your ED

THE ED
Then and Now

KNOWING YOUR OWN STRENGTH
Why Mentoring Matters

HOSPITAL ACCESS TARGETS
Time to Re-brand

GLOBAL EMERGENCY CARE
Liberia, Tanzania and the Solomon Islands.

Australasian College for Emergency Medicine

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

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Message from the Editor

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

In this issue, we discover just how significantly life in the ED has changed in the last 40 years by speaking to one of our Founding Fellows, Dr Edward Brentnall.

We interview Dr Dharminy Thurairatnam, who was responsible for a very early detection of COVID-19 in South Australia. We take a look at the appropriate use of time-based targets to improve whole-of-hospital for acute patients and we focus on the epidemic of violence in the ED: what can be done about it?

We also look at the characteristics of Aboriginal and Torres Strait Islander patients and gain a more in-depth understanding of the *Traumatology Talks, Black Wounds, White Stiches* Report.

This issue also reflects on mentoring support, knowing your own strengths and how a good mentor can really help.

In this issue's Global Emergency Care stories, we learn about the challenges, lesson and joys of living and working in Liberia. We also discover more about nursing adventures in Tanzania, and how training has pivoted online in the Solomon Islands.

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

In **October**, in her capacity as Chair of ACEM's Mental Health Working Group, Dr Clare Skinner wrote an opinion piece, published by *The New Daily*, for World Mental Health Day (10 October). In the context of the COVID-19 pandemic, recent release of the *Nowhere Else to Go* report, and the Australian Federal Budget, Dr Skinner outlined her experiences of providing mental healthcare in the emergency department (ED), and the need for major systemic reforms, with collaborative input from consumers, carers, general practitioners, community-based clinicians, social leaders, governments and ED staff.

'This World Mental Health Day, imagine the care you would hope to receive if experiencing mental distress, or the treatment you would like for a friend or family member', said Dr Skinner. 'Let's collectively strive to provide it.'

In **October**, a suite of articles across the media covered the College partnering with Volunteer Service Abroad (VSA) Te Tūao Tāwāhi. The five-year partnership agreement will support emergency medicine and emergency care development across the Pacific.

In **October**, the College announced that Dr Clare Skinner was declared President-Elect at the College Annual General Meeting held 21 October. Dr Skinner said: 'I am grateful to have received the endorsement of my colleagues, to represent them and the interests of our wonderful specialty of emergency medicine'.

In **November**, ACEM's Victoria Faculty Chair Dr Mya Cubitt provided commentary to *The Age* and *The Sydney Morning Herald* on a Victorian Government report, which revealed a sharp rise in the number of teenagers seeking emergency care for mental health during stage four COVID-19 restrictions.

A confluence of economic and social factors contributed to the problems, she said, and government reporting failed to capture the increased severity of mental health cases presenting in EDs more generally. 'We're not getting really good data on the pointy end, which includes what are referred to as code grey and code black cases, where hospital security or police are required to intervene, or the patient is in possession of a weapon', said Dr Cubitt. She said the issue posed a significant safety threat to ED staff.

In **November**, in light of a COVID-19 outbreak in South Australia, ACEM called for major and dangerous issues of ED crowding and access block to be urgently addressed. 'It is particularly concerning that one of the initial confirmed cases in this latest outbreak relates to a patient who spent some time waiting for treatment at an Adelaide hospital', said ACEM South Australia Faculty Chair Dr Mark Morphett.

'This highlights many issues ACEM has repeatedly, and over a long period, raised with the government as part of efforts to find solutions to dangerous ED crowding. Even when we're not dealing with a pandemic, crowded EDs and hospital access block increase the risk of worse outcomes for patients.'

In **November**, ACEM released the sixth annual *Alcohol and Methamphetamine Harm in Emergency Departments* snapshot survey, which received widespread media coverage. The survey recorded the proportion of alcohol and methamphetamine-related presentations at 19 EDs in New Zealand and 113 EDs in Australia at 2:am on Saturday, 21 December 2019. The report showed that 16 per cent of patients in New Zealand's EDs were receiving treatment for alcohol-associated issues. The figure was 13 per cent in Australia. The survey found the issues were most pronounced in Western Australia and New Zealand.

ACEM Western Australia Faculty Chair Dr Peter Allely said that alcohol-fuelled harm was a significant burden on the state's EDs, which affects emergency services for other patients. 'Often, they come in completely uncontrolled and a danger both to themselves and to staff.'

'With our state's health system already under so much strain, the frustrating tragedy of so many of these presentations is that they are preventable.'

In New Zealand, ACEM President Dr John Bonning said alcohol harm remains one of the biggest preventable public health issues facing EDs. 'Emergency doctors are still far too frequently facing the terrible, short and long-term aftermath of high-risk drinking.'

Throughout **November**, issues of access block and ED overcrowding at Launceston General Hospital continued to get media attention.

'We call on the government to commit to measures which ensure 60 per cent of patients requiring admission to hospital from the ED are admitted within four hours of arrival, and 100 per cent are admitted in 12 hours of arrival', said ACEM Tasmania Faculty Chair Dr Juan Carlos Ascencio-Lane in *The Examiner.*

In **November**, the Victorian Government announced plans to decriminalise public drunkenness. Dr Cubitt said in *The Age* that, while she supported the decriminalisation plans, EDs were not equipped to absorb more alcohol-affected people – often also experiencing mental health issues – who could present dangers to themselves and staff. 'Emergency departments are not good places for these people and we are already overwhelmed with such issues. We would love to be engaged in consultation processes so we don't unintentionally make things worse.'

In a heatwave in **November**, NSW Ambulance recorded its third busiest day on record. FACEM and Chair of ACEM's Public Health and Disaster Committee Dr Lai Heng Foong was interviewed on ABC Radio National. She said that heat-related illness was often called 'the silent killer' and that, 'more people have died from heated-related illness in the last hundred years than any other natural hazard, including bushfires'.

Following the September launch of ACEM's *Nowhere Else to Go* report, in **December**, News Corp published an article about hospitals across Australia struggling to cope with a mental health crisis. 'A lot of people with mental health problems are best treated in the community by people that know them and have a longitudinal relationship with them, but, unfortunately, many of our community mental health systems have become overloaded and so the backup plan becomes the emergency department', said Dr Skinner.

In **December**, former ACEM President Dr Simon Judkins discussed thunderstorm asthma in *The Age*.

'Thunderstorm asthma is triggered when there is a sudden change in weather conditions', said Dr Judkins. 'The movement from a hot and windy day, where there is an increased pollen load in the air, to an incoming storm front, which adds a lot of moisture to the air, will see pollens absorb the moisture and burst. This releases thousands of tiny allergen particles which are then inhaled by people and can trigger asthma attacks.'

In **December**, *The Guardian* wrote about a burgeoning mental health crisis for young people. Dr Bonning said that the number of young people aged under 17 presenting to EDs with mental health issues has increased by 25 per cent through September and October, in some regions.

'The COVID-19 pandemic has exposed the gaps in Australia's mental healthcare systems as being more like chasms and made already dire situations all the more urgent.'

In **December**, ACEM raised concerns about pressures facing Victoria's hospitals after Ambulance Victoria declared a code red, with more than 2,000 calls in hot weather on one evening – a 20 per cent increase on a regular day.

'It is a bit of a perfect storm of a whole range of factors', said Dr Bonning. 'There's this post-lockdown phenomenon, which has occurred in many countries, where we see more accidents and acute health issues as the population has this big release. In Victoria, there's a push to ramp up elective surgery that was put on hold; that takes up beds. Drugs and alcohol are a big factor again; between 15 and 25 per cent of presentations on a weekend night are due to alcohol. Mental health presentations, particularly among young people, are huge at the moment. It's an entire hospital system issue that manifests in the emergency department and we're seeing it all across Melbourne.'

Dr Judkins said many hospital workers were tired or on leave after a year with bushfires and COVID-19.

'We have an emergency system working at capacity and beyond', he said. 'Emergency departments always seem to become the melting pot or last resort for patients. We are the only door open 24/7, especially at the moment.'

In **December**, ACEM raised concerns after the government – without consultation – lifted physical distancing requirements in emergency waiting rooms. Dr Cubitt told *The Age* the changes had left her increasingly concerned for patient and staff safety. She warned that EDs were going to get even more stretched over summer.

'Physical distancing is a key concept in our layered defence strategy against coronavirus', she said. 'A waiting room is a place where a whole lot of undifferentiated people arrive – people with all sorts of illnesses, many of them, spread through physical contact or through respiratory droplets ... the less people we have in a room, the less chance we have of spreading the infection.'

In **January**, ACEM commented further in the media regarding the critical and longstanding access block issues at Launceston General Hospital.

'These have been longstanding issues and we acknowledge they take time to work through. However, finding solutions must remain a key priority', said Dr Ascencio-Lane.

In **January**, the issue of alcohol-associated harm in New Zealand was raised again, with Dr Bonning raising concerns in *The New Zealand Herald* that the issue was a much more significant problem than what was reflected in official data, which had some significant gaps.

'If you end up in an ED as a result of drinking, you are harming not only yourself but others and using valuable healthcare resources', said Dr Bonning.

In **January**, Dr Bonning featured in the media in New Zealand discussing the large numbers of seriously ill and injured patients presenting to the country's EDs.

'We're seeing a lot of people getting more chronically unwell, the elderly, people in nursing homes, and there is some trauma, alcohol-fuelled violence, motor crashes', Dr Bonning told Newshub.

'This is a system capacity issue that is manifesting in the emergency department.'

Dr Bonning warned the system would struggle to cope if a serious outbreak of COVID-19 occurred in New Zealand.

'We are getting patients staying for 24 hours or more in emergency departments waiting for a bed', said Dr Bonning.

'The Government needs to focus on some targets around acute access to care and emergency departments otherwise there will be unnecessary deaths.'

PRESIDENT'S WELCOME

Kia ora koutou,

Welcome to this issue of *Your ED*. The past few months have been marked by yet more uncertainty over city, state and bi-national border arrangements resulting from localised COVID-19 outbreaks, as well as snap lockdowns in Queensland, Western Australia, New Zealand and Victoria in the early stages of 2021.

Despite this uncertainty, I believe there are definite signs of hope emerging with case numbers in our countries remaining extremely low allowing freedoms not seen elsewhere in the world, and the commencement of the rollout of the first vaccinations against COVID-19 in Australia and New Zealand, with some of our colleagues among the early recipients.

Though the rollout is enormously welcome, it is not the end of the struggle. Vaccinating the populations of our two nations – twice – including rural and remote communities is no small feat. The vaccine is, of course, our only chance to reduce the critical impact of this virus, and we will continue to support these largescale efforts.

The overriding hope is that as a layer of vaccination defense against COVID-19 is formed, we can take another step towards COVID-normal, the eventual opening of our international borders, and a safer and more stable world generally. Time will tell us if this can be achieved.

For the world to recover any semblance of certainty, vaccination coverage must reach as much of the planet's population as possible.

Meanwhile, ambulance ramping, access block, emergency department (ED) crowding, dangerously long waits for mental health patients, and the longer term issue of maldistribution of the medical workforce in rural and regional areas continue to present challenges in almost every jurisdiction.

Amid the complexity and uncertainty of the pandemic response, the College continues to press the importance of addressing these issues on governments and health system leaders.

Our advocacy on workforce, access block, time-based targets and mental health with politicians, health managers and others we partner with as we try to improve the care for our patients, in our EDs, run by our people, continues.

Given the enormously trying times our members and trainees have experienced, another important focus is the wellbeing of our emergency medicine workforce. Fatigue and burnout are real and present risks with our work. We must all remain mindful of this and look out for each other. Remember the importance of compassion; for our patients, our colleagues, and for ourselves.

I encourage you all to make the most of the various resources, contacts and support available via initiatives such as the ACEM Wellbeing Network, on our website. Help is there if you need it, so please do reach out.

I hope also that you will find inspiration from the many wonderful initiatives, achievements and activities our members, trainees and College have been involved in, many of which are covered in the pages of this magazine.

As we move towards a hopefully more stable time, thank you, as always, for your tireless work.

Ngā Mihi,

Dr John Bonning

ACEM President

'dangerously long waits for mental health patients, and the longer term issue of maldistribution of the medical workforce in rural and regional areas continue to present challenges in almost every jurisdiction'

CEO's Welcome

Dr Peter White

Are we there yet? No matter the context, it is likely we can all recall hearing that question at some time, with answers usually something along the lines of, 'Soon', 'Almost', 'Nearly', 'Not long now', 'Over the next hill', or 'Just around the next bend'. Currently, whatever form it is articulated in, the response most likely to be heard is 'As soon as the vaccine is rolled out', or similar. We certainly don't want to hear, 'After the next wave', or 'As soon as this lockdown is finished'.

And so, in mid-March 2021 as I write this piece to welcome everyone to the first edition of Your ED for the year, there is hope in the air, along with an understanding that things can still change very rapidly and with little warning that maybe, while we aren't there yet, we are closer than we have been for some time. 'There', of course, is the so-called 'new normal' or 'COVID normal' that will allow us to relax a little, back off the extent of mandatory mask wearing and other requirements, interact and travel in a manner that bears some resemblance to 'how things used to be'.

We are all aware of the toll that COVID has taken in a range of respects, both personally and professionally. In both Australia and Aotearoa New Zealand we can be seen to be more fortunate than a lot of other countries, due to factors such as the approach taken from the early stages of the pandemic. Indeed, while some other countries, such as the United Kingdom, are starting to see some encouraging signs in relation to case numbers and mortality, others, such as Brazil, are having no such respite. This is still an unpredictable and fluid situation.

From a College perspective, while there has been much done in terms of advocacy for the profession and ensuring training and assessment activities continue, the running of ACEM as an organisation has also had its complexities during COVID and this is also not over yet. As I write this column preparations for a staged, flexible return of college staff to the Jeffcott Street offices are being put into practice, the Wellington Office having been available for use for some time due to the different COVID arrangements in place there.

The ACEM staff now number in excess of one hundred full-time equivalents. In partnership with College members and others they are there to ensure that the work required and expected of a specialist medical college is accomplished in a manner that meets contemporary expectations. Doing this in a manner that ensures work health and safety and other human resource requirements are met is as important as meeting the outputs expected of stakeholders.

In essence, it is not yet possible to have all College staff back at Jeffcott Street and ACEM functioning as it was prior to mid-March last year. At this time, College staff are due to begin returning to Jeffcott Street on Monday, 22 March 2021. The return will be on an alternating, week-in, week-out approach, with staff involved in different sections of the College attending on different weeks. For the time being, individual staff will work from Jeffcott Street or work from home based on the perceived needs of the organisational unit in question, as determined by their General Manager or Executive Director. Arrangements to ensure that staff are able to be contacted through the College, regardless of where they are working from will continue to be in place.

This is not the first time during the period affected by COVID that plans for a return to Jeffcott Street have been close to being put into action, though it is the furthest advanced that we have managed to get to seeing them realised.

While perhaps not at the so-called 'front line' of workers during the COVID pandemic, the ACEM staff have done a tremendous job in keeping the important work of the College going and I have been extremely fortunate to have had a committed group of people to lead during this time. As a professional group, ACEM members should be aware of the efforts that have gone into keeping the College working during the pandemic. It has not been straightforward, it has required considerable commitment and, perhaps at the risk of invoking some greater influence, all involved realise that it is not over yet.

On behalf of the ACEM staff, my thanks to all College members and others who have worked with us throughout the past twelve months to accomplish what the College has been able to. We all look forward to being able to welcome people back at Jeffcott Street for face-to-face meetings (in a COVID-safe way) in the not too distant future.

For now, my best wishes to all as we continue to work for the specialty that the College exists for and the communities that benefit from what we accomplish. As always, I hope you enjoy this edition of *Your ED*.

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ACEM Mental Health Roundtables

Since launching the '*Nowhere Else to Go*' report in September 2020, ACEM has hosted a series of roundtable meetings across Australia to discuss local issues, actions needed to improve care for people in mental health crisis, and address unsustainable pressures on emergency departments (EDs).

So far, events have been held in Queensland, South Australia, Tasmania and Western Australia, with more than 140 representatives attending from emergency care, psychiatry, general practice, first responders, consumers, carers and government. The events have been invaluable for building partnerships and developing consensus, with agreement that state and national governments must:

- Respectfully engage the lived experience of consumers and carers to create culturally safe and trauma-informed care
- Ensure the supply of psychiatric inpatient beds and non-hospital alternatives, and community mental health services (particularly after-hours) meet local needs
- Develop and fund innovative diversion, alternative care models, and linkages with primary care providers and after-hours community services, to provide an alternative to and pathways out of the ED setting
- Develop action plans to reduce excessive stays (more than 12 or 24 hours) in EDs
- Commit to reducing the use of restrictive practices in EDs through funding and governance arrangements that enable appropriate clinical care
- Invest in multidisciplinary services that respond to the complex needs of people in mental health crisis, including physical health comorbidities, drug and alcohol use, and homelessness
- Develop workforce plans that address gaps in mental health expertise, psychiatric leadership and the peer workforce, particularly in regional and rural areas
- Enhance education and continuous professional development for ED staff in providing care for people experiencing mental health issues.

The ACT roundtable event will be held on 31 March 2021 and Dates for the New South Wales, Northern Territory and Victoria roundtables will be posted online soon.

Author: Emily O'Connell, Policy Officer, ACEM

The ED: Then and Now

We sat down with ACEM co-founder, Doctor Edward Brentnall, who reflected on his time at the Box Hill ED, and the changes in emergency medicine over the decades.

It's hard to imagine what the emergency department in an Australian hospital looked like in 1975. Before the establishment of many of the things we now take for granted: before triage, before supervision – when junior doctors worked alone at midnight, scared – without easily accessible X-ray, without even the internet or many medical books for reference. Before ACEM existed to teach doctors how to work in emergency medicine, and before emergency medicine was established as a vital and legitimate specialty.

But nonagenarian FACEM Dr Edward Brentnall remembers this time. In 1975, he remembers, doctors avoided the ED. They regarded it as similar to the 'traditional "dunny" at the bottom of the garden,' he says. 'Necessary, but only to be visited when unavoidable.'

After qualifying in medicine (MBBS) in 1952, and after two residencies, and a stint as a doctor in the Royal Army Medical Corps in Singapore, Dr Brentnall migrated from the UK to Australia. Here, a chance conversation with a friend he was in St Johns with –Alan Davis, the Medical Director of Box Hill hospital – led to Dr Brentnall's illustrious career in emergency medicine.

A job was coming up at Box Hill, said Dr Davis, as the Director of Accident and Emergency. 'That sounds interesting,' Dr Brentnall replied. He got the job and, in July 1975, Dr Brentnall became Director of the Accident and Emergency Department, known as 'Casualty' – or 'Cas'– at Box Hill Hospital. It was then a medium-sized hospital, serving a population of 750,000 people.

He spent the first day of his job wandering around the ED '… meeting all the staff members, finding out what they did, and wondering what on earth I was supposed to do. I had no training or preparation for the job', he says. Back then, 'there wasn't any'.

In 1975, the Box Hill ED was made up of a central waiting area, nine cubicles and one room with privacy. There was also one resuscitation room with one table, and one procedure room, plus a small observation ward, and a tiny 'distressed relatives room'. Near the cubicle area were two cubicles altered for use by the doctors and nurses. There was also a preparation area with the drug cupboard, trolleys and various supplies. There was also, Dr Brentnall remembers, 'a tiny office with no windows, next door to the patients' toilets, that had a filing cabinet and a desk – and me.'

Back then, the director had to do, and be, everything. The director dealt with police, media and patient relatives. They solved medico-legal problems and staff problems – such as 'when the duty surgeon was short-tempered and unreasonable'. They were 'administrator, teacher, expert in resuscitation, politician' and 'back stop'. If the fractured nose clinic had no ear, nose and throat surgeon available, it was the director who stepped in to reduce the noses.

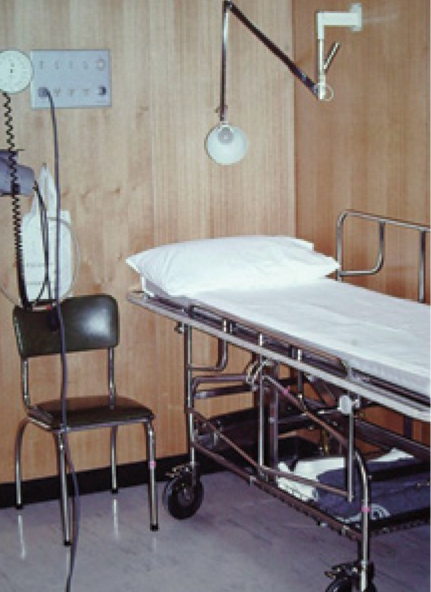
At that time, 'many of our patients were using the department as a substitute for the family doctor', says Dr Brentnall.

Before Medicare, people were charged a fee at the doctor's office. While most doctors were careful not to charge people who couldn't afford much, 'the people who didn't or couldn't pay went to the hospital'.

Waiting times were long, 'and there were many mistakes'. It was poorly staffed, badly organised and ill-equipped. Box Hill Hospital had such a bad reputation that local parents would instruct their children's school to not 'under any circumstances' take their child to Box Hill Hospital – the rumour was that some children even had a tag around their neck that said this. 'It had a terrible reputation in the general community and I remember well that my ambition was to turn that into a good one.'

There was no triage system and patients were seen in the order of their arrival, unless it was obvious they needed urgent attention. In many hospitals, the clerical staff decided this. Dr Brentnall says, 'Patients who were vomiting, bleeding all over the floor or unduly noisy were thus seen ahead of the quiet patient with severe chest pain or "indigestion".'

There were five interns to run the ED. 'There were two in the morning, two in the afternoon and evening, and one overnight.' An intern would work on the ED alone on night duty. 'It was terrifying', recalls Dr Brentnall.



The line of 10 cubicles, and the interior of one.

Dr Brentnall says, the intern was 'usually scared stiff for the first few nights, imagining all the catastrophes waiting to arrive'. The hospital saw a lot of road trauma, often alcohol-related, which often came in overnight.

Little information was available for the ED staff. There were no computers and no internet to search for information. Access to the hospital library was from 9am to 5pm and the ED library had barely any books. 'There was a 1955 edition of Hamilton Bailey's Emergency Surgery and a 1938 edition of Nelson's Medicine.'

While the senior could, theoretically, be rung, interns were reluctant to call them unless it was absolutely necessary. Luckily, there were the nurses. Nursing staff were 'the backbone' of the hospital, says Dr Brentnall. The senior nurses were typically very experienced. They knew how to recognise really sick patients and what was needed. They also knew how to tactfully, and firmly, guide the junior doctors. 'The nurses were wonderful', says Dr Brentnall, 'They would say, "Dr So and So usually orders this for such a problem".'

At night, there was no X-ray facility – unless the radiologist could be convinced to get out of bed – and there was no pathology service after 10.00 pm. The ED never got new equipment. They only had rudimentary monitors and defibrillators – 'usually "hand downs" from the ICU' and the ECG machine was a single channel model. 'With a nervous patient in a strange environment – possibly in severe pain as well – tracings were not marvellous.'

Another difficulty in the early years was that ambulance officers, called 'drivers', were not highly trained. Communication between the ambulances and the hospital was rarely useful.

However, a new initiative – Mobile Intensive Care Ambulances (MICA) which was piloted in 1971 at the Royal Melbourne, in a reconditioned Dodge 129, then established elsewhere – were staffed by well trained and resourceful officers.

The attitude from hospital staff towards 'Cas' was poor. 'Most of the specialists were concerned with their elective patients', says Dr Brentnall, and emergencies interrupted the elective surgeries they would have preferred to be doing.

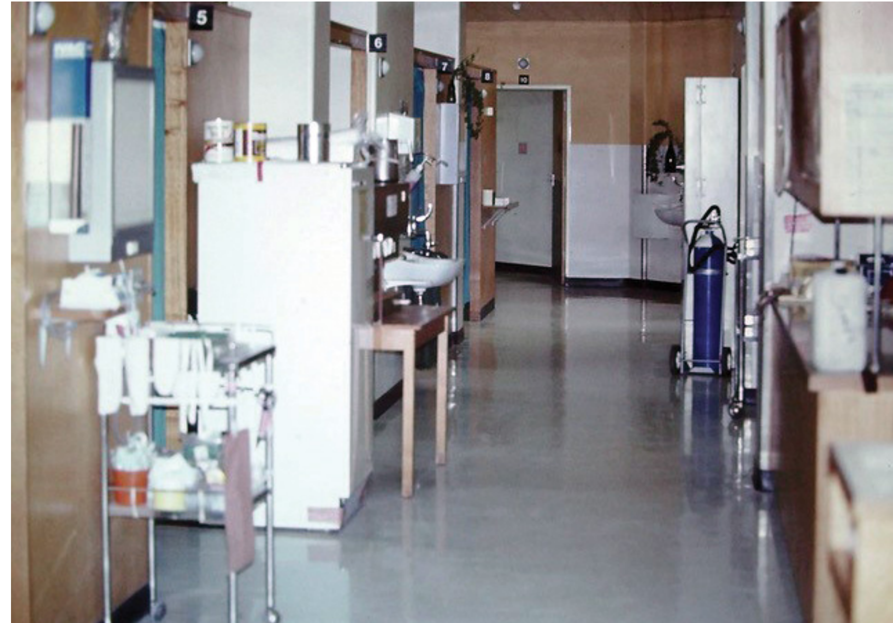
Occasionally, some staff believed they could use 'Cas' for their own purposes, including their private practices – commandeering the rooms, equipment and staff for their private clients. Once, a consultant paediatrician started to send his private patients from his rooms nearby to the ED for penicillin injections. 'His rationale was that if he gave the child a painful injection, he or she would remember and hold it against him at the next appointment' and he didn't want to hire a nurse to do it.

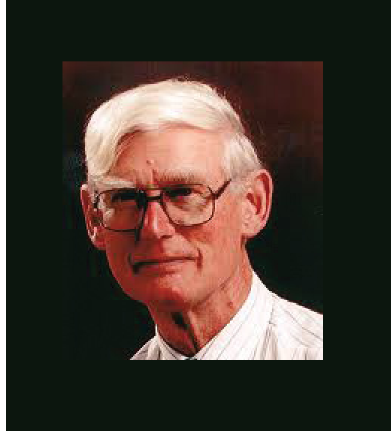
Another time, a general surgeon saw a friend's son in his private rooms with a large cut that needed stitches. 'He sent the boy with a note to the ED, and followed to take over a cubicle, ask the nurses to set up a tray for suturing, and completed the job.' Dr Brentnall reprimanded him. 'He claimed that he was trying to help by doing the repair, instead of giving us the work. I pointed out that he had used the Department for his own convenience. He never did it again.'

'… physicians – it's a tough life, especially during the training. It's hard work. But it's always exciting, it's always interesting. You see things you've never seen before. I wouldn't have missed emergency medicine for anything.'

Other changes at Box Hill 'Cas' were to change the face of emergency medicine.

At this time, there was no triage system in Australia – which now seems strange as the need for it is so obvious. 'The army has been doing basic triage ever since the Battle of Waterloo', says Dr Brentnall. 'But nobody had a triage system in civilian hospitals.'





Left: The corridor outside the Resuscitation Room and the Procedure Room.

Above: Dr Edward Brentnall 30 years ago when at Box Hill.

In 1976, the Sister-in-Charge, Mrs Noel Pink, and Dr Brentnall devised a triage system at Box Hill.

It started with three categories, with colours: 1) the urgent (yellow) 2) the run-of-the-mill (blue), and 3) the non-urgent (white). They used corresponding coloured sticker dots on patient records for fast reading. Recalls Dr Brentnall, 'We also found the dots very useful for amusing small children!'

The introduction of the Triage system was a success and was copied throughout Australia. The College Triage Scale is based on the Box Hill system, and is now copied internationally.

Patient numbers dropped rapidly as the non-urgent patients went elsewhere. 'At Box Hill', Dr Brentnall recalls, 'our numbers dropped from about 50,000 per annum to about 36,000. We were too busy to worry about whether this was a good thing, or politically correct.'

Things steadily improved. Dr Brentnall and others 'pestered' hospital hierarchy and government departments for improvements in staffing levels. Staff numbers increased and the EDs changed. The Melbourne Metropolitan Ambulance Service improved communication with emergency departments and the ED began to utilise the ambulance's Category One – lights and sirens – system.

As emergency medicine changed, the need for a cohesive organisation to advocate for the collected interests of practitioners arose.

The organisation that was to become VEDA (the Victorian Emergency Department Association) started in 1974, and it became a vital tool for communication, mutual encouragement and education. 'We used to invite all sorts of people to give us talks – for doctors and nurses.' Even more importantly, it became an effective political unit – as it represented both doctors and nurses, the politicians listened. 'We got to the stage where we were having regular meetings with the Minister of Health.'

By 1980, amid discussions to establish a doctor-only organisation, the Australasian Society for Emergency Medicine (ASEM) was formed.

Next, they wanted to expand VEDA and make it a national organisation. Dr Brentnall and other Victorian members wanted a group made up of nurses and doctors, believing it would have better numbers and, hence, better political advantage.

But WA and NSW refused to join any organisation that included nurses. 'There was no choice but to propose the formation of a College for Emergency Medicine', said Dr Brentnall. 'Rather bad temperedly, that is what I did!'

This idea was fiercely opposed by some of the established medical colleges, particularly the surgeons. They tried hard to persuade them to, instead, join the College of Surgeons – as the anaesthetists and ophthalmologists had. 'When they suggested that we were seeing mainly surgical patients, we asked them about babies with feeding problems or gastroenteritis, the rape patient, toxicology and overdoses, psychiatry, placement problems – at that point, they threw up their hands and agreed that we should go it alone.'

The Australasian College for Emergency Medicine (ACEM) was formed in 1983.

'There was no choice but to propose the formation of a College for Emergency Medicine', said Dr Brentnall. 'Rather bad temperedly, that is what I did!'

It created a training program, an examination and a qualification – FACEM. Founding members of the College, including Dr Brentnall, were automatically granted Fellowship. 'If you are going to set up a qualification, who are you going to have as examiners but the people who are already doing the job?'

VEDA continued for some years, but eventually faltered and disappeared. The ASEM and the College worked together, as it was clear that there would always be a need for an

Today, in full retirement, almost 50 years since he began his career in EM, Dr Brentnall is thrilled with the growth and change in emergency medicine. 'There's no comparison,' he says. 'It is now a place that is safer for patients. But it's also much safer for the young doctors.'

organisation to serve the needs of those who were not yet Fellows or did not wish to sit the 'very tough' examination.

But ACEM still had to convince the Canberra Committee that they were a medical specialty, as, despite the formation of the College, their EM specialty was still not recognised by medical and surgical colleagues who saw the application to be specialists as 'nonsense'. 'Our application was not looked on with any favour', recalls Dr Brentnall. 'The attitude was, "Any fool can manage in Cas". In some quarters, it still is.'

However, they persisted, and in 1993, emergency medicine was officially deemed a specialty.

Once it was officially recognised as a specialty and a career, 'Resident Doctors seized the opportunity. We were able to appoint Registrars, and many of the Box Hill residents have had distinguished careers in Emergency Medicine.'

This was the point at which the quality of care in the ED moved into the excellent category, and this started to become recognised by patients, colleagues and the hospital,' says Dr Brentnall.

After 19 busy years, Dr Brentnall retired as the Director of Box Hill in 1994. Today, in full retirement, almost 50 years since he began his career in EM, Dr Brentnall is thrilled with the growth and change in emergency medicine. 'There's no comparison', he says. 'It is now a place that is safer for patients. But it's also much safer for the young doctors.'

EDs are no longer run by frightened and unsupported interns. 'Now interns love the emergency department because it's the only place in the system where they can see patients first – the first presentation.' But, importantly, they also have back up. 'They have senior doctors, a registrar to consult with, and to look over their shoulder so they're safe, and they feel so much better about it.'

Recalling that Box Hill Hospital ED used to have to fight to use old, shared equipment, he enthuses, 'In the emergency department now, they have two X-ray rooms – just for the emergency department – plus a C.A.T scanner, plus an ultrasound room. And that's just for the department! The rest of the hospital doesn't use them.'

While most changes in EM are positive, he believes bureaucracy in all medicine has gotten worse, and has concerns with how triage – designed as a clinical tool – is now being used as an administrative tool. For example, 'Are people seeing the right amount of people in the right time frame? – all this sort of thing – which I think has made it much more complicated, and, very often, it's not helpful.'

He remembers one occasion where nurses were so pressured because of time frames to see certain categories of patients in a certain time, they started downgrading the category of some of the patients. 'The real answer of course', says Dr Brentnall, 'was to say, this shows how overloaded we are'.

A lot has changed in emergency medicine in the last 40 years, but one thing remains: the emergency physicians remain dedicated and professional. 'It's not for some people', says Dr Brentnall. 'Some people do surgery because they want to make a lot of money. But emergency physicians – it's a tough life, especially during the training. It's hard work. But it's always exciting, it's always interesting. You see things you've never seen before. I wouldn't have missed emergency medicine for anything.'

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Knowing Your Own Strength: Why Mentoring Matters

Dr Katherine Gridley
Dr Gridley is a FACEM Training Program Advanced trainee based in Brisbane, Queensland.

Like many trainees, I spent most of my medical training believing that a mentor was just a consultant who you got along with, maybe someone who inspires you. A trustworthy senior colleague who also happens to share common interests; a listening ear for your exam stress or issues in the workplace. While that all sounds reasonable, what I have just described is more in keeping with a work friend, not a mentor.

Mentoring is much more than just friendship in the workplace. It's not just a friendly face and casual chats over coffee. Mentoring done well is a deliberate and long-term commitment to your professional development and takes time, trust and vulnerability from both mentor and mentee. It requires a mutual commitment to a common goal – that of developing the mentee to their full potential.

The Merriam-Webster dictionary defines a mentor as a 'trusted counsellor or guide'. For the etymologists, the word comes from *Homer's Odyssey*, where Mentor was an old and trusted friend to Homer, who took his son Telemachus under his wing to show him the ways of the world. The word 'mentor' is considered to be synonymous with coach, pilot and lead. Not friend.

Likewise, in the true definition of the word, mentorship is not synonymous with friendship. Mentorship is a relationship built on mutual trust, where the mentor guides the mentee through their own experience and knowledge, under the premise of developing and improving the performance of the mentee. Mentoring is neither synonymous with wellbeing or resilience, although it can be used to help develop these qualities. The overarching principal of mentorship is growth.

Note that a mentoring arrangement needn't be rigid in structure in order to be successful.

Informal mentoring can be the natural progression of a workplace friendship. Should a potential mentee and mentor readily identify with one another, they may naturally engage in mentoring-type conversations. This partnership can then be deliberately progressed into a more structured mentoring arrangement, with a commitment to a series of progressive conversations towards agreed goals and a redefinition of expectations and boundaries. In recent years, many emergency departments (EDs) have established formal mentoring programs that encourage and enable matching of mentoring partners. Formal mentoring has been shown to provide multiple benefits to the mentor, the mentee

and the organisation, particularly where leadership and organisational values are concerned.

There is no one best way to mentor. A range of models have been debated. In the apprenticeship model, the mentee seeks the knowledge and guidance of a more experienced professional. The nurturing model uses the mentor more as a facilitator who encourages the mentee to try things for themselves and discuss the lessons learned along the way, while the peer mentoring model refers to partnerships between colleagues with the same rank in the hierarchy, such as buddy systems for orientation of new staff. Each of these models have their place, suiting different career purposes, personality styles and time constraints.

I have a unique perspective on mentorship having trained at a semi-professional level in the combat style of the martial art *Taekwondo*. For over 20 years, I have trained with the same instructor. She has seen me grow from an awkward, uncoordinated 10-year-old child into the proficient senior martial artist that I am today, albeit one who's much less flexible with age. She has coached me through the toughest physical challenges I have ever faced, through literally hundreds of fights and board breaks. She has witnessed all of the tears, the injuries and the self-doubt. Over time, she has grown to know exactly when and how she can push me, and she knows when to let me figure it out on my own. I respect her enormous wealth of experience and knowledge, even when it stretches me to my limits. In trusting her advice, I have achieved things I never thought possible.

A great coach or mentor brings out the best in us. The reason they can do this is not because they are a supportive friend – it is because they push us to be better, even if that means challenging us.

Many coaching moments occur within our EDs. A colleague helps you to nail the difficult intubation by suggesting you optimise the patient's position. The boss allows you as a trainee to do your shift report on a particularly hectic day in resus, letting you lead from the front while they quietly support you from the back. The FACEM debriefs the team after the kind of bad resus that makes you want to change careers, and instead of stroking your ego or pitying you, they inspire you to reflect and become a better clinician tomorrow. In these moments, the coach goes beyond just teaching or telling – they instead facilitate learning and growth.

Mentoring extends beyond a single moment. A mentor facilitates learning and change over time by providing consistent support, specific to the individual person, with maintained focus on the goal.

The role of a mentor is not to make life easier but to help make you stronger.

You may wonder why this distinction matters, particularly if, at the end of the day, the mentee appears to be progressing well. It's a matter of potential – as a clinician you can choose to continue being good at what you do, or you can aspire to get even better. Likewise, as a leader in your department, you can choose to be just a friendly face in the workplace, or you can choose to be a person who takes an active interest in inspiring others and supporting growth of the department as a whole.

Effective mentoring is like any other skill, it's made better with purposeful practice.

For the mentor, this begins with training in mentoring skills, which are distinct from medical skills. Strategic encouragement and skilled questioning enable the mentee to reach their potential. The effective mentor is genuinely inquisitive about the needs, goals and aspirations of their mentee, not driven by their own agenda. For the mentee, this means being open and willing to bring issues, insights and challenges to the mentor. The mentee who is motivated and commits to action can make the most of what the mentor offers. The mentee can self-reflect on not only their ambitions, but also which style of mentoring is likely to suit them along the way.

Much like emergency medicine as a specialty, mentoring is a team sport. It is based on trust, respect and encouragement that empowers team members to improve their own performance, which in turn builds trust and enhances the performance of the whole team. Whether it's commencing FACEM training, making the leap from senior registrar to new Fellow, or becoming a departmental lead, every one of us has the ability to achieve great things. When we don't know our own strength, sometimes all it takes is a great mentor to show us.

For all members and trainees, the ACEM Mentoring Reference Group have pioneered a suite of online modules to assist with developing and supporting the professional growth, leadership skills and resilience of mentees, as well as understanding the nuances of a truly effective mentor-mentee relationship. These modules are now available on the ACEM website.

ACEM Mentor Connect

ACEM is committed to representing and supporting members in their professional life in a manner that enables longevity of emergency medicine professionals and sustainability of the wider emergency medicine workforce. The HYPERLINK "https://acem.org.au/getmedia/cfa46235-818d-4823-91f2-23c1574f3a0d/MSH773_v1_Mentoring_Program_Policy" ACEM mentoring program (known as Mentor Connect) is being introduced as part of the implementation of College's Discrimination, Bullying and Sexual Harassment (DBSH) Action Plan. By embracing mentoring, the emergency medicine profession will institute and support healthy workplace cultures, leadership and professionalism in emergency medicine. Mentor Connect aims to connect members and trainees with an emergency medicine colleague outside their immediate jurisdiction. Applications to participate in Mentor Connect as a mentor can be made through the College website.

Hospital Access Targets: Time to Re-brand

'Over the two decades I have been working in [emergency medicine], the state of [emergency departments] has changed dramatically. Each year, there are more presentations, access block continues to worsen, staffing levels do not increase enough to deal with the increasing workload, administrative targets become more unrealistic, we deal with more violence, there is no time to eat, go to the toilet or take time to teach on a shift.'

So said a FACEM in the ACEM 2019 Workforce Sustainability Survey.[1] This comment fairly accurately represents the feelings of many.

ACEM is a strong supporter of the appropriate use of time-based targets (TBTs) in emergency departments (EDs) to improve whole-of-hospital performance for acute patients. Improving hospital performance, in particular, safely reducing hospital length of stay (HLOS), improves access to hospital from the ED, decreasing ED overcrowding. The benefits are system-wide with improved patient experience and trust, improved staff experience, and decreased patient harm and mortality. But it hasn't quite happened like that.

ACEM supported and drove the introduction of TBT in New Zealand in 2009 and Australia in 2011.

- In New Zealand, the Shorter Stays in ED (SSED) aimed to have 95 per cent of all patients admitted or discharged within six hours of arrival.
- In Australia, the National Emergency Access Target (NEAT) aimed to have (by 2015) 90 per cent of all patients admitted or discharged within four hours of arrival.

Initial results were promising; even though few jurisdictions fully achieved what were essentially 'stretch targets', patient flow improved, EDs were less overcrowded, and inpatient mortality decreased.

- In New Zealand, ED departure within six hours increased from 80 per cent (range 65-97 per cent) in 2009-10 to 94 per cent (range 90-97 per cent) in 2014-15.[2] Significantly, it was estimated that the SSED led to around 600 fewer deaths than predicted in 2012.[3]
- In Australia, ED departure within four hours increased from 64 per cent in 2011-12 (range 58-80 per cent) to 73 per cent (range 64-76 per cent) in 2015-16. Over the same period, the average time taken for most people (90 per cent) to depart the ED decreased from eight hours and 28 minutes to six hours and 53 minutes.[4] There is also a clear link in terms of patient outcomes, in particular, in-hospital mortality for emergency admissions, which improved following the implementation of NEAT.[5]

The last five years have seen these gains lost:

- In New Zealand, by 2019-20, the number of patients departing the ED within six hours of arrival had almost reverted back to 2009-10 levels (87 per cent; range 70-97 per cent).[2]
- In Australia, by 2018-19, the number of patients departing the ED within four hours of arrival had decreased to 70 per cent, with the average time taken for most people (90 per cent) to depart the ED increasing to seven hours and 29 minutes.[4]

This has occurred on a backdrop of increasing demand for emergency medical services:

- From 2011 to 2019, ED attendances in New Zealand increased by 200,000 (18 per cent increase) to over 1.2 million presentations.[6] In Australia, they increased by 1.8 million (28 per cent increase) to over 8.3 million presentations.[7,8] These increases exceeded population growth.
- In Australia, this has been compounded by increased admission rates from 28 per cent of ED attendances in 2011-12 to 31 per cent in 2018-19. In absolute terms, this represented an increase from 1.85 million acute admissions to 2.59 million.[7,8]

It's important to acknowledge that underlying these deteriorating numbers are untold levels of stress and anguish for ED staff, who feel undermined in their mission to provide timely and safe care for their patients.

Even more importantly, these numbers are associated with increasing risks and poor outcomes for patients, including mortality. This has been well established in several studies, most recently by FACEM Dr Peter Jones, whose retrospective cohort study of 5.8 million ED visits in New Zealand found that access block was the crowding measure with the strongest association with increased mortality for patients presenting to EDs.[9] New patients presenting to EDs had a 10 per cent relative increase in mortality when more than 10 per cent of current patients waiting for admission were suffering access block (waiting longer than eight hours).

An inflection point was reached around 2015-16 (the exact time will vary in different jurisdictions). Improvement in ED performance (through discharge streams and Short Stay Unit (SSU) streams) and inpatient performance (through the admission stream) became overwhelmed by workload. ED staff now spend 30 per cent or more of their time caring for people who, in a well-functioning system, would be on a ward being cared for by an inpatient team. This obviously leaves less time to attend to the emergencies arriving at the front door.

When organisations are under great stress, diversionary arguments again come to the fore by system managers responsible for problems they feel unable to solve. These include:

- **GP patients are blocking EDs:** Overcrowding is overwhelmingly due to admission stream delay, not the discharge stream delay. Patients who should 'see their GP' instead of coming to an ED, by definition, do not have conditions requiring hospital level care and admission. ACEM supports improved access to primary care but there is little evidence that improved GP care decreases access block, the most dangerous form of overcrowding. Radical system redesign such as the Canterbury Model[10] can slow the rate of increase of hospital usage, but those changes take a decade or more to achieve, and patients have a clear and present danger, which can't wait.
- **It's the EDs fault:** With more skin in the game, emergency medicine has often responded far more pro-actively than our inpatient colleagues to redesign the system to improve patient flow. Administrators pressed to improve their flow metrics for performance appraisals, in turn, press EDs, as we have in the past been responsive to improve discharge times. Continuing this, 'flogging until morale improves' diverts attention from the root cause of lack of access to inpatient beds. Just as the solution to constipation is not a bigger colon, most of the solutions to this issue lie outside the ED.
- **It's possible to hit the target but miss the point:** This was clearly exemplified in the UK's National Health Service when patients were simply shunted to a different space in the hospital without proper emergency care.[11]

NEAT (and to a lesser extent SSED) have lost traction in our access block advocacy at federal and jurisdictional levels. Our health systems are under greater stress than ever. We need to counter diversionary arguments and focus on the substantive issue; overcrowding kills and decreasing harm to patients (and constituents) is primarily about inpatient bed access.

The 2018 ACEM survey on the impact of TBTs[12] found high levels of support for their continued use. This was mitigated by concern around a range of unintended consequences, including the focus on patient throughput over quality of care, and pressure on ED staff to resolve problems in patient flow that are beyond their scope of control.

In response to this, ACEM has spent the last two years refreshing ED TBTs. We've tried to make them more pragmatic and achievable and to concentrate on inpatient bed access, so we can better engage funders at federal and jurisdictional levels.

Development of these new measures has involved a comprehensive member survey, the ACEM ED Access Measures Working Group, ACEM's Health System Reform Committee, ACEM Faculty Boards, Directors of Emergency Medicine, and member-based consultations. In September 2020, the Council of Advocacy, Practice and Partnership (CAPP) endorsed the new TBTs.

In a perfect world, these TBTs should not have to be known to ED staff; they should simply reflect the environment in which they work. We will never live in that world, but we believe these TBTs can be used by hospital executives to target effort where the evidence shows it is required, depend less on 'chasing an impossible number', and focus on improving the trend. Access block is a hospital-wide issue that is manifest in ED and requires whole-of-hospital solutions. The evidence is clear that appropriately implemented TBTs can improve patient outcomes.

Hospital Access Targets (Australia and New Zealand)

For patients needing to be **admitted** to hospital or **transferred** to another hospital:

- ≥60% should have an emergency department length of stay (EDLOS) no greater than four (4) hours
- ≥80% should have an EDLOS no greater than six (6) hours
- ≥90% should have an EDLOS no greater than eight (8) hours
- 100% should have an EDLOS no greater than twelve (12) hours

For **SSU** patients:

- ≥60% should have an EDSSULOS no greater than four (4) hours upon SSU admission
- ≥95% should have an EDSSULOS no greater than eight (8) hours upon SSU admission
- 100% should have an EDSSULOS no greater than twelve (12) hours upon SSU admission

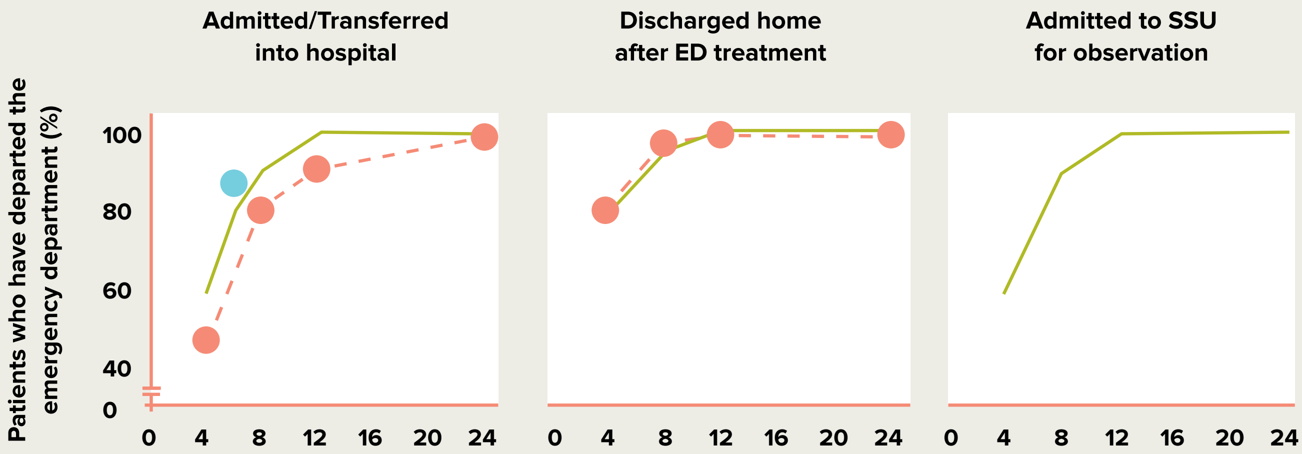
For **discharged** patients (Australia):

- ≥80% should have an EDLOS no greater than four (4) hours
- ≥95% should have an EDLOS no greater than eight (8) hours
- 100% should have an EDLOS no greater than twelve (12) hours

For **discharged** patients (New Zealand):

- ≥95% should have an EDLOS no greater than six (6) hours
- In New Zealand they wish to retain the old SSED target of ≥95% of discharged patients to have an EDLOS no greater than six hours

These targets are represented schematically below.



In New Zealand, ACEM plans to advocate based on a slightly nuanced version of these proposed TBTs. New Zealand's numbers sit on a graph in keeping with the Australian proposals, with 80 per cent admitted at six hours, 90 per cent at eight hours and 100 per cent at 12 hours. In New Zealand, 95 per cent of discharges within six hours has been an achievable target, and this will remain. The New Zealand Ministry of Health is currently convening a new national advisory group for acute care, which, as well as emergency medicine leaders, will include the relevant stakeholders outside ED (for example, general physicians, surgeons, CEOs, primary care) and be chaired by the Director of District Health Board Performance.

While it has taken some time for the College to develop and agree on these new measures, the real challenge will be how we work with jurisdictions across both countries to get them accepted and implemented. For this, we will need active engagement of our own members, governments, other craft groups and health professionals. As we know, the stakes for winning this fight are high, with the wellbeing of our members and, importantly, the safety of our EDs at risk, if we don't persuade governments to acknowledge and act to address deteriorating access block in our hospitals.

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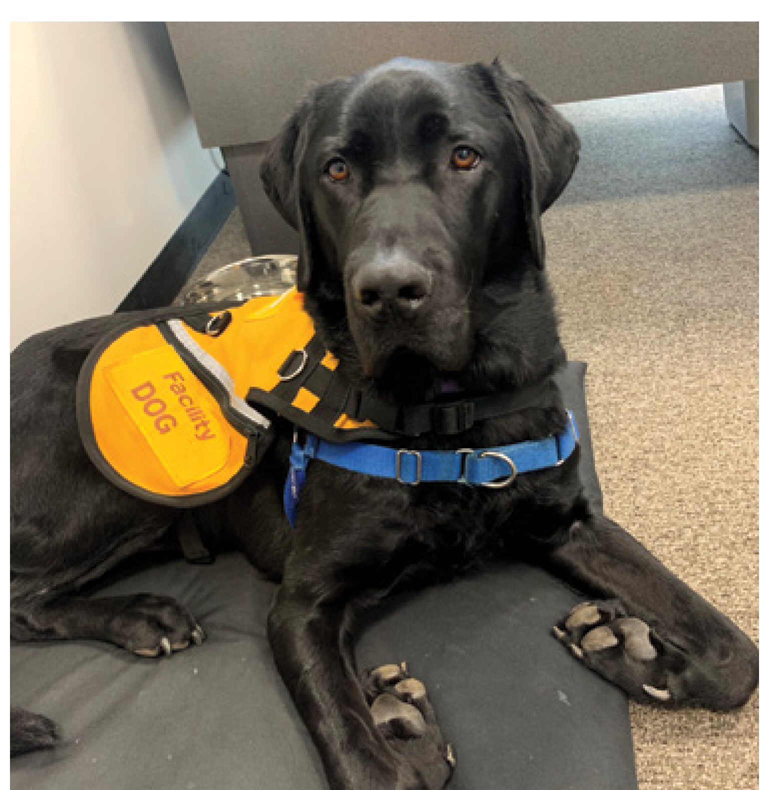

Gilbert the ED Dog

The past year has been tough for everybody, and this was no exception for Gilbert the dog. While he may not have had too many concerns about the COVID-19 pandemic he, like many Australians, lost his job in 2020.

Gilbert is a fully trained guide dog but due to ongoing knee injuries was unable to perform his duties for a person living with blindness or low vision. The future looked uncertain for Gilbert, a highly skilled yet unemployed dog, then residing with Guide Dogs Tasmania.

FACEM Lucy Reed and the welcoming team at Launceston General Hospital Emergency Department turned out to be just what the doctor ordered.

With a COVID-19 outbreak in northern Tasmania, a wave of negative media reports and the worst bed block in the country, Launceston General Hospital needed some good news. FACEM Lucy Reed, Director of Emergency Medicine, had seen therapy dogs deployed to boost morale in other hospitals, and felt a morale boost was sorely needed at her hospital.

'I was listening to one of the wellbeing sessions at the ACEM scientific meeting (ASM) online and just thinking what I could do for this department, which is struggling at times', Lucy says.

When she contacted Guide Dogs Tasmania in late 2020, she didn't know quite what she was looking for.

'It was just a thought bubble, I contacted Guide Dogs and asked where would I get a dog and how would I train it. And it was just serendipitous that they had this dog available'.

Gilbert's luck was about to turn.

'He needed a home and a job and they just reckoned that he'd be perfect in an emergency department. The other part was that they needed a home for him over Christmas. So, two weeks out, I said "yes, I'll have him"'.

Since December 2020 Gilbert has been living with Lucy, already an experienced dog owner. He had a home, but still needed support to begin his new career. Luckily, Lucy knew that the environment she needed to get approval through was a dog-positive one. With important hospital administrators being dog-owners and dog-lovers, they were happy to support the project.

Gilbert has now found a new purpose in life as a Facility Dog, an emerging field of dog employment where the dog provides companionship and affection to those staying in a facility. He is only the second of his kind in Tasmania, the other being Archie the hotel dog. But while Archie is just there for pats from hotel guests, Gilbert's role has the extra responsibility of comforting the sick and injured, and bringing a smile to some very stressed hospital staff. He's doing a fantastic job, Lucy says.

'He's therapeutic for staff predominately, but also there are various interactions with patients that are phenomenal. People's worlds light up when they see a dog, they grin and smile and you break down a barrier'.

Gilbert has been a very positive addition to the department and has behaved impeccably owing to his rigorous training as a Guide Dog. Of course, there were some preparations to do before the good work could begin.

'We wrote a guideline that spoke about infection control practices, the safety of dog and staff, rules around feeding, toileting, the cleaning of my office where he sits all the time.

And we have the agreement with Guide Dogs that says they will support us throughout. We pay them for that, so I essentially had to put in a business case to pay for the dog as well.'

Gilbert comes to work with Lucy and has her office as a base. Visits to the ED are managed from there.

'He's obedient enough to sit quietly in the office if we're really flat out, without whining, barking or worrying.'

Support and training from Guide Dogs Tasmania has also been essential to the success of the program.

'Guide Dogs continue to support us. He still belongs to the Guide Dogs and they have put five of us through the handling course, which has just been three hours training us how to handle the dog properly with the commands they are used to.'

Now that staff are trained up to handle Gilbert, there is plenty of opportunity for him to do his good work around the department.

'I've got one of the volunteers on board and she just takes him around and picks out those who have been there overnight, those who are in pain or those who have dementia and are confused and struggling, or children that need procedures.'

Lucy says that even though she spent some time organising to have Gilbert, it was all worth it.

'I get out on the floor and I realise that it's a little bit of extra coordination in a day for a heap of benefit. So much benefit. Better than me going out there alone and going "Are you all ok? How's it going?". Take the dog and they all smile.'

It can be difficult to get to know everyone in a busy department, but Lucy finds that having the dog by her side facilitates interactions that she wouldn't normally have.

'I've spoken to more of the specialty registrars than ever before because they literally come up to see Gilbert and you get into conversation and you get to know people.'

Not every dog could make it in this tough line of work, but Gilbert has a set of characteristics that make him right for the job. Lucy says that he is extremely calm, very subdued and not upset by noisy patients or large equipment being hauled around.

'Nothing phases this dog. Nothing.'

In the difficult times that Launceston Emergency Department has seen, even before the pandemic, Lucy says Gilbert has been a shining light and she is very grateful for the supportive leadership at the hospital.

'It's been really hard and actually just to bring something in that's so easy, that brings so much joy to the place is unbelievable. Who'd have thought that a dog could change the face of this place?'

He can't take away the ongoing problems of bed block and ambulance ramping, but according to Lucy the feedback on Gilbert has been overwhelmingly positive and the benefits to patients are plain to see.

'It takes their head away from the awfulness of being ramped. It takes their head away from their pain, their anxiety over being in ED. It just gives that positive slant to every interaction we have.'

'He puts a smile on everybody's face. It's amazing for morale. Amazing.'

Author: Katie Lee, Campaign Assistant

Dr Lydia Lozzi

Why emergency medicine?

I always wanted to be a surgeon but as a medical student I did a surgical rotation and the registrar was on call 24/7 for three months straight. I don't think I would be a very nice person if I lived like that so I chose another path. I loved the emergency department (ED) as an intern and decided it was way more fun than surgery – I could have a life and when the shift ended, it ended. The people are awesome too.

Most challenging/enjoyable part of the job?

As a registrar I found the night shifts the most challenging because I really like sleep. However, they're also where you have a bit more responsibility and more fun. I remember some scary times but it's after those nights I feel like I've made a difference.

Maintaining wellness

I have three children – ages 10, eight and two. When I'm not working I am with my family – usually stopping the toddler from putting Lego up his nose or biting the dog. Lately, we have gotten into the game Among Us. We play it together but a real-life version, which we play a bit like that old Murder in the Dark game. My kids love it and it gives the dog a break. We also quite often go out on the boat or to the beach.

I think your brain needs a break to maintain wellness. Luckily, I have no neurons left for work when I'm with my kids.

Greatest achievement

My children! They are lovely, beautiful little people.

Career accomplishment

I recently published *Squid's Little Pink Book*, which has been a personal project of mine for the past decade or so. As a registrar, I was worried about night shifts so I brought a little pink notebook and wrote everything in it I might need to know in a hurry. Since then, I've kept adding to it and after Fellowship I even created a digital version.

The book has become well known. My nickname is 'Squid' (rhymes with 'Lyd') so my colleagues know it as *Squid's Little Pink Book*. On shift, I often get asked to check something and I've had quite a few people ask for copies. I thought about printing it off but I realised it would cost me $50 to give a copy to a friend. Luckily, I went to publisher Elsevier for help and they've published it!

I really hope it helps. Many times I've tried to find something online and couldn't or I've tried an app but it needed updating. There's something very comforting about a book sitting in your pocket – it doesn't need batteries or wi-fi and it won't disappear into the cloud. It's lovely to think that this book might help someone, even if it's just giving comfort to a doctor on night shift.

What inspires you to work in ED

People – most people in the ED are genuinely good – staff and patients. Everyone is different and a little weird (or a lot weird), but I am inspired by how kind and lovely people are. The random acts of kindness I see – a security guard who bought me food when I forgot my dinner; a patient's family who brought me dried flowers as a thank you because they didn't know when I would be in; or the boss who drove to my house to pick up my glasses because I forgot them for my night shift.

Piece of advice

There is no need to race through your training. Put life first. I worked part-time after my son was born (most of my senior training). I also had time off for maternity leave. I worried it was taking me too long and that my interns had become consultants before me, but in the end it didn't matter. I got there, no regrets. I'm glad I spent as much time as possible with my young kids. Do what suits you and your life – fit training into your life, not life into your training.

Looking forward to

A vaccine! Also, I've taken a position at Macquarie University coordinating the medical students' final year critical care. I'm excited to get started – hopefully I can inspire some students to pursue a career in emergency medicine.

More information

Get *Squid's Little Pink Book*: www.elsevier.com/books/squids-little-pink-book/lozzi/978-0-7295-4376-7

Dr Ruchi Fernando

Why emergency medicine?

Emergency medicine became such a marvellous part of my work life pretty late on in my junior house officer years. Having trained overseas, emergency medicine as a specialty wasn't really a service the hospital provided, the "Emergency Room" was staffed with a PGY2 or 3 medical officer and essentially called the relevant service needed to manage and admit the patient or just sent them around to clinic if they weren't really that sick. The expectation wasn't, as in an episode of ER, cowboy doctors who saved lives. ED eluded me until PGY3/4. I really enjoyed and even flourished grinding on the junior role of ward rounds, clinics, theatres, being the gofer for our team coffees, late nights, early starts, back-to-back-to-back. Every term was a fresh approach to a new system of organs to focus on, casually omitting the holistic approach we were taught once upon a time. Then ED came along and I had to bring about all of these skills into one, and change it up for the elderly and young alike. I also had three to four days off, Vit-D levels started rising and I reintroduced myself to my non-medical friends. Life was great before but it got better. When I moved to Sydney as a fresh registrar, I was extremely lucky to start at the friendliest department – Hornsby. My colleagues and bosses were amazing and the job I felt was, again, a lot different from my great experience back in Auckland – it really confirmed this was the career path I wanted to follow. Since then, with lots of support and encouragement, I've moved on to Liverpool ED – where nearly every shift is like being in an episode of ER.

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

Communication between services is a challenging area in our line of work – we are all busy and it can take a toll on our emotions and endurance on the shift. Having a conversation about patient care that requires an admission sometimes requires "offering your firstborn" (I read this somewhere – thought it was hilarious, some may consider to be true). It weighs heavy on the head after a busy shift and it's usually the part of the job which I go over and over, rather than all the good that's taken place.

And it really shouldn't be. This is why the most enjoyable part of the job is a collaboration between services that provides a smooth transition for a patient in need to get the treatment they require. It's also awesome bringing the dying back to life.

What do you do to maintain wellness/wellbeing?

When the timing works and if I'm lucky to get a few words in, spending time on video chat with my cute nieces, Ava and Sammy, is probably the best 'destresser'. Other than annoying my other half, I've also recently gotten into plants and drone photography. While at work, however, I'm very lucky that at Liverpool, I work with such an awesome cohort of trainees who are well looked after by our DEMTs and consultant group. There is great comradery and time is always taken to have banter, check on each other, and crack a joke despite the >50 patients waiting to be seen.

What do you consider your greatest achievement?

I feel it is the desire to keep achieving. If it isn't one exam then there is another or if there is one way to do something then there must be something better. Keeping that attitude is something I try and have. Plus, nothing I do is comparable to what I'm surrounded with, my partner went through university again, worked while studying, all the while being super supportive. My parents moved around multiple countries, learned new languages, gained degrees whilst raising children. And my brother, keeps me looking forward – even though he works in a completely separate field (Google Cloud Corporate Leader in New Zealand and prior to that the first chief design and technology officer for IBM New Zealand) he's definitely my greatest role mode – he has a such a way of gentle motivation with generous encouragement – I definitely would not be where I am today without him.

What inspires you to continue working in this field and what's the future of Emergency Medicine?

Emergency Medicine is definitely changing. It isn't the same job it was 10 years back and I doubt it'll be this way in 10 years' time. From subspecialties in Ultrasound, PEM, GEM, Tox, and Retrieval to name just a few, the list is only going to get larger. It's exciting times, we need to and should be highly adaptive. I'm passionate about education at all levels of medicine to continue adapting and it's this future expectation and working alongside the women and men who are making this happen is really what inspires me.

PROV-ED Project

Dr Andrew Hobbins-King
Dr Hobbins King is the Co-Professional Lead PROV-ED Project,
FACEM Sunshine Coast Hospital and Health Service

I'll be honest, when I started as a FACEM I didn't really know about Quality Improvement. It certainly wasn't the 'sexy' side of emergency medicine, not like doing a thoracotomy or dealing with a crashing patient, but I could recognise a great idea when I saw one and was amazed at how innovative we can be in emergency medicine. I have my health service mission statement embroidered on my scrubs: 'Exceptional people. Exceptional healthcare.' I constantly ask myself, 'Are we really exceptional? Can we do better?'.

Sometimes life in emergency medicine leads you down unexpected paths …

During my time as an advanced trainee at the Royal Brisbane and Women's Hospital (RBWH), I had the opportunity to work with Professor Louise Cullen on a cardiology presentation. If you don't know the RBWH, registrar presentations were (and still are) quite a big thing. You even get a prize for the best one (damn you Rob Mitchell and your fantastic ability to inform and entertain). If you don't know Professor Cullen, she is quite a big thing in the world of research, cardiology and emergency medicine. The presentation went well and I didn't make a fool of myself. I learnt a lot and I think I made a good impression on Professor Cullen.

Fast forward several years. As a new FACEM starting in a temporary position at the Sunshine Coast Hospital and Health Service (SCHHS), I landed myself the much coveted cardiology portfolio. I started working with a state-wide team, called the Accelerated Chest Pain Risk Evaluation (ACRE) project, to redesign our chest pain pathway. It was headed by Professor Cullen. I really enjoyed the process of working with our local team, supported by the experienced Project officers; introducing a chest pain nurse role, educating our staff, and finding solutions to the inevitable problems and hurdles we hit along the way.

While travelling around Queensland sorting out chest pain, the ACRE team kept coming across innovative and unique initiatives stuck in the 'silos' of individual emergency departments (EDs). Frontline clinicians were making meaningful and lasting changes in their own departments but had no way of sharing and spreading their great ideas. No one likes re-inventing the wheel and sometimes the best ideas are just in the ED up the road. Thus, the PROmoting Value-based care in the Emergency Department (PROV-ED) Project was born to support value-based healthcare across Queensland Health by disseminating successful piloted initiatives. It isn't easy to make state-wide changes. PROV-ED is funded and supported by the Healthcare Improvement Unit (HIU) of Clinical Excellence Queensland (CEQ), the Queensland Emergency Department Strategic Advisory Panel (QEDSAP), and hosted by Metro North Hospital and Health Service (MNHHS) in Brisbane.

In early 2019, the ACRE team informed me of the creation of PROV-ED and that they were looking for applicants for a co-professional lead. I thought I would give it a go as it might be something I enjoy and possibly be good at! I applied and, to my surprise, got the job. I now work one day a fortnight with the PROV-ED team in Brisbane and I'm loving it!

We kicked off in May 2019 with a state-wide expression of interest calling for written applications of unique ideas and projects, which were shortlisted by a multidisciplinary panel from CEQ, QEDSAP and PROV-ED. Shortlisted applicants were invited to present a three-minute pitch to the panel at the PROV-ED Pitchfest, a shark tank-like event with consumer representation, a panel and audience participation. Six initiatives were selected for state-wide rollout and we spent the rest of 2019-20 scaling up and refining the projects, involving key stakeholders including the Royal Flying Doctor Service (RFDS), LifeFlight, Retrieval Services Queensland (RSQ), Office of the Chief Nursing and Midwifery Officer (OCNMO), the State-Wide ED Nurse Educator Committee (SWEDNEC) … the list was endless and the acronyms confusing!

We then travelled the state performing innovation showcases in EDs to staff, leadership and executives. It was fabulous meeting old registrar friends in new positions across the state, networking, and learning about the challenges and frustrations faced by each site. We now have 20 EDs implementing

individually tailored initiatives through locally appointed, co-funded Local Project Champions (LPCs) that are making meaningful changes to departmental culture, patient and staff satisfaction, saving money and reducing waste. The Projects were all given brilliant acronyms and cool logos:

Transforming EDs Towards Cultural Safety (TECS), *Cairns Hospital, Cairns and Hinterland HHS*

An ED-focused initiative on building relationships, demonstrating understanding, and improving departmental safety and cultural capability for patients identifying as Aboriginal and Torres Strait Islander.

Standardised and Safe Intubation Package (SSIP), *Gladstone Hospital, CQHHS*

A suite of resources, including an equipment shadow board, a drug draw up guide, and pre-and post-intubation checklists, providing a standardised and safe approach to patient intubation.

Cannulation Reduction in the ED Intervention Toolkit (CREDIT), *RBWH, MNHHS*

An initiative reducing unnecessary and potentially harmful cannulation through education, promotion and establishment of a culture asking 'Are you 80 per cent sure?' that patient needs a cannula.

Nurse Initiated X-ray (NIX), *Logan Hospital, MSHHS*

A comprehensive package of online education, local work guidelines and clinical skills assessments to upskill nursing staff to initiate specific x-ray investigations, reducing waiting times and ED length of stay.

The Blood Clock – Eliminating O-Negative Blood Wastage in the ED, *RBWH, MNHHS*

A simple alarm clock timer attached to the blood box triggering timely return to the blood bank, avoiding the blood going into the bin.

Pre-filled Saline Syringe (PreSS), *RBWH, MNHHS*

Introduction of pre-filled saline syringes designed for flushing vascular access devices, optimising workflow efficiencies, saving money, and standardising care.

We've had some great successes and achievements in the short time we have been running:

- Combined data from eight hospitals alone demonstrated a potential annual saving of 12,974 staff hours and $1,159,607 through implementing the CREDIT initiative. That's more time and money for patient centred care.
- Engagement of rural and remote facilities across Queensland through dissemination of SSIP resources, included in the 2020 update of the Rural and Remote Emergency Services Standardisation (RRESS) guidelines to upwards of 140 rural and remote facilities.
- Robust uptake of the TECS initiative by Queensland EDs with widespread evidence of efforts to improve cultural safety for Aboriginal and Torres Strait Islander peoples. We have partnered with the QH Suicide Prevention in Health Services program to offer eight x $35,000 grants to improve the relationships between emergency departments, mental health services and those at risk of suicide.
- Installation of digital screens in participating EDs to help promote the PROV-ED value based care messages as well as the six ACEM Choosing Wisely recommendations. The striking visuals were so popular that they are now being promoted nationally by Choosing Wisely Australia!

Then 2020 and COVID-19 arrived, so we quickly had to adapt to becoming socially distanced and increasingly digital. We hosted our second Pitchfest online in August 2020, with four more exciting initiatives (all with cracking acronyms and logos) selected for state-wide roll out:

REDuce Urine Contamination in Emergency (REDUCE), *PAH, MSHHS*

Illustrations and instructions to help stop urine sample contamination as a result of poor collection techniques.

Resuscitation Medication Safety (REMS), *Logan Hospital, MSHHS*

A benchtop board and visual prompt for nursing staff allocated to the drugs role to ensure correct medications are prepared during resuscitation.

Safer Ventilation in Emergency (SAVE), *Bundaberg Hospital, Wide Bay HHS*

A bedside educational resource to assist with clinical decision-making and track patient progress.

Safe, Well organised, Inter-Facility Transfer (SWIFT) process, *QEII, MSHHS*

A bedside safety checklist conducted at the time of a patient transfer by the senior doctor and senior nurse to ensure safety criteria are addressed prior to transfer.

Now it's 2021 already and we are busy planning, editing and organising our initiatives for launch in March. We are excited to be collaborating with a whole host of new stakeholders, including CEQ Bridge Labs and Queensland Ambulance Service (QAS), to ensure we have the most flexible, efficient and practical products to provide value-based care.

I think we are constantly striving for the best and, of course, we can always do better. It just takes finding the right people, and with some passion, collaboration and great acronyms, we can achieve Emergency Department Quality Innovation!

Characteristics of Aboriginal and Torres Strait Islander ED Patients

It's well acknowledged that Aboriginal and Torres Strait Islander peoples have poorer health outcomes and a significantly reduced life expectancy in comparison to other Australians, with higher hospital admission and mortality rates frequently reported.[1] It's also well known that First Nations Australians are more likely to use public hospital services. Emergency departments (EDs) are often the first point of contact with the health system for many First Nations peoples and, as such, they are over-represented among ED attendances.[2] With this in mind, EDs are uniquely positioned to monitor the health issues impacting on First Nations peoples and contribute to improving their health outcomes.

A number of studies have looked at the patterns of ED presentations among these patients, however these have focused on a single ED or a localised area.[3,4] Importantly, a small number of studies and anecdotal reports suggest that EDs are often viewed as unwelcoming environments for First Nations peoples, with some experiencing cultural insensitivity and even discrimination during their presentation to Australian EDs, which affects the care they receive.[5,6]

With this in mind, ACEM is committed to monitoring the use of EDs across Australia by First Nations peoples, to better understand the areas of need and gaps in care. To do this, ACEM has sourced annual data from the National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD, de-identified data) held by the Australian Institute of Health and Welfare, which has been used to undertake an exploratory quantitative study to examine and compare the profiles of this cohort and other Australian ED patients. This serves as a fundamental step to advocate for change, if and where needed, towards the goal of 'Closing the Gap'.

Characteristics and trends of presentations to Australian EDs

There has been a significant increase of more than 40 per cent in annual attendances to public EDs for First Nations patients over the last five years to 2018-19, from 417,600 attendances in 2014-15 to 589,651 in 2018-19, with two-thirds attending EDs located in regional and remote Australia. In 2018-19, they accounted for 7.1 per cent of 8.4 million ED attendances nationwide, compared with 5.7 per cent in 2014-15; an annual average increase of five per cent (Figure 1). This reflects an over-representation in First Nations patient ED attendances at a rate of 724 presentations per 1,000 First Nations peoples versus 267 presentations per 1,000 other Australians.

Consistent with their age distribution among the Australian population,[7] the age distribution of First Nations ED patients was skewed, with more than 60 per cent aged under 35 years. Only six per cent of First Nations patients were aged 65 years or over; four-fold less than the proportion (23 per cent) of other Australian ED patients. Interestingly, a larger proportion of females (53 per cent) than males (47 per cent) was seen among First Nations ED presentations, which was disproportionate with their equal gender composition in the wider Australian population. This was consistently seen over the last five years (between 2014-15 and 2018-19).

First Nations patients were significantly more likely than other Australians to arrive by ambulance and police or correctional services vehicle to EDs across Australia (metropolitan, regional and remote areas) despite the lower accessibility of these services outside of metropolitan areas. First Nations patients were more frequently triaged as less urgent, with 52 per cent versus 47 per cent of other Australian patients triaged as semi-urgent or non-urgent.

When the reasons for presenting to EDs were assessed and compared with other Australians over the five-year period, First Nations patients were consistently more likely to present due to respiratory system illness, mental or behavioural disorder, and illness of the skin or subcutaneous tissue. Other Australian patient presentations were more likely to present for reasons associated with circulatory system illness, single site major injury, and digestive and neurological system illnesses. Among the First Nations patients, differences in diagnosis were also observed by age group, with mental health-related disorders more common among adult patients, while circulatory system illness was the most common principal diagnosis among geriatric patients (aged 65 and over). Illness of the ear/nose/throat and illness of skin/subcutaneous tissue were more common among paediatric patients (aged 0-14), compared with adult and geriatric patients.

Each year, a comparable proportion of First Nations and other Australian patients departed from EDs after emergency care was complete. Overall, First Nations patients were less likely to be admitted to hospital (27.4 per cent versus 33.3 per cent in 2018-19), however, they were significantly more likely to be admitted than other Australians to EDs located in remote Australia (26.3 per cent versus 14.6 per cent).

First Nations patients were significantly more likely to leave EDs without being seen or before care was complete (9.8 per cent versus 6.4 per cent in 2018-19), which has been seen in other studies. This trend was seen consistently over the five-year period (Figure 1) across all kinds of ED locations (metropolitan, regional and remote). Importantly, our analysis found that there was a higher percentage of First Nations patients who were classified as requiring immediate care or care within 10 or 30 minutes, who left the ED without being seen or before care was complete. This was despite similar

Figure 1. Proportion of all ED attendances (primary y-axis); and the proportion of ED attendances who arrived by ambulance who were admitted and who left without being seen/care complete (secondary y-axis) for First Nations patients (a) vs. Other Australian patients (b), between 2014-15 and 2018-19.

waiting times for ED care reported for both First Nations and non-ATSI patients, with a similar proportion seen on time for each triage category.

Conclusions and future direction

For the first time, the characteristics of and longitudinal trends in ED presentations by Aboriginal and Torres Strait Islander patients have been assessed at a national level, with the findings further validated by consistent trends over the last five years. Our analysis provides important insights into the key differences in how the ED is used by First Nations patients in comparison to other Australians, and highlights areas for ongoing research and advocacy work to improve ED services and the quality of care provided to First Nations peoples.

In response to these findings, ACEM has undertaken a collaborative project with Karabena Consulting and the Lowitja Institute to conduct qualitative research and further explore the experiences of First Nations patients, focusing on how emergency care can be improved and be culturally safe (see page 32).

Authors: Katie Moore, Research Manager and Jolene Lim, Research & Evaluation Officer

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Pathway Through a Pandemic

Dr Dharminy Thurairatnam was doing a medical ward round in a tertiary hospital in Malaysia, when there was an overhead pager requesting doctors to the emergency department. There was a mass casualty event nearby with multiple trauma presentations.

She had never been exposed to emergency departments prior to this encounter. The only depictions she had seen of an emergency department (ED) were what she saw on television series such as *ER*.

That trauma call was her first meaningful exposure to ED.

'It was a life-changing and career-defining experience', Dharminy says.

'That afternoon, I was certain about my career in Emergency Medicine (EM) and I haven't looked back since.'

Today, Dharminy works in the emergency department at Lyell McEwin Hospital, where her supervisors encouraged her to take on the Emergency Medicine Certificate in view of her clinical acumen and aptitude.

Dr Anit Manudhane and the consultant team at Lyell McEwin Hospital suggested the program after reviewing her performance. 'I can't thank them [Anit and course supervisor Dr Ignatius Soon] enough for all their support, motivation, encouragement and the dedication they have shown in guiding me towards this path – the right path.'

Dharminy says the course has enriched her knowledge of emergency medicine.

'I've been equipped with essential skills to manage and treat emergency presentations in the ED.'

Like many medical trainees, Dharminy had the added complexity of COVID-19 over the past year and is trying to balance COVID-safe work with COVID-safe training.

'2020 was an extraordinary, eventful and memorable year, with many unforeseen turns.

'Everyone at Lyell McEwin Hospital has been very receptive to the changes so we can have a COVID-safe working environment. The team has demonstrated flexibility and adaptability with the ever-changing COVID-19 situation.

'We've embraced the ups and downs as best as we can.'

The consultant team have looked after the psychological wellbeing of the staff throughout this time.

In late 2020 Dharminy made the news as the junior doctor who identified the first case in the South Australian 'Parafield' cluster of COVID-19.

'As a state we had no community transmission at that time. There were cases among returned overseas travellers, but they were all in quarantine.

'I had a patient who presented with malaise. It was based on a high index of clinical suspicion the respiratory swab was ordered for the patient. This resulted in a very early detection of COVID-19 community transmission, which could have been potentially catastrophic in many ways to South Australia.

'This story highlights the need to think about COVID-19 with every patient, even with the vaccine roll-out.'

She says credit for the state's success managing COVID-19 belongs to everybody.

'Premier Steven Marshall, Chief Public Health Officer Nicola Spurrier, Minister for Health Stephen Wade, SA Health Chief Executive Chris McGowan, South Australia (SA) Police Commissioner Grant Stevens and many others on the front line of the respone have worked relentlessly to contain and curb the spread of COVID-19 second wave in the state.

'The people of SA have also come hand in hand with the government of SA by doing the right things to get on top and stay ahead of the game.

Main photo far left – left to right
Chief Executive SA Health Christopher McGowan, SA Police Commissioner Grant Stevens, Steven Marshall Premier of South Australia, Minister for Health and Wellbeing, Stephen Wade, Chief Public Health Officer Professor Nicola Spurrier, Dharminy Thurairatnam.

Left – LMH Nurses from left to right
Lija, Stephanie, Jayne, Dharminy, Jodie, Ali, Ruby.

Above – LMH Family from left to right
RN Laura, ED Liaison Nurse Donald Olds, RN Kerrin, ED Consultant Jane Rowlands, ED Reg Le Nguyen, Dharminy Thurairatnam, ED Consultant Henry Limgenco, January Delos Reyes, ED Consultant Anit Manudhane, ED Consultant Tanya Boast, RN Phong, ED Consultant Mustafa Haidermota.

Top Left – LMH Consultant from left to right
Ignatius Soon, David Pope, Kathy Underwood, Dharminy Thurairatnam, Peter Bruce, Sean Casey, Nehvi Tariq, Aman Anand, Keiko Morioka.

Images and caption text kindly provided by Dharminy Thurairatnam.

'It was a bit scary at the time, but you have to have hope and faith that it will work out fine. And it did', she said.

The encounter with that patient forced Dharminy into hotel quarantine within weeks of her scheduled EMC examination.

'The Parafield cluster meant I didn't really know if I would be able to sit the exam. I was scheduled to sit it under supervision with other candidates, but didn't know if that would be possible in quarantine.'

She was also dealing with intense media interest in her story.

'It was a bit of a frenzy. I had planned to use the time to do my final revision, but I hadn't really counted on multiple media interviews'.

Fortunately, special arrangements could be made to enable Dharminy to complete the examination from her hotel room.

'Dr Ignatius Soon, ACEM EMC Training Coordinator Caroline Mulchinock and ACEM CPD Coordinator Kylie Parker, who invigilated me, all understood the situation I was in and made sure I was able to sit the exam. I thank them for making it possible.

'It – hotel quarantine, the media interest, the exam in quarantine – was intense pressure, nerve wrecking and overwhelming.

'The most challenging scenario in the past year has been my continuing separation from family, with the significant restrictions on international travel and a paucity of international flights. There is that saying that behind every great man there's a woman, but behind me stands a strong man, my dearest husband Pravin Thiruchelvam, and my boys Thaarman and Coshaal. I can't thank them enough for being there and supporting me through this unprecedented year.'

Even with these challenges and media spotlight, Dharminy successfully completed the EMC exam and is now an EMC graduate, with her eyes set firmly on a future in ED.

'I am very passionate about emergency medicine and hope to advance my career by joining the [FACEM] training program'.

'There are no words to express how grateful I am to my colleagues at Lyell McEwin Hospital. They went above and beyond to support me through that period. People made sure to check in with phone calls and messages, they provided home-cooked meals – roast chicken! – and sent me thoughtful gifts.

'They know who they are, but the kindness will forever be remembered, treasured and cherished.'

Author: Natasha Batten, Communications Advisor

Structure of the Emergency Medicine Certificate (from 2021)

- Start of placement and reflection meetings
- Five Mini-Clinical Evaluation Exercises
- Six Direct Observation of Procedural Skills
- Two Case-based Discussions
- One Procedural Checklist
- Advanced Life Support 2 workshop
- Online learning modules
- Online examination

The Hidden Epidemic: Violence in the ED

In 2019, cardiothoracic surgeon Patrick Pritzwald-Stegmann was killed by a one-punch attack during a shift at Box Hill Hospital in Melbourne. While emergency physicians tend to downplay the impact of violence in their workplaces, this tragic loss of life was a harsh reminder of what is at stake.

Healthcare workers, particularly those in emergency departments (EDs), face a significantly higher risk of violence at work than others, and are less likely to report it due to a culture of under-reporting and poor data collection practices.[1]

The data that we do have show that incidents of violence against ED staff are increasing, with the most common being verbal aggression, followed by threats and physical violence.

ACEM President Dr John Bonning recently told the Safe & Secure Hospital & Healthcare Worker Conference, 'In the 25 years that I've worked in emergency medicine, I've been kicked and punched. I have had to personally disarm a knife-wielding patient. I've lost count of the number of times I have been abused. Just two weeks ago a patient screamed half a dozen times that she was going to kill me after she had swung at me three or four times'.

Unfortunately, this will sound familiar to many ED physicians. Eighty-eight per cent of respondents to the ACEM 2016 Workforce Sustainability Survey said that, in the past 12 months, they had felt threatened by a patient or their carer, with 43 per cent having been physically assaulted. Females and trainees were slightly more likely to report having felt threatened, while assaults were equally experienced by all genders, but trainees were more likely to be assaulted.

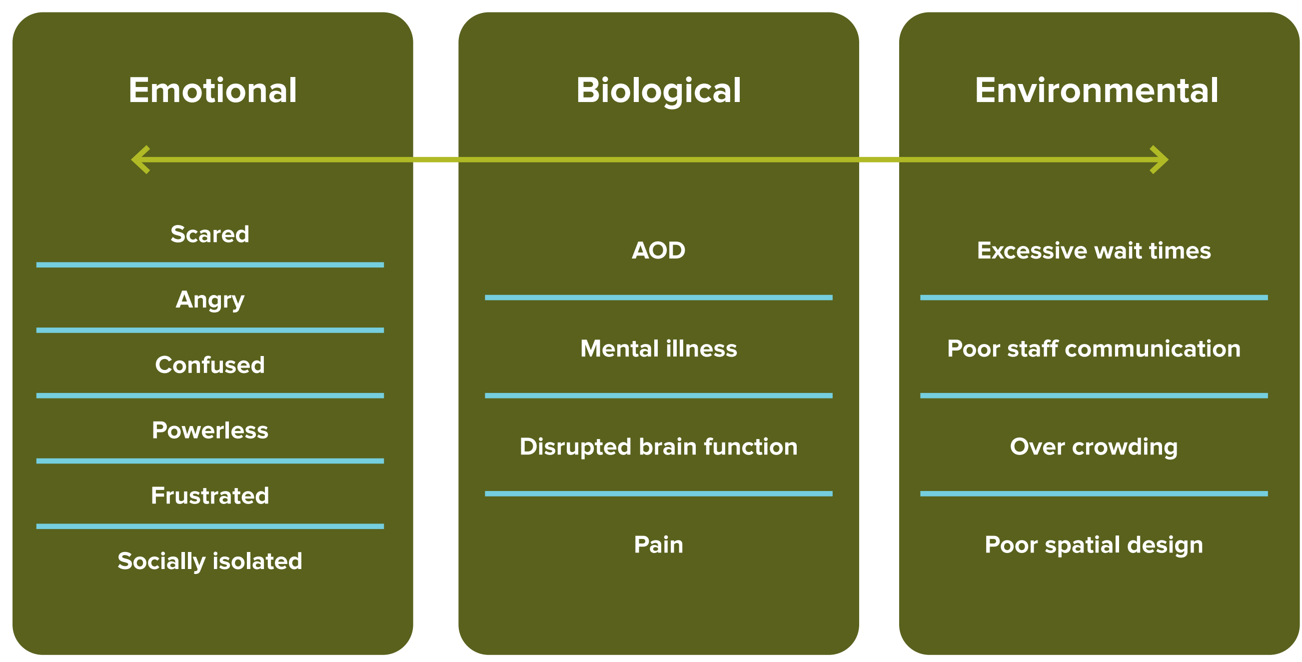
Other studies have shown higher rates. Egerton-Warburton et al[2] measured alcohol-related aggression in 2014 and found that nearly all (98 per cent) of ED staff had experienced verbal aggression from patients affected by alcohol and 92 per cent had experienced physical aggression. Forty-two per cent of respondents said they were experiencing this aggression on a weekly or monthly basis. Based on the 3.6 violent incidences per 1,000 patient attendances at an ED, this equates to one incident every one or two days per ED.

As a point of comparison, a large survey of Australian GPs and hospital doctors reported that one in three had experienced physical aggression in the past year. This is still an unacceptable number, but is notably lower than the prevalence in EDs, where violence and aggression has been the norm for too long.[3]

What triggers violence in the ED?

People presenting to EDs are rarely in a good state of mind. A combination of emotional, environmental and biological factors can all contribute to people committing acts of violence.

As when violence occurs in other settings, people are usually expressing feelings of fear, anger, confusion, powerlessness or frustration.



People affected by alcohol and other drugs (AOD), or those experiencing mental illness or a health condition that disrupts normal brain function, are more susceptible to these emotional states, and are also less inhibited and more impulsive, making them more likely to act on their emotions.

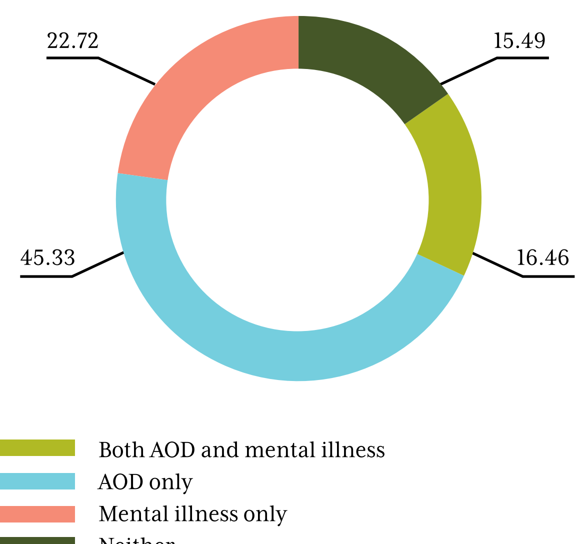
Environmental factors are layered onto this emotional state, with patients experiencing a stressful environment that does not always meet their needs. The crowded, busy and chaotic ED environment may feel unsafe, while poor spatial design contributes to patients feeling confused or unrecognised. This can occur when spaces are confusing and hard to navigate, or when it's hard to communicate with staff (for instance if there is a glass barrier at reception).

Beyond the physical triggers, patient expectations of the health system and poor communication from ED staff (often due to high workload, burnout and/or compassion fatigue) can create a sub-optimal experience. For instance, we know that violence is most likely to occur in a triage area when people are first waiting to be seen and may not understand why other patients who arrived after them are seen first.

The big issues

Drugs and alcohol, mental illness, and often a combination of both, are implicated in nearly all violent incidents. Nikathil et al[4] reviewed the activity records of security staff over a three-year period in an adult metropolitan hospital for all incidents of patient-perpetrated violence. More than 60 per cent of perpetrators were under the influence of drugs or alcohol, including 16 per cent who also had a psychiatric diagnosis. Around one in five were recorded as having a psychiatric diagnosis without the presence of drugs and alcohol. Notably, only 15 per cent of perpetrators were neither under the influence of drugs and alcohol or had a psychiatric diagnosis.

Figure 1: Presence of AOD intoxication or psychiatric diagnosis in perpetrators of violence[5]



The timing of most violent incidents is also clearly linked to social patterns of substance use, with violence occurring more commonly during the evening and weekend shifts. Unfortunately, these shifts are also more likely to have reduced staffing and less experienced staff rostered on.

As detailed in the *Nowhere Else to Go* report launched by ACEM in 2019, patients presenting with mental health needs often experience long delays due to access block, often waiting days for definitive care. This is a recipe for disaster, increasing frustration and exacerbating mental disturbance.

Restraint and sedation

Current levels of violence in EDs mean restraint and sedation of violent patients is an unfortunate reality.

Wherever possible, ED staff avoid the use of restraint and sedation, instead using prevention strategies such as verbal de-escalation and appropriate medication. However, if staff are not able to verbally de-escalate a situation, physical restraint and sedation need to be employed to ensure the safety of the aggressor, staff and other patients.

While the use of restraint and sedation is routinely recorded in public hospital psychiatric wards and other mental health facilities, the use of restrictive practices in the ED is not part of routine data collection because there is not the time or resources to collect it. There is limited data to improve our understanding of the use of restrictive practices, which is impairing the potential for any progress towards reducing or eliminating the use of these practices.

Knott et al[6] have shone some light on the prevalence of sedation and restraint in EDs, undertaking an audit of patients who had attended four Victorian hospitals in 2016, to understand clinical practice when responding to behavioural emergencies, determined by a code grey (unarmed threat) being called.

This audit found that code greys were called for 1.5 per cent of all patients (1,853 events), with restrictive interventions applied in a quarter of these cases. The patients were more likely to be young and male. Importantly, where a code grey had been called, less than one in six patients were admitted to an inpatient bed, indicating that such presentations could have potentially been prevented through the provision of adequate community and crisis services or more timely treatment in ED.

Evidence from other studies suggests that patients who are intoxicated with alcohol or drugs are less likely to respond to verbal forms of de-escalation and are more likely to require sedation compared to patients with a sole diagnosis of mental illness.[7,8] More than 80 per cent of ED clinical staff felt that alcohol-related presentations adversely affected patient wait times and the care of other patients within the ED.

Reducing the use of sedation and restraint is a policy priority in Australia and New Zealand and has been supported by changes to legislation, policy and clinical practice. It will always be required in some instances, but prevention of violence must be the primary aim.

Risk minimisation

The ways violence in the ED can be reduced are multiple, and are primarily the responsibility of government decision-makers, health bureaucrats and hospital administrators.

At hospital and health system leve, standardised risk management and incident reported processes are needed that will support a change in culture, from accepting that violence is an unavoidable part of working in emergency medicine, to saying it is unacceptable.

Staff need to be trained on how to respond when violence occurs and formally report every instance. By better capturing the incidences, we can then learn from the data. After the event, hospitals also need to ensure staff get the support they need, be it legal, medical, psychosocial or assistance returning to work.

At a government policy level, we need to address access block, whereby patients become stuck in the ED because of a lack of inpatient beds or services for the next stage in their care. By reducing waiting times, we will reduce the likelihood of people becoming frustrated and, in turn, violent.

Policy responses are also needed that recognise the ED is not an ideal place for people experiencing acute mental health and AOD issues. While there will always be people who need our help, there are safer and more therapeutic alternatives than the ED, which is a highly stressful environment.

As most EDs are publicly funded, governments also have a role in ensuring funding for adequate staff-patient ratios, as well as specialist mental health staff and security personnel.

'At hospital and health system level, we need standardised risk management and incident reporting processes that will support a change in culture'

ACEM's advocacy

Violence in the ED is becoming more prevalent and ACEM is working in several jurisdictions to find solutions with government decision-makers. A review of ACEM's *Policy on Violence in Emergency Departments* is underway, reflecting rapidly evolving evidence in this area. A draft will be available for members to comment on in late 2021. If you are aware of new evidence or emerging data in this area, please contact policy@acem.org.au

Author: Jesse Dean, General Manager, Policy and Regional Engagement

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Alcohol and Methamphetamine Harm in EDs – Findings from the 2019 Snapshot Survey

Background

Alcohol and other drug (AOD) harm is one of the largest, preventable public health issues facing emergency departments (EDs) in our region. It represents significant challenges for the acute health system, affects ED function, significantly impacts staff wellbeing, and exerts a negative impact on the care of other patients.

To inform ACEM's advocacy on this issue, the Alcohol and Other Drug Harm Snapshot Survey has been conducted on a weekend night in December every year since 2013 in more than 100 EDs in Australia and Aotearoa New Zealand. The aim has been quantify the burden of alcohol in EDs and better understand its contribution to the ED workload. Since 2018, the Snapshot Survey has also examined methamphetamine-related presentations.

2019 findings

Of 167 eligible EDs, 113 EDs in Australia and 19 EDs in Aotearoa New Zealand completed the survey at 2:am on Saturday, 21 December 2019.

At a national level:

- 13 per cent of ED presentations were alcohol-related and 2.8 per cent of ED presentations were methamphetamine-related in Australia.
- 16 per cent of ED presentations were alcohol-related and 1.9 per cent of ED presentations were methamphetamine-related in New Zealand.
- Alcohol-related ED presentations remained constant at 13 per cent in Australia from 2016-2019, whereas in New Zealand, they decreased from 23 per cent in 2016 to 16 per cent in 2019.
- Methamphetamine-related presentations decreased slightly in Australia (3.0 per cent in 2018 versus 2.8 per cent in 2019) and increased in New Zealand (0.7 per cent in 2018 versus 1.9 per cent in 2019).

At a jurisdictional level in Australia:

- Western Australia consistently had the highest percentage of alcohol-related ED presentations, with more than one in five (22 per cent) patients there in relation to alcohol.
- There were minimal changes in the percentage of alcohol-related ED presentations across jurisdictions from 2016-19; the largest change was in South Australia, where alcohol-related presentations reduced by 5 per cent (15 per cent in 2016 to 10 per cent in 2019).
- All jurisdictions had similar percentages of methamphetamine presentations in 2019 (ranging from 2.0-3.8 per cent).
- Western Australia reported the largest difference in methamphetamine-related ED presentations in 2019 compared to 2018, reducing from almost 5.9 per cent to 3.3 per cent.

So what?

As outlined in ACEM's Statement on *Alcohol Harm and Statement on Harm Minimisation Relating to Drug Use*, there is great potential to prevent AOD harm and the cost of ED care through appropriate public health action.

Priority actions:

- Implement compulsory collection of minimum AOD presentation data through addition of AOD data elements to the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), with further investigation to determine the optimal coding method.
- Improve ED resourcing to enable the delivery of screening, brief intervention, and referral to treatment (SBIRT) programs by trained AOD staff, with evaluation conducted to build the evidence base.
- Reorient EDs to include multidisciplinary models of care that integrate mental health, substance use and primary care services.
- Improve the integration and resourcing of AOD services to reduce the need for people to visit the ED in crisis (for example, community-based AOD services; in-hospital withdrawal services and specialist psychiatric support; and integrated care pathways out of EDs and into specialist treatment programs).
- Create safer environments to reduce harm from drug use, such as needle and syringe exchange programs, community prescribing of naloxone, medically supervised safe injection rooms, and drug checking services (pill testing).
- Trial and evaluate long-term demand and supply reduction strategies to reduce the availability and affordability of alcohol (minimum unit pricing and volumetric tax on alcohol sales; licensing policies to reduce alcohol outlet density; greater regulation on alcohol promotion and advertising; and more active enforcement of regulations on off-licence and online alcohol outlets).
- Establish independent regulatory bodies in Australia and New Zealand to control alcohol advertising, sponsorship and promotions, and strengthen regulation, including complaints and enforcement provisions.
- Introduce legislation to phase out alcohol sponsorship of sports teams and alcohol advertising during televised sport.

Author: Emily O'Connell, Policy Officer ACEM

Read the full 2019 Snapshot Survey Report at acem.org.au/AOD

Traumatology Talks – Black Wounds, White Stitches

So many of those presenting to our EDs carry with them deep and pervasive societal wounds, which cannot be stitched back together by emergency medicine alone and thus will never heal. Although our emergency departments (EDs) are well versed in identifying and addressing clinical interventions, they need to shift their practice to consider the social and cultural determinants underlying health and illness. – *Traumatology Talks – Black Wounds, White Stitches* Report

ACEM recognises that the provision of culturally safe, acute healthcare in Australian EDs is not only vital to true reconciliation with First Nations Australians, but also necessary to ensure that healthcare is safe and effective. Health equity for Aboriginal and Torres Strait Islander peoples is a strategic priority for ACEM. The College has an Indigenous Health Committee reporting to the ACEM Board, as well as a *Reconciliation Action Plan* and a *Māori Health Equity Strategy – Te Rautaki Manaaki Mana.*

In 2018, ACEM's research team identified a pattern in Australian Institute of Health and Welfare (AIHW) data, where Aboriginal and Torres Strait Islander patients were more likely to leave the ED before their treatment was finalised. This trend was statistically significant and consistent across Australia. There was a lack of published research about the reasons for this pattern and, in particular, very little research that had asked Aboriginal and Torres Strait Islander patients about their experiences accessing the ED.

To address this paucity, in 2019, ACEM commissioned a research project to study cultural safety in ED settings from the perspectives of service users and emergency service providers. Developed in partnership with Karabena Consulting and the Lowitja Institute, the project's aims were to develop a set of recommendations to improve emergency care delivery for Aboriginal and Torres Strait Islander peoples; to identify conceptions of cultural safety from First Nations Australians and ED staff; and to apply this information to education and training, ED design, and ACEM's research activities.

The project used methodologies that are inclusive of First Nations research leadership, narrative practices, cultural protection and data sovereignty, and that involve community members as co-creators in the processes of engagement, implementation, evaluation and knowledge exchange.

The project research team worked with three EDs across Australia where the 'did not wait' rate was particularly significant for First Nations Australian patients. Working closely with Aboriginal researchers, community groups and hospital Aboriginal Liaison Officers, groups of community were interviewed about their experiences in the ED. Interviews were also conducted with clinical and non-clinical ED staff.

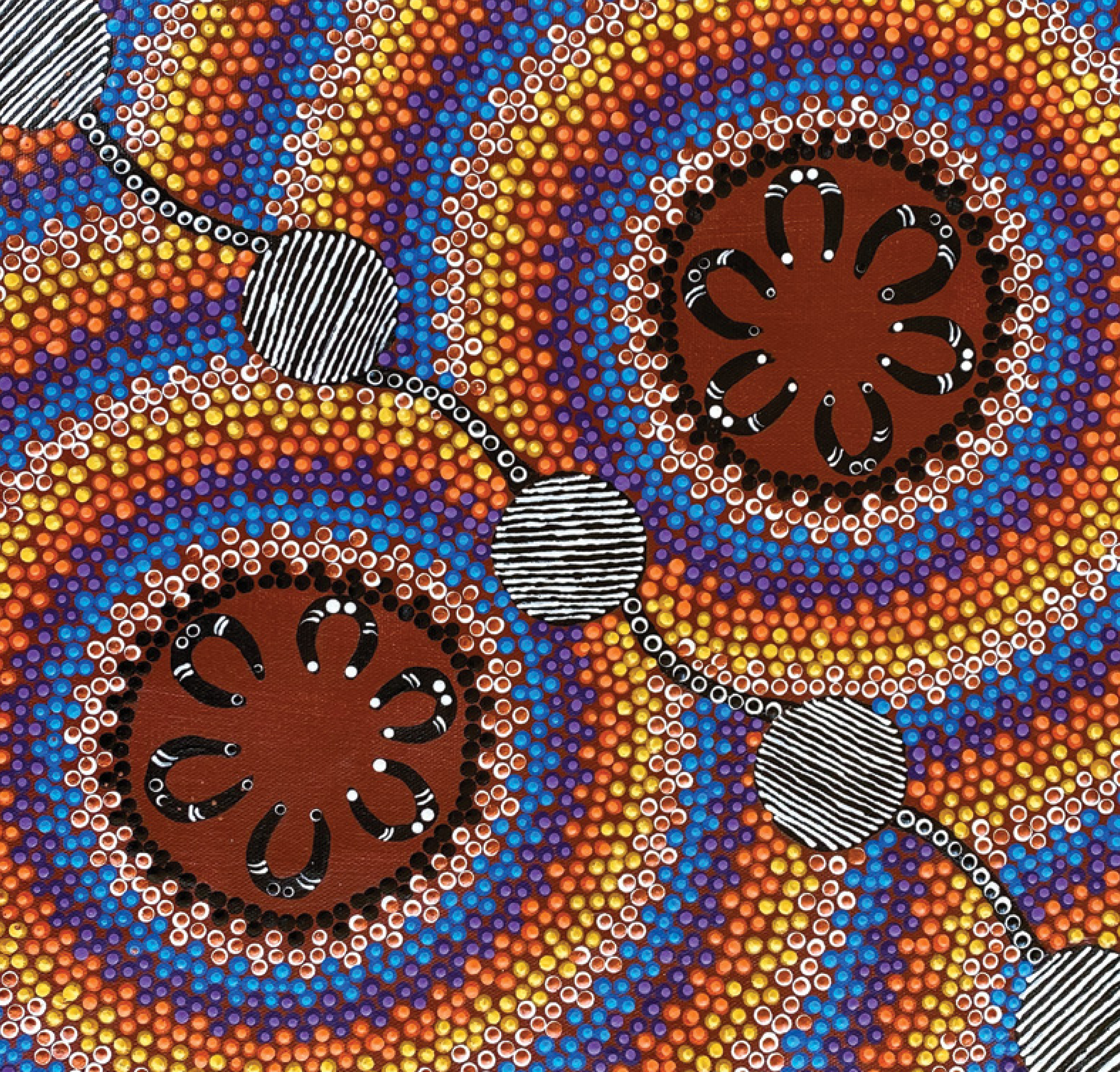
Although our EDs are well versed in identifying and addressing clinical interventions, they need to shift their practice to consider the social and cultural determinants underlying health and illness.

The project was completed in December 2020, despite the challenges of seeking ethics approvals from six ethics committees, the bushfires in early 2020, and the COVID-19 pandemic.

ACEM is pleased to share the final research report with members: *Traumatology Talks – Black Wounds, White Stitches.*[1]

The report provides a comprehensive set of recommendations for ACEM to consider. These include:

- Consideration of a Social Emergency Care discipline
- Extensive recommendations for cultural safety training
- Advocacy to increase the recruitment and retention of Aboriginal and Torres Strait Islander clinical and non-clinical roles in the ED
- Advocacy to increase Aboriginal-led businesses providing support services to the ED
- Recommendations for improving the cultural safety of the ED environment



Artwork: Margie Lankin

- Developing an ACEM cultural safety research program based around discrete projects led by Aboriginal researchers.

Based on the report, the Project Reference Group will be finalising an implementation plan in the first quarter of 2021 for ACEM to progress.

The report recommendations will have significant implications for the work ACEM undertakes over the longer term, while also influencing the focus of our advocacy work. We look forward to sharing our progress with you.

ACEM thanks community and staff participants in this research for the generosity of their time and insights.

Author: Angela Wadsworth, Project Lead, Indigenous Health

‘The project used methodologies that are inclusive of First Nations research leadership, narrative practices, cultural protection and data sovereignty’

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ACEM Liberia Report

Dr Alison Mitchell

Dr Mitchell writes to us from Liberia. The story below is a reflection of her experience in-country on a third-party assignment.

Like many Australians, I couldn't have pointed out Liberia on a map. I may have vaguely heard about it in reference to civil war or the Ebola crisis, but that's as far as my knowledge went. That is, until I found myself riding out a global pandemic in Liberia's capital city, Monrovia.

My journey started with a desire to experience medicine in a developing country context and a Google search. I contacted an organisation Mission, who help place short-term medical volunteers in developing country hospitals. Through their efforts, I heard about Liberia and organised a placement.

The original plan was to volunteer at a Hospital in Monrovia for three months. I arrived on 27 February 2020 and have been in Liberia ever since! Like so many of us, COVID-19 has disrupted my plans and brought unexpected challenges, but it has also presented unforeseen opportunities and experiences.

Now that I've been in Liberia for eight months, what have I learnt? I think that would be broadly divided into two categories – things I've learned about Liberian and medicine, in a developing country generally and things I've learned about myself.

By measure, when looking at the Human Development Index (HDI) or the Sustainable Development Goals (SDG), Liberia classifies an impoverished nation. It routinely ranks in the bottom 10 for any metric of disadvantage, the economy is failing and there is widespread corruption. Civil war and the Ebola epidemic have left deep social and psychological scars. I found this country's healthcare system to be profoundly dysfunctional.

On arriving at my host hospital, I was almost overwhelmed by the rudimentary nature of the hospital. I've been working in an Emergency Room (ER) of 25 beds. They are crammed into three rooms with no air conditioning and very little ventilation.

It's constantly hot, noisy and filled with offensive odours.

Resuscitation capability is virtually non-existent. The 'airway' equipment consists of a cardboard box filled with used oxygen tubing, nasal cannulae and some Hudson masks. There are no ventilators in Liberia and no non-invasive capabilities. There is no defibrillator, no infusion pumps and no monitors. Routine stock, like gloves or syringes, are frequently missing and vital medications may or may not be available.

While these limitations were confronting, it was the attitude of the Liberian staff that I found to be the greatest challenge. I perceived an apathy toward patient care that pervades the hospital. Many instructions are simply not followed, critically-ill patients are ignored, and as much of the shift as possible is spent sitting or lying down. I will never know exactly what promotes this attitude, but I suspect it arises, in part, from constantly witnessing tragedy and being powerless to do anything about it.

Tragedy is a daily part of life in Liberia. People die in our ER every day. Most are children or young people with preventable or treatable illnesses. They die from sepsis, malaria, hepatitis and stroke. They die because they don't know when to seek help, don't have the money to pay to go to hospital, and haven't been immunised. Given the extremely limited nature of the hospital's resources, we are often unable to stem this tide of death.

As you can imagine, transitioning into this environment was a massive challenge. Where and how to make any sort of difference was the immediate question. After eight months, I'm still trying to answer this. But, ultimately, I believe that any impact I'm having falls into three broad areas: leadership, process and education.

Firstly, I've always believed in leading by example. Hard work generally inspires hard work; commitment inspires commitment. And so, at my host hospital, I've tried to set an example of patient-centredness – arriving on time, listening,

doing whatever needs to be done. And it has been satisfying to watch the staff respond. The ER staff, particularly the nurses, have grown in their concern for their patients. They are listening better, working harder and showing more compassion. It has taken time, but we are starting to function as a cohesive and caring team.

The second major focus of my efforts has been on process. An ED is only one in name without two essential processes – triage and flow. To my dismay, I discovered that the ER at my host hospital possessed neither of these. Patients were reviewed in order of arrival or based on some other metric, such as wealth, social status or who they knew. And patients remained in the ER for multiple days – often up to a week.

With the aid of an Australian nurse, I developed a triage tool and had dedicated training days on its use. We created a designated triage area and organised staffing and equipment.

Working on these processes has been challenging and not always successful. With the aid of an Australian nurse, I developed a triage tool and had dedicated training days on its use. We created a designated triage area and organised staffing and equipment. Unfortunately, old habits die hard. Our triage form and area are still in use, which has streamlined things somewhat. But the staff still haven't grasped the concept of seeing patients based on acuity rather than arrival time. For now, I have accepted the gains and will continue to assess how to make improvements.

On the positive side, we have made significant advances with flow. Each day, after taking handover of the ER, I walk around the whole hospital and find out what beds are available. The nurse supervisor and I then prioritise which patients can go to those beds and get them moving. Slowly, I'm starting to see the staff understand that a successful ER visit does not necessarily mean an overnight visit. They are following my lead more regularly and moving patients home or to the wards. It's slow progress, but at least there is progress.

I have also been focusing on clinical processes. Soon after my arrival, it became clear to me that the only sort of medicine that will work in an environment like my host hospital is the pragmatic sort. Given the extreme limitations of diagnostic and therapeutic resources, finesse has to give way to practical procedure. For example, you can't use a Diabetic ketoacidosis (DKA) protocol that requires an insulin infusion if you don't have infusion pumps.

So, I have worked to establish some key protocols for common presentations, such as stroke, DKA, heart failure and coma. It's my hope that by learning and following these protocols, the local staff can maximise the good they can deliver within the limitations of the setting. Again, I've been encouraged by small gains, particularly from the physician assistants who are the backbone of the ER workforce.

Like everything in Liberia, progress is slow. But, if nothing else, these teaching sessions usually leave me feeling more hopeful.

The third area where I've tried to focus my attention is education. Much of this happens at the bedside. Frustratingly, much of it must be repeated again and again. I have also engaged in some formal teaching, including weekly sessions with the physician assistants, assisting in a paediatric training course designed by a colleague, and ad-hoc teaching of the residents. Like everything in Liberia, progress is slow. But, if nothing else, these teaching sessions usually leave me feeling more hopeful.

While I may or may not be changing anything at my host hospital I am astounded at the ways in which this experience has changed me. Working in this sort of environment is humbling, frustrating, exhausting and indescribably rewarding. I have learned how little I knew about this developing country and its real needs. I've been forced to change habits that have been years in the making. My blunt pragmatism has had to be tempered by cultural sensitivity and heightened compassion. I've had to learn to bite my tongue – often the hard way!

I've experienced the emotional toll of repeated trauma and I marvel at my Liberian colleagues. Like most of us in 2020-21, I've learned to live with uncertainty. I've learnt to improvise – who knew how versatile indwelling catheters could be? And I hope I'm learning how to keep going, even when the task feels insurmountable.

What I have learnt most, that in moments where I feel distressed or disheartened, is to take a walk outside the compound walls. It is in those moments that I make the choice to keep going, to keep helping, to keep showing compassion.

ACEM encourages those considering undertaking independently sourced global emergency care opportunities to partner with established and reputable organisations that provide comprehensive safety, security and pastoral support.

The West Point slum is home to about 75,000 in the capital of Monrovia, Liberia.

iStock.com/ BethanyFank

Nursing Adventure in Tanzania

Libby White and Marwa Obogo

This article is dedicated to the memory of Upendo George (1981-2020) – one of the first female emergency specialists in Tanzania. A pioneer, champion, legend and amazing friend who lived every day of her life to the fullest.

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Muhimbili National Hospital (MNH) is in Tanzania's capital of Dar es Salaam. This tropical seaside city is home to over five million people and the dusty streets are vibrant with colour and life during the daytime. Buses spewing black smoke are crammed full of people, while motorbike taxis zip in and out of the busy traffic, honking their horns, not wearing helmets. There are always people walking along the roads, carrying babies while balancing buckets of shopping on their heads or trying to sell goods through open car windows at the lights. Police shut down roads at a moment's notice to allow dignitaries clear passage, causing even more chaos on the congested roads.

A stone's throw from the ocean, MNH proudly offers healthcare to all Tanzanian citizens, who are often referred from far-flung locations for specialist care.

The first fully equipped emergency medicine department (EMD) in Tanzania was set up in 2010 by taking a multi-faceted approach to creating change within the public hospital system. This included an in-country international nurse and doctor support team, hand-picked local leaders, and a constant rotation of international visiting emergency medicine specialists and nurses to lead education and development of clinical skills.

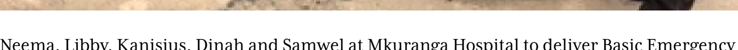
Support from MNH's nursing management was vital in creating change, by minimising the movement of skilled nurses out of the EMD, and by providing a much larger number of nurses to work in the EMD than were historically on the wards.

The local nursing leader, Sister Angelina Sepeku was in the first group of three nurses to complete a Master of Critical Care and Trauma. Along with her strong work ethic and nurturing personality, she spent many long days and nights in the EMD. She developed equipment and supplies processes, billing methods, and protocols of how the EMD would fit within the hospital structure, as well as upskilling around 80 nurses and health attendants. An electronic medical record (EMR) was used from the beginning, but for most staff, who had never even turned on a computer, training them to utilise this technology was a feat in itself.

I was offered an opportunity to work at MNH for one year (I happily stretched it to three) as a Clinical Emergency Nurse Educator, to support the nursing team. I had travelled to Africa before and vowed to return one day – that day arrived in September 2016. Sister Sepeku welcomed me with a huge embrace and I just knew this was going to be an amazing adventure. She introduced me to Marwa Obogo, the current Nurse Manager of the EMD and, together, they helped me settle into Tanzanian life and work.

Listening to Sister Sepeku and Marwa's stories of those early days, it was incredible to see how far they'd come. I spent time working in all areas of the ED to build relationships with the nurses and understand their workflow. The nurses' training was in English so I could communicate with them, but most patients only spoke the national language, Swahili, so I had to quickly get to work learning another language.

The MNH EMD had been part of an African Federation for Emergency Medicine (AFEM) pilot program and set up a group of specialised nurses, called Clinical Nurse Trainers (CNTs), to be the educational leaders in the EMD. These nurses ran daily teaching sessions.



Neema, Libby, Kanisius, Dinah and Samwel at Mkuranga Hospital to deliver Basic Emergency Nursing Care Training

Sister Angelina Sepeku, Libby and Marwa Obogo at the first ever Tanzanian Conference on Emergency Medicine (TACEM)

Assisting the CNTs with teaching nurses in Arusha

The CNTs also taught at the university and initiated emergency care in the nursing curriculum. This led to development of a more locally delivered emergency care course, as we noticed that patients being transferred to MNH from the peripheral hospitals were not receiving adequate care. I worked with the CNTs to develop a teaching program for regional hospitals as EMDs began to open around the country. The CNTs travelled to these hospitals and delivered teaching specifically developed for nurses, however, doctors often attended as well. The program was delivered through didactics and hands-on workshops to ensure knowledge translated into practice, as there are no specific clinical educators in the Tanzanian nursing system.

The CNTs are pioneering emergency nursing in Tanzania. They take it all in their stride and are very humble. Every day, I was amazed at their achievements and motivation to ensure all Tanzanians have access to quality healthcare. The CNTs understand the importance of testing every patient's blood sugar levels, as many of them are hypoglycaemic, and life-saving glucose can be administered urgently. Patients would often present in DKA and be so acidotic it was hard to believe they were still awake and talking. Clinical protocols guide nursing actions in treating patients, which is vital as there is only a small medical team, while the resus rooms are overflowing with patients.

As emergency clinicians, we are exposed to many confronting situations but one of the most emotionally upsetting group of patients are little children with burns. Tanzanians cook mostly over a fire with wood and charcoal or sometimes a hob attached to a gas bottle. Put these cooking devices in a small, busy home with many children running around and the result is severe burns to these tiny humans. The nurses skilfully use ketamine to provide analgesia before dressing the kids' burns, which works well. Tanzanian children are remarkably quiet and don't complain or cry much – it seems they believe that being in hospital is a privilege and, along with their parents, are very grateful for any care they receive.

As in many low- and middle-income countries, non-communicable diseases are prevalent and many patients present with hypertension, renal failure and diabetes-related complications. Often, they are very young. Patients who have been involved in trauma commonly present with severe head injuries after being struck by vehicles or being involved in motorbike accidents. Shortly after I arrived in Tanzania, small sachets of alcohol were banned from being sold at local shops. This showed great progress, as motorbike riders were often seen outside the shops downing a couple before they collected a passenger and drove off down the road.

The EMD at MNH is an incredible example of how emergency care can be developed and help improve the healthcare standards of the community. I believe one of the key factors to development of a successful EMD is to bring the nurses along with the doctors. In Tanzania, nurses make up the majority of healthcare professionals. The World Bank reports there are 0.584 nurses per 1,000 people (2017) compared to 0.014 doctors per 1,000 people (2016). It makes sense to involve nurses in emergency care training from the beginning, to ensure they have access to knowledge and skills. But more than that, it helps to build team spirit and improve the culture of working relationships.

The EMD at MNH is leading the country in providing emergency care. I feel extremely privileged to have been able to support the staff there in a small way to continue the amazing work they are doing.

Pivoting to Online Emergency Medicine Training in Solomon Islands

Dr Donna Mills
Dr Mills is a FACEM employed by the Sunshine Coast Hospital and Health Service, Queensland, and a member of the Solomon Islands Global Emergency Care team.

From Left to Right (clockwise): Dr Trina Sale (NRH Head of ED), Dr Noel Siope (Dip EM candidate), Dr Colin Banks (external examiner), Dr Georgina Phillips (external examiner), Dr John Tsiperau (UPNG examiner), Dr Mangu Kendino (UPNG examiner), Dr Desmond Asai (UPNG examiner)

2020 has been the year of mastering remote meetings and education sessions for many of us. This has been no different for Post-graduate Emergency Medicine (EM) training in Solomon Islands and the support that ACEM have provided for the Emergency Department of the National Referral Hospital (NRH) in Honiara.

In 2019, I lived and worked in Honiara as an Emergency Consultant Advisor as part of the Solomon Islands Graduate Intern Supervision and Support Project (SIGISSP), a program managed by AVI in collaboration with the Australian Department of Foreign Affairs and Trade, the Australian Volunteers Program and the National Referral Hospital, Honiara. 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 interns returning from international medical schools, however support for training in emergency medicine was also a key priority.

Prior to 2020, trainees who wished to specialise in emergency medicine had no option other than to live and work in either 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. With ACEM support through SIGISSP, Dr Trina Sale (ED Director NRH) and Dr Patrick Toito'ona (Deputy Director NRH), have been able to negotiate with the University of Papua New Guinea (UPNG) to allow their curriculum for the Diploma of Emergency Medicine to be delivered for one candidate (Dr Noel Siope) in Honiara in 2020.

Initially, there were four x two week in-country FACEM visits scheduled for 2020 to support the delivery of the EM Diploma curriculum through intensive education sessions and continue with emergency department (ED) development activities. As the COVID-19 pandemic hit, this became impossible.

After some initial issues navigating dodgy internet connections and lack of access to computers, video-conferencing became a lifeline. Registrar case reviews, research workshops and grand-rounds were held over zoom. There was a hectic week in July where every ED registrar at NRH presented a case review with either Dr Trina or Dr Patrick in the room and a FACEM (Dr Georgina Phillips, Dr Rob Mitchell or myself) remotely assessing on zoom.

We heard about GI hemorrhage complicated by thrombocytopenia from concomitant dengue and a self-inflicted knife wound requiring a surgical airway in ED. These sessions allowed objective assessment of the registrars' clinical reasoning and a chance to discuss their general progress. They also provided an opportunity for peer support as Trina and Patrick are the only two Emergency Consultants at NRH. Support for the EM Diploma continued via FACEMs writing some practice written examinations and practice OSCEs on Zoom.

In an amazing effort in a very difficult year Dr Noel not only managed to pass his final examinations for the UPNG EM Diploma but received the top mark. This is also testament to the investment in education by Dr Trina and Dr Patrick.

2020 has shown the possibilities for post-graduate training in the Solomon Islands and hopefully 2021 will see this progress, both through virtual and in-person support from FACEMs.

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.

2020 ACEM Diversity and Wellbeing Award Winners Sow Hopeful Seeds

ACEM Diversity Award	ACEM Wellbeing Award
Gold Coast Health ED (Group/ED)	**Dandenong Hospital ED** (Group/ED)
NoWEM (Group/ED)	**QEII ED** (Group/ED)
Dr Ashes Mukherjee (Individual)	**Dr Jamie Burrows** (Individual)
Dr Kim Yates (Individual)	

2020 saw the introduction of the ACEM Diversity Award, an annual accolade that seeks to celebrate diversity and inclusion initiatives among groups, individuals and emergency departments (EDs) similar to the ways in which the ACEM Wellbeing Award has been celebrating wellbeing initiatives for the past three years.

In the circumstances of the pandemic – and on the frontline of the response to COVID-19 – there was a strong response to the 2020 nominations call for both awards, with the Wellbeing Award inviting self-nominations for the first time.

Each nomination was assessed by the Diversity and Inclusion Steering Group and their recommendations were endorsed by the ACEM Board, with seven winners announced across the two awards.

ACEM President Dr John Bonning says the number of entries and breadth of their initiatives underpins how much positivity there is going forward in emergency medicine.

'It's really extraordinary, particularly for 2020, to have so many truly inspiring initiatives happening.

'It shows, again, how robust this specialty is, and the strength and determination of the people who work in our emergency departments. This work is not going on just for today, this will have lasting impact for these departments and how they operate into the future.

'It's something quite special and I congratulate and thank everyone involved in each and every entry.'

ACEM Diversity Award

Gold Coast Health Emergency Department won the award for their work in supporting quadriplegic intern Dr Dinesh Palipana in pursuing his medical career as a student, intern and resident, despite the physical challenges he faces. The ED has embraced Dinesh and the opportunity his situation presented to design a workplace built on inclusivity, including voice recognition technology and flexible rostering.

The award also recognises the department's first-of-its-kind inclusive medical intern program, which is under development.

Network of Women in Emergency Medicine (NoWEM) won the award for a range of diversity initiatives and activities, including their founding advocacy work to encourage and enable women leaders in emergency medicine, as well as more recent anti-racism activity, including a 2020 online forum and toolkit. The network – led by FACEMs Dr Rhiannon Browne, Dr Helen Rhodes and Dr Ellen Meyns – has more than 400 members, an active blog and website, and hosts several events and networking evenings each year.

FACEM Dr Ashes Mukherjee won the Diversity Award for his work as a consultant mentoring International Medical Graduates within his department and encouraging them to pursue opportunities (for example, skill development in ultrasound). His nomination emphasised his efforts to get to know individuals, including knowing and acknowledging days of personal cultural significance, and encouraging registrars and junior doctors to upskill and take on available opportunities. Specifically, with ultrasound as one of his personal interests, Ashes is credited with the base of junior and senior doctors in his hospital who have a special interest in ultrasound and its advancement in emergency medicine.

FACEM Dr Kim Yates won the award for her work as a Māori leader and educator in her department, hospital and beyond, including through regular teaching sessions on tikanga (protocols), Te Reo (Māori language) and Te Tiriti o Waitangi (the Treaty of Waitangi).

Kim has developed a cultural orientation for new registrars, and as a member of the College Manaaki Mana Ropu (Steering Group) continues to work on Te Rautaki Manaaki Mana.

She also took a lead role advocating to ensure patient care protocols and algorithms for COVID-19 did not adversely affect Māori patients.

ACEM Wellbeing Award

The Dandenong Emergency Department Welfare Group won this award for a range of wellbeing activities supporting a culture of wellbeing in their ED, including: a welfare newsletter; a shout-out board; access to physical wellbeing activities (such as yoga and on-shift exercise sessions); coffee vouchers; Tim Tam Tuesday; and a buddy program that pairs staff so that everyone has someone checking on them.

Another noted activity is the Tough Shift Award, which gives chocolate or wine to up to two individuals on shift who've been nominated as having a tough shift.

The initiatives are open to all staff – medical, allied health, ward clerks, patient services and security guards – with an emphasis on everyone having the opportunity to get involved.

The Wellness Interest Group at QEII Hospital Emergency Department won the award for a range of wellbeing activities introduced since they were established in 2018. The group has used existing processes as a scaffold for building wellbeing into the department. Initiatives include: access to healthier foods, such as fruit on Fridays, a staff resus trolley, and free quick oats; a focus on mindfulness, such as mindful colouring, guided meditation and formal mindful medical education; and visits from therapy dogs once a week through Delta Therapy Dogs.

FACEM trainee Dr Jamie Burrows won the award for her program Wellbeing Outreach While Seconded (WOWS), which she set up specifically to provide peer support to trainees on and returning from secondment to other departments and hospitals. The program recognises the upheaval secondments can cause in a trainee's life, including meeting and working with new people, and adjusting to new routines, roles and work environments. WOWS provides a central contact for trainees on or returning from secondment and includes access to educational resources, lifestyle recommendations, and a cheat sheet for each rotation.

Jamie's nomination also recognises her work for wellbeing more broadly through COVID-19, including 'Feed Our Heroes', an initiative that saw Jamie coordinate a community-funded food donation scheme – and an industrial fridge to store them in – to provide meals for her colleagues during the stress of COVID-19.

Additionally, the nomination recognises her efforts to makeover the staff change room, providing hygiene essentials and a boost to the morale of staff showering at the hospital after work, while also improving health hygiene practices.

Winners of ACEM's Diversity and Wellbeing Awards have been profiled on the ACEM website.

My First Day on the Job

Dr Shannon Mulder

My first day in the emergency department (ED) of a Johannesburg hospital was an uneventful day of orientation. I was excited and apprehensive about the year ahead.

Little did I know, it would be the minutes after my first shift that would be most memorable. Shift over, I stepped through the ambulance doors, lunch bag in hand, just as a screeching of tyres sounded up the ramp. A seen-better-days Corolla careened round the corner. It was the feet on the dashboard and the terrified face of the man who catapulted out of the driver's seat that really caught my attention.

Little did I know, it would be the minutes after my first shift that would be most memorable.

I realised the screaming was coming from the front seat – behind that pair of bare feet pressed against the windscreen. My lunch bag dropped to the floor as I U-turned back through the doors to grab a pair of gloves (and call for help). I made it back to the passenger door, left hand gloved only, just in time to literally catch a baby in the footwell. A friendly registrar helped a glove onto my right hand so I could safely bundle the baby boy into a hastily provided sheet.

I learnt that day that my job doesn't end at the door. I also knew that emergency medicine was 100 per cent the career for me.

Dr Bob Scott

I vividly recall starting my emergency medicine (EM) career as a senior house officer (SHO) at the age of 31, in Wythenshawe Hospital, South Manchester, UK, in August 1990.

I was post-MRCP(UK) and had decided that EM would suit my personality and temperament, having just completed six months as an orthopaedic SHO in preparation, memorised Current Emergency Diagnosis & Treatment and an ATLS manual!

I learned to expect, respect and appreciate the unexpected.

I was still apprehensive about all things non-medicine as I picked up my first patient with a two-day old 'whiplash' injury to his neck. This guy was in a lot of pain so I ordered a trauma series of cervical spine views. Imagine my surprise as I discovered that he had been walking around with a C5/6 fracture/dislocation!

That has really set the tone for my career in EM so far. I remember that everyone in the department fell over themselves to help me and that people appreciated when you demonstrated to them you cared about what you did and their personal outcomes.

I learned to expect, respect and appreciate the unexpected. I also learned the value of preparation, as I'd spent six months coaching myself for the transition.

I'd like to thank everybody I've worked with on this trip so far, especially those who have coached and encouraged me, particularly here in Australia. I wouldn't be where I am now without you. You know who you are!

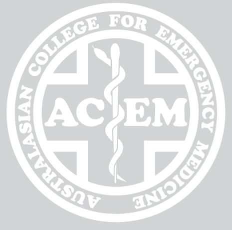
Dr Paul Pielage

42 years have expunged specific memories of the first day. It was at Royal Perth, which had a very new and very advanced ED for the time with

Memories of that period that stick in my mind include the vast amount of major trauma, mainly road, with types of injuries I haven't seen for decades.

24 hour registrar cover and a huge patient load. Memories of that period that stick in my mind include the vast amount of major trauma, mainly road, with types of injuries I haven't seen for decades. Now we have trauma teams but back then there would have been no point as it was well grooved daily practice. Diabetes meant Type 1, Type 2 was inconsequential in numbers and co-morbidity. The morbidly obese were not to be seen and the main reason for dialysis was analgesic nephropathy, not diabetes. Huge STEMI's were rife, although the terminology was yet to be invented and thrombolysis still several years away. Massive haematemesis and melaena were common as Barry Marshall was yet to start his research and ever more potent NSAIDs were being introduced whilst endoscopic management was not invented. We used an enormous amount of blood. Emergency medicine has changed enormously, now being dominated by the elderly, the obese, the multiply co-morbid with barely enough major trauma to keep us familiar with its management.

Assistance program



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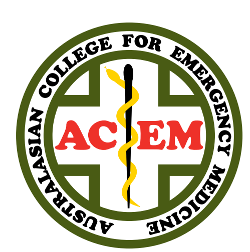

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