your ED

WELLMOB
Mental Health Resources For First Nations Patients

IFEM AWARD WINNER
Professor David Taylor: 'It Was so Much Fun'

RUNNING ACEM EXAMINATIONS
During a Pandemic

GLOBAL EMERGENCY CARE
Vanuatu, Mapping GEC and Madagascar

Cover: Professor David Taylor dives under the ice in Antarctica.

Australasian College for Emergency Medicine

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Your ED

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

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Message from the Editor

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

In this issue we feature stories of leadership in and out of the emergency department with Dr John Sammut, we speak with IFEM Award winner Professor David Taylor about his life and career in emergency medicine and we reflect on the Manaaki Mana Ngā Ara ki te Taumata o te Pae Ora Hui. We highlight WellMob and the work they do in providing mental health resources to First Nations patients and hear from Dr Laksmi Govindasamy about air quality and what we can all do to support urgent climate action.

We feature a story on running ACEM examinations during a pandemic and we hear about Emergency Medicine Education and Training (EMET) from Dr Beverley Cannon in Tasmania.

Our Global Emergency Care (GEC) stories focus on prioritising emergency care in Vanuatu, nurse and paramedic Sophie Knott tells us of her time in Madagascar and we map GEC around the world with ACEM's Global Emergency Care Desk.

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

ACEM in the Media

In **July**, during NAIDOC Week, the *Cape York Weekly* featured an interview with FACEM Training Program trainee Dr Nathan Passi, where he discussed his Torres Strait Islander heritage, and working in emergency medicine.

In **July**, then ACEM President-Elect Dr Clare Skinner was interviewed by the ABC's World Today program discussing the situation in Sydney's emergency departments (ED) in the context of an increase in COVID-19 cases and the city's lockdown.

'The feeling is that we're nervous and weary but we're ready for it. We're really worried that the workforce now hasn't had a break for a long time and burnout is a critical issue but we've known for some time that a surge could be coming', said Dr Skinner.

'Our hospital emergency department are already over stretched and overcrowded and when you throw infection control measures into the mix, it gets very difficult.'

In **August**, then ACEM President Dr John Bonning told Mike Hosking on Newstalk ZB that the current pressures on the health system in Aotearoa New Zealand are 'predictable' and that COVID-19 simply 'broke the camel's back'.

Dr Bonning said, 'This has been coming down on us for about ten years and we've hit the ceiling'.

In **August**, Dr Skinner told ABC's World Today program that there were increasing numbers of people with COVID-19 presenting to EDs across Sydney, and that coordination across the healthcare system was needed to address the national crisis of COVID-19.

Dr Skinner said, 'What we would like to see is really good coordination between healthcare leaders and political leaders at all levels. We'd love to see everyone working together with a united response to what we see as a national issue'.

In **August**, Chair of the Western Australia Faculty Dr Peter Allely was interviewed on 6PR regarding Western Australian Deputy Premier Roger Cook's claim that the pressure on the healthcare system in Western Australia was due to the COVID-19 pandemic.

Dr Allely said, 'The pandemic is a factor, but like all things in health, it is much more complicated than that. The health system is just full and overflowing. That's why we've got ambulance ramping out the front, people queuing to get into the system because there is simply not enough capacity in the system'.

In **August**, Deputy Chair of the Northern Territory Faculty Dr Stephen Gourley was interviewed by ABC Darwin about a code yellow at the Royal Darwin Hospital, and said that the hospital was struggling to meet demand.

Dr Gourley said, 'It is not just making more emergency beds. It's about making the whole system more robust. We need better community care, we need better GP services, we need more hospital beds in Darwin because it has not kept up with the growth – the population growth and the growth in demand for services'.

In **August**, Dr Skinner was interviewed on ABC News about the health system's capacity to cope with the surge in COVID-19 cases in New South Wales. Dr Skinner urged the public to take COVID-19 seriously, to wear masks, get tested if have symptoms and to get vaccinated.

Dr Skinner said, 'It's fair to say we're pretty exhausted but we're trying to work as hard as we can to get infection protocols in place and look after patients safely'.

In **August**, the College released a statement welcoming the Western Australian Government's $1.9 billion health investment in the 2021-22 Budget, including a $100 million ED support package.

The College urged the government to ensure the investment is delivered swiftly and with equity of access across urban and struggling rural and regional areas, to create smart solutions for solving COVID-19-related recruitment problems and to provide incentives for staff to work in rural and regional locations.

In **August**, Dr Allely was interviewed on 6PR Perth about the Western Australian Government's health investment and said the investment must be delivered swiftly and that a greater focus needed to be given to planning for the future.

'The 332 beds will bring us close to the national average for beds per capita. But, if it's going to take four years to open them, we'll probably need another 332 beds by then.'

In **August**, ACEM was one of four specialist medical colleges that released a Wellbeing Charter for Doctors that defines wellbeing and sets out the shared responsibility for supporting doctors' wellbeing.

Dr Bonning said, 'Wellbeing is a collective responsibility. We have a duty to support and advocate for workplaces and systems that promote wellbeing and empower individuals to access solutions that work for them'.

In **August**, the College released a media statement calling for urgent and cooperative action from state, territory, and federal governments to support healthcare workers to cross state and national borders and to assist overseas healthcare workers to reach Australia, including the creation of extra positions in quarantine in addition to those already available for returning Australians.

Dr Bonning said, 'The existing workforce is spread thin due to demand, large numbers of exhausted staff needing leave and domestic border restrictions curtailing opportunities for inter-jurisdictional movement'.

'We are also seeing large numbers of the frontline healthcare workforce furloughed, or facing the possibility of furlough, due to potential COVID-19 exposure. There are no reserves in local workforce for when this happens, which leaves large sections of the workforce understaffed.'

In **August**, Dr Bonning was interviewed by Newshub in Aotearoa New Zealand on access block and the potential impacts of an increase in COVID-19 cases on the healthcare system. Dr Bonning said he was worried as EDs were already overstretched.

'Our business-as-usual is at capacity.'

In **August**, the College released a statement launching its *Environmental Strategy*, affirming its commitment to addressing climate change and its impacts on health and healthcare systems.

Dr Bonning said, 'Emergency clinicians know an emergency when we see one, and we have important and leading roles to play in educating and advocating on the need for urgent climate action, to mitigate the severe impacts on community health and healthcare systems'.

In **August**, the College released a joint statement with six other specialist medical colleges across Aotearoa New Zealand and Australia welcoming the postponement of all non-urgent elective surgery in areas of high prevalence of COVID-19 infection across the two countries.

The statement said, 'In areas of high prevalence of COVID-19 infection, all non-urgent elective surgery in public hospitals should be postponed. Private hospitals should be mobilised to accept urgent surgery and deploy staff to areas of community need. Regions not in lockdown may need to send staff to affected regions to help'.

In **August**, Dr Skinner was interviewed on ABC's The World Today about the COVID-19 outbreak. Dr Skinner said the system was stretched, but that staff were working hard to keep it safe.

She urged people to seek care when required.

'Please don't delay, the hospital system is there for you.'

In **August**, Dr Beverley Cannon was interviewed on ABC Northern Tasmania about the Emergency Medicine Education and Training (EMET) program in Tasmania, discussing the benefits of the program and the training methods used.

In **August**, Dr Peter Allely told 6PR that Western Australia could not cope with a potential COVID-19 outbreak like New South Wales was experiencing.

'I'm hearing reports from some of the major Sydney hospitals that there are 75 COVID-19 patients a day presenting to the ED. There's no emergency department in Perth that could cope with that.'

In **September**, Dr Bonning featured on ABC Radio Adelaide and said that, despite having no COVID-19 outbreaks, South Australia, Tasmania and Western Australia were the worst performing states in the nation for hospital overcrowding and ambulance ramping.

'This is about acute hospital capacity for patients who come in in emergencies, it's predictable and the states I have mentioned seem to be the poor performers in terms of planning for these emergency patients', he said.

'It's not some peri-pandemic blip and we would be seriously worried if/when COVID-19 hits your states.'

In **September**, Dr Allely spoke to Channel Seven Perth about the severe pressures on the Western Australia health system. Dr Allely said, 'It feels like health system is on the brink of collapse essentially'.

He warned, 'It could lead to situations where emergency departments have to close overnight as you can't safely staff departments'.

In **September**, Dr Bonning spoke to Breakfast New Zealand about Aotearoa New Zealand's health system preparedness for COVID-19 surges. He said that EDs have the capacity and staff to deal with the current outbreak of COVID-19 in Aotearoa New Zealand, but there's concern if the country's outbreak isn't controlled.

"At the moment, we've got capacity but we're waiting for a further wave potentially."

In **September**, former ACEM President Dr Simon Judkins spoke to *The Age* about the entire health system in crisis. He said that ramping, access block and ED overcrowding had become the norm. 'It's Groundhog Day', Dr Judkins said.

'These are the sort of things that used to be the exception to the rule, but there is a grave concern from emergency doctors that this is almost like a new normal.'

In **September**, the College released a media statement calling for whole of healthcare system approaches to prepare for and manage greater numbers of COVID-19 cases across Australia and Aotearoa New Zealand.

Dr John Bonning said, 'While much of the public discussion has focussed on ICU capacity, staffing and ventilators to treat critically ill COVID-19 patients, there is a need to make sure that the whole healthcare system is supported, to ensure patient care is not delayed, and that an already strained and stretched workforce is kept as safe as possible'.

In **September**, Dr Bonning was interviewed by *The Guardian Australia* about the New South Wales COVID-19 outbreak and warned that EDs would see five times as many patients as ICUs.

'We need to coordinate, because we know this is coming in terms of approximate volumes, and how many are going to need admitting, and it is going to need absolute statewide coordination.'

He said other states should look to what was happening in New South Wales to prepare for similar surge requirements before an outbreak occurred. 'I don't want to give a picture of complete chaos, but it's something that just needs to have real planning'.

PRESIDENT'S WELCOME

This edition of *Your ED* marks my first as College President. I feel deeply honoured to have been chosen to lead the College in this vital work and I assure you that I will do my best to represent you for the next two years.

Firstly, I would like to thank our Immediate Past President, Dr John Bonning.

Despite the challenges of COVID-19, as President, John raised the profile of emergency medicine in Aotearoa New Zealand. He brought Fellows, members and trainees in our two countries closer together. He advocated, tirelessly, for remedies for the problems that affect us.

John urged us to choose wisely and he encouraged the use of Te Reo Māori language, customs and culture in the everyday business of the College.

Integrally, John provided warm, optimistic and energised leadership. Pai ake means better in Te Reo Māori. I believe we all agree that John leaves the College pai ake than he found it.

Now, as I begin my term as President, I am contemplating: where to from here for us as a College, and for our specialty of emergency medicine?

The COVID-19 pandemic has defined the last two years of our lives – at work and at home. Emergency departments are at the centre of the pandemic response and emergency physicians among its leaders. Together, we continue to adapt to this new disease, to new ways of working, and new ways of connecting with each other.

But now, even though the pandemic is far from over, it is time to start writing our next chapter.

Together, let's create a sustainable way of working and living. Let's review the role and function of emergency departments, and design our processes to provide high quality, high value and compassionate care.

Let's build relationships with other specialties and services to ensure our precious skills and resources are used for maximum good.

Let's define ourselves positively – by what we do well – while providing an important safety net for people who are not able to access other forms of urgent medical care.

Let's review the role of emergency physicians and recognise that our acute generalist skill set, and our systems approach to problem-solving, make us useful beyond the emergency department.

Let's build and promote our leadership skills and ensure that our trainees can look forward to satisfying and sustainable careers in safe, supportive, healthy workplaces.

Equity, in its many forms, should be at the centre of all that we do – for people who require emergency care, and for each other. Let's celebrate our differences, learn from each other, and draw on our vast, collective range of experiences to develop and grow.

Let's work on inclusion until our membership, and our leadership, reflect the communities that we serve.

This won't be easy, and we must be prepared to have difficult conversations and to hear uncomfortable truths. Let's be guided by our Core Values – respect, integrity, collaboration and equity.

Let's help create a sustainable world. Climate change poses the greatest threat to human health globally, and the effects of climate change will exacerbate inequities in health experiences and outcomes.

We must continue to advocate for both urgent, meaningful climate action and for structural interventions that can address the socioeconomic determinants of health inequity.

There is work to be done.

But first, what I wish for each of us is time for restoration. Please, where possible, find time for rest and recovery, and to re-establish personal and professional boundaries. Please, if you can, reconnect with the people, places and activities that sustain you.

In closing, I want to remind you that it is each of us that makes the College. We are the College. We set the agenda. We create the culture. I encourage you to get involved – to join a network, a committee or your faculty board.

When we work together, we can achieve remarkable things.

Best wishes,

Dr Clare Skinner

ACEM President

"Equity, in its many forms, should be at the centre of all that we do"

CEO's Welcome

Dr Peter White

Since last I wrote, COVID-19 has continued to create disappointments, and yet there has been good news also. The College's Annual General Meeting (AGM), which, for the second year in a row, was held virtually due to the ongoing limitations of the COVID-19 pandemic was a success. Unfortunately, the pandemic required the cancellation of the College's Annual Scientific Meeting (ASM) that was scheduled to be held in Christchurch in the early part of November. This was another disappointment and a lost opportunity for face-to-face connection among ACEM members, trainees, staff and others.

The positive news I have to share at this time is that we have had a return of College staff to the College offices in Melbourne. This return began on November 24th, the date when the 90% vaccination target for 'eligible' Victorians was reached and coincided with reduced government restrictions in relation to occupancy rates of buildings and removed the requirements for mask-wearing indoors. All full-time ACEM office staff are required to be present at the ACEM office for a minimum of three days per week, specifically Tuesday to Thursday. The other two days will enable individuals to work in a flexible manner, with arrangements made between the individual and their supervisor, with all staff expected to be contactable during working hours. This extends the flexibility that ACEM has always afforded to staff and acknowledges the achievements of the College during the pandemic.

Along with the return of College staff to the Melbourne offices, arrangements for enabling the return of meetings of ACEM entities to Jeffcott Street have begun, as well as travel for ACEM members, trainees and staff to College events held in places other than the College's offices in Melbourne and Wellington. It has, of course, been some time since meetings of College entities have been able to be held in Melbourne, and the desire to resume meetings on platforms other than Zoom and Teams is well understood.

That said, even with some interjurisdictional borders 'opening up', some difficulties remain. Accordingly, it is envisaged that it will be the first half of 2022 before meetings of College entities are able to resume based on being consistently held with (at least some) members present in person, as well as the College being able to sanction travel for staff and others to ACEM events. We anticipate that many events will be 'hybrid', a mixture of in live and virtual attendees, for the foreseeable future. The December meeting of the ACEM Board was a hybrid event and involved the physical attendance of a small number of ACEM staff and Board members, with the rest of the Board members attending via Zoom.

Through this column and other mechanisms, such as the weekly ACEM Bulletin, all College members, trainees and others will be kept informed of progress in relation to this aspect of College activity.

In the previous edition of *Your ED* I acknowledged the significant work done by Dr John Bonning during his period as ACEM President, which has now finished. I reiterate that acknowledgement here and sincerely welcome Dr Clare Skinner to the role. Clare has already made significant contributions to the College during her involvement with the College over time and she brings significant experience and energy to the role.

I will also take this opportunity to acknowledge the contributions of Lyn Johnson to the College during her time at ACEM in the role of Executive Director of Education and Training/Deputy CEO. I have had the privilege of working with Lyn in different organisations over a considerable period and ACEM has been able to reap the benefits of her significant expertise and guidance over the past five years. Lyn, who retired on December 10th, recently attended her final meeting of the Council of Education (COE). While the recent bestowing of an ACEM Distinguished Service Award to Lyn was formal acknowledgment of her contributions to the College, the feelings of COE members regarding her pending retirement were clearly expressed during that meeting. I am certain that there are large numbers of other ACEM members, trainees and staff who share those feelings. I sincerely wish Lyn well for the next phase of her life.

In closing, and as always, I thank all College members, trainees and staff for their ongoing commitment to the work of the College and for enabling the provision of emergency care to all who need it during these trying times. Perhaps we are nearing the resumption of activities according to a 'new normal'. In echoing the thoughts of the new ACEM President in her column overleaf, it will be good if that results in positive outcomes, such as restoration, recovery, reconnection and renewal in the times ahead.

Keeping Up Standards

When the ACEM Standards and Endorsement Committee (SEC) was established in 2019, members highlighted that they couldn't locate important College policy documents. In response, the College set out to create a searchable one-stop portal, not only for standards, but also important reports, submissions, and resources or tools developed by the College.

The first stage was to create a common language for categorisation, which was achieved through the development of the ACEM Taxonomy of Emergency Medicine. The next stage was to develop a Standards and Advocacy Library, launched in August 2021 as the result of a great team effort across multiple areas of the College.

Why do we need standards?

ACEM Standards – the collective name we give to College guidelines, position statements and policies – provide advice across the range of member professional activities, and are foundational advocacy tools for ensuring members are appropriately supported and resourced to provide the best care to their patients.

Standards define what the College means when it uses terms such as 'access block', 'ambulance ramping', 'access target', 'handover', 'admission' and 'short stay unit'. In doing so, standards lay down expectations around the functions and resourcing of emergency departments (EDs) within a whole-of-hospital system. They also articulate reasonable expectations in terms of the roles and responsibilities of members as individual clinicians and participants in the ED and hospital team. Most ACEM standards apply equally to all jurisdictions across Australia and Aotearoa New Zealand.

How are standards developed?

Standards are subject to continual environmental scanning and are reviewed every three years. The need for new standards is often flagged by members through their regional faculties, alerting the College to emergent needs or existing gaps in support for the professional activities of members. For example, the College recently received a number of concerns about new Australian Health Practitioner Regulation Agency (AHPRA) licensing provisions, prompting the rapid development of the ACEM *Position Statement on Exposure Prone Procedures*.

A number of new and revised standards are in the pipeline, providing advice in areas such as: immunisation of vulnerable populations; use of restrictive practices; reducing violence in the ED; senior workforce sustainability; quality and safety frameworks; and medical assessment of those presenting in mental health crisis.

SEC reviews all standards ahead of Council of Advocacy, Practice and Partnership (CAPP) consideration. While SEC develops some standards, many others sit within the remit of particular College entities. For example, the review and maintenance of the ACEM Policy on Immunisation in Emergency Departments is the responsibility of the Public Health and Disaster Committee.

When a standard does not belong to a particular group, a call will be issued for subject matter expertise from within our membership, such as for the recent review of our *Policy on Violence in Emergency Departments*. New standards are always issued for member consultation via the College's communication channels.

Why didn't I know about this?

Although compliance with College policy is required and, in the case of trainees, the content of standards is examinable, the College was aware that members could not locate important College documents on the website.

In response, we have launched a new Standards and Advocacy Library, providing a single gateway to our portfolio of standards, advocacy and research reports, and key consultation submissions. For easy navigation, all documents have been categorised against subject headings or 'Categories' derived from the new ACEM Taxonomy of Emergency Medicine, enabling controlled language searching via topic selection.

Search tip:

Always limit your search by selecting 'Document Type' in combination with 'Subject Category' or free-text keyword(s). For example, if 'Access to Care' and 'Standard' are selected from the 'Category' and 'Document Type' drop-down menus (left side of screen), this will retrieve a subset of some of the College's most important policies.

What next?

There is more work to be done, specifically in mapping and referencing standards directly within the Curriculum, and in auditing policies to ensure they apply equitably across EDs of all types, sizes and locations. We also want to enable member access to clinical guidelines that are externally produced but College endorsed, including badging of what we consider trusted collections of such advice.

Author: Richard Whittome, Policy, Research and Partnerships Coordinator

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i More information

Visit the ACEM Standards and Advocacy Library at:
acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Policies-and-Guidelines-Library
Or click the link in the top bar of the ACEM Home Page.

iStock.com/ST.art

Never Taking Off Your N95 Mask: Air Quality Proves Environmental Health is a Burning ED Priority

Dr Laksmi Govindasamy
Dr Govindasamy is a public health physician and ACEM advanced trainee with Austin Hospital, Victoria.

It feels like much more than two years since the Australian Black Summer bushfires of 2019-20, the pandemic playing havoc with my sense of time. The summer 2020 edition of *Your ED* included firsthand accounts of emergency department (ED) physicians working on the front line in fire affected communities. Driven by climate change, an exceptional 1.8 million hectares of southeast Australia was burnt in high-severity fires, killing an estimated three billion animals and with major social and economic consequences.

Even those of us relatively untouched were in some way affected by those fires. I was overseas initially, helplessly refreshing the FireNSW app as the emergency spread across the state. Subtropical rainforests in the National Parks near my hometown, the lands of the Yugambeh and Bundjalung Peoples, started burning in spring – it was "unprecedented." My brother evacuated his home on the New South Wales mid-north coast before fire temporarily closed off the Pacific Highway. I returned to Sydney to find my partner had barricaded our inner-city rental with towels stuffed under the doors and around windows, but the air inside was still gritty. Outdoor get-togethers were hastily moved inside, not for the rain we all wished for, but because the Air Quality Index (AQI) was too hazardous for pregnant friends and their kids. Not long before community-wide lockdowns were implemented for COVID-19, the public health advice was for the vulnerable to shelter in place and spend more time indoors.[1] This was the summer where instead of throwing open all the windows to catch a breeze, we huddled inside cranking up aircons and air purifiers, ultimately burning more of the fossil fuels that had brought us here.

One memory is particularly vivid. My partner and I tried to take advantage of a small window of better conditions on New Year's Day to go for a short bushwalk. The AQI was only poor, a relative improvement, and we triple-checked the emergency apps to make sure we weren't taking any unnecessary risks. About halfway along, the wind changed direction and what had initially registered as a distant smell of burning increased in intensity. Instead of the usual calm and tranquillity from simply being in the bush, we felt the eeriness as birds quieted and the natural noises hushed. We rushed out of there, never in any real danger from fires but unnerved by the smoke haze and feeling choked by it. I felt panicked, with an existential dread that would not abate. Family superstitions about New Year's Day reflecting the year to follow felt ominous. My eco-anxiety spiralled into worry for my possible future children. Better writers have shared their stories of doubt about bringing children into a climate emergency. I have not yet resolved this conundrum, but if I do have them and they ask me when I really knew the climate crisis was here, this would be the summer I remember. Gnawing at me is the other question they should ask: so, what did you do about it?

Air quality affects our health

It seems painfully obvious, but clean air is vital to our good health and there is a mounting body of evidence demonstrating negative health effects at even lower concentrations of air pollution than previously thought.[2] The World Health Organization (WHO) estimates air pollution kills seven million people globally every year.

The key sources of anthropogenic air pollution in Australia are motor vehicles, industry, and commercial and domestic activities, like woodfires, with significant contributions from events like dust storms and smoke from bushfires and prescribed burns.[3] It is increasingly recognised that there is no safe level for particulate matter (PM) and that the WHO Guidelines should be seen as minimum standards.[4] In Australia alone, the health effects of anthropogenic PM2.5 is estimated to contribute to 2,600 deaths annually, at a cost of $6.2 billion per year in terms of the economic cost of life years lost.[5] Notably, this represents more lives lost than the annual national road toll and these costings are likely an underestimate as they focus on mortality alone and do not include costs associated with increased hospital presentations and admissions, adverse birth outcomes, and increased medication use.

The groups who are more physiologically vulnerable to poor air quality include pregnant women, children and young people, people living with underlying heart and lung diseases, and older adults.[1] Outdoor workers, homeless people and people living in poor quality housing are also at increased risk because of prolonged exposures. Surely all of us have family members who fall into these groups, if not ourselves at some point in the life course.

Smoke from bushfires and prescribed burns contains a complex mixture of PM, chemicals and gasses that can travel long distances, creating population-level exposures and health harms.[6] Irrespective of source, the short-term effects of PM are generally similar; PM cause a range of pathophysiological responses that increase pulmonary and systemic inflammation, with consequent increase in asthma and cardiovascular presentations.[6] During the 2019-20 fire season an estimated 417 excess deaths were associated with air pollution, with bushfire smoke responsible for an estimated 1,124 cardiovascular hospitalisations and 1,305 asthma presentations to EDs in New South Wales, Queensland, the Australian Capital Territory and Victoria.[7]

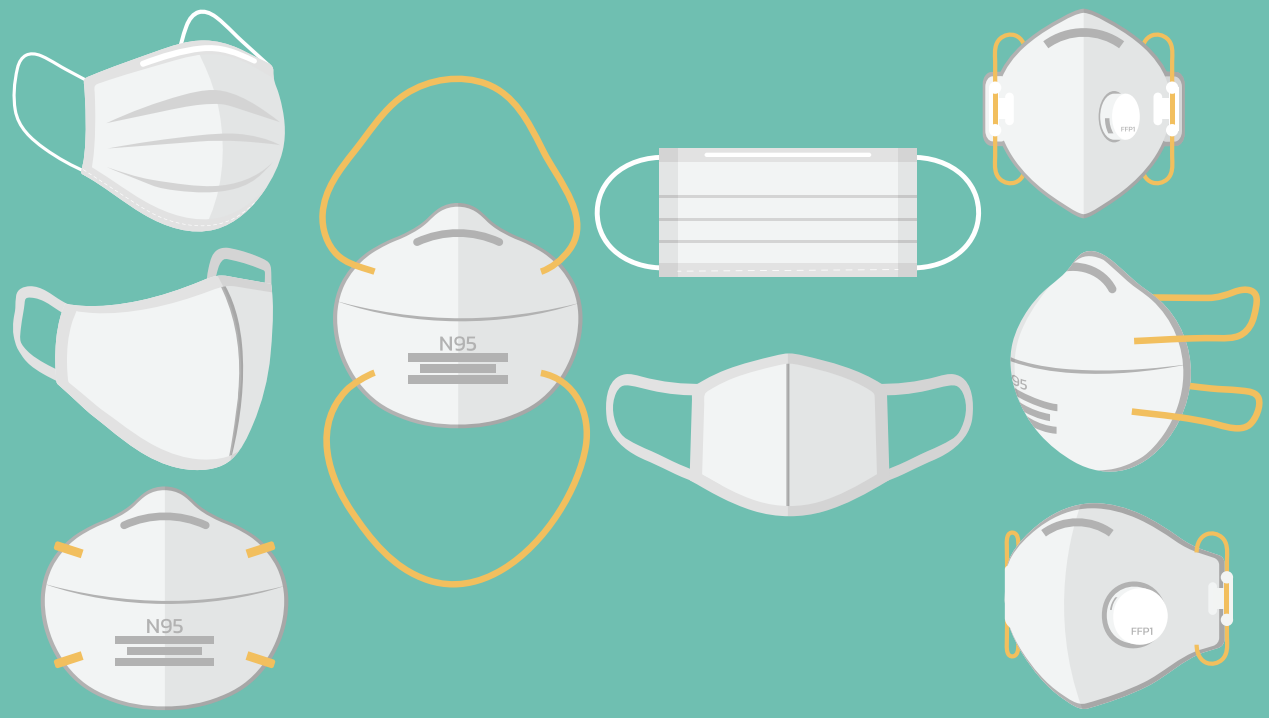
As we have learned throughout the pandemic, these kinds of numbers each represent individual tragedies. One such story from the UK is that of nine-year-old Ella Kissi-Debrah. She lived in Lewisham, south-east London, near a notoriously congested road. She died in 2013 from asthma, during a spike in air pollution in her area. This year, her death was determined to have been caused by excessive traffic-associated air pollution, the first time in the UK air pollution was listed as a cause of death.[4] Major UK health organisations, including medical specialty colleges, have responded to this ruling and the Coroner's concern that the adverse effects of air pollution are not being adequately communicated to patients by healthcare workers.[4] While patient education about air pollution is important, there is a clear need for government policies and action to ensure unsafe levels of air pollution are prevented and appropriately managed.

Air quality and the social gradient

As a country-kid transplanted to the city, and still nursing that chip on my shoulder, sharing my minor recollections feels inconsequential in the face of such great suffering during that Black Summer. In New South Wales alone, 26 lives were lost and 2,448 homes destroyed. Beyond the immediate devastation, plumes of smoke covered the most populated parts of Australia for weeks in prolonged smoke events. These smoke events meant my fellow city-dwellers gained insight into the relentlessness of natural disasters faced by rural communities. Rural and regional Australian communities experience greater social disadvantage than urban counterparts and are at the frontline of the climate crisis. As the pandemic exposes the very narrow margins of rural health systems, facing chronic workforce and resource shortages, preventing the regional and urban health gap from widening is yet another reason for urgent climate action.

The responsibility for ensuring clean air should not rest with individuals alone, not least because of the underlying inequities associated with air pollution exposures. Families with the least means also have the least choice when it comes to housing and heating, and limited ability to implement adaptation measures. Public and rental housing cannot readily be modified by tenants and older Australian housing stock are "leaky," so outdoor pollutants can penetrate indoors and compromise indoor air quality.[8] People experiencing socioeconomic disadvantage are also more likely to be living with chronic disease, increasing their vulnerability to air pollutants.

Urban disadvantage manifests in postcode-based health outcomes in our cities. Think about the proximity between affordable housing and busy motorways and roads in your area. Unsurprisingly, roadside detectors have measured elevated PM2.5 during morning peak traffic at key locations in Sydney. More should be done at a systems level to reduce vehicle emissions, including stricter standards and bans on diesel vehicles, incentivising public and active transports and optimised urban planning, all of which would have co-benefits for healthier communities. Although air pollution risks do not negate the health benefits of active travel,[9] those working roadside and active commuters (pedestrians, joggers, cyclists) should avoid busy roads during rush hour to reduce repeated exposures.[10]



We can all support urgent climate action

Working as a public health registrar with the state peak Aboriginal Community Controlled Health Service, it was dizzying to send supplies (salbutamol and n95 masks) to bushfire smoke-affected members for their communities, only to follow this soon after with PPE supplies for the first wave of COVID-19. As climate change increases the frequency and severity of disasters, we can no longer expect to depend on recovery time between these events. In the last few years, many places in Australia and Aotearoa New Zealand have faced a series of health threats with consequent traumatic effects on patients, communities, and the healthcare workforce. Whether through immediate injury or long-term mental health effects, these patients make their way to our EDs. We simply cannot afford to miss this closing window for preventing the disastrous health effects of the climate crisis.

Despite the clear scientific consensus behind ambitious decarbonisation, as I write this the Australian Government are representing us at the United Nations Climate Summit in Glasgow with a weak plan. This is the same mob that have waged climate wars, delaying progress and sowing division on what should be bipartisan, evidence-based policy. As trusted voices and experts, we must help our patients, colleagues and communities better understand the vital importance of urgent climate action to prevent negative health outcomes.[11]

Amidst the more dramatic airborne threat of COVID-19 and La Niña weather events that squelch the urgency of prolonged droughts and consequent bushfires, it can be easy to lose sight of the more insidious effects of air pollution. Although many of us have become accustomed to long shifts in PPE and regular mask wearing in the community, I for one am glad for the chance to take off the respirator and enjoy moments of respite in fresh air. I don't want any more summers where we can never take off the n95.

What climate action can you take?

- Be part of a movement – join Doctors for the Environment Australia and urge your organisation to join Global Green and Healthy Hospitals
- Support the Climate Health Alliance by writing to your local MP
- Have a difficult conversation – use these tips to explain your climate health concerns and why this influences your vote.
- Divest your banking, superannuation and insurance from organisations that still invest in fossil fuels.

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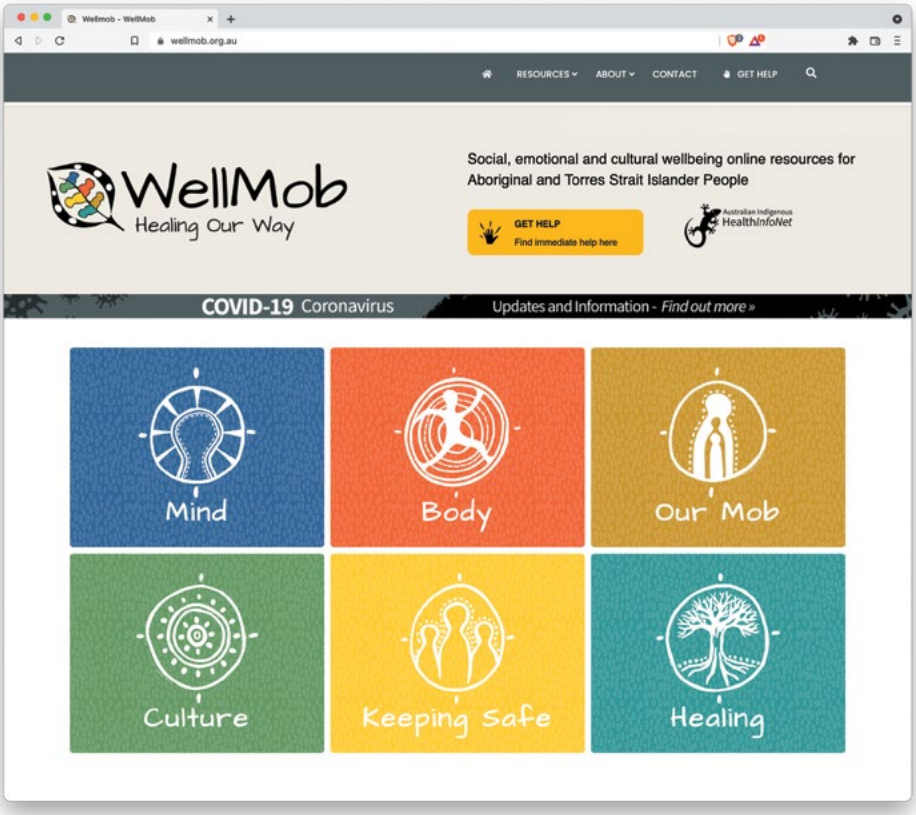


WellMob – Mental Health Resources For First Nations Patients

David Edwards
David is Co-Director of the WellMob Indigenous wellbeing website project at the University of Sydney for the e-Mental Health in Practice consortium.

Whether you work in the city or in the bush, or somewhere in between, we now have a one-stop shop of low intensity mental health and wellbeing resources for Aboriginal and Torres Strait Islander patients across Australia.

What is *WellMob*?

WellMob is a digital library of more than 250 mental health and wellbeing digital resources for First Nations Australians, including websites, videos, fact sheets and apps, together in one place.

The website was developed to make it easy for frontline health and community workers to find culturally appropriate online resources for First Nations peoples.

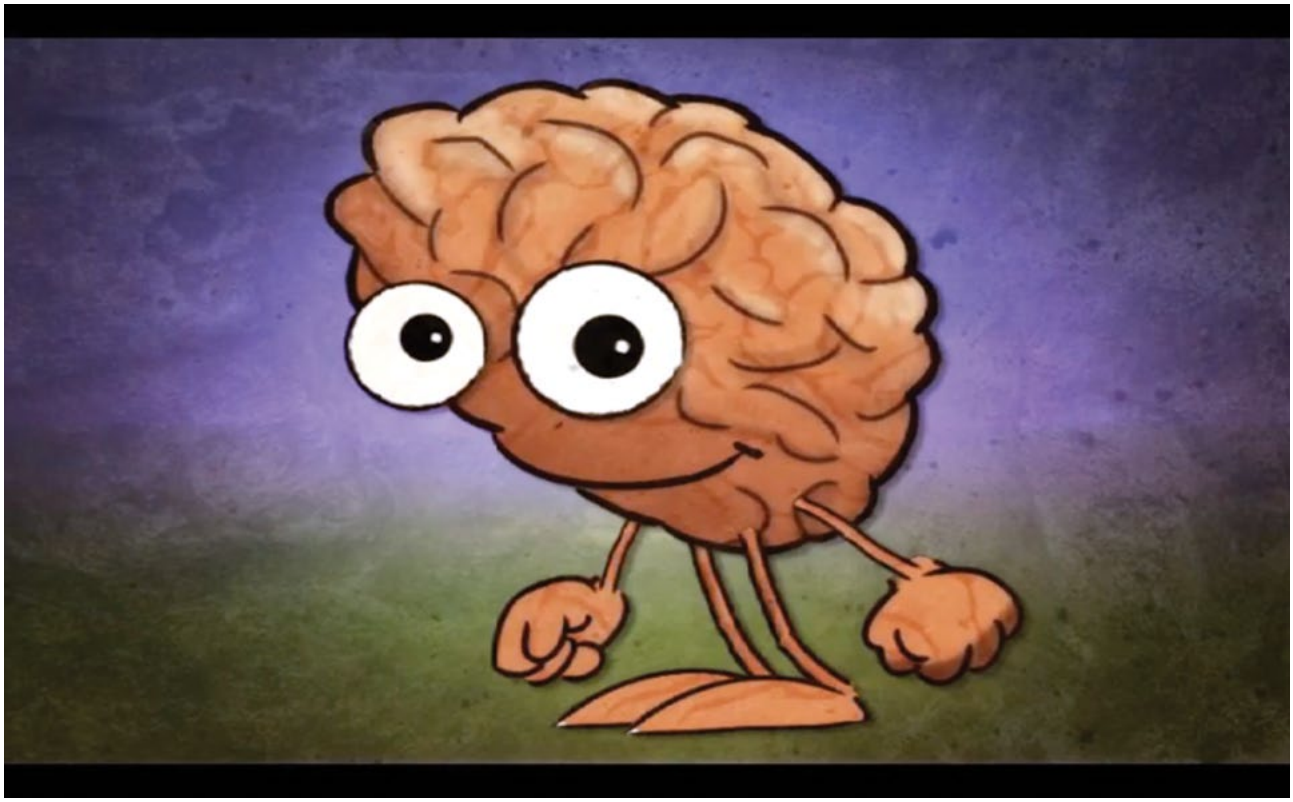
Health promotion resources – a digital talking stick

The *WellMob* website brings together health promotion resources that have been made for or by Aboriginal and Torres Strait Islander people. One of its strengths is that it captures health information and messages that are presented in a culturally responsive way to make it easy to understand and inviting for First Nations people.

In particular, *WellMob* has a variety of digital content using storytelling techniques to supply information, rather than just giving a set of facts. As well, videos, podcasts and e-brochures can be a really great way for non-Indigenous clinicians to discuss a health and wellbeing issue and build rapport with their Indigenous clients.

"Our diverse mob often learn and connect with information through story. It doesn't have to be a formal health program every time. It can be something as simple as a video that talks about someone's challenges dealing with stress, anxiety or depression, and how they overcame them through connecting to support. They're able to say, 'Look at them, they are a deadly person who inspire me'."
– David Edwards, Worimi man and *WellMob* website co-director

The idea of focusing on positive, strengths-based tools is an important part of the philosophy behind *WellMob*.



'I think it's nice to have those more positive stories – to sell the strengths of our culture and how we can reconnect in times when we're feeling sad, worried, or stressed,' says David.

It is important to note that *WellMob* features online resources that go beyond the mental health of Aboriginal and Torres Strait Islander peoples. A model of Indigenous Social and Emotional Wellbeing was used as the framework and content focus for the website. This concept takes into consideration that mental and physical health are only some of the domains that make up the wellbeing of an Indigenous person. Connection to traditional country, culture, community and kin also makes a significant contribution to Indigenous wellbeing. Clinicians are invited to find out more via the *WellMob* website.

How to use the *WellMob* website?

The website landing page has six main topics. You can search these for resources for your Indigenous clients or for your own professional development. These wellbeing topics include:

- Mind;
- Body;
- Our Mob;
- Culture,
- Keeping Safe; and
- Healing.

Under each of these main health topics there are numerous sub-topics you can also search under. There is also a search and advanced search function that allows you to refine what type of resource and what subject matter you are looking for. The website is a useful tool for our clinical and allied health community to use both in and out of session.

In many consultations the use of visual and audio resources can help to explain important healthcare concepts and messages. Sitting with a patient and watching a short video and using the content to open up conversations can be a helpful strategy. This is particularly helpful when working with First Nations people.

An example is discussing a sensitive issue such as alcohol misuse. By searching "alcohol" on *WellMob*, you will find a range of resources including the The Grog Brain Story by the Menzies School of Health Research.

And though the idea of bringing resources like these together in one place was developed long before the pandemic began, the *WellMob* website is even more crucial during the restrictions and uncertainty brought about by the COVID-19 pandemic.

As we know, medical presentations can often be underpinned by anxiety, depression and other mental health conditions. The website can be used to help non-Indigenous health professionals to build cultural competency and their understanding of complex trauma that First Nations Australians in this country may have experienced.

Printing a brochure can help you better understand how to explain to an Indigenous patient how experiencing a trauma such as abuse can be triggered and some coping mechanisms that may support them. The brochure Coping with the Impacts of Trauma by The Healing Foundation is an easy and informative resource on this issue that can be found on the *WellMob* website.

Register for a free one hour accredited webinar to earn CPD points

The WellMob team have collaborated with the Black Dog Institute to develop some accredited webinars about the website and using online resources with your Indigenous clients. You can earn QI/ CPD or ACRRM points if you register for a free one hour webinar titled *Supporting Indigenous wellbeing through digital resources: an introduction for clinicians*. Either sign up via the Black Dog Institute's webinar page or go directly to the Medcast website at medcast.com.au/courses/364.

Why develop *WellMob*?

The *WellMob* website is useful in a range of primary health care and preventative care settings for Indigenous people. It has online resources on a range of health topics, not just on mental health.

The *WellMob* website was developed as a 'one-stop shop' of culturally relevant resources for health workforce to use with their Indigenous clients.

"It was like looking for needles in haystacks to find culturally safe, Indigenous-specific wellbeing resources. Most practitioners just used Google, but it was hard to narrow down to Australian Indigenous online resources that were evidence-based or had been vetted to ensure cultural-safety for our community."
– **David Edwards**

WellMob fills a cultural gap within the digital mental health space that isn't met by mainstream online providers such as Beyond Blue, Black Dog Institute and Headspace, which were all consulted in the website's development. One of the local Bundjalung health workers stated:

'We need digital resources across a wide range of topics, such as healthy living, connecting with country, dealing with grief, identity etc. that fit within a social and emotional model of care'
– **Anonymous Health Worker, 2016**

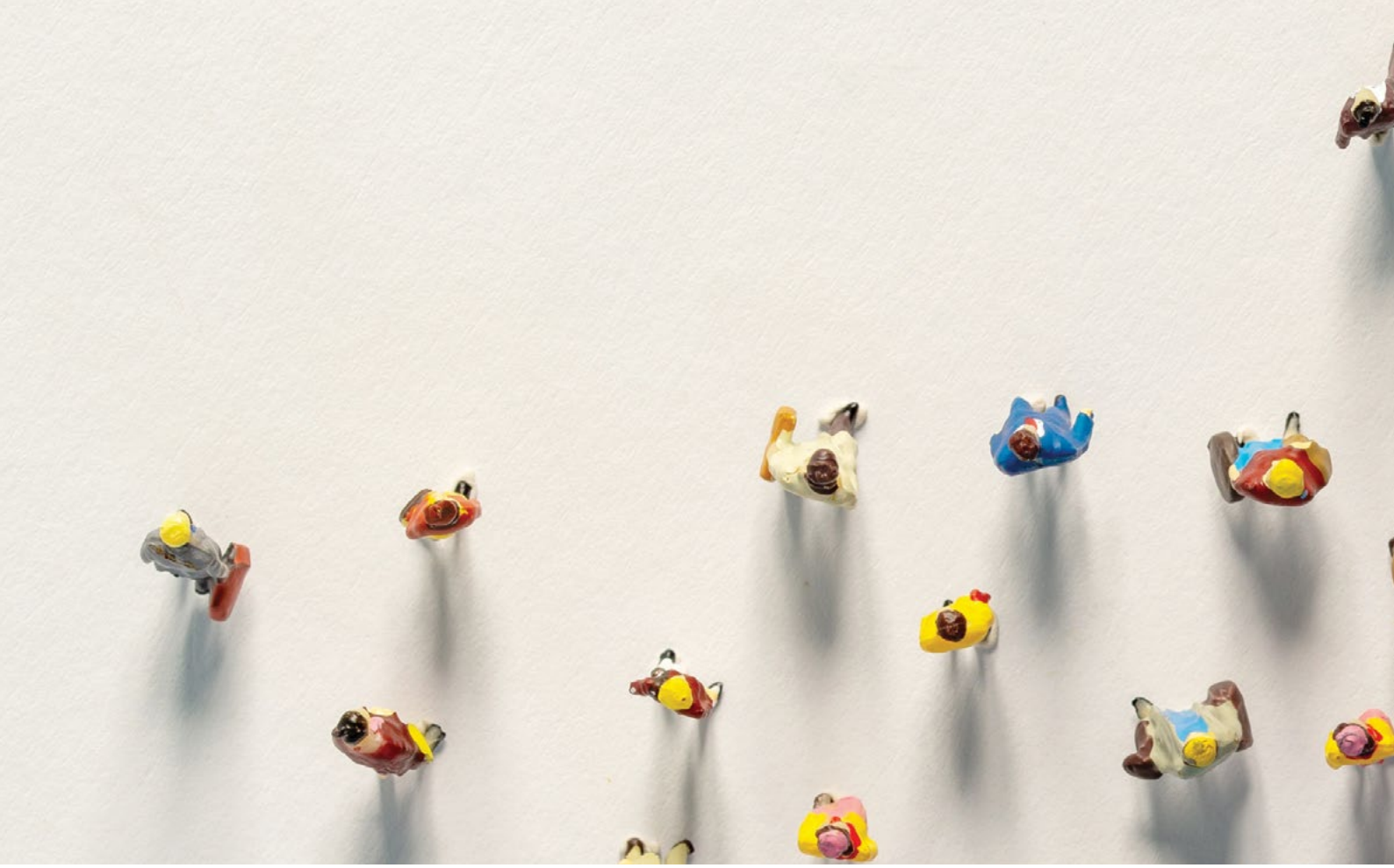
How was *WellMob* developed?

The website was co-developed with health workers in different parts of the country. Reference groups guided website development in Larrakia (Darwin, Northern Territory), Kaurna (Adelaide, South Australia) and Bundjalung (Lismore, New South Wales) country to ensure it met the needs of diverse First Nations Australians. Through these Reference Groups, *WellMob* is able to meet the diverse needs of the many different Aboriginal and Torres Strait Islander communities as part of their wellbeing practice.

The website was developed under the national e-mental health in practice (eMhPrac) project in collaboration with the Australian Indigenous Health*InfoNet*. The *WellMob* team are based at the University Centre for Rural Health (Lismore, NSW) and are part of the University of Sydney Faculty of Medicine and Health.

More information

wellmob.org.au
If you would like to be sent out some free 'calling cards' to write online resources down and leave with your First Nations patients, please contact David Edwards: d.edwards@sydney.edu.au.
Facebook: www.facebook.com/WellMobAU
Accredited webinar: medcast.com.au/courses/364



Dr John Sammut on Leadership – In and Out of The ED

I am the Director of ICU and Senior Emergency Physician at Canterbury Hospital in New South Wales, the Executive Clinical Director at Canterbury Hospital and President of the New South Wales Medical Council.

Before I studied medicine, I started a psychology degree. But I was always fascinated by the science of medicine, and after a year I moved across to medicine.

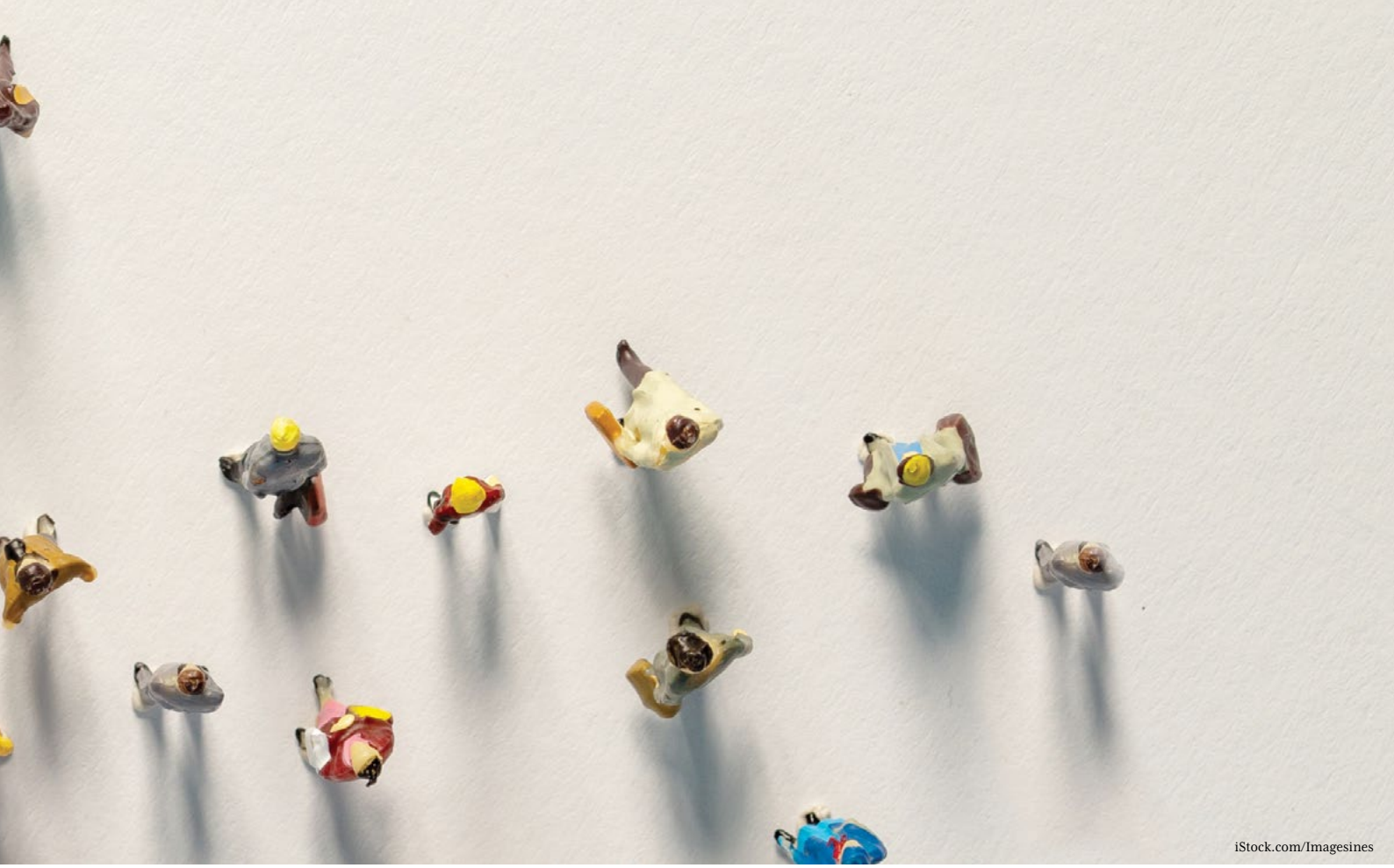
I chose emergency medicine because I have always loved the variety that comes in the specialty. I stay because I am inspired by the sense of purpose, the enjoyment and fulfilment I get in this field. I love the quick thinking that occurs, and the immediacy of the work and results. I also like working in an environment where there is a lot of collegial interaction and others around you. The most enjoyable part of my role is the challenge of solving complex issues.

I moved around in my training years with the College – Hornsby, Nepean, Westmead, RPA and St George – to get the depth and breadth of exposure that comes with that approach. I started my consultant job at Liverpool Hospital – a very busy trauma centre. I have been very fortunate to work in many different roles before settling in my current work at Canterbury Hospital.

It wasn't a strategic or deliberate move that led me into leadership spaces. Opportunities came to me organically through the work I was doing at the time. My work in Canterbury Hospital led to me being approached to consider the Director's role in ICU. my work in Major Incident Medical Management Support (MIMMS) led to me being approached to take on the role of overseeing the provision of medical care during the Sydney 2000 games in the Main Stadium, and a role in providing medical disaster response advice. Similarly, I was working for the Medical Council as a hearings assessor and then as Chair of several committees before being approached to take on the role as President.

I believe that external leadership and leadership in medicine shares many similarities: transparency with, engagement of, and empowerment of the people you lead. Also, being hands-on and very proactive in your role and demonstrating enthusiasm and energy for the tasks at hand.

There are various positive things I feel I have implemented during my time in leadership. I believe I have ensured



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I chose emergency medicine because I have always loved the variety that comes in emergency medicine. I stay because I am inspired by the sense of purpose, the enjoyment and fulfilment I get in this field.

greater recognition of, and engagement with, the people who complete the bulk of work, day in and day out. I think I make people feel valued for the work they do and to feel included in the decision-making involving the way work is done.

I have had struggles along the way. Learning on the job has had its challenges – it can be hard to learn how to do the job well when there has been so little preparation for the role. When I was working as a full time emergency physician in a busy trauma centre, we struggled to keep up with the demands of the population we were there to serve. There were so many issues, so many demands and so little control. There was also difficulty in engagement with other units and specialities to find workable solutions.

I wish someone had told me earlier in my career to simply enjoy the ride: the road is long, the opportunities are many and things have a way of working out in the end – no matter which way they go.

There are common mistakes in leadership. One common error leaders make is to display an insensitivity to the needs of those they are leading, coupled with a failure to understand how important it is to empower people to truly have a voice and to be prepared and enabled to speak up about issues – the solutions lie there, more often than not. Every leader needs good listening skills.

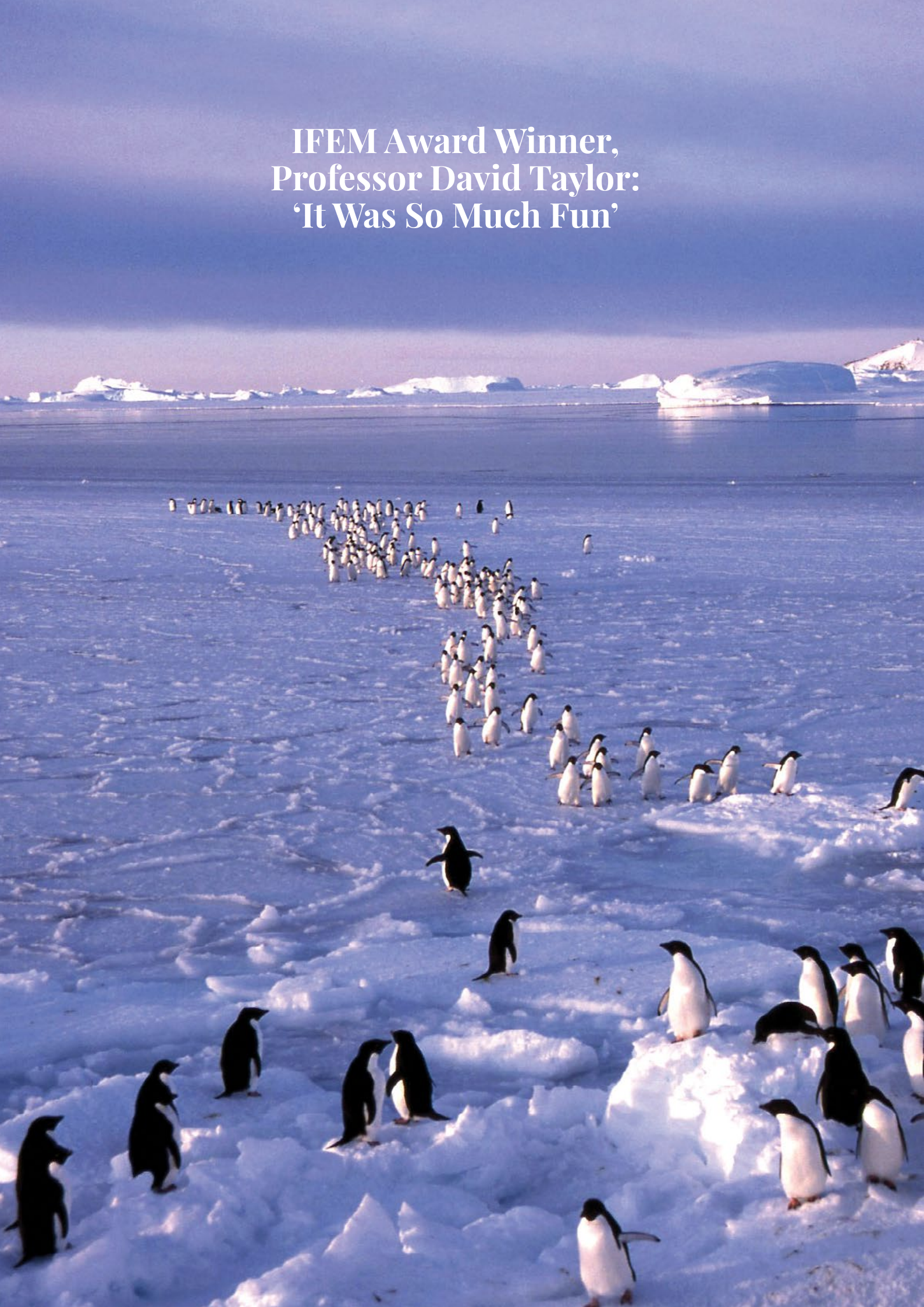
I work on my leadership skills and qualities, and there are things I work on tempering. My passion for getting things done and my strong views can sometimes come across as strong and intimidating.

I try to foster a positive work environment by being positive, and by highlighting good things that are happening. I encourage people to communicate and to engage with each other in the workplace.

I believe that the concept of work-life balance is incredibly important. For me it is always about recognising how important it is that when you are at work you do the best job you can. But that does not mean you also commit to it 24/7. When you are not at work, you let it go and you see life for what it is – so much more than your job!

As told to Inga Vennel

IFEM Award Winner, Professor David Taylor: ‘It Was So Much Fun’



From the suffocating heat of Papua New Guinea to the ice sheets of Antarctica, a hunger for adventure led recently-retired Professor David Taylor first to research, then to emergency medicine, then back to research – whilst almost losing his life a few times along the way.

But let's start the story from the beginning. After graduating from Melbourne University in 1978 – after setting a still unbroken sprinting record: the APS school's 4 x 100 metre relay record – completing his intern and resident years and three years in the UK, David was hungry for adventure. He joined the organisation, Australian Volunteers Abroad, which matches skilled Australians with partner organisations in the Indo-Pacific region to support them to achieve their development goals.

He was asked to go to New Britain, an island province off the mainland of Papua New Guinea (PNG), to work as one of six doctors at a German mission. He said, it was 'a wonderful community in one of the most beautiful parts of the world I have ever lived in. The beach is right there, the volcanoes in the distance and the weather, of course, was wonderful.'

Every morning the doctors would have coffee together and plan their operating list for the day. In the morning, David administered the anaesthetics, then in the afternoon he was in charge of a ward: perhaps the men's, the women's, or the children, sometimes obstetric.

It was varied 'interesting' work. There was also a lot of infectious diseases, so it was, at times, heartbreaking. During one measles epidemic, the community lost 71 children while he was there. 'There was nothing you could do about it. They would get the measles, which is a very infectious and deadly disease, and these poor children were compromised because of anaemia, worms, various other infections, sometimes malnutrition or tuberculosis. It just wiped them out. It was devastating to see.'

Out of work hours, he joined a diving club in Rabaul, 20 kilometres from the mission, and learnt how to scuba dive – sometimes diving up to five times a week. Rabaul is 'under a ring of volcanoes, with an immense very deep harbour, with a lot of World War II wrecks'. It was, he thinks, 'the second best' diving in the world.

This interest in diving led to a new opportunity: the Rabaul diving club sponsored him to do a four-week course in hyperbaric medicine. They flew him to the HMAS Penguin, in Sydney, to do it. In repayment, David did all the medical examinations for the dive-club free of charge.

Papua New Guinea also sparked one of David's lifelong interests – an interest that can be seen inside ACEM today.

As an old German mission, it was full of antique medical gear. He said, 'I'd open a drawer and it'd be full of all this gear that was used fifty, seventy years ago.'

With the permission of the Mission, he began collecting it. 'I'd find all these little things in my letterbox – staff would come and put things in there.'

In the US, his wife got involved, too, collecting antique pharmacy equipment and their collections grew. 'It was so much fun', he said. 'The serendipity of it, the prowling around the American countryside and coming across these antique stores and going in there and finding a little poison jar, or a little strange thing that I didn't have, or my wife didn't have.'

It was kept in drawers, or crammed in cupboards, for years. One day he thought, 'No. The College might really love this'.

In 2016 he donated his substantial collection to ACEM, where it is displayed in one of the meeting rooms at Jeffcott Street.

Whilst in PNG, he was attacked by Raskols twice. Raskols are violent criminal gangs in Papua New Guinea, primarily in the larger cities, that emerged in Port Moresby in the 1970s, that inflict murder, theft and rape.

In 1985, David and a mate flew to the northwest of PNG to paddle down the Sepik river. They bought two dugout canoes, or canoes made from hollowed out trees, strapped them together and fashioned a lid to protect them from the sun. In Wewak, they stayed with a group of friends for a few nights. One evening, they heard a strange sound – 'Tick! Tick' – then a bang on the door. Raskols burst in, brandishing homemade shotguns, machetes and other weapons. The gang members held machetes to their throats and demanded to know where their guns were. 'Of course, we didn't have guns!.' The raskols looked in the freezer – 'Apparently that's where people store their guns'. They stole all their money and travellers' cheques but, to their relief, didn't hurt the women with them. 'We were pretty shaken up by that, that was really quite concerning.'

Another time, he was driving three friends into Rabaul to climb a volcano to see the sunrise. It was 4:30 am when they drove into a village with people running around, screaming, or lying on the ground. What was going on? David carefully edged the car through the crowd and they, at first, made their way through. But then they drove straight into a group of highland people, who the local people had been fighting. 'They were really aggressive. They started throwing things at the car. They wrenched open the passenger seat door and started to pull out the fellow who was sitting in the front there. He was able to bash their hands away and close the door.' The windscreen was smashed, then his driver's window. He was hit in the head by a brick. 'For about three weeks, I kept pulling out little bits of glass from my head.' David veered off the road and was fortunately able to drive through the bush and escape. 'If we had been stopped, we would have been killed. There is no question about that.' They made it to Rabaul and decided, 'Let's climb this damn volcano anyway – a little bit later than we thought.'

He also survived a shark attack. On a diving trip to a remote area, a group of two-metre long white-tipped reef sharks – 'who are not usually aggressive' – started to 'look agitated' and get aggressive. The sharks arched their backs, shook their heads and started darting at the men. 'We backed up against the reef and pretended to be a bit of coral.' The sharks darted in, swinging out at the last moment. 'If one of them had nipped us and drawn blood, this could have set them off into a frenzy.' Finally, luckily, they lost interest and then the two shaken divers swam to the surface and gestured at a group of locals to come retrieve them in their dugouts.

But it wasn't the sharks or the gang attacks that got to him in the end – it was the heat. 'It was horribly hot and humid up there. It was so hot and humid that I once saw a dog chasing a cat – and they were both walking!' He'd had enough. After three amazing years, he thought, 'This is too damn hot here. I'll go down somewhere really cold.'

He went home to Australia and applied for the job of medical officer at one of the coldest places he could think of – Antarctica.

As part of the selection process for the role, they sent him off to get a psychological test with the army. At the army barracks in St Kilda he met upper atmosphere physicist and academic, Russell McLaughlin. He was going down to Antarctica for the second time. He said to David, 'What sort of research are you going to do down there?' David was taken aback. 'Oh, I hadn't thought about doing research, I'm just going down there.'

McLaughlin told him, 'When I was down there was a doctor who did all this research, and she wrote it up for her Doctor of Medicine degree'.

This conversation stayed with David. 'I'd never done any research before.' He went to the interview and asked the Director of Polar Medicine, Dr Des Lugg, 'Is it possible to do research down there'?

It was, Lugg told him – in fact, he himself had received his Doctor of Medicine through research undertaken in Antarctica.

He stayed at Davis Station, an Australian Antarctic station, roughly 20km from the edge of the continental ice sheet. His quarters were five shipping containers welded together, and inside was the surgery, his bedroom, 'a funny little bathroom-type thing', an operating room, a storeroom, and a consulting surgery room. He was there to care for around 30 people, mostly tradespeople – carpenters, electricians – and researchers.

Ten days after he arrived, he had his first serious case. Two men had gone out on a snow-mobile, got caught on ice and slipped and had fallen down an ice-cliff. The men were conscious and had radioed that they were up a fjord.

The helicopter arrived in five minutes and flew up. 'Sure enough, I could see the snow-mobile and these two guys on the ground, lying down.'

The helicopter couldn't land, but it hovered allowing David to jump out and have a look at the two men. One man had two very badly broken ankles and a broken wrist, and the other had a broken ankle and a broken elbow. They took them back to Davis Station where David gave them analgesia and fluids and took X-rays. He then administered the anaesthetics while the former doctor, who had stayed on to travel, set the fractures.

It took careful liaising between various Russian and Australian stations, then a series of helicopter and plane rides, with stops at stations across Antarctica then to Tahiti, before the men were finally taken to Australia for surgery.

His research project in Antarctica was studying fatty acids, cholesterol and triglycerides and how they are affected by changes in the diet. 'These guys [in Antarctica], we'd cook a special diet for them, and they couldn't run off to the pizza shop and ruin the diet, could they? They had to eat what we gave them.'

It took careful liaising between various Russian and Australian stations, then a series of helicopter and plane rides, with stops at stations across Antarctica then to Tahiti before the men were finally taken to Australia for surgery.

Like in PNG, he also escaped death twice in Antarctica.

In his second Antarctic summer, David was the medical officer for, and one of four divers in, an under-ice scientific diving program. They had very specialised equipment, including a hyperbaric chamber that David 'drove', and helicopter transport to dive sites. Usually, the ice had to be drilled through to access the water underneath. But this time, it was summer, so the ice had cracked, allowing them to dive into the crack. They took turns diving under the metre-thick ice to a depth of sixty feet. Two divers were 'fully kitted up' in diving gear at each time – one under the water, and the other above it ready to jump in at any sign of trouble. Their air supply came from the shore, from a huge air tank connected with a hose. But on their backs they also wore a large air cylinder and a small 'pony' one as a backup. They also wore heavy metal helmets with radio systems that allowed them to communicate with the surface and a dry suit, a loose underwater suit that keeps out all water.

When it was David's turn, he dived under the water through an ice crack, took photos, gathered his specimens, and swam back up to the surface to emerge. Except, something had gone wrong. Somehow the crack had shrunken, and he couldn't fit through. He was trapped under the thick polar ice. He didn't know what had happened. Had they misread, or miscalculated, the tides? He swam back and forth under the ice, fifty metres to the left, fifty metres to

the right, but could not find a way to escape. It was, he says, understatedly, 'pretty spooky'.

He returned to the small crack. His experience in PNG had taught him to not panic in life-threatening situations. 'Had I panicked, that would have been it.'

He thought carefully. There was one thing to try. He wriggled out of all the heavy gear, 'which was incredibly difficult to do' cramped in the freezing water, under ice, and then, struggling hard, pushed it ahead of him through the crack. He then had a small enough profile to squeeze through the tiny crack to safety.

Another time, he was diving under a fjord on an overcast day through a drilled hole in the ice. He couldn't see very well under the water. 'It was very gloomy under there.' He was to take photos at various depths, starting at the deepest point of 60 feet and moving up towards the surface, 10 feet at a time. He took the photo at 60 feet, then 50, then, as he swam up to 40 feet, there was a tremendous bang and he hit his head on ice. Puzzled, he shook his depth gauge. No, it was still 45 feet. He decided to abort the dive, alerted the others on the shore and swam upwards. But it was still so dark, and murky, and visibility was poor, and he couldn't find the hole. 'The water was filthy brown and nasty.' He followed the air hose back to the surface and escaped, climbing out of the water covered in foul-smelling gunk from the dirty water. But what had happened?

He discovered afterwards that a Weddell seal – a friendly, large seal with a dappled grey and black back and a white belly – had found the hole, sat in it, and defecated into it. The gunk was seal poo. And why had he banged his head at 45 feet? It turned out he had swum under a glacier, which they had thought was a land spit covered with snow.

He had a lot to do with seals down there. Because the doctors didn't have a lot to do as 'everyone is pretty healthy' – he was also expected to take care of another Antarctic job: tagging and logging the seals. 'In the summertime, the elephant seals – the young males, massive five and a half metre things – would 'haul out' and sleep on this filthy great mound. The seals and would wee and crap in each other's faces and they'd fight and do all sorts of things.'

He would have to wait until they were asleep then sneak up and look at the seal. Did they have a tag on already? If they did, they would need to note the colour and number very quickly. If they didn't have a tag on, they had to quickly tag them on the tail.

But the best part was in the spring when he spent three separate weeks driving up and down the sea ice looking for the female Weddell seals who had just given birth to their 'little babies on the ice'. 'That was lovely,' he said. 'You'd get the mother and read her tag, if she had one, then you'd get the little baby and put a tag into their flipper. It didn't hurt them. Once one was asleep and I put a tag on him, and he didn't even wake up!'

When he got back to Australia, he secured a fellowship at Deakin University in Geelong while he analysed his data and wrote up his findings. He began to run out of money. 'Well', he thought, 'Better get some kind of job'.

He got a job at the emergency department in Geelong as a 'GP Supervisor' a few days a week and every second weekend, and then as a registrar under 'an enormously enthusiastic' Peter Cameron – 'And that is how I got involved in emergency medicine'.

After that, he got married in 1996, then David and his wife spent three years in Pittsburgh, Pennsylvania. His wife did her Doctor of Pharmacy and David did a research fellowship in emergency medicine at the University of Pittsburgh

Medical Centre – 'a massive, big organisation, one of the biggest transplant centres in the world'. One third of his time was clinical, one third in research and the other third working towards a Master of Public Health. He did a lot of research in hyperbaric diving medicine and later became involved with underwater medicine groups.

In the US, his wife and he undertook research on the various drugs that divers take, such as Dramamine or Sudafed, to clear their ears, and to help with seasickness. They would give the divers blinded doses of various drugs then 'throw them in the recompression chamber'. The chamber simulated the pressure the divers would be under in the water. They would then give them psychometric tests and other things. 'That was lots and lots of fun!'

After some months of travel in Europe, he returned to Australia and to emergency medicine. 'I really enjoyed the thrill of it and the variation of it.' But, after the hard work in the US he found himself burning out. 'It's a tough job', he says of emergency medicine. 'It really is a tough job.'

In 2000, he decided to leave clinical work and focus solely on emergency medicine research. 'For me, it was the right thing to do.' He worked part-time at Monash University, then at the Royal Melbourne Hospital and later the Austin. Until he retired on the 12th of September, he was the Director of Emergency Medicine Research and earlier as Chair of the Human Research Ethics Committee at Austin Health, Melbourne, Australia. He has also served as Chair of the IFEM Research Committee and the Chair of the ACEM Clinical Trials Group and ACEM Foundation. He has almost lost count of all the other chairing roles he has had, or the committees he has been on. But you don't go into these roles, or into these committees, he says 'for any reason other than you feel like you can contribute'.

David believes that academic research can add greatly to the quality of patient care by generating evidence that leads to practice changes and ultimately better treatment. 'It's been shown, time and time again, that in academic departments and institutions, where they do a lot a research, the patient outcomes are better.'

As a member of the IFEM Research Committee since 2012 and Chair from 2014 to 2019, David has led many major projects and developments to improve research in emergency medicine, including developing awards, endorsement programs, networks and guidelines for ethical conduct in research. He also has a mammoth 300 publications under his belt.

In 2020, he received the Order of the IFEM for his dedication to emergency medicine research. 'It was great to have all the work that I've done recognised in that way.' COVID-19 scuttled plans to attend the award ceremony in Buenos Aires, and it was instead given virtually. 'I watched it at 21:00 on my computer.' He's waiting on the medal and certificate to be posted to him. 'I won't hold my breath', he jokes.

Despite all of these adventures and achievements, his work/life balance, David says, is 'fantastic'. 'I've been able to work 10-hour days Monday-Thursday, which means I have a long weekend every weekend. We have a couple of teenage

kids and we're running about with them on the weekends. We love lots of other things, I've got loads of things I like to do outside: I love surfing, I used to do a lot of scuba diving, I love skiing, hiking, walking, cooking, gardening – a whole lot. Long weekends certainly facilitated all of that.' But, there has been one change: He gave up diving in 2017 after one of his students did a PhD that proved that 'old buggers die diving' – due to a lack of fitness, comorbid diseases such as heart disease and diabetes. Realising his own mortality – and being a steadfast devotee to research and data – he gave away his diving gear.

He likes to build houses. He has built two holiday houses himself, one in Mt Hotham, and the other at Point Lonsdale. The Point Lonsdale house is built of sandstone from Castlemaine. He laughs, 'This massive truck with huge trailers came and dumped all this stone.' He spent 10 and a half years building the walls out of this 'random lovely yellow sandstone'. He is looking forward to spending more time there after his retirement.

In 1980, he bought 53 acres near Mt Hotham, on a slope looking over the valley, and built a house. He poured the slab and made mudbricks. 'It's still there. We just keep on improving the place. It's full of wildlife – from snakes to wombats to wallabies to kangaroos. We've even got deer up there, flying foxes – just lovely. It's just so much fun to go up there.'

'We get some breeze up there, so we call it 'Passing Wind'. He is writing a book on the 'incredible' adventures he has had on the property, 'with the animals and things, the disasters that happened (including two bushfires)'. The book is going to be called, 'Passing Wind in the Victorian Alps'.

As he finishes up his illustrious career, what tips does he have for doctors who might want to pursue emergency medicine? 'The thing is – and this is important – emergency medicine is sort of like law. You don't do law and just become a lawyer. And you don't do emergency medicine and just work as an emergency physician in an emergency department. We've had so many people – like Dr Chris Baggoley, the former Chief Medical Officer, or people like myself where the second half of my career was in research. A lot of people go into retrieval medicine, a lot of people go into toxicology. In a sense, it's a degree where you can work as an emergency physician in an emergency department, or you can use it to springboard to other sub-specialities – which I think is fantastic.'

But, perhaps, if doctors truly follow his lead, they should simply follow their interests, say yes to opportunities – and have fun? David agrees and says, 'Here I am, at the end of my career looking back and I think, gee whizz, I've done a lot of stuff! And I've really enjoyed it. And there's been so many opportunities, which I have just jumped at'.

Author: Melissa Howard, Media Relations Manager

Dr Joshua Mortimer

Why emergency medicine?

To be honest, back when I was a student, emergency medicine isn't really something that I ever saw myself doing. What I did know was the more I experienced hospital medicine, the more I hated the hierarchy behind it all. I worked in emergency on my first rotation out of medical school and immediately fell in love. What was this strange world where everyone was equal and just got on and did the job that needed to be done? Five years later and that love affair is going strong.
I love that when I walk through the door each day, I never know what I'm going to get. I have a short attention span and enjoy getting my hands dirty with a variety of procedures. I get to work so closely every day with my colleagues and get to know them as people. And at the end of the day, I get to go home and switch off, knowing that when I come back I'll have a whole new set of patients with a whole new set of challenges. I honestly can't understand why anyone would do anything else!

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

The breadth of what we do is at the same time what I love most about emergency, as well as being one of the most challenging parts. Going from dealing with the greatest depths of human loss and suffering one moment to blowing bubbles for a kid with a stubbed toe the next takes a special kind of adaptability. We see people at their absolute worst and at their best; and the privilege of that is something I remind myself every day to never take for granted. I think it's important at the end of each day to reflect on both the good and the bad; and then let it go and take comfort in doing something that you love – for me, cuddling with my dog usually does the trick!

What do you do to maintain wellness/wellbeing?

I find things that I love doing that have absolutely nothing to do with medicine. For me, it's often just getting outdoors and onto a bike, into my canoe, or into my garden. Find your own form of mindfulness. I like woodworking and fixing things around the house – things which take absolute physical concentration without the intellectual burden that comes at work. I find if I have a project to work on, the world just melts away. In recent years I've taken up recreational flying – there's something about being alone 5,000 feet up in the air as the sun rises over the ocean that really puts the world into perspective. It's a beautiful planet we live on, so try to make the most of it!

What do you consider your greatest achievement?

Marrying my beautiful wife and starting a life together. She challenges me every day to be a better person and keeps me grounded in what really matters.

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

I consider myself very much still a baby doctor in the scheme of things – or maybe a troubled adolescent? – but some of my proudest achievements to date have been making it to the finals of the NSW Health Awards for research I was involved with into the provision of cancer services in regional New South Wales, and representing my fellow ACEM trainees as the New South Wales representative on the College's Trainee Committee.

What inspires you to continue working in this field?

Without a doubt, it's the people I work with who inspire me the most. I can honestly say that every single one of my colleagues has given me something that I want to incorporate into my own practice – whether it be a clinical pearl, an attitude towards learning, their approach to life, the way they care so sincerely about their patients or the way they interact with the people around them. This is what inspires me to be a better person and a better doctor so that one day I might have the privilege of inspiring someone else.

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

Take it with a grain of salt whenever someone tells you what your career or your life should look like. I'm a firm believer in finding your own path – we're only here once after all.

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

I look forward to the day when where you live has no bearing on the level of care you receive. With advances continually being made in telehealth and the provision of emergency services in rural/regional areas, I truly believe we can get there.

Manaaki Mana: Ngā Ara ki te Taumata o te Pae Ora Hui

Dr Kate Anson
Co-chair Manaaki Mana

The best-laid plans are nothing in the face of COVID-19 lockdowns and so it proved for the ACEM Manaaki Mana Pae Ora hui (meeting) in Aotearoa New Zealand. With less than six weeks to go, we scrambled to convert our two-day hui on a Gisborne marae to a one-day virtual gathering.

Manaaki Mana is ACEM's strategy to achieve Pae Ora – excellence in emergency care for Māori – launched at the ACEM Winter Symposium in Rotorua in May 2019. Since then, kaikōkiri (champions) have been established in most emergency departments (EDs) across Aotearoa.

We wanted to bring our kaikōkiri together with key partners and anyone interested in equity in acute healthcare. Our aim was an educational and inspirational hui, and, despite a few technical issues and a growing COVID-19 outbreak, it all came together on the day.

Manaaki Mana is ACEM's strategy to achieve Pae Ora – excellence in emergency care for Māori – launched at the ACEM Winter Symposium in Rotorua in May 2019.

Dr Inia Tomas, Manaaki Mana Co-chair, kicked off proceedings with karakia and mihi, welcoming and thanking hui attendees and speakers in te reo Māori and English. Dr John Bonning, the first ACEM president from Aotearoa, spoke of ACEM leadership's commitment to delivering the new constitutional objective of providing excellent and equitable emergency care to the Indigenous peoples of Aotearoa, Australia and the Torres Strait Islands.

I briefly recapped the history and purpose of Manaaki Mana, before Inia and I presented our proposed Pae Ora standards on ngā ara (pathways) to achieve te taumata (summit of Pae Ora), alongside what it means to honour Te Tiriti (the Treaty of Waitangi) in the context of emergency care.

We were blessed to have incredible speakers with expertise on a wide range of topics including: the role of Te Tiriti; why Manaaki Mana and our Pae Ora goals are needed; the new Māori Health Authority in a restructured healthcare system; cultural safety; anti-racism; manaakitanga (hospitality and ethics of care); ED equity research; end-of-life care from a Te Ao Māori perspective; and how rongoā (traditional Māori healing) offers solutions not found in Western medicine.

Each of the three sessions were followed by a robust and engaging Q&A panel with questions from hui attendees. A lively discussion forum was active throughout the hui, while program breaks provided opportunities to whakawhanaungatanga – meet others, establish connections and build relationships.

While it wasn't the hui we'd planned, with waka ama (canoeing) on the rivers, and kapa haka (dance) and waiata (songs) at the marae, the silver lining of lockdowns was that many people attended who wouldn't have been able to travel to Gisborne, including Australians. More than 160 people attended the hui online live and over 350 registered to listen at a later date – 134 SMO's and registrars, 82 nurses, 45 Māori health workers and 18 allied health, including health professionals from intensive care and rural medicine – who all share our aim of equitable emergency and acute care.

Feedback on the virtual hui has been overwhelmingly positive. I'm excited at the groundswell of momentum that's building. Our draft Pae Ora document shows the steps that will lead us to the taumata (summit of Pae Ora). 'From little things, big things grow.'*

We hope to hold a kanohi ki te kanohi (face-to-face) marae-based hui in 2022, with in-depth debates and workshops on topics similar to this year, plus entertainment, activities and networking. However, this year's virtual hui has been a call to action.

Karawhiua! Go for it!

*Paul Kelly and Kev Carmody song lyrics telling the story of a landmark land rights struggle by Indigenous Australians

Running ACEM Examinations During a Pandemic

The ACEM examinations timetable rolls on, year after year, consistently and reliably, and, to some, with seemingly minimum effort. Like the proverbial gliding duck, however, much paddling goes on under the surface, to facilitate around 1,600 candidates through their examinations annually. Sources tell us, however, that a duck doesn't need to paddle to stay afloat but does so to move efficiently toward its destination and, where needed, paddles with extra effort to overcome challenges such as adverse currents. The ACEM examinations operate in a similar way.

Numerous FACEMs are part of this significant effort, as examiners, standard setters, organisers, and as part of decision-making committees and question writing working groups. The FACEMs are assisted by the unceasing efforts of the ACEM Education Assessment team who organise and facilitate the examinations and compile candidate results and feedback. This team is responsible for all arrangements for the examinations – the logistics being too extensive to detail here – but any FACEM or trainee who has enrolled in, or attended, an examination in any capacity will know the many considerations, details and communications involved in staging that examination.

In the weeks following their examination sitting, candidates frequently enquire as to why their examination result and/or feedback has not yet been released. The steps involved in the processes for these are also numerous and each may take days or weeks of intense effort, especially during a pandemic. For example, there are around 20 post-examination processes for the Fellowship Clinical Examination (OSCE).

Overview of the examinations

The FACEM Training Program involves four examinations that all trainees complete as part of their training pathway: the Primary and Fellowship written examinations (PEx Written and FEx Written); and the Primary and Fellowship clinical examinations (PEx Viva and FEx OSCE).

The task of running these examinations has been impacted in a major way during 2020 and 2021 as a result of the escalating COVID-19 pandemic and the varying restrictions imposed by Government Health Departments affecting all regions across Australia and Aotearoa New Zealand.

Assisting trainees to sit their examinations and progress through training in these challenging times, while maintaining the usual high standards of assessment expected by past, present and future candidates, has been a primary goal of the College during the pandemic.

To facilitate the overarching goal of progressing trainees through the FACEM Training Program or the SIMG pathway, the following principles have been key:

Figure 1. Steps In Results Calculation and Candidate Feedback – Fellowship OSCE

1. Download scores from online marking system
2. Check all scores are present
3. Download and process all video recordings
4. Calculate candidate, station and domain psychometrics to determine passing score as well as candidate and station performance
5. Calculate marking variances, identify candidates close to the passing score, and arrange for third marking using station video recordings
6. Extract examiner feedback comments and begin the editing process to improve readability
7. Calculate preliminary results including third marking scores
8. Undertake rigorous checking process of all results
9. Review candidate and examiner station feedback in combination with station psychometrics
10. Review candidate and examiner feedback on stations to identify issues where present
11. Prepare analysis report including results, psychometrics, historical examination statistics and discussion
12. Examinations Committee reviews results and station performance, station removal if necessary, and recommendation to Council of Education regarding results approval
13. Recalculation of all results if station removal required – ensuring 'no disadvantage' applies
14. Council of Education vote to approve results
15. Results released to candidates
16. Summary results released to DEMTs and Regional Censors
17. Collate generic and written examiner feedback and prepare feedback letters and Area of Concern (AOC) notifications
18. Provide feedback to unsuccessful candidates and AOC notifications to those identified
19. Prepare the examination report for publication, with domain criteria, overall results, station details, and examiner feedback
20. Collate and provide examiners with marking feedback in comparison to other examiners.

- Ensuring the safety and health of all participants
- Maintaining the integrity, validity and reliability of all examinations
- Ensuring that all candidates have a comparable and standardised experience of the examination, notwithstanding any examination modifications and sitting location.

An Examinations Contingencies Working Group (ECWG) comprising key Fellows, trainee representatives and senior staff of the College was formed in early 2020, to explore and advise the Council of Education (COE) on the issues and options regarding the delivery, format, and venues for FACEM Training Program examinations scheduled during the pandemic. This group continues to meet regularly. During the pandemic, COE has regularly published communiqués to inform all stakeholders of decisions relevant to examinations and the FACEM Training Program.

A key decision made in 2020 was to provide trainees with an extension of six months to their training due date, and a commitment that the College would make every endeavour to enable trainees to sit their examination where possible. Other concessions were made to individuals particularly affected by an examination cancellation, a postponement of their examination attempt, or other extreme circumstance.

By early 2021, all candidates who were scheduled to sit an examination in 2020 had been given the opportunity to sit their examination, despite the disruptions to the examinations program and the delays that resulted.

Table 1 shows a summary of the examinations that were held in the period affected by the pandemic, including numbers of candidates and pass rates.

Key contingencies and priorities

Many contingency arrangements were devised and implemented so that the examinations could continue to run during the pandemic. These varied according to examination type and evolved over time as circumstances changed. Challenges often escalated with each subsequent examination due to rapidly changing circumstances and with sometimes little notice.

For all examinations, venues were needed that would accommodate the requirements imposed by COVID-19, especially when the venues usually used were not available. Cliftons event centres were used for most of the clinical examinations when the Australian Medical Council (AMC) National Test Centre (NTC) in Melbourne became unavailable.

Enabling candidates to sit at the next available opportunity was a priority in several cases where examinations were cancelled or postponed, or if candidates were not able to sit due to a restriction on candidate numbers.

A further priority was to ensure candidates were fully informed of arrangements, including contingency requirements, for their forthcoming examination.

For the written examinations, contingency arrangements included expanding the number of examination sites to include additional smaller regional sites to minimise travel for candidates. It also included implementing the Monash University remote invigilation program to enable candidates to sit their examination from home when lockdown and quarantine restrictions prevented their travel to an examination centre.

Table 1. Summary of ACEM examinations held during the COVID-19 pandemic in 2020-21

Examination	Date	Candidates Sitting	Passing Candidates	Pass Rate %
2020.2 PEx Written	2 October 2020	231	222	96.1
2020.2 PEx Viva	6 November 2020	154	145	94.2
2020.2 FEx Written	13 November 2020	348	214	61.5
2020.2 FEx OSCE	15-18 December 2020	157	99	63.1
2021.1 PEx Written	5 February 2021	208	192	92.3
2021.0 PEx Viva	12 February 2021	211	171	81.0
2021.1 FEx OSCE	16-19 March 2021	154	120	77.9
2021.1 PEx Viva	6-7 May 2021	218	205	94.0
2021.1 FEx Written	21 May 2021	186	111	59.7
2021.2 PEx Written	6 August 2021	255	232	91.0
2021.2A FEx OSCE*	31 August–2 September 2021	116	77	66.4
2021.2 PEx Viva	28-29 October 2021	218	205	94.0
2021.2 FEx Written	19 November 2021	256	174	68.0
2021.2B FEx OSCE	25-26 November 2021	58	45	77.6
Total		2770		N/A

* The 2021.2B OSCE was rescheduled to November 2021 for candidates originally enrolled to sit in Sydney and Auckland but who were unable to, due to the restrictions in their locations at the time.

For the clinical examinations, in addition to staging these at key regional centres, a major undertaking in itself, other modifications to existing processes were needed. To maintain the standard of two examiners at every station, as well as accommodating COVID-safe practices, technology was used so that one examiner from the local region was present 'on site', and one examiner from another region examined remotely. The technology to support this was organised prior to the 2020.2 PEx Viva examination.

An online marking platform (designed in-house) for examiners to enter scores and feedback comments, was also implemented. This removed the need for the handling, storage, transport, and processing of hard copy scoresheets. The requirements of some stations were modified to facilitate examination by remote examiners, for example by modifying stations of the PEx Viva, so that candidates could answer verbally, rather than being required to write, draw or point.

For the OSCE, it became clear early in the pandemic that numbers in the examination room would need to be reduced. The Simulation (Sim) station that traditionally requires three or four role players was modified as a Standardised Case-Based Discussion (SCBD), to require only an examiner to be physically present. The physical examination stations were modified to not require a 'subject for examination' in the station. All modifications were advised to candidates well in advance of the examination and published on the College's Education Resources site.

The ACEM examinations journey 2020-21

At the commencement of 2020, the eight ACEM examinations, as published in the 2020 Examinations Calendar, were scheduled to run. The progress of these examinations through the 'turbulent waters' of the COVID-19 pandemic is described below.

2020.1 Examinations

The two first examinations in early 2020, the 2020.1 PEx Written in February and the 2020.1 FEx OSCE in March, were run under normal conditions. The 2020.1 FEx OSCE represented the final time (to date) the ACEM clinical examinations could be run under the accepted, usual protocols at a specific purpose facility in one location. Despite this apparent 'normality', concerns about the impact of the pandemic on subsequent examinations and the management of these were under discussion.

Following these examinations:

- The two ACEM examinations scheduled for May, the 2020.1 PEx Viva and the 2020.1 FEx Written, had to be cancelled.
- All candidates enrolled in the PEx Viva and the FEx Written were advised they had been automatically enrolled in the respective 2020.2 examinations to be held in November 2020.

A COE Communiqué published on 5 August 2020 outlined the examination arrangements and contingencies proposed for the remainder of 2020.

In the second half of 2020, the focus was on accommodating the trainees who had been unable to sit the two cancelled examinations, as well as those becoming eligible to sit. The focus was also on managing the consequential larger numbers in the context of the escalating COVID-19 situation and its impact on emergency departments and the ACEM community, including trainees, examiners, role players and College staff.

2020.2 Written Examinations

- The 2020.2 PEx Written was postponed from August to October 2020 and was run in nine centres.
- The 2020.2 FEx Written ran as scheduled in November 2020.
- A record number of candidates (348) sat the 2020.2 FEx because of the 2020.1 FEx Written cancellation and all eligible candidates being permitted to sit.

2020.2 Clinical Examinations

- The 2020.2 PEx Viva in November 2020 was the first pandemic clinical examination conducted regionally under the contingency enhancements for clinical examinations.
- Candidate numbers for the PEx Viva were limited to candidates either enrolled in, or eligible for, the cancelled May Viva, to enhance the reliability of the first ACEM Viva held under contingency arrangements.
- A small group of Tasmanian Viva candidates, who were unable to travel to an examination centre interstate, sat their examination in Hobart via remote access.
- The trainees who were eligible but not permitted to sit the 2020.2 PEx Viva were offered an additional PEx Viva proposed for February 2021.
- The 2020.2 FEx OSCE was postponed from September to December 2020.
- The 2020.2 OSCE was held in six regional locations – the first OSCE run regionally in multiple centres in the pandemic.
- Candidates who were eligible for, or unable to sit, the cancelled May 2020.1 FEx Written and met all other eligibility requirements for the 2020.2 OSCE, were permitted to sit without first having passed the FEx Written, to facilitate their training timelines and progression.

The challenges in organising and running a 12-station OSCE over four days in six locations and across five time zones, with 100 examiners plus role players, cannot be overestimated and these challenges have continued at subsequent clinical examinations.

Given the combination of a later than usual (pre-Christmas) sitting of the 2020.2 OSCE and the additional scheduled 2021.0 Viva in February 2021, examinations in this period were conducted under great pressure for all involved in the organisation and staging, the post-examination processes of result and feedback compilation, and approval and publication.

A new examinations year began with a calendar of nine examinations instead of the usual eight. By September, this number had increased to 10.

2021.1 Written Examinations

In preparation for the written examinations in this period, the College arranged with Monash University to use the remote invigilation platform, if needed, to accommodate candidates unable to attend at a designated centre. The platform enables candidates to sit their online examination from home while being invigilated remotely.

- The 2021.1 PEx Written was held, as scheduled, in February 2021 in nine locations.
- In Perth, 17 PEx Written candidates affected by a snap lockdown sat via remote invigilation.
- The 2021.1 FEx Written was held, as scheduled, in May 2021 in nine regional centres.

2021.1 Clinical Examinations

- An additional Viva, the 2021.0 PEx Viva, was held on 12 February 2021 to accommodate only those trainees who had been eligible, but unable, to sit the 2020.2 PEx Viva in November 2020 because of a restriction of numbers.
- Trainees who passed this examination had their progression to Advanced Training backdated to their original planned progression date in recognition of their inability to sit the 2020.2 Viva.
- The 2021.1 PEx Viva and the 2021.1 FEx OSCE were held, as scheduled, in March and May, again in regional centres and under contingency arrangements.

By August 2021, Melbourne, Sydney and some regional locations were in COVID-19-related lockdowns. Border restrictions between states were in place and Melbourne-based ACEM staff were again working from home in extended lockdown conditions, for the sixth time since March 2020. Auckland was declared a COVID-19 hotspot and, soon after, a lockdown was imposed across New Zealand.

2021.2 Written Examinations

- The 2021.2 PEx Written was held, as scheduled, in August 2021 in expanded locations, given the escalation of the pandemic in Sydney and other regions.
- The Monash University remote invigilation solution was used for 51 candidates from regional Queensland, regional New South Wales and Sydney LGAs after tighter restrictions were imposed that prevented travel to the examination centres.
- In effect, candidates sat the 2021.2 PEx Written at one of 64 approved sites.

2021.2 Clinical Examinations

- The 2021.2A FEx OSCE proceeded in August/September as scheduled, however, at three locations only – Brisbane, Perth and Melbourne.
- The College developed a set of guidelines for all attending the examination venues that included current information from the Health Departments of the various jurisdictions.
- At the 2021.2A FEx OSCE in Melbourne, requirements included a negative COVID-19 test for all attendees and mask-wearing under advised conditions.
- The 2021.2B FEx OSCE proceeded in November as an additional examination, held to accommodate 58 candidates sitting in Sydney and Auckland, who were unable to sit in those locations in September. The examination was again conducted under COVID-19 restrictions.

The current situation

As the pandemic continues to evolve, the College, as it has done over the past 18 months, will continue to provide, as far as possible, an ongoing examinations program that meets its core objectives to uphold the safety and health of all participants, to maintain the integrity, validity and reliability of the examinations, and to ensure that all candidates have a comparable and standardised experience of the examination, notwithstanding any contingency arrangements applied. In so doing, the College will continue to evaluate the progress of the examinations and actively monitor developments, in Australia, New Zealand and overseas, to ensure all methods for the assessment of ACEM trainees continue to be considered and, where feasible, offered as best 'pandemic practice' for examinations.

Acknowledgements

That the ACEM examinations program has been able to proceed as it has during these challenging times is testament to the commitment, creativity, diligence, and talent of many in the ACEM community who have spent long hours in the pursuit of dependable and reliable solutions, in drafting communications to ensure clarity to all involved, and in organising, preparing, staging, examining, and supporting the examinations in this period. In particular, I take this opportunity to acknowledge the following people:

- members of COE, the Examinations Committee and ECWG
- FACEM examiners, many of whom volunteered hours well in excess of the 'normal' requirement
- FACEM role players, examination facilitators, standard setters, and members of the various examination working groups
- Senior ACEM officers and the ACEM Education Assessments and Resources teams.

The College acknowledges the diligence and resilience of the many trainees who have steadfastly worked to maintain their training commitments and examination preparation in extremely challenging times and congratulates those who have been successful in their examinations during the period. We acknowledge the DEMTs and supporters of the candidates preparing for examinations and thank them for their ongoing support of the trainees and SIMGs, and of the teams working so hard to keep ACEM examinations at the forefront of good practice in COVID-19 specialist college examinations.

Author: Lois Lowe, General Manager, Education Assessment

Building My New Normal: Emerging From Post-Acute COVID

Dr Mya Cubitt
Dr Cubitt is an emergency and acute medical unit physician at The Royal Melbourne Hospital. She is also chair of the ACEM VIC faculty.

In 2020, I was diagnosed with COVID-19 after being exposed at work as an emergency physician in Melbourne. I wrote a piece for the ABC about my shame, guilt, profound loneliness and the stigma. For me, at the time, those emotions were more overwhelming than the disease itself.

It took four weeks before I felt able to return to work, determined that my experience – inconsequential when measured against the experiences of those I sought to serve – wouldn't impede my ability to contribute alongside my colleagues. But, as all in the caring profession know, that determination would only carry me so far.

Anyone who has had to re-enter the world after an enforced absence will recognise the challenges. Those who have suffered a life tragedy, severe illness, maternity leave, or an intense period caring for another. The world, previously shrunk and simplified, looks daunting. It feels too crowded and complex. Years earlier, re-emerging after the shock of my first child, I was acutely aware of my tentative hold on incorporating responsibility for another human into my life. Back then, it took the persistent insistence of my husband to push me back out into the world. He saw the risk that the hard work of re-entry, the fear of failure, was beyond me if I faced it alone.

In February 2021, I admitted defeat. Although the pandemic seemed in hiatus in Victoria, Christmas in emergency departments (EDs) and at home away from family had been hard. And now, with school re-starting, so was the impossible juggle of drop-offs, pick-ups, childcare, afterschool activities and homework, alongside the careers of two ambitious professional parents.

I was exhausted, angry and, most of all, terrified. The effort required to do what I had previously done with a smile felt more than I could give. That lost feeling of returning to a carpark, but not having a clue where to find my car, was with me every day. To others, I looked no different. But I didn't know myself. I was too aware of the risk of error – in clinical decision-making, communication, in priority setting. Supervising and being responsible for leading a team felt a heavier weight to carry and maintaining my performance seemed to leave a 'me' that was increasingly letting others down.

Finding my way back

I'm grateful to my GP. She sat and listened as I wept. She believed me. She named what was happening to me. It was post-acute COVID and probably burnout. She gave me permission to put myself at the top of the priority list – something I had long ago lost the ability to do. She took control and prescribed a direction.

Regular debriefs with my psychologist have taught me that emergency clinicians should probably be doing that regularly, to prevent the slow accumulation of micro-traumas that we box away tightly so that resuscitations might continue uninterrupted.

My neurologist, an expert managing several colleagues with post-acute COVID, a pragmatist, and a patient believer in the ubiquitous healing power of time, reassuringly avoided unnecessary assessments and interventions.

I took a sabbatical. The privilege of it, with no patient-facing time, gave me the space to invest properly in my recovery. Absenting myself from the clinical work environment, shift work and broken sleep helped me regain my psychological resilience and avoid the constant comparison of my current and former selves. Not everyone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'He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata'. This translates to, 'What is the most important thing in this world? It is people, it is people, it is people'.

will have access to this but redressing the balance of clinical and non-clinical work, using accumulated sick leave to roster some extended breaks, reducing shift hours, or changing roles for a time and admitting that you need to, are other paths to take.

Crucially, I took on new cognitive challenges: an advisory role, some research, and a course in debriefing. These challenges worked my synapses and helped maintain and build back my mental agility.

But the most lifesaving element of my recovery has been the humanity, connection and conversations with the National COVID-19 Clinical Evidence Taskforce Consumer Panel. They have helped me rediscover my passion and reason for practising medicine. For them, I will forever be grateful.

Today, I'm starting to feel ready for the scariest part of the journey – re-entry into an ED.

Going back to work as a consultant emergency physician was hard every time I did it after maternity leave. After twins – a life event that threw me into what was humorously called 'extreme adjustment disorder' – it felt impossible.

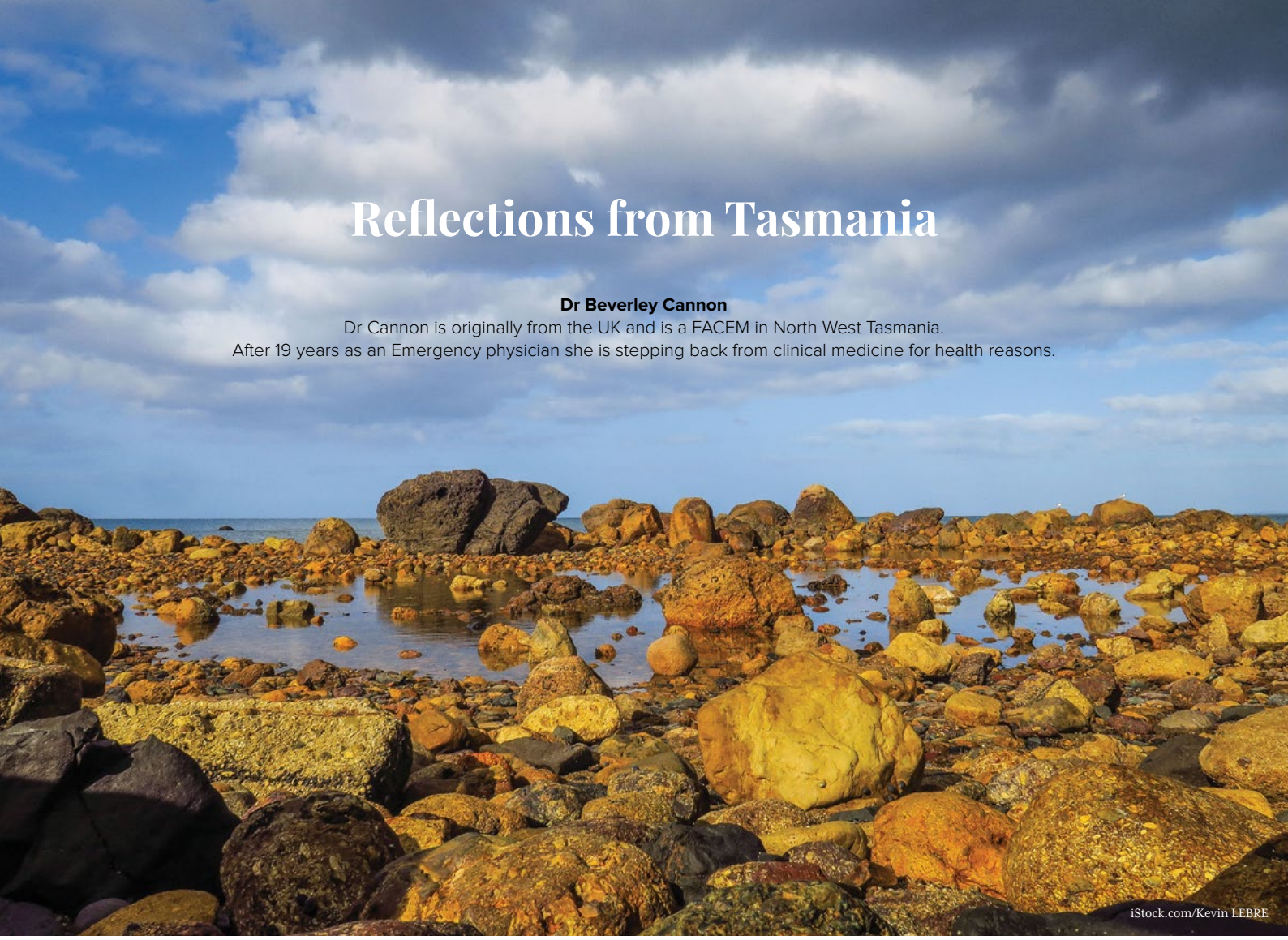
This time, as with every time, it will be different. The healthcare system, broken before COVID-19, is now hanging together through the dogged determination of my exhausted colleagues. It looks threatening to those of us broken and recently patched back together.

There are many silver linings in COVID-19 to take forward with us. From my post-acute COVID cocoon, I implore the healthcare system to embed and measure ourselves against a basic shared value. A Māori whakatauki (proverb) reminds us, 'He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata'. This translates to, 'What is the most important thing in this world? It is people, it is people, it is people'.

On 24 August 2021 the first global summit on ending physician burnout was held. As I chart the next phase of my journey towards my new normal, I welcome this vital global conversation and rediscovering my joy at work.

Reflections from Tasmania

Dr Beverley Cannon
Dr Cannon is originally from the UK and is a FACEM in North West Tasmania.
After 19 years as an Emergency physician she is stepping back from clinical medicine for health reasons.



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'Have you thought about applying for EMET funding?' asked 'Someone from the College'.

'What's EMET?' I replied.

That was 2014 and 'Someone From The College' was Caroline Mulchinock, who many FACEMs will remember as a wonderful ACEM asset until she moved back into education earlier this year. I was a relatively recent FACEM import to Northern Tasmania from the UK via Perth, Western Australia (Rockingham, to be precise). Our busy emergency department (ED) was 'fed' by seven GP-run rural hospitals around the North and I'd been asked to provide some paediatric-themed emergency training to the sites. Initially, I used my non-clinical time and committed to one visit per site, but I had to make it clear there was no funding for ongoing visits. Needless to say, the visits were a great way to meet clinicians who were referring in to our ED, starting relationships, and building trust.

Fortunately, I was wrong about the funding. EMET (Emergency Medicine Education and Training) is a Commonwealth-funded program, which ACEM oversees. The program enables FACEMs from a hub hospital to visit their rural sites, with the aim of delivering training (and/or supervision) to non-FACEMs (GPs, rural generalists, nurses, volunteer paramedics) who deliver emergency care to a significant number of patients across Australia. The funding criteria includes support for the Emergency Medicine Certificate (EMC) and the Emergency Medicine Diploma (EMD) programs, which was unchartered territory for us at that time, as well as outreach training to teams in smaller hospitals.

We ticked the right boxes to become a hub for EMET but our funding application needed broadening to include non-paediatric topics. Our business manager and I worked out how many days would be needed to allow two visits per year to each site (including some overnight stays to accommodate the distances). We were excited to learn we could also bid for equipment and we went 'wild in the aisles', purchasing an infant and child manikin, and an iSIM. My wish list these days is far more sophisticated and expensive!

We were delighted to be awarded funding and, with our newly-appointed program support officer (PSO), I set about firming up our first round of site visits.

I remember being quite anxious about what exactly I would be teaching. Luckily, I was able to attend the Brisbane EMET Hub meeting before our Tasmania project kicked off. As I sat, hearing about all these fantastic EMET projects, I found myself sinking lower in my chair and feeling like a fraud. When it came to my turn to speak, I nervously explained that a) We'd just received our funding and were

yet to get going, and b) I was wondering exactly what our program would and should look like. I was overwhelmed with support, ideas and reassurances.

Lesson Number one: There's a wealth of EMET expertise around Australia and they all want to support and enable new projects; sharing resources is a given – ideas too. I stopped worrying when they convinced me that it was OK to start small, build relationships, and find our own niche.

It suited our ED for me to take a two-week period of EMET leave (back-filled by locums, which is what the bulk of the funding paid for) and we gave those dates to our sites to choose from, along with options for a full-day/half-day and what they'd like to cover. In retrospect, I made it difficult for myself but I was so keen for the sites to feel in control and therefore to 'buy-in' that I basically gave them a blank sheet of paper. I also spent a lot of time speaking to the Nurse Unit Managers (NUMs), Directors of Nursing (DONs), and local GPs to explain EMET and (hopefully) drum up interest and attendance.

The first round of visits took myself and Kathy (our PSO) from Flinders Island in the north to St Helens in the east, Deloraine in the middle, and another four sites in between. Not huge distances by our mainland cousins' standards but it was just me delivering the teaching over those two weeks and, as I've already admitted, one size did not fit all!

Lesson Number two: Each site has differing needs and perspectives; flexibility and patience were key. It took time for them to appreciate that this was a program for their benefit and not feel threatened by a FACEM.

I offered a mix of interactive talks, skill stations and low-fidelity simulations for anything from three to seven hours but, invariably, attendees were keen to discuss cases they'd seen and/or referred on to the ED. There's no doubt this remains one of the most valuable aspects of the EMET program and, along with building relationships and shared understanding, why each site visit was an early eye-opener to what this funding was enabling us to do.

I was astounded by the difference in equipment available at each site: a rural hospital with a recent tragic paediatric severe sepsis case only had a single intraosseous needle, which failed, while other sites had EZ-IO intraosseous drills. The island, which was frequently weather-locked and unable to have patients retrieved, only had an automatic external defibrillator (AED) – which thankfully correctly interpreted ventricular tachycardia (VT) as shockable when they had an unstable conscious VT patient present – whereas another hospital 30 minutes away from ED on lights and sirens enjoyed the luxury of a manual machine.

It was a real lesson in flexibility as an educator. Looking around their resus area and working out, for example, what they could use to splint a femoral shaft fracture in the absence of a formal traction device; practising scenarios and realising the room set-up needed to change; or noticing that the only paediatric bag-valve-mask (BVM) size on the resus trolley was neonatal and why that wouldn't cut the mustard if a six-year-old near-drowning came in, but how they could safely improvise with the adult BVM if they knew how.

With the first round of visits under our belt, we sought feedback (thankfully positive), tweaked the program, and continued the conversation to try and overcome barriers to staff attending.

Lesson Number three: GPs and rural generalists were hard to pin down initially. They generally preferred weekends (no risk of income loss) but nurses preferred weekdays. NUMs were reluctant to pay weekend rates – some didn't pay at all, after all, this wasn't the dreaded 'mandatory training' – but it was multidisciplinary, targeted and relevant in their own environment, which the feedback overwhelmingly told us was priceless. But I was yet to learn the 'Secret of Doctor Buy-In'.

I was lucky enough to move into the emergency medicine team in North West (NW) Tassie in 2016 and, rather than being a Lone Ranger (Kathy had just retired), I found myself amongst a great team of FACEMs, who were enthusiastically spreading the EMET love around the five rural sites in the NW. With our Director's encouragement and in the absence of anyone to run the EMET program in North Tassie, ACEM supported us to continue running all the north sites from the NW.

Lesson Number four: There's more than one way to eat a pie! With Matt as PSO (emergency nurse by background) and Director support for two FACEMs to deliver a day of RACGP and ACRRM-accredited material, we were now delivering education, M&M (Morbidity and Mortality) meetings, and support to 12 rural sites twice a year on average. And lo and behold – the doctors were coming.

We're now five years down the track and EMET in Tassie remains strong. There have been highs and lows: it's the NW's turn to struggle with FACEM availability but new faces in the North quite rightly asked 'Why aren't we doing that?' and now they are. Hopefully, they will be ready to become a hub in their own right once again before too long.

Pre-COVID, the annual EMET and PSO meetings were a great way to summarise your own program, troubleshoot roadblocks, and see what other hubs were doing. Networking with like-minded colleagues was priceless. The amazing ACEM EMET team were always in the background to facilitate, encourage, advise and provide support.

In August 2021, we ran our first state-wide weekend EMET workshop in the Rural Clinical School in Launceston. With the relevant colleges having accredited two days of material, the workshop was full, and it really was a team effort with FACEMs from the NW, North and South of Tassie delivering the education to GPs, rural generalists and EMC/EMD candidates. Practical advice from our Bendigo colleagues (who've been successfully running weekend workshops for some time) was hugely appreciated and the hard work of PSOs Ruby and Kylie paid off – hopefully to be repeated annually after encouraging feedback from attendees.

So as I prepare to step back from clinical medicine and EMET (after all, I can't have all the fun) it was a good time for the amazing Mathew from ACEM (honestly – a legend of support and patience) to ask, "Would you consider writing a piece reflecting on EMET in NW Tassie?"

Hopefully I just did. EMET is a true success story. If you enjoy education, building local networks, and developing solutions to benefit your rural sites and patients – and want a change in focus from the crazy pace of day-to-day ED work – EMET might just be for you.

My Time at LifeFlight Training Academy

Dr Shima Ghedia
Dr Ghedia is an Emergency Physician who trained in Sydney and London. Over the years she has had roles as ED Director, Co-DEMT, and medical school Tutor, working in both public and private hospitals in Sydney. Currently she is a Retrieval Registrar working in Mackay, Queensland.

I am beyond excited to finally achieve my childhood dream of working as a retrieval medicine doctor. It's something I've worked towards all my life, it seems, and now it's all finally coming together. The timing never seemed right before now: I felt tethered by raising two kids, emergency medicine training, and working hard for years as a FACEM in various emergency departments (EDs in Sydney.

But, peeps, I say: keep your eyes on the goal and set your heart on following your dreams. It's never too late. At the mature and fantastic age of 51, I'm venturing back into the world of registrar-hood and all the shift work and training that comes with that. I've embarked on a six-month retrieval registrar post as an RACQ LifeFlight Rescue Critical Care Doctor, working on the RACQ CQ Rescue helicopter, moving north to the central Queensland sugar-lands of Mackay with my wonderful partner and two cats.

Twice a year, new registrars undergo a training week at the LifeFlight Training Academy based at Brisbane Airport. We have lecture mornings followed by rigorous practice simulations and drills into the afternoon. The trainers are a wonderful group of knowledgeable and experienced leaders in the field of retrieval medicine. Scenarios are set up to simulate disasters, traumas and medical emergencies. They become increasingly more realistic and challenging.

The thing is, you're trying to decide where to intubate that confused head-injured trauma victim: outside, down a slope, in the heat or wind or dust, with medical equipment you carry yourself. Although there's always clinical support available over the phone, I quickly realised I was far from the familiar well-stocked, well-staffed resuscitation bay in an urban ED. Scenario training culminated in a day and evening spent at the Queensland Combined Emergency Services Academy at Whyte Island, with real overturned vehicles, old planes, and realistic buildings in which to play retrieval doctor.

Towards the end of the week, I experienced one of the most important and challenging days of my medical career so far: I underwent my Helicopter Underwater Escape Training (HUET) accreditation.

In the highly unlikely event of a chopper going down over water, the top-heavy nature of the rotor wings means that it's going to turn upside down. You will have seconds to prepare, to go from a calm, ordinary humdrum shift to a critical emergency situation.

The sudden call of 'brace, brace, brace' may echo in your headset comms and you and your crew might plunge from the air into dark water, spin over and begin to sink. The only thing holding you in your seat will be your four-point seatbelt. If you can, you take one last deep breath as the water rushing into the cabin passes your waist. You close your eyes and prepare to survive.

LifeFlight teach us to expect the unexpected and prepare for the worst. We undergo hours of theory and practical sessions. We practise wearing life-jackets fitted with Emergency Breathing Systems (EBS). We study what's involved in rescue life rafts and survival techniques. They walk us through all the precise steps we need to take to avoid disorientation and exit a crashed helicopter in the dark and upside down.

I spent my childhood swimming and cavorting in swimming pools: breath-holding competitions were a constant source of play and amusement. But HUET was much more of a mind game; an exercise in listening carefully to instructions and following them precisely. We learnt to trust the knowledge and experience of the instructors. We learnt how to remain calm under extreme pressure.

Maybe that's the point. After all, it takes a bit of nerve to do this job, don't you think?

I'm not ashamed to admit I had to undergo a few of the exercises twice. I forgot the sequence of what I was supposed to do. Or I couldn't hold my breath long enough. I became disoriented and tried to exit the wrong way. Or I didn't realise how hard it would be to unlatch myself from the lead that protects me from falling out an open helicopter door.

But then that's the whole point. To practise and practise until you get it right. The patience of the instructors was amazing and humbling. They were prepared to do everything it took to train us to survive in case disaster strikes. Investigations from previous helicopter crashes over the years have shown that this really is the difference between life and death for the crew of a ditched chopper.

When I finally passed the tests, I was totally wired! Buzzing with adrenaline, unable to sit still, feeling dizzy and exhausted, yet unable to sleep. Images of the day ran through my head. The feeling of impending doom. The water rising up my body and taking that last breath. The rushing sound as the chamber turned over. Imagining my hands moving to cross my chest in BRACE, closing my eyes, my inside hand moving to reference my seat, finding and using my EBS (if present), otherwise doing a breath-hold, my other hand finding my knee and thence to the aircraft window, the reference hand undoing the seatbelt and my grip tightening on the window

and pushing out, moving my arm along the frame and pulling myself out and up. To hopefully deploy my life vest and ascend, following the rising bubbles: to breathe and live.

I did it. And god forbid I ever have to do it in real life.

Another highlight was winch training. This procedure is one of the most challenging that can be performed by aircrew. It involved hours of lectures in equipment and safety. More hours of going through every piece of equipment and how things work; putting things together and taking them apart. Analysing what could go wrong. Trying hard to develop some kind of muscle memory when I'd never done any of these things before.

Static winching training is next. We winch out and back in, with the helicopter at ground level. We practise again and again until we are weary. Finally, after hours of intense concentrated information about aviation, it's Assessment Time: Live Winching.

We walk outside in the blinding afternoon sun wearing our flight suits. Luckily, there's a bit of shade where we can set up and then go out to the winching stations. In small groups, we put on our harnesses (worn every time we are in a helicopter) and perform a five-point buddy check on each other. Helmets are donned and instantly the world narrows to what is only seen in front of you. You can no longer hear properly, then the chopper rotor blades are added in and there's no more talking, only gestures – exaggerated nodding and shaking, the thumbs up, and other signals become the most important way of communicating without comms.

I'm up nearly first. My heart is beating fast (I run through check sequences in my head) as I stride out to the open field to begin my winching assessment. The rest of the time goes by in a blur of talk-shouting, expansive gestures and deliberate movements. Of being whipped in the eye by some stray hair and ducking to avoid dust and heat. I can't say I remember the sensation of being lifted in my first non-tourist MEDEVAC helicopter. But the winching was exactly as described in training. The drills play out in precise sequence, just as we had trained.

The whole experience was thrilling.

I sincerely hope that I never have to use these skills because if the doctor is being winched to a scene (instead of a rescue person or a paramedic) then the situation is likely dire. But of course it happens. RACQ LifeFlight Rescue Critical Care Doctors can be on aircraft tasked to offshore ships and islands where accidents and medical emergencies may make landings unsafe. And that's where winching to land on a ship to deliver treatment or to evacuate an injured patient may be the time-critical, life-saving procedure needed.

And now … to do my very first shift!

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A Recipe to Prioritise Emergency Care on a Tropical Island

John Foley and Libby White
John Foley is a Critical Care Registered Nurse currently working at Royal North Shore Hospital in Sydney.
Libby White is a Critical Care Registered Nurse working at Alfred Health in Melbourne.

Libby and John were supported by the ACEM, Australian Volunteers Program Partnership. The Australian Volunteers Program is an Australian Government initiative that is managed by AVI in a consortium with Cardno and the Whitelum Group and provides key safety, security and pastoral support to global emergency care volunteers

For this recipe to succeed, firstly you need to prepare one professional body with a long-term vision and motivated members. Then fold in logistics and support provided by a volunteer organisation. Add a sprinkle of enthusiasm, a pinch of excitement, and simmer for a couple of months.

When everything is steaming, whisk in two emergency nurses and put in a warm place for six months. Ensure they are mixed well with the local leaders to form a cohesive dish. As coconuts are plentiful and the sun is shining, sprinkle with some learning and laughter, then place in a ground oven, for best results. Check the seasoning and this meal is now ready!

Of course, like any good starter, keep some of this mixture aside and be ready to add more people and ideas to create the next delicious feast.

The recipe being referred to here is the ACEM partnership with Vila Central Hospital (VCH) and the Australian Volunteers Program, an Australian Government initiative. It's unique because it's a collaboration of many parties working together to achieve a common goal, which, sadly, is not common enough when supporting low-and middle-income countries.

This long-term vision has been created by the ACEM Global Emergency Care (GEC) team, who visited VCH in the archipelago nation of Vanuatu and, through a needs assessment, identified a plan of support to improve emergency care. The GEC team organised a string of nurses and doctors to work at VCH alongside the local team, to achieve a series of goals.

The logistics and support comes from Australian Volunteers Program. They prepare Australian healthcare professionals to experience the culture of this tiny Pacific Island nation. The in-country team ensures a smooth transition into the tropical island lifestyle.

My nursing colleague John and I were lucky enough to be selected to travel to Vanuatu in December 2020. Although plans were underway for several months, with the obvious interruptions 2020 brought, we had 24 hours to organise our lives and get on a flight.

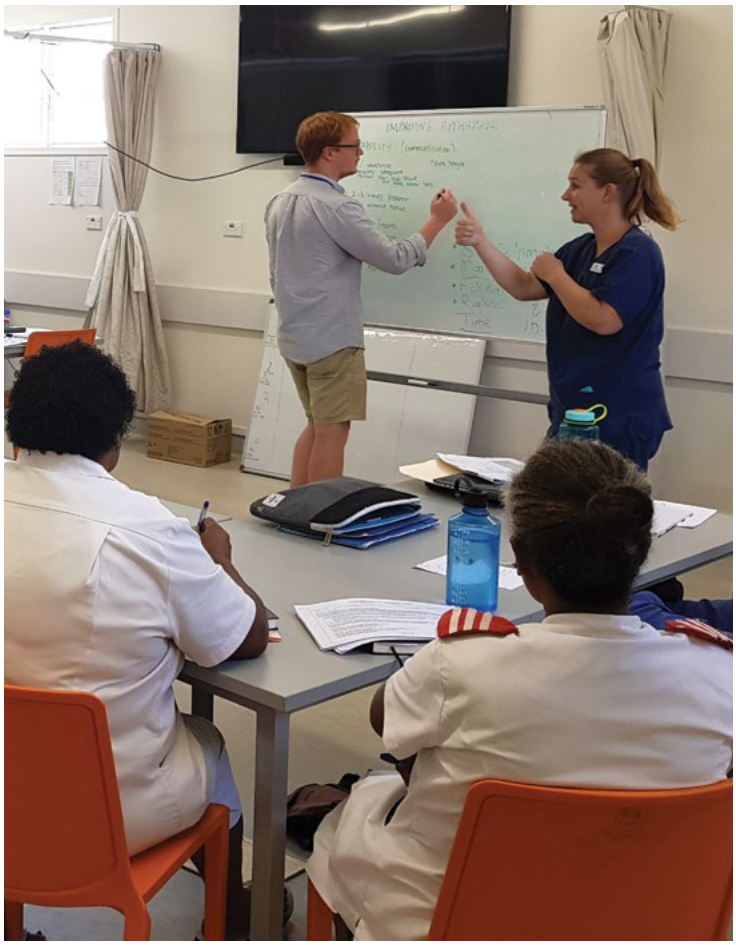
It's easy to love Vanuatu, with its friendly people, idyllic turquoise waters lapping at the beach, which you have all to yourself, and lush tropical bushland. It has 83 islands, 65 of which are inhabited, and has a population of nearly 300,000. There was cause for much celebration last year as Vanuatu moved from being classified by the United Nations as one of the world's least developed countries to a developing nation.

VCH is the national referral hospital for the country, located in the capital, Port Vila, on the island of Efate. Patients are flown in from all the islands to receive the most specialised healthcare the country has to offer. The hospital is nestled into a hillside, looking out over a lagoon, and is surrounded by tropical bushland. There are 156 beds making up the medical, surgical, obstetrics and gynaecology, maternity, and paediatric wards.

On our arrival at VCH, John and I were warmly welcomed and shown around the hospital, meeting all the amazing people who keep things running smoothly. The staff were smiling and happy to chat, even though they had heavy workloads, and there appeared to be many patients in their care.

John was volunteering as the Intensive Care Educator but, with his emergency nursing background, we worked closely together. We were tasked with teaching and supporting the implementation of a triage system at VCH. We had six months to achieve this goal, with regular support from ACEM. We learnt about previous implementation successes and challenges from Papua New Guinea and the Solomon Islands through ACEM, and were provided with teaching resources and infrastructure plans. An emergency nurse and an emergency registrar had been at VCH prior to our arrival, and had commenced many projects for us to continue.

In the first few months, we worked to build relationships, trust and understanding of the systems in place. We worked clinically with our colleagues and learned so much, as the scope of nurses is very different in Vanuatu. Medical staff are even more scarce than nurses, so the nursing staff often assess, treat and discharge patients independently. Slowly, this is changing as doctors from neighbouring Melanesian countries come to support the developing healthcare workforce. Currently, in the ED, there is a doctor on most shifts. ACEM are providing support through their Visiting Emergency Medicine Registrar Program (VEMRP) also in partnership with the Australian Volunteers Program.



John and Libby teaching hospital leaders about performance appraisals.

Celebrating after completing triage training – there's always much laughter in Vanuatu!

The Melanesian bond flows into nursing, with several nurses in the hospital and emergency department (ED) from the Solomon Islands, as there is a chronic nursing shortage in Vanuatu. This is a great short-term solution, as the Solomon Islands nurses have a similar scope of practice and have experience in emergency care, as well as a deep understanding of Melanesian culture and how that affects healthcare.

The exchange of knowledge was incredible as John and I learnt about the large burden of non-communicable diseases (NCDs), and kastom (traditional) medicine. The weekly presentation of diabetic foot sepsis, destined for amputation, was confronting. We saw record-breaking blood pressure readings every day in young Ni-Vanuatu men and women. The number of young women with breast and cervical cancer, for whom there is no treatment or palliative care service, was overwhelming. The ED staff took care of these patients and did their best to provide adequate pain relief and explanations to familes.

John and I shared our critical care knowledge and did our best to role model emergency nursing as we knew it, blending in local needs. We encouraged more than one set of observations to be recorded for a critically unwell patient and advocated for nurses to document the care they had given. We cleaned, tidied, and stocked the ED. We spoke to everyone we knew to gather supplies and ensured the resus trolley had everything required.

We made checklists more user-friendly and removed unnecessary donated items, like port access needles, as there are no ports to access. We continued advocating for asthma patients to use a metered-dose inhaler (MDI) instead of a nebuliser, which is a project started by our predecessors. We supported the nurses in caring for patients and were able to provide some clinical teaching, such as explaining ECGs and trauma patient care.

The Ni-Vanuatu are very friendly and communicative, so the weekly Bislama (pidgin or creole) language lessons provided through Australian Volunteers Program were vital to understand conversations and really connect with patients. It was fun to learn a new language and I hope it showed the Ni-Vanuatu that we were there to work with them in every way.

The patients listened to the advice they received from the staff in the ED and public trust in the healthcare system is continuing to build. I remember one patient had a blood pressure of 235/120 and he wanted to try kastom medicine before taking prescription medication. The ED staff encouraged him to come back in two weeks and re-check his blood pressure. When he did return, his blood pressure had not reduced after drinking kastom tea, so he agreed to try medication. This is a great example of holistic care and how NiVan healthcare professionals are trying to educate their community.

Throughout our time in Vanuatu, we had fortnightly meetings with the ACEM team in Australia and Aotearoa New Zealand to update them on our progress and discuss plans. We submitted budgets for triage training and prioritised what we could achieve.

Of course, there were many distractions, like COVID-19-positive patients who were identified in hotel quarantine and transferred to the hospital. John and I jumped in and supported the team to prepare the isolation ward and ensure the two patients received the care they needed. We reviewed how the nursing staff donned and doffed PPE and entered and exited the ward. As we were working in the isolation

ward, we couldn't go into the rest of the hospital until we had isolated at home and received a negative COVID-19 test.

After much planning and preparation, we delivered the triage training, which was well received by the nurses and doctors within the hospital. Attendees included hospital managers, nursing interns, and nurses from the Vanuatu College of Nursing Education. The Integrated Interagency Triage Tool (IITT) was developed by the World Health Organization (WHO) with input from the Red Cross and Médecins Sans Frontières (MSF). IITT has been given a Pacific twist by the ACEM team, to make it specific for the conditions and the people using it.

Staff came from all departments to understand how the new triage system would work and how it would impact the hospital. Some staff highlighted that triage could be used in their workplaces as well. For example, the nurses from the Children's Outpatients Department identified that a triage system would help them to formally organise their workload. The nurses in maternity who received all new referrals on Monday's believed it would be useful in their area too. Staff were thinking outside of the ED about how to improve their own departments using the available resources.

We ran several days of training, which were all well attended and we finished up each day of training by accessing the hospital computer lab, to ensure every nurse was logged on to Tembo training to continue their learning. Tembo is a free training platform developed by MSF that teaches the WHO triage system. It initially turned out to be a whirlwind of nurses with no email addresses and forgotten passwords, due to a lack of computer literacy. But everyone was keen to give it a go.

Tembo offers a certificate of completion at the end of each module, which helps incentivise the nurses to finish. The ED nurses have access to a computer, thanks to the "recipe to prioritise emergency care", through ACEM's vision and a grant from Australian Volunteers Program. Another beautiful example of how collaboration is working at VCH.

John and I delivered training to the paramedics, who are also supported by Australian Volunteers Program. It was great to get their feedback and they appreciated understanding how the hospital system would change. We also had a training session with the hospital filing clerks, as they will instruct patients where to go. They will also collate data to track progress. The filing clerks were very engaged in learning about the triage process and including them in training reinforced that they are crucial members of the ED team.

After the training, while John and I were out buying supplies to support the new triage system, the nurses started triaging on their own, using the knowledge and resources available to them. It was exciting to see them implement it without any input from us. This felt incredibly rewarding and we left Vanuatu with smiles on our faces, hoping the NiVan nurses got as much out of our time there as we did.

As mentioned above, this recipe to prioritise emergency care will continue to ferment and grow in the warm climate of Vanuatu. With ongoing support from ACEM and AVP, another ED registrar has just landed in Vanuatu and will continue building on knowledge and skills to improve emergency care. All that's needed now is a few more nurses. Please contact the ACEM Global Emergency Care Network at gecnetwork@acem.org.au if you are a Critical Care Nurse interested in working in Vanuatu right now.

Thoughts from Dr Vincent Atua, ED Consultant, VCH:

'The main benefits of having staff from Australia is the new culture they bring to the ED, along with updated information, knowledge and skills they can share with the local staff. And, of course, the friendship and professional networking opportunities.

There have been huge changes to the way we do things here in the ED, including culture, processes and staff morale. The nursing staff have been used to having visiting doctors from Australia or other developed countries come and work in the department, but never a nurse who could stand shoulder to shoulder with them.

Beneficial changes include:

- Ditching the nebuliser and increasing the uptake of MDIs
- New ED protocols
- Reorganising the ED and clearing all the clutter
- Mentoring and support for the nurses, nurse interns and nursing students
- Assistance running ALS courses
- Improved staff appraisal processes
- The first VCH Ball and Staff Awards
- The first 'girls' day out'
- Learning how to use CPAP (continuous positive airway pressure therapy)
- New ED triage and observation charts
- Access to grant funding for the first disability toilet and shower in the medical ward and triage funding
- Money for an improved staff tearoom.

Three things to tell someone coming to VCH ED for the first time:

1. Come with an open mind. You are coming to, until last year, one of the least developed countries in the world, so things are done a little differently with whatever resources our country can afford.
2. What we lack in resources, we make up with heaps of happiness to share in one of the safest countries in the world, which is very popular with tourists.
3. Get involved in a small project if you can – leave a footprint when you go that we can cherish long after you've gone.'

The following words are from Jeffery Samana, Nurse In Charge of the ED at VCH.

What are the main benefits of staff coming to VCH ED from Australia, with ACEM and Australian Volunteers Program?

Better management of nurses and staff, patient flow and the patient tracking board, patient data records, and triage. Organisation of the storage room and staff changing room, and using spacers more than nebulisers.

Other benefits are continuous education, nursing supervision, better support for the unit manager, nurses and patients, and a lot more.

MAPPING GLOBAL EMERGENCY CARE AT ACEM

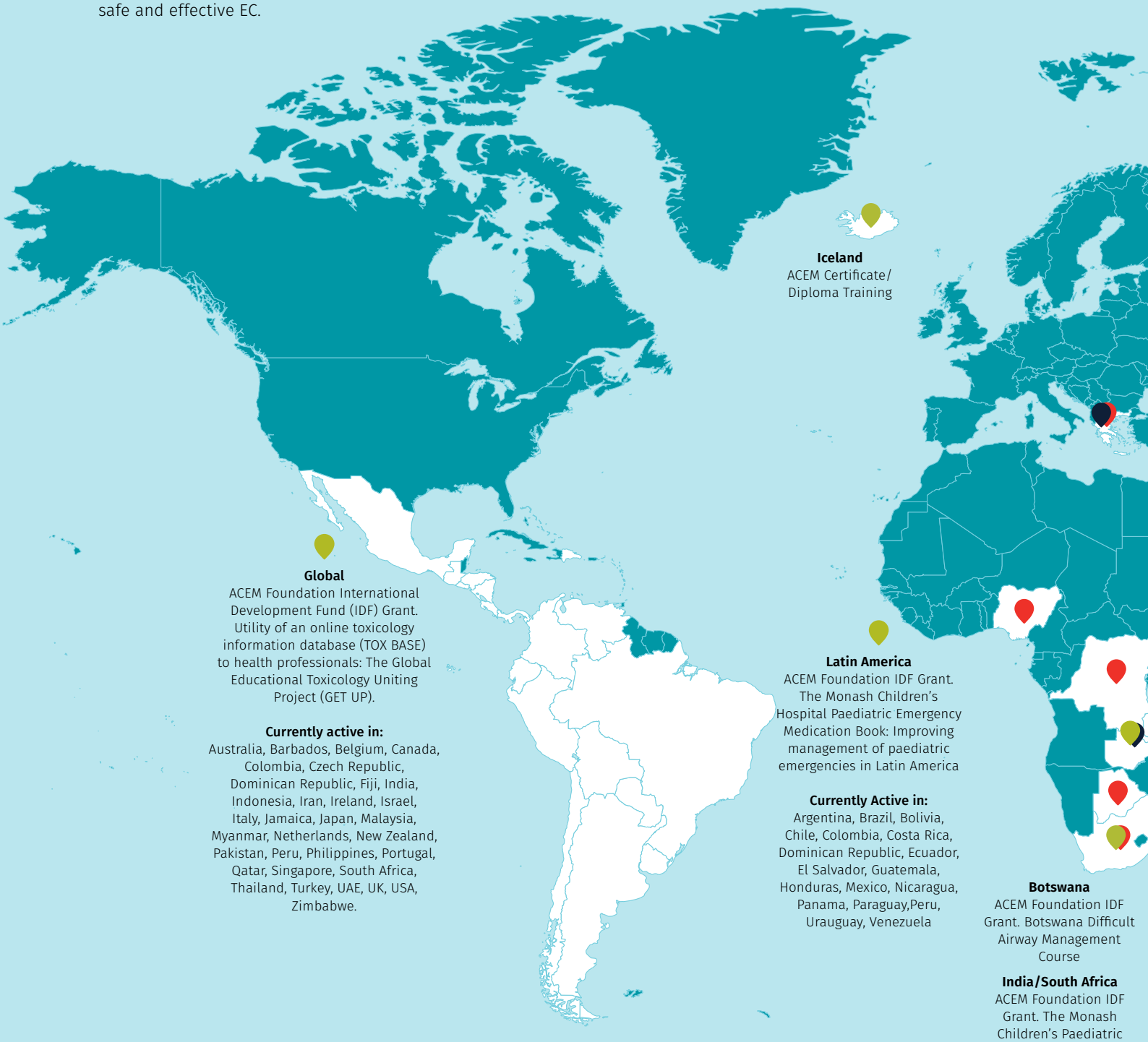
This map features ACEM's 2020-2021 portfolio of work in GEC.

ACEM supported projects and activities are a growing body of work managed by ACEM's GEC Desk focused on building capacity in emergency care in LMICs. This work supports locally-led development and adheres to best practice in volunteering for development.

GECCo's 37 Country Liaison Representatives (CLRs) are in 32 locations and act as a point of linkage between local providers of EC and ACEM to facilitate discussions and opportunities to support LMICs countries to deliver safe and effective EC.

Fellows in the field (FIFs)/ trainees in the field (TIFs) are individuals supporting GEC activities independently of the College. We link in with our FIFs and TIFs and share information via our GEC Network.

If you are a FIF or TIF and do not see the geographical location of your work reflected on this map please reach out the GEC Desk at **GECNetwork@acem.org.au**. We would love to hear about your work in GEC.



Iceland
ACEM Certificate/ Diploma Training

Global
ACEM Foundation International Development Fund (IDF) Grant. Utility of an online toxicology information database (TOX BASE) to health professionals: The Global Educational Toxicology Uniting Project (GET UP).

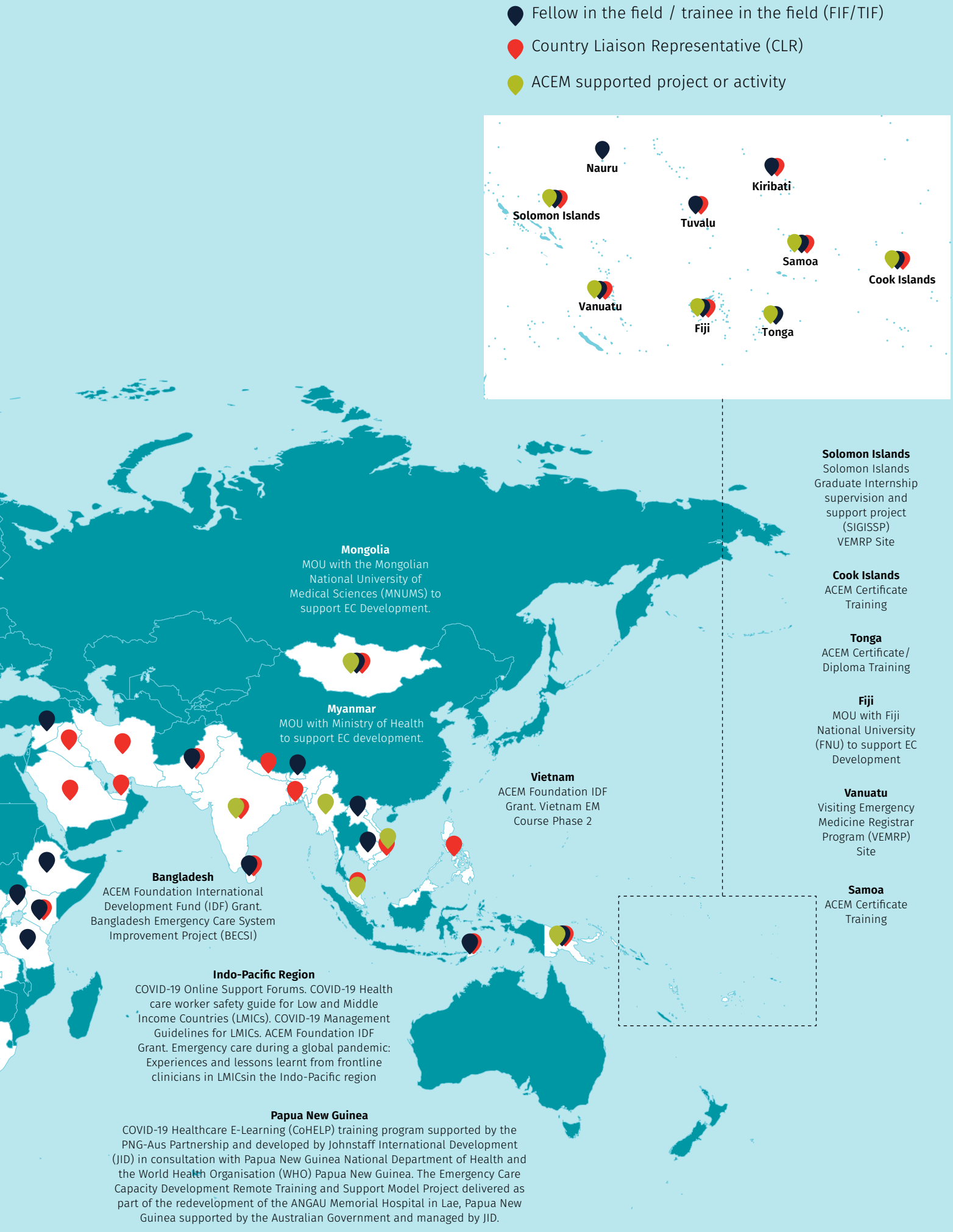
Currently active in:
Australia, Barbados, Belgium, Canada, Colombia, Czech Republic, Dominican Republic, Fiji, India, Indonesia, Iran, Ireland, Israel, Italy, Jamaica, Japan, Malaysia, Myanmar, Netherlands, New Zealand, Pakistan, Peru, Philippines, Portugal, Qatar, Singapore, South Africa, Thailand, Turkey, UAE, UK, USA, Zimbabwe.

Latin America
ACEM Foundation IDF Grant. The Monash Children's Hospital Paediatric Emergency Medication Book: Improving management of paediatric emergencies in Latin America

Currently Active in:
Argentina, Brazil, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay,Peru, Urauguay, Venezuela

Botswana
ACEM Foundation IDF Grant. Botswana Difficult Airway Management Course

India/South Africa
ACEM Foundation IDF Grant. The Monash Children's Paediatric Emergency Medication Book: Developing Resources for LMICs


Fellow in the field / trainee in the field (FIF/TIF)
Country Liaison Representative (CLR)
ACEM supported project or activity
Nauru
Kiribati
Solomon Islands
Tuvalu
Samoa
Cook Islands
Vanuatu
Fiji
Tonga
Mongolia
MOU with the Mongolian National University of Medical Sciences (MNUMS) to support EC Development.
Myanmar
MOU with Ministry of Health to support EC development.
Vietnam
ACEM Foundation IDF Grant. Vietnam EM Course Phase 2
Bangladesh
ACEM Foundation International Development Fund (IDF) Grant. Bangladesh Emergency Care System Improvement Project (BECSI)
Indo-Pacific Region
COVID-19 Online Support Forums. COVID-19 Health care worker safety guide for Low and Middle Income Countries (LMICs). COVID-19 Management Guidelines for LMICs. ACEM Foundation IDF Grant. Emergency care during a global pandemic: Experiences and lessons learnt from frontline clinicians in LMICsin the Indo-Pacific region
Papua New Guinea
COVID-19 Healthcare E-Learning (CoHELP) training program supported by the PNG-Aus Partnership and developed by Johnstaff International Development (JID) in consultation with Papua New Guinea National Department of Health and the World Health Organisation (WHO) Papua New Guinea. The Emergency Care Capacity Development Remote Training and Support Model Project delivered as part of the redevelopment of the ANGAU Memorial Hospital in Lae, Papua New Guinea supported by the Australian Government and managed by JID.
Solomon Islands
Solomon Islands Graduate Internship supervision and support project (SIGISSP)
VEMRP Site
Cook Islands
ACEM Certificate Training
Tonga
ACEM Certificate/ Diploma Training
Fiji
MOU with Fiji National University (FNU) to support EC Development
Vanuatu
Visiting Emergency Medicine Registrar Program (VEMRP) Site
Samoa
ACEM Certificate Training

Dr Anoushka Perera

Why emergency medicine?

Interestingly, I didn't enjoy my ED rotation as a medical student – I found it "haphazard" and it didn't appeal to my sense of order and "neatness".
As an intern however, my second rotation was in the Mildura ED and there I found my spiritual home. I'll always remember the day I put in an ICC then treated someone with complete heart block and someone with status epilepticus, all the while, seeing patients with minor injuries and illnesses. I was struck by the broad skillset and knowledge base that EM physicians had to have along with the ability to recognise significant illness, while ensuring that every patient's complaint, no matter how minor, was given the fullest attention so patients felt heard. The generalist nature of our work means it is never boring, the need to continuously problem solve keeps the brain working hard and the ability to have an immediate effect on people by sometimes doing quite "minor" things is rewarding and something quite unique about emergency medicine. I was hooked!

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

An inherent power imbalance tends to exist between the ED and the rest of the hospital. There is the perception that the ED is "always asking for something" – a review of a patient, an admission, an investigation. There is not always the acknowledgement that we are the one department in the hospital that can't close its doors because it is full. Those who have come before us in EM have done an amazing job of educating others as to what our skillset is and how the ED fits into the larger health system but there is still work to be done in this sphere. Change in the public hospital system often happens at glacial speed and it is challenging to continuously deal with issues of access block and overcrowding, or less than ideal interactions with other staff in the hospital. My goal for hospitals is to realise that every department is one cog in a giant machine and in order for it to work, we have to co-ordinate and collaborate rather than work in isolation. The best part of EM is working in a team of people who are all striving for the same thing – great patient care in a timely manner. There's something quite amazing about watching the team lift when the surge of patients occurs. The knowledge that you are all in this together and have each other's back makes the ED a really special place to work. When it's 3am and you're wading through the list of patients and someone brings you a cup of tea because they think it might help, you really understand what it is to have a work family. They make the job what it is.

What do you do to maintain wellness/wellbeing?

I've never been very good at sitting still or meditating, so over the years I've had to find other ways to "quiet the mind". Packing up and getting physically away from work, camping or hiking in remote Australia, where access to devices is nil and fresh air and the sound of nature is plentiful, is the ultimate way for me to find calm and relaxation.
As life can't be one big holiday, on a day to day basis, fresh air, exercise and getting to bed early when I can, are the things that keep me going. Spending time with friends and family helps keep me grounded and reminds me that there is a whole world going on out there, particularly when work matters seem to dominate my thoughts.

What do you consider your greatest achievement?

While winning three spelling bees at school was the peak of my academic career until I achieved my FACEM, officially I would have to say running a half marathon in the Melbourne Marathon Festival in 2011 and getting to do a lap of the 'G' in the final 400m. As a self-assessed non-runner, completing this event without stopping at any stage, felt amazing and I was filled with such a sense of achievement.

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

In 2020, the intern group at our hospital nominated me for the PMCV educator of the year in Victoria and I was extremely humbled to win this award. It was based around my work in orientation for our emergency department and I feel glad to know that this program that I've developed has helped them feel a bit less nervous about working in our busy ED.

What inspires you to continue working in this field?

Ultimately, the thing that keeps me going back is the service that we provide to the community. A lot of what we do is not strictly "emergency" work, but we are a place for any person with any problem to come for help and for some, we are the only place for them to access care. It feels good to be part of the solution for so many people.

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

Fight the battles that actually need fighting and let the rest fly over you and not bother you so much.
Remember that change takes a while but that doesn't mean you shouldn't keep striving for it.

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

A growing involvement in a wider solution to what is plaguing our health system – over demand and under resourcing. emergency medicine staff have a bigger picture way of thinking and a solution focused mindset and this should be harnessed by those who ultimately make the big decisions. Many people within our specialty and within ACEM have been gradually getting us more involved at higher levels of government. This work has been so impressive, and the instigators should be congratulated for putting us in the frame. I look forward to all of us having a part to play in the improvement of our service and the public health system as a whole.

Para-d'isolation

Sophie Knott
Sophie is a British Nurse and Paramedic with a background in emergency and critical care. She now works in Aeromedical Retrieval and calls Australia home.

'Doctor, nurse or paramedic wanted for private resort on a paradise tropical island off Madagascar.'

My eyes lit up when I came across this dream posting and, without a second thought, I threw my name into what was undoubtedly a very large hat. For a single position with an international and multidisciplinary pool, I never expected to hear anything more of it. I'm a British-trained ED nurse and paramedic, happily employed with NSW Ambulance Aeromedical. Still, I'm always ready for the next adventure. To my surprise, I was shortlisted for the position, had a few phone interviews and was offered the job, with just a few weeks' notice.

In October 2019, I enjoyed a blissful six-week placement in paradise, providing on-call medical cover to guests of the exclusive private island, first aid training to the staff, and basic medical cover to the locals. As the helicopter transported me back to the mainland of Madagascar for the mammoth journey home, I couldn't believe my luck to have been gifted such an opportunity in this incredible corner of the world.

In February 2020, I received another unexpected call asking if I'd like to return to paradise for three weeks in March while they waited for the long-term recruit to become available. While the heat had dissipated from our catastrophic bushfires, there were whispers of an emerging respiratory illness in countries beyond our shores, but somewhat off the Australian radar. So, completely oblivious to the imminent global health crisis and without further ado, I jumped at the chance for another visit to paradise. Who wouldn't?

By the time I reached the island five days after leaving Sydney, it was apparent that there was a significant shift in the global situation. I was given 24 hours' notice to leave Madagascar before the international airport closed. Faced with the ethical dilemma of leaving the island staff and locals with no medical coverage during an evolving pandemic and the sheer logistical challenges of trying to leave, a non-decision ultimately resulted in the decision to stay on the island, still oblivious to the true magnitude of what lay ahead.

With international borders closed and no incoming tourists, the hotel mothballed into hibernation, with significant employee redundancies. The island went into survival mode. Those who had somewhere safe to stay on the mainland were relocated to reduce the demand for incoming supplies and improve their access to government health facilities. When the dust settled, 150 people remained on the 5km^2 island while I frantically attempted to source an oxygen cylinder and PPE.

Villages on the island have simple wooden houses with no electricity or water and a drop toilet shared by the entire community. Preventing community transmission would be near impossible if the virus reached the island; prevention was the only option. As an ED nurse at heart, infection control was never high on my list of joys, but became critical as the pandemic developed. I was reliant upon online information provided by the World Health Organization (WHO), the Africa Centres for Disease Control and Prevention (CDC), and ACEM Indo-Pacific webinars. I wrote and revised policies and guidelines endlessly, hopeful that people would read them.

With careful planning, we reduced food and fuel supply deliveries from the mainland to fortnightly, with an extensive bleaching process for all items brought ashore. We placed the disgruntled boat crew into quarantine in the closed village school. To create jobs for the island residents, we sourced materials from the mainland and taught individuals to sew masks, in preparation for what seemed an inevitable addition to island life, but thankfully, were still avoiding at that stage. Additional employment opportunities were created with a temporary school to provide childcare and education for the children, while the government-funded school was closed and parents worked.

While the infection numbers slowly crept upwards on the mainland, predominantly in the southern capital of Antananarivo, the days passed without significant incident on the island. Routine medical complaints included gastrointestinal upsets, simple wounds (albeit one caused by an axe), and infected insect bites and tropical ulcers. Pregnant mothers were shipped to the mainland, as was one suspected case of typhoid.

What would I tell my February self? Buckle up for the adventure of a lifetime and you're going to need a jumper.

The worst injury sustained was, in fact, my own, after an inversion injury rendered me non-weight bearing with a suspected fracture. I fashioned a makeshift CAM boot in lieu of an X-ray or plaster. The nearest hospital is three hours by boat and then three hours driving on unsealed, often flooded roads. The island resort operates a helicopter service for guests. But this was unavailable as it awaited inspection by an accredited engineer, who was unable to reach us due to the mainland lockdowns.

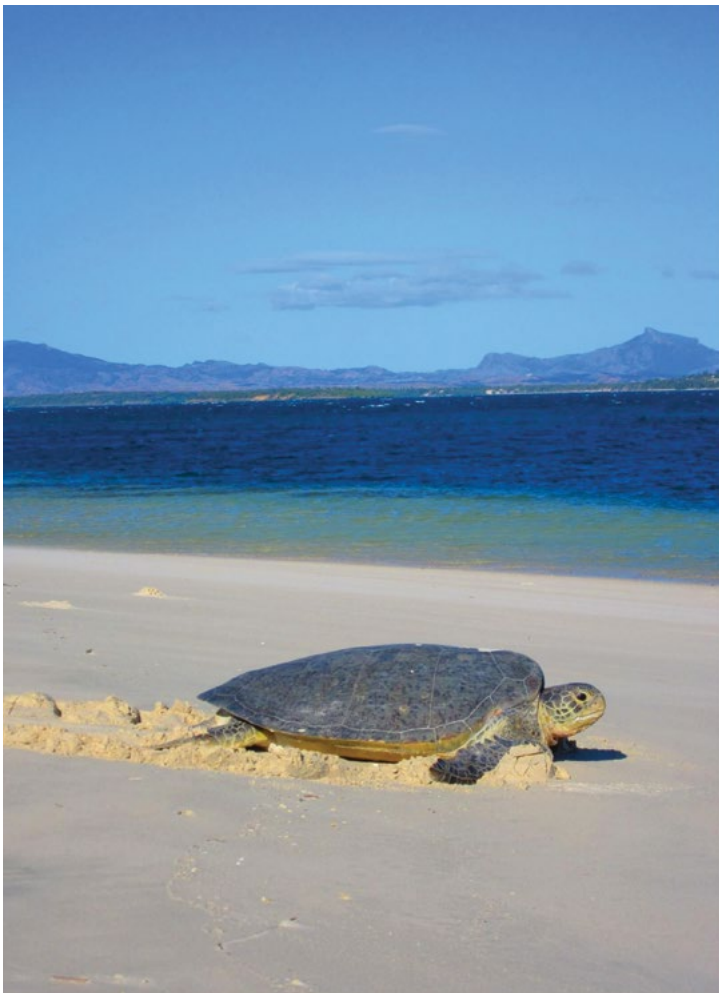
The windy, wintry season arrived in June, bringing with it significantly cooler temperatures, cold winds, grey days and rough seas, making the boat crossing increasingly challenging, ocean swimming a lot less enjoyable, and my very limited wardrobe options entirely inadequate!

When I wasn't busy with island work, I worked on my Master's degree and some research publications, but knew that I also needed to look after myself. When I was feeling down, spending time playing, singing and dancing with the village kids rarely failed to lift my spirits. I relied on the support of friends and family around the world via our patchy internet connection, threw myself heavily into exercise, and practiced tai chi and yoga. I read endless books, listened to music, immersed myself in nature, watched sunrises and sunsets almost every day from the beach, and did A LOT of thinking.

Since the initial closure of the international borders, there were occasional repatriation flights to France and South Africa, but these all departed from Antananarivo, which would require a three to five-day journey considered too unsafe by the British embassy. All the while, battling my conscience and the ethical dilemma of leaving remained. By August, my mental health was an increasing battle and, when Air France announced the first flight from the northern airport to connect to a flight to Paris, I made the difficult decision to take it and visit my family in Europe on the way back to Australia.

The transition from island life to European society was dramatic. As I witnessed the true impact of COVID-19 first-hand, I felt like I'd landed from Mars as I experienced for the first time the restrictions which most people were now used to. It's lucky that I had become so practised in spending time alone because after two weeks isolating in the UK, France and then the UK again, and four cancelled flights to Australia, I finally made it back to Sydney and had another two weeks in hotel quarantine. I missed the ocean but enjoyed the food choices and Wi-Fi. I continue to practise gratitude and put perspective back in my 'normal' life.

What would I tell my February self? Buckle up for the adventure of a lifetime and you're going to need a jumper.



ACEM Year in Review 2021

With the hope and determination that this year's Annual Scientific Meeting (ASM) would be delivered as a hybrid event, it became apparent over the months leading up to the event that the vision of bringing the emergency medicine community together in Otautahi was not going to be possible. The decision was to cancel the ACEM 2021 ASM and have our colleagues join us for the Year in Review 2021 online event held on Tuesday, 9 November 2021.

With FACEM Dr André Cromhout welcoming participants to the event, over 400 attendees logging on to take part in a day full of incredible hours of reflection, celebration and learning, featuring engaging guest speaker presentations from Magistrate Harriet Grahame and FACEM Dr Mark Garcia. Magistrate Harriet Grahame explored how the Coroner's office can advocate for improvements in the healthcare system and the advancement of broad social justice issues that impact the health of individuals and communities, and Dr Garcia explored innovation and improving learner engagement in emergency medicine education and training.

The College acknowledged and congratulated those members who were awarded an ACEM Distinguished Service Award in 2020 and 2021. The award recognises significant high-level service to an area or areas of activity of the College, and contributions that support the College in delivering core functions at an exceptional level over a period of time.

Presidents' reflection and handover

It was not the traditional presidential handover at ACEM; the virtual event provided a poignant opportunity to hear final words from Dr John Bonning as President and to welcome President Dr Clare Skinner.

Dr Bonning has provided wonderful leadership over these past two years in some truly extraordinary circumstances. His final messages were of hope, comfort, and confidence.

Dr Skinner spoke of renewed opportunities and returning challenges as the College continues to advocate for structures and systems that better enable and support the delivery of equitable emergency care, while confronting the challenges of COVID-19, climate crisis, and others.

Guest speakers and performers

The College gives special thanks to the guest speakers and performers who are enormously talented musicians (and physicians!) on the day (in order of appearance):

- Magistrate Harriet Grahame
- FACEMs Dr Kathryn Clarke, Dr Kim Yates and Dr David Schaevitz (Dream a Little Dream)
- FACEMs Dr Michaela Mee, Dr Rachel Lind and Dr Gerard O'Reilly (Tchaikovsky's Andante Cantabile from his String Quartet No.1 (Opus 11)
- FACEM Dr Mark Garcia
- FACEM Dr David Mai (Rona – a Quarantune)

The online delivery and access to on-demand content during and after the event was extremely well received.

A special thanks must go to the Year in Review working group comprising of Dr Bonning, Dr Skinner, Dr Barry Gunn, Associate Professor Didier Palmer, Dr Kate Field, Dr Kimberly Humphrey, Dr Harriet Jennings, Dr Shannon Townsend, Robert Lee, Lyn Johnson and Dr Peter White. Individually they stepped up to put the program together at short notice and played a significant part in facilitating the online event.

As we take learnings from achievements throughout 2021, the College now looks forward to delivering the International Conference on Emergency Medicine (ICEM) 2022 in Melbourne as a hybrid event. ACEM looks forward to welcoming you to ICEM in 2022 in-person or online.

Assistance program

ACEM Assist

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

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