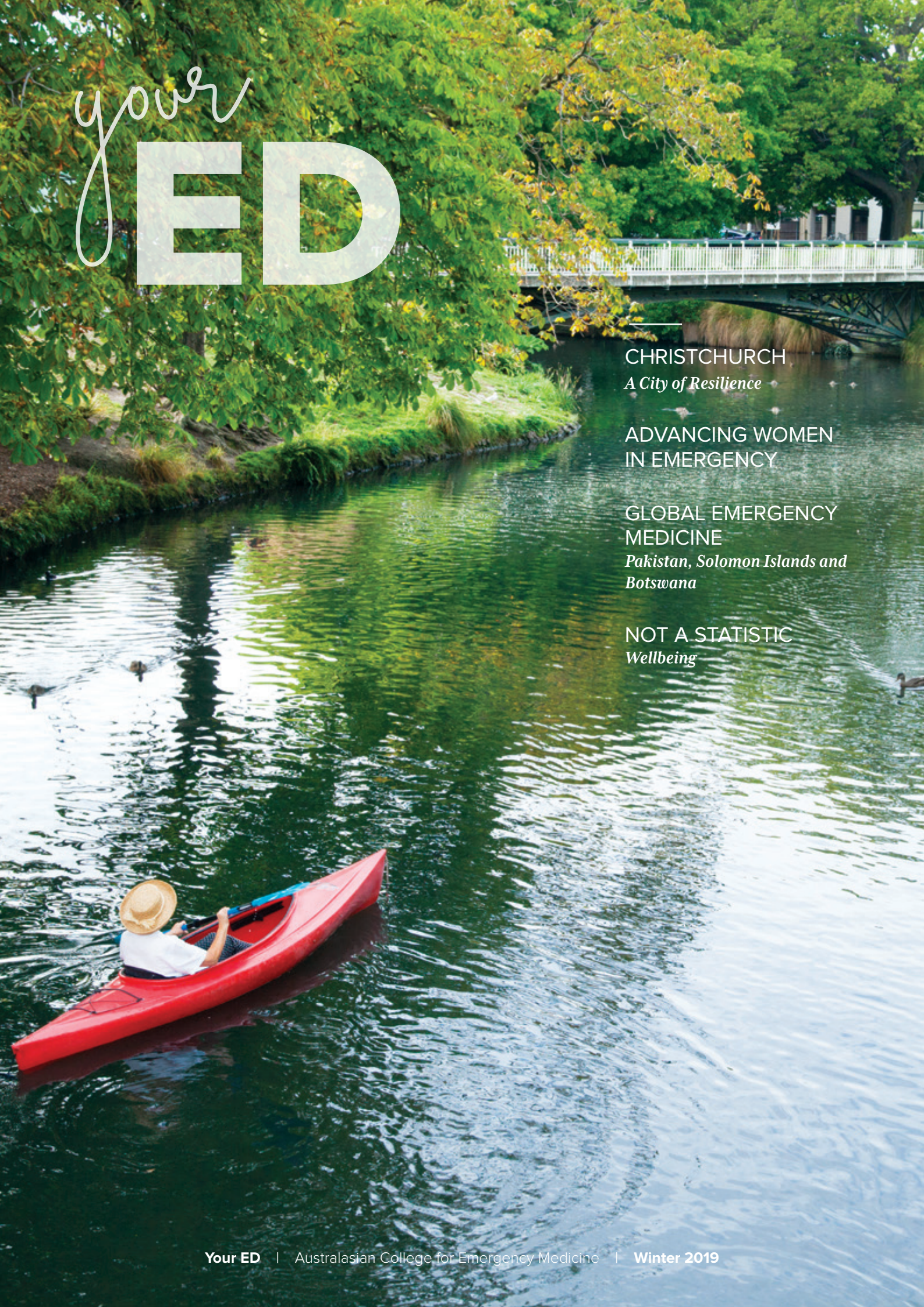


your ED

CHRISTCHURCH
A City of Resilience

ADVANCING WOMEN IN EMERGENCY

GLOBAL EMERGENCY MEDICINE
Pakistan, Solomon Islands and Botswana

NOT A STATISTIC
Wellbeing

iStock.com/travellinglight

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).

Disclaimer
All rights reserved. ACEM reserves the right to change material submitted.

Contents

Inga Vennell

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

Message from the Editor

Welcome to the second issue of *Your ED*. The College was encouraged by the positive response to our first issue and look forward to bringing you more emergency medicine features from across Australia and New Zealand. We are also excited to feature stories in our Global Emergency Care section from Botswana, the Solomon Islands and Pakistan.

Our lead feature comes from Christchurch as the city continues rebuilding – eight years after the 2011 quake – and shows its true resilience following the terrorist attack earlier this year. We are also pleased to introduce our three new Board members following the passing of special resolutions earlier this year, and to introduce the new College Core Values.

In this issue, we again highlight some of the incredible work being done in emergency care by all of you. These are your stories.

We hope you enjoy these perspectives on emergency medicine.

ACEM in the Media

During **June** ACEM hosted the Aotearoa New Zealand Mental Health in the Emergency Department Summit at Wellington's Te Papa Museum, with the event receiving significant media coverage.

The Summit brought together more than 80 emergency doctors, psychiatrists, consumers, clinicians and key decision-makers to discuss and agree on nine key principles to tackle New Zealand's mental health crisis. Coverage of the summit featured on New Zealand radio news bulletins and online, including on Newstalk ZB, RadioNZ, LiveNews NZ and LawFuel.

ACEM is investigating further opportunities for media advocacy on the issues highlighted in the Summit Communiqué, which was also announced in a media release at the time.

In **June** Dr Lisa Walker, Dr Waseem Hassan and Dr Michael Humphreys received recognition in the media after being awarded the Buchanan Prize. The prize is named after one of ACEM's founders, Dr Peter Buchanan, and is awarded to the candidate(s) achieving the highest score in the Fellowship Clinical Examination.

In **June** ACEM again supported #crazysocks4docs, a day to encourage conversations about mental health and help reduce the stigma for doctors experiencing mental illness. The day was started by Dr Geoff Toogood, a cardiologist in Frankston, Victoria, and a long-time campaigner for doctors' mental health.

In **June** the *Coonabarabran Times* and *Daily Liberal* in New South Wales reported on the success of Emergency Skills Workshops for rural medical professionals, hosted by the Dubbo Health Service in late May as part of the Emergency Medicine Education and Training (EMET) Program.

The articles acknowledged the involvement of FACEMs Dr Randall Greenberg and Dr Michael Golding in delivering the workshops.

EMET provides education, training and supervision to the large number of doctors and other health professionals working in emergency departments and emergency care services – particularly in rural, regional and remote Australia – who are not specifically trained in emergency medical care.

In **June** ACEM continued to play a key role in advocating for patients and staff, and being part of the solution to long-standing issues of access block, patient flow and ambulance ramping at Royal Hobart Hospital, as well as similar issues in Launceston.

ACEM's involvement in the Access Solutions Meeting, which focused on the issues at Royal Hobart Hospital, but also aimed to bring about better outcomes for patients and all Tasmanians, received widespread media coverage, including on ABC TV, radio and online platforms, as well as *The Mercury* (Hobart), *The Examiner* (Launceston) and *The Advocate* (Burnie), and local radio news.

'The Royal Hobart Hospital and its emergency department staff now need the support and commitment from the clinical leaders in inpatient areas and the hospital executive to implement actions identified to improve patient flow', said ACEM Tasmania Faculty Chair Dr Marielle Ruigrok, following the meeting.

ACEM President Dr Simon Judkins added 'ACEM was heartened by the combined agreement on the issues and actions required to bring about sustained change, and will closely monitor and support progress. We acknowledge that the hard work starts following yesterday's meeting'.

In **June** ACEM released the findings from its fifth annual Alcohol and Other Drug (AOD) Harm Snapshot Survey, conducted at 2:00am local time on Sunday, 16 December 2018 in emergency departments across Australia and New Zealand.

The report shows the highest prevalence of alcohol-related presentations were found in Western Australia and New Zealand, with almost one in five presentations in those jurisdictions during the survey proved alcohol-related.

'Alcohol has never been cheaper or more heavily promoted than it is now and we see the very real effects of this in emergency departments in Australia and New Zealand. In what is already a high burden environment, we bear the brunt of inadequate alcohol regulation', said ACEM President Dr Judkins.

In **June** ACEM made a public call urging that overcrowding, bed block and ambulance ramping must not be the new 'normal' for hospital emergency departments in South Australia.

ACEM President Dr Judkins highlighted the real and persisting issues at all emergency departments in South Australia, which pose a risk to patient safety, adding that ACEM had been in discussion with the South Australia Health Minister for some time about its concerns.

In **July** FACEM and Director of Emergency Medicine at Hornsby Ku-ring-gai Hospital, Dr Clare Skinner, was featured in the *Hornsby Advocate* highlighting the need for more women to work in the male-dominated field.

'I think it's important because the profession should reflect real life', Dr Skinner told the publication. 'I think we live in a very diverse wity and medicine is a very male domain. They (women) have empathy, they're good at nurturing, communicating and that works well in emergency medicine.'

In **July** FACEM Professor Gordian Fulde appeared on the ABC program Anh's Brush with Fame. During a wide-ranging

interview Professor Fulde reflected on his life and work, including more than 30 years as Director of Emergency at St Vincent's Hospital in Sydney.

In **July** ACEM President-Elect Dr John Bonning featured in the media as part of his involvement in the Choosing Wisely movement. Dr Bonning spoke about the risks to patients that overtreatment can pose.

'Healthcare is getting more and more complex — our ability to do stuff is growing, we have more treatments. But in trying to be good doctors, sometimes you can inadvertently cause harm', said Dr Bonning.

Dr Bonning's comments were featured in the *New Zealand Herald, Northern Advocate, Hawke's Bay Weekend* and *Whanganui Chronicle*, with New Zealand's *The Project* TV program also following up with an interview.

In **July** an article by ACEM President Dr Simon Judkins on alcohol policy failures contributing to emergency department overload was published by *Croakey*.

'It simply does not make sense that emergency departments around the nation are struggling with overcrowding, bed block and ambulance ramping, and yet we are still waiting to see a national alcohol strategy developed as part of a promised federal whole-of-government drug strategy', wrote Dr Judkins.

In **July** comments from ACEM President Dr Judkins featured in media coverage of concerns over workplace safety in New South Wales hospitals and calls for industrial action from the Health Services Union after an increase in assaults by patients.

Dr Judkins told the *Sydney Morning Herald* that emergency rooms were 'not the right environment' for agitated patients who need treatment for mental health or drug and alcohol issues.

'It's a very unsuitable environment to bring patients who are already aggressive into that sort of a melting pot', Dr Judkins said. 'It's just a recipe for disaster.'

The issues have continued to receive coverage, with FACEM Professor Gordian Fulde also interviewed on the matter in early August.

During **July** an EMET workshop attended by 24 doctors and nurses, hosted by the Western Australia Country Health Service in Merredin, received coverage in *The Avon Valley and Wheatbelt Advocate*.

FACEM and EMET lead Dr Stephanie Schlueter told the publication the program was about supporting rural health professionals to confidently and effectively deliver emergency care, and build networks with both metropolitan and country colleagues.

In **July** ACEM featured in media coverage of emergency department data exposing alcohol harm in Melbourne and Canberra hospitals. The data was collected and released as part of the Driving Change Project, a partnership between ACEM, Deakin University and participating hospitals.

The data received coverage in the *Herald Sun* and ABC radio in Melbourne, and the *Canberra Times* and local radio and TV news in the Australian Capital Territory.

'Emergency physicians regularly manage the devastating effects of excessive alcohol consumption on individual health, as well as assaults or verbal and physical threats from drunk patients. It is incredibly stressful and confronting to see and have to manage this every weekend', said ACEM President Dr Judkins.

In **July** national broadcaster Radio New Zealand aired a long form documentary on New Zealand's mental health system, having shadowed ACEM President-Elect Dr Bonning in the Waikato ED in June.

Dr Bonning told the program that, for those in mental distress, the scenes in the ED are, in many cases, the opposite of what they need. 'These are high-need patients. We want to look after them, but they can also have drug-induced psychoses, and we've had instances of staff being physically and verbally threatened.'

In **July** ACEM publicly raised concerns that overloaded EDs at Queensland's Logan and QEII Hospitals were continuing to jeopardise patient safety.

'Rapid off-loading has worsened, in which patients on ambulance stretchers are unloaded onto wheelchairs, chairs or stretchers in corridors when there is no suitable treatment space. This is unsafe and has led to patient harm', said ACEM Queensland Faculty Chair, Dr Kim Hansen.

In **July** comments from ACEM President Dr Judkins indicating 'grave concerns for patients' stemming from budget cuts at Victorian hospitals were covered in the *Herald Sun*.

Dr Judkins told the publication 'Budget shortfalls that affect hospital capacity and services will exacerbate an already critical situation in most EDs'.

Dr Judkins was also interviewed and featured on Victorian TV news in follow-up coverage.

In **August** ACEM featured extensively in media coverage of 'crisis point' capacity and ambulance ramping issues at Cairns Hospital.

ACEM President Dr Judkins was interviewed on ABC Radio in Far North Queensland, while a joint ACEM-Australian Medical Association Queensland media release calling for urgent action received widespread coverage across print, online and TV media.

'The ongoing capacity issues represent an increased threat to patient safety, including a heightened risk of medical errors, delays to treatment, and tying up ambulance resources. This all could have been avoided by long-term planning and investment', said Dr Judkins.

For all ACEM Media enquiries please contact

Andrew MacDonald
Media Relations Manager
andrew.macdonald@acem.org.au
+61 3 8679 8813

Vienna Richards
Media Relations Coordinator
vienna.richards@acem.org.au
+61 3 8679 8866

PRESIDENT'S WELCOME

Dr Simon Judkins

Welcome to the second issue of Your ED. This is in fact my last issue as President, but it has been a wonderful project to be involved in and I look forward to contributing in a non-presidential capacity to many of its future iterations.

It has been a busy few months in emergency medicine and at ACEM. I'm exceptionally proud of the hard work that goes into our specialty – both from a clinical perspective and from a College perspective.

There is a lot to be proud of.

One thing I am especially keen to highlight is the success of the two special resolutions in our 'Get On Board' vote in May and June to amend the Constitution. We're incredibly pleased to introduce the new members to our Board resulting from those votes – two Fellows and a Community Representative. All three will be pioneers in their roles on the Board and I know they have plenty to contribute to the growth and success of this College and emergency medicine. There's a complete wrap-up of the vote and profiles of our new Board members on pages seven and eight.

We had in the first issue of *Your ED,* a feature on Pre-Hospital and Retrieval Medicine (PHRM), with FACEM Dr Mark Elcock, who works out of Queensland. Since that issue it's been great to see PHRM gain so much engagement. There was an official release in July of details of an upcoming diploma, and in coming months there will be more detail about the shape and nature of 'DipPHRM'. This program will be the result of great work by many passionate people over the course of several years. This project in particular has highlighted the value and power of our collaboration with the Australian College of Rural and Remote Medicine (ACRRM), the Australian and New Zealand College of Anaesthetists (ANZCA) and the College of Intensive Care Medicine (CICM).

Other items to look out for in this issue are our core values and our great global emergency care feature, which highlights some of the work our members and trainees are doing across the world.

Finally, I just wanted to take a moment to talk again about the sustainability of this magazine. It is something that was raised following our first issue. I want to thank those who have called it out as it is something we are very aware of and that is important to us. We have taken the utmost care to ensure this magazine meets with the sustainable values of our College's members and trainees. We are committed to ensuring it is as eco-friendly as possible, and the providers we engage are just the same, including use of biodegradable wrapping, as well as recycled water and paper, and the use of vegetable-based inks. However, we do understand you may prefer to read the magazine digitally. If so, please contact the College to unsubscribe from this hard copy edition (communications@acem.org.au).

I look forward to seeing many of you at this year's ASM.

Very best wishes to all for the coming spring months.

CEO's Welcome

Dr Peter White

Thank you to everyone who contributed to the positive feedback on the first issue of *Your ED*. A lot of effort went in to ensuring that the offering was of high quality, with content that resonated with the target audience, and raised awareness of the wide range of activities that College is involved in. The College President has commented on the environmental sustainability aspect of this initiative in his Welcome, and I do want to reiterate his remarks. Along with the healthcare sector and society more generally, the College is increasingly aware of this issue and its responsibilities around resource stewardship and sustainability.

Once again, *Your ED* provides a snapshot of the initiatives being conducted in Emergency Medicine where 'the College' has a role. Now, more than at any time in its existence, the College is working for the public good in Australia and Aotearoa New Zealand, as well as elsewhere, particularly in the Asia–Pacific region. Sometimes this is through activities relating to what is generally considered its absolute 'core business' of education and training. Sometimes this is through supporting, facilitating or enabling the contributions of others, or through advocacy or awareness raising. Sometimes it is through the organisation itself ensuring that it evolves in a way that ensures it is meeting the requirements of society by operating in a manner that meets contemporary expectations. This edition of *Your ED* contains much that illustrates the work of ACEM in all these respects.

Finally, I would like to take this opportunity on behalf of all ACEM members and staff to thank Dr Simon Judkins for his contributions over the two years of his term as President, which is nearing its end. Simon has worked in an indefatigable manner for the good of the College, the profession and the public during his Presidency and it has been a privilege to work with him during that time. For Simon, of course, these contributions did not simply start at the beginning of his term as President and will not finish at the end of this time. As Immediate Past President following the College's Annual General Meeting in November, he will remain on the Board for a further 12 months and is aware that he has unfinished business to progress during that time. In combination with the in-coming President, Dr John Bonning, the College will be in good hands going forward.

I hope you enjoy this issue of *Your Ed* and look forward to seeing many of you in Hobart at the College's Annual Scientific Meeting, as well as other ACEM events in the time leading up to that.

Constitutional Change

In May and June this year, Fellows – by an overwhelming majority – voted to change the ACEM Constitution. The changes – enabled by two special resolutions – have seen the appointment of two general Fellows and a Community Representative to the Board.

ACEM is pleased to announce the appointment of FACEMs Dr Rebecca Day and Associate Professor Melinda Truesdale, and Community Representative Jacqui Gibson-Roos to its Board, effective 26 August.

The appointments are the culmination of more than a year's work to discover what members and trainees considered appropriate representation on the ACEM Board and in College governance structures; and to translate those ideas into tangible change.

The first consultation paper on the matter of diversity in College governance was released in August 2018. It asked members and trainees to consider whether the composition of the Board, Council of Advocacy, Practice and Partnerships (CAPP), and the Council of Education (COE) represented appropriate diversity to inform the College's strategic priorities, and what, if any, barriers existed to participation in ACEMs governing bodies.

A majority of respondents indicated the Board did not represent sufficient diversity; although had fewer concerrns about the composition of CAPP or COE. The greatest concern was the lack of female representation on the Board, however, other concerns included a lack of cultural diversity and regional representation and the constraints of time in a Board comprising four ex-officio positions.

In November 2018 a second paper on diversity in College governance was released. It sought feedback on ways to remove barriers to participation on the Board. The position paper contained six recommendations for change, with the following three recommendations carried through to the vote in early May:

- Remove the positions of Deputy Chair of CAPP and Deputy Chair of COE at the expiration of their current terms;
- Replace the Deputy Chair positions on the Board with two positions to be occupied by Fellows from the general membership; and
- Appoint a Community Representative to the Board.

Each of these required change to the Constitution, and therefore the passing of special resolutions. With the Board having determined to conduct the process by postal ballot, this meant 75 per cent of voting Fellows would need to support any proposed resolution.

The Board gave strong support to the passing of these resolutions and encouraged widespread publicity.

It was adopted on social media under the hashtag #GetOnBoard, and promulgated through the College's regular email updates (Bulletin, Faculty Update, Trainee News), as well as in the President's Blog and in videos of member support.

On 4 June, a little past 5.00pm, President Dr Simon Judkins emerged from the office of CEO, Dr Peter White, with a wide grin and two thumbs up. Both special resolutions had passed. The final details of the vote, including the numbers, were released that same afternoon by email and on social media.

Movement since to make these appointments has been swift. The first and most urgent call of order was to appoint a Board Nominations Committee, which was composed to make recommendations on the FACEM appointments to the Board. Following this, a call for expressions of interest to join the Board was released to Fellows, and to Community Representatives already serving on College entities). Those who wished to express interest were asked to respond to seven selection criteria, seen to reflect the qualities and aptitudes required to help in the growth of the College.

At its meeting in early-August the ACEM Board appointed the Community Representative and in mid-August the committee forwarded its recommendations to the Board, which ratified the recommended FACEM appointments.

President Simon Judkins says: 'I'm very pleased that we have moved ACEM – through changes at Board level – to a position that much better reflects who we are.'

***Author: Natasha Batten**, Communications Advisor*

Resolution 1 – to replace the positions of the Deputy Chairs of the Council of Advocacy, Practice and Partnerships and the Council of Education with positions occupied by two FACEMs from the general Fellowship – was voted on by 936 FACEMs, with 892 votes (95.3 per cent of voting FACEMs) supporting the resolution.

Resolution 2 – to appoint a Community Representative to the Board – was voted on by 936 FACEMs, with 793 votes (84.7 per cent of voting FACEMs) supporting the resolution.

FACEM Dr Rebecca Day

Emergency Specialist and DEMT at Royal Darwin and Palmerston Regional Hospitals

I nominated for the Board because it had always been my intention to slowly pick my way up through the ACEM ranks to get a position on the Board, and I had got as far as the Council of Education. I guess I have realised increasingly that clinical work on the floor benefits individual patients, but that if you want to improve things on a grander scale, you have to get involved at an organisational and political level. I still have the classic impostor syndrome and I truly held the belief that I wasn't yet experienced or knowledgeable enough to take on a Board position as a fairly junior FACEM. I thought it was such a long shot that I nearly didn't apply, but was given a kick up the backside by FACEM Dr Clare Skinner.

I feel so rewarded in this career, mostly by the patients. You meet so many people in the Top End who are doing it tough but still manage to smile, have a laugh and tell you their story. It's the contact with patients that makes the job so spectacular. I was lured to the Top End in 2014 searching for something new as a freshly minted Fellow. It was only meant to be for 12 months, but I fell in love with the out-there medicine up here, and haven't looked back.

I got involved in College business fairly early. There was the chance to become a DEMT and also an examiner and I put my hat in the ring fairly quickly. I most enjoy being a DEMT. It's such a privilege to help trainees navigate their journeys towards Fellowship. I've learnt so much from all the trainees I've supervised. It's really a mutual opportunity to learn.

Most of the leaders that I look up to are people who I have worked closely with over the years, and I have tried to borrow ideas and attitudes from them. My current director of emergency medicine, Dr Didier Palmer, has taught me that as an effective leader you cannot always be everybody's friend and still do a great job. Sometimes you have to prioritise the organisation over your own ego or self-interest.

Dr Skinner from Hornsby Hospital has also been a big inspiration. She is tireless in her advocacy for those who cannot advocate for themselves. She isn't afraid to tactfully ruffle feathers to make meaningful change, but always remains kind. I have always said that when I grow up, I would like to be a cross between Dr Jennie Martin, an amazing examiner who has nailed the tough love in exam prep, and JFK (Dr John Kennedy) who is easily one of the best DEMT around.

FACEM Associate Professor Melinda Truesdale

Director at Royal Melbourne, co-located at the Royal Women's

I've had several interests spanning my career, including ultrasound, retrieval medicine, standards and patient safety, and quality.

Becoming a Board member seemed a natural progression for my career – I've been a director across multiple emergency departments and chair of the Accreditation Subcommittee since 2017. It's an honour to have been appointed to the Board – to have an opportunity to help set the strategic direction and future for the College.

I was attracted to emergency medicine as a student and undertook an elective in an emergency department in Canada. I knew it was the career for me when I commenced a full-time position there as a registrar in 1991. I could see advantages and disadvantages, but had the drive to see many patients, diagnose, stabilise/resuscitate each day. There are very few people who wake up expecting to end up in an ED. It's a very vulnerable point for people and for me it is always a privilege to potentially make a difference in that person's outcome.

I've been inspired in my life and leadership pursuits by Neil Armstrong and Sir John Monash. Neil had the bravery to literally shoot for the moon, the tenacity to study and face personal challenges and to overcome fear in the pursuit of a human dream; Sir John Monash was a masterful military tactician and civil engineer who laid down much of the grid work for the electricity system of Victoria and had the foresight to benefit future generations.

Community Representative

Jacqui Gibson-Roos

Member of the Victorian Mental Health Tribunal, Community Representative ACEM Council of Education and Co-chair ACEM Reconciliation Action Plan Steering Group

I have not thought of this work as a career but more as a series of passions and opportunities that I wanted to be involved in, as I could see how this could improve the health care experience for some or all members of our community.

I started with the College in 2011. I was the first Community Representative on any of its entities. It was the Curriculum Review Project and I remember that first year was a very steep learning curve to understand the changes to training. It spurred me on though – inspired me to continue to be involved in the College.

I nominated for the Board because I found the voice of the Community Representative here is not only sought, but valued and encouraged. I was also inspired by the voluntary work Fellows and trainees do with the College – there is such a drive to continually improve the specialty for patients and their families.

I was very honoured to be asked to speak at the launch of the Inaugural National Reconciliation Action Plan (RAP) Conference, as I was fiercely proud of the work that went into the RAP and its implementation. I am so fortunate to have Dr Elizabeth Mowatt as a Co-Chair for this committee; her advice and guidance to me have been invaluable, and she has managed to harness my passions and, at times, outrage into real improvements for Aboriginal and Torres Strait Islander healthcare.

Have you downloaded the *Emergency Medicine Australasia* app yet?

Read the latest issue on your Android or iOS device, anytime, anywhere.

- Login with your ACEM membership credentials
- Only a median of 3 days from submission to first decision
- Consistently growing Impact Factor
- Published 6 times per year
- Download and subscribe HERE:

GET IT ON Google Play

Available on the App Store

AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE
ACEM

WILEY

19 - 565101

iStock.com/naumoid

Christchurch, a City of Resilience

With thanks to the people of Christchurch Hospital for sharing their stories. For the work they did that day, and continue to do.

Christchurch Ōtautahai is the largest city in New Zealand's South Island, home to about 400,000 people. A very English southern hemisphere city, a decade ago it was known locally for its gardens and greystone buildings, and the punts that ferried tourists up and down the meandering Avon Ōtākaro River in the city centre.

Today Christchurch is famous for resilience in the face of tragedy – a flipside to the city's beauty. In 2011 its iconic stone buildings were reduced to rubble in the most damaging earthquake to ever strike a modern city, an earthquake that claimed 185 lives and injured thousands more, leaving many more homeless. Christchurch has experienced adversity and trauma on a heartbreaking scale.

Earlier this year I sat with Christchurch Hospital Emergency Department FACEM Dr Jan Bone. I wanted to hear about how the Emergency Department coped the day the earth shook on 22 February 2011. Eight years following the earthquake I wanted to know how staff worked in a damaged hospital through a tragedy that struck at the heart of their own homes and families. How had that affected them in the months and years that followed the quake, and what was the rebuilding process?

Little did we know that, weeks later, Christchurch Hospital ED would again be activating its Major Incident Plan; this time to deal with the trauma of a mass shooting that would claim the lives of 51 people.

Instead of one, I have two stories. Both about courage and strength and both about the incredible work of the people of Christchurch Hospital ED on two very different days.

Christchurch, Friday 15 March 2019

Friday is a holy day for Muslims. At Christchurch's Deans Avenue and Linwood Avenue Mosques, men, women and children arrive for prayers. Many are inside for prayers, others still arriving.

———

1:40pm

A lone gunman opens fire at Al Noor Mosque in Deans Avenue, shooting men, women and children before driving across the city to Linwood Avenue Mosque – and shooting more. His spree is over at 1:58pm. He is arrested on the way to a third potential location.

Police apprehend the alleged gunman within 18 minutes of the first shots being fired. Within 30 minutes, the city is in lockdown.

For the staff of Christchurch Hospital ED, this is only the beginning.

A pre-school-aged victim arrives at the ED less than ten minutes after the shootings begin, she is carried in by a bystander who had run with her from the Deans Avenue Mosque. The Mosque is only 1,400 meters away across Hagley Park.

Multiple other victims rapidly arrive, along with armed police. The massive influx causes an activation of emergency plans ten minutes after the first shots are fired.

In the next 45 minutes, the ED will receive 44 more critically injured gun-shot victims.[1]

Almost all the injured are taken to Christchurch Hospital ED. It is a place that is prepared for disaster – experienced in it, recovering from it. On hand in this ED is a Major Incident Plan and Emergency Preparedness and Response Manual, something that has been revised again and again as new challenges and disasters have visited upon the city.

Within 14 minutes the pre-school child is on her way to an operating theatre. She's been intubated, CPR instituted, had an intra osseous line inserted, filled with blood and output returned.

———

Lockdown

It is not even 3:00pm when the media begins to report the hospital is in lockdown. Residents are advised to steer clear, except in case of emergency. Armed guards line the entrance to the ED, where staff are now at the frontline of caring for victims of the first terror attack in New Zealand's history. Elsewhere in the hospital, appointments are being cancelled, and patients and staff are told not to leave.

'Do not go outside', people are told. 'It is not safe'. There are rumours circulating; eight shooters on the loose, a shooter in the hospital. It is not for hours or days that the actual facts of the incident come to light. As with such major events, at the time there are many unknowns, so much more uncertainty. Mostly, nobody thinks or has time to notify their families: 'We are safe'.

Many people are not aware of the extent of the terror facing their city.

The last victim leaves the ED for theatre just two hours after the first one had arrived. The ED part of the journey for these victims is over rapidly and efficiently, which is a powerful testimony to the ED team and the response from the wider hospital. You need this total hospital teamwork for the response to be truly efficient.

———

Let out

The hospital stays in lockdown until the early evening. At 7:30pm, staff and patients are finally able to leave and new ones arrive. Within an hour, Prime Minister Jacinda Ardern makes her first address to the media. She confirms already 40 fatalities and says that, for the first time, New Zealand's national security threat level is at 'High'. Police request that all Mosques across the country shut their doors and advise people not to attend them until further notice.

Canterbury District Health Board later reports 118 people were treated or admitted in relation to the incident.[2]

The load on the whole hospital continues for hours, days and weeks while care continues for the multiple patients and their injuries.

———

Keeping faith

Within the ED, the prayers never stopped.

'Most victims were silent, but some were calling out to their God,' one consultant says.

'In all this overwhelming bloodshed and crying, it was too much for my colleague. She started sobbing and we ended up standing by a patient hugging with all the madness around us. It gave us just enough to keep going.'

The staff at Christchurch ED saw some of the worst injury cases of their careers. Many said it was made worse due to the fact that they knew the injuries were deliberately inflicted. What many now recall are the words of compassion and love that resounded the most that day, and in the days, weeks and months since.

Doctors, nurses, social workers, admin and radiology staff, physiotherapists, pharmacists and many others in the hospital that day speak of the compassion they felt and the support everyone shared.

One staff member recalls the hugs, words of kindness and the outpouring of love that was felt the most. 'At one point, when most of the patients had left the ED, there was a man I

1. Rapid Literature Review: Wellbeing recovery after a mass shooting. Canterbury District Health Board, 28 May 2019, p.3.
2. ibid.

was looking after who kept saying "thank you". I was telling him he was safe and we were looking after him. He started swearing and then started crying and praying in Arabic. Then we cried together. I took a step back and was tearful. One of our ED consultants saw me, stopped walking and gave me an enormous hug in the middle of the chaos. He later told me he needed it as much as I did.'

Most staff spoke of the feeling of working with their head down, following instructions given by police, but mostly, just powering through and making sure they were all performing to the best of their ability in these difficult and tragic circumstances.

One nurse remembers police holding their rifles outwards in a moment of urgent radio exchange, with fears of an active shooter in the department, something that was later found to be false. 'I was getting messages from friends and family, telling me there was a gunman outside shooting at the ambulances', she says. 'A policeman came over the loudspeaker telling us to get away from the doors and windows.'

'I came out of a bay intending to get some paracetamol for a patient', says a registered nurse who was on shift that Friday. 'I walked past the ambulance bay and saw a car pull up. Calling out for staff to join me, I hurried to the door to assist them. As I approached the glass doors, armed police appeared in front of me – guns forward.

'I backed away into the ED to find out what was going on. I was told there had been a shooting. As I walked over to the bay I was allocated, I noticed armed police had rapidly filled the department. I quickly texted family members: "I am at work, I am ok".'

She had no more contact with her family for the next two hours. 'I felt my phone vibrating a lot in my pocket – not knowing what had happened I just kept working. I later heard that the story of a gunman in the department caused untold stress to my family.'

Before 1:40pm it was your average day in the Christchurch Hospital ED, an ED physician wrote of her experience on 15 March.

I was in the 'workup' area and thought I would try and expedite the care of a man who'd been sent in by community radiology. He'd had a scan that showed a large space-occupying lesion in his brain that was causing pressure effects. He didn't want to stay in hospital – he had self-discharged two days earlier. He was worried about his dog at home alone.

I called the neurosurgical registrar and we disputed who needed to liaise with them after arranging the scan. It was such a common disagreement in ED.

I saw the social worker to find out if we could arrange something for his dog or anything else that might help. She told me she'd heard a child was coming in after being shot.

I wandered through to the resus area (through triage) and could already see armed police outside the waiting room. That alone was pretty emotional, but then a man ran in with a lifeless-looking child in his arms.

A team gathered. She was quickly intubated and they got chest compressions underway. I phoned the paediatric anaesthetist, who tried a couple of times to tell me I had the wrong person and must phone the duty person – until I mentioned 'mass shooting' and CPR on a child.

I grabbed the ultrasound machine and had a look at the child's heart – no fluid. No view in the abdomen – just an awful hole in her. The paediatric surgeon whisked her away for what we thought would be futile surgery. We heard later the child survived. It was truly miraculous. I took my ultrasound machine to a couple of other cubicles to perform some imaging, and saw more injured victims.

I recall the expression on all of our faces – a mix of true horror and determination to help.

As I approached the glass doors, armed police appeared in front of me – guns forward.

At one stage, I saw a man on the floor in resus and thought someone had fallen over, but it was bystanders who had rushed him through the door onto the floor, and were yelling that he was a victim of the shooting. We got him onto a bed before more victims were placed similarly. Ultrasonographers took over. They went cubicle to cubicle and I was directed to the trauma room to see a patient with brain on view. He was distressed with wounds in his torso and lower body.

But it didn't add up – how could he be distressed if it was his brain? We cleaned up to find the actual wounds and realised that the tissue wasn't from him. It was someone else's brain on his face and scalp.

Next in the trauma room was a man with non-survivable injuries. Suddenly, I was side by side with the neurosurgical registrar; all disagreements forgotten, he couldn't have been more helpful. Along with his consultant, they made the call that this was non-survivable. I left a trainee intern squeezing the bag for his breathing, while the social work team tracked down his wife.

My interaction with the neurosurgical registrar reminded me of the magic that seems to come over a department when we are challenged in the extreme like this. No more territories. No more egos. We all excel. We all work together.

I moved to the other side of the room to see a terrified-looking man with bullet wounds who had overheard the entire proceedings, including the decision to withdraw further active treatment on another victim. I held his hand to place an IV line and he squeezed tight. I reassured him he would survive and was safe here. I didn't think he would let go.

An orthopaedic registrar came to help and after some analgesia, line and basic imaging, the patient was sent for CT and on to recovery. The orthopaedic registrar would coordinate his care from there. It felt so much like the earthquake shift, but I had to remind myself we still had access to CT, and the power was on. We had working lifts. This was a different disaster – a human-made disaster. It was an awful truth and that made it all the more difficult to process.

Police arrived at the ambulance door saying they had an unconscious man. We grabbed a trolley and put him on. I could see his eye lashes fluttering as if he was feigning unconsciousness and told them to put him in another bay, rather than the trauma room, as he was not as unwell as he appeared. I followed him to the cubicle and took all his clothes off. There were no injuries. I asked for a police guard in case he was a gunman.

He woke and was complaining of chest pain. He was moved through to the observation ward and was later able to verbalise – he had been under several dead bodies, including a child and an elderly man. He had played dead and couldn't process what had happened. He was crying and had no family in town.

My patient with non-survivable injuries was now extubated in the observation ward. I wandered through to see his stunned family member sitting with him. A friend explained they had fled their country and another war zone and were refugees to New Zealand, where they were very happily settling in. Their two children attended local schools. One of their children had been located with injuries and was on the plastic surgery ward, but they were very worried about the eldest child, who they hadn't located yet. Later, I heard the child had been found on another ward, but this was incorrect. The child had died at the Mosque and never made it to hospital.

The department was now looking very empty, but we were advised we were in lockdown and unable to leave. It was only then that reality started sinking in and I suddenly realised that maybe we were at risk too. We were told to keep away from windows.

> *"I held his hand to place an IV line and he squeezed tight. I reassured him he would survive and was safe here. I didn't think he would let go.*

I opened my phone to see an enormous number of messages from concerned family and friends. My youngest son and daughter had become convinced I had been killed, as they hadn't been able to get in touch with me and the news had reported that the gunman had gone to the hospital. To my horror, I discovered my 14-year-old son had watched the attacker's live stream at school while in lockdown. The rumour had been that the attacker had driven from Al Noor Mosque straight to the hospital.

We were eventually released from the hospital later that evening. A colleague drove four of us home. There were hugs as we met other colleagues leaving the hospital at the same time. An incredible number of people work at a hospital and it's quite a sight seeing them all emerge through the main entrance. We were not allowed to exit through the emergency department. We passed a perimeter of slightly on-edge armed police. I tried to find comfort in this sight, but could not, even weeks later.

I arrived home. My family and neighbours had lit the outside fire and were supporting each other. This is how we managed after the earthquakes. After the quake, we had no power or water and freezers full of food that needed eating. We had many communal barbeques and supported each other.

This horror felt different. I couldn't do this. I hugged my children and sat inside. I was in awe of Jacinda Ardern on television. My brain was mush and she was standing there supporting us all, putting words to something unspeakable.

I didn't sleep well and was still in bed the next morning when my colleagues started texting their thanks to me. I just cried. Writing this now brings tears to my eyes again. Then my daughter and her friend came into the bedroom with a rose for me. More tears.

This horrific event brought out such an incredible response. So much love and support, refocusing on hate as the real evil, rather than a group of people. Hate formed out of fear and ignorance. It's been difficult processing all of the emotions, including guilt.

I like to think we are all bound closer together as a result of this experience. I am so grateful to have been a part of the care that day, and so grateful I was already at work, so I didn't have to think about coming in. I was also rostered on the earthquake shift and that decision was removed from me then, too. What an incredible privilege to do the work we do.

Returning to work

As Muslims in New Zealand returned to Friday prayer the following week, so did many doctors and staff to their ED. Some of those rostered on during the attack chose to take time to be with their families and friends, to gather their thoughts and try to come to terms with what happened in their hospital and to their city. Some chose to come back first thing, arriving the next day with hopes that the routine would provide them with a sense of normalcy at an emotionally chaotic time.

A head ward assistant spoke of her feelings in the aftermath. 'I found how very supportive people were and the kindness offered to staff was amazing,' she says. 'It brought people closer together. It made me feel proud to be part of this team. We all found it hard to believe something like this happened in New Zealand. I think we were in disbelief.'

'I am a new registered nurse and I was amazed at the teamwork, skills, confidence, empathy and support by all my team mates', says another nurse on shift that day. 'I believe the ED had a great response to the attack and everyone tried their best to help and support patients and colleagues. Fear was a passing thought. My main focus was helping and caring for people coming into the ED. I didn't think much about whether I would be at risk, as I was very focused on what was going on around me. It wasn't until afterwards that fear and risks crossed my mind.'

She added how touching it was to see the flowers around the botanical gardens. 'I was moved by the support and love from the Christchurch community.'

The trauma that comes with an event such as this has a flow-on effect that impacts so many people. The value of checking in with colleagues, supporting each other's mental health and remembering to seek help, even when busy, is vital. The medical community, both locally and globally, banded together with a flood of offers for support, wanting to help in any way, shape or form. It was this support that left those in the ED feeling less alone.

the release of adrenalin and other chemicals in such an event is like running a marathon! It gives you a heightened sense of alert, hence the fatigue. It's only weeks or months after that you realise the true extent of this incident.

When asked if she could identify a single act of kindness she had seen or experienced since that attack, hospital pharmacist Louisa Powerby said, 'So many! From outside the ED. The kindness from outside the ED was important. I'm really grateful, as it showed us we weren't alone in dealing with it and provided a bit more strength to get through some of the difficult days'.

'Inside the ED, people were constantly checking up on each other, taking time to talk and open up. Many hugs. Having the debrief sessions and talking with other ED colleagues, ED social things; it was so important, as those removed from the event, such as friends and family, could not quite understand what we had been through and, subsequently, how we were dealing with it.'

One of the physiotherapists on shift that day spoke of her experience following the attack. 'I felt the input by a police psychologist was very valuable,' she said. 'He put into context the simple things, such as tiredness. Apparently, the release of adrenalin and other chemicals in such an event is like running a marathon! It gives you a heightened sense of alert, hence the fatigue. It's only weeks or months after that you realise the true extent of this incident.'

Having lived through a disaster before prepared some hospital staff in how to handle the aftermath; the emotions that come with it, and the best way to care for their own mental health and the mental health of those around them. The whole-of-hospital support, not just the ED, is part of what got people through the 2011 earthquake and the devastation that surrounded them. Also, the support from colleagues around New Zealand, Australia and the rest of the world. Now, following this act of terror, it is that same avenue of seeking help, offering help and knowing what is available to you and others, which sustains people.

Author*: Inga Vennell, *Editor*

After the Quake

Dr Jan Bone

Dr Bone is an Emergency Physician in Christchurch, New Zealand. She has a special interest in teaching and trying to understand what makes people tick.

We wanted to share Dr Jan Bone's story on the aftermath of the Christchurch earthquake in 2011. Her words still mean so much and the horrors of the 15 March 2019 terror attacks in no way diminish the spirit of growth and rebuilding that is still abuzz in the city of Christchurch.

It has been eight years since the 2011 Christchurch earthquake which rocked the city and destroyed so much in its wake. In the lead-up to the opening of the new Christchurch Hospital – on the same tectonic plate – FACEM Dr Jan Bone reflects on that day, the emotional aftermath and the resilience of a city rebuilding brick by brick.

Jan had just finished night shift and walked into her multistorey apartment building when a 6.3 magnitude quake hit the city of Christchurch on 22 February 2011 at 12:51pm.

She describes it as 'truly terrifying'. Her home was shaking, cracking, breaking in front of her. Its walls shuddered, things were falling and through her building a thundering creak echoed. Jan did not think she would make it out. She knew her building was not safe.

Throughout all of this, like many of her peers, she could only think to return to her ED. 'I wanted to be somewhere I was needed and could do some good. And I knew in the ED I would be with all of my best mates', she says.

Christchurch's only hospital ED has since been praised locally and around the world for its response to the disastrous earthquake.

The early medical response in Christchurch Hospital highlights the need for preparation when it comes to disaster plans. The fast-responding hospital was responsible for a significant reduction in lives lost and the burden of injury, international medical journal *The Lancet* reported post-quake.

Jan describes the devastation of not only the city, but also the ED. On arrival she found the waiting room ceiling collapsed, furniture thrown around and beds everywhere. Her colleagues were visibly shaken and had not been able to stand through the tremors. Despite the damage and difficult working conditions, the ED team have been commended for their effective response in the face of an overwhelming influx of casualties.

Jan describes the disaster planning at Christchurch Hospital as extremely effective, especially following earlier quakes that hit the city in September 2010. Those quakes allowed staff to activate their disaster action plan in

iStock.com/Adrian Wojcik

response to the 97 injured people and were a lesson on how to effectively put their practice into place for the far more catastrophic quake of 2011.

Christchurch Hospital faced a number of obstacles immediately following the quakes, many due to extensive damage to the building in the aftermath of the powerful tremors. Some parts of the hospital lost power due to damage to the back-up generator, forcing staff to use head torches and mobile phone lights.

The loss of communication systems also meant that hospital departments had no knowledge of the extent of the damage and could not accurately anticipate the number of casualties that would come through their doors.

Patients arrived on foot, carried by members of the public, in the back of trucks, or strapped to the roofs of people's cars. Long lines of vehicles, including police, shuttled the injured to the doors of the hospital for urgent care. In response to others who were too frightened to go into the building for fear of its collapse, staff set up an open-air ambulance service to provide triage.

Rolling blackouts affected the entire hospital. In the pathology lab, staff drew blood by torchlight, then scurried through the darkened hospital to get it to the ED.

Within the first hour after the quake, 231 patients had been treated. 'We saw every sort of blunt trauma imaginable,' Jan recalls. The influx of patients led to concern that there were not enough units of blood to treat everyone. Alarmed, many staff and others volunteered to donate blood to ensure continued supply so patients could be treated.

Rolling blackouts affected the entire hospital. In the pathology lab, staff drew blood by torchlight, then scurried through the darkened hospital to get it to the ED.

'We made a decision that we would try to do the best for every patient, unless we got completely overwhelmed; only then would we resort to disaster triage', Jan says. Disaster triage would have meant that any patient or casualty who did not look like they would survive would not be treated. 'We were incredibly fortunate we were able to continue without resorting to that.'

In the aftermath of these natural disasters, the stories of the lengths to which Christchurch Hospital staff stretched themselves to give the critically ill care are incredibly harrowing.

The hospital, like the rest of Christchurch, is now rebuilding. Although plans for a new ED were already in place, the 2011 quake gave the process new urgency.

David Meates, Canterbury District Health Board CEO, has made an exceptional effort to limit the effect of changes, interruptions and disturbances to normal medical care for staff and patients in the hospital, according to Jan. 'He has an amazing ability to integrate management with clinical care.'

The new hospital has been designed with significant staff consultation. FACEM Dr Rob Ojala, a practising emergency physician at Christchurch Hospital and the clinical lead on the redevelopment project, spoke with the leaders of departments to understand their needs and to ensure the hospital's design is functional, as well as architecturally striking.

'There has been an effort made to maximise natural light and acoustics of the building, to create an open and airy space and reduce noise pollution. It's been an excellent opportunity for staff to have their say in the design, so that the building can facilitate best practice', Jan says.

The hospital rebuild is another significant milestone in the city's recovery. 'Seeing new development across the city is inspiring', Jan says. 'It gives people a feeling that there are things to look forward to, that the future is bright. For so long, we were grey and everything was broken. There are some mixed emotions, but it's mostly excitement now.'

Jan reflects on all of the support that Christchurch received, not only from their local and New Zealand community, but the ED community across the globe.

'During this horror and chaos there was an unwavering feeling of support. It made us all realise how connected we are in what we do and how supported and uplifted we all felt from the influx of community spirit', Jan says.

Now she and her team are looking forward to jumping in and getting started. 'We all can't wait to hit the ground running in the new facility. For a long time, we've been watching the progress and it's exciting to see; not only the progress here, but progress across our city.'

Jan's words, written before the mosque attacks – what Jacinda Ardern eloquently called New Zealand's darkest day – still resonate so strongly with the spirit of the Christchurch community. They were in the process of rebuilding when terror came to their city and they continue to rebuild now. They are a powerful and strong people who have now been through some of the worst horrors imaginable.

Christchurch is truly a city of resilience.

Author: Inga Vennell, *Editor*

The initial health-system response to the earthquake in Christchurch, New Zealand, in February, 2011, Prof Michael W Ardagh, PhD, Sandra K Richardson, PG Dip Heal Sci Viki Robinson, R Comp N, Martin Than, MBBS, Paul Gee, MBChB, Seton Henderson, MBChB, et al. April 16, 2012
Access at: https://doi.org/10.1016/S0140-6736(12)60313-4

Converge International Support Program

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

The program is a professional counselling service that offers confidential, short-term support for a variety of work-related and personal problems that may be affecting you at work or at home. The program gives you access to qualified professionals, including psychologists, social workers and management coaches.

Available for up to 4 sessions per issue. Sessions can be held over the phone, face-to-face or online, and are available 24 hours, 7 days per week to allow for assistance in crisis situations.

Your support program can help with a range of issues and concerns, including:

- Career
- Conflict
- Lifestyle
- Management
- Money
- Personal
- Work

1300 687 327 Australia
0800 666 367 New Zealand
www.convergeinternational.com.au

Converge international

Advancing Women in Emergency Section

The Advancing Women in Emergency Section (AWE) has elected its inaugral six-person executive, comprising five FACEMs from Australia and one from Aotearoa New Zealand. The AWE Executive will guide the purpose and activities of AWE, which was established in late 2018 to lead, nurture, facilitate and advocate for the leadership of women in emergency medicine.

FACEMs Dr Kim Hansen, Dr Clare Skinner, Dr Kimberly Humphrey, Dr Belinda Hibble, Dr Jenny Jamieson and Dr Suzi Hamilton have been elected to lead the Section, comprised already of more than 230 members of all genders.

'We see the scope of this work as very broad, supporting female emergency doctors through various career stages, from new trainees to senior leaders', says AWE Chair Kim, a FACEM of more than ten years, director of emergency medicine and consultant based in Queensland.

Kim and Clare submitted the initial proposal for the Section to ACEM in October 2018.

Following formal approval, AWE membership has tracked at a remarkable rate since it was first invited on the eve of the 2018-19 festive season, but Kim and Clare are not unfamiliar with strong responses to their push for growth in the culture and number of women in leadership positions in emergency medicine.

'We had more than 150 signatures within 24 hours of circulating our original proposal to form the section and now we have more than 230 members. It's a clear response from ACEM's members and trainees and we're glad to have the College's support,' Kim says.

The AWE Executive will work closely with the Section's members to achieve meaningful advancement for women in emergency medicine.

'I'm encouraged by the activity of women's networks in emergency medicine. There has been this great flurry, but now we need to harness that energy into meaningful policy change', Clare says.

The group has varied experience in leadership and College activities, but none are new to College life. Each has participated in a steering group, special interest group, panel or Faculty Board; or as an assessor or supervisors; or as a Council or committee member.

To be seen

Almost half of the College's nearly 2,500 active trainees in the FACEM Training Program are female, however, only 20 per cent of the directors of ACEM-accredited emergency departments across Australia and New Zealand are female.

Kimberly, a FACEM based in South Australia, says it has been vital for her to see that personal or family life need not be a barrier to her career advancement.

'It's important to see evidence that what you aspire to is possible. My director (who is a woman) has young children, as I do, and her success in this position shows me it is possible to juggle work with family life.'

For members of the Executive, AWE offers an opportunity to work with like-minded people to remove barriers, bias and glass ceilings that exist for women working in emergency medicine.

'It makes a big difference to have someone who I can go and sit with and chat about the struggles that I have, about such things as unconscious bias or barriers to leadership, and to get perspective from someone who has walked the same path as me and encountered the same challenges.'

For members of the Executive, AWE offers an opportunity to work with like-minded people to remove barriers, bias and glass ceilings that exist for women working in emergency medicine.

AWE Deputy Chair Jenny joined the group hoping the Section can find tangible means of addressing the issues facing women in emergency medicine.

Left to Right; Dr Clare Skinner, Dr Kimberly Humphrey, Dr Belinda Hibble, Dr Kim Hansen, Dr Jenny Jamieson and Dr Suzi Hamilton

'I want to advocate for more balanced representation on ACEM committees and the Board, as well as speaker representation at ACEM conferences. The success with the recent Constitution vote is certainly a step in the right direction, but this Section has an ongoing opportunity to help promote female leaders in emergency medicine', she says.

'A decade ago, as a young trainee and aspiring FACEM, I wouldn't have believed a group like this was needed. However, the facts show otherwise and the overwhelming response to AWE since its inception demonstrates that AWE is needed and wanted.'

Collectively, the group speak of not necessarily recognising that barriers existed for them until they came upon them.

Suzi – a FACEM since 2017 – says: 'The guys I was working with were great, but I went along to an event for women and I began to realise just how differently men and women work, develop and progress in their careers. Many career challenges affect women disproportionately and, often, they are not even noticeable until you hit them.'

She joined the Section because she felt the opportunity to work with like-minded people was 'an opportunity too good to miss'.

To be heard

Clare found perceptions of her changed when she had children. Even so, until recently she didn't see a need to talk about issues in emergency medicine that might be gendered.

'I feel that I am now in a position of relative safety. I want to make it easier for women to achieve things that I have been able to.'

Belinda says she has always been passionate about the advancement of women in emergency medicine, but was galvanised to join the Section and Executive by the incredible work of her female colleagues.

'Emergency medicine is not immune to the glass ceiling. AWE has an opportunity to bring gender discussions to the forefront of emergency medicine, to facilitate a safe space for members to seek and provide support, and to establish a mentoring network to encourage female leaders.

'I hope this will be a supportive space where we can agitate for change effectively by creating a clear and unified voice on issues relating to gender equity within the specialty.'

Kim, who first advocated for the Section and what it might achieve, hopes it can empower people.

'I want the Section to empower people – irrespective of gender – to overcome systemic biases and achieve their greatest potential.'

AWE reports to the Council of Advocacy, Practice and Partnerships. Applications to join the Section membership are open and available to any member or trainee of ACEM.

***Author: Natasha Batten**, Communications Advisor*

i More information

Apply online: https://ace.mn/AWE-Section

Contact:
AWEExecutive@acem.org.au
@hansendisease
@claski
@drhumki
@belinda_hibble
@drjennyjam
@Suzi_NZ
#AdvancingWomenEM

ACEM Core Values

ACEM has worked diligently to create a set of core values that reflect the best of each individual in the College and the collective spirit that drives us to advance emergency medicine. These values were decided upon following consultation with members, trainees and staff, and represent the standards of behaviour and attitude we work to each day. Our values embody the personal and professional growth we are capable of, and the work we do with and for our communities.

Equity

We are fair to one another, to our patients and to other health professionals. We work in ways that are impartial and aware. We acknowledge disparities in health outcomes across Australia and Aotearoa New Zealand and we strive for a system and service that is better.

Respect

We work for one another, for patients and for other health professionals. We practise in ways that defer to the inherent humanity of others, that give space and opportunity to the thoughts and minds of the people we work with, and that give regard to their position of strength or vulnerability.

Integrity

We care for one another, for patients and for other health professionals. We practise in ways that are honest, authentic and upright, and uphold the guiding principles and standards of emergency medicine.

Collaboration

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

At the heart of it

FACEM Dr Clare Skinner attended the College's Diversity and Inclusion Steering Group (DISG) meeting on 3 July. After several hours working through the day's agenda, the DISG discussed varying topics, including its own purpose and in what shape it will continue (if at all) once the second of its assigned years has passed (in mid-2020).

The meeting was attended by several members of DISG, as well as College staff: CEO Peter White; Executive Director of Education and Training Lyn Johnson; Membership and Wellbeing Manager Andrea Johnson; People and Culture General Manager Lisa English; and an array of other staff members from the College's Policy and Communications teams.

Clare stood in as chair for the meeting in place of President Dr Simon Judkins, who had flown to Canberra to discuss the Medevac Bill, and the importance of doctors and medical experts – not politicians – making decisions about health for small children detained indefinitely far from home.

Among the items discussed at the steering group meeting were the College's core values, an organisational set to represent, guide and gather into cohesion the College's members, trainees and staff. The values will supercede an existing set of staff values.

Selected Diversity and Inclusion Steering Group members – on developing the core values

"

These core values represent a set of standards that will hopefully help to hold us all to account; some common beliefs that all of us (trainees, members and staff) can abide by. They describe how we treat each other, our colleagues and our patients, and how we expect to be treated in return.

Jess Forbes

"

Developing the ACEM core values was so much easier, and more fun, than I thought it would be. It was easy to identify a small group of values which resonated well with the work of both FACEMs and trainees working in a clinical environment, and with ACEM staff supporting us with education, policy and regulation. While agreeing on the values was not hard, finding the right words to express the importance and meaning of our work was much, much trickier – we wanted to get it just right.

I hope that the core values will bring us all closer together. They will be useful when developing and prioritising strategy for the future. They will also be useful if conflict and tension arises, by making it clear that we are striving towards a common purpose.

Clare Skinner

The organisational values were chosen prior to the DISG meeting. They were determined by a consultation process with members, trainees and staff in late 2018 and early into 2019; and approved in June 2019 by the Board. The approval follows a process to discover what the selected values – integrity, respect, equity and collaboration – might represent.

The values are patient centred; however, also represent the best of what the College lays out in its mission and vision to do.

- Be the trusted authority for ensuring clinical, professional and training standards in the provision of quality, patient-focused emergency care
- Promote excellence in the delivery of quality emergency care to all of our communities through our committed and expert members.

Following the DISG meeting, Clare was invited to speak at the ACEM staff meeting, which is held monthly to discuss the latest College business and activities.

Clare spoke clearly and passionately about her work and her affiliations with the College. It's rare for a FACEM to attend and address staff at these meetings. From her place at the lectern she introduced herself and spoke of her team, the people, and all of the moving parts that go into making emergency medicine a success.

'I'm a director of emergency medicine at Hornsby Ku-ring-gai', she says. 'It's a hospital on the northern outskirts of suburban Sydney.

'We have a team of 200 medical, nursing, clerical and technical staff. We treat 45,000 patients a year. About 30 per cent are children, about 25 per cent are aged over 70.'

Clare explained her role as chair of the Emergency Medicine Network for Northern Sydney Local Health District, 'The district has a catchment of just over one million people relying on our hospitals for emergency medical care', she says.

She describes how none of this would be possible without teamwork, every person working together towards a successful outcome.

'You are all part of my team', she states and her voice hangs in the air, resonating with the ACEM staff.

With these words Clare highlights the collaboration and teamwork that epitomise the values of the College. The words reiterate why we do what we do, the College as a whole, its members and trainees and every moving part that goes into building emergency medicine step by step.

Moving forward

There are several more steps to go as the College seeks to embed the values in the day-to-day business and activities of ACEM and all its people.

The first among many implementation plans is to translate these values into Māori and Woi wurrung, the traditional language of the Wurundjeri people of the Kulin Nation, upon whose lands the College's Melbourne office sits.

Other steps will be more subtle. The values will be rolled into branding on reports, posters and at events; screensavers will be developed and email signatures changed.

But the physical roll out of these values, is not the only way they will become visible and adopted. That will also come from their personal absorption by several thousand individuals across Australia and New Zealand; each of whom cares for patient outcomes; each of whom strives to achieve better each day for the health and wellbeing of all involved in their care; and all of whom couldn't do any of this without the equity, respect, integrity and collaboration of their team.

***Authors: Natasha Batten**, Communications Advisor*
***Fatima Mehmedbegovic**, Strategic Priorities Implementation Manager*

"

Sitting around brainstorming words and then narrowing them down to a select few did feel like we were getting to the core of something. The reality that I saw was that most people have inherently good core values; being able to translate that into College processes and have that flow-on effect into all ED workspaces would be fantastic. I was really glad that the consultation with the membership revealed alignment with what we thought was core. Rendering what we see as core as a collegiate group into four values should help attract the right partners, inspire the right people and guide us in making everyday decisions.

Ajith Thampi

"

Our values shape us. In my initial nomination letter, I spoke of my core values, those elements of me which keep me focussed and allow me to reflect on decisions made, interactions with others, and how I approach challenges at work and outside of work. The core values we have agreed on for ACEM, its members and staff, should be integral and central to how we approach our work, our interactions and the decisions we make for our College, our EDs, our staff and patients. We often speak about having common goals. They give us a sense of purpose and a common direction. I think agreeing on our core values will do much the same.

Simon Judkins

Associate Professor Geoff Couser

Associate Professor Geoff Couser is a Senior Staff Specialist in the Emergency Department at Royal Hobart Hospital and is convener for the upcoming Annual Scientific Meeting (ASM) in November.

Why emergency medicine?

I love the variety and the challenge of dealing with the unexpected and being on the side of the patients and the emergency services. I feel I identify more with my colleagues in the emergency services than I do with other medical colleagues – that's the way emergency medicine is. We really are a team and we understand the systems. The reasons that attracted me into emergency medicine initially are still just as valid, which is pleasing. We, as a specialty, are the practical expression of a universal and equitable healthcare system, and that's something to be proud of.

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

The problem solving is what I love, and working with the residents, registrars and nurses to deal with diagnostic and management dilemmas, and then navigating an increasingly dysfunctional system to make what needs to be done a reality. Both are enjoyable and challenging!

What do you do to maintain wellness/wellbeing?

I reduced my workload to half time nearly 13 years ago when my second child was born, and I have to say that's been fantastic. In addition to being around for the family it's made me realise that at this stage of my life the most precious asset I have is flexibility. That's allowed me to pursue my other interests, such as politics, land conservation, bushwalking and reading. And still be around for the school drop-offs and pick-ups whilst they're still a thing.

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

Developing emergency medicine as a recognised discipline at the University of Tasmania. I managed to introduce some worthwhile innovations that were very well received by students and staff alike. This exposed medical students to the need for specialist medical knowledge in acute care and demonstrated to them that emergency medicine plays a critical role in the health system. I feel that will pay dividends for us and our patients in the years to come.

What inspires you to continue working in this field?

The opportunities to make things better for our patients. This might sound like a bad reason, but if good people don't step up and put themselves into 'uncomfortable' or 'unpleasant roles' (like convening an ASM – ha ha, or being rostered in a busy ED at 11:00pm on a Saturday night), then we'll all be the poorer. Our communities rely on us. It's the same reason I ran for parliament (and nearly got elected) a few years back.

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

Go for it, pursue your passions with vigour, but understand that Rome wasn't built in a day or even your lifetime.

Why convene another ASM?

That's a great question, of which I'm not really sure of the answer myself. The last one was a lot of work! I believe in 2012 we broke some new ground about how conferences should be run, and it's important to remember that if you're going to assemble around 1,000 people together you'd better make it worth their effort. We don't go to conferences for the latest information - knowledge is disseminated so quickly and effectively these days - but we go for the connections and the interpretations. My view was that this year we'd all benefit from hearing from speakers from outside our world, in that they can shine a light on our practices and force us to reflect and reinterpret what we do. It's also a conference for the members by the members…it's a real creative process to bring it all together, so I hope it works.

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

Apart from the 36th ASM in Hobart in November, I'm looking forward to the attitudes and philosophy of emergency medicine permeating the rest of the healthcare system. That our sense of urgency, patient advocacy and systems thinking infiltrates our inpatient colleagues so that it's not a chore to be on-site at 11:00pm on a Saturday night. That we 'Choose Wisely' and reduce low value care in the system. Emergency medicine is at the forefront of so many good things, and when we deal with the overcrowding and access block we'll be free to focus on so many positive things. Oh, the things we'll do…

Dr Rachel Goh

Dr Rachel Goh is an ACEM Advanced Trainee currently working at Alice Springs Hospital on rotation from St Vincent's Hospital in Melbourne, with an interest in paediatric emergency medicine and Indigenous health.

Why emergency medicine?

I initially wanted to do ophthalmology. As a medical student, I did my Bachelor of Medical Science at the Centre for Eye Research Australia and loved the diagnostic, technical and procedural aspects of being an ophthalmologist. However, as an intern at The Royal Melbourne Hospital, I had a fabulous time in the Emergency Department, thanks to the amazing consultants who encouraged my growth and learning. I still remember one of my consultants, Dr Martin Dutch, patiently talking me through my first lumbar puncture — a rare champagne tap! What I loved about ophthalmology I found in emergency medicine, but with greater variety, greater momentum and more emphasis on team-based care (and a whole lot more fun!).

After spending a year as a resident at The Royal Victorian Eye and Ear Hospital, Dr Stephen Parnis, who, at the time, was President of the Australian Medical Association (AMA) Victoria and had always believed in me, convinced me to follow my passion and join him where I currently work as a registrar at St Vincent's Hospital in Melbourne. I love my job and I feel so grateful to have the colleagues and mentors that I do.

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

I garner great satisfaction from being able to diagnose and make someone feel better on one of their worst days. However, I suffer imposter syndrome on a daily basis. As a trainee, I often look at my consultants and wonder how I will ever be as wise and knowledgeable. It took me a few years, but I've finally come to realise that learning something new every day is what makes the job challenging and enjoyable.

What do you do to maintain wellbeing?

Wine, cheese and good friends! I'm currently in Italy inhaling pasta, gelato and Chianti with two girlfriends. When I'm not on annual leave, I love learning new skills with friends. I recently learnt how to ride a horse and make blue cheese, both of which were immensely fun. At work, it's my fabulous nursing and medical colleagues who listen, debrief, laugh and cry with me, and keep me sane whenever things get a little too hairy. We're a little family.

What do you consider your greatest achievement? What do you look forward to in the future of emergency medicine?

Through a number of leadership roles in the AMA, I have had the privilege of being part of a committee of junior doctors lobbying for a better culture in medicine.

I am so proud of our current trainees. The new generation of doctors is acutely aware of the bullying and training issues that plague our profession, and we are determined not to repeat them.

What advice would you have liked to receive when you began your training?

At the end of the day, what makes you a good doctor is how much you care about your patients. It does not matter what training program you get into, how many papers you have, which professors give you a glowing reference, or how much money you make – what matters is that you care about your patients. The honour of being trusted to give advice, the gratitude for treating someone through a difficult illness, the warmth of knowing you've helped a colleague grow – these things never grow old.

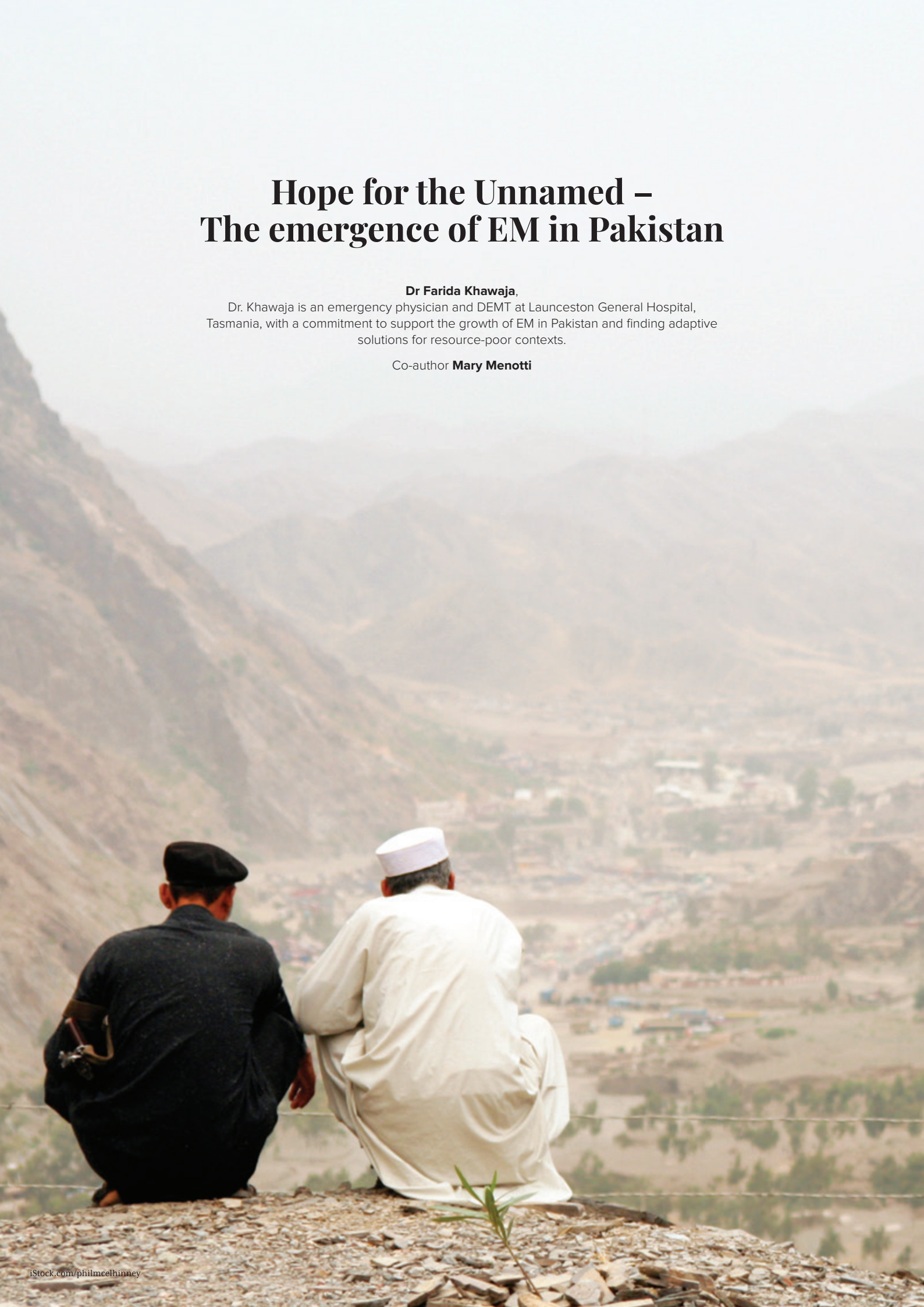
What inspires you to continue working in this field?

Becoming half the physician my mentors are. The doctors I greatly admire and strive to role model are the ones who somehow, incredibly, manage to unfailingly treat patients, colleagues and juniors alike with compassion and kindness in the face of endless clinical demands, exorbitant waiting times, aggressive patients, exam after exam, unreasonable bureaucracy, and a host of patient personality disorders. The long hours and challenging work we do wear us all down from time to time, but these superstars inspire me and push me to be a better doctor.

Hope for the Unnamed – The emergence of EM in Pakistan

Dr Farida Khawaja,
Dr. Khawaja is an emergency physician and DEMT at Launceston General Hospital, Tasmania, with a commitment to support the growth of EM in Pakistan and finding adaptive solutions for resource-poor contexts.

Co-author **Mary Menotti**



iStock.com/philmcelhinney

At a rural hospital in Pakistan, a mother keeps vigil next to her sick daughter. Quietly, she swats away flies. Near her, 100 other children and their mothers share the same circumstance. Among them, six nurses struggle to impart care at the 20-bed paediatric emergency department.

In some parts of rural Pakistan, children under the age of five are not named.

United Nations Human Development Indicators show 78.8 out of 1,000 children born in Pakistan will die a preventable death by age five. Australia suffers 3.7 such deaths per 1,000 births, and New Zealand 5.4.

As is the case in many low-income countries, access to reliable emergency care in Pakistan is scarce, contributing to increased morbidity and mortality.

In impoverished areas, life-saving interventions are significantly delayed by a lack of first responders, and by the lack of structured emergency care in many of the country's regional and remote areas.

Over the past 15 years significant local and international effort has gone into developing emergency medicine in Pakistan. The aim is to garner support from all sectors of healthcare; public, private, not-for-profit and military.

Tireless work by emergency physicians, surgeons and general practitioners to raise awareness of structured emergency care has raised hopes for the delivery of critical healthcare in Pakistan.

One of the groups working towards greater care is the Pakistan Society of Emergency Medicine (PSEM), founded as a platform to discuss current and future challenges of emergency medicine, and to deliver messages on the importance and value of emergency medical care.

Emergency Life Support International

In 2018 PSEM played a significant role in the local launch of Emergency Life Support International (ELSi), a not-for-profit two-day course designed in Australia to assess and stabilise common emergency medicine presentations. The Society had identified a need for a basic non-trauma course in Pakistan that would impart a standardised approach to non-trauma conditions such as shock, sepsis, neonatal resuscitation, ischaemic heart disease, diabetes, seizure and poisoning.

Support from the Sri Lankan EM Society, and exposure to the established ELSi program in Sri Lanka, convinced visiting EM physicians from Pakistan of the course's relevance and adaptability to the Pakistani context.

Since 2018, four courses have been held locally – run jointly by a group of self-funded FACEMs and local trainee facilitators. The courses have been conducted at major hospitals in Lahore and Islamabad, as well as at district hubs, where the training was given full support by local authorities.

Among its advantages, ELSi gives consideration to the local context and its healthcare priorities. Since its launch, 80 Pakistani physicians have participated and low participant-to-facilitator ratios have maximised opportunities to practice and empower often under-resourced frontline physicians.

Trainee facilitators are also playing a key role. The idea is to establish a cohort of ELSi facilitators who can provide ongoing training, however, the process is not without challenges.

The need to upscale rapidly and deliver quality, resource-intensive training is difficult and logistically complex, particularly when travelling to remote areas. Additionally, the delivery of ongoing ELSi support while working in a clinical setting is equally challenging. One option being explored is to use a trainee-focused clinical discussion group on the social platform WhatsApp. It is being trialled, with discussion moderated by local and overseas emergency physicians.

Another challenge is the sustainability of the course in a low-income environment. To date, local and international emergency physicians have volunteered their time and given financial aid to ensure the course could run. In major cities the courses have been subsidised to minimise the fees for participants, while in district health centres, course costs have been donated. PSEM is devising a fee structure for the course in Pakistan, but ongoing support (through cash or time donations, or agency funding) will be essential to support the ongoing delivery of ELSi in Pakistan.

Moving forward

ELSi has created a broader awareness of emergency medicine in Pakistan; bridging the gap between medical specialties. A shared goal to create a common understanding, a language for healthcare that everyone can speak.

This is a turning point for emergency medicine in Pakistan. These past few years have seen exponential growth in training, care and service provision, and have exemplified the great strength and possibility that comes with the wholehearted commitment of a global community.

ELSi participants have so far provided overwhelmingly positive feedback about the skills they have learnt and the opportunities ELSi is providing their country.

Two physicians, Dr Ghanzafar Saleem and Dr Saima Salman, from the Indus Hospital in Korangi, Karachi developed the Certificate Program in Emergency Medicine (CPEM). The one-year program addresses the need for doctors who are trained in mid-tier emergency medicine.

The certificate program also has international support, with Harvard Medical School Brigham and Women's Hospital's Dr Megan Rybarczyk and Dr Zayed Yasin working closely with the Indus Hospital team to develop a responsive, robust and accessible certificate program.

For the past year, the program has been run by emergency physicians from around the world who have volunteered their time and expertise to share their skills and knowledge with local candidates. The trips have been funded by the Harvard Medical School Centre for Global Health Delivery – Dubai and the Habib Bank Foundation, which paid for transport, board and lodgings. I was one such volunteer in 2018. I spent six incredible weeks facilitating CPEM, and found much to gain from the breadth, complexity and number of patients presenting each day. I found it to be a model program from which other institutions can learn how to impart emergency medicine skills and meet a need for emergency approach.

One distinct advantage is the way it is fostering collaboration between different specialties and institutions. Patient outcomes are being enhanced by the generous spirit involved in running and sharing the program, which Dr Saleem and Dr Salman have wholeheartedly tried to do.

This is a turning point for emergency medicine in Pakistan. These past few years have seen exponential growth in training, care and service provision, and have exemplified the great strength and possibility that comes with the wholehearted commitment of a global community. As the capacity of emergency medicine grows in Pakistan, the challenge will be for local physicians to lead continued growth, and to support ongoing collaboration in the delivery of quality training and emergency medical care.

More information

For further information please contact the Global Emergenecy Care (GEC) Country Liaison Representatives for Pakistan, Dr Farida Khawaja, sitarifari@gmail.com; Dr Rizwan Qureshi, rizwan_azhar@yahoo.com

FACEMs participating in ELSi

Rehan Akram, Andrew Climie, Timothy Cowan, Lai Heng Foong, Yasir Khattak, Farida Khawaja, Nadia Maqbool, Fiona Reilly, Asim Shah and Alan Tankel. With thanks also to PSEM leaders Dr Abdus Salam Khan and Dr Khawaja Junaid Mustafa.


iStock.com/hartmanc10

Emergency Medicine Abroad

Dr Kago Mokute
Dr Mokute is an emergency physician working in Princess Marina Hospital in Gaborone, Botswana.

Botswana has a population of just over two million people, smaller than many cities. The capital, Gaborone, has a few hundred thousand people. The country has 30 hospitals, with 28 public and two private hospitals (a third opening soon). Two public referral hospitals (one yet to be opened) and all three private hospitals are in Gaborone. There are only four emergency physicians in Botswana, all of whom are based in Gaborone; two in private practice and two in public hospitals.

I am an employee of the University of Botswana at the country's main referral hospital, Princess Marina Hospital, in Gaborone. We run a joint specialty program with the University of Cape Town, South Africa, in order to meet the huge need for emergency physicians in Botswana. Our registrars spend half of their four-year training program in Botswana, completing the examination of the South African College of Emergency Medicine and their Master of Medicine dissertation. Following this, registrars transfer to Cape Town for further clinical rotations in preparation for their Fellowship examination.

I work full-time as a lecturer and emergency physician. At Princess Marina Hospital, we see 1,800 to 2,000 patients a month; the ED staff comprises 16 doctors, of whom two are emergency physicians, 27 nurses, and eight healthcare auxiliaries and orderlies. Despite patient numbers that are not so high, the emergency department is often overcrowded, due to input, throughput and output factors. Recently, overcrowding has become a significant problem and has led to some patients waiting more than 24 hours to be seen. Patient flow factors are mainly related to an acute shortage of doctors. Triage is run using a modified version of the South African triage scale.

Our most common presenting complaints are first trimester pregnancy complications (15 per cent), of which incomplete miscarriages are the most frequent (7.8 per cent). We see a high proportion of trauma, with closed fractures being the single most common presentation (8.6 per cent). The remaining complaints are a mix of infectious and non-infectious diseases. Being a tertiary referral hospital, we see a large number of very sick patients. Our admission rate is about 40 per cent of all patients seen.

The biggest day-to-day challenges facing an emergency doctor in Botswana are mostly management-related, the main test is managing a department that I have little control over. The management of public hospitals in Botswana is centralised and doctors on the ground do not have much say around how the hospitals are run. Most of the essential resources are under the control of the central government, be it staff, equipment or medications. In my experience, resources provided are not always reflective of needs and shortages.

Not unique in this context, staff turnover is high. There are always new people coming and experienced people leaving, either on transfer or in search of new opportunities. As in many countries, people are driven away by the frustrations of working in a public hospital. Currently, the Botswana Ministry of Health and Wellness is transferring doctors throughout the country. This process is done without any consultation or contribution from the clinical departments in which these doctors work. Although this has good intentions, as it endeavours to improve the availability of doctors in rural and under-resourced areas, it impedes the growth of our ED. We are continuously losing doctors that we have worked hard to train and develop in emergency care. We find ourselves having to teach and deal with the same things over and over again.

If I could advocate for one change in emergency medicine in Botswana, I would aim to decentralise healthcare management and allow EDs more control over their resources. This change would help the whole health system, not just EDs.

Working in the Princess Marina Hospital Accident and Emergency Department is both paradoxically frustrating and fulfilling at the same time. There are challenges, many of which are man-made. I feel it would help greatly if I had more input or control over certain management processes. However, many challenges also mean that there is much difference to be made. I guess that is what I love most about my job, the feeling that I am making a difference in my patients' lives despite all the challenges that together we face daily.

Postcards from the Edge: Solomon Islands

Dr Donna Mills

Dr Mills is a FACEM employed by the Sunshine Coast Hospital and Health Service, Queensland, currently working in the Solomon Islands.

iStock.com/Mickrick

Australian Aid

Interviews with FACEMs and trainees returning from global emergency care work, highlighting their experiences and involvement in emergency medicine abroad.

This edition's Postcard comes from Dr Donna Mills.

Welkom lo Hapi Isles.

The Solomon Islands is a beautiful archipelago of 1,000 atolls and islands that are home to 700,000 people, who live scattered throughout the nine main provinces from the Shortlands in the west to the remote islands of Temotu in the east. The National Referral Hospital (NRH), in the capital of Honiara, provides care to the 90,000 people living there, as well as providing tertiary-level care for all the provinces. As a developing nation, the healthcare system and, in particular, the NRH Emergency Department faces many challenges, just one of which is the burden of communicable diseases, such as dengue, malaria and tuberculosis that are seen on a daily basis, where a 'simple' case of epistaxis may actually be dengue. Another challenge is the growing prevalence of non-communicable diseases (NCDs), such as diabetes and cardiovascular disease. The impact of these NCDs is further exacerbated when there is little infrastructure to manage the conditions before the patients present to the ED with acute complications.

Tell us about your global health work

For the past five months, I have worked alongside Dr Trina Sale (Director) and Dr Patrick Toito'ona (Deputy Director) in the NRH ED as an Emergency Consultant Advisor. My role is part of the Solomon Islands Graduate Intern Supervision and Support Project (SIGISSP), which is funded by the Australian Government's Aid Program and managed by AVI (formerly known as Australian Volunteers International). Technical support is provided by ACEM as a key project partner.

This project was initially set up at the request of the Solomon Islands Government to assist with the supervision and support of medical graduates for internship. Specific assistance was requested for the NRH ED after a report in 2014 deemed it to have no capacity to supervise or train these interns. At the time of review, conducted by ACEM, there were no specialist emergency physicians in the Solomon Islands. Increasing urbanisation and the burden of communicable and NCD, without the associated development of ED capacity, led to near breaking point for the department. The review identified the following intial priorities: increased leadership capabilities; improved triage procedures; improved patient flow and timeliness of care; and support for training in emergency medicine.

As part of this project, a Solomon Islands Triage Scale was designed and implemented with the assistance of previous SIGISSP volunteers, Dr Rob Mitchell (FACEM and former SIGISSP senior registrar and intern supervisor) and Lynne Wanafalea (former SIGISSP ED nursing advisor).

In the last 18 months, there has been increasing focus on postgraduate training for emergency medicine in the Solomon Islands and this has been a large focus of my time at NRH. Currently, trainees who wish to specialise in emergency medicine need to live and work in Papua New Guinea or Fiji for four years in order to obtain a Masters of Emergency Medicine. Their studies are funded by the Solomon Islands Government, however, they are lost to the Solomon Islands medical workforce. On average, scholarships are awarded to emergency medicine trainees every four years, meaning there is a significant delay until there are enough qualified emergency physicians to enable full staffing at NRH and provincial hospitals, such as Gizo and Kilu'ufi. In collaboration with Dr Trina Sale, Dr Patrick Toito'ona and Dr David Symmons (FACEM), the groundwork has begun for a pathway to postgraduate training in the Solomon Islands.

What has been one of your highlights while working at NRH?

Experiencing the enthusiasm of the ED doctors to improve their personal knowledge and their department, and to further emergency medicine as a specialty has been a highlight. Doctors of all levels regularly turn up on days off for education sessions and workplace projects (including cleaning the department!). This is despite significant challenges, both at work and home, that impact on their ability to do their job. In spite of the significant numbers of patients presenting after hours, x-ray and pathology are only open during normal working hours. The malaria lab is shut on the weekend. The blood bank is not open overnight. Some doctors travel for hours before and after shifts on public buses or hospital transport to get to and from work. Some of them have no electricity at home.

Another significant highlight of my time at NRH has been working alongside a young, strong female leader, Dr Sale, as she strives for change in emergency care for both her department and her country.

Tell us about some of the challenges you have encountered

Working at NRH has been a big learning curve for me. One particular case brought home some of the significant differences between working in the Solomon Islands and Australia. Just before handover on a Friday afternoon, a taxi pulled up in the ambulance bay. Four young men raced in carrying a sick child and placed him on a bed that was vacant only because the previous occupant had gotten off when he saw what was happening. Not long after being placed on the bed, the patient went into respiratory arrest. Bag-valve-mask (BVM) ventilation was commenced and the patient, a five year-old male, was intubated shortly afterwards. Collateral history proved difficult as his family and witnesses could not be found. On examination, a large boggy mass was identified behind his left ear with an associated hemotympanum. Pupils were bilaterally dilated and minimally reactive. There is no CT scanner in Honiara (or the Solomon Islands, for

that matter). There is no intensive care unit in the country. Organ donation is not available. Once the family were contacted and arrived in the ED, they explained that the patient had been sleeping in a hammock near people who were playing with a slingshot. He was hit by a stray rock in the back of the head and fell out of the hammock. We then taught his family how to hand ventilate with the BVM and advised them that once they had all said their goodbyes, they could stop ventilating their son/brother/cousin. I have since learnt that this 'wantok ventilation' is not uncommon.

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

Balancing an active engagement in international emergency medicine with full-time employment in Australia can have its challenges. Fortunately, I have had the support of the Sunshine Coast Hospital and Health Service ED. This has allowed me to access leave without pay for my current assignment and the use of leave for shorter visits.

One piece of advice for FACEMs or trainees looking to become involved in global emergency care?

One of the biggest lessons I have taken away from my experience is the importance of building relationships with local colleagues. These relationships have enriched my personal experiences and, more importantly, allowed me to help work towards goals for local emergency teams. It isn't always easy. I had to shift my expectations from the immediate cause and effect that we as emergency practitioners in Australia and New Zealand are accustomed to, instead looking towards long-term goals and results. However, maintaining an ongoing relationship with colleagues in Fiji (and hopefully the Solomon Islands) has allowed me to see the growth and achievements of the inspiring young doctors and nurses working in the Pacific and that is what keeps me coming back for more!

AVI
inviting change

AUSTRALIAN HIGH COMMISSION
HONIARA

More information

SIGISSP is an ACEM-supported activity. The project is managed by AVI, with funding for the project and Dr Donna Mills' position provided by the Australian Government's Aid Program in the Solomon Islands.

Global Emergency Care Conference

Education and research: the building blocks of effective global emergency care capacity development

This two-day event is designed to equip emergency clinicians with the skills, resources and networks to become involved in the development of emergency care in resource-limited settings.

Global Emergency Care Workshop
18 September 2019

An interactive, small group workshop developed by a team of clinicians with extensive experience working with multiple aid/health organisations in countries such as Myanmar, Papua New Guinea, Uganda, Tanzania, South Africa and Afghanistan.

The Workshop is your opportunity to develop the skills you need, before engaging in emergency care projects across the world.

Explore and discuss:

- The current status of emergency care globally
- The identified priorities for global emergency care development projects and clinicians
- How to complete a needs assessment
- How to create, develop and deliver a project framework
- The essential toolkit of skills, networks and resources an emergency care clinician requires

Global Emergency Care Symposium
19 September 2019

A one-day symposium bringing together a wealth of local and international speakers with unparalleled expertise in emergency education and research in resource-limited settings. Be inspired by incredible projects and learn more about what's planned.

The program is filled with opportunities for interaction and networking. It will open your eyes to your potential to impact global health outcomes.

The program includes insights into:

- The essential elements of emergency care education in resource-limited settings
- Appropriate methods for effective teaching and learning
- What resources already exist?
- What is the evidence-base for global emergency care programs?
- How can emergency care programs be more effective?
- What areas of research should be prioritised?

WHEN
18 September: Workshop
19 September: Symposium

LOCATION
Workshop:
Monash University
553 St Kilda Road, Melbourne

Symposium:
Royce Hotel
379 St Kilda Road, Melbourne

WEBSITE
https://cvent.me/NGLmW

CONNECT WITH US
@EmergEdu
EmergEdu

CONTACT
E: etc@alfred.org.au
T: +61 3 9903 9298

AlfredHealth

MONASH University

ACEM ACCREDITED CPD ACTIVITY

Each day of the conference is equivalent to eight hours of CPD.

www.emergencyeducation.org.au

Innovation and Collaboration – Delivering Emergency Training in Urban Pakistan

Dr Rizwan Qureshi and Dr Faryal Waqar

Dr Qureshi is an Emergency Physician at Liverpool Hospital, Sydney, NSW, with an interest in focussed learning in emergency medicine. Dr Waqar is an emergency physician in Sydney, NSW, with an interest in global emergency care and teaching.

On a hot and humid afternoon in Karachi, an unconscious young man was rushed to the ED of a local hospital by a panicking mob of relatives. He had fallen from a ladder after being electrocuted. The senior medical officer on duty rushed to assess the patient. Much to the dismay of the crowd, he pulled a piece of cotton from his pocket, tapered it between his fingers and gently touched the corners of his patient's eyes, and then turned and gave them the news of his demise. The crowd burst into tears followed by screams of despair.

This was a common scenario 15 years ago in Karachi. Unfortunately, even today the country faces similar challenges in managing time-critical resuscitations across public and private hospitals. The approach for dealing with this type of presentation was, and often still is, unfamiliar to many Pakistani clinicians practising emergency medicine.

FACEMs Dr Rizwan Qureshi and Dr Faryal Waqar are originally from Karachi and Lahore, respectively, two of Pakistan's most densely populated cities. Both cities, Karachi (16 million people) and Lahore (nine million people), have extremely high incidents of trauma, cardiac and paediatric emergency presentations. Pakistan is a country with a population of over 200 million people, with nearly 40 per cent living in cities and towns. Most cities have limited access to a centralised ambulance service and very few have properly equipped EDs. A typical urban ED manages 600 to 800 presentations a day, a few hundred of these patients travelling more than 100km from extremely poor rural areas to access care. Recognising these limitations, both Rizwan and Faryal wanted to return to Pakistan and help in whatever way they could.

Joined by a team of eight other enthusiastic emergency physicians of Pakistani origin, from both Australia and the United Kingdom, they delivered two-and three-day courses focused on the principles of trauma resuscitation, adult and paediatric resuscitation, ultrasound and communication. Pitched at predominantly urban emergency practitioners working in Karachi and Lahore, participants ranged from junior doctors to emergency physicians working in public and private sectors.

Emergency Focus Course – collaboration and innovation

Rizwan and Faryal met with a group of emergency physicians associated with the Pakistan Society of Emergency Medicine (PSEM) to better understand the state of emergency medicine in Pakistan. This meeting highlighted some of the existing challenges of delivering quality emergency care. These challenges included the absence of a structured EM training program, and the need for training and upskilling junior doctors and emergency physicians.[1,2,3] By utilising the knowledge and skills of their self-funded group of ten emergency specialists, an inexpensive course was developed to enable a range of doctors from across the country to attend.

The course aimed to cover core EM principles and included point of care ultrasound skills. The course also sought to create a mentoring platform where participants had the opportunity to seek ongoing professional guidance.

A three-day course was run in Karachi (55 participants) and a two-day course in Lahore (35 participants) in January 2019. The three-day course content included topics based on high presenting instances encountered in these cities, namely trauma (day 1), resus and cardiac presentations (day 2), paediatric emergency presentations (day 3), as well as communication skills.

Faculty demonstrations of resuscitation simulations were

1. Rehmani R. Emergency medicine: a relatively new specialty. *Journal of Pakistan Medical Association*. 2004 May;54(5):232-233.
2. Razzak JA, Ahemd A, Saleem AF, et al. Perceived need for emergency medicine training in Pakistan: A survey of medical education leadership. *Emergency Medicine Australia*. 2009 Apr;21(2):143-146.
3. Shahid M. Development of emergency medicine in Pakistan. *African Journal of Emergency Medicine*. 2009;1:99-100.

provided, as well as short lectures highlighting core topics in EM. Skill stations and simulation sessions were run in small groups. Participants were tested on key areas taught throughout the day and provided with detailed feedback, both in their roles as team leader and team member.

Trials and tribulations: Communication skills, equipment and navigating local systems

The greatest highlight of running this course was witnessing the joy of learning on the faces of participants and hearing about how the training would benefit them in their daily work. The feedback was particularly positive for the team training and communication skills segment, which was expressed both verbally and in participant surveys. As an area in which clinicians in Pakistan often have little formal training, the 'breaking bad news' segment was commended as especially helpful and relevant.

As is often the case, there was a broad range of skill levels to navigate when delivering the course, with participants, ranging from consultants to registrars and medical students. It was necessary to organise participants according to their level of experience wherever possible, as seniority could affect the willingness to modify or adapt practice.

The group faced multiple challenges along the way, including sourcing equipment required for the simulations, and was ultimately overcome by loaning equipment from Australia. Fortunately, local medical colleagues were able to loan their ultrasound machines. Other challenges met revolved around navigating different cultures and systems of medical practice. However, possessing a faculty who were originally from Pakistan certainly helped with this, as all were fluent in the local language and familiar with the culture. This also gave them the benefit of having some pre-existing understanding of the medical systems in Pakistan.

The future: Enhancing the specialty of emergency medicine

One of the main ambitions of this group was to enhance the specialty of emergency medicine across the major cities in Pakistan, as well as meeting local training needs and delivering useful and affordable emergency medical training to frontline doctors. As this course progresses it will be shaped by participant feedback and local needs, with the aim of expanding its reach to other metropolitan sites. Looking to the future, all planning will depend on resources, particularly equipment and the self-funded faculty. The group aims to keep the course as affordable as possible so it remains accessible for all frontline emergency doctors working in urban Pakistan. This course would not have been possible without the collaboration of local physicians.

Rizwan and Faryal remain hopeful that the course will continue supporting the broader development of emergency medicine across the country.

More information

FACEMs and United Kingdom emergency physicians involved in this project: Dr Mohammad Akbar, Dr Usman Ghani, Dr Nadia Maqbool, Dr Alamgir Qureshi, Dr Immad Qureshi, Dr Rizwan Qureshi, Dr Abdus Salam Khan, Dr Hajra Usmani, Dr Shahan Waheed and Dr Faryal Waqar.

From the 'Wilderness' back to the 'Mothership'

Dr Matthew Turp

Dr Turp is an ACEM trainee working in the Royal Adelaide Hospital, South Australia. He is currently working towards the Fellowship examination.

Working in an urban district hospital is a challenging but rewarding experience.

It is a College requirement for FACEM Training Program trainees to spend at least six months in an accredited non-tertiary hospital. This exposes trainees to a different set of challenging circumstances that they would not expect to find in a better equipped hospital. The term 'non-tertiary' is difficult to define and encompasses a vast array of different hospital types, ranging from rural/regional locations to large urban referral hospitals.

I recently completed a placement in the ED at Modbury Hospital, an urban district hospital in South Australia, which has limited resources, despite being located in a metropolitan area. The ED is the only critical care service within the hospital, with no intensive care or anaesthetic department on hand should support be needed. Overnight the emergency registrar is the most senior doctor on site and covers code blue*s* on the wards (and occasionally in the car park!). During the day, from 8:00am to midnight, there is excellent consultant support. At night the responsibility of patient care is in your hands; although a FACEM is on-call for backup, this backup is often 40 minutes away. Departmental management during these night shifts has developed my clinical skills and clinical acumen at an accelerated rate.

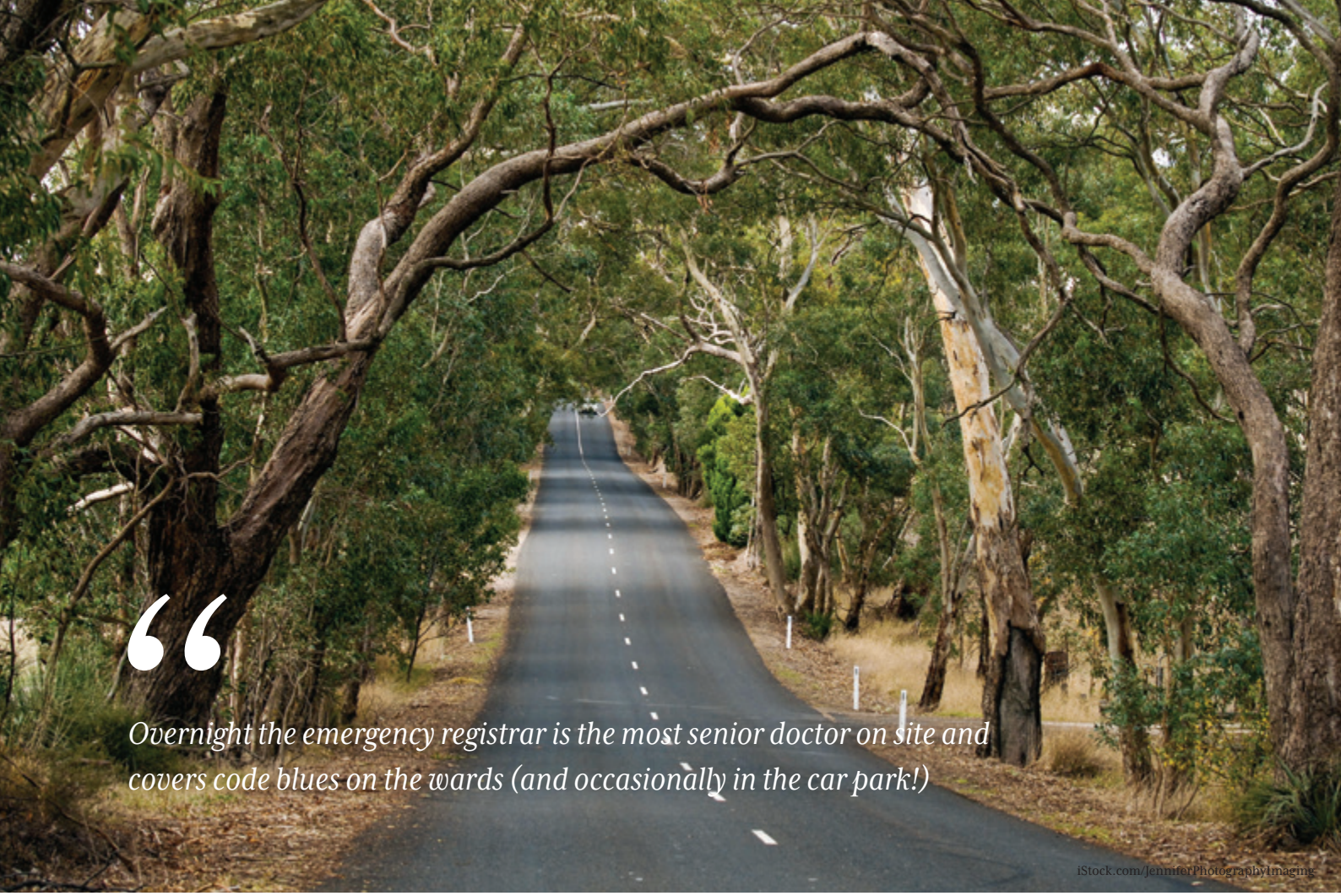
The ED sees, amongst other major trauma, surgical, orthopaedic, medical, paediatric and obstetric patients. Only short-stay medical, palliative care, psychiatric and rehabilitation patients may be admitted on site. Due to limited specialties within the hospital, many patients, including those who are critically unwell, require an inter-hospital transfer. This decision is often a complex one and requires balancing the risks versus benefits of transferring an unstable patient. Working in isolation is obviously challenging, however, the rewards of successfully managing critically unwell patients until they can be transferred for definitive care, are high. Trainees get the chance to completely manage the patient – from intubation, to arterial lines and central venous access.

The training benefits for emergency registrars that come from working in such places are immense. I strongly recommend trainees seek out and spend time working in these departments, to push the boundaries and get out of their comfort zone. In turn, you will become a more confident and decisive physician. Of course, any type of medical, surgical, paediatric or obstetric emergency, can come through triage at any point and there is no choice other than to manage them to the best of your ability. The department I worked in had excellent protected teaching, with ready access to many FACEMs involved in teaching and mentoring, including ACEM Examiners. This was an excellent place to complete Workplace-Based Assessments (WBAs) – especially core Direct Observation of Procedural Skills (DOPs), as you do a lot more procedures here than you do in a tertiary centre. This is usually due to there being fewer trainees, and fewer inpatient teams fighting over procedures.

The role of the 'feeder' hospital is frequently underestimated by larger centres. These hospitals are often incredibly busy and serve large communities. The ED takes on a lot of this load, caring for many complex patients requiring enormous amounts of time and resources. The trust the community has in their local emergency service and the army of volunteers keeping district hospitals afloat, brings an atmosphere that I have not experienced in a tertiary hospital. Within six months I felt part of this community and there is a great deal of satisfaction in this.

I have been the lead in critical cases ranging from haemorragic shock and intractable hyperkalaemia to major obstetric blood loss, without any in-house specialist support. When there is no one else around you are required to act quickly and efficiently. For emergency doctors who work in such places none of this will come as a surprise and I have found that they are some of the most pragmatic clinicians around. On a daily basis they make very difficult choices, ranging from rationing and prioritising care to transporting patients. Who will you choose to be transferred to the major hospital first? The septic neonate, or the teenager with life-threatening asthma? There are lots of sweaty-palm moments like this in smaller hospitals, but they are the moments when we learn the most. They are the moments that ultimately help us transition into confident and able clinicians.

Of all the cases I encountered, one in particular will always stay with me. It's a case that highlighted for me the struggles of a peripheral site, in which emergency departments have



Overnight the emergency registrar is the most senior doctor on site and covers code blues on the wards (and occasionally in the car park!)

iStock.com/JennniferPhotographyImaging

an essential role in managing true emergencies. A worried nurse called me into a cubicle to review a young woman who had just been wheeled in, screaming in pain. It soon became obvious that she was in active labour. Very soon I had a healthy baby in my hands and was fumbling around trying to cut her cord. For a brief moment all seemed to be well; that was until the surprised new mother lost consciousness, then her pulse, and developed cardiac arrest. This was most likely secondary to a large post-partum haemorrhage. The woman underwent resuscitive measures for what seemed like the longest time. The emergency department worked long and hard and in isolation. We split our small number of staff into two teams - one for the baby and one for the mother - meaning that for hours almost all the other patients in the department had to wait. Two retrieval teams were activated for mother and child, however, due to the mother's instability a hotshot obstetric team were driven to our resus rooms. By the time the midwife, obstetrician, anaesthetist and retrievalist arrived, the situation had stabilised and they were able to safely transport the two patients for definitive care. Both mother and baby, thankfully, made a full recovery.

Having recently returned to the state's largest tertiary referral hospital, I was met by a different world (despite being only a 30 minute drive away!). Unfair statements such as *'welcome back from the wilderness'* and *'welcome back to civilisation'*, greeted me. These misconceptions are rife. In the tertiary hospital, there's a distinct feeling of an airport departure lounge with coffee shops, sushi bars and 'meditation rooms'. Very different from the volunteer-led café I'd grown to love. I overhear the familiar conversations in the 'staff hubs' about heroic and life-saving procedures. Young surgeons tell tales of performing resuscitative thoracotomies, surgical airways and craniotomies all before they've ordered their first cappuccino of the day. Physicians excitedly exchange stories of nailing Goodpastures syndrome and curing hypokalemic periodic paralysis – of course, all of this with the support and every form of back-up on ready call. It is good to return to this environment with the valuable perspective of what it is like to work somewhere where all resources are not so readily available.

Working in a lesser resourced and supported hospital, such as Modbury Hospital, offers a trainee the chance to deal with a diverse case mix, often with prolonged patient care due to the limited subspecialties within the hospital. It gives you great opportunities to challenge your communication, prioritisation and leadership skills, as are required to care for these patients. I have also had the chance to facilitate regular inter-hospital transfers. All these skills are vital for trainees in their progression towards consultant level, and are ideally catered for trainees at any level of their career.

There's no doubt that working in a tertiary hospital is an essential requirement of training, but spending some time working away from the 'mothership' has given me a more balanced perspective, particularly highlighting for me the realities of non-tertiary medicine. It has been beneficial, not only for my training, but for my confidence as a clinician, and I urge other trainees to look for experiences like this. The skills developed are invaluable and help you gain an understanding of what much of Australasian emergency medicine truly entails.

A Week of Growth and Wellness in Rotorua

Dr Tatum Bond

For FACEM Training Program trainee Dr Tatum Bond, attending the Winter Symposium in New Zealand was an opportunity to explore something close to her heart.

I had the pleasure of attending the ACEM 2019 Winter Symposium in Rotorua in April as a recipient of the 2018 ACEM Foundation Conference Grant. This year's theme was Te Wero, or The Challenge. Throughout the program, many challenges were put forward for discussion and reflection, from the Christchurch shooting ED response in March 2019, to the launch of ACEM's *Manaaki Mana: Excellence in Emergency Care for Māori*. I have always had a deep interest in Māori culture and was pleased to be immersed in this throughout the whole symposium.

Further highlights included the keynote address by Assistant Police Commissioner Tusha Penny on the *Privilege of Leadership*, a talk that had the entire room laughing and crying. It had me thinking about how I can use my privilege of being a leader in EM to try and better the lives of those less privileged, by letting go of bias towards people who can't help themselves, such as those living with domestic violence, those from low socioeconomic backgrounds, and those who have had poor educational experiences. The program had a perfect balance of clinical workshops and updates, along with emotional discussions about stress, work-life balance, mental health and wellness, and a refreshing push for everyone in the room, and the profession, to recognise the need for wellness in our careers and lives. Dr Jan Bone's closing address about two colleagues close to her heart who had suffered from mental illness and depression, with one sadly losing the battle, had the entire room in tears. The overall feeling in the room, however, was one of love and compassion.

The Winter Symposium wasn't all work. There were some amazing cultural and social experiences on offer, from the treetop walk through the forest, to the opening ceremony at Te Puia Geyser, where ACEM President Dr Simon Judkins accepted the challenge from a local warrior. We finished with the Gala Dinner at the stunning Blue Baths and one of the most epic dance floors of any conference I have had the pleasure of attending.

The Symposium has taught me a number of things; accept the challenge and be a leader in EM, as, when we all do this, great things can happen. Look after yourself and your ED family; a hug and a chat can go a long way. Finally, emergency physicians work hard, but they certainly know how to play hard too. I'll be sure to practise my dance moves prior to the next ACEM conference I attend!

More information

Dr Bond attended the ACEM 2019 Winter Symposium as a recipient of the 2018 ACEM Foundation Conference Grant.

The ACEM Foundation Conference Grant supports Aboriginal, Torres Strait Islander and Māori medical practitioners, medical students and other health professionals in attending the ACEM Winter Symposium or the Annual Scientific Meeting (ASM).

This year's ASM will be held from 17- 21 November in Hobart.

2019 Lowitja Institute International Indigenous Health and Wellbeing Conference

Dr Max Raos, FACEM

The 2019 Lowitja Institute International Indigenous Health and Wellbeing Conference was held in June in Darwin, Northern Territory. 2019 ACEM Foundation Grant Recipient, Dr Max Raos, reports on his experience at the conference.

The Lowitja Conference was unlike other conferences I have been to. Despite speakers from across the globe, there were uniform themes of thinking, speaking and being, which were expressed over three days of lectures and small group sessions spanning research, ideas and lived experiences.

The first day was thematically aligned to 'Thinking'. There were several outstanding speakers, including Peter Yu, who set the tone of the conference with his wonderful keynote address. He talked about 'upside risk', the positive possibilities in the unknown and how self-determination can fuel opportunity outside those traditionally dictated by colonial powers. He also touched on 'positive framing', the idea of decolonising health statistics so that Indigenous people can decide what is important for health outcomes, rather than having them dictated externally.

The second day was 'Speaking'. The opening lectures built on the themes of the previous day and focused on the notion that, in cultures with an oral tradition, language is culture. The lectures and sessions were engaging. It was great to be introduced to Bruce Pascoe, who is changing the narrative about Indigenous Australians and unveiling the horticultural heritage of Australia. The work of Professor Tahu Kukutai was very innovative and explored data sovereignty with respect to Māori owning their data and being able to use it to serve Māori needs. The highlight of the day had to be seeing the women of the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council explain the effect of English through performance – it was the pinnacle of storytelling.

The third day centered on 'Being'. The opening of the day fell to Bruce Blankenfeld and Dr Abhay Bang. Mr Blankenfeld outlined the history of the Polynesian Voyaging Society and the incredible story of rediscovering traditional navigation after a 600-year hiatus for the maiden voyage of Hōkūle'a. Dr Bang gave a very compelling talk about the Indigenous people of India who make up 30 per cent of all Indigenous people in the world. The work currently underway in India is phenomenal and reflects what is seen the world over, but on a scale that is astounding.

It was wonderful to attend the Lowitja Conference; I found myself in awe of the excellent work being done in Indigenous health and wellbeing. The positive framework for viewing Indigenous knowledge permeated the event and there was a real sense of purpose among those in attendance.

To all those who supported me by giving me a travel bursary, thank you.

To the wonderful people of Larrakia, thank you for having me.

It was wonderful to be awarded this bursary and I would encourage everyone to support the Lowitja Institute. I am looking forward to their next conference, because this year's was truly inspiring.

ACEM Al Spilman Award for Culturally Safe Emergency Departments

The Al Spilman Award for Culturally Safe Emergency Departments was established in 2018 following a generous donation by Mr Al Spilman.

The award recognises the outstanding efforts of an ACEM-accredited emergency department 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, Torres Strait Islander and Māori peoples.

The award consists of an Aboriginal or Māori artwork and accompanying explanatory plaque, to be displayed publicly in the emergency department.

For more information and to download an application form, visit: acem.org.au/awards.

The Ice Caps in Greenland are Melting

Dr Lai Heng Foong

Dr Foong is an emergency physician currently based in Sydney, Australia. She is the current Chair of the ACEM Public Health and Disaster Committee and is passionate about climate action, Indigenous health, international emergency medicine and wellness culture in medicine.

In years past, the ice that drifted south from Greenland's north-east was thick. It had built to a thickness of several metres over the course of many years, inviting people to hunt seals from it and children to play on it.

This year the ice that drifts in is new and slight; the large sheets are thin, fragile and break easily. 'We don't hunt from it, we are too scared to fall into freezing waters', my friend Kelly says. He's a resident of Ammassivik, a settlement on Greenland's southern coast.

Without that opportunity to hunt, families have no chance to store seal meat and its blubber. Historically, seal meat is an important cultural delicacy in Greenland, but it is also a vital food supplement through freezing winters.

The melting ice caps are a symptom of something far more sinister. We have a climate emergency on our hands. Climate change has been officially documented for at least 30 years. In 1990, the United Nations Intergovernmental Panel on Climate Change (IPCC) warned of catastrophic changes in weather patterns, extinction of species and severe impacts on global health due to climate change.

As emergency physicians, we see firsthand those catastrophic effects of climate change. We see how it impacts the health of our population. We see it in increased rates of heat-related illnesses in vulnerable populations. We see it in the increasing number of victims of flood and forest fires presenting to EDs.

Globally, 157 million more people were exposed to heatwave events in 2017, compared to the year 2000. It is estimated that 153 billion hours of labour were lost due to heat-related illness or inactivity in that year. Meanwhile, a 2016 World Health Organization report[1] found more than 90 per cent of the world's population breathe air that is not compliant with its air quality guidelines and that about three million people a year are killed by the effects of ambient air pollution.

A 2018 report released by the IPCC warned again of the severe impacts of climate change and global warming, including: greater rates of human death and illness; extreme weather volatility; substantial degradation of natural systems (species loss); and malnutrition, particularly where such conditions are already prevalent (Africa, South-East Asia, South America). Weather events disproportionately affect poorer and less developed nations.

ACEM has started to take action against the effects of climate change by divesting from all fossil fuel-related investments and advocating for more action by governments. In 2018, the College was a signatory to a letter by the Climate and Health Alliance to Australian politicians, urging them to progress climate actions and policies (in the lead-up to the Australian federal election). The College's Public Health and Disaster Committee is working on a Sustainability Action Plan to find actions the College, its members and trainees can commit to in order to reduce our carbon footprint and impact on the environment.

We are also seeing more severe tropical storms, floods and vector-borne diseases, such as dengue, malaria and vibrio cholerae. These diseases cause large disruptions in infrastructure and food supply chains, and overwhelm resources in EDs and hospitals. Historically, Australia has not hosted dengue or malaria, but cases have been seen from travellers visiting or returning to Australia. When I worked on a Médecins Sans Frontières (MSF) project in Angola in 2001, I was stationed in Kuito, the rebel stronghold. Kuito is situated at an elevation of 1,695m. There is usually less risk of malaria at this altitude (above 1,500m), but I was already treating severe malaria in children at that time. We were seeing the effects of global warming and adaptation of vectors then.

We see natural disasters often in the news cycle. These are not one-off extreme weather events. They are events that have occurred with more frequency, more severity and with more casualties due to the effects of climate change. In February 2016, there was an alarming global temperature spike of more than 1.5°C of warming, just months after the Paris Climate Accord set an aim of not exceeding that limit. Scientists report that Arctic air temperatures are currently rising at twice the global average rate.

We are seeing unprecedented melting of ice caps in the Arctic, which will raise the sea water level. The IPCC has predicted the oceans could rise by as much as 98cm by the end of the century, which would be high enough to swamp

1. World Health Organization. Ambient air pollution: A global assessment of exposure and burden of disease. 2016. https://apps.who.int/iris/bitstream/handle/10665/250141/9789241511353-eng.pdf?sequence=1

iStock.com/Explora_2005

major cities across the world, including Hong Kong, Miami, Osaka, Rio de Janeiro and Shanghai. In the age of technology, we are inundated with information from so many sources about everything. How do we sift through all the information out there and focus on important issues that we can do something about?

There has been inaction from world leaders, ranging from denying climate change actually exists, to muted complacency. Again, our youth have shown the way in demanding change from our politicians. The recent School Strike 4 Climate Action, which I attended in Sydney with another FACEM, was an inspiring gathering of young people and others who cared enough about the environment to demonstrate the urgency for action.

We need to change how we pitch this problem and galvanise more people to take on the challenge of ensuring we have a viable planet for future generations. The remarkable Swedish 16-year-old Greta Thunberg, who initiated the worldwide school strike actions, has said, 'You don't listen to the science because you are only interested in solutions that will enable you to carry on like before'. As physicians at the frontline of treating climate change trauma, we cannot afford to carry on like before. We are experts at disaster preparedness and response. We can build a community in our workplace and our neighbourhood that actively advocates for ways to mitigate climate change, and we can train communities to be more resilient and respond to natural disasters. We can cooperate with other agencies to have a more robust and prepared emergency response system. We can also show, by example, how to work and live in a more sustainable way.

We have to address this emergency – the climate emergency – with all the armamentarium that emergency physicians possess. The Earth is critically ill. We must manage the risks and do so speedily. I want us to start today for #ClimateAction.

Reading

Watts N, Amann M, Arnell N, et al. The 2018 report of the Lancet Countdown on health and climate change: shaping the health of nations for centuries to come. *Lancet*. 2018 Dec 08; 392(10163):2479-2514.

Annotated Bibliography - Climate Change, Migration and Health. Global Health Education and Learning Incubator, Harvard University.
Access at: https://ace.mn/2d1

Ryan B. These Days, It's Not About the Polar Bears. New York Times. 2019 May 13.
Access at: https://www.nytimes.com/2019/05/12/climate/climate-solutions-polar-bears.html

Learnings from the Coroner: Button Batteries


iStock.com/storeg

Button batteries are small, circular, about the size of a two dollar coin and power everything from calculators and bathroom scales to children's toys. Once lodged in the respiratory and gastrointestinal tract, their corrosive make-up begins to react, ulcerate, corrode and even perforate the mucosal lining. Immediately following ingestion of these seemingly innocuous batteries, which power everyday household items, initial symptoms are often non-specific, making it difficult to diagnose. If left untreated, however, their ingestion can cause serious injury and even death.

Children are extremely curious and will often place foreign objects in their mouths. Emergency physicians often see paediatric patients who have swallowed coins, Lego pieces, and other items that pass naturally and without complication. Button batteries are, however, different and young children aged one to five are the most common group for button or disc battery ingestion or insertion (often in the nose or ears). The Australian Competition and Consumer Commission (ACCC) has previously stated that approximately 20 children present to Australian EDs every week from swallowing or inserting button batteries.[1]

Once swallowed, saliva triggers an electrical current in the battery that consequently generates hydroxide as the battery hydrolyses tissue. Damage to the oesophagus can occur within two to three hours. The extent of injuries associated with button battery ingestion differ from person to person and are dependent on the amount of time they are ingested, the size of the battery, and the amount of electrical charge that remains in the battery.[2] Even after they are removed, button batteries can continue to cause damage.

Tragically, in recent years, ingestion of button batteries has led to the deaths of a several young children. Other children have survived ingestion, but have been left with profound injury.

The first known death as a result of button battery ingestion occurred in a four-year-old girl in Queensland in 2013. Following the inquiry into her death, the State Coroner recommended that all products containing button batteries be fitted with child-resistant battery compartments and that manufacturers place warnings on their products. At the time of writing, all children's toys containing button batteries require a screw or dual hand motion to release the battery.[3] However, for items that are not considered toys, such as car remotes, calculators and scales, the same requirements do not apply, and such measures are voluntary. As a result, young children may still easily access button batteries from everyday household items, with ingestion or insertion continuing.

Button batteries can be easily swallowed and if there is no incidence of choking or gagging, parents may be unaware that their child has swallowed anything. Children may be reluctant to admit to swallowing button batteries, and there have been reported instances where children have continued to deny swallowing batteries even after ingestion was confirmed via x-ray.

In 2015, an infant girl died as a result of button battery ingestion, which prompted an investigation by the Victorian State Coroner. While the parents had suspected she had swallowed something, they did not witness her swallow the button battery. Unfortunately, over a 19-day period, the button battery lodged in her oesophagus and caused an aorto-oesophageal fistula as a result of necrosis, leading to the child's death by gastrointestinal haemorrhage.[4]

After a child swallows a button battery they may be asymptomatic for a period. Following this, children may develop non-specific clinical signs and symptoms, such as chest pain, cough, decreased appetite, nausea or vomiting, haematemesis, diarrhoea, epigastric pain, abdominal pain and fever. Symptoms can also differ, depending on where the battery lodges in the oesophagus, making button battery ingestion particularly difficult to diagnose.

As the Victorian State Coroner found, 'the difficulty is getting to the point of suspecting button battery ingestion', particularly if ingestion is not witnessed by the parent or

guardian. X-rays are considered to be the gold standard for confirming a diagnosis of button battery ingestion.

The Victorian Coroner made a range of recommendations, including to manufacturers, which seek to prevent children from accessing button batteries in the first place. There is a need for strengthened legislation requiring manufacturers to develop products that will prevent such unnecessary harm. The Coroner recommended that ACEM, the Royal Australasian College of Physicians, the Royal Australian College of General Practitioners and the state ambulance services raise awareness of occult button battery ingestion and the importance of timely diagnosis and treatment. Additionally, work is being undertaken to increase community awareness about safe storage and disposal of button batteries and the potential harm they can cause if children, in particular, ingest or insert them.

Advancing quality and patient safety in EM

Coroners' cases such as those outlined above provide an opportunity to enhance the quality and safety of emergency medicine. ACEM is committed to raising awareness, advancing patient safety, reducing error in the field of emergency medicine, and shaking the unenviable title of 'a natural laboratory for the study of error'.[5]

The ACEM Quality and Patient Safety (QPS) Committee is striving to make button battery deaths a thing of the past by focusing on addressing safety and error. A key aspect of the Committee's work is to drive a systematic approach to quality and patient safety through education and training, learning from incident reporting, and developing policies applicable to emergency medicine. The QPS Committee has a keen interest in reviewing incidents we can learn from. This has, in turn, led to the development of an anonymous reporting system, the Emergency Medical Events Register (EMER). When fully operational, EMER will enable analysis of trends in incident subtypes to drive systematic improvements in emergency medicine.[6]

Often, we can be focused on the catastrophic consequences when, infrequently, things go wrong in healthcare (known in literature as 'Safety I'). Coroners' cases are an example of Safety I, as they analyse the factors resulting in death and recommend prevention strategies to enhance patient safety into the future.[7] Often, the approach following adverse events is the implementation of policies or processes to reduce instances of error in the future.[8] ACEM also acknowledges that clinicians can be the 'second victims' of adverse incidents and coronial inquiries, which commonly cause anxiety and doubt about one's professional judgement.[9] However, we know that error in medicine extends much further than developing new, or fastidiously adhering to existing, policies or procedures. Interruptions, fatigue, poor organisational culture and cognitive bias can all play a role in not only medical error, but also in job dissatisfaction and burnout of emergency physicians.

While we want to understand the pitfalls in the system, we also want to learn from the many circumstances when things go right – the 'good saves'. This approach is known as 'Safety II'. The Safety II paradigm adopts the perspective that, in most circumstances, things go right and it seeks to further understand why that is. Healthcare is increasingly complex, interconnected and requires a considerable amount of discretion and professional judgement. As a result, viewing patient safety from a systems lens assists in understanding the pitfalls as well as the safety nets designed to prevent adverse outcomes.

ACEM is developing a Safe ED framework. This framework considers how leadership, culture, education and training, staffing, work-life balance, workplace culture and system-wide approaches can produce an environment, workforce and standard of care that is safe for all ED staff and patients. The opportunity awaits for emergency medicine to redefine itself 'as a natural laboratory of safety'.[10]

The future

While we hope that no other child has to experience a catastrophic injury or die from button battery ingestion, unimagined hazards will emerge into the future, potentially threatening the lives of young children. Our specialty, and the healthcare system as a whole, must collectively work towards adopting a system that builds on its strengths and seeks to eliminate the pitfalls.

---

i More information

Thank you to Dr Mary McCaskill and Dr Matthew Chu for their contribution and to the members of the Quality and Patient Safety Committee.

Dr Mary McCaskill - Paediatric Emergency Physician, Executive Medical Director, Sydney Children's Hospitals Network NSW

Dr Matthew Chu – Senior Specialist in Emergency Medicine, Director of Prevocational Education and Training, Canterbury Hospital Sydney Local Health District NSW

Author: Freya Saich *Policy Officer*

1 ACCC (2016) *Button battery national strategy*, available online at: https://www.productsafety.gov.au/news/button-battery-national-strategy
2 Victorian Coroner English, C. (2019), Inquest into the Death of Isabella Estelle Rees, Coroners Court of Victoria, Melbourne.
3 Hutton, J. (2015) Inquest into the death of Summer Alice STEER, Queensland Courts, Brisbane.
4 English (2019)
5 Croskerry P and Sinclair D. Emergency medicine: A practice prone to error? *Canadian Journal of Emergency Medicine*. 2001;3(4):271-276.
6 Crock C and Hansen K. Error and safety in Emergency Medicine. *Emergency Medicine Australasia*. 2019 Aug;31(4):662-664.
7 Cunningham N. How Do Coroners' Findings in Australian Jurisdictions Apply to Health Care Practitioners within Safety-I and Safety-II Paradigms? *Journal of Law and Medicine*. 2018 Jul;25(4):1079-1099.
8 Cunningham (2018).
9 Cunningham (2018), p1088.
10 Crock and Hansen (2019).

Mental Health Crisis at Logan

Logan Hospital, in southern Brisbane, is one of Queensland's busiest EDs. From a community hospital in 1990 with just 48 beds, it has grown to a 436-bed facility sitting just off the M6, sandwiched by Brisbane to its north and the Gold Coast to its south. The ED sees more than 88,000 presentations a year in one of Queensland's fastest growing areas.

In March, Logan Hospital ED was the scene of a staff assault that raised state and nationwide questions about the ways in which access block and ED overcrowding play a role in poor outcomes for patients presenting with mental health issues.

A distressed young man presented to the ED with his concerned mother. After several hours – about 5:20am – the man used a knife against a staff member and others who attempted to restrain him. He was subsequently sedated and arrested by police.

The issue is much greater than just the problem of overcrowding; with this one patient, however, the repercussions were extensive. Many hospital staff were left feeling unsafe in their workplace, a mother seeking assistance for her son was let down by a system that is increasingly unable to provide appropriate care to people who present to ED with mental illness; a patient who needed help was forced to wait in an environment of sensory overload not suited to someone in his circumstances; and doctors felt disheartened they were unable to offer help to someone crying out for it.

ACEM President Dr Simon Judkins responded to the reports of the arrest at Logan Hospital's ED.

'After hours waiting in the noisy and chaotic environment, the patient's mental health crisis intensified, staff were assaulted.

'Police were called and the young man is now facing assault charges. As his devastated mother has told us: "He came in seeking help and now he is being treated as a criminal".'

'Long waits for mental healthcare in emergency departments are unacceptable and discriminatory and are likely to lead to serious deterioration in the wellbeing of patients.

'Our members report feeling heartbroken and burnt out in their inability to adequately assist people who come to the ED seeking help and are deeply worried for their patients' safety, as well as their own. More concerted, systemic action must be taken to protect the safety and wellbeing of ED staff and patients.'

In the aftermath, the College advocated for the patient and his needs for care, for his distraught mother, and for the thousands of other people in Australia and Aotearoa New Zealand who suffer long waits as mental health patients in our EDs.

ACEM's advocacy response

Access block, defined as a situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED because of a lack of inpatient bed capacity, is the single most serious issue facing EDs in Australia and New Zealand. Access block can manifest in many ways: an overcrowded ED, patients waiting long hours, staff feeling the pressures of their workload. For patients, access block means staying in the hospital longer, increased errors in their care and increased likelihood of dying while in hospital.

On its own, access block is a disturbing phenomenon and illustrates a problem with the whole of hospital system. For the most vulnerable people, particularly those who come to the ED in acute mental health crisis, the impact of access block is felt profoundly. Although Australian Institute of Health and Welfare (AIHW) data show that mental health presentations account for only four per cent of all ED presentations, they make up 29 per cent of all cases of access block.

The ED is not the best place for mental health patients in crisis. EDs are often crowded, loud environments with bright lights and a lack of privacy. For people who present in a state of distress, the highly stimulating environment can further agitate them and exacerbate their condition. When combined with the high rates of access block, it is obvious that for those in mental health crisis, the ED is a challenging place.

On 26 March 2019, the College became aware of the incident at Logan Hospital. The events on that day encapsulated the very worst outcomes of mental health access block: a patient in distress, brought in by a loved one to seek help, was unable to receive treatment in a timely manner and became increasingly agitated. Unfortunately, this resulted in a violent outburst against staff, and the patient who arrived seeking help left the ED in police custody.

The incident at Logan Hospital required the urgent attention of Australian health ministers, and the College worked actively to focus attention on what had happened. The College wrote to every health minister in Australia to raise its concerns and request meetings to discuss state-specific issues around access block and wait times.

The ACEM President visited Logan and Redland hospitals to draw attention to the ongoing pressures facing Brisbane's South Metro area. The attention the visit brought was significant – all major news outlets, including the *Courier Mail, Brisbane Times* and the ABC, reported on the wait times in Queensland's EDs, bringing the system under greater scrutiny.

In the aftermath of the incident and the President's visit, Queensland Health Minister Steven Miles announced $3 million in emergency funding as a short-term solution to the unfolding crisis. With the cash injection, the health system was able to open beds in private hospitals and resource additional staff to respond to the access block, as well as manage the demand.

On the ground, the College heard that this emergency funding allowed hospital staff to empty their frenzied corridors for the first time in some time. Having the College champion their cause on their behalf also enabled staff to push for changes within their hospital. The impact of the response spoke for itself, hospitals in the South Metro area that had been locked in a state of code yellow due to overwhelming demand were noticeably less crowded and became mercifully more manageable, providing a very welcome reprieve.

Although everyone would prefer that they not occur in the first place, incidents like the one in Logan Hospital can be the impetus of real change. More needs to be done to understand the causes of access block and violence in EDs. No one should come to an ED and be subjected to extended periods of wait and left to languish. The College will continue to advocate for change and is constantly seeking opportunities to push for short-term measures and long-term solutions.

Authors: Ryan Angus, *Policy Officer*
Inga Vennell, *Editor*

COE Update

The role of the Council of Education (COE) is to provide educational strategic direction and leadership and promote improvements in education and training.

A myriad of educational committees and entities undertake the work of COE, and they are supported by over 45 staff in the Department of Education and Training. These entities oversee the development and conduct of a range of activities across four key areas: Training; Education Program Development; Education Assessment; and Accreditation, Continuing Professional Development and the National Program.

A spill of all entities (committees, subcommittees, and panels) under COE is currently in progress. Expressions of interest were called for during August, and appointments will be made by COE to take effect from the date of the College Annual General Meeting to be held on 17 November 2019. In the lead up to this process, COE confirmed the Terms of Reference of all enteties ensure diversity, and positions are available for Fellows, Certificants, Diplomates, and trainees. COE, with staff in the Department of Education and Training, look forward to working with new and reappointed entity members to continue the significant body of work.

In this edition of *Your ED,* the COE update focuses on various projects undertaken within the Education Assessment area, and more specifically the FACEM Training Program examinations.

Education and Training Update

Examinations

The focus of the College is to provide high quality, robust, defensible and fair assessments, which reflect best practice, and to describe these assessments as fully as possible in published resources. These resources allow trainees and DEMTs to be fully informed about what to expect when the trainees are planning to sit an examination. As such, the College continuously reviews, refines and enhances the examination processes, and develops new resources to assist trainees in their preparation.

All examinations are overseen by the Examinations Committee (EC), which reports directly to COE.

In order to enhance the quality of its examinations, the College has drawn on the experiences of other specialist medical colleges and on the advice of internationally recognised experts in the field.

On this basis and after due consideration by the COE, the College has implemented procedures that effectively improve the quality o f the examinations for candidates:

- The College has implemented steps to address equity and diversity considerations in its recruitment of new examiners
- At least two examiners independently examine candidates in every question in the short answer question (SAQ) component of the Fellowship Written Examination and in every OSCE station in the Fellowship Clinical Examination
- All OSCE stations are now recorded for uses as outlined in the *Policy and Procedure for the Recording of Stations at the Fellowship Clinical Examination (OSCE)*. Unsuccessful candidates who have only one attempt remaining, are now able to view the recordings of their performance in stations of the most recent OSCE.
- An OSCE 'Area of Concern' report is made when a candidate makes a serious error in the examination, that has the potential to endanger patient safety. These reports are now provided to all such candidates whether they have been successful or not at the examination.
- A timetable of examiner training workshops has been initiated for all examiners. The program includes standard setting, an OSCE calibration exercise and ensuring fairness to candidates.
- In August 2019, the College ran its 18th online Primary Written Examination and in 2020 candidates will attempt both components of the Fellowship Written Examination online. A contingency plan was published in 2018 to advise trainees of the preparations undertaken by the College to reduce the likelihood of technological issues with online examinations and to address any such incidents in the unlikely event they occur.

With the aim of having an even more informed and confident trainee cohort, the College has recently developed a greater range of resources that describe specific aspects of the examinations processes.

For those preparing for the Fellowship Written and Clinical Examinations, comprehensive 'Information About' and 'Preparing For' resources describe the examinations and give trainees tips on how best to prepare for them. An 'OSCE Preparation Checklist' has been added to provide further guidance for trainees and their supporting FACEMs.

Feedback from trainees often indicates that many are unaware of how the examinations work behind the scenes and some have developed serious misconceptions that can hinder their success in the examinations. For this reason, the College has published specific information about the processes behind examinations, such as how standard setting determines the pass mark for the examinations, how the OSCE marking works, how examiners and role players are recruited and trained; and the aspects that may be assessed at an OSCE. A key resource for trainees is the OSCE Domain Criteria that describes the specific criteria candidates are assessed against.

In response to requests from trainees and their DEMTs, for more comprehensive and timely feedback for unsuccessful OSCE candidates, a system has been developed to provide electronically generated feedback for their Fellowship Clinical (OSCE) Examination. The feedback is based on a sample of the domain criteria that a candidate at a 'minimum level of competence' would be expected to adequately address and provides a summary of the key elements that were tested in the respective domains in each station. The feedback is intended to help guide candidates towards the broader areas/ themes where further development may be needed.

New video resources are under development to support trainees undertaking examinations. In the first of these, Reflections on the OSCE Journey, three OSCE veterans describe their OSCE journey and the actions that made the difference for them, in achieving OSCE success. A further OSCE video resource in which six ACEM examiners give their advice to OSCE candidates, is due for release in September 2019.

The ACEM OSCE Preparation Program has been introduced and is now run twice yearly to assist candidates preparing to sit the OSCE, by providing information about the mechanics of the OSCE, tips for success and practice opportunities with feedback from examiners.

A new document OSCE Facts and FAQs has been developed to help clarify College processes and procedures regarding the OSCE and to correct a number of prevalent misconceptions regarding the ACEM Fellowship Clinical Examination.

All documents described are available to trainees and DEMTs on the Fellowship Examination Resources page in the College's Educational Resources site.

Educational Resources

As part of ACEM's commitment to developing and sharing excellent educational resources with members and trainees, an Educational Resources Panel of Fellows and trainees has been established and work plans have been implemented to update the appearance of and content available on the Educational Resources website. The result is that in the last two years, 138 online learning modules relating to various emergency medicine-related topics and programs have been written, reviewed and updated. More than 200 extra resources have been reviewed and made available to support ACEM members and trainees in categories such as 'General Emergency Medicine Resources', 'Fellowship Exam Resources', 'Primary Exam Resources' and 'DEMT Resources'. Members and trainees are invited to suggest resources for review to add to the continually updated area.

Of particular note are two specific sets of online modules which assist ACEM Specialist CPD Program participants with meeting the CPD cycle requirement to complete an approved cultural competence activity. These modules include the ACEM Assessing Cultural Competence course (three modules released in July 2017); and the ACEM Indigenous Health and Cultural Competency course (10 modules revised and re-released in November 2017). The introduction of the cultural competence requirement reflects the commitment of ACEM to the integration of cultural competency into the practices of emergency medicine physicians. All ACEM Fellows (and other participants in the CPD program) are now required to complete a minimum of one approved cultural competency course every three years. In addition, Fellows involved in any College committee, entity or role, such as DEMT or Examiner, were required to complete the ACEM Assessing Cultural Competence Course by the end of 2018.

The numbers of Fellows and FACEM trainees who have completed Cultural Competence and Indigenous Health and Cultural Competency modules are included in the figures below.

ACEM Cultural Competency online course completion	July 2017 – July 2019	
Cultural Competence Course (3 modules)	Number of ACEM Fellows who have completed	Number of FACEM trainees who have completed
Foundations of Assessing Cultural Competence	1,780	316
Assessing Cultural Self-Awareness & Cultural Adaptability	1,676	251
Assessing Cultural Literacy & Cultural Bridging	1,618	216

ACEM Indigenous Health and Cultural Competency online course completion	November 2017 – July 2019	
Indigenous Health and Cultural Competency Course (11 modules)	Number of ACEM Fellows who have completed	Number of FACEM trainees who have completed
Introduction to Culturally Competent Care in ED	211	88
Culturally Competent Communication in the ED	165	73
Understanding Health Literacy and Diversity of Health Beliefs	138	57
Understanding Language Diversity and Working with Interpreters	99	38
Improving ED Access and Experiences for Aboriginal and Torres Strait Islander Patients	95	45
Collaborative Practice: Understanding the Role of Aboriginal Liaison Officers and Families in ED care	73	34
Culturally Competent Discharge Planning	72	35
Culturally Competent End of Life Care	63	40
A Culturally Competent Approach to Challenging Presentations: Aboriginal and Torres Strait Islander Patients	67	35
A Culturally Competent Approach to Challenging Presentations: Refugee and Migrant Patients	62	32
Māori and Pacific Island Health – module from the Emergency Medicine Diploma	32	19

EMET

Emergency Medicine Education and Training (EMET) is an ACEM-managed program funded by the Commonwealth (Australian) Department of Health's Specialist Training Program.

Of the over 600 hospitals with EDs or emergency services in Australia, only 25 per cent are staffed by FACEMs. In rural and remote Australia, most EDs are staffed by clinicians who are not specifically trained in emergency medicine.

EMET delivers education, training and supervision to doctors, nurses, allied health and other health workers in these rural, regional and remote areas through a national network of regional 'hubs' that tailor training to sites according to local need.

ACEM resources the EMET hubs to deliver the popular Certificate (EMC) and Diploma of Emergency Medicine (EMD) that aim to upskill doctors in emergency medicine care. The EMET program funds doctors undertaking the EMC/EMD training as well as emergency medicine specialists supervising the program.

ACEM recently celebrated a milestone with 1,000 doctors graduating from the EMC.

EMET has funded the acquisition of high-fidelity mannequins that provide invaluable training in procedures that rural and remote doctors don't routinely see. Participants in EMET training value this opportunity to hone their skills and receive immediate feedback from the trainers.

Every week somewhere in rural and remote Australia, or in one of the many regional EMET hubs, there is likely to be an EMET workshop or training event helping to build and sustain emergency medicine workforce capability.

---

i More information

For more information about the EMET program, contact Mathew Davies, ACEM National Program Manager at Mathew.Davies@acem.org.au

To view EMET hubs please visit https://cdn.acem.org.au/emet_map/emet_map.html

Questions about ACEM examinations?

If after checking out the Resources and the Facts you still have unanswered questions, please contact the ACEM Assessments Team by phone +61 3 9320 0444 or email at Fellowship.Exam@acem.org.au

Calendar – Education and Training

Trainees

Fellows

SEP			
6	2019.2 PE Viva Examination	Applications close	
8	Training Term 3 Ends (New Zealand)		
9	Training Term 4 Commences (New Zealand)		
10-13	2019.2 FE Clinical OSCE	Examination date	*Melbourne*
20	FE Written 2019.2	Applications close	
OCT			
31 Oct-1 Nov	2019.2 PE Viva Examination	Examination date	*Melbourne*
NOV			
3	Training Term 3 Ends (Australia)		
4	Training Term 4 Commences (Australia)		
15	2019.2 FE Written Examination	Examination date	*Various locations*
26	Resilient Leadership Workshop		*Melbourne*
27	OSCE Preparation Program		*Melbourne*
DEC			
2	2020.1 PE Written Examination	Applications open	
8	Training Term 4 Ends (New Zealand)		
9	Training Term 1 (2020 Training Year) Commences (New Zealand)		
9	2020.1 FE Clinical OSCE	Applications open	
JAN			
10	2020.1 PE Written Examination	Applications close	
17	2020.1 FE Clinical OSCE	Applications close	
SEP			
16	EMCD Supervisor Workshop		*Auckland*
OCT			
22	DEMT Workshop		*Adelaide*
23	WBA Assessor Workshop		*Adelaide*
NOV			
25	FE SCQ Writing & Review Workshop – Open to all FACEMs		*Melbourne*

CAPP Update

The Council of Advocacy, Practice and Partnerships (CAPP) is supported by seven committees, each with a committed membership drawing upon the experience and expertise of ACEM members and trainees.

Standards and Endorsement Committee (SEC)

SEC has completed an audit of all of the College's existing standards to ensure policies, statements and guidelines are up to date and reflect contemporary evidence. In addition to this, a number of standards have recently been updated and published on ACEM's website, including:

- S27 – Statement on Rural Emergency Care
- P02 – Policy on Standard Terminology
- S127 – Statement on Access Block.

Health System Reform (HSR) Committee

After ten years of the four and six-hour time-based targets in Australian and New Zealand EDs, the HSR Committee is leading a review of measures of ED performance in a whole of hospital system. Where they have worked well, time-based targets have provided a powerful driver for efficient and timely management of demand, inpatient admission, hospital occupancy rates and discharge processes. Where they have been poorly implemented, hospital executives have failed to resolve those system-wide issues that are responsible for inpatient bed block that flows through to access block in the ED.

The HSR Committee's review of ED performance measures is informed by a range of projects, including the findings from the survey of members in 2018. Most important, however, is the systematic review, led by Associate Professor Peter Jones, of international evidence on time-based targets in the ED and their influence on the quality of care. Once drafted, the updated College position on ED access measures will be put to members for broad consultation.

Quality and Patient Safety (QPS) Committee

In March, the QPS Committee hosted a Patient Safety Workshop in Melbourne. Fellows and trainees heard from recognised experts about the challenges facing emergency care in Australia and New Zealand, the range of factors contributing to medical errors in the ED, and how to develop and support teams and cultures that create a safe ED for patients and staff. The program combined presentations from leading researchers and panel sessions with practitioners with group discussion of cases.

Feedback from attendees showed widespread support for an annual quality workshop, which the QPS Committee has already started planning for 2020.

Research Committee (RC)

We are pleased to announce that the first ACEM Research Network Symposium will be held after the upcoming ASM on Friday, 22 November 2019 at the Hobart Royal Automobile Club of Tasmania (RACT).

The symposium will be an opportunity for seasoned researchers to discuss research proposals, strategy, funding opportunities and collaboration. All College members and trainees may register to attend.

The RC is also preparing for the inaugural two-day Annual Research Meeting in August 2020. It is hoped that an expanded 2020 event will have a program that is attractive to both experienced and early career researchers. If you are passionate about research, put this event in your diary.

Rural, Regional and Remote (RRR) Committee

The RRR Committee has commenced the development of a Rural Health Action Plan that aims to improve equity of access to emergency care across Australia and New Zealand, regardless of where patients live.

A group of RRR Committee members are working with staff from ACEM's Policy and Advocacy Unit to develop a draft Action Plan under three domains: Workforce, Service Delivery, and Engagement and Collaboration. The Action Plan will identify and drive the implementation of measures intended to report on a mix of aspirational and tangible goals and targets, underpinned by an evidence base of existing data.

Public Health and Disaster Committee (PHDC)

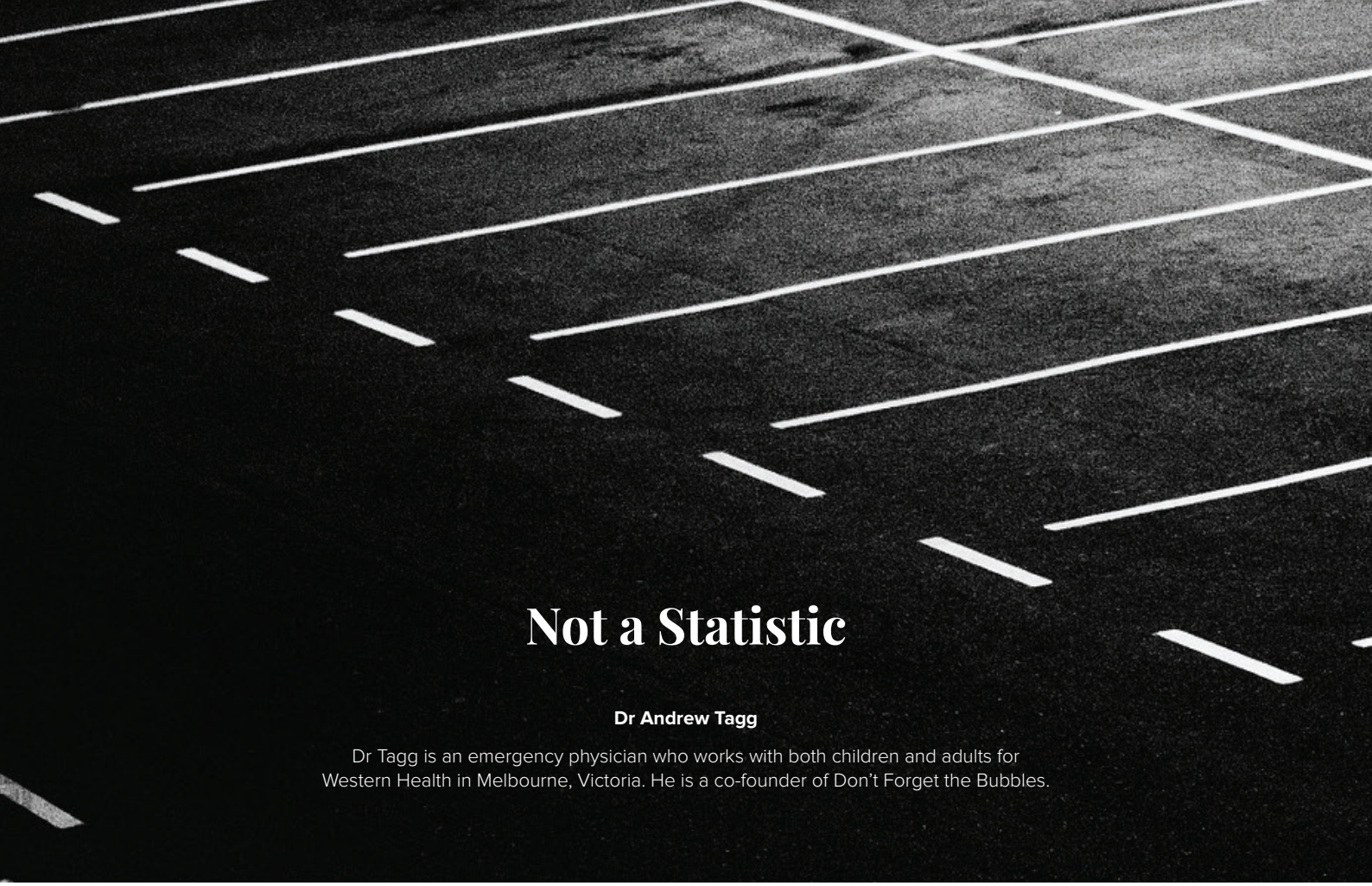
EDs will be at the forefront of global warming, disaster management and health. In recognition of the significant impact of climate change on health and wellbeing, and the increased demand on EDs, the PHDC is working to develop a Sustainability Action Plan for Australian and New Zealand EDs and to update ACEM's Statement on Climate Change (S68).

Global Emergency Care Committee (GECCo)

The GECCo supports the delivery of locally-led projects and activities that facilitate the capacity of developing countries to deliver safe and effective emergency care. The GECCo drives the College's work in Global Emergency Care (GEC), with a focus on improving health outcomes and health equity for all acute and urgent aspects of illness and injury where resources are limited. As at July 2019, the GECCo has appointed 31 Country/Region Liaison Representatives across 28 countries/regions via the GEC Network. This year, the GECCo and the College more broadly continue to remain highly engaged in work across a number of countries, with a particular focus on the Indo-Pacific Region.

Regional Faculties

Regional Faculties continue to provide engagement and networking opportunities for members. In line with the College's Strategic Plan, Faculty meetings and conferences provide members with support for contributing to the College's educational activities, the opportunity for advocacy and engagement within local jurisdictions, and the facilitation of regionally-tailored scientific content.



Not a Statistic

Dr Andrew Tagg

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

I am one of the one in five doctors who suffer from depression. I am the one in four who have thought of suicide. I am one of the one in 50 who have tried. Twenty years ago, a series of life events collided in a way that led me to overdose and a short stay in a mental health institution. But this isn't about my life as a junior doctor. It is not about the little red pills or the hours of therapy. It is about what happened after I stood up and told the world what I had been through.

In 2017, we hosted our first Don't Forget the Bubbles conference in Brisbane and were in need of a keynote. Never shy about these things, I put my hand up and volunteered to speak. I chose to tell my story of depression and its consequences. There had been a spate of high profile suicides reported in the lay press and it seemed as if there was something secret going on. Something that people didn't want to talk about. Journalists wrote about the stigma of mental illness as if there was something fundamentally wrong with a doctor being unhappy — that having a mental illness precluded them from being a good physician. I knew that was not true.

Standing up in front of 450 people, I challenged the audience to recognise the truth; many of us have been touched by depression, either directly or indirectly. Talking about it in hushed tones and behind closed doors does nobody any favours. I challenged the audience to normalise the conversation, not stigmatise it. And I left the stage, my work supposedly done.

Talking about something that personal was emotionally exhausting, so I left for the privacy of backstage. I had an early night, then tried to focus on the rest of the conference, making sure the coffee was always topped up and the rest of the speakers performed at their best. Having removed the mask of normality, I was wary of mixing with people. In the run up to coming out about depression, I had sought counsel from friends and psychiatrists about what might happen. I knew some of the things I was going to talk about might trigger strong reactions, but I was unprepared for what happened next.

At the gala evening I hung around the edges of the crowd, just like I had always done. Donning my professional mask once more, I smiled and made small talk, thankful that the modern renditions of eighties classics made anything else impossible. I nibbled at canapes, sipped bubbly water and waited for the right time to make my exit.

But then, somewhere between *Come on Eileen* and W*alking on Sunshine* I saw you heading my way. You smiled, though I struggled to place you.

'Thank you. Thank you for making me feel normal', you said.

You were women, you were men. You were medical students, trainees and consultants. You had been heard. You had been validated. We had shared some of the same stories and that was okay. That was normal.

There is profound stigma around mental illness in physicians and nurses. Conversations skirt around ideas of resilience and burnout, but stop shy of the word 'depression'. It is as if it is contagious, as if merely saying the word might make you 'depressed'. But that's as likely as talking about pregnancy making you pregnant. By normalising the

There is profound stigma around mental illness in physicians and nurses. Conversations skirt around ideas of resilience and burnout, but stop shy of the word 'depression'.

pixabay/harutmovsisyan

conversation, it makes it easier for those who are struggling to seek help without fear of judgement. Since I spoke out, I have had many conversations about the mental health of hospital staff. Some behind closed doors, some via email and text, but a large number in public forums. Every time, I remind the audience that they are not a statistic. They, or the person sitting next to them, has felt the oppressive black cloud over their head at one time or another.

Hospital administrators talk of mandatory yoga sessions and training to improve the mental strength of junior doctors, but they fail to address the system-wide issues. As part of the ACEM working group that looked into discrimination, bullying and sexual harassment (DBSH), I acknowledge there is a part we can play in reducing possible incidents. As a six-foot-three, white, cis-male, I know that I am relatively lucky in my exposure to DBSH behaviours, but that does not mean I can't call it out when I see it. Since coming out as someone who suffers from depression, I have made sure that my door, and my inbox, is always open. One in 50 doctors is one too many.

I used to wonder how much I, as an individual, could actually do. I realised it is not just about large numbers of people, but also about the one in front of you. Offering support to just one person can make all the difference.

Stories make statistics come alive; they give power to the numbers. My personal narrative is much more powerful than a bar graph or pie chart of anonymous data. So I take my story to chief medical officers and heads of department, to Grand Rounds and registrar training, in order to effect change.

How many medical units make sure all of their staff have a general practitioner? How many departments allow staff leave to attend appointments with psychologists and psychiatrists without judgement? How many heads of units understand the importance of 'mental health days'?

Are those staff some of the one in five that have been diagnosed with depression? The one in five that are more than just a statistic?

More information

Converge International
Australia: 1300 687 327
New Zealand: 0800 666 367

Lifeline
Australia: 13 11 14
New Zealand: 0800 543 354

Beyond Blue
Australia 1300 224 636

Suicide Call Back Service
Australia 1300 659 467

New Zealand
Doctors Health Advisory Services (Wellington) 0800 471 2654

The events team at ACEM has been working to deliver events across Australia and New Zealand over the past few months.

There was record-breaking attendance at the biannual Winter Symposium in Rotorua New Zealand, with over 345 participants from throughout Australasia. The opening ceremony will be remembered for the Pohiri, the talented local Raukura kapa haka group and for the powerful opening address from Tame Iti. The theme of 'Te Wero' resonated throughout the proceedings and reflected the many challenges facing the emergency medicine specialty, our community and both our countries. College President Dr Simon Judkins and ACEM would like to again extend our gratitude to the organising committee for putting on such a memorable and successful event.

Queensland Autumn Symposium In May, the College held the 15th Annual Queensland Autumn Symposium in Brisbane, connecting with more than 200 FACEMs and trainees from throughout the Sunshine State. Dr Sharyn Smith described the event as thought-provoking and engaging, with sessions covering topics including trauma in pregnancy, difficult paediatric patients and mental health. The symposium also included breakout sessions with free papers, a New Fellows Workshop and a Wellbeing Workshop. 'It's a great Opportunity to network with other ED clinicians between sessions and at the symposium reception', Sharyn says.

ACEM Mental Health Summit The ACEM Mental Health Summit was also held in New Zealand this year. The summit saw more than 100 emergency doctors, psychiatrists, consumers, clinicians and key decision-makers discuss and agree on nine key principles to tackle New Zealand's mental health crisis. ACEM President-Elect Dr John Bonning said, 'Mental illness is a major health and social policy issue, and so when this issue manifests in the emergency department, we all realise something needs to be done'. The summit built upon the momentum created by the New Zealand Government's Wellbeing Budget and ACEM hopes to see that momentum continue.

Faculty Networking Evenings Across Australia, ACEM has celebrated its Faculties with state-based networking evenings, encouraging people to get together and engage with others in the EM specialty. Throughout July and August networking events were held in Western Australia, New South Wales and Queensland.

ACEM Events

Five reasons to attend the ACEM 2019 Annual Scientific Meeting and visit Hobart, Tasmania

1. Experience the world-renowned Museum of Old and New Art (MONA) at the ASM Welcome Reception. As Australia's largest private museum, it houses everything from ancient to modern to contemporary art in a setting that the owner and curator, David Walsh, has fondly referred to as 'an adult Disneyland'.
2. Participate in one of the many wellbeing activities, including a kunanyi/Mount Wellington guided walk, a Hobart history walk with Dr Bryan Walpole or a round of Golf at Kingston Beach Golf Club.
3. Embrace your inner Tasmanian Gothic at the ASM Dinner, being held at Hobart Goods Shed, Macquarie Point, and enjoy an evening inspired by the history, darkness, remoteness and wildness of Tasmania.
4. Visit the converted colonial warehouses of Salamanca - on Saturdays there is the Salamanca Market, Tasmania's most visited attraction. Next to the Hobart waterfront and with over 300 stallholders it is an experience that is hard to beat.
5. South of Hobart are the clear waters and stunning coastline of Bruny Island. The Island has some of Tasmania's most beautifully preserved natural environments, with abundant wildlife and stunning cliff top views. Take time to enjoy the famous local produce; Bruny Island is home to producers specialising in oysters, cheese and chocolate.

SEPTEMBER	Western Australia Annual Conference, *Bunbury* | 21 to 22 September
OCTOBER	New Zealand Emergency Department Conference, *Taupo* | 23 to 25 October
	South Australia Faculty Networking and Awards Evening, *Adelaide* | 25 October
NOVEMBER	ACEM Annual Scientific Meeting 2019, *Hobart* | 17 to 21 November
	ACEM Research Networking Symposium, *Hobart* | 22 November

My First Day on the Job

Dr Mike Cameron

He was a 20-year-old surf lifesaver, as was his father. I was a 23-year-old intern, new to the ED. He and his dad were renovating their house, using a power drill. He drilled into a live wire and electrocuted himself, his father beside him at the time. They were just around the corner from the hospital where I and my intern colleague were on duty. He had the best bystander CPR ever, and arrived in the ED by ambulance with reactive pupils, some respiratory efforts and a fibrillating heart. We knew the protocol. We had both been to a cardiac arrest before. We expected him to survive.

He was a 20-year-old surf lifesaver, as was his father. I was a 23-year-old intern, new to the ED.

Two hours later, the medical registrar who had joined our little resus team called it. Nothing we tried had worked. He died.

The waiting room was full. There was no time to grieve or debrief. I remember him looking at me, before his pupils gradually enlarged and stopped reacting. I remember my silent apology for failing to save him. I remember how the people in the waiting room looked at me as I moved on to deal with their problems. I remember feeling inadequate and alone.

Dr Sarah Limbourn

'Terrified' and 'overwhelmed' are two words that instantly come to mind when I reflect on my first day as an intern in the ED at The Townsville Hospital. I could take a history, examine a patient with chest pain and initiate some simple management, but I had no idea what to do about the person with the sore big toe or the strange rash, or how to approach the irritable, unwell toddler. I felt I spent the whole day asking for help. Under the guidance of a 'freshly minted' team of FACEMs - Peter Aitken, David Cooksley, Deanne Crosbie, Mark Elcock, Kirsty Lindsay and Niall Small - I was supported and welcomed into the ED team.

There are still moments of feeling overwhelmed and being a part of an ED team is still inspiring!

This was something that stood out and was different from my previous rotations and I knew I wanted to be a part of it. I sometimes wonder if those emergency physicians know how instrumental they were in determining my chosen path in medicine. Twenty years later, I am an emergency physician. The medicine is fortunately much less terrifying. There are still moments of feeling overwhelmed and being a part of an ED team is still inspiring!

Dr Paul Spillane

My first day on the job as an intern was in January 1988. We were nervously getting a tour of the tertiary ED and happened to be in the resus room when the doors burst open and the resus team entered, followed shortly after by a patient in cardiac arrest from a penetrating knife wound to the chest.

I remember thinking, 'I'm gonna love this ED gig'. I still do 31 years later!

Resuscitation and cardiothoracic team ED thoracotomy followed … but, sadly, this did not prevent the patient's death. Things settled but we were still 'on tour' in the resus room shortly after when a patient with status asthmaticus presented … intubation, difficult ventilation … then placed on a 1988 vintage ECMO, as the gear was still in the back corridor where it had been placed in anticipation for the previous case.

I remember thinking, 'I'm gonna love this ED gig'. I still do 31 years later! Not all days are like that first morning for sure, but I always feel I am making a difference for people who are generally having a tough day.

On opposite page : Photo Credit: MONA/Jesse Hunniford. Image courtesy of the artist and MONA Museum of Old and New Art, Hobart, Tasmania, Australia

36th ACEM Annual Scientific Meeting
17 - 21 November

HOBART 2019

the changing climate of emergency medicine

5 REASONS TO ATTEND THE ASM

Welcome Reception at MONA

ASM Dinner at Hobart Goods Shed Macquarie Point

Wellbeing Activities

Salamanca Market

Bruny Island

REGISTER NOW

@acemonline #acem19

acem2019.com

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