I'm going to tell you a story –

Once upon a time…

- In the dim, dark recesses of time, at the dawn of the new millennium
- A brave and idealistic Emergency trainee – in the throes of medical adolescence – PGY3
- Made a big, bold decision – time to 'man-up' and enter the Sydney real estate market
- The cunning plan - do rural locum shifts to gather a deposit

Big city hospital – where she usually worked

- Sort of place where – paper cut sent to Integrated Hand Unit
- Anaesthetics Fellow stored in bottom drawer of the difficult airway trolley
- Trauma – means dealing with the psychological aftermath of your over-privileged upbringing – just imagine the emotional scars – your best friend's parents bought her an Audi when she got her L plates, but you only got a Hyundai

Rural hospital – where she did locum shifts

- One room
- One doctor
- Two nurses
- Two cardiac monitors
- One ventilator – Oxylog 1000 (next seen in a practice VAQ for the fellowship exam)
- The sort of place where they bring you lunch on a tray, roast chicken and veggies, under a silver cloche – just like on Masterchef! And lemon coconut slice for desert – because they noticed that you really liked it last time
- Trauma – as I learnt on about my 9th shift (because I'm sure that you have worked out, by now, that the trainee is really me) – means two cars hitting each other at high speed at the intersection between the motorway and the exit ramp from the McDonalds roadhouse

The resus

- Late afternoon, ambos dropped off 5 patients from 2 cars
- 3 were unconscious, 2 were elderly, 1 had brain visible through an open skull fracture
- Woman in her 30s with an obviously dislocated shoulder – screaming 'I've killed my family'
- 4yo boy – seemed absolutely unscathed
- Paramedics told us that they had requested a helicopter retrieval, and that help would be arriving soon – and then they left

We got to work

- Intubated patient 1 – feeling mighty proud of myself as first time without a consultant standing behind my right elbow – and got the ancient ventilator up and running
- Nurse doing bag mask ventilation on patient 2

- Sedated patient 4, reduced her shoulder (completely breaking proceduralist/sedationist rule), then gave her repeat doses of midazolam to keep her quiet and out of the way
- Let patient 5 watch telly in the tea room and eat biscuits – he was perfectly happy
- And did nothing for patient 3 – just not enough hands! Plus his daughter (patient 4) amidst her wailing, had reported that he had pancreatic cancer – and I felt that grey matter on my gloves during the secondary survey was a poor prognostic sign

Called for help

- 30 mins in, promised helicopter had not arrived – called in local GP anaesthetist, who intubated Patient 2 and ventilated her by hand
- 60 mins in, helicopter had still not arrived – called networked trauma centre in big city, was asked to call back when I had done xrays to confirm position of the ETTs – only problem was that this was the sort of place where you took the films yourself…
- 90 mins in – helicopter finally arrived

The retrieval

- Three men in flying suits – perfectly demonstrated the ABCs of critical care
- Accuse, blame, criticise
- No introductions
- None of them made eye contact
- They didn't listen to my handover
- They took over the two intubated patients
- They fiddled with tubes and lines
- They criticised me for not intubating and ventilating Patient 3 – who was basically dead
- They criticised me for sedating Patient 4 without a clear clinical indication
- They criticised me for not doing a formal trauma survey on Patient 5
- About 20 minutes later – reinforcements arrived by road – more men in jumpsuits
- They talked amongst themselves, they twiddled, they twaddled, and they twoddled
- Then they packed up the patients and took off for the city, all in a good day's work…

The aftermath

- We thanked the Anaesthetist sent him home
- The nurses and I wiped the blood from the floor, tidied the resus bay
- We saw the rest of the patients on the waiting list – most had waited for hours
- I found the locals pretty understanding compared my usual big city waiting room crowd
- I remember removing pieces of sea urchin from a man's foot that day. My hands were shaking, and I was close to tears. In this town, he just had me and some local anaesthetic, doing my best. In my usual hospital he would have gone to theatre with a foot surgeon.
- And, at the end of the worst shift of my career, I drove myself home – all the way back to the big smoke – 2 ½ hours – listening to Triple J (no Smooth FM yet = 'Breeze'/'Coast' in NZ)
- The next day I called the trauma centre ICU and asked for an update – I was told they couldn't tell me anything because I was not a member of the treating team

Follow-up

- I called the agency and pulled out of all my shifts – decided to leave clinical medicine
- I enrolled in Masters of Public Health, found a policy job – mapped out a career in academia
- BUT – the NUM rang me the following night, to check if I was okay – and I really wasn't
- And she rang me the next day, and I still wasn't okay – but I felt safe to talk about it with her
- And she rang me a week later, and told me what an excellent job I had done, and how the team really liked working with me, and how I had kept four people alive against the odds, and how lucky those people were that I had kept my head together in a difficult situation, and could I please come back and work there again soon
- And – she eventually talked me into re-joining the ED training program – so I did. And here I am today

Don't Ever Forget **Wellbeing**

- As you've probably worked out, this talk is about my approach to wellbeing – it's all the rage to include a wellbeing session in critical care conferences these days, and it's tempting to be cynical given growing ED workloads and pressures, but I'm glad we are finally talking about it
- The aim of this talk is very simple – to make you stop and think – about some really easy things you can do to improve wellbeing and prevent burn-out
- Because resus, and critical care, and emergency medicine, are difficult – for all of us

Emotional Leadership

- This is honestly the easiest thing we can do to improve wellbeing – think about it – doesn't require a committee or a budget or an implementation plan
- (A disclaimer: as the owner of disproportionately long legs and a psyche that bubbles like a Rotorua mud-pool – I'm unspeakably bad at yoga and mindfulness)
- Acknowledge emotion – and the impacts of emotion – it's alright to feel stuff
- Project (and channel) positive emotion – motivate through praise and encouragement, discourage criticism and judgment, reflect on the good things, say 'please' and 'thank you'
- Allow yourself to show emotion and be vulnerable – be a real human being
- Respect the emotions of others – they don't have to feel the same way you do – that's okay
- Make time and space for follow-up – it's easier than you think – just ask and listen – have a cup of tea together, pick up the phone, send an email or text, the rest usually falls into place

Some wisdom from my Year 11 English teacher

- 'Your Perceptions are Your Projections' – basically the concept that you psychologically get back what you give out (borrowed from Carl Jung) – mindset is everything – at my work I'm known as an 'anti-magnet' – objectively I do see my fair share of difficult cases, but because the team thinks my shifts will go well they usually do
- 'Be a Honey Bee – Not a Fly' – bees seek out flowers and honey, flies are drawn to shit
- Make an active choice to be a Honey Bee – choose to be the sort of colleague that you would like to work with, and choose to be part of creating a workplace culture that allows you and your colleagues to thrive

- What makes a good department? A culture of safety and trust - it's visceral, you can feel it
- The secret? – we all know this! Good departments have a sense of family. Good EDs are all about LOVE – for your patients, for your colleagues, and for yourself
- This is important – because happy clinicians are safer and more effective

Behave yourself

- I wish I didn't need this slide – but sadly I suspect I really do – some etiquette pointers
- Assume that your colleagues are intelligent, well-educated and want to do a good job
- This should be the assumption on which your behaviour is founded at ALL times
- Introduce yourself, make eye contact
- Hold conversations – don't just talk at or over people – applies to patients and colleagues
- Respect the skill and care of others – don't take over unless you are invited to, or unless you really, really, really have to
- We all work with critical care superheroes – vigilantes in scrubs – with special clinical powers
    - They buzz around resus – and do irritating stuff, like:
        - take over the tube – just after induction drugs are given
        - insert intraosseous needles – just because they can
        - ultrasound random body parts
        - ignore directions from the team leader
- I've been thinking about what drives these strange and magical creatures – how do they know when their super powers are needed?
    - Used to think they were drawn to the bright light shining from under the CMAC blade – but the beam doesn't make it all the way to the back rooms of fast-track
    - So, starting to think they're attracted to the scent of a freshly opened vial of rocuronium – maybe their super senses can sniff it out?
- Regardless of what drives them, their behaviour is discourteous and disrespectful
    - It undermines the confidence and authority of their colleagues
    - They should probably just… buzzzzzzzz… off!

Another story

- We've all turned to a colleague after a resus and said 'gosh, that was pretty tough'
- Then the colleague says – 'you think that was hard – let me tell you about the time that I did a resuscitative C section… with nothing but a rusty screwdriver and a banana peel… while dangling upside down from a helicopter… while crocodiles were nipping at my testicles…'
- And honestly that kind of response makes no-one feel good
- The correct response: 'Yes – that was really tough. Are you okay?'

Never invalidate the emotional responses of others

Because the only knobs which are required in the Emergency Department are of the mechanical variety

Thanks – and remember that CIVILITY SAVES LIVES