspects in the initial management of a head injury, assessment, confirming the diagnosis, providing key information to the patient and their family/carer about follow-up, and an eventual graded return to play once medical clearance is given.

Another great resource that has been made freely available by the AFL is HeadCheck. Developed as a collaboration between the AFL, leading child concussion experts, the Murdoch Children's Research Institute, and the Royal Children's Hospital, HeadCheck is an app to assist parents, guardians, first aid trainers and coaches to recognise the symptoms of a suspected concussion and its severity. The app also provides important advice on resting periods, medical follow-up and a safe return to play.

Multifaceted leadership shown by the AFL is shifting community attitudes to management of sports-related concussion through: changes to rules to protect players' heads; the introduction of the Community and AFLW Concussion Guidelines; a minimum mandatory rest period of 12 days; and a commitment to spend up to A$2.5 million a year over 10 years on a longitudinal study for concussion. We expect to see even greater numbers of athletes presenting to

EDs following head knocks. The key advice the AFL has for ED doctors is that management of concussion in the ED is not just about ruling out a structural head or neck injury, observing the player for a period of time, then sending them home. Management should involve guidance on early treatment (for example, a brief period of rest followed by symptom-limited activity), and medical follow-up to assess recovery and guide return to school, work and sport.

ACEM President Dr John Bonning echoes these sentiments from the AFL and other sporting organisations, stating that: 'ED doctors are exceptional at responding to a vast array of health conditions presenting to EDs. When it comes to head injuries, there's often an initial emphasis on CT scans looking for structural brain injury, which is serious and important to diagnose. While some serious concussions result in structural derangement, the vast majority of concussions result in a functional brain injury. It's of great importance to recognise that when the CT scan comes back clear, or when a CT scan is not even indicated, that there's still a problem that needs attention and follow up.'

The AFL is committed to ongoing improvements to the guidelines to ensure effective translation at all levels of competition, as well as timely and efficient use of community medical resources. To assist with this process, the AFL is seeking interest from ACEM members to collaboratively review the guidelines, specifically in relation to acute management and effective patient education. If you are interested, you can submit an Expression of Interest to policy@acem.org.au noting your relevant experience.

Download The Management of Sport-Related Concussion in Australian Football guidelines at

https://resources.afl.com.au/afl/document/2021/04/26/9a186f44-ad48-4fab-b6ab-e4be45a578d7/Management-of-Sport-Related-Concussion-in-Australian-Football-25-April-2021-FINAL.pdf

Author: Hamish Bourne, Policy Officer

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Regional New Fellows Champions Profiles

Each year, new Fellows across Australia and Aotearoa New Zealand emerge from the hurry and haze of the FACEM Training Program into the bright and brave new world of consultancy. In 2021, ACEM has introduced Regional New Fellows Champions to support new Fellows in finding their feet.

The role of the champions is to optimise communication between new Fellows and the College – to ensure new Fellows are aware of the opportunities and initiatives targeted at their cohort and feel ably supported in their transition to Fellowship.

With appointments progressing in all jurisdictions, some of the first appointed Regional New Fellows Champions outline their view of this important role.

Kim Bruce
New South Wales

In every progression in FACEM training, it's important to feel supported as you move into a new role. As the world of clinical and non-clinical challenges faced by new Fellows continues to evolve, so too do the services available to help navigate them. Like other apprenticeships, new Fellows previously learnt how to manage this on the job, but as the number of Fellows each year grows, it's important that everyone has access to develop these soft skills. Similarly, this growing group of junior consultants will face issues not previously dealt with by their predecessors, such as a tightening job market. The role of the Regional New Fellows Champions is to help guide new Fellows to master this transition, motivate them to creatively approach new career challenges, and be a voice for this new cohort within the College.

Conor Kelly
Victoria

My name is Conor Kelly, a newly qualified Fellow working in Geelong, regional Victoria. I completed my undergraduate medical degree in Galway, Ireland, before emigrating to Australia in 2011. I have worked in both metro, tertiary and rural/regional hospitals. I became fascinated with emergency medicine early on and have not looked back since deciding to embark on this career path.

I believe the newly created Regional New Fellows Champion role has the potential to help all new Fellows make a smoother transition from trainee to junior consultant. I hope to represent my fellow junior consultants well. I'm interested in College processes and aim to become more engaged in creating and promoting some useful College initiatives, which will make a difference at the clinical coalface.

Akmez Latona
Queensland

I work in the retrieval environment and in the emergency department. As a new Fellow, I'm familiar with some of the challenges we all face when transitioning to consultant life. I'm looking forward to promoting initiatives via ACEM to support new Fellows in this dynamic future of emergency medicine. I believe in building a strong peer support network and developing resources for FACEM trainees and Fellows to ensure smooth transition from trainee to Fellow and meet the needs of new emergency medicine consultants. From a workplace culture perspective, I grew up in Mauritius, lived in different countries and have an understanding on how culture/diversity impacts trainees and FACEMs.

Amy Wilson
South Australia

I wanted to be an advocate for new Fellows as the transition from trainee to FACEM can be challenging. I'd like to provide support by establishing new FACEM coaching workshops and creating a local peer support network. I also think it's important, as new Fellows, to engage with the College, advocate for what's important for our trainees and Fellows, and understand how ACEM can help support regional initiatives. I look forward to developing this role and working closely with the new Fellows in South Australia. *Image not provided.*

Syam Ravindranath
Western Australia

I am an emergency physician working at Armadale Health Service in Perth and I am very excited to represent my tribe of newly Fellow-ed colleagues from Western Australia.

I am dual-trained in emergency medicine and intensive care medicine and do part-time clinical work in both specialties. My particular area of interest is critical care education and Point of Care Ultrasound.

I have a vested interest in training, mentoring and the wellbeing of trainees and colleagues.

Having recently gone through the process, which I call FACEM Part 3 or the transition phase, it's an evolving area with an unmet need for continuing support.

I was looking for a way to help colleagues who approached me for advice on how to get a job as an ED consultant when I found out about the ACEM Regional New Fellows Champion Role. My mentor suggested I would be a good person for this role, having worked in most health services across the state and therefore being a familiar face.

Dr Rachael Nightingale

Why emergency medicine?

My road to emergency medicine was certainly not direct. I had always been driven towards a career in surgery, until I had a baby and very quickly realised that I needed a better work-life balance. I was lucky enough that the emergency faculty took me on in a junior role as I attempted to figure out what direction to go in. It took less than a month for the diversity of the work, the ability to still get your hands dirty and manage extremely unwell patients, leaving (almost) on time at the end of a shift and the comradery between emergency department (ED) doctors and nurses to convince me that emergency medicine was the perfect fit for me.

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

I find it challenging letting go of cases at the end of a shift. When I am invested in a diagnostic dilemma, or emotionally invested with a patient or family who has received bad news, I can find it hard to switch off. I hate handing over patients, however the ability to do this is what makes emergency medicine a great job for getting home to your family. The most enjoyable part of the job is the people. I love coming to work every day with a crew of great doctors, nurses, wardies, admin staff and more! Good banter and a supportive network make a 10 hour shift fly by!

What do you do to maintain wellness/wellbeing?

I don't know if I am very good at making a conscious effort to maintain my wellbeing. I think that having non medical family is good in some respects as it forces you to switch off from everything. I am a passionate Swans supporter and love a weekend full of footy as well as just hanging with good friends. An evening wine to unwind is a frequent occurrence and I also find that yoga or going for a run puts me in a good headspace.

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

My most eminent accomplishment would be receiving an Emergency Medicine Foundation Grant for the research I am currently doing into Cellulitis in the ED. Something that I certainly would not have achieved without the support of some wonderful colleagues and mentors. Whilst not exactly eminent, other achievements that I am proud of are studying for (and passing) my Primary Examination while having a premature newborn in the special care nursery and keeping a toddler entertained, plus simple things like the compliments that people take the time out of their busy lives to write.

What inspires you to continue working in this field?

I am inspired by my colleagues. I work with wonderful clinicians who are experts in research, ultrasound, education, and teamwork. Others handle themselves with such grace and aplomb in a job that can be described as chaotic. They inspire me everyday to be better. To be a strong team player who does the best by her patients, who is striving to improve and who is also able to have a good laugh. We are privy to vulnerable people's scary life moments working in emergency. Being able to provide medical expertise and kindness in those moments is a real privilege.

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

Every year you work as a doctor you gain valuable skills that serve to make you better. Do not stress about the time it takes to finish training and become a consultant, follow the opportunities that arise – you will be better for it.

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

There is so much to look forward to! The variety of what we see allows for a massive scope for advancement and improved patient care. I think that ECPR is exciting and will start to be increasingly used in ECMO capable centres for refractory cardiac arrest. It is also nice to dream of a day where COVID-19 is not such an ever-present factor in the running of the department. Bring on vaccinations!

Regional Wellbeing Champions

This year, ACEM is pleased to introduce Regional Wellbeing Champions, a group of FACEM and trainees who will facilitate improved communication between the College, and its members and trainees in relation to the ACEM wellbeing initiatives. We're pleased to introduce your newly appointed Regional Wellbeing Champions.

Joanne Crogan
Australian Capital Territory

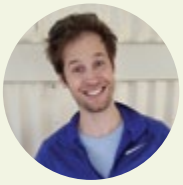
Wellbeing has been around for many years, but with the stressors of recent times, it's becoming more and more relevant to our daily practice. We are working in an increasingly challenging, high pressure environment. Whether it's an unexpected bad outcome in a patient, the stresses of training, or commitments in our lives outside of our jobs, none of these operate in isolation from each other, and it's important we recognise this. There are only a handful of other sectors where people are exposed to the level of trauma that emergency department (ED) staff deal with and it's important that we develop the right tools, strategies and networks to help us through difficult times. We need to make sure we have happy and healthy people. A strong wellbeing program is important. I'm excited to be a Regional Wellbeing Champion and advocate in this area.

Charlotte Durand
Northern Territory

As a trainee, it can be hard to influence the structural or cultural things that impact on the wellbeing of a department. Most of my advocacy to date has been in the realm of dismantling structural barriers to health and wellness. I hope being a Regional Wellbeing Champion will allow me to weigh in on new initiatives that will support my colleagues for years to come. I'm excited for the opportunity to collaborate with inspiring and passionate team members to create some wonderful things.

Josh Monester
Northern Territory

I'm a strong believer that we can apply a wellbeing lens to much of our work, both on the floor and from a systemic perspective in our EDs. Small changes to rostering, staffing and communication within the department can have significant impact on our wellbeing and enjoyment of work – especially for trainees who variably have examination and family pressures in the mix. If we approach small, systemic changes through a wellbeing lens, it helps us focus not only on what's best for our EDs, but also for the people who form it. Regional Wellbeing Champions do just that: integrate this mindset into our day-to-day work and advocate for tangible improvements in our work with wellbeing in mind.



Michael Hale
Western Australia

As a Regional Wellbeing Champion for Western Australia, I hope I can learn more about what wellbeing means to trainees and FACEMs throughout the region. Wellbeing means something different to each of us, which is what makes this such an interesting and exciting role. I hope I can connect with trainees while helping to establish a supportive network that shares experiences and grows to understand the importance of wellbeing for sustainable careers in emergency medicine. There are many great initiatives Australasia-wide. I would like to keep pushing those boundaries so that wellbeing is front and centre, and trainees and FACEMs can continue to look after ourselves and those around us.

Clare Dibona
Western Australia

Wellness is important to me because I know how stressful life can be when we get wrapped up in work. Balance is a huge challenge when we are geared to be the best version of ourselves in our many roles in life. I hope to help bridge the gap between the wellness initiatives ACEM offers and what's used by trainees and Fellows who may be having a hard time. Let's prioritise our happiness!

Tim Mettam
Tasmania

The ED can be a bustling, fast-paced, chaotic mix of extreme highs and lows. This can have a significant (and sometimes unnoticed) impact on shaping who we are as clinicians. Compared with other high-stakes professions, medicine has historically lagged in its consideration of personal wellbeing and self-care. I feel emergency medicine, as a sub-group, is making real efforts to change the culture and reduce this gap. I'm excited to contribute to this evolving space.

Elissa Pearton
South Australia

You can't pour from an empty cup. Now more than ever, we need to focus on our wellbeing. In taking up the role of Regional Wellbeing Champion, I hope I can remind others of the importance of self-care, as well as help navigate the barriers that prevent us from working on our wellbeing.

To read about all twenty-one Regional Wellbeing Champions, please visit: acem.org.au/Content-Sources/Members/My-Wellbeing/ACEM-Regional-Wellbeing-Champions

ACEM Rural Health Action Plan

A call for rural health action – one more crucial piece in the emergency medicine jigsaw

Over the past 30 years, ACEM has delivered many great outcomes for the health system, patients and communities across Australia and Aotearoa New Zealand.

We have a world-leading specialist emergency medicine training framework across two countries and provide support in our region. The curriculum and accreditation processes are constantly refined to ensure the highest possible quality of education and training. ACEM has extended training opportunities by establishing the Emergency Medicine Certificate (EMC), Emergency Medicine Diploma (EMD) and Emergency Medicine Advanced Diploma (EMAD).

Additionally, ACEM and College members have led national evidence-based decision-making on critical issues such as access block, hospital flow and emergency mental healthcare, and have advanced public health initiatives on many fronts.

The College has a clearly articulated Reconciliation Action Plan and Manaaki Mana that recognise the history and ongoing needs of First Nations and Māori people.

Equity, diversity and inclusion are now a focus.

The key part of the jigsaw that ACEM members and trainees must tackle is addressing the health inequity in rural, regional and remote (RRR) communities across Australia and Aotearoa New Zealand

Australia and Aotearoa New Zealand are similar when it comes to the challenge of delivering healthcare equitably. There is a clear and present workforce maldistribution in both countries. Many communities in RRR areas are not able to access the gold standard of specialist-led emergency medical care.

While urban areas often receive healthcare across the full range of medical specialties, RRR areas don't receive the same privilege. As is often the case, nowhere is this more pronounced than in the emergency department (ED). RRR patients deserve the same benefit of care when they access emergency medical treatment.

In June 2021, ACEM released its inaugural Rural Health Action Plan (RuHAP). Developed by the Rural, Regional and Remote Committee, this plan outlines a roadmap for ACEM to strengthen emergency medicine in RRR areas through workforce advocacy, training initiatives, research, collaboration, planning and development. The ultimate goal of the RuHAP is to ensure high standards of emergency care are accessible to all.

The plan is intended to improve the experience of College members and trainees working in RRR areas and to encourage College trainees and members to train and work in such settings. It will also contribute to reducing health inequity for RRR communities, so they have the best possible access to timely and appropriate care.

The RuHAP provides a clear framework, reference point, and accountability, as the College works to improve emergency medical care and achieve better health outcomes for RRR communities.

Why is an action plan needed: the evidence

In Australia, approximately one-third of the population live in non-capital cities and communities, and in Aotearoa New Zealand, more than half of the population live outside of its three biggest cities. These people have shorter lives and higher levels of injury, illness and disease risk factors than those in major cities, yet receive less quality healthcare than those in densely populated areas.

This is a well-entrenched disparity. For example, the first report of the Australian Institute of Health and Welfare (AIHW) on rural health in 1998 found that Australia's RRR populations have poorer health than their metropolitan counterparts with respect to several health outcomes: higher hospitalisation rates for some causes of ill health, higher mortality rates, and, consequently, lower life expectancy.[1]

The public health systems in Australia and Aotearoa New Zealand are funded and delivered on the basis of universal access to healthcare, regardless of location. In practice, this principle has not consistently delivered equity of availability or access to healthcare.

This long-term trend requires concerted and coordinated action from healthcare funders, service providers, consumers, and other key stakeholders to improve population health outcomes. However, in Australia and Aotearoa New Zealand, there is a gap in rural health action planning, particularly in the area of emergency care.

These issues are exacerbated by the geographic maldistribution of the existing workforce (see Figures 1 and 2). Despite the growth of the emergency medicine specialty, an equivalent increase in the number of trainees and FACEMs working in RRR areas has not occurred.

In 2019, just over a quarter (26.1 per cent) of all FACEMs worked in a RRR area, with 23 per cent of FACEMs in Australia and 49 per cent of FACEMs in Aotearoa New Zealand working in RRR locations as their primary workplaces (Figure 1). Encouragingly, these numbers have risen since 2016, from 22 per cent and 41 per cent in Australia and Aotearoa New Zealand respectively.[2] In 2019, only 17.7 per cent of trainees in Australia were working in RRR localities as their permanent workplace compared with 36.6 per cent of trainees in Aotearoa New Zealand (Figure 2).[3] These figures show a slight increase from 15.6 per cent and slight decrease from 37 per cent in Australia and Aotearoa New Zealand respectively since 2016.[4]

Geographic maldistribution of the medical workforce is one factor associated with disparities in patient access to healthcare, as well as health outcomes. While differences in health outcomes are multifactorial, and not solely due to workforce disparities, improving geographic distribution will contribute to more equitable health outcomes for RRR communities. This is a widely recognised issue and is a headline in the National Medical Workforce Strategy published in April 2020 by the Australian Department of Health.

Figure 1: Distribution of FACEMs' primary workplace, by region and remoteness, in 2019.

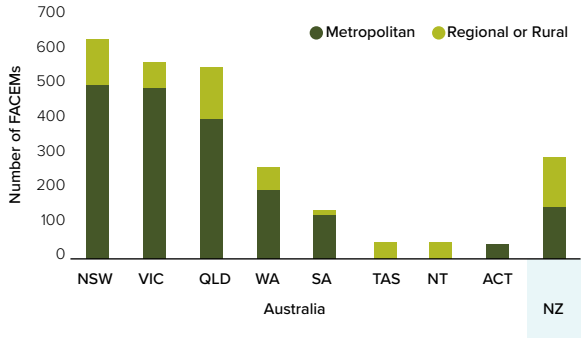
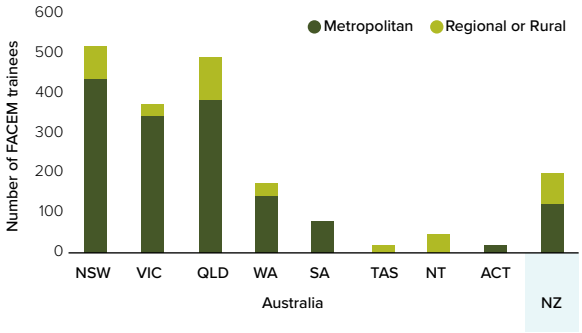


Figure 2: Distribution of FACEM trainees' workplace, by region and remoteness, in 2019.



What is in the plan?

The actions set out in the RuHAP work towards increasing rural training opportunities, a more equitably distributed workforce, increasing our evidence base on rural health disparities (pivotal to improving RRR services), and ensuring education and training opportunities are readily available for all College members and trainees providing care to RRR communities.

The action plan has four strategic priorities and each priority has a list of focus areas and actions to be implemented that will be monitored and evaluated by the RRR Committee annually.

1. Workforce

Attract, grow and retain the emergency medicine workforce in RRR areas, increase the number of trainees undertaking training in RRR areas, and support the wellbeing and educational needs of the existing emergency medicine workforce in RRR areas.

2. Evidence

Increase the understanding of doctor and patient experiences and needs in RRR areas, build research capacity in RRR medicine, and work towards developing a measure of equity of access to emergency medicine in RRR areas.

3. Service provision, planning and development

Increase the visibility of RRR experiences and needs in the emergency medicine standards, policy and advocacy work of ACEM.

4. Collaboration

Strengthen relationships between RRR members and trainees and the wider RRR health practice community, and promote collaboration between RRR and metropolitan emergency medicine networks on a clinical basis.

We will provide progress updates through direct communications to members, trainees and external stakeholders, and via ACEM's website. A review of the RuHAP and its outcomes will be completed prior to the development of the next action plan.

This first action plan focuses on building the foundations for understanding how best to strengthen emergency medicine in RRR areas, particularly workforce, research, collaboration and service provision, and planning and development. The College expects to develop another action plan for the year 2024 onwards that will build on these foundations and focus on the next stage in improving health equity in RRR areas.

College members and trainees are encouraged to read ACEM's Rural Health Action Plan and consider how you and emergency medicine are contributing to enhancing rural emergency care services.

Our vision for rural healthcare:

- A sustainable and permanent rural, regional and remote emergency medicine workforce supported by robust, effective emergency medicine networks
- An equitable distribution of emergency medicine specialists throughout rural, regional and remote Australia and Aotearoa New Zealand providing equitable access to emergency care for their communities
- An improved understanding of health and emergency care practice in rural, regional and remote communities
- ACEM plays a key role in improving health equity, particularly access to emergency medicine, in rural, regional and remote areas in Australia and Aotearoa New Zealand.

Author: Jonathan Longley, Policy officer

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Environmental Strategy

The threat of climate change has long been talked about in the media and debated as a contentious political issue. While many of our leaders, local and international, still dispute the necessary actions, these threats are increasingly being felt as real climate events for people across the globe. One point that cannot be disputed is that climate has a big impact on human health.

The medical implications of climate change are far-reaching and serious. The Lancet Countdown on Health and Climate Change 2020 report[1] names four key health challenges related to our changing climate: heat-related mortality, wildfires, climate suitability for infectious disease transmission, and terrestrial food security and undernutrition.

Recent extreme weather events such as bushfires and droughts have brought the health implications of climate to the forefront in Australia. Visits to hospital emergency departments for respiratory conditions increased by 86 per cent in the New South Wales Riverina region, and by 50 per cent in the Capital region, during the 2019-2020 bushfire season.[2] Emergency departments (EDs) will require increased resourcing to respond to and manage the increased presentations caused by climate-related disasters.

ACEM has declared climate change a medical emergency with the release of its *Position Statement on Climate Change and Health*[3] in November 2019. To ensure that EDs in Australia and Aotearoa New Zealand are prepared for and equipped to address the impacts of climate change, the ACEM Public Health and Disaster Committee has developed an Environmental Strategy.

The strategy outlines how the College, together with the emergency medicine workforce, can prepare for and mitigate the harmful impacts of climate change on human health. It aims to make environmental sustainability a core part of our work, from the perspective of our own impact on the environment and in our readiness to deal with the impact of climate change on the health system.

The Environmental Strategy focuses on six priorities: leadership, research, advocacy, partnerships, education and culture.

Leadership

College members and trainees can demonstrate leadership in sustainable healthcare to other hospital departments and areas of the healthcare sector, and take leadership in enacting climate action.

ACEM will show leadership as an organisation by identifying measures to reduce its carbon footprint and improve the environmental sustainability of the organisation.

Research

Research is necessary to support education and advocacy on the impact of climate change on EDs. Climate-related research projects in the scope of emergency medicine should be conducted and supported by the College community.

Emergency medicine disaster planning should also include mitigation of climate-induced disasters.

Advocacy

Advocacy campaigns on climate change-related disaster preparedness for EDs need to be developed and supported by the College community.

The College and its members and trainees must advocate for equity of access and outcomes for those most vulnerable to the health impacts of climate change, such as older people, Aboriginal, Torres Strait Islander and Māori people, those with pre-existing health conditions, and people from lower socioeconomic backgrounds.

Health resource stewardship initiatives, such as Choosing Wisely, need to be promoted to improve effective use of healthcare resources.

Partnerships

Establishing and furthering partnerships with hospitals, healthcare providers and other organisations assists with influencing decisions, supporting the adoption of sustainability practices, and strengthening climate change activities.

Members and trainees are encouraged to seek out effective partnerships at all levels to ensure the health system and communities are prepared for climate emergencies.

Education

Education is key to ensuring members and trainees understand the impact of climate change and have knowledge of sustainable activities they can participate in.

The College community must be equipped with the necessary knowledge and skills to plan, prepare and respond to climate change-related disasters.

Culture

ACEM's response to the climate emergency incudes the development of a culture that normalises sustainability in all activities and policies. The College community should foster sustainability in daily practice and be accountable for its environmental impact.

An *Environmental Action Plan* accompanies the strategy. The College has identified actions to undertake in all priority areas and will report on these to the ACEM Board and the membership. EDs and clinicians are encouraged to participate in the Environmental Strategy by incorporating the relevant sections of the Action Plan into their workplace.

Author: Katie Lee, Campaign Assistant

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Learning, Connecting and Engaging with Aboriginal, Torres Strait Islander and Māori Trainees and Fellows

Supporting trainees

Elisa Carbone is ACEM's Training Services Coordinator for the Education and Training department. She coordinates a team of five staff who assist trainees with planning their rotations and meeting deadlines. The team aims to ensure trainees are aware of the options available to maximise their training experience.

Elisa is the direct liaison for Aboriginal, Torres Strait Islander and Māori FACEM trainees who would like or need individualised assistance in planning their training, receiving tailored support or understanding what the College can offer. She has a deep understanding of College regulations and policies, and the avenues available to provide flexibility where needed.

Aboriginal, Torres Strait Islander and Māori trainees are encouraged to reach out to Elisa by email at Elisa.Carbone@acem.org.au or by calling the College.

Further developing our knowledge – attendance at workshops

In recent years, College staff members Alicia Hewes, Education Development Coordinator, and Anna Kaider, General Manager Education Programs, have attended a series of workshops designed by the Leaders in Indigenous Medical Education (LIME) Network for specialist medical colleges.

The inaugural event, the LIME/AIDA Indigenous Health Education Workshop for Specialist Medical Colleges, was held in Canberra at The Australian National University on 12-13 March 2019. Participants included representatives from each of the specialist medical colleges in Australia, the Australian Indigenous Doctors' Association (AIDA), Medical Deans Australia and New Zealand, and the Australian Medical Council. A follow-up workshop for specialist medical colleges was held in late 2019 at the LIME Connection VIII conference in Christchurch. These workshops help to increase our knowledge and understanding so we can better support and engage with College trainees and Fellows.

Workshop themes have included 'Thinking about Race, Colonisation and Medicine' and 'The Journey into Specialisation', the latter of which focused on recruiting and supporting Aboriginal, Torres Strait Islander and Māori trainees to specialist medical colleges.

The most recent workshop 'Cultural Safety in the Specialist Medical Colleges – a Conversation' examined:

- the conceptualisation of cultural safety
- cultural safety in specialist medical colleges
- what cultural safety means for those working in healthcare in Aotearoa New Zealand and Australia
- the role of the specialist medical colleges.

In 2020-2021, the LIME workshops have been conducted virtually. They continue to be a fantastic way for representatives from specialist medical colleges to come together to hear from experts in the fields of Indigenous health and education. Key messages and concepts will continue to inform ongoing work in these areas at ACEM.

Supporting prospective trainees – workshops and presentations

The College acknowledges the invaluable role of Aboriginal, Torres Strait Islander and Māori doctors in improving healthcare delivery and outcomes at all levels, for all people. However, Aboriginal, Torres Strait Islander and Māori doctors continue to be underrepresented across all medical specialties in Australia and Aotearoa New Zealand.

To encourage and support prospective Indigenous doctors to join emergency medicine, Dr Glenn Harrison, first Aboriginal FACEM and a proud Wotjobaluk man, Dr Ryan Dashwood, a proud Budawang man, Dr John Zorbas (ACEM Selection Subcommittee representative), and Anna Kaider (Then General Manager, Education Program Development), in conjunction with representatives from the ACEM Indigenous Health Committee ran a workshop at the 2019 AIDA Conference.

The focus of the workshop was to provide attendees with increased understanding and insights about how applications for selection are evaluated and processed. Learning from the stories, experiences and knowledge of the facilitators, attendees discussed strategies to strengthen their application skills, complete their CVs and choose referees. It encouraged prospective trainees to reflect on their personal attributes and capabilities, including cultural strengths, and how they might articulate these characteristics in their applications and with prospective referees. The workshop was well attended and participants commented that they found it helpful and enjoyable.

At the LIME Connections conference, Anna Kaider and Dr Max Raos (FACEM) gave a presentation that examined the reasoning, design and implementation of Selection into FACEM Training (SIFT) at ACEM and outlined plans for continuing engagement with, and support of, prospective and current Aboriginal, Torres Strait Islander and Māori trainees and Fellows of the College.

ACEM was to host a workshop for prospective Māori trainees, similar to that which was conducted at the AIDA Conference, in April 2020 at the World Organization of Family Doctors (WONCA) Conference to be held in Aotearoa New Zealand. Unfortunately, COVID-19 disrupted these plans. It's hoped that this workshop can be run at future conferences.

Border closures and other disruptions due to COVID-19 resulted in cancellation of face-to-face events for much of 2020 and this continues in 2021. ACEM staff Anna Kaider, Elisa Carbone and Alicia Hewes were planning to attend the AIDA Roadshow in Melbourne in late July where, along with Dr Glenn Harrison, they were to run a workshop for prospective trainees, similar to that which was held in Darwin in 2019. Unfortunately, with another lockdown in Melbourne, the event was cancelled. However, Anna, Elisa and Alicia are looking forward to yarning with trainees and Fellows at a similar event when it is able to take place.

Exploring assessment

The College recognises the challenges associated with appropriate assessment of the cultural awareness and culturally safe practice of its trainees across Australia and Aotearoa New Zealand. The ACEM Indigenous Health Committee and the ACEM Fellowship Examination Working Groups, with the support of the Education Development and Assessment teams, will continue to work collaboratively on creating best practice assessment tools that are applicable across Indigenous populations in Australia and Aotearoa New Zealand.

Planning for networking events

With COVID-19 making it difficult to arrange any face-to-face networking events, initial planning is underway to host a series of virtual events for Indigenous trainees and Fellows. Hopefully, these online events will be a great opportunity for ACEM members and trainees to hear from speakers, meet with others and share experiences, hear about College events and opportunities, and meet College staff.

As ACEM continues to adjust and re-adjust in the COVID-19 world, College staff look forward to continuing to yarn with Aboriginal and Torres Strait Islander members and korero with Māori members about further ways to collaborate with and support Indigenous trainees and Fellows, and engage with prospective trainees.

ACEM's Education and Training department recognises that collaboration is an important feature of the ongoing work in engaging and supporting Aboriginal, Torres Strait Islander and Māori trainees and Fellows. Education and Training staff thoroughly enjoy collaborating and are always excited and energised when engaging with prospective and current trainees and Fellows at conferences such as those hosted by AIDA, LIME and Te ORA, as well as at ACEM events, committee meetings and working groups.

Thank you and ngā mihi nui.

Author: Alicia Hewes, Education Development Coordinator

Diversity and Inclusion Committee

The Diversity and Inclusion Steering Group (DISG) was established in 2018, to develop and oversee the implementation of ACEM's Discrimination, Bullying and Sexual Harassment (DBSH) Action Plan. In late 2020, the Diversity and Inclusion Steering Group became a standing committee, which was approved by the ACEM Board. Further to this, the ACEM Board determined at its February meeting that the updated Terms of Reference would reflect the Committee to now be known as the Inclusion Committee. In 2021, the membership of the Inclusion Committee was renewed, and the new Committee members met virtually for their first meeting in July 2021.

Bhushan Joshi

My name is Bhushan Joshi and I'm currently a FACEM Training Program advanced trainee working in metropolitan Sydney.

I was born in Gujarat, North India, to working class parents. We migrated to the UK when I was two and I grew up in a predominantly Caucasian school with a culturally Indian background at home. Being migrants, my brother and I were always pushed to excel, which contributed to my progression into medical school.

During my time as a university student, I also came out as gay. Juggling my cultural background, my profession, my sexuality, and personal growth was challenging to the say the least. Fourteen years later, I can safely say I'm proud of who I am and who I've become. Having had insights into both Eastern and Western culture, as well the queer community, I've found myself better able to relate to the diverse range of patients and staff who I work with every day.

Outside of medicine, I chair an organisation called GLADD (the Association of LGBTQIA+ Doctors and Dentists Australia), an organisation I founded in 2013 following my first Sydney Mardi Gras. From being bullied at school, GLADD has become one of my greatest achievements; helping other medical professionals shine in who they are.

I'm proud to serve and represent diversity and inclusion in our College and am excited about the future that each of our unique backgrounds can bring to the table.

Kathryn Duffy

Kia Ora tātou
Nō Aerana me Ingerangi ōku tūpuna.
I whānau mai au i Liverpool.
Ko tauiwi ahau.
Kei Whakatāne ahau e noho ana.
Ko Kathryn tōku ingoa.

Kia Ora! I'm Kathryn, born in the UK but very grateful to have called Aotearoa home for the last 12 years. I'm a cis queer white woman FACEM living in Whakatāne, working in both Whakatāne and Tauranga EDs. I'm passionate about equity and have been working on implementing Te Rautaki Manaaki Mana over the last couple of years. I'm looking forward to working with the Diversity and Inclusion Committee to explore how we can improve representation of culture and diversity at all levels.

Kiri Manning

Kiri Manning Cert HSC, MBChB
University of Auckland
Emergency Trainee.
Pronouns: her/she

I'm Ngāpuhi and Ngāi Te Rangi descent. I grew up in Auckland, Aotearoa New Zealand, and was lucky enough to be part of the inaugural Certificate of Health Science through the Māori and Pacific Admission Scheme (MAPAS) at the University of Auckland. MAPAS, an equity strategy to gain more Maori and Pasifika medical students as part of the Vision 20:20 initiative, aimed to increase the number of Māori and Pasifika healthcare workers to 10 per cent in Aotearoa New Zealand by 2020.

I'm currently working as a Fellow at Middlemore Hospital in South Auckland, serving the Māori and Pacific Island population of Auckland. I'm involved in the Manaaki Mana group within the hospital and am looking forward to the October Hui (meeting) in Gisborne.

I trained mostly in Melbourne, Australia, recently moving back to Aotearoa New Zealand in April 2021.

I'm passionate about Indigenous health and equity, trainee advocacy, and equity for parents, women, LGBTQIA+ and others in the workplace, and in society as a whole.

I'm looking forward to working with the Diversity and Inclusion Committee and incorporating my experience from Australia and Aotearoa New Zealand.

Shanta Raghwan

I'm a FACEM working at Logan Hospital in Brisbane, Queensland. Since medical school, I've had an interest in gender equity in medicine and finding the path to achieve it. In particular, I have a keen interest in addressing intersectional and structural bias in medicine. I organised and moderated the Network of Women in Emergency Medicine (NoWEM) webinar 'Antiracism in Emergency Medicine' and organised a workshop on Equity in the Emergency Department for the ACEM 2020 Annual Scientific Meeting. I'm also an Executive Member of ACEM's Advancing Women in Emergency Section and a Regional Wellbeing Champion.

John Bonning

John is President of the Australasian College for Emergency Medicine (ACEM). He's been a specialist emergency medicine physician for over 15 years, and was Director of the Department of Emergency Medicine at Waikato Hospital in Aotearoa New Zealand until 2017, and Chair of the Aotearoa New Zealand Faculty of ACEM until 2018. He'was elected as the first New Zealand President-Elect of ACEM. He's also Chair of the New Zealand Council of Medical Colleges.

Having worked extensively in emergency departments throughout New Zealand, Australia and the UK, he has a firsthand knowledge of different models of care in a variety of settings, from the smallest rural to the largest tertiary hospital. His passions in emergency medicine include equity and sustainability, both organisational and personal.

John has various other roles as an Advanced Paediatric Life Support (APLS) and Advanced and Complex Medical Emergencies (ACME) Instructor, a Police Medical Officer, and an expert advisor to the Police, Coroner, Courts and the Health and Disability Commissioner.

Clare Skinner

Clare is President Elect at ACEM. She is a specialist emergency physician with interests in leadership, advocacy, workplace culture, quality and safety, clinical redesign and health system reform. Clare has been a member of the Council of Advocacy, Practice and Partnerships (CAPP), and a range of other College committees and entities in recent years. She was the Deputy Chair of CAPP in 2019 and serves as a member of the Health System Reform Committee.

Clare was a Junior Medical Officer at Canberra Hospital before moving back to Sydney to undertake training in emergency medicine at Royal North Shore Hospital. She also completed a Master of Public Health. Since attaining Fellowship in 2011, she has worked clinically across Northern Sydney and as Curriculum Advisor for Sydney Medical School.

Her current areas of focus include transformation of the emergency department workforce, improving care of people with mental health symptoms, building positive culture in hospitals, and fostering diversity and inclusion in health services.

Jean-Yves Kanyamibwa

I am a French-born Rwandan-British late-phase FACEM Training Program trainee working on the Sunshine Coast in Queensland.

I spent the first three years of my life in Montpellier, France, before moving with my family to Butare, Rwanda. It was there we witnessed some of the worst atrocities of the latter part of the last century. We were briefly refugees and escaped to Zaire, and then were evacuated to Bangui, Central African Republic, where we stayed in refugee camps and homes awaiting further evacuation. Eventually, we were air-lifted out of Bangui, with the assistance of family friends in France and the French military.

We stayed in Montpellier for another two years before moving to the UK when I was eight. I grew up in Cambridge, where I studied at St George's, University of London, and moved back to Cambridge and King's Lynn for my foundation medical studies, then moved to Australia in 2013.

I joined ACEM shortly after arriving and have trained in Newcastle, Port Macquarie and the Sunshine Coast. I've travelled across Australia working in all states and territories except the Australian Capital Territory. I think it's an incredible country.

I feel quite fortunate to be part of this group. I look forward to learning from all the members' diverse experiences and advice.

I want to contribute to the Diversity and Inclusion Committee in any way I can, and, specifically, to share insights that working and training as a young black male doctor can bring.

Libby Pallot

Libby is a lawyer and a Principal of Russell Kennedy Lawyers. She's also a member of the firm's Board and Head of Russell Kennedy's Workplace Relations, Employment and Safety team and practice. She has worked at Russell Kennedy Lawyers for over 20 years.

Libby is an experienced legal practitioner in the area of employment law, industrial relations, and workplace health and safety. She has significant experience in advising employers in all aspects of the workplace in a number of different industries including health, allied health and education. Libby regularly presents as an expert on employment law and industrial relations to numerous sectors. She's been recognised by Best Lawyers from 2014 to 2021 for expertise in Employee Benefits Law and Occupational Health and Safety Law.

Libby has previously been a board member of a large not-for-profit aged care provider and is a Graduate Member of the Australian Institute of Company Directors.


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"It Has Been a Challenging Day": A Day in an Emergency Department in a NSW COVID-19 Hotspot.

Dr Guruprasad Nagaraj
Dr Nagaraj is a senior emergency physician, founding member of Geriatric Emergency Medicine Section (GEMS) ACEM and former Vice Chair of GEMSIG International Federation of Emergency medicine. He is a passionate advocate of physician wellbeing

All eyes are on New South Wales as it battles a COVID-19 outbreak. But what is a typical shift like for an emergency physician? Dr Guru Nagaraj writes of the despair, the anxiety – and the mateship – in this fictionalised account, based on his real experiences.

It's an evening shift in a busy Sydney emergency department when John, an emergency doctor, sits down to write notes on his last patient. Sarah, a 42-year-old woman with COVID-19, is day eight of a COVID-19 infection and presented with breathing difficulties. John and his team had to resuscitate her, and she is now in the Intensive Care Unit (ICU). She is also 16 weeks pregnant with her first child, after multiple attempts at IVF. John knows that pregnant women are 60 per cent more likely to die of COVID-19 and he is worried for her. She may have caught COVID-19 from her brother-in-law, a construction worker. Her husband and in-laws have also tested positive but, at this stage, are okay.

Suddenly, the bat-call goes off, heralding the arrival of a new patient in an ambulance. John runs to the resuscitation area and listens to the ambulance handover. The ambulance is four minutes away and is bringing in an unconscious five-year-old child. The child's father is in isolation, as he has visited a COVID-19 hot spot.

The in-charge resus nurse, Claire, hangs up the phone and looks at John. They are both pale. In normal circumstances, resuscitating a child is clinically and emotionally challenging. The child about to present is possibly COVID-19 positive and this makes it much more difficult.

This child will be John's fourth COVID-19 patient for today. Of the four, one has died, one of them is on a ventilator in ICU, and the last one was Sarah.

It has been a challenging day. The hospital is too full. They also do not have enough doctors and nurses as many staff are in isolation due to COVID-19 exposures. There are many ill patients in the resus area. One man has been stabbed. The team has resuscitated him and now he is on a breathing tube, waiting to be transferred to the ICU. Another man is waiting to be transferred to a different hospital's ICU as the ICU here is full. Two more patients have been waiting for more than eight hours to go to the wards but there are no free beds in the wards either.

Claire is desperately trying to move the previous patient in COVID-19 resus room, who has been in ED for almost six hours, to another room or ward bed.

The ED is full. Eight or nine patients are waiting in the waiting room to come into a bed inside. Two of them have chest pain, and one of them is an older person who is very confused. There are also two ambulances waiting to offload patients. One of them is another elderly patient with a possible broken hip, and the other is a patient with kidney stones, who is writhing in severe pain.

Claire asks the nurse in charge for help, who escalates it up the chain of command. They decide they are going to send two patients up to the ward, which is already full. This means that when these patients get to the ward, they will have to be looked after by the nurses already overly stretched looking after the existing patients.

When the COVID-19 patient is moved, Rozario the cleaner steps in to urgently clean the room. Rozario must put on the same amount of PPE as doctors and nurses, and any breach in it means he will be exposed. He knows meticulous cleaning of this room is of paramount importance. If he misses one spot, that might be enough to spread the virus.

Rozario puts on his PPE then checks with one of the nurses to make sure it is on correctly. He says a little prayer in his head to enable him to clean perfectly, for if not, it could have significant consequences to the staff and the patients.

The child that may be COVID-19 positive will be here any moment. John, Cindy the nurse and Tom, the junior doctor put their PPE on, as, although COVID isn't confirmed, they must treat this child as if they were COVID-positive.

Cindy watches John put on his headcover, the goggles on top of the glasses that he usually wears, a visor, a gown, gloves, shoe cover and the N95 mask, which has been fitted to make sure there is no air leak. John puts a special bandage on his nose, as he has a bruise on the bridge due to pressure from the tightly fit mask. Cindy gives a thumbs up: the PPE is on correct.

The ambulance crew suddenly come barging into the resus area. They are having to support the airway of the child, and oxygen saturation is 86 per cent. John's heart sinks, his heart starts to race and his mind starts working at a thousand miles per hour.

Claire immediately directs them to the COVID-19 room. The ambulance officers continue to support the child's breathing. Their PPE is sticking to their bodies from sweating profusely due to physical exertion and emotional distress.

The ambulance officers give a quick handover: they were called to a five-year-old child who was seen to have seizures, was noted to have a fever then had laboured breathing and became unconscious.

The child is transferred to the bed, and the ED team takes over care. They attach the monitor and, with further airway manoeuvres and high flow oxygen, the saturations come up to 95. They all breathe a sigh of relief but know that the challenge is far from over. Tom tries to get a cannula into the child's tiny hands. But with all the PPE on, he is having difficulty. John steps in to help then realises that the child is not waking up. His airway is still challenged, so they must secure and support their breathing. John calls out to Cindy, "Can we prepare for intubation?". He tells the nurse outside the room to call Raj, the other senior doctor, on the shift.

John gets the IV line in, and they start fluids and get ready for intubation. They know that once they intubate, they cannot open the door for almost 30 minutes. Intubation is a high-risk procedure that can cause the virus to spread very quickly in large numbers so they plan everything meticulously. They go through the several checklists. Raj arrives outside the room, talks over the speakerphone, and checks in with John. John explains that they have a sick five-year-old who needs intubation. The reason for deterioration is not clear, but it might be related to COVID-19 or it might just be related to fever from other sources, and the breathing might be due to aspiration. They draw up appropriate drugs, which they triple check, as they know that when drawing up medications for a child, often there can be mistakes. They then again quickly check their PPE, drugs and go through their COVID-19 intubation checklist. John tells the team their plan A, B, and C. He lets Raj know that if there are any issues, he might need to come in and help, and he can see Raj showing a thumbs up from the window.

With one final check at the monitor and making sure drugs are all correct, they proceed with the intubation.

Tom pushes the dose of a sedative and a muscle relaxant and starts the timer. At around one minute 20 seconds, they decide to have a look. John uses a laryngoscope and has a look at announces grade one view. Outside, Raj feels a slight relief as that means it should be relatively straightforward intubation, but he also knows that things can go very wrong during, and after, intubation. Suddenly, with horror, he notices that John's mask loop has snapped. This means that the seal is not airtight and John will now be deemed a close contact.

Now John, one of the senior doctors, must isolate for 14 days. Raj knows that he and his wife had a baby, just a few days ago, and his wife is alone at home with the child. He knows that the new family don't have any family in Sydney and his wife will be left alone.

John looks up. He has realised what has happened and he looks at Raj with a look of horror and despair. John tells Tom to take over the care and announces to the team that, just as he had finished intubation and connected the ventilator, the mask loop snapped.

They all know if they open the door, everyone around the room will become exposed.

Still, the longer John is there without a properly fitting mask, the higher his chances of catching COVID-19. Raj dons PPE quickly and yells to John on the phone, "Come out immediately!" Raj tells the outside nurse to seal the area for the next one to two hours and to call infectious disease people to get advice on what they should be doing now.

John comes out and changes his PPE. As he walks out of the department to get fresh air, the whole incident sinks in: the fear of losing the child, the stress of trying to do this with half-the-usual staff, and the high-risk exposure that means he will not be able to see his new baby, or his wife, for at least 14 days if the sick child comes back COVID-positive. He takes a deep breath under his mask and tries to hold back his tears.

Raj comes outside to see him. They debrief while they wait for the child's test result. Raj feels like throwing his arms around John, and consoling him, but due to the situation and the restrictions, he cannot.

They walk back into the resus area, still gathering their thoughts. Claire sees them and runs up, her eyes soft with relief. She has good news: the five-year-old child is COVID-negative. Both Raj and John breathe a sigh of relief. This time, they were lucky. John can go home to his wife and new baby. But next time, they might not be.

The bat phone rings, heralding a new patient. This time it is a 43-year-old COVID-19 patient with severe respiratory distress. The patient will be in the ED within five minutes. Raj looks at John. He smiles and says, "Mate, I will take this one."

A Term at Gizo Hospital in the Solomon Islands

Dr Aruna Shivam
Dr Shivam is a dual trainee in ICU and ED. Her interests include global emergency care and the environment.

On 23 November 2016, a slightly rattly Twin Otter landed on the air strip of Nusa Tupe in Solomon Islands. I was met by a smiling man in a boat who spotted me on the tarmac. He beamed and said, 'Doctor! Welkam!' He hauled my rucksack onto the boat and after a 20-minute ride to add to my three plane trips, I was standing at the entrance of Gizo Hospital, unsure what to expect or whom to meet. Everyone already knew me – I was a Doctor and the next three-month visitor from Sydney who worked in the emergency department (ED).

My hospital in Sydney began a relationship with Gizo Hospital in the late 1990s. Term after term, for nearly 30 years, a senior resident medical officer would catch the same three planes and boat to Gizo Hospital, stand at the entrance and be welcomed as the incoming Doctor, not knowing what to expect. I've spent time with nearly all of these doctors since. Their reflections are the same as mine; very few of us wanted to catch the boat and three planes back to Sydney.

Gizo is the capital of the Western Province of Solomon Islands. It's the largest province in the country, with a population of about 76,000 distributed across hundreds of islands. The town of Gizo has 3,000 residents and is the central business district for the province. The town centre is an 800-metre stretch of dusty road with a hospital, police station, marketplace and several government buildings, including a small courthouse 4x4m in size in a Queenslander style shack with a healthy coconut supply in the front yard.

on market days, the waiting room is filled with the chatter of local islanders at market to sell their goods and treat their ailments

Much like far north Australia, the seasons are wet or dry and temperatures hover in the mid-30s year round. Twice a week, the markets are filled with produce brought in by surrounding islanders in canoes and outboard motors, and the town bustles as everyone runs errands, looks after their medical needs at the hospital, tends their stalls, and visits family and friends. On non-market days, the marketplace is sparsely populated, produce dwindles into the basics and the town is quiet, with very few tourists making the detour.

Gizo Hospital is an airy white building built in 2007 by the Japanese Government. It's the second largest hospital in the country after the National Referral Hospital (NRH) in Honiara and receives patients from community health centres of the surrounding islands. The hospital has an ED with a nurse-led 'see and treat' clinic that sorts patients into those who need quick advice and antibiotic treatment, and those needing assessment by a doctor, further investigations, and admission to the wards.

On non-market days, the patient load is lighter, with a trickle of local people throughout the day. But on market days, the waiting room is filled with the chatter of local islanders at market to sell their goods and treat their ailments. These days are busy and the nurse-led team can see up to 200 patients in quick succession. Patients who need to be investigated further are seen by the emergency doctor and admissions are made to the wards based on gender or paediatrics.

The hospital has a radiology service that does x-rays and ultrasounds, a pharmacy that stocks most medications within the national formulary, and a laboratory, including a separate malaria lab, that can perform pathology 24 hours a day if needed. The intensive care unit can hold two patients – typically those who have an oxygen requirement, as there is no plumbed oxygen into the building and cylinders are sent from Honiara as needed.

The hospital is staffed by a solid team of nurses who are highly procedurally skilled, have incredible clinical acumen, and can manage almost everything that comes through the door. There's always an annual rotating roster of three junior doctors from NRH who put my junior doctoring skills to shame. As postgraduate first year (PGY1) and second year (PGY2) doctors, they manage critically unwell patients with limited resources on the wards. In addition, they have the surgical skills to perform caesarean sections, tubal ligations and below knee amputations – skills that I didn't have as a PGY3 doctor and still don't have as an almost FACEM.

Many of these rotating junior doctors train in Cuba, where medical training is provided to low and middle-income countries, and a portion of them train in Fiji. They return to the Solomon Islands to complete their junior doctoring years and wait their turn to join a specialty training program run through NRH. The doctors I worked with had interests in obstetrics and gynaecology, paediatrics and anaesthesia. They talked frequently of the slow process of selection into these programs, as many of them are run through Australia, Fiji and Papua New Guinea and can manage only one or two entrants a year.

Traditionally, the visiting doctor worked in the ED, seeing and admitting patients after early investigations. The local doctors worked on the wards where their vastly greater skillsets take most patients through their journey in hospital and home again to their islands. Sicker patients were referred to the NRH for more advanced therapy, specialist input and general surgical involvement.

I recently skimmed through my small logbook of cases I saw while I was in Gizo Hospital. I kept a record of the most interesting patients. There were many asthma exacerbations, cases of anaemia, pulmonary oedema, sepsis, often with an unclear source, and peripheral vascular disease. I had a cluster of cases I marked with asterisks which, to this day, are fresh in my mind. One case was a woman who had her arm caught in a tuna shredder. I still recall her sitting calmly on a chair in the ED. When I asked her if she wanted some pain relief, she told me she was fine and that she had taken some Panadol, which was doing a great job.

Another memorable case was a woman who presented balancing a chair on her head. Her mother told me she was at her wits' end because the chair had been balanced on her daughter's head for three days and she refused to take it off. She turned out to have cerebral malaria and, several days into anti-malarial treatment, I visited her on the wards, where she

was sitting on the very same chair looking out at the ocean from the balcony. During my time in Gizo, I was unlucky enough to catch dengue. I woke up bleary-eyed from an afternoon nap one day to loud knocking at my door. The mother of this girl had heard in the marketplace that one of the doctors had dengue and she had brewed me some paw paw leaf tea for my fever. The mixture was muddy brown and bitter and she watched me like a hawk as I drank it. I'm not sure how much research has gone into the role of paw paw water as an antipyretic, but my fever broke the next day and I was back at work three days later.

Since my trip in 2016, I've been back to Gizo once. My hospital's program sending residents to Gizo was approaching its end and a small team of doctors and I had hoped to continue a relationship; to revive the three-month term and even evolve the role from a service provision to a capacity-building position.

We started a workplace giving program that ran successfully for nearly a year and a half. Staff were generous in Sydney, New South Wales, donating to help send equipment and supplies over. Many staff, over the years, had heard about Gizo Hospital from residents who'd spent time there and wanted to help. Unfortunately, the donations were unsuccessful in salvaging the program and in the third term of 2019, the hospital sent its last resident to Gizo.

I'll always be eternally grateful for the experiences, for the time I spent with the incredible people of Gizo, and the chance I had to make the trip to the Solomon Islands. I miss the smiling faces of cheeky kids. I miss fishing trips on canoes that were too small to fit us all and drinking coconuts on the pier with the nurses after a shift while watching the sunset.

COVID-19 has changed the way we engage with our EC colleagues in countries like Solomon Islands and ACEM's Global Emergency Care Committee (GECCo) have done an incredible job supporting our Pacific neighbours online through education forums and programs. It's really hard to know how much of this support trickles down to small regional hospitals like Gizo. I have to say, if the chance came to catch those three planes and a boat again, I'd jump right on it.

i More information

Are you a Fellow or trainee in the field undertaking an independent activities in Global Emergency Care. We would love to hear from you gec.network@acem.org.au

Dr Richard Pellatt

Dr Pellatt is a FACEM based at Gold Coast University Hospital, Queensland, Australia, currently completing a research fellowship. He also works for LifeFlight Retrieval Medicine, flying out of the Toowoomba base once every three to four months.

Why emergency medicine?

I trained at Bristol University in the UK and initially considered a career in urology. After moving to the Gold Coast in 2012, I completed terms in most surgical specialties but also spent time in the emergency department (ED). The ED at Gold Coast University Hospital was so welcoming, friendly and supportive that I soon switched my career focus to emergency medicine.

I feel privileged to have been nurtured and mentored by inspirational seniors, nurses, allied health specialists and admin staff. The flat hierarchy of our department, and family-like bond, meant there was really nowhere else I would rather train. I consider myself very fortunate to have grown in such a place.

Emergency medicine also acted as a conduit for travel and adventure. One of the best six month placements I did was in Alice Springs, in the Northern Territory. I became involved with LifeFlight during my final registrar rotation and there isn't a day that goes by in the helicopter where, again, I feel incredibly lucky at the way life worked out. I've also done some volunteer work in the Solomons and Papua New Guinea.

What do you do to maintain wellness/wellbeing?

My main sporting activity is rock climbing and I try to get out and about in Queensland. I spend most mornings at some fabulous boulders on the North Burleigh headland, before a dip in the sea. But I enjoy all sports; a consummate amateur, not terribly good at anything in particular, but passionate about playing – and a few beers in the pub after.

Reading and writing are a reflective outlet. You can live a million lives through the characters and words on the pages of a novel, and learn a lot about thought and life. People never change. The emotions, fears, loves and hates are the same in 1621 as they are in 2021. I was lucky to go to a university that encouraged me to complete an undergraduate degree in English Literature and Philosophy, and it remains one of the most important and relevant periods of study that I completed.

What do you consider your greatest achievement?

I went three seasons of touch rugby without scoring a try, as well as more dropped balls than catches, general unfamiliarity with the offside rule, accidental fouls and more sideways/reverse movement than anything forwards. I actually managed to place the ball BEFORE the try line in a game that we lost by a point.

But persistence pays off. In an elaborate (and accidental) move by Alex 'the giraffe' Nash, the ball somehow travelled into my hands, and I finally got a try in a game that we won.

In all seriousness, that touch team is a mixed nurse-doctor-admin-anyone-in-ED-team, and represents everything that I value in my department.

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

Being able to act as a mentor to more junior staff at all stages of training.

What inspires you to continue working in this field?

This is, I am sure, the best job in the world. Every day is different. There are problems to solve, improvements to make. And, along the way, we are able to help people in what may be the worst moments of their lives.

My involvement in research has made me committed to improving our care for mental health patients. I am an advocate for the way research can both provide a foundation for practice, but also catalyse change. A department driven by research will constantly challenge itself, and never accept a status quo.

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

Life is linear. Most things only happen once. A few mistakes and misdirections are fine. But make the most of what happens along the way. Become involved. Look forward to your work and the challenge from day to day. Consider yourself privileged to be able to work in such a role. Do everything that you can and more. Enjoy life. Make the most of it; it won't ever come again, in the same way.

Lessons From the Frontline: Documenting the Experiences of Pacific Emergency Care Clinicians Responding to the COVID-19 Pandemic

ACEM Global Emergency Care COVID-19 Research Team

Low- and middle-income countries (LMICs) across the Pacific region have been severely impacted by the COVID-19 pandemic, and our colleagues in emergency care (EC) have been on the frontline of response efforts. EC clinicians have been involved significantly in everything from triage and clinical management of patients with COVID-19 to health system leadership and coordination, exposing them to a range of ethical and operational challenges.[1]

From the beginning of the COVID-19 crisis right through to now, ACEM's Global Emergency Care Committee (GECCo) continues to provide technical assistance and support. This includes collaborative development of practical resources[2] and coordinating online support forums for EC providers across the Indo-Pacific region to discuss COVID-19 preparedness and response.[3]

ACEM has partnered with the World Health Organization (WHO) and the Pacific Community (SPC), an intergovernmental scientific organisation mandated with providing scientific and technical functions for its 26-member Pacific states and territories.[4] The forums have been pivotal in facilitating South-South cooperation and learning. In addition, they provided a valuable platform for care providers in LMICs to share knowledge, innovations and adaptive behaviours, and problem solve and professionally support each other during this stressful and complex time.

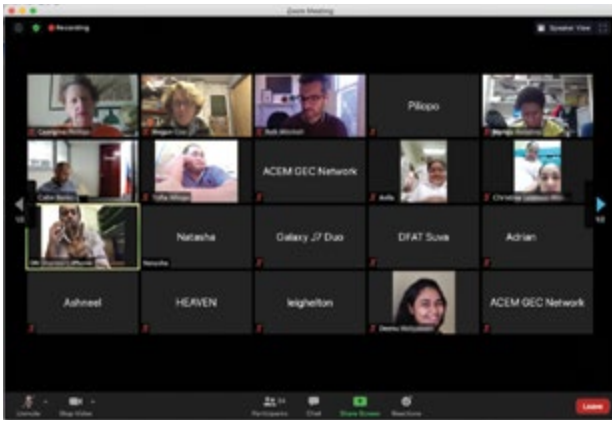
In the course of these forums, participants have identified localised and shared ethical challenges. Key themes emerged, such as the challenges emergency departments (EDs) face as unique frontline response areas, required to respond to COVID-19 as well as maintain 'business as usual'. There were numerous stories of a 'mismatch' between donated equipment and what was required to meet local needs, and what could be utilised given in-country infrastructure and resources, particularly staff capacity.

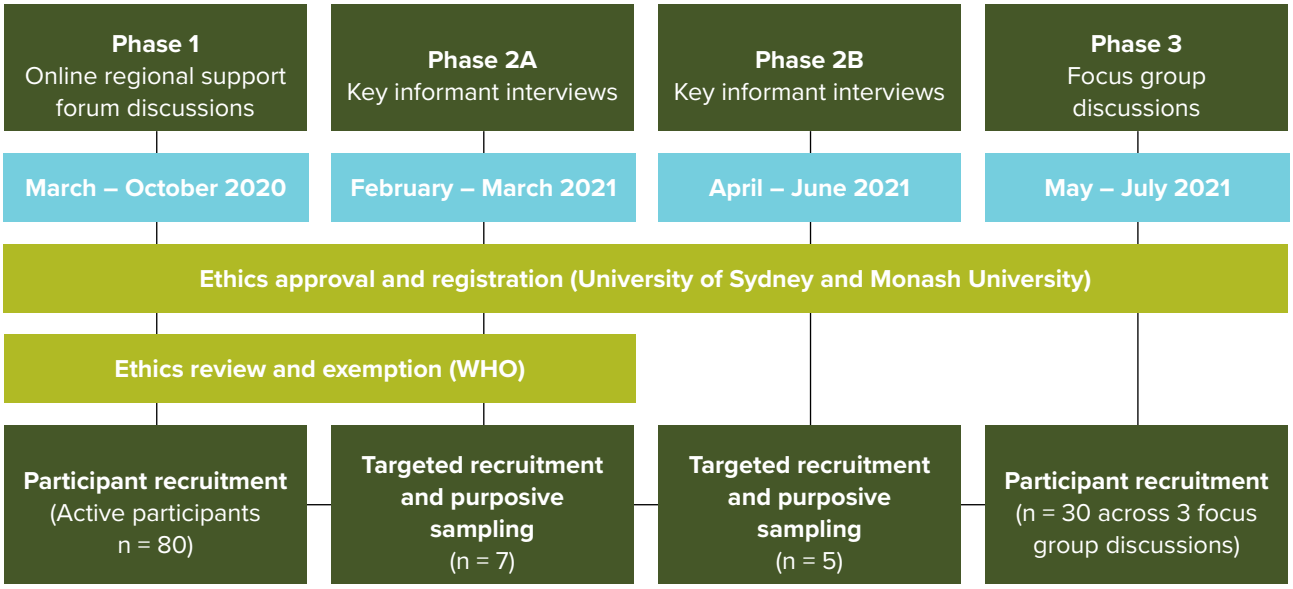
'The mismatch came when we got four ventilators and then realised we don't have enough staff to run those ventilators.'

In the forums, we saw EC clinicians as experienced innovators in disaster response and triage, showing flexibility and vision under pressure, when faced with the significant ethical challenges of clinical decision-making in resource-limited environments.

As the webinars progressed, GECCo members noted that, although guidance has been generated for healthcare worker protection and the allocation of scarce resources during public health emergencies, it's not easily translated to the LMIC context.[5] The webinars constantly highlighted lessons for all countries from the adaptive, innovative and pragmatic responses to COVID-19 implemented in LMICs, especially in relation to the ethical and operational challenges faced by frontline clinicians.[6]

We decided to examine these issues in-depth for the current COVID-19 response and use the outcomes to improve resilience and readiness for future communicable disease outbreaks.





Courtesy of co-funding from WHO and the ACEM Foundation, ACEM, in partnership with SPC, initiated a rapid, prospective, qualitative research project to explore the experiences of EC clinicians and other key stakeholders in Pacific LMICs responding to the pandemic. The study was conducted as a collaboration between Australian and Pacific researchers affiliated with ACEM and SPC, and employed rapid, prospective, qualitative research methods aiming to explore the lived experience of participants from their perspectives. We deliberately used strengths-based, appreciative inquiry as a fundamental underpinning of our qualitative data collection, to counter the ubiquitous deficit narrative that commonly accompanies research about LMICs.

Data collection and analysis methods were informed by WHO health system building blocks, adapted for the Pacific EC context. These building blocks reflect the importance of human resources (such as trained clinicians), infrastructure (such as Infection, Prevention and control-compliant resuscitation areas), and processes (such as triage) to effective emergency care, and have been endorsed through regional consensus involving clinicians across multiple Pacific Island Countries and Territories (PICT).[7]

Data were gathered from EC clinicians and other relevant stakeholders across Pacific LMICs in three phases: via online regional EC support forums (Phase 1), in-depth interviews with key informants (Phase 2), and focus group discussions (Phase 3).

Phase 1 and 2 of our data collection and analysis is complete and we are currently analysing and triangulating data for Phase 3. The third phase involved data collection via focus group discussions with EC stakeholders from recognised geographical regions of the Pacific: Micronesia (encompassing the Federated States of Micronesia, Kiribati, Marshall Islands, Palau and the northern Pacific states); Polynesia (Cook Islands, Samoa, Tokelau, Tonga, Tuvalu and other small island states); and Melanesia (Fiji, Papua New Guinea, Solomon Islands, Vanuatu and Timor Leste).[8]

Our study aims to capture the rich and diverse voices of EC clinicians in the Pacific region, and document lessons learned to inform recommendations for improved health system preparedness in future public health emergencies. To the best of our knowledge, it's the most in-depth qualitative study bringing to light the voices and lived experiences of EC clinicians in the Pacific region as they respond to the COVID-19 crisis.

We anticipate the findings will fill important knowledge gaps on COVID-19 and the responsibilities of EC clinicians, and contribute to greater understanding of the ethical tensions implicit in public health emergencies affecting the Indo-Pacific region. Importantly, this work will help facilitate context-specific ethical guidance that builds on existing COVID-19 resources and frameworks.[9] Study results, to be published in subsequent papers, will inform efforts to improve health system preparedness for future public health emergencies. Importantly, the findings will strengthen EC system capacity to provide timely, quality and accessible care during routine operations as well as surge events.

Although a significant amount of technical guidance has been generated during the pandemic, much of it has focused on high-income settings with advanced public health and clinical care capacity. Given the wide variation in health system responses to COVID-19 across the globe, all countries stand to benefit from structured analysis of the innovative and pragmatic solutions implemented in LMICs.

This article is an adapted extract from the report Cox, M., Phillips, P., Mitchell, M., Kôrver, S., Herron, LM., Sharma, D., Brolan, CE., Kendino, M., Masilaca, O., Gerard O'Reilly, G. Poloniati, P., Kafoa, B. 2021. 'The Ethics of Public Health Emergency Preparedness and Response: Experiences and lessons learnt from frontline clinicians in low- and middle-income countries in the Indo-Pacific region during the COVID-19 pandemic' Research Report 2021, Melbourne, Australia: Australasian College for Emergency Medicine

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A snapshot of some of the highly valuable insights collected in Phase 1 and 2 of this research study. This table identifies barriers and challenges to, and enablers and strengths of, EC responses in the Indo-Pacific region. These are categorised in relation to each of the five Pacific EC Health System Building Blocks: human resources and training; infrastructure and equipment (including medications); data (information and research); processes; and leadership and governance. The complete report can be found on the ACEM Website acem.org.au as well as summaries from the webinars. LMIC COVID-19 resources can be found on the ACEM website: https://acem.org.au/Content-Sources/Advancing-EmergencyMedicine/COVID-19/Resources/ACEM-Resources

Pacific EC health system barriers and enablers

Pacific EC Health System Building Block	Barriers	Enablers
HR and training	• Fear and safety concerns • Physical and mental health impacts • Workforce shortages and gaps • Lack of information, recognition and/or engagement • Inadequate compensation, unavailability or non-payment of allowances • Lack of knowledge and/or training • Stigma • Gender and cultural barriers	• A staff safety culture • Professional duty and motivation • Psychosocial and other staff support • Recruitment of volunteers • Regular and open communication • Leadership, advocacy and donations • Education and training
Infrastructure and Equipment	• Limited space and capacity to provide intensive care • No or inadequate essential equipment and supplies • Inappropriate use of PPE, poor continuity of supply	• Flexibility and adaptable spaces; donated infrastructure • Donation of supplies and equipment • Storage and management processes • Re-use and innovation
Data	• Data unavailable or not shared • Lack of complete patient records	• Access to necessary/useful data • Clinician commitment to improved patient data
Processes	• Access block and overcrowding • Sub-optimal PPE use/management/fatigue • Lack of or inadequate testing • Incomplete or incorrect implementation of new processes • Inefficient communication and referral pathways	• Effective management of ED space and patient flow • Safety culture and emphasis on IPC • Appropriate testing equipment and criteria • Consistency and clarity in communication and processes • Simulation and rehearsal • Effective communication • Multidisciplinary decision-making
Leadership and Governance	• Lack of government leadership and/or support • Disconnect between health system or hospital management and ED	• Collaboration – whole-of-hospital and with public health services • Government/Ministry of Health leadership and support

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ACEM Winter Symposium

27 – 30 July, Hybrid – Cairns Convention Centre and Online

2021 saw ACEM deliver event content in a new way, with the College holding its first hybrid-model event, the Winter Symposium, delivered face-to-face in Cairns, Queensland and online. Both options provided delegates with access to keynote and invited speakers, oral presentations, pre-conference workshops, panel discussions, networking opportunities, and exhibition space.

The Winter Symposium 2021 showcased what members and trainees do best, how we flourish in times of change and find opportunities where others only see threat. With a focus on issues relevant to the individual's health, a crumbling environment and the entrenched inequities of today's society, the symposium examined how vulnerabilities amplify risk and how resilience is an act of resistance.

With more than three days of content, including engaging presentations and live Q&A sessions, the hybrid delivery and access to on-demand content during and after the event meant this year's Winter Symposium was extremely well received.

By offering a hybrid model, ACEM events herein can be more inclusive and welcoming to a larger community, including those who may not attend in person due to travel, health, budget, or other restrictions. We look forward to continuing to deliver hybrid events to College members and trainees.

More information

acem.org.au/events

My First Day on the Job

Dr Gayatri Madhavan

Ramachandra Hospital, India

I remember walking into the department for the first time. CPR was going on for an OPC poisoning case, while I was headed to the academics hall for course initiation.

That got me thinking, "Can I really do this kinda stuff especially under so much pressure?" Then initiation started, and a senior resident asked me, "Girls find EM tough – how long do you think you will last?", and sniggered.

The chief introduced me as – daughter of an internationally renowned senior emergency physician. Everyone looked at me with disgust, probably thinking I was the poster child for nepotism. After that session, we were called to the emergency department (ED) when a case of hemodynamically unstable hemoptysis turned up. The staff turned to me and asked, "What do we do now Doctor, what do you want us to do?" I just stood there, blank. The seniors were laughing at me. The next case was a respiratory failure, and I had no clue about ventilators and their settings, let alone how to intubate.

"Girls find EM tough – how long do you think you will last?"

I went back to my room that night, devastated and rethinking my options. Now, I'm an Emergency and Critical Care Physician, with special interest in respiratory diseases and hemodynamic monitoring.

Dr Ashiela Narang

Rockingham General Hospital

I arrived from the UK for a two-year adventure as an ED Consultant.

I walked in just before 8:00am to find no medical staff to be seen as they were in a formal handover elsewhere (not what I was used to).

Ramping, access block. Meth. So much toxicology!

I stood at the back of the room listening intently and realised I had no idea what they were talking about. Was I in the wrong handover room? Abbreviations were flying around that I had never heard of. Ramping, access block. Meth. So much toxicology! Patients were in ED for more than 12 hours. Yet so many doctors!!! Surely this must be the handover for the entire hospital??

I stood listening impatiently, ready to start and looking very keen. Eventually I was 'summoned' to what I thought was to help supervise the SMO on the ED ward round – only to realise that I had been mistaken for the intern! My lack of presence, looking uneasy, vulnerable and hiding at the back in unidentified scrubs led the SMO to this belief (she hadn't noticed the grey hairs).

That was nine years ago. The SMO has never lived it down. My grey hairs have got greyer. The meth use has got bigger. I haven't grown any taller, but I have grown in knowledge, experience, and culture. I have come a long way, quite literally.

Assistance program

ACEM Assist

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

Australia: 1300 687 327
Aotearoa New Zealand: 0800 666 367

Australasian College
for Emergency Medicine

34 Jeffcott Street
West Melbourne VIC 3003
Australia

t +61 3 9320 0444
f +61 3 9320 0400

acem.org.au