# your ED

THE MOUNTING PRESSURE OF COVID-19
*Leadership in a Time of Crisis*

SURVIVOR'S GUILT AND COVID-19
*The Emotional Rollercoaster*

EMET GOES BUSH
*Rural Health in the Kimberley during Coronavirus*

GLOBAL EMERGENCY CARE
*Fiji, Myanmar and the Indo-Pacific Region*

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# Australasian College for Emergency Medicine




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**Your ED**



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




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

# Contents





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## Message from the Editor

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

In these unprecedented times, witnessing the hard work and resilience of Emergency Physicians is inspiring. We sat down with Immediate Past President, Dr Simon Judkins, and ED Director of the Northern Hospital, Dr Megan Robb, to discuss the pressure that comes with being a leader during a pandemic. We look at managing wellbeing and burnout during these trying times, how the College can help and how important mental health is, especially now.

We hear stories of Emergency Medicine Education and Training (EMET) from the rough and remote landscape of the Kimberley in Western Australia. We discuss what it takes to improve care for older people in residential aged care during COVID-19, give you an insight into veteran care in the ED and we hear from Dr Katie Walker to better understand what it takes to improve research capacity.

In this issue we share Global Emergency Care stories of dealing with rising COVID-19 numbers in Myanmar, offering assistance through zoom calls with the Indo-Pacific Region and stories of responding to the pandemic in Fiji.

We hope you enjoy these perspectives on emergency medicine and take care of yourselves.

# ACEM in the Media

In **May**, ACEM featured in the *Medical Journal of Australia's Insight+* publication discussing ED presentation trends during COVID-19 lockdowns in Australia. College President Dr John Bonning said, while generally there had been a downturn in ED presentations at the height of lockdowns, anecdotally, these differed proportionally, with sports and motor vehicle trauma generally down, but mental health presentations less so.

ACEM's Immediate Past President Dr Simon Judkins re-iterated these sentiments in comments to *The Age* and *Sydney Morning Herald*, highlighting the need for additional mental healthcare support.

'The concern is we're going to see a significant rise in the number of mental health presentations due to the stress that COVID-19 has introduced', said Dr Judkins.

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In **May**, ACEM issued a media statement welcoming the release of an independent evaluation showing a reduction in alcohol-fuelled harm following reforms introduced by the Northern Territory Government.

'Alcohol-fuelled harm remains a significant concern in the Northern Territory, but clearly this report shows promising signs', said Dr Stephen Gourley, Deputy Chair of the ACEM Northern Territory Faculty Board.

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In **May**, ACEM welcomed the strong focus on health in the budget handed down by the Aotearoa New Zealand Government, as the nation continued to confront the COVID-19 pandemic. In particular, the College highlighted the need to avoid a return to chronic ED overcrowding and access block, as well as a need for a strong focus on mental healthcare.

ACEM New Zealand Faculty Board Chair Dr André Cromhout said: 'While the additional funding is encouraging, as always, it is crucial that this funding is supported with clinical engagement with frontline emergency department staff to achieve the objective of an accessible, equitable, high quality and safe health system'.

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In **May**, Emergency Medicine Education and Training (EMET) program activities involving clinicians in the Northern New South Wales Local Health District were covered by local media.

FACEM and Byron Central Hospital ED specialist, Dr Blake Eddington, said the training was important to ensure the best care and safety practices for patients in the region.

'Because of this training, funded through the Federal Department of Health and the Australasian College of Medicine, hospitals all around Australia are running these lifesaving scenarios which protect patients, but also protect staff and their community as a whole', he said in comments featured in the *Byron Shire News*, *The Northern Star* and *Tweed Daily News*, among other publications.

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In **June**, FACEM Professor Diana Egerton-Warburton featured in an article in *The Guardian* raising concerns about the severity of alcohol-associated harm being witnessed in EDs during COVID-19 restrictions.

'With lockdown we have seen less of the random bar and street assaults, and random injuries from people drunk on the streets and falling over hurting themselves and others, and more family violence, and more very extreme examples of people with severe dependency and intoxication who are being harmed while drinking at home', said Professor Egerton-Warburton.

In a separate article in the *Herald Sun* and *Geelong Advertiser* ACEM's Victoria Faculty Chair Dr Mya Cubitt raised concerns about the harm being done as a result of excessive alcohol consumption, behind closed doors at home, during lockdown periods.

'What struck us with alcohol (presentations) was that the problems were significantly complex — and that's really concerning because what we were seeing was it was still escalating to the point where the really serious or injured people were still coming, just at a late point in their disease (or abuse)', Dr Cubitt said.

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In **June**, ACEM featured extensively in media coverage of an increase in ED presentations following the easing of some COVID-19 restrictions in Australia and New Zealand, as well as the 'unethical' return of hospital access block and crowding during the ongoing pandemic.

Dr Judkins told the ABC: 'As we're seeing elective surgery being reintroduced into the system, we're seeing the hospitals starting to fill up again … we're seeing, across the country, a lot of access and overcrowding happening in EDs and, of course in the COVID era, when we need to make sure we maintain infection control and physical distancing, it's becoming a real concern'.

Meanwhile, Dr Bonning spoke of an increase in ED presentations in the New Zealand media, following the easing of restrictions to 'stage one' in the country. Dr Bonning also featured in a story in *The Age* and *Sydney Morning Herald* warning of the increased risks to patients as a result of re-emerging overcrowding and access block in Australia.

'There will be deaths', Dr Bonning said. 'In ramped ambulances, of people who are sick of waiting and leave, of people that don't get the right care in a timely fashion because the emergency department that might have 30 treatment places has got 50 patients in it.'

Later in the month, following media reports of the death of two patients who had waited outside Victorian hospitals in ambulances, Dr Cubitt told *The Age* and *Sydney Morning Herald* that measures were needed to improve patient flow and relieve pressure on EDs.

'It is completely unacceptable to have patients crowded together

in emergency departments', Dr Cubitt said. 'It is equally unacceptable to have these patients being treated in ambulances for extended periods as they wait for space to free up inside the hospital.'

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In **July**, ACEM issued a media statement cautioning against blaming 'GP-type' patients for ED crowding following the release of new data by the Australian Institute of Health and Welfare.

'It is a popular but misguided public narrative that GP-type patients are the main cause of crowding and therefore access block in EDs', said Dr Bonning. 'In reality, patients with relatively minor ailments who present to EDs generally do not require beds or admission to hospital. Attributing the dangerous crowding and access block which occurs in EDs to such patients risks distracting from the systemic and deep-rooted causes of such issues.'

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In **July**, Dr Cubitt featured in an article promoting the new Channel Nine program *Emergency,* which provides insight into the work of staff in the ED at The Royal Melbourne Hospital. 'I think the process of having the camera crew there was really interesting, and I ended up really enjoying the conversations we had, learning from them what the public imagines we do, and letting them know what we really do', said Dr Cubitt of the experience of having television cameras in the ED.

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In **July**, ACEM Tasmania Faculty Chair Dr Juan Carlos Ascencio-Lane featured on ABC Radio in Hobart to discuss concerns the College had raised in relation to access block and ED overcrowding in Tasmanian hospitals, as well as the ongoing response to COVID-19.

'We have had a good response and level of engagement from the Department and particularly with the Secretary', said Dr Ascencio-Lane.

'We're pushing and we're holding the executive team to task here. We know what our patients need and we know what our staff need and we are pushing hard … and we are making these regular meetings to ensure that we do move forward with flow and with access within all hospitals in Tasmania.'

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In **July**, ACEM featured extensively in media coverage of the resurgence of COVID-19 cases in Victoria, particularly in relation to mounting concerns over the increasing number of infections among healthcare workers, and associated impacts on the emergency medicine workforce.

'Any case of healthcare workers contracting COVID-19 is deeply concerning and our thoughts are with affected colleagues in Victoria, who are doing an incredible job under very difficult circumstances', Dr Bonning told the *Sydney Morning Herald* and *The Age*.

'It is our strong view that frontline staff must be involved in decision-making processes as part of ongoing hospital and healthcare system responses to this fast-moving and dynamic situation.'

Later in the month, in response to the news an emergency medicine trainee was gravely ill in hospital with COVID-19, the College issued a statement reiterating the difficult and challenging times being faced by the emergency medicine community. Dr Bonning also called for greater transparency and reporting of official data to allow for better understanding about how and where infections were occurring, as well as consistent PPE guidelines and supply, to ensure the safety of healthcare workers at work remained a top priority. 'Our thoughts and deepest sympathies are with the doctor concerned, their family, friends and colleagues, as they are with all healthcare workers affected by this terrible virus', said Dr Bonning in comments reported by the media.

'These risks are further exacerbated by the lack of inpatient beds currently facing many hospitals and the long periods of time that patients wait in emergency departments for an inpatient bed.'

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In **July**, Dr Bonning featured extensively in New Zealand media emphasising the need not to become complacent in the fight against COVID-19, particularly in light of a resurgence of cases in Australia.

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In **August**, ACEM welcomed the Victorian Government's announcement of crisis funding for additional mental health services during the COVID-19 pandemic. In a media statement picked up by *The Australian*, the College highlighted the need for sustainable, whole-of-system improvements to mental healthcare and services across Australia and New Zealand, which both relieve pressure on hospital EDs, and ensure mental health patients have access to the care they need at the time they need it.

'EDs, of course, have a key role to play in providing care to mental health patients, but they must be adequately resourced and supported', said Dr Bonning.

'That role also cannot extend to caring for mental health patients waiting for definitive psychiatric care for days on end, simply because they have nowhere else to go.'

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In **August**, an opinion piece by Dr Mya Cubitt highlighting the need to avoid a culture of blame in the ongoing response to COVID-19 and instead focus on transparency and the open sharing of information to improve systems and responses was published by *Croakey*. These sentiments were reiterated in a follow up interview with ABC Radio in Melbourne.

'This is a health problem. It's about the safety and health of our communities and our clinicians, and we need to approach it that way. We can't approach it with a political message and the last thing we want is blame and shame', said Dr Cubitt.

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For media inquiries, contact ACEM Media Relations Manager Andrew MacDonald e: Andrew.MacDonald@acem.org.au

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# PRESIDENT'S WELCOME

*Amid many stressors and anxieties, much tremendous work has continued; some of it is covered in the pages of this magazine.*

The COVID-19 roller coaster of 2020 has continued apace since the previous edition of *Your ED*. In early June we were experiencing what appeared to be relatively under control transmission rates across both of our countries and from mid-June there was a gradual, then sudden, surge in Victoria and the virus reappeared in other states and Aotearoa New Zealand. We've now seen persistent, and worryingly increasing, clusters in New South Wales, as well as occasional cases in other Australian jurisdictions. At the time of writing, in Aotearoa New Zealand, after 102 days of zero community transmission, where hopes were held for elimination, we are contending with something of a reality-check in a burst of COVID-19 activity in Auckland.

All of this solidifies the realisation that, in our 'new normal', this virus is with us for the long haul, endemic in the world, and we will continue having to live with and manage it. Suppression (of outbreaks) and mitigation (of the effects on vulnerable populations) must be our priorities.

In this environment, a number of issues sit at the top of our College's priority list, in particular, our focus on the wellbeing of our members and trainees. This has included looking at how best to, and advocating for measures that, help address the worryingly high numbers of healthcare worker infections, such is the case in Victoria.

As a College we have, and will continue to, emphasise that the safety of Emergency Physicians and trainees in their workplaces at the frontline must be at the very top of the priority list for governments, health departments and systems, hospitals and politicians.

Some of these leaders could take some lessons from the way we, as a profession address medical error and seek to foster environments that take the emphasis off blame and recriminations, and instead promote the frank and open sharing and discussion of information; looking at ways to improve the systems in which we work and as we learn more, address issues and try to prevent adverse events happening again.

Amid the daily challenges of dealing with COVID-19, we also acknowledge the particular toll uncertainty over College examinations has taken on our trainees. Another of our priorities has been to provide a level of certainty, within what the circumstances allow. Our paramount consideration is to move trainees through the training program, to set examinations and to do so whilst protecting their personal safety.

This priority has been the subject of comprehensive consideration by the College, and we continue to keep our trainees updated with the latest developments in detailed communiqués, as we proceed with our commitment that the College will make every endeavour to enable those trainees who wish to sit their examinations, to do so in a safe and fair environment.

Just as important is promoting kindness and understanding. While fatigue can set in given the sheer length of time we have been contending with this virus, I will continue to emphasise how important it is to find the time to focus on wellbeing.

ACEM continues to offer an assistance program for those who need it, as well as a range of peer-reviewed resources to support both workforce wellbeing and individual welfare. The College's Membership and Culture team can be contacted via wellbeing@acem.org.au.

Amid many stressors and anxieties, much tremendous work has continued; some of it is covered in the pages of this magazine. I encourage you all to take a bit of downtime, take strength and inspiration from our work and the work of our colleagues, and enjoy.

Finally, I wish to acknowledge the passing of Dr Tom Hamilton, ACEM's inaugural President in his 88th year in Perth. Tom was one of the giants on whose shoulders we all stand now who helped start ACEM on its trajectory in 1982. One of the numerous quotes used at his funeral to describe Tom was that he did things because they were right, not because they were easy. A full memorial event for Tom will be held in 2021 when travel restrictions ease. Vale Tom Hamilton.

# CEO's Welcome

**Dr Peter White**

Clearly, everyone's focus in recent times has been the impact of COVID-19 and the ways in which we have all needed to adjust as the pandemic plays out across the world. The development of potential vaccines is followed closely and the frailties of healthcare systems, including aged care and mental health, have become obvious, along with the fragility of economies. Here in Victoria, there is close interest in daily COVID numbers for the state and, tragically, the associated number of fatalities. We are also monitoring figures in other Australian jurisdictions and Aotearoa New Zealand, aware of the fragile nature of any stable situation with no community transmission.

Along with the uncertainty created by COVID-19, there is the realisation that the day-to-day activities of life continue and need our attention. This is true at a personal level, as well as a professional level. All associated with the College are aware of the clinical issues associated with the delivery of frontline care to all patients, COVID, SCOVID or clear, and there is little doubt that most of us will know someone who has been affected directly by the clinical effects of the virus.

Throughout the pandemic, the College has worked to promote and advocate for the wellbeing of healthcare workers, particularly those working in emergency departments. The range of issues, the number of meetings involved and the amount of time committed has been significant. The engagement of members and trainees with the efforts of the College has been testament to the way in which ACEM can function not only as an effective training and education body, but also as an effective engagement and advocacy body, focused on the delivery of high quality, safe emergency care.

During this pandemic, the role of College staff in enabling ACEM to deliver support to the membership has been significant and I continue to be proud to be a part of a team that has stepped up to provide an exceptional level of professionalism and service that is aspired to, both in so-called 'normal' times, as well as the times in which we have found ourselves recently. Ensuring that the College's core activities continue to run as expected in the context of the myriad of issues that need to be dealt with as a result of COVID-19, has required significant effort. I thank all College staff for their contributions towards what I have always considered to be a 'partnership' between College members, trainees and staff, making ACEM the best possible organisation that it can be.

This edition of *Your ED* offers a number of different perspectives of COVID-19 and its effects on the practice of emergency medicine. From its outset, *Your ED* was envisaged as a way of communicating to you what is happening in the world of emergency medicine in Australasia, celebrating the achievements of ACEM members, trainees and staff, and spreading the 'good news' stories that happen in and as a result of ACEM's work. The ACEM Board committed to a review of *Your ED* around this time when it was launched just over a year ago and readers are invited to have their say. The magazine exists to inform and to celebrate the achievements of your College, and I would strongly encourage you to give feedback when the opportunity arises.

As has the College President, I will close by noting the passing of Dr Tom Hamilton AM. As many of you will be aware, Dr Hamilton was the first President of ACEM and, along with others, was a significant figure in the formation of the College and the recognition of emergency medicine as a specialty in Australia during the 1980s. I was privileged to witness a moving service in his memory as he was laid to rest in Perth and I thank his family for allowing me the opportunity to be present. I am currently reviewing the draft of the history of ACEM's first 35 years and what comes across clearly is Tom Hamilton's vision and determination that advanced emergency medicine during times that were different to what they are today. I am reminded every day of the responsibility we have as custodians of the legacy of Tom Hamilton and the early pioneers of emergency medicine in Australasia.

# Managing Wellbeing During COVID-19

Emergency medicine (EM) is a highly-rewarding yet challenging career, and that is never more true than in our current climate. The constant exposure to patient ill-health and injury and heavy physical and emotional demands can affect your wellbeing. During this unprecedented pandemic, the College is acutely aware of the difficulties facing physicians and has taken initiatives to alleviate some of the stress and pressure you face. ACEM endeavours now, more than ever, to help to support you to look after yourself whilst caring for others.

It is appreciated that the nature of your work and education commitments as doctors in emergency medicine can often be difficult to balance while maintaining a personal quality of life. During the trying times of COVID-19 it is even more important to maintain wellbeing and personal resilience.

ACEM has partnered with an experienced assistance provider offering services to members and trainees to support your wellbeing. Counselling and coaching services offer support to you for professional or personal matters.

The College has also created the ACEM Wellbeing Network, an online space where you can source information, resources and initiatives that support you as emergency medicine doctors both at and away from work. Here you can create virtual discussions, discover wellbeing events and campaigns, request an EM mentor and obtain insight into what your colleagues are doing to support themselves and each other within the ED and beyond.

Some of the wellbeing initiatives implemented by the College include; workforce wellbeing audio series (new), assistance program for coaching and counselling (ACEM Assist), online resource peer-review process, Wellbeing Award, conduit to external wellbeing services and resources, individual case-by-case support and more.

The Membership and Culture Unit is also available for all members and trainees. They are responsible for the administration of incoming and outgoing members of the College and provide a range of programs, ideas and resources aimed at supporting the wellbeing and culture of members and trainees.

The College also has a Trainee Support Unit, with staff who can provide advice to FACEM trainees who are concerned about their progression in training as a result of particular circumstances.

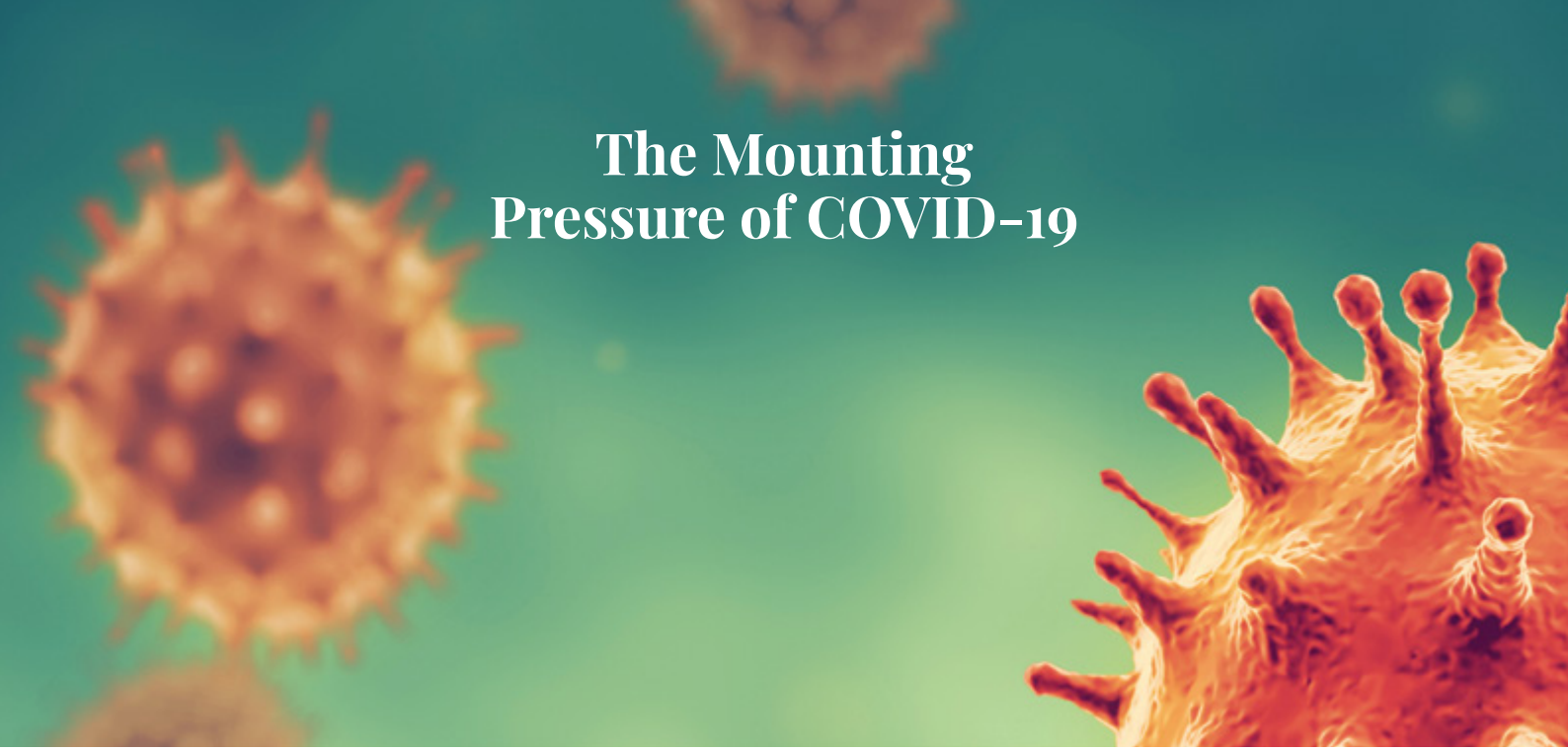
We know that this time is difficult and unparalleled. Wellbeing is important, particularly in emergency medicine. The threat of burnout and trauma fatigue make it difficult to maintain wellbeing even in the best of times. ACEM is here to support you through this pandemic and beyond.

**More information**

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

Need Help Right Now?

| Australia | | Aotearoa New Zealand | |
|---|---|---|---|
| Suicide Call Back Service | 1300 659 467 | National mental health & addictions helpline | 1737 |
| beyondblue | 1300 224 636 | Samaritans | 0800 726 666 |
| Lifeline | 13 11 14 | Lifeline | 0800 543 354 |



# The Mounting Pressure of COVID-19

***With the announcement in early August of Stage 4 restrictions for greater Melbourne, 'ACEM' immediate Past President Dr Simon Judkins and Dr Megan Robb sat down to discuss the mounting pressure, both personally and professionally.***

New Zealand had been without a new case for nearly 100 days when Stage 4 restrictions are imposed on greater Melbourne and the Mitchell Shire of Victoria. The restrictions impose curfews, mandatory masks and shop closures. They are, to date, the most comprehensive restrictions seen in Australia and follow the most devastating outbreak – hundreds of daily new cases – that the country has seen.

The restrictions were looming for weeks. The clarity of their announcement comes in some parts as a relief – a surer pathway to reducing the numbers of COVID-19 cases in Victoria, to reducing the lethal impact on communities. The restrictions follow in part the pathway taken by Aotearoa New Zealand, but that country went this hard early – before community transmission took hold. Its results have, to date, been exceptional, outstanding – the envy of the world.

In the first week of Stage 4, Melbourne's numbers continued to rise – 600 new cases, 700 new cases.

No one understands this better than the healthcare workers at the frontline of this emergency.

'COVID-19 has changed the way we work, both personally and professionally', says Dr Simon Judkins. He is based mostly at the Austin Hospital, in Melbourne's north-east; as the department's former director, he understands the pressures that come with that role.

'The tricky thing about ED work is that its 24 hours a day seven days a week', says Simon. 'As an ED director you're never actually switched off. You know that at any time anything could happen, and you could be called in to help out. People say, 'no don't, that's not your job' but you can't help but stay engaged, this is your big family of people and if something happens, you want to be there. It makes is almost impossible to have down time.'

'I haven't been able to switch off, I've been constantly on', Dr Megan Robb says. Megan is the emergency department director at Northern Health, where a known outbreak has taken place.

'Even if I turn my phone off for a day when someone else has taken the reins from me, my mind doesn't stop. You worry that things are going to change, or something is going to happen in the department or to one of your staff, so you are never able to disconnect.'

She says work–life balance is not as good as it should be.

'Sometimes I feel like I live here. But that's what happens as a director of an emergency department through a pandemic.'

There is now a new level of responsibility on a department director when it comes to the health and safety of their staff, patients, colleagues and community. Both Megan and Simon have faced enormous challenges to prepare for this pandemic.

The usual 'chain of command' has gone out the window. The way in which people work and the way the hospital functions, have had to change. This change has affected the protocol of how people communicate – people don't go to the people they usually do, and communication has intensified.

'You become the key contact person for a range of different people that you don't usually interact with', Megan says.

'I have had increased interactions with other departments such as Infectious Disease, Gen Med, ICU, and directors from other emergency departments. I am also in contact with other departments such as engineering. They all need to speak to someone and you're it.'

There have been positives. Longstanding departmental barriers have broken down.

'The sense of, we can do this, we're ready and we're in a team, is really important.'

'Not just in the ED, but across the hospital as a whole. Any issues between departments in the past have now been forgotten.

There is a sense of support knowing we are going to get through this collectively. It's been one of the things I'm most

proud of. The way we have banded together to look after ourselves, each other and our communities, it's something I think we can take a lot of pride in. It has been one of the positives that has come from the past six months.'

'Oftentimes you have a question and there's not always someone to ask for advice', says Simon.

'If you have staffing challenges or a struggle with an executive decision, there is not always somebody to ask. Because of the situation we now find ourselves in, we have regular conference calls with other ED Directors and all of a sudden you have a large cohort of people who have exactly the same problem as you.'

Simon says these meetings – this breakdown of barriers – has been good to ward off the sense of isolation.

'You can breathe a sigh of relief, 'thank god it's not just me'. Being a director can sometimes be a unique and lonely role. Without having someone to bounce ideas off, it can be isolating. So, this improved form of regular contact has been a huge win, if anything good can come from this pandemic.'

Megan agrees.

'The ED directors have a meeting on the Monday and ACEM DEM leadership Zoom meetings have been vital.

'It makes you feel really supported in a time where you can feel a bit lost sometimes.'

This feeling of isolation has been very real for both physicians, particularly when it comes to shouldering the responsibility of staff wellbeing and support. Nothing could have prepared them for the emotional toll that the pandemic has taken on them and their staff.

'You're working in an environment where there is a very real threat to your staff and your family', says Simon. 'We often deal with difficult scenarios, like a code grey, where you come so close to everything going wrong, but now your home family and your work family are both in very real danger.

'You feel a personal level of responsibility to make sure people are safe. Most of the time in the ED you know that you'll see multiple traumas and tough moments, then there's debriefing and making sure we're all okay. However, in this new world, making sure your staff is okay is something that's ever present. The next phone call could be the news of an infection control breech and staff are impacted.'

'My biggest fear is that something will happen to my staff', Megan says.

'Either they would get COVID-19 and potentially lose their life, or struggle with the aftereffects or feelings of being isolated and other psychological impacts. I worry that we will lose staff in this profession, that they might give up and walk away or other things would happen in their lives, and we would lose them. For me, that is the hardest thing personally to wrap my head around. The onus you take on and the fear that you carry is immense.'

Megan says she has seen a professional coach who is also a psychologist, to put some strategies in place to deal with the situation.

'It felt like my responsibility to protect them', she says. 'I felt responsible, that if my staff weren't okay that it was somehow my responsibility. Was there something I should have done differently?'

'We can't be in everything, even though we try to be, the best thing you can do is allow people to have the empowerment to make decisions', says Simon.

'There was a change of structure during this time at Austin. This divestment of leadership has allowed people to step up and move into roles they wouldn't normally have.

*You're working in an environment where there is a very real threat to your staff and your family.*

We're having conversations and there's a collaborative approach to how we proceed with changes.'

'At the start when all of this was happening, we thought the tsunami was coming and we were having to get ready very quickly', says Megan.

'I very much found I had to change to a command and control leadership style due to the short time turn arounds. As we have progressed into the year, I have been able to divest a lot of the work to my leadership team. Their support has been invaluable. However, when something acute happens it again falls to you as the leader. It's a wave and it can be quite draining at times.'

'When we heard this was coming, there was, not excitement, but an adrenaline rush. This was new and novel and something we hadn't experienced before. So, there was a surge of activity and preparedness', Simon says.

'Now we're in this chronic phase of intense stress all the time, you feel tight and unsettled. We're out of the acute phase and into a chronic scenario. There's a constant level of heightened anxiety.'

As an ED director you need to be the one to maintain the most positive, yet pragmatic, outlook all the time. You are the one who must find that balance and project it to your staff.

'Trying to find that balance and project that to your 500 odd staff members, whether that's nursing, medical, PSAs, clerical staff etc., that's a pretty tough thing to do', Simon says.

'Sometimes you just want to close your office door and yell an obscenity or two, but you can't do that.'

'One of the hardest parts', says Megan, 'is trying to steer the ship and provide a lot of support, yet every five minutes you get a phone call saying something has changed. You need to immediately adapt. You then have to implement and explain these changes, in a clear and concise way. Communicating well and often has been one of the keys.

'You get asked to change the PPE, change the way you're doing this or that and then you're told, we're changing the definition of testing, so you're constantly updating your staff. During this time the most difficult part of your job is giving your staff the right level of reassurance.'

Simon says delivering certainty is nearly impossible and it is something he has struggled with.

*There is a loss of connection, which is difficult. To be able to hug a friend after a bad day is human and I know we miss that.*

'As a director you want to provide certainty in a time when you're not quite sure what's around the corner.

'You're trying to find some stability through such an uncertain time. It becomes one of the most stressful parts of the job.'

There has been no blueprint for coronavirus. No manual for directors to take down from the shelf and follow. Escalation plans had to be built quickly as no one had any idea of what was coming. The underlying fear was that no matter how much was planned – looking at Europe and the escalation of cases there – Australia may not be prepared.

'It was incredibly challenging to begin with – watching what was and wondering if we were going to be ready. It was part of my role to create the plans of how we were going to deal with the rise of patients'.

'We had a multidisciplinary, evidence-based approach, constantly updating our procedures as things evolved and changed. The adrenaline began to wear off as we didn't get the cases', Megan says.

'We returned to business as usual, but in a COVID world.'

In early July a number of staff from the Northern Hospital Emergency Department tested positive to COVID-19. The hospital took immediate action, beginning extensive contact tracing and undertaking a deep clean of the ED. All non-urgent and elective surgeries and outpatient appointments were postponed and all staff in the emergency department were tested as a precaution.

'It was a challenging time', Megan says. 'I was on annual leave and all I could think about was my staff and our patients. We had to think about how we were going to change our models of care to best service our community.'

'The assistance from other hospitals was immediate. It was overwhelming to see their support; we felt a lot of guilt about re-directing ambulances to their already busy EDs; we were conscious of ramping and overcrowding. However, no one batted an eye, it was so collegiate, as if they were all saying, "we'll take the strain, we're here for you".'

The Northern Hospital is now back to a fully functioning ED, one of the busiest in Melbourne. Megan reflects that it was the unwavering support of other EDs, directors, hospitals, executive and, especially, the support of her department that got them through the turbulent time.

The level of collaboration during this time – both doctors agree – has been incredible across the board. There has been an enormous system response to develop capacity to change things such as access block and ramping during these times, where it simply cannot be allowed, had also been something to celebrate. The ED relationship with the rest of the hospital, while always good, has significantly improved, with other departments coming forward to offer support and try and find avenues for non-critical patients in other departments.

While Megan and Simon agree that there is difficulty in the uncertainty of what's coming and it's hard to manage, they are used to dealing with uncertainty, there's always variation of that in the ED. However, it is the trying to regain control in an unexplored environment that is the most difficult thing to overcome. They are evolving as they go, feeling both surprised and sometimes overwhelmed by the support and gratitude they have received for doing their jobs.

'The ED staff have been amazing and have really stepped up', Simon says.

'They haven't complained. They turn up because they want to turn up for everyone.'

'We really miss aspects of our work that are no longer possible during a pandemic', Megan says.

'The simple act of sitting down and chatting face-to-face as we debrief is gone and so is the personal touch. There is a loss of connection, which is difficult. To be able to hug a friend after a bad day is human and I know we miss that.'

Looking to the future, Megan and Simon both fear the stress and angst of society and the enormous impacts that COVID-19 will have on their communities, both now and in the long term. They worry for other patients as they watch the demographics of ED presentations change dramatically, wondering where those patients have gone. However, both agree that out of crisis comes opportunity. COVID-19 in many ways has exposed the fault lines of healthcare. Megan and Simon both look forward to working in smarter, more effective, more integrated and collaborative healthcare systems.

*Author: Inga Vennell, Editor*

# Improving Care for Older People in Residential Aged Care

**Dr Carolyn Hullick**
Dr Hullick is an Emergency Physician and Emergency Department Director at Belmont Hospital in Newcastle, New South Wales. She is the Chair of the ACEM Geriatric Emergency Medicine Section.

It has been a tumultuous year for all emergency physicians in all aspects of our lives. One of the great things about working in the emergency department (ED) is a really strong sense of belonging to a team. For all Australian and New Zealand Emergency Physicians, ACEM is an important part of that team, helping us cope with the COVID-19 pandemic. Thank you!

ACEM's Geriatric Emergency Medicine Section has had a busy 12 months. We recently released the updated *Policy on the Care of Older Persons* in the Emergency Department, timely for the challenges we are currently facing. The Policy outlines that older people should receive person-centric and high standard acute care, which, where feasible, is delivered in their chosen environment (whether this be their own home, the ED or residential aged care facility).

At the end of 2019, we represented ACEM at the Royal Commission into Aged Care Quality and Safety. Recent COVID-19 outbreaks in Australian residential aged care facilities (RACF) have reinforced our assessment of the significant gaps in systems of care for residents. Important ethical issues about the healthcare rights of older persons, with often concerning social discourse and media portrayal, contribute to ageism, discrimination and stigma for this frail cohort. During COVID-19, the World Health Organization (WHO) has described how RACF residents have sometimes been denied hospital care based on discriminatory criteria. WHO states that access to acute care shouldn't be rationed based on age or disease, instead it should be guided by people's needs and preferences for care. In contrast, hospital transfer policies in Australia have ranged from mandatory transfer of all COVID-19 positive residents to hospital, to all residents being managed in the RACF, regardless of care needs.

We assert that policy should instead be based on the following imperatives:

1. The ability to achieve adequate infection control;
2. The older person's values, goals of care and acute healthcare needs; and
3. The RACFs capacity to adequately manage the care need.

In June, ACEM responded to the Royal Commission's call for comment on the impact of COVID-19 on aged care services. The key issues and recommendations discussed in ACEM's submission are as follows:

### 1. Pandemic planning and governance

- The complex and fragmented nature of the aged care system, inconsistent guidelines and unclear governance has contributed to suboptimal outbreak response and management.

### 2. Personal Protective Equipment (PPE)

- Adequate resourcing is needed to keep RACF staff and residents safe. This includes masks, long-sleeved gowns, eye protection, gloves, and cleaning and sanitation products. Implementation of social distancing measures and visitation policies is also needed.
- Aged care staff have often received inadequate training in the use of PPE and infection control.
- System wide improvements are needed to mandate PPE training for all RACF staff and guarantee appropriate supply levels.

### 3. RACF staffing

- Aged care workers are reporting significant levels of stress, pressure and a lack of support as the sector grapples to combat COVID-19.
- A review of minimum staffing levels and workforce capacity building will be an essential part of preventing further spread and outbreaks.

### 4. Hospital transfer, admission and discharge

- During COVID-19, FACEMs have been strongly aware of the need to give special consideration to vulnerable groups, such as older persons, and sought to avoid unnecessary hospital transfer of RACF residents.
- The College has developed older person-specific recommendations as part of the *Clinical Guidelines for the management of COVID-19* in Australasian Emergency Departments and supports the guidance provided by the Communicable Diseases Network Australia (CDNA).
- It has been positive to see increased levels of ED outreach in some locations and the temporary expansion of MBS telehealth services to increase care options and reduce unnecessary hospitalisations. We recommend continued delivery of such collaborative, patient-centered models of care beyond the pandemic.

### 5. Ageism, discrimination and stigma

- COVID-19 has raised ethical issues about how best to prioritise the allocation of scarce resources. Unfortunately, we have witnessed ageism underpinning discussions about excluding older persons from care and abandoning RACF residents.
- Ethical decision-making frameworks are essential to ensure that older people, including RACF residents, have access to healthcare and are treated with dignity and respect.

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# Survivor's Guilt and COVID-19

**Dr Katherine Gridley**
Dr Gridley is FACEM Training Program Advanced trainee and senior emergency registrar at the Royal Brisbane and Women's Hospital, Queensland.

It goes without saying that the COVID-19 pandemic has been a challenging, unpredictable and at times frightening experience for all of us front-line healthcare workers. First there was the never-ending media coverage, the fear-mongering and the panic buying. Then there was the calm before the storm, when the country locked down and we appeared to be in control, before the dreaded second wave hit the southern states of the country. This once in a lifetime pandemic has been nothing short of a roller coaster of emotions for us.

Like fear, when we were told in March and in no uncertain terms to prepare for double shifts and for long hours without breaks in PPE so as not to waste our precious supplies. When my colleagues and I started double checking our life insurance policies to make sure pandemics were covered and calling our solicitors to ensure our financial affairs were in order 'just in case' we were one of the unlucky ones.

Utter disbelief, when the public initially ignored social distancing and began panic buying groceries. On the tail of the recent bushfires, we had enormous hope in the generosity of our fellow Australians; a hope which all but instantly vanished when we saw people fighting over toilet paper in supermarkets.

Pride, when groups of civilians started sewing scrub caps, checking up on our elderly neighbours, staying at home when instructed to do so, and making international headlines by dressing up in outrageous outfits just to take the bins out. When Facebook groups became dedicated to spreading kindness and adopting healthcare workers, often started by people who had already lost so much.

Solidarity, when we started working in the new COVID zone and our consultants would swap out with us when we reached the point of sweating profusely and rebreathing too much of our own $CO_2$ under our mountain of PPE. When we picked up extra shifts for each other to cover for every colleague awaiting their own swab results.

Cautious optimism, when we had a brief moment of reprieve, with restrictions lifting and what appeared to be a flattened curve …

… followed by sheer helplessness as the case numbers and death rate soared, and our own colleagues started to fall ill as the full weight of the second wave hit Victoria.

*Guilt will not fix this pandemic, but a touch of kindness will certainly make it easier, and that kindness extends to ourselves as well.*

Anger, with the unfortunate rise of pseudo-science, conspiracy theorists and anti-maskers, whose conviction and irrational beliefs born out of fear seemed impenetrable by our logic, whose ignorance flew in the face of the enormous risks and sacrifices we would have to make as healthcare workers.

And pandemic fatigue, wondering when life would ever go back to normal.

But there has been one feeling that has been surprisingly hard to name. It's a deep, gnawing sense of unsettledness. A sense of being a relative bystander in an unprecedented disaster that has rocked the world, and some (but not all) of our own states to their very foundations as a society.

A sense of awkward unease mixed with hopelessness upon seeing our ED physician colleagues elsewhere succumb to the disease they have been so tirelessly fighting. A sense of undeserved privilege when many of our northern Australian ICUs lay void of the thousands of COVID patients we were expecting. A sense that we've come off lucky, as an island that had the luxury of closing its borders to the rest of the world, and as states that could do the same to its affected neighbours.

That feeling? It's guilt.

The concept of 'survivors guilt' occurs when a survivor of a traumatic event, such as war or disaster, feels guilty for surviving when others have not. It doesn't necessarily have to involve death – for example, a survivor can feel guilty about keeping their superannuation during a global recession, or not losing their house in a seasonal flood when their neighbours house was washed away. It's the guilt associated with 'having' when many others 'have not'.

In the DSM-5 it is considered a component of PTSD. However, it is also recognised that survivor guilt can occur in the absence of a formal mental illness diagnosis. Survivor guilt is a very real phenomenon in healthcare workers, as has been documented by researchers in the wake of the H1N1, Ebola and SARS outbreaks before COVID.

Survivor guilt is partly to blame when we find it is so hard to watch the news. Whether it was in March dominated by footage of overseas EDs struggling to keep up with the demand for non-invasive ventilation, or in August when community spread inundated Victoria and New South Wales – it's hard to escape the uneasy inequity of being one of the 'lucky ones'.

It's the reason that many of us felt uncomfortable at the very start of the pandemic when we were flooded with gifts and messages of support from the general public, when it felt like all we had achieved at that stage was manage sparse waiting rooms and treat patients with injuries from lockdown boredom related misadventures.

It's the reason that we downplayed the label of 'hero' only a few months after our firefighters lost their lives saving people in the bushfires, because our brainstem-tickling nose swabs and "you need to self-isolate" spiel didn't quite seem heroic by comparison at the time.

It's the reason we have felt unworthy to accept 'healthcare worker discounts', because at least we have a job during such an unprecedented economic downturn. A job with the highest risk of COVID exposure for us and our family members; a job that's physically and emotionally exhausting at the best of times; but a job nonetheless. We are emergency physicians and this is our 'grand final', our time to shine – who are we to complain about this opportunity?

During a pandemic, or any disaster situation for that matter, there are certain elements that we cannot control. These elements never were, and never will be, our fault personally. For example, how both Australia and New Zealand are islands that can close their borders from the rest of the world, or that our world-class universal healthcare systems don't rely on patients having health insurance. The fact we have some job security, our lack of community transmission in some states – none of these are entirely our fault on an individual level. While attributing a sense of guilt and shame to it is possible, it's not the best use of our precious energy.

When a survivor feels guilt, the locus of control is often external – so rather than focusing on the things we cannot change, we should be concentrating on the things we can.

Feeling guilty because a local community group has been supplying your department with hot meals, despite having low or no COVID cases in your area? Donate your time or cash to them when you can, pledge to dine with local restaurants once restrictions lift, or order their takeaway and provide a tip to the server.

Feeling ashamed because you have a job when some of your friends don't anymore? Offer to help them in whatever way you can, even if that's just a contactless grocery drop or a glass of wine over Zoom to let them talk.

Feeling uneasy because your ED has been relatively unscathed compared to some of our colleagues in other states and overseas? Connect with them on social media. Reach out to them, support them, but ensure you learn everything you can from them - don't let their experience be in vain.

Guilt will not fix this pandemic, but a touch of kindness will certainly make it easier - and that kindness extends to ourselves as well. We cannot be the best doctors for the patients in front of us if we're totally absorbed with the things we cannot fix. Our patients deserve our best attention, and while we may no be able to change the entire world in that moment, we still have the power to change the patient's world for them.

For those of us who find ourselves fortunate, perhaps the best way to be thankful for the situation we find ourselves in is to be present – to our patients, our families, our friends and our colleagues. To anyone who needs us, because that's what makes a real hero.

It is still our time to shine as emergency physicians – just don't let the guilt ruin your sparkle.

# A Surge in Domestic Violence During COVID-19

**Dr Akmez Latona**
Dr Latona is a final year FACEM Training Program Trainee and currently working as a retrieval registrar with RACQ LifeFlight.

Here I am on the threshold of being a new Fellow, reflecting on the experience of completing emergency medicine training. Intense training and robust examinations ensure that my knowledge and skills translate to expertise ready to tackle any emergency situation. In reality, there are still situations that challenge me. Looking after patients experiencing domestic violence is one of these challenges.

Experiencing COVID as an emergency physician has been complex. The community's engagement with social distancing has been, for the most part, positive in limiting numbers of infection. Social distancing, we all know, comes at a cost for everyone. For some in the community, that cost has been noticeably higher. Those experiencing domestic violence is one of these groups. Here are some Australian statistics:

- One woman per week (on average) is murdered by her current or former partner.
- One in six women experience abuse before they turn 15 years old.
- One in three young people presenting to homelessness services have experienced domestic violence.
- Nine out of 10 women with a disability have been sexually harassed.
- Australian police deal with a domestic violence situation every two minutes.

These figures outline domestic violence as a serious, common public health issue and human rights violation we face as a community.

Domestic and Family Violence (DFV) is not like other crimes. It's not because you're in the wrong place; you should be safe at home. It's perpetrated by someone you know, who often claims to love you, who tells you it's your fault it happens. I don't know how many people experiencing DFV attended my ED last week, but I remember 'Emily' (fictitious name). I cared for her and the interaction remains vivid.

Emily was wheeled in on an ambulance trolley as I was surviving my night shift. As I sat at the handover desk, I first saw her through the glass panels of the write-up area. Her gaze met mine and quickly lowered to the floor, trying to hide her black eye. She avoided eye contact with the paramedics and nurses. Tears dropped onto her cheeks. She looked scared. She tried to cover her bruised arms. A quick glance at the triage note – 'alleged assault – likely DFV'.

In the cubicle, I took a chair and sat next to her. She was physically hurt, mentally exhausted and emotionally destroyed. I asked her to tell me what's been happening.

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'Where do I begin?', she said, 'My journey to hell started when I was nine years old'.

I started my history taking and an examination to look for injuries. She didn't flinch even when it was obvious she was in pain.

'He's good at not leaving them where they could be seen,' she whispered apologetically, as I respectfully uncovered her body to look for signs of trauma. I listened to her chest and palpated her abdomen. I tried to maintain eye contact with her, but it was difficult.

A CT scan of her face diagnosed facial fractures, only requiring conservative management – no surgery. Time would fix the broken bones. I gave her pain relief for her broken ribs. She hadn't wanted to disclose that she got punched in the ribs; she thought it showed weakness and was ashamed. It was clinically obvious, and I had to gain her trust for her to be vulnerable enough to tell me. To assess her properly, she needed to feel safe, to be comforted, to be seen as a person.

*Her gaze met mine and quickly lowered to the floor, trying to hide her black eye.*

Emily was in my world, the ED. Here, I could provide a safe space for her, treat her with dignity and respect, and offer support. She was admitted to the short stay unit overnight for care and would see the ED social worker in the morning.

Emily was still in her world, at least in her head. It was completely different and frightening, with repercussions and consequences for this attendance, and what happened in ED was not as important to her. She was grateful for the care and space, but her self-worth did not allow her to think she deserved it. The darkness of her world persisted.

There has been a surge in domestic violence presentations in the ED during COVID social measures. Or am I just recognising DFV in my patients more? Is it the Baader-Meinhof phenomenon? DFV affects people from all walks of life regardless of gender, age or socioeconomic status.

In my training, I have learnt to treat medical emergencies, manage trauma, break bad news, and de-escalate situations. The challenge of combining all of this, and more, in one patient presentation, to constructively engage with those experiencing DFV, extends beyond my training. It starts with kindness. It starts with empathy and compassion. It starts with recognition. It is strengthened with care, communication and support.

We need to embed hope in the reality of DFV – for those experiencing it as a patient and those who care for them in ED and other services. We need to draw upon the values we base our practice on. Shame traps people in a cycle where they feel judged and worthless. We can break that cycle by speaking to the shame and engaging with empathy. The destructive cycle is reinforced by intolerance, indifference and dismissing or under-recognising its existence.

*Shame traps people in a cycle where they feel judged and worthless. We can break that cycle by speaking to the shame and engaging with empathy.*

It is often said that, in emergency medicine, the patients we see are having their worst day. For someone living in a world of DFV, that same ED experience is not their worst. What comes when they leave ED is more frightening, riskier, worse. They are trapped by shame, fear, guilt and intimidation. This can be undone, however, and the process can start with us in emergency medicine.

This leaves me asking, 'Where to from here?'. All clinicians must recognise DFV cases and their effect on other presentations to ED. We must not subconsciously filter it out, we must start asking our patients about their experiences. How do we, as emergency physicians, collectively engage with and treat this public health issue in our emergency medicine context and beyond? Think about it. Even some of our colleagues are living with it. We provide excellent care in the ED. We must develop excellence in our management plans and post-attendance care. The responsibility lies with us.

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# On the Other Side

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

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We all have those moments in our lives that we look back on and say, that was the time when everything changed. Those moments are seared in your memory like the afterglow of a long burnt out lightbulb. You close your eyes and you can still see the images, blurred a little by time. With just a heartbeat, they pull back into sharp focus. This is one such moment. A moment that changed how I practise medicine forever.

It has been said that patients don't have stories — discrete episodes with a beginning, a middle and an end — they have lives. And while we may pay attention to just one healthcare encounter, we must be mindful that this is one of many in a life. This 'story' takes place at 7:48am on a Sunday morning in mid-October, but for those involved, it becomes their life.

It could take 45 minutes to drive to the local maternity hospital if the traffic was bad, but at 5:00am, unhindered by the stop-start crimson of frustrated tail lights, it took just 20 minutes. Her waters had broken and, at the midwife's behest, she and her husband were making their way in. A waddle to reception, a swift wheelchair ride, and they were in the birthing suite. The overnight bag, having laid by the front door for so long, was thrown into the corner of the room and forgotten as she put on a gown.

The midwife and the mother-to-be exchanged tired smiles as the blood pressure cuff was unfurled and tightened around her arm. The squeeze was nothing like what she was experiencing in her belly. The resident came in and introduced themselves as the woman tried to relax onto the bed in between contractions. Sterile gloves on, the obstetrician examined and probed, before turning around on her stool to reach for something on the tray next to her.

'We'll need to rupture the rest of your membranes', she said as the wicked looking hook was pushed between her legs. The pad was there, ready to catch the life-sustaining liquor. But instead of the expected clear gush, the fluid ran a dark red.

The mood, initially light, darkened. The patient and her husband, unaware of what was going on between her legs, sensed the change.

'What's going on?'

There was a look on the doctor's face, an 'oh sh!t' look that the husband recognised instantly. Torn between wanting to look and wanting to support his partner, he held her hand tight. The midwife moved faster now, fumbling with the CTG belt, struggling to pull it around the full belly. Transducers slick with gel, she looked at the screen.

'I can't find a trace.'

The resident got off the stool so quickly that it slid into the wall and she went over to the phone. She whispered into the phone, words unheard by the parents-to-be, words that were soon echoed by an overhead address. There was an audible click as the speaker came to life. 'Code green, code green, birthing room 2.'

Doors slammed open and a horde of faceless blue scrubs entered the room. Orderlies had already pushed a trolley in as the senior doctor made his way around to the foot of the bed. She was going to theatre for an emergency operation. Yes, it had to happen now. No, they didn't know what was going on. And with that, they were on their way, the husband lagging behind.

Another blue-clad orderly barged open the doors to the operating theatre. A harsh white fluorescence carved apart the dawn light as she crossed the threshold of the operating room. He, devoid of the proper credentials, left behind to sit and wait …

… and wait

… and wait.

Sitting in the half light of recovery on a Sunday morning, he wondered what was going on behind those doors, as the team scrambled to deliver the baby. Another overhead announcement and another troupe of blue-clad helpers entered the forbidden room. Silence once more. And then the noise. Footsteps, slow, clip-clopping on the vinyl.

'I'm sorry, Mr Tagg. I have some very bad news for you. Despite everything, we were unable to save …' And with those words, I was lost.

———

Over the course of my career, I have been involved in many resuscitations, some successful, many not. It is the paediatric ones that I remember the most. I remember the toddler that had been playing, unseen, in the driveway as their father reversed. I remember the infant, unattended in the bath as their mother was on the phone. I remember the chronically ill young girl who we would never have been able to save, but we tried for the sake of the parents who were there. In all of these cases, the parents were present. And while it was hard for the team to hear their cries, it had to be done.

There is plenty of evidence to suggest parental presence during infant resuscitation is best practice. It helps with understanding and the grieving process, and lets the parents know that everything that could be done was done. But what about in the resuscitation of a newborn child, even if the mother is unconscious?

Elizabeth died at 7:48am on a Sunday morning, having lived for 14 minutes. Neither my wife nor I were there. My wife, unconscious and intubated, and me outside the room. Neither of us were able to hold her as she took her last breath in a room of strangers.

This one moment, in my lifetime, will forever change the way I see the world. No matter the circumstances, I bring loved ones into the room if they want it. I make sure there is someone to guide them and coach them through the experience so that they will never be left wondering if everything was done.

When I say 'I'm sorry' I recognise that this very moment will be remembered forever. My words will be heard forever. How I say those words and what I do will be remembered forever.

# Educating in the time of COVID-19

**Dr Casey Bennetts**
Dr Bennetts is an emergency registrar based at Queen Elizabeth II Hospital, Queensland. MBBS, BHlthSc (Nutrition & Dietetics) (Hons), BAppSc (Human Movement Studies) (Hons)[1]

As I sit at my desk, writing about wolves, bricks and sausages, I am thinking of the emergency departments abroad that have been overwhelmed by COVID. Many were not afforded an opportunity to prepare before their houses were blown down in the most vicious of fashions. Many haven't had a spare second to educate, let alone reflect on COVID, or write analogous opinion pieces. I am not claiming to know better, or that we have mastered all things education. Rather, this piece is an appreciative reflection of how our ED education team has banded together to use medical education as a weapon against the threat of COVID.

| External | |
|---|---|
| **21 January** | Queensland's first patient is COVID-tested[1] |
| **28 January** | Queensland's first case of COVID is confirmed[1] |
| **29 January** | A statewide public health emergency is declared[1] |
| **Internal** | |
| **23 January** | First 'suspect COVID case' at QEII (final diagnosis non-COVID) |
| **1 February** | COVID Microsoft Teams channel opened |

COVID-19. The big, bad wolf. His reputation preceded him. He was a filthy beast with a voracious appetite for human life, and had blown down thousands of houses in villages afar. He was hungry for more and was headed our way.

3 February 2020. My first day in a new role. I am a freshly minted 'little pig' medical educator at QEII Hospital Emergency Department, Brisbane. There are currently two cases of COVID amongst Queensland's population of ~5.1 million1[1,2]. On my first day I am given access to a 'Coronavirus Huddle Group' Microsoft Teams channel, and am tasked with development of hand hygiene promotional videos to be released within the week. The ball was already rolling and it was clear I needed to keep pace.

## Tip 1

Aggressive anticipation

| External | |
|---|---|
| **13 March** | Queensland suffers its first COVID death[1] |
| **18 March** | Scott Morrison announces restrictions on gatherings to 100 people indoors, and 500 people outdoors[3] |
| **Internal** | |
| **6 February** | Rollout of Hand Hygiene education package |
| **10 March** | Rollout of COVID PPE education package |
| **18 March** | Rollout of COVID Intubation education package |

Whilst the COVID wolf was slow out of the blocks in Queensland, taking 53 days to reach its 50-case milestone (which it did on 14 March 2020)[4], our department was not.

Early educational strategies employed in preparations at QEII included:

- **Interdepartmental**: senior staff engaged in frequent consultation with public health, infectious diseases, and hospital executive. Subsequent information dissemination to emergency staff occurred via Microsoft Teams (below).
- **Intradepartmental**:
  - **Microsoft Teams**: early uptake of a single information-sharing platform was used to 1) deliver up-to-date COVID information, 2) to allow staff to ask any question at any time, and 3) to receive timely, quality feedback from a local source. Posts were visible to senior staff, which allowed 4) cognitive error, anxieties and information gaps to be addressed readily. Further, the use of a single information-sharing platform 5) demonstrated transparency and an 'in-it-together' team environment.
  - **Multimodal education delivery**: COVID-specific local education packages were developed and rolled out by the education team, focused on new skill sets required for the COVID outbreak. Film, part-task training, translational simulation, and daily drills were embraced in these packages, which included: Hand Hygiene; PPE Donning and Doffing; Intubation; BiPAP; Cardiac Arrest; and Paediatric Wheeze. Packages were rolled out in synchrony with the teams assigned to developing new COVID departmental work instructions.

**Tip 2**

Control the Information Glut

| | |
|---|---|
| **External** | |
| **20 March** | 1.5m and 4m$^2$ per-person social distancing rules introduced[5] |
| **Internal** | |
| **20–28 March** | Decentralisation of Teams channels to task-specific channels |

Information exhaustion was a sequelae of this aggressive approach, and was observed as early as mid-March, when there were under 400 cases in Queensland[5]. Contributing to this overload was individual information hunger/research, relentless COVID media saturation, and, of course, the huge emotional burden of the known and unknown ramifications of this pandemic.

Remodeling supersaturation into empowered productivity was addressed by:

- **Role assignment**: staff were assigned to task-specific, small COVID working groups (example: RSI/Intubation; BiPAP), led by senior medical staff. Early engagement of senior nursing staff to co-lead working groups was identified as important quality control measure.
- **Microsoft Teams restructure**: COVID information was compartmentalised into specific Teams channels with familiar headings: RSI/Intubation; PPE/Hand Hygiene; Paediatrics; Questions from Staff; and COVID Information.
- **Version control**: document/policy updates were given version numbers, and revised at agreed intervals.

These actions provided: 1) a controlled, structured approach to COVID; 2) permission to cognitively unload from decision-making assigned to others; 3) individual ownership over tasks; and 4) 'heard' contributions within focus groups, undiluted by general COVID conversation.

As a result, efficient development of high-quality output occurred, and the department evolved into a focused and confident team.

**Tip 3a**

Trim the fat

| | |
|---|---|
| **External** | |
| **24 March** | Queensland experiences its greatest 24-hour case rise: 78 new cases[4] |
| **26 March** | Queensland border closes to nonessential Australians[1] |
| **30 March** | Queensland introduces two-person rule for gatherings outside of household[1] |
| **Internal** | |
| **16-27 March** | University of Queensland students removed from clinical environments |
| **26 March** | New, COVID-adjusted registrar education |
| **30 March** | FACEM clinical support time cancelled for greater on-floor presence |

As worldwide cases soared, it was clear the COVID wolf would shortly be on our doorstep. 24 March 2020 saw Queensland's largest to-date case rise, with 78 new cases in 24 hours[4].

The first major personnel change during this period was removal of medical students from the clinical environment. Formal didactic registrar education was postponed indefinitely. Junior doctors were seconded to ED from other specialties, and newly employed from reaches as far as India and the UK. Next, FACEMs were excused from their nonclinical loads and redeployed to the floor. These measures increased clinical medical staffing by 36% (January.vs April. 2020). Concurrently, daily patient presentations plummeted by 23%; falling to numbers not seen since February 2014.

| Tip 3b<br>Use the fat to make sausages | |
|---|---|
| **External** | |
| **4 April** | Queensland reaches 900 cases, 21 days after its 50th case[4] |
| **16 April** | Queenland reaches 1000 cases[4] |
| **20 April** | Queensland's records '0 new cases' overnight[4] |
| **Internal** | |
| **2 April** | RBWH online registrar education |
| **8 April** | Interdepartmental simulation: COVID Intubation + Anaesthetics |
| **12 April** | Rollout of COVID BiPAP education package |
| **14 April** | Rollout of COVID Arrest education package |
| **22 April** | Translational simulation: Paediatric COVID Presentation |

The time gifted to the department as a result of these measures, and the strategic retention of medical education and simulation registrars' non-clinical roles, provided a unique opportunity to deliver wide-ranging education, on demand.

### In-department COVID education

Medical education and simulation registrars engaged the department in the abovementioned COVID drills, simulations, part-task training sessions and videos. Sessions captured both nursing and medical personnel, and on a number of occasions, ICU and Anaesthetics departments. Sessions were run repeatedly, with participation logged to maximise staff capture (proudly, >90% of ACEM trainees had completed COVID RSI training by early April).

### Junior doctor and trainee education

Social distancing regulations necessitated a shift in approach to regular education:

- **Delivery of small-group and 1:1** education sessions replaced didactic seated sessions. Procedural skills and simulation featured heavily, and included ICC insertions, eFAST, pericardiocentesis, USS-guided line insertions, Resuscitaire use, neonatal PPV, transcutaneous pacing, regional nerve blockade, normal SVD and massive haemorrhage management. Skills stations were delivered both during allocated education time and opportunistically, department workload permitting.
- **Workshop-style** small-group registrar education was introduced, with rotating lectures/skills stations in separate rooms.
- **Online education**: the neighbouring tertiary facility, Royal Brisbane and Women's Hospital (RBWH), rolled out their 'TEd' program on Teams, on 2 April. Each weekly topic included props, case discussions and trainee-led answers to topical questions. RBWH included QEII in their 'TEd' program, which was an excellent supplement to ongoing education in the department.

### Medical student education

Medical students, whilst removed from the department, continued lessons from home. Existing online education modules were supplemented by Zoom surrogate teaching experiences, run by QEII registrars and staff specialists (in many cases in unpaid time), to ensure ongoing quality education. Behind the scenes, academic leads undertook extensive restructuring of student curriculum and assessment to align with the new era of socially distant learning.

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And so we return to the wily COVID wolf. He has huffed. He has puffed. He has bared his filthy teeth just outside the door, exhausting himself, whilst our team inside has only grown stronger, more confident, and more cohesive each day. For now, he's asleep on the front porch of our fortress formed of the bricks of dynamic, evolving medical education, and held together by the sturdy mortar that is our team and an incredible public health response to this crisis.

A second surge of COVID is entirely possible as restrictions begin to ease. If the COVID wolf wakes, his only option into our home will be the chimney. We will have the fire blazing.


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# Council of Advocacy, Practice and Partnership

As a result of the upheaval in 'business as usual' due to the COVID-19 pandemic, the Council of Advocacy, Practice and Partnerships (CAPP) has met twice since the last issue of *Your ED*, via videoconference on 29 May and 31 July 2020.

At the July meeting, Dr Jessica Forbes was welcomed on Council as a new representative for Queensland, and Associate Professor Sally McCarthy was congratulated on being inaugurated as President of the International Federation for Emergency Medicine. Dr Lynda Vine has stepped down from her role as CAPP representative for Western Australia and was thanked for her outstanding contribution.

### COVID-19 update

At both Council meetings, jurisdictional representatives provided an update on the COVID-19 situation in their area. A common observation across jurisdictions was a reduction in ED presentations, although these tended to be at the low acuity end. While the number of presentations was trending upwards again, they were 10-35% below pre-COVID levels. Nevertheless, patient flow was still slow within some jurisdictions, with access block sustaining or reappearing in many areas. The spatial requirements around suspected COVID-19 cases was contributing to ED overcrowding. In addition, workforce concerns were raised, with reluctance to travel, flight costs, and border closures affecting EDs that rely heavily on a locum workforce or international doctors.

By July, the re-emergence of COVID-19 in Victoria had led to an exceptionally challenging situation in some Melbourne hospitals, a major component being the quarantining of up to 30% of staff. Low-level community transmission and clustering of cases in New South Wales had created some nervousness, although staff were confident in their levels of preparedness. Other jurisdictions remain anxious about the virus re-emerging in their localities, with difficult decisions to be made around whether, and how, to de-escalate some of the extraordinary measures introduced to combat the virus.

Some of the key themes emerging from the jurisdictional updates with respect to the College's advocacy priorities were:

- A need for the College to continue to address patient-specific flow concerns as they emerge in localities.
- Advocacy for more consistent advice on the use and availability of PPE.
- The need for a College position statement on 'COVID business as usual' for EDs post-pandemic, focusing on the quality and safety of care for both patients and staff.
- Ensuring that the gains in collaboration between clinicians and governance bodies are cemented in enduring and formalised relationships moving forwards.

### Emergency medicine standards

Since the start of 2020, CAPP and its associated entities have been undertaking a review of the College's Emergency Medicine Standards in collaboration with staff from the Policy and Strategic Partnerships department. The following policies and statements have been approved:

- *P455 Policy on End of Life Care*
- *S738 Statement on Gender Equity*
- *P60 Policy on ED Data Integrity*
- *P395 Policy on Internet Access in the ED*
- *P39 Policy on Family and Domestic Violence and Abuse*
- *S43 Statement on Alcohol Harm*
- *S769 Statement on Harm Minimisation Relating to Drug Use*
- *P59 Policy on Heatwave and Health*
- *S731 Statement on Consent for Patients Highly Dependent on Medical Care*
- *P40 Policy on Early Access to Defibrillation*

### Mental health working group (MHWG)

At its July meeting, Council was updated on recruitment of members to the ACEM MHWG. The number of expressions of interest received has been greater than the number of ordinary positions on the MHWG, necessitating a selection process.

### Research strategic plan

At its May meeting, CAPP approved a Strategic Plan for research at the College, which was developed by ACEM's Research Committee. At the moment there is no pathway for trainees who want to undertake research as part of a portfolio career. The Strategic Plan envisages a maturation process whereby emergency medicine adds self-reflective practice to a profile dominated somewhat by pure service provision, and aims to deliver a future where research is a key pillar of the College that underpins the professional development of emergency physicians.

### Volunteer Service Abroad (VSA) Partnership

CAPP approved a partnership agreement between the College and VSA – Te Tūao Tāwāhi at its July meeting. Currently, formal partnerships for Special Skills Placements (SSPs) exclude New Zealand-based trainees. The VSA Partnership will provide opportunities to support Global Emergency Care SSPs and/or volunteer placements for New Zealand trainees.

### JMO recruitment

Prompted by concerns expressed by CAPP, the ACEM President has received written reassurance from the Department of Home Affairs (DHA) that international JMOs, are not precluded from applying for skilled visas and exemptions. The DHA has updated its website to reflect this clarification. This has resulted in a number of departments successfully recruiting JMOs however issues persist with access to flights, flight costs and quota's in international arrivals.

*Authors: Dr Robert Lee, General Manager, Research and Policy*
*Richard Whittome, Policy and Research Administrator*

**More information**

https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Emergency-Medicine-Standards

# Research Capacity

**Dr Katie Walker**
Dr Walker is an Emergency Physician, Adj Clinical Associate Professor for Health Services at Monash University, Melbourne, Victoria.

Where are we now with the ability to conduct research in our EDs in Australia and New Zealand?

As mentioned in the Autumn 2020 issue of *Your ED*, there are many reasons for our EDs to be involved in research. In order to provide the best possible care to the nine million patients who attend our EDs each year, we need to be able to test interventions (therapies, procedures, processes, knowledge translation) to see which work and which should be put aside. The way to do this is to undertake research that provides robust information on the topics that bedside clinicians want answered. We need everyone in our communities to be represented in trial data, so that the research is undertaken in our environment and we can have confidence that the results apply to our patients. This means ACEM needs to be conducting high-quality, multi-centre interventional trials focused on emergency medicine.

In order to understand how the ACEM Clinical Trials Network (CTN) might facilitate increasing the number of well-resourced and conducted trials, we needed to understand our baseline capacity for research – sites, personnel, resources, skills, research cultures, etc. The end result of improving trial capacity should be that we better understand how to treat emergency patients at the bedside.

The ACEM CTN conducted a survey in 2019 to describe our current ED research activities.[1] We thank those who contributed to this project. In total, 122 (84%) of our EDs contributed data and we found the following:

- We have research leads at 66 sites (59%) and Directors of Emergency Medicine Research (DEMR) at 32 sites (29%)
- 96 sites (66%) contributed to multi-centre studies in the last five years
- 21 sites (17%) were highly productive and well-resourced for research
- 60 to 70 centres (50-58%) had limited resources and struggled to undertake research
- Paid time for research directors was associated with increased research output
- ACEM sites have the capacity to undertake large multi-centre studies with a varied network of sites and researchers, representing all types of patients from all regions.

*Many departments don't yet have a research lead, but expressed enthusiasm for and interest in research if resources could be obtained for their teams and governance issues could be surmounted.*

We found that our researchers had varying levels of experience and skills. Some were full professors who were leading teams and obtaining large grants. Others were earlier in their research journey and requested support from the ACEM CTN regarding mentoring and advocacy for emergency medicine research.

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Current projects in our EDs span a vast array of topics. Pretty much everything we do is being investigated. Research is underway on: disease and age-specific questions; the utility of decision instruments or tests; emerging therapies; technology; emergency and hospital systems; public and emergency worker health; pre-hospital, community, nursing home and battlefield environments; emergency epidemiology; and many other areas.

*Some of us work in environments supporting research, enjoying good research infrastructure and strong relationships*

Many sites had authored or co-authored research papers or obtained grants over the last five years. However, 47 sites hadn't published any manuscripts. There was a strong relationship between the presence of a research lead or DEMR and the median number of papers or value of grants. In the last five years, sites with a DEMR published 26 papers and obtained $105,000 in grants, on average. Sites with a research lead (not a DEMR), on average, published six papers and obtained $0 in grants. Sites without either type of research lead didn't publish or obtain grants.

Our research culture varies. Some of us work in environments supporting research, enjoying good research infrastructure and strong relationships with hospitals, administrators and colleagues, and find it straightforward to recruit patients. Others feel unsupported at some or all levels, describing issues with infrastructure, governance and prioritisation of research.

Many departments don't yet have a research lead, but expressed enthusiasm for and interest in research if resources could be obtained for their teams and governance issues could be surmounted. These sites represent research potential that, with a little support, should be able to deliver patient trial data representing their patient populations. An initial step to facilitate multi-site research (without increasing overhead costs) might be to identify a research lead for each site, so that researchers initiating multi-site projects are able to invite diverse sites to participate in data collection.

In summary, Australian and New Zealand emergency medicine is well placed to conduct large, multi-centre clinical trials, although resourcing remains an issue. With time, ongoing advocacy and trial facilitation, the ACEM CTN hopes to see this capacity increase and we look forward to having a better understanding of how we should care for our patients.

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# Dr Marcus Kennedy

Dr Marcus Kennedy has been an ACEM member since 1989. He was Director of Emergency Medicine at The Royal Melbourne Hospital, then Adult Retrieval Victoria (ARV), before retiring in late 2018.

### What did you do to sustain your career?

In a job characterised by relentless workload and bureaucratic impediment, even the most stimulating caseload can fail to maintain your mojo. I always thought that diversification was important – looking for different angles and challenges – being prepared to move jobs and work in more than one role. Flexibility and change fuel resilience.

### What do you see as the greatest achievement in your career?

Being able to maintain a real commitment to quality, safety and good governance. This was always about preserving integrity, with a compass fixed on the patient and the system. The work I did in the last 10 years of my career in pre-hospital retrieval medicine (PHRM) was probably the most significant in terms of achievement. The month I started at ARV, an 'expert' told me we'd fail – 10 years later the service was mature and effective. It had provided care to 50,000 patients and increased medical retrieval ten-fold, while working inside an ambulance service that was actively unsupportive of medical retrieval systems. The 'expert' was proved wrong by a great team of people, but there's still a long way to go. ACEM is helping with PHRM development.

### What would you do differently?

So many things. I didn't focus enough on balance. Relationships, health and wellness, and career should be equal partners.

Active management of burnout is important, as it is a big risk for emergency physicians. If it's happening mid-career (usually due to shift work, repeated head-banging, repeated wasted effort in patient advocacy), active strategies are extremely important.

There's another version of burnout, which is the 'I see retirement on the horizon and I really just want to move on' version. This is a bit different, reasonably common and completely understandable – after two to three decades, the battery is spent and it's time for a rest and a change. Towards the end of my career, I became less tolerant of people and systems that didn't see things my way (grumpy old man). On the other hand, maybe it's OK to be grumpy when the system is broken and people choose not to fix it.

### How would you describe the experience of retiring?

Despite 2020 and COVID-19, I have found moving into retirement a positive experience – I was very much looking forward to it. Having networks to provide support and ongoing connection can be important. I believe ACEM is developing resources in this space. The Australian Medical Association also has good resources.

Extracting myself from the routine and structure of full-time work has been a challenge, so having a project like writing a book has helped. Writing has required me to learn new things about editing, publishing and book production, marketing, social media, web page construction, blogging and so on – that has been pretty full on, not to mention the months and months of actual writing! Life-long learning is important.

In my book, *The Cut*, I was able to draw on my own experiences to a degree, which was a bit cathartic. Having said that, I didn't want to just do a thinly disguised memoir – there's much more to it than my anecdote library!

It's a work of medico-political drama based in emergency medicine, which wanders into the thriller/crime space as well as having strong philosophical threads. In a way, a heavily dramatised version of a realistic workplace felt like a natural place to start a first novel; that was crucial so that the characters and their experiences felt plausible and relatable.

### More information

*The Cut* by Marcus Kennedy is available now. Direct order at: https://marcuskennedy.net or online bookstores.

# Dr Minnette Monteith

Dr Minnette Monteith is FACEM Training Program Advanced Trainee in Christchurch Hospital, New Zealand.

### Why emergency medicine?

I moved to Hawke's Bay, New Zealand from Central London after my few years of ED training. It was quite the contrast going from grappling with the varied London drug scene one week to the tractor injuries and gang crime of rural New Zealand the next. There can't be many jobs in the world that give you such a raw insight into the full breadth of society.

I love the ED team environment. It is fantastic and I feel very lucky to work with such a great group of people.

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

The thing I like best is the variety and unpredictable nature of emergency medicine. You never quite know what is around the corner. I think that it is easy to forget that we have such a privileged insight into people's lives, often at their worst but also at their best.

The last year in Christchurch Hospital has thrown a few challenges our way with the Mosque shootings and the Whakaari White Island explosion, to name a few. Whilst these were fairly challenging days on the job, they were very humbling. People came together and showed such unconditional kindness in the face of adversity. Now there is COVID…

### What do you do to maintain wellness/wellbeing?

Thankfully, with the adventure playground that is New Zealand, this is not challenging. It really could have been a country designed for me with mountains on the doorstep. I'm an enthusiastic but not overly skilled cyclist/ski tourer/tramper/surfer. I'm also not ashamed to mention my new found appreciation for the (rather scruffy) garden with a disproportionate amount of excitement shown towards produce from the veggie patch.

### What do you consider your greatest achievement?

Convincing the night time MDT to do 'fab ab' workouts at 3:00am has got to be pretty up there (and trying not to buckle during said enforced minute plank).

I also joined the British Army after medical school as a Reserve Army Officer. During my military training I was commissioned as the top officer in a predominantly male field, which did take me by surprise! It was a small achievement but did make me realise I was a bit tougher than I had given myself credit for. Training with the New Zealand Defence Force has been interesting. It's Emergency Medicine but from a very different perspective with a different style of leadership and lateral thinking. Whether it's negotiating evacuations at sea or setting up casualty receiving stations in abandoned buildings in the depths of Waiouru. I love this challenge and the expanded way I'm learning to think about Emergency Medicine.

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

I am pretty light on accolades and like to think that the highlight of my career is yet to come. I do feel proud of having got this far, feeling like I do a good job at work and being happy. I think that's pretty easy to overlook and take for granted in the culture of medicine.

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

The advice that was given to me and I would pass on is go feet first, take opportunities as they arise and don't be afraid to get stuck in. What you put in is what you get out of the job, but you do need to keep it sustainable.

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

Improving interdepartmental relationships, the growing respect for emergency medicine and its scope as a specialty.

# ACEM Educational Resources Website

### What does the ACEM Educational Resources Website have to offer?

The ACEM Educational Resources website was initiated in 2010 to facilitate discussion between ACEM Fellows and trainees. In technical terms, the website is known as a Learning Management System (LMS); an online platform designed to enhance learning processes. Since 2010, significant work by Fellows, trainees and ACEM staff has developed the website into a huge collaborative hub, which aims to provide members, trainees and other health professionals with access to relevant and contemporary educational materials, and with the ability to collaborate on topics related to emergency medicine.

### Basic facts about the website (June 2020)

Web: elearning.acem.org.au
Software: Moodle
Number of active webpages: 230
Number of registered users: 14,548
Support: helpdesk@acem.org.au

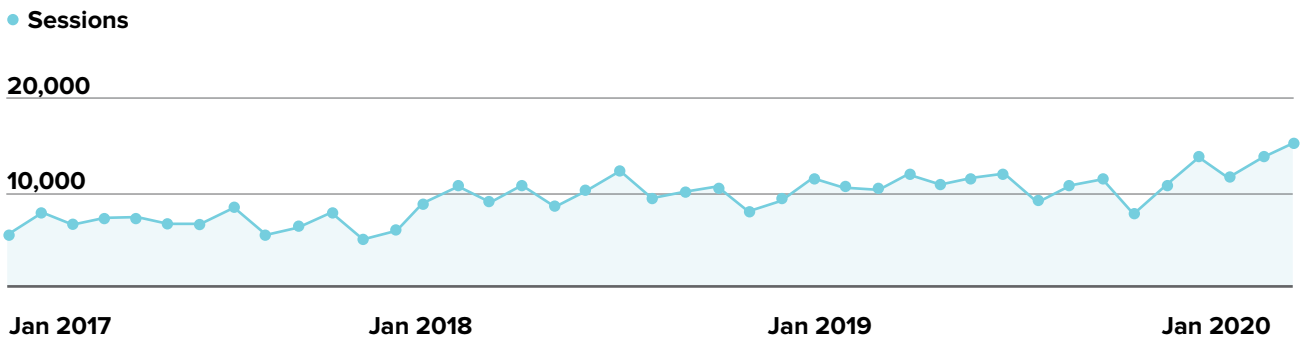
### Use of the website

The Educational Resources website is accessed by ACEM members, trainees and external health professionals according to ACEM policy COR721: *Access to ACEM Online Educational Resources Policy.*

Considering the use of the website over recent years, Figure 1 gives a snapshot of how the Educational Resources website has been used between January 2017 and May 2020. (Note: A 'session' is a period of active use on a website). The following observations can be made from Figure 1:

- There has been an increase in the number of sessions on the Educational Resources website between 2017 and 2020. This suggests that improvements to resources and website functionality has increased its usefulness.
- The peaks in numbers of sessions prior to ACEM examinations suggests that resources are useful for trainees preparing for examinations. This pattern occurs before all ACEM examinations - Primary, Fellowship, Emergency Medicine Certificate (EMC) and Emergency Medicine Diploma (EMD).
- There are troughs in the number of sessions during Christmas and summer holiday periods.

**Figure 1: Number of sessions on the ACEM Educational Resources Website Jan 2017 – May 2020**




**Source**: Google analytics

### What resources are available on the Educational Resources website?

Figure 2 provides information about some of the resources available on the website. The numbers of individual people who have visited each online area at least once since it was released are also displayed. Resources are reviewed by Fellows and trainees on authoring groups and the ACEM Educational Resources Review Panel.

**Figure 2: Overview of ACEM Educational Resources**

| Resource | Description | Number of unique users who have accessed these resources at least once |
|---|---|---|
| **Fellowship Examination Resources** | Information about the ACEM Fellowship Examination. Resources include:<br>• General examination information<br>• Online SAQ practice questions<br>• ACEM procedures for Fellowship Examinations<br>• Past papers<br>• Examination reports<br>• ACEM OSCE scenario videos<br>• Other free external resources. | 3,108 (Fellows and FACEM trainees since 2018) |
| **Primary Examination Resources** | Information about the ACEM Primary Examination. Resources include:<br>• General examination information<br>• Primary Examination Written practice questions<br>• Past Primary Viva Examination papers<br>• Examination reports<br>• Other free external resources. | 2,263 (Fellows and FACEM trainees since 2018) |
| **Emergency Medicine Certificate** | eLearning resources, as well as program and assessment information about the Emergency Medicine Certificate (EMC):<br>• 55 eLearning modules are available on a wide range of emergency medicine topics related to the EMC Curriculum. | 2,863 (Fellows and FACEM and EMC trainees since 2017) |
| **Emergency Medicine Diploma** | eLearning resources, as well as program and assessment information about the Emergency Medicine Diploma (EMD):<br>• 41 eLearning modules are available on a wide range of emergency medicine topics related to the EMD Curriculum. | 1,363 (EMD trainees, Fellows and FACEM trainees since 2018) |
| **General EM Resources** | A general collection of ACEM-developed and external resources arranged under FACEM Curriculum Domain headings. | 2,581 (Fellows and FACEM trainees since 2019) |
| **Shared Education Resources** | Developed in April 2020 to facilitate the sharing of study resources for the FACEM Training Program. Resources contributed are published quickly on this page for sharing with all trainees and Fellows, then reviewed for inclusion in the General EM Resources area. | 240 (Fellows and FACEM trainees since April 2020) |

### ACEM Educational Resources for external health professionals

Since 2017, online modules have been released for access by ACEM Fellows, trainees, other members, and external health professionals, via a self-generated login to the website. These resources include the *Indigenous Health and Cultural Competency modules* (2,193 users), *Assessing Cultural Competency modules* (4,017 users) , and *Critical Care Airway Management modules* (2,334 users).

*Author; Katharine Ebbs, Educational Resources Manager*

### More information

Improvements to the resources available for Fellows, trainees and other members is ongoing. If you have any questions or wish to share resources, please contact educationalresources@acem.org.au

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# Emergency Medicine Education and Training

**Dr Patrick Buxton**
Dr Buxton is a rural generalist/GP anaesthetist and ACRRM Fellow, working as a District Medical Officer in Kununurra, East Kimberley , Western Australia and also as remote DMO for Top End Health Services, Northern Territory Health.

The East Kimberley region of North West Australia is known for its strong and significant Aboriginal heritage that dates back more than 50,000 years. The language, culture and Indigenous law remains vibrant. The landscape has a spectacular beauty, rich in spirituality, that makes you appreciate the unique connection between the traditional owners and Country.

For those of us providing emergency medical care, there is also a harshness and an isolation. Critical illness does not respect geography. The serenity of the land contrasts starkly with the feeling of loneliness, even trepidation, in being the sole doctor in the hospital when a patient arrives with a life-threatening condition. Not uncommonly, it occurs at 3:00am.

The social and health problems faced by Indigenous Australians today are strikingly obvious. Diabetes, chronic renal failure, mental health and alcohol-related issues are all a standard part of our daily work. This translates to our common emergency presentations: sepsis; fluid overload; trauma; cardiac and rheumatic heart complications; infections (melioidosis, MRSA, diabetic foot, crusted scabies, skin sores with secondary Group B strep APSGN, etc); domestic violence; exacerbation of chronic respiratory conditions; paediatric; obstetric; and mental health.

*The social and health problems faced by Indigenous Australians today are strikingly obvious.*

Kununurra Hospital has no permanent onsite specialists; it is run by a dedicated team of rural generalists. There is no trauma team or surgeon to help with the single vehicle rollover; no intensivist to provide immediate help with the crashing septic patient; no obstetric consultant to manage the life-threatening postpartum haemorrhage or fitting pre-eclamptic; no anaesthetist to help sedate the 150kg male with drug-induced psychosis; and no paediatrician to take over the neonatal resuscitation.

Our nearest intra-state tertiary referral centre is over 3,000km away. Distance and limited resources can mean managing critical patients for up to 12 hours or longer while awaiting Royal Flying Doctor Service (RFDS) transfer. In the meantime, there is you. Back up? That is still you and perhaps a rural generalist colleague. In tertiary medical practice, there is an evolving emphasis on sub-specialisation and increasing multi-disciplinary support, but in remote medicine, the opposite is often the case. While our team consists of general practitioners with anaesthetic or obstetric procedural skills, all of us need support to maintain the skill set required to provide best practice emergency care.

In this era of increasing access to online resources, remote area medical practitioners remain at a disadvantage, with limited opportunities to attend live conferences and courses. For this reason, education provided by visiting specialists is vital. The Kimberley Emergency Medicine Education and Training (EMET) program (led by FACEMs Dr Steph Schlueter and Dr Jo McDonnell) has been at the forefront over the past eight years; a crucial and much appreciated component in our ongoing professional development.

The program focuses on our specific needs as a team of rural generalists, making it entirely relevant to our workload. Steph and Jo make regular visits, providing a range of educational activities including case reviews, simulations, debriefings, demonstration of use of equipment, updates on clinical guidelines and current concepts. The program focuses on team building inclusive of nursing and St John Ambulance staff, improving morale and, as a direct result, helping improve staff retention. The EMET program strongly promotes the use of Emergency Telehealth as an invaluable remote support system. It has helped develop lines of effective communication with other FACEMs, most notably at Royal Darwin Hospital, who often accept our patients when tertiary-level management is required in a time-critical manner.

Our patients deserve a safe and high standard of medical care. Jo and Steph's commitment to progressing the Kimberley EMET program is integral in our delivery of best practice emergency care. The Kimberley EMET is a trusted and precious resource, and one we hope continues to receive the funding needed to maintain its pivotal support role for East Kimberley rural generalist doctors.

# EMET Goes Bush

**Dr Stephanie Schlueter**
Dr Schlueter is an Emergency Physician in Albany, Western Australia and the EMET Lead for WACHS Kimberley and Central with a special interest in inter-professional EM education tailored to the needs of rural and remote practitioners.

The Western Australia Country Health Service (WACHS) has received ACEM Emergency Medicine Education Training (EMET) funding since its inception in 2012. In 2015, I had the privilege to be asked by my predecessor, Dr James Rippey, to take over the WACHS Kimberley EMET Lead.

EM education has always been my passion and when I was asked if I wanted to 'do a bit of education in the Kimberley', who would say no? I had no idea what I'd agreed to; as a junior FACEM you do tend to say yes to pretty much everything. Now, five years on, I am excited to share my exceptional experience with you; the challenges, the successes and the impact the EMET program has had in the Kimberley.

## Location, location, location

The Kimberley region in northern Western Australia (WA) is geographically spread comprising an area of 424,517 km$^2$; almost twice the size of the state of Victoria and three times that of the UK. Six hospital sites who receive EMET funding are spread across this vast region: Broome, Derby and Fitzroy Crossing in the West Kimberley, and Halls Creek, Wyndham and Kununurra in the East Kimberley, with Broome being the regional and EMET hub.

Significant distances must be overcome to travel between the sites for training; travel by car from Broome to Kununurra (1,100km one way) takes 11 hours with no breaks, obeying the speed limit and no livestock incidents. During the wet and cyclone season (November to March), some sites are not accessible due to flooding. Face-to-face training is less frequent and is delivered through video conferencing or based solely at Broome Hospital.

The workforce consists of rural generalists with specialisation in anaesthetics, obstetrics and/or EM — a phenomenal, inspiring group of practitioners — jacks of all trades. Unlike other regional centres in WA, there are no resident FACEMs in the hub or spoke sites. The program is overseen and delivered by FACEMs from Perth and, recently, New South Wales on a fly-in fly-out basis, six or seven times a year for up to 10 days.

## The Kimberley EMET faculty

What started as a lonely and challenging 'one woman show' rapidly grew into a team of like-minded, local and inter-regional colleagues who share a passion for EM education and training. Dr Jo McDonnell is a dedicated educator and clinician who brought fresh ideas and a different style of teaching. We shared the load, the hours, and the reports,

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used each other as simulated patients, took turns working on the floor to get the local doctors and nurses to each other's education sessions, and shared long drives and evenings in Kimberley motels thousands of kilometres from home. When a monstrous cane toad jumped into Jo's room on her first night in the Kimberley, I thought she would never come along again. Three years on, only having a brief 'baby break', she can't wait for the next trip.

In 2018, emergency nurse educators and Emergency Telehealth Service (ETS) clinical nurse specialists Mel Goode and Kane Guthrie, as well as Robbie Amm (emergency nurse practitioner), joined the team to assist with the delivery of a comprehensive program tailored to the needs of our interprofessional nursing, medical and paramedic colleagues. Let's face it – there are EM topics that are better delivered by our nursing colleagues and, as we work in interprofessional teams, our education should be tailored to this environment and delivered by content experts.

Behind the scenes, an enormous body of work is coordinated by Kylie Bull, our Program Support Officer. Kylie coordinates our visits, organises logistics, liaises with the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) for continuing professional development (CPD) accreditation, summarises feedback, keeps us on track with EMET reporting and finance requirements, administrates equipment stocks, moulages our simulated patients, and occasionally enjoys being a simulated patient herself. We would not be able to function without Kylie.

In 2018, Kirsty Freeman, a simulation education specialist, then from the University of Western Australia, joined our team, sharing her expertise in health professional education delivery. She provided us with regular feedback on how we educate — our sessions, the way we deliver topics, our learning conversation and debriefing styles — developing us as educators. Confidence and competence in delivering effective health professional education is immensely important if you want to accommodate the diverse learning styles of your adult learners and impact on their practice.

Kirsty supported us in presenting the ACEM EMET program at the Australian and New Zealand Association for Health Professional Educators (ANZAHPE) conference in Canberra in 2019. In January 2020, we travelled together to San Diego to facilitate a conference workshop as part of the International Meeting on Simulation in Healthcare (IMSH 2020) titled: Building sustainable simulation programs — a rural and remote perspective. It was based on the learnings and experiences of our ACEM WA EMET program. Unfortunately, COVID-19 has put a stop to such amazing networking opportunities for now.

The newest member of our team, who joined us at the beginning of 2020, is Dr Sebastian Rubinsztein-Dunlop. Seb has been working on and off in Broome for many years as a GP anaesthetist fly-in fly-out from NSW, and he is pretty much one of the locals. Now qualified as a FACEM and GP anaesthetist, with a passion for EM education, we visited the West Kimberley sites together in March (pre-COVID). Due to his depth of clinical, rural and locally specific knowledge, which he explains with ease, natural ability and enthusiasm, he is an absolute asset to the EMET team and will be integral to the continuation of the Kimberley program going forward.

### The Kimberley EMET recipients

You have to be a special kind of breed to do what 'they' do 'up there and out there'. Read Dr Patrick Buxton's piece on the Kimberley EMET Experience and if you still struggle to understand, just go and work up there for a while.

There are many challenges in this line of work: the tyranny of distance; the remoteness, with its inherent challenges; the professional and personal isolation; the variety of critically unwell patients; the sparse resources you have to care for them; the challenging demographic of the community; the long hours of being one of the only, or the sole, practitioner, with fatigue a constant companion. It is not surprising that the workforce in such remote areas is highly fluctuant. The hospitals rely heavily on locum and agency staff with variable, at times very minimal, experience in EM and critical care, and for whom it is almost impossible to access high level, quality EMET. In the five years we have been providing education, every time, we meet new faces and teams.

Although the Kimberley EMET program provides only one relief point to the myriad of aforementioned challenges, it is an essential one. Being able to access high-end EMET close to home contributes to professional growth, and instils confidence and competence to look after critically ill and injured patients. It strengthens and supports local resources by providing EM specialist input in process improvement, such as EM guideline and pathway development, clinical governance and equipment standardisation.

Without the ACEM EMET program and regular EM specialist support, training opportunities would be challenging to non-existent. But this is no one way street. The exchange of education, experience and skills goes both ways. By working alongside our rural generalist colleagues on the shop floor, when there was no time for formal EMET as there were patients requiring care, they shared their knowledge and expertise in areas I had no clue about. To give you some idea: rural women's and Aboriginal health; regionally specific diseases (not necessarily encountered in a southern urban or metropolitan WA hospital), such as melioidosis; first presentations of rheumatic fever; management of decompensated rheumatic heart disease in children; and delayed presentations of incredibly sick patients.

My rural colleagues shared such cases and their challenges with me, some I would never have encountered otherwise. They took me to outpatient clinics, showed me the 'local Kimberley medicine' and answered many, at times, naive questions. I have learned so much from the team 'up there and out there', clinically and non-clinically. I have grown professionally and personally and I am immensely grateful for the opportunity. I think this is testament to the many benefits of the EMET program — for patients and clinicians, for recipients and educators.

### The Kimberley EMET program

Where to start, where to stop — we cover anything and everything – all core EM topics and skills such as airway management, resuscitation, sepsis, trauma and paediatrics. The content is identified through individual needs analysis, feedback and evaluation post-training, case reviews, face-to-face reports, critical incidents and case study requests. It also covers aspects of retrieval medicine, aiming to equip practitioners with the skills to identify cases that require early retrieval. The content is context specific, taking into account the rural working conditions, the individual practitioners' needs, as well as the medical needs of the local communities, of which 85 per cent are Aboriginal.

Training is delivered through interactive presentations, workshops, case reviews and simulations of all fidelity. All EMET courses and sessions are accredited for CPD with RACGP and ACRRM. The use of ETS is practised throughout the simulation sessions, improving use of referral process technology, communication skills and ability to interact well on camera.

The overall ethos of our program is to 'deliver critical care out there' and 'do the basics well'. Participant evaluation and feedback post-training have demonstrated that, as a result of the program, staff are more familiar and confident with managing critically ill patients, and feel more capable and comfortable using resuscitation equipment. The same is reported for ETS, with an increase in the use of the service as a result of the training.

As part of the EMET program, we provide supervision and support for practitioners undertaking the ACEM Emergency Medicine Certificate (EMC) and Emergency Medicine Diploma (EMD), with provision of direct and remote supervision. We also facilitate medical exchange to other regions for the trainees, for example, a trainee from Kununurra Hospital recently completed their mandatory supervision hours for the EMC/D at Albany Hospital. This not only supports individual training needs, but also builds relationships and networks, which leads me to share another big focus of our EMET program – the growth of a rural and remote community of practice.

The EMET program's main aims are the delivery and exchange of EM knowledge and expertise, as well as relationship and network-building for clinicians in rural and remote environments – for the Kimberley, from the hub hospital, Broome, to spoke sites, across state borders to Darwin in the Northern Territory (NT) (due to its closeness), as well as to the metropolitan link hospitals in Perth thousands of kilometres away. Establishing clinician, practice and training networks for rural and remote teams facilitates the exchange of knowledge, enhances support structures through relationship-building and strengthens the quality of care provided to our most isolated patients.

The community of practice concept is about growing, building and retaining networks that provide support on many levels in isolated environments. It is about collaboration, enhanced communication, sharing and exchanging knowledge, and, most of all, mutual respect for each other.

This community reaches far and wide and is greater than just WACHS. For the Kimberley, it reaches across interstate borders to the NT; many emergency transfers from the Kimberley are to Royal Darwin Hospital. FACEMs and intensive care specialists based at Darwin have facilitated EMET courses in Kununurra Hospital. Likewise, clinicians from the NT have participated and been the recipient of the WA EMET program. It provides a phenomenal platform for networking, relationship-building and fostering this community of practice.

### Impact of EMET Kimberley

These points have been taken directly from feedback of EMET recipients and data from the ETS:

- Increased regular access to locally delivered high-quality critical care education and training
- Access to opportunity to enhance and practise critical care skills
- Increased confidence of the regional workforce in caring for critically unwell patients
- Improved interprofessional team performance including leadership, communication and resource management at remote sites
- Networking and relationship-building between hub and spoke, inter-regionally and across borders (NT)
- Access to remote supervision (ACEM EMC/EMD) and accredited CPD close to home (ACRRM and RACGP)
- Stakeholder accessibility and increased utilisation of ETS
- Rigorous governance and standardisation.

Strengthening the workforce – in such a remote and harsh environment, it is difficult to build a stable workforce. While it is difficult to measure whether the program has had an impact on retention, we noticed that morale and team cohesiveness has improved, which leads to better patient care and, subsequently, impacts outcomes. It may also lead to improved retention and encourage practitioners to stay longer and/or return to the Kimberley region.

Improved quality of care – through case discussions and reviews over the past five years, we have noticed that the emergency care provided has excelled. Clinical responses are more robust and documentation is more concise and standardised. Although there is no hard evidence, and we can only rely on self-reported data, we believe that the EMET program has contributed significantly to these outcomes.

### Where to from here

We are very lucky to have received further funding until the end of 2021. Now that the regional borders within WA are open again, visits will resume in August. It has been an amazing journey, a steep learning curve and a huge privilege to meet, work and train with so many inspiring colleagues, some who I am very lucky to now call friends.

The ACEM EMET program has been around since 2012. Eight years seems like a long time, but it feels like this is only the beginning of something much bigger and more powerful, with a sea of opportunities to be explored. Think of your local EMET program; what it offers, what it could be, what you can make of it, what it can make of you, what it brings to your community and your patients. Then share it; share it far and wide, amongst the EMET community, the College's community, the newspapers, the local members, the radio …

The core component of the ACEM EMET program is the delivery of high-quality, interdisciplinary EM and critical care education to isolated rural and remote practitioners, with direct impact on the delivery of best practice, high quality emergency care to our most remote patients. The growing and fostering of community of practice is another core component. Let's nurture this community; a network of clinicians for clinicians to become the best we can be – together.

# Myanmar: Nothing Like a Pandemic for Perspective

**Dr Rose Skalicky**
Dr Skalicky is an Emergency Medicine Specialist, Prof(Hon.) EM UM1, currently based in Yangon, Myanmar as part of the ACEM-Myanmar EM Development Partnership.

*'COVID-19 case numbers inch upwards in Myanmar'[1] is a phrase that has featured in the media since 23 March 2020 when the first official case was announced. Unlike other countries, where numbers have risen slowly then exponentially creating increased strain on health systems, Myanmar's coronavirus cases have adopted a slow and steady pattern, leading to a lack of confidence and a sense of uncertainty.*

## Confidence and uncertainty?

In a country of over 53 million people,[2] only 287 confirmed cases have been diagnosed according to COVID-19: Situation Report 75.[3] Given that Myanmar shares a 1,000km border with China and other borders with Thailand, Bangladesh and India, this is a remarkable number.

The national strategy has centered on controlling borders: quarantine of all arrivals, contact tracing, restrictions and targeted lockdowns. While people in Australia voice concern and fatigue over 14-day quarantine, in Myanmar it is 21 days.

These measures have mitigated transmission and given people confidence, which has sometimes taken on a nationalist flavour: 'The lifestyle and diet of Myanmar citizens is beneficial against the coronavirus … Myanmar does not share the customs of greeting with handshakes, hugs or kisses that [some] countries have. It also does not have a high number of credit card users compared to other nations, as the person handling credit cards at the counter would be in close contact with hundred[s] of different people in a day. This is avoided by Myanmar's predominant use of paper currency' (Spokesman, State Counsellor's Office). However, against this backdrop of confidence is uncertainty. A sense of unease that, despite all these measures, the virus may be present but undetected and perhaps not all is as well as it seems.

Much of this unease is primarily due to limitations in testing. Initial tests were sent to Thailand, an exercise that was expensive and created delay in obtaining results. Although Myanmar is now accredited for testing, there was a rate of one test per 1,000 people in June.[3] An emphasis on testing quarantined individuals rather than the general community has led to uncertainty within the medical community. Many are confident that Myanmar has 'dodged a bullet', while others remain unsure in the absence of robust data collection.

## Emergency medicine

Emergency medicine (EM) in Myanmar is still a young specialist group, with its leaders having recently graduated in 2013.

From a clinical perspective, it has been very encouraging to see EM take a lead in informing the acute response to COVID-19. In January, emergency departments (EDs) initiated preparations in line with the national response to a point where the EM community were visibly directing many COVID-19 strategies and responses. The EM community led national personal protective equipment (PPE) training, creating videos in Burmese, so that doctors and nurses anywhere in Myanmar had access. The EM opinion was sought on infrastructure for COVID-19 hospitals, as well as medical transportation. Considering the limited number of EM specialists, the response has been impressive. A positive aspect of the pandemic is that, in Myanmar, EM is being recognised for the work and leadership it is providing as a new specialty.

From a social perspective, it has been hugely encouraging and yet also sad. There was confidence among staff, borne from good training and preparation, that they were ready for this 'fight'. Although there were initial fears of PPE shortages, there were innovative responses with local production of gowns and face shields, as well as donations according to Buddhist and local culture. In addition, proximity to China meant that fears of PPE shortages did not eventuate.

However, when the first positive case was diagnosed in the EDs, there was a seed of doubt – has the PPE been enough? Are we OK as frontline workers? Having witnessed healthcare workers in other countries falling, this was a reasonable fear in a country where resources are already limited. Quarantined and tested, there was much joy and relief when staff tests returned negative.

By April, the number of cases under investigation had increased. At Yangon General Hospital, in April, the ED took responsibility for 184 critically ill suspected COVID cases, with a mortality number of 26.[6] The EM community came together, helping each other clinically and socially to get through this emergency. The lecture room became a sleeping room as doctors completed 24-hour shifts. A washing machine and clothesline were installed in the office to allow ED scrubs to be cleaned onsite. Other administrative rooms were turned over to the ED for storage.

The flip side of this has been the unseen toil of the emergency workers as they have balanced family and friends, and the fear of transmitting the virus to others, knowing the limitations of the health system. A recent article highlighted this toll:[7]

*Myo Hein, EM specialist at Yangon General Hospital, hasn't been home since late March, when a patient tested positive. 'It's been stressful.' His parents, who he usually lives with, are in their 70s. He's kept his promise to call his mother twice a day, though he often hears her crying on the other end of the line. 'Whenever I miss her call, she thinks I've been sent to Waibargi Specialist Hospital for quarantine. She always wanted me to become a doctor, but now she almost regrets I am one.'*

*Wunna, another EM specialist doesn't want to infect his elderly mother, but goes home every night so that she is not alone. She has heart disease and he doesn't want her to be alone in case she has a heart attack. Ambulances are difficult to come by here; there is still no state or national system. Like other doctors around the world, he washes his clothes, disinfects his shoes and distances himself from his mother as much as he can. 'It's suffocating. How long is this going to last?'*

Many of the EM staff have similar stories. Some families have asked their relatives who are health professionals not to come home until this is over.




**When will this be over?**

This is the million-dollar question with no answer yet. Like other countries, we are now seeing 'virus fatigue' in many sectors. Masks, while mandatory in public, have variable compliance, although recently 1,600 people were fined for not complying.[8] Living in small apartments means social distancing can be difficult, as can hand washing without reliable sources of water. Lack of a national welfare system means the majority of people need to work to eat.

As for me, I am an Australian Emergency Physician who has been working alongside my Myanmar colleagues as part of an ACEM partnership to help develop emergency medicine. A conscious decision by my family (husband and 15-year-old daughter) was made to stay and continue to provide 'real-time' capacity building at Yangon General Hospital. As a family, our township was put in lockdown and our daughter stayed in our small apartment for three months. As essential workers, we were allowed out, but my husband and I would alternate days ensuring that if we were quarantined, one of us would hopefully still be at home.

*I am very proud of how the EM community in Myanmar has risen during this crisis and taken the lead.*

I am very proud of how the EM community in Myanmar has risen during this crisis and taken the lead – it is a great outcome, although at times very stressful. We have shared frustrations while battling clinical care versus fear-based care. We have been challenged by politics and hierarchy. Now, we are facing the trials of COVID-19 fatigue. As we enter the season for dengue, malaria, chikungunya and influenza, we still have many challenges ahead. With my colleagues, our goal now is to ensure that our EM staff continue good patient-centred care in proper PPE and remain safe in body and mind. This virus is a marathon, not a sprint, and longevity of EM is key.

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# Zooming with Our Indo-Pacific EM Colleagues

**Dr Megan Cox on behalf of GECCo**
Dr Cox is an Emergency Medicine Specialist, NSW Ambulance and SEAHS, NSW Senior Lecturer, Sydney University Faculty of Medicine and Public Health, Sydney, New South Wales.

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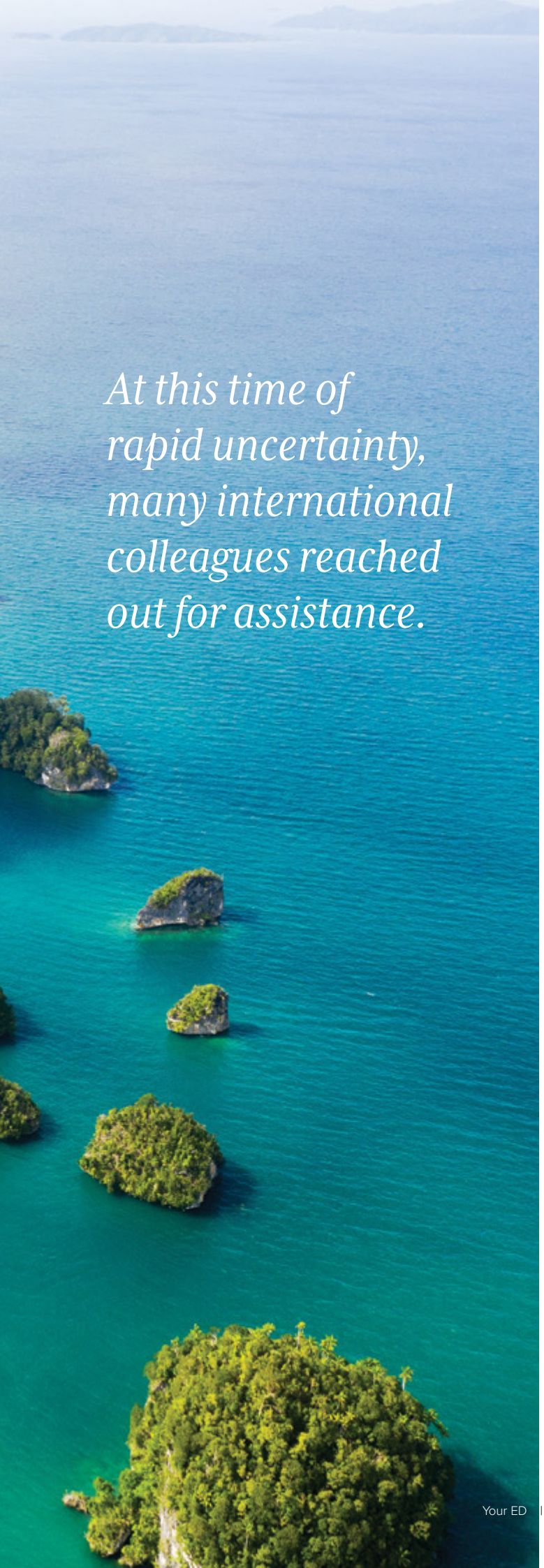

*At this time of rapid uncertainty, many international colleagues reached out for assistance.*

In March 2020, our lives quickly changed. Meetings went online, conferences were cancelled, and indefinite travel bans in and out of Australia and New Zealand loomed. Our government restricted numbers for socialising, enforced physical distancing and enacted quarantine. Our health system set up fever clinics for testing and stockpiled resources, and our hospitals rapidly transformed into hot, warm and cold zones.

At this time of rapid uncertainty, many international colleagues reached out for assistance. Members of ACEM's Global Emergency Care Committee (GECCo) swiftly released guidelines[1] to assist and on 25 March unanimously agreed to initiate regular Zoom meetings with our international EM colleagues. With support from the GEC desk and ACEM, the first webinar was ambitiously scheduled for 31 March.

Invitations were emailed to international EM colleagues via ACEM in-country partners, GEC members and country liaison representatives. The Pacific Community (SPC), the principal scientific and technical organisation in the Pacific region, and the Fiji-based Pacific World Health Organization (WHO) team, were invited to attend the webinars to assist with logistical and technical advice if required. SPC works closely with WHO and Australian and New Zealand governments as part of a daily taskforce to investigate and coordinate support requirements across the Pacific region. ACEM's GEC desk was involved in supporting emergency care staff remaining in Vanuatu and the Solomon Islands through in-country partners, and aided many to obtain reliable internet access.

The aims of these webinars were to deliver informal peer support, share ideas and advocate for our international EM colleagues. Despite the uncertainty of COVID-19, we scheduled fortnightly meetings and agreed to email a summary of key points afterwards for all who registered.

The first meeting started with introductions and awkward pauses. Most participants were attending their first ever Zoom meeting, many only limited to audio access. Australian and New Zealand GECCo members initiated honest discussions about their anxieties working with COVID-19, and authentic conversations soon flowed. Previous longstanding GECCo partnerships with many Indo-Pacific networks facilitated open, practical and supportive communications. After the success of the initial webinar, we decided to utilise the Indo-Pacific COVID-19 resource themes[1] as a guide. Participants became familiar with introducing themselves in the Zoom chat sidebar, and weekly discussions were guided around the themes of systems and space, supplies or staff.

Right from the beginning, these webinars highlighted the

pivotal leadership roles of our Indo-Pacific EM colleagues in the COVID-19 response. Most Pacific countries rapidly closed international borders, and many had never experienced a COVID case, but updates on the leadership skills of our EM colleagues have been inspiring. Participants described setting up testing, developing quarantine spaces, educating ED and hospital staff, liaising with their communities, and advocating for staff safety and resources.

Our eighth and most recent webinar was on 7 July, and we have shared with 335 participants since March, averaging 55 per cent engagement from low-and middle-income countries (LMICs). More than 20 countries have participated — Australia, Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Madagascar, Marshall Islands, Myanmar, Nauru, Nepal, New Zealand, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Sri Lanka, Timor-Leste, Tokelau, Tonga, Tuvalu, Vanuatu, and representatives from the Pacific Community (SPC).

Through these webinars, ACEM has joined a team of professional regional organisations providing crucial expertise and peer support to clinicians and emergency care (EC) stakeholders across the Indo-Pacific. Certain themes have been highlighted, especially the importance of nursing collaborations. Key nursing colleagues were invited to the webinars and encouraged to share ideas and concerns, and this multidisciplinary sharing and support has been pivotal to their ongoing success. New networks have been built and multidisciplinary partnerships strengthened for ACEM and GEC. These partnerships have led to a regional publication advocating for EC in aid and development and a guide for oxygen usage in low-resource settings.[2,3]

*It has been an absolute privilege to facilitate these webinars over the last four months and see the strengths of our colleagues across the region.*

Another highlighted theme has been staff protecting themselves and their family in this pandemic. In collaboration with feedback from Indo-Pacific colleagues from the webinars, resources were developed to support EC health professionals working on the frontline. These resources include a PPE document in progress, made specifically to address local Pacific nurses' concerns on protecting their families after work.[4] A staff safety document, borrowed from the Monash Health document, was shared to help structure shift preparations.[5]

It has been an absolute privilege to facilitate these webinars over the last four months and see the strengths of our colleagues across the region. I am constantly impressed with their flexibility, openness, care and concern for their work colleagues and community, their humour and thoughtful responses to difficult situations. Perhaps, paradoxically, we have ended up being more connected than ever with our Indo-Pacific colleagues through this health crisis. Hopefully, these webinars have assisted ACEM in developing a reputation as an accessible, open organisation, willing to listen and learn, and support our colleagues across many disciplines.

As recent events in Melbourne have illustrated, this pandemic is far from over and constant challenges will emerge as countries open up and try to get back to their 'new normal' activities. With tourism and trade restricted, for potentially many more months, further difficult decisions will have to be made by governments. Our partners have requested us to be available, flexible and adaptable – GECCo are committed to this approach. As a group, we hope to learn valuable lessons that can be shared widely to improve resilience and responsiveness for future public health and surge events across our region. We plan to continue working in partnership with regional EM colleagues in the long term, and hope these webinars have opened up many future collaborative pathways.

### More information

Summaries from the webinars, as well as LMIC COVID-19 resources, can be found on the ACEM website: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/COVID-19/Resources/ACEM-Resources

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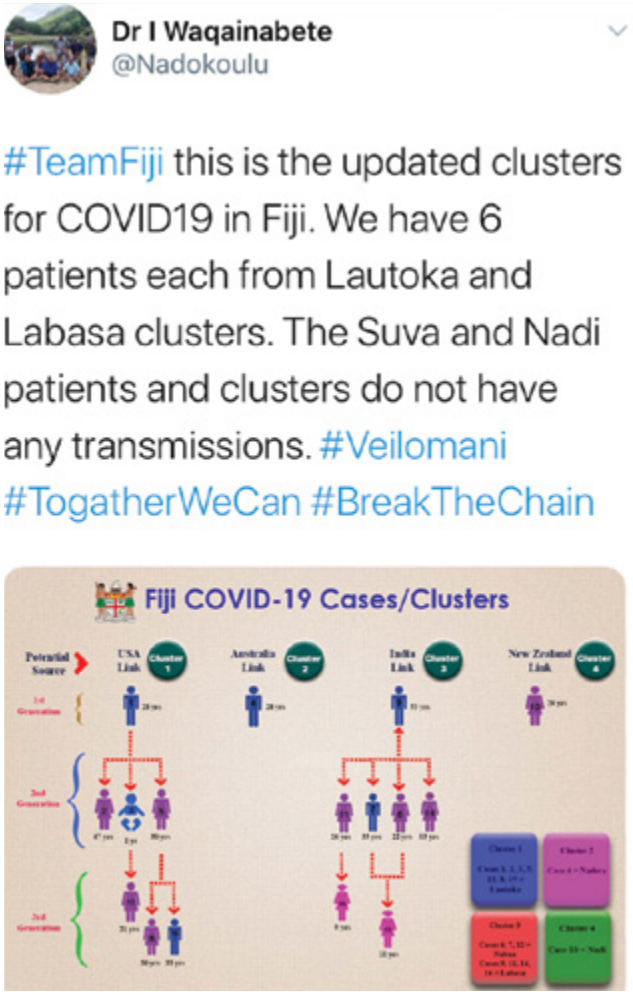
# Responding to the Challenges of COVID-19 in Fiji

**Dr Anne Creaton FACEM** and **Dr Deepak Sharma MMED(EM)**
Dr Creaton is an emergency medicine specialist who has spent four years teaching in Fiji. She enjoys taking emergency care outside of the hospital.Dr Sharma is an Emergency Consultant based at Colonial War Memorial Hospital Suva, Fiji. With interest in teaching especially short courses and leadership.

The first case of COVID-19 in Fiji was reported on 19 March 2020. The patient was a flight attendant with Fiji Airways who had travelled back to Fiji from San Francisco. As of 17 June, the country has had a total of 18 cases, all directly related to international travel or close contacts of those who have travelled. All cases have since recovered and more than 60 days has elapsed since the last positive case.

Early decisive action was taken by the Fiji Government, with a coordinated multi-sectoral approach. There was a strong focus on border control, strict quarantine of those returning from overseas, suspension of public gatherings and non-essential travel, school closures, and a curfew was imposed between the hours of 10:00pm to 5:00am . With strong leadership from the Ministry of Health, and support from the World Health Organization (WHO) and donor partners, the Fiji Centre for Disease Control and Prevention (CDC) rapidly established testing and contact tracing capability. Those who tested positive were isolated in hospitals, including Nadi, Lautoka and Navua hospitals on Viti Levu and Labasa Hospital on Vanua Levu.

As of 15 June, a total of 4,126 tests, with 4.6 tests per 1,000 population (more than Japan and Taiwan based on current data), and a test positivity rate of 0.4%. The number of COVID-19 tests performed per confirmed case in Fiji is 214.7, which compares to 230.9 in Australia and 261 in New Zealand.




Dr Waqainabete, Fiji Minister for Health, clearly communicates to the public the link between social distancing measures and breaking the chain of transmission.


Fiji Attorney General Aiyaz Sayed-Khaiyum highlights that the low COVID-19 infection rate is confirmed by a high testing rate.


Dr Deepak Sharma receiving the Mika Ah Kuoi Award for Excellence from ACEM President Dr Simon Judkins at the Developing EM Conference in Fiji, 2018. Pictured with Dr Anne Creaton (left) and Dr Georgina Phillips (right).

Emergency medicine is a relatively new specialty in Fiji, with the first specialists completing the master's program at Fiji National University (FNU) at the end of 2016. Dr Deepak Sharma is an emergency physician based in Suva, who graduated in 2018 and received the Mika Ah Kuoi Award, which is jointly awarded by FNU and ACEM for academic excellence.[1]

Dr Sharma has been a regular contributor to the fortnightly COVID-19 discussion forums run by ACEM's Global Emergency Care Committee (GECCo). He agreed to answer some questions about how the response to COVID-19 has affected his ED in Suva.

### How was EM involved in the COVID-19 response in Fiji?

EDs played an important role in the COVID-19 response as we are one of the points of entry into the hospital. The ED team was included in several areas of discussion from the National Taskforce, to National COVID-19 training and Hospital Taskforce teams.

I am a member of the National Taskforce for COVID-19, and, together with two other ED consultants, I am part of our Hospital Taskforce. I am also a member of our local COVID-19 Adult Case Management Guidelines team.

### What changes were made to space and processes in response to COVID-19?

COVID-19 significantly changed how we did a lot of things in the ED. We had to install an isolation room with intubating facilities separate from the ED, but located close to the ED. In addition to suspected COVID-19 patients, we had our usual patients, and we had to ensure that quality emergency care was still provided in all areas.

All incoming patients were screened outside the department and cleared as safe to enter the ED. If a case of COVID-19 was suspected, they were assessed in the isolation room.

Staff wore personal protective equipment (PPE) to provide care to suspected COVID-19 patients. We established social distancing rules and managed the flow of visitors to the ED, as well as controlling the thoroughfare from ED to the rest of the hospital.

The ED at Colonial War Memorial Hospital, Suva, Fiji.

Screening of patients prior to entry into the ED at Colonial War Memorial Hospital, Suva, Fiji.

### What were the challenges?

Given the uncertainty of the whole situation, several challenges were encountered. We had to establish isolation rooms to treat suspected COVID cases while waiting for transfer to the designated admission facilities.

We needed to set up systems and processes for attending to suspected cases. This was a trial and error exercise as flowcharts and processes were implemented and tested with each suspected case, and refined to adjust to all the issues arising. All system implementation was discussed at a hospital level to reach a consensus and have a unified approach.

Managing staff was a challenge. With great leadership within the ED from fellow consultants, individuals volunteered to be part of the COVID teams. We began with four teams of doctors and nurses doing two sets of shifts. The COVID team was responsible for screening all patients and attending to suspected cases in isolation, then transporting them to the designated facility. The non-COVID teams were responsible for providing emergency care to all other patients presenting to the ED.

Next was the challenge of PPE. This was fortunately taken care of by the infection control team. They did daily counts of PPE stock available at all points of entry to the hospital, including ED, and replenished supplies.

Some ED doctors engaged with the Good Samaritans and donors, such as the International Women's Association (IWA Fiji), who provided several PPE packs and hand sanitiser for staff for use, and a hardware company who provided face shields and hand sanitiser.

### What factors do you feel contributed to a successful outcome in managing COVID-19?

One of the key factors that contributed to a successful outcome was, and still is, our strong public health response and our strong public health teams, including the Fiji Centre for Disease Control.

Another key factor was the good communication between the hospitals and public health teams, communication among the hospital teams and the relaying of information to the workers on the ground.

### What lessons were learned that will guide future responses?

We learned how to contribute on behalf of EM and the ED at all levels of decision-making, ensuring our voice is heard, especially at a hospital level.

We learned that communicating clearly with the correct information is crucial during a crisis, especially to win your staff over and have everyone on the same playing field.

We are still in the process of learning as the pandemic is not yet over.

I would like to acknowledge the support of well-wishers in their efforts to assist our work in the ED.

**References**

1 https://acem.org.au/News/Jan-2019/Hard-work-earns-reward

# Legacy of a Hero: Helping Deliver a Legacy

**Dr Peter Wirth**
Dr Wirth is an Emergency Physician with a deep passion for occupational health and welfare, including care of colleagues.

Keith Payne VC, 1968

Six years ago, I commenced a new FACEM position in Queensland, while still on the board of a Melbourne-based men's health charity where we worked with male role models, mainly from sport, to inspire men to have regular health checks.

In Queensland, I struggled to find equivalents to our AFL heroes to play a similar role. Then I was introduced to Keith Payne VC, an old soldier who was about to turn 80, with the most amazing memory and ability to tell a story.

He was keen to help and, over the last six years, I have grown very close to Keith and his family.

I have no military veterans in my family, but I was very aware that the Victoria Cross (VC) was hugely significant.

I quickly learned that there have only been 1,300 VCs awarded (never 'won') in total, and only 100 in Australia's history, since the medal was first awarded in 1857. It is the highest award for military valour in Britain and their former colonies.

Keith was awarded the VC from his time in Vietnam, when in 1969, he rescued 40 of his men, under heavy enemy fire while injured, in the dark. He openly describes the trauma he faced when he returned to civilian life and freely describes the severe post-traumatic stress disorder (PTSD) he still suffers at 86 years of age.

Having suffered workplace burnout myself, we bonded very deeply over this subject. For 50 years, Keith has used his profile to work tirelessly to raise awareness and improve care for veterans with PTSD and their families.

Last year, I attended a function where three VCs from three other nations (Nepal, New Zealand and UK) were present, along with hundreds of 'ordinary' veterans. I was commissioning a documentary about Keith's post-war life and his legacy of trying to help his 'digger mates'.

For the first time, I met veterans from a wide range of backgrounds, ages and conflict experiences, who felt safe to open up and talk about their pain, and the ways in which the health system is not meeting their needs. Most of us never hear these stories.

Since then, I have been privileged to meet many more veterans, and have heard many stories about feeling discarded and worthless upon leaving the military.

I have been working with Keith to improve understanding of veterans and the care they receive. Over the past 12 months, I have learned that there are 4,600 ex-service organisations in Australia. I have also learned that the Department of Veterans' Affairs (DVA) has an annual budget of $13 billion and, yet, is only aware of 25 per cent of our veterans.

It is quoted by the Government that there are more than 641,000 veterans in Australia.

Where are the others? Some do not need the services of DVA. Some have had negative experiences in trying to make claims, often because of the issues they and their GPs face with the bureaucracy involved in lodging a claim. Some are too damaged to make themselves known.

Keith Payne VC, 2018. 'I am proud to have served my country. I am also proud to have worked for 50 years to help my fellow diggers and their families when they came home.'

Many veterans have told me of their reluctance to attend a GP or ED, despite needing medical attention. Some relate this to the culture of the military, where physical or mental injury will probably impede their promotion or deployment.

Some describe the noise and crowds in ED waiting rooms as 'triggering' to their PTSD. Some react very badly to having police or security guards near them. Almost all believe that ED staff do not understand their backgrounds or needs.

In Townsville, a retired lieutenant general has set up a veterans welfare hub to provide a single point of access to veterans transitioning out of the Defence forces, who might need help finding work, housing or counselling, and accessing advocates to assist with processing claims.

Before the recent Federal election, the Coalition promised five more hubs around Australia in Adelaide, Perth, Darwin, Nowra and Wodonga.

I am now working in Tasmania and have learnt that this state is deficient in services for veterans. Along with Keith, we have lobbied the Minister for Veterans' Affairs, Darren Chester, to add an extra hub in Tasmania.

Our proposed model for a hub includes access to, and training of, counsellors, GPs, psychologists and support from telepsychiatry. Our panel of psychiatrists will be available for clinical governance.

We are also lobbying for dedicated private in-patient beds within Tasmania, to end the need for travel to Melbourne for admission.

The formal proposal is with the DVA.

An adjunct to this proposal includes advocacy for an online modular education program that could be delivered to all doctors, nurses and clerical staff in EDs across Australia and New Zealand to:

- Raise understanding of the experiences of military personnel and the resultant issues facing veterans
- Teach how to recognise and provide sensitive care to veterans attending ED
- Inform what services are already available through the DVA for veterans, which we are currently unaware of.

Once staff within an ED have completed the education, ideally, posters could be displayed in waiting rooms, and promotion could be undertaken in the veteran and wider community, that the ED is now able to provide more empathetic care.

It is our vision that welfare hubs for veterans and first responders will collaborate with local EDs through bilateral referral, continuing education and quality improvement.

### Further support to improve and extend veteran care

Keith and I have formed a group of prominent people who share our desire to improve veteran care. We have:

- Four VCs (see photos and quotes below from Keith Payne VC, Dan Keighran VC, Willie Apiata VC and Johnson Beharry VC)
- Several retired military commanders, including Sir Peter Cosgrove
- Five psychiatrists of international renown for their work with veterans and PTSD
- The University of Tasmania
- Numerous ex-service organisations
- Many veterans
- A prominent group of mothers who have lost sons and daughters to suicide while serving in the Australian Defence Force or as veterans
- The Northern Tasmania Veterans' Support Hub, headed by Gina Timms, who all have relatives affected by PTSD
- Many other veterans' families.

In regard to my own burnout, Keith and I are very keen to extend the planned services to include civilian first responders such as police, firefighters, paramedics, and ED doctors and nurses.

While an Afghanistan veteran may have seen terrible things in intense conflict situations, we emergency service workers often have a cumulative type of psychological damage. The resultant damage is not vastly different.

Dan Keighran VC, 2019. 'It is the duty of our servicemen, servicewomen and our first responders to protect Australia and our way of life. It is our duty as Australians to support them when their service has concluded.'

Johnson Beharry VC (UK), 2018. 'We must all work hard to help our veterans and emergency workers. I fully support these efforts from my friends in Australia.'

Willie Apiata VC (NZ), 2019. 'Willie Apiata VC and Post Transition New Zealand support all men and women of service and first responders to promote better support, services and wellbeing of our people. We fully support our Australian diggers; we are ANZACs.'

Other ways we as a medical specialty can assist:

- Form a special interest group to advise ACEM on service and ED design, and interface with DVA and veteran organisations
- Collaborate with mental health professionals and GPs on these issues
- Include veteran care, especially PTSD, in Maintenance of Professional Standards (MOPS) activities and curriculum
- Research with the University of Tasmania, including numbers of 'invisible' veterans attending EDs, and details of the issues they face in presenting for help.

I urge any FACEMs who have an interest in helping veterans and first responders to contact me with a view to establishing a special interest group within ACEM.

Our GP and psychiatrist colleagues have special interest groups for veterans in their colleges, as do mental health nurses, rehabilitation counsellors, occupational therapists and psychologists through their peak bodies.

By forming an ACEM special interest group, we will have a voice in discussions with our professional colleagues and governments, and will be able to contribute to planning services for safe discharge of this group.

If we can make the decision to present to an ED easier for veterans, and the experience more comfortable, then we will have helped many current and future veterans, and contributed greatly to the legacy of Keith Payne VC.

### More information

Please contact ACEM, or Dr Peter Wirth directly, pwirth@optusnet.com.au if you are interested in forming this special interest group.

As with all other areas of College business, the ACEM Foundation has been working hard to adjust to life with COVID-19. Each of the Foundation's three pillars have been pivoting their focus to ensure they can support ACEM's work in the time of a pandemic.

The Global Emergency Care pillar (formally International Emergency Medicine) have been running fortnightly support forums for colleagues outside Australia and New Zealand. They have been well attended, with up to 50 emergency care colleagues, predominantly from the Indo-Pacific, joining each session to share their experiences, resources, advice, and seek guidance from peers within ACEM and across the region. Global Emergency Care have also contributed resources to ACEM's COVID-19 webpage.

The Indigenous pillar have worked hard to develop tools and resources to support members and address the specific challenges faced by our Aboriginal, Torres Strait Islander and Māori patients and members during COVID-19. Members have worked closely with Indigenous organisations, including the Australian Indigenous Doctors' Association (AIDA), Te ORA and The Leaders in Indigenous Medical Education (LIME) Network, to help in any way they can.

Members of the Research pillar have been busy considering the many questions raised by COVID-19 and how the College can support this important research, including questions about the impact of COVID-19 on our EDs, on patient presentations, outcomes, and other areas of emergency medicine.

The Foundation has been reviewing the awards, grants and scholarships offered each year. This work was started early in the year, but has taken on particular importance as the implications of COVID-19 on all aspects of our activities has been realised. The ACEM Foundation want to ensure that the awards offered each year are delivering on the vision of the Foundation and supporting the three pillars to the greatest extent possible. The Foundation's financial position has been reviewed and the committee, supported by the College, are developing a five-year financial plan.

*The Indigenous pillar have worked hard to develop tools and resources to support members and address the specific challenges faced by our Aboriginal, Torres Strait Islander and Māori patients and members during COVID-19.*

As a result of COVID-19, the ACEM Foundation has considered how to progress the awards program in 2020. Where possible, awards will run as usual this year, with the Joseph Epstein Scholarship, Research Awards and Al Spilman Award for Culturally Safe Emergency Departments among those open in 2020. Some awards and grants won't be offered in 2020, including scholarships for Indigenous Trainees and International Scholars to attend the ACEM Annual Scientific Meeting and the sponsorship of a number of conferences. The Foundation is considering how to support these activities in other ways, for example, sponsoring colleagues to attend the online ASM event. A full list of all of the Foundation awards, grants and scholarships offered in 2020 is available on the ACEM website along with further information about the work of the ACEM Foundation.

# ACEM Events Going Virtual for the 2020 ASM

The ACEM Board have been monitoring the COVID-19 situation closely and, due to ongoing risks, travel and gathering restrictions, a decision has been made to replace the traditional College Annual Scientific Meeting (ASM) with a Virtual ASM.

This decision was not an easy one, however, in the interests of health and safety of our delegates, staff, sponsors, exhibitors, and the wider community, it is a necessary one.

As we adjust to a world changed by the COVID-19 crisis, the Virtual ASM format will provide members, trainees, and delegates from around the world an exciting opportunity to share educational and scientific content, without the need to meet face-to-face, and from the comfort of their own home. A highly interactive program is currently being developed to include engaging keynote presentations and panel sessions, with topical content and networking opportunities, showcasing both national and international presenters.

The final make-up of the program, dates and timings have been decided upon by an internal working group, with content to be delivered over a four day period during the initially scheduled time period. The registration fees have been kept low in comparison to previous years, as a way to bring more members together during this uncertain time. The event will have a larger focus on keynotes and plenaries; While the event will have a larger focus on keynotes and plenaries, attendees will be able to participate in interactive workshops, breakout sessions, live Q&A's, networking activities and a mix of engaging social events. All sessions will be made available within a designated time period via an on-demand service, before being made available as a resource online via ACEM's platforms.

*A highly interactive program is currently being developed to include engaging keynote presentations and panel sessions, with topical content and networking opportunities, showcasing both national and international presenters.*

The theme for the 2020 ASM will be: No Going Back -- An Opportunity to Redefine the Role of Emergency Medicine. No going back is about redesigning our acute health system based on necessities and learnings from the pandemic.

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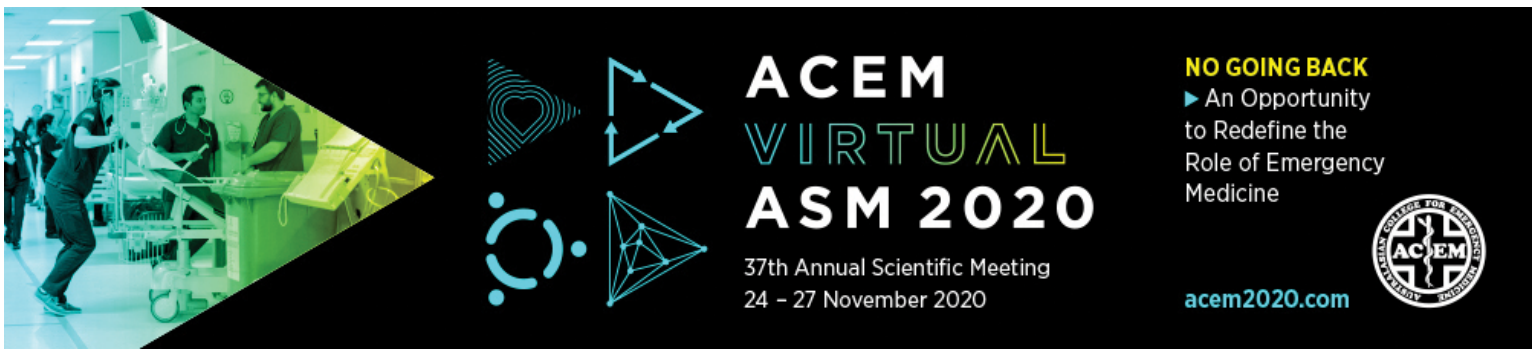
**More information**

To find about more about the 2020 ASM please contact the ACEM events team e: events@acem.org.au



# My First Day on the Job

### Dr Helen Willcock

What if they remember me? Is that a good thing? Did I make a name for myself as a cranky registrar? Will they think I didn't have the sticking power for general surgery and defected to emergency medicine? Who changes specialties within the same hospital? These thoughts run through my head as I arrive for my first shift.

Some of the nursing staff look at me like they know me from somewhere, but now my scrubs are green not blue. 'You're Helen the surgical registrar!' This is it … 'Yes, I was but I've changed to ED'. I steel myself for their reaction. 'Oh that's great. Welcome to the department. It's good to have you here.'

*I always remember that welcome and appreciate that a little kindness goes a long way.*

One of the consultants comes over with a big smile on their face. 'Hi Helen, it's great to see you back! Get stuck in and ask if you have any questions.' Just like that, I am part of the team.

I always remember that welcome and appreciate that a little kindness goes a long way. Four years later, I'm now a part of the furniture and remind myself to welcome new registrars with the same warmth that was shown to me.

### Dr Domini Martin

On my first day as an emergency physician, I was nervous. I was returning to the hospital I had trained at after a year away, and was eager to make a good impression.

*I thought to myself, I can do this job. I'm an emergency physician.*

I arrived ridiculously early, changed into scrubs and went to the staff room for a cup of tea. All was quiet. I had just sat down when one of our senior nurses came in. The night registrars were having trouble intubating someone in the resus bay, she said, so she had come to the admin area hoping to find a senior medical officer to help out.

I ditched my drink and headed onto the floor. A registrar I didn't know looked very pleased to see me. He briefly outlined the clinical details. They had tried two or three times to intubate, with no success. I confirmed that intubation was indicated. The patient was still paralysed and sedated and was being bagged successfully. I picked up the laryngoscope and took a look. After suctioning, it was a grade one view. I put the tube straight through the cords. Everyone in the room was relieved and impressed. The tube was secured and the position confirmed. The patient was connected to the ventilator with no issues.

I was back in the admin area in time for the 0800 hour handover. But I wasn't nervous anymore. I thought to myself, I can do this job. I'm an emergency physician.

### Dr Melanie Rule

My first day working in the ED came at the very end of my intern year. I had heard all my fellow interns' stories about working in an ED and I am a bit embarrassed to say that I wasn't really looking forward to it. It sounded like a chaotic and scary place to work.

I arrived for my first shift and was amazed at the buzz of the place. Constant activity with new and interesting patients arriving all the time. Nurses and doctors running between patients. Stretchers lined up in the corridor. The environment was so dynamic and intimidating, but exciting at the same time.

*This was interesting medicine, with so much variety and so many sick patients.*

I was tasked to see an elderly lady presenting with syncope, who midway through my very thorough history went into cardiac arrest. The nurse leapt across and to my surprise gave her a very impressive praecordial thump. Buzzers went off and the resus team arrived, and my patient was successfully defibrillated. I continued taking care of my patient who was referred for pacemaker insertion. The rest of the team went back to their work like it wasn't anything unusual.

At the end of my first shift, I realised I was hooked. This was interesting medicine, with so much variety and so many sick patients. I wanted to be part of this team of highly skilled clinicians that save lives every day. That was the day I decided emergency medicine was for me, and I still love it more than 20 years on.

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

–Sadhguru

## Need tips for managing competing demands?

Speak in total confidence to a Converge International consultant.
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