Society News

Newsletter of the Australasian Society for Emergency Medicine Inc

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# Don't forget your flu vaccine!

## Editorial

Dear Readers,

Whilst Winter brings coughs, colds and the flu, I hope it has also given you a chance to enjoy a nice cup of hot tea, a warm blanket and perhaps even a trip or two to the local snowfields!

Anecdotally, Winter sees an increase in the number of patients presenting to Emergency Departments across Australia. In particular, we see an increase in the number of patients with exacerbations of respiratory illness, most commonly asthma and COAD. Whilst the message should be a year-long one, this is the time to ask your patients 'Have you had your flu vaccine?'. Don't forget the pneumococcal vaccine for high risk groups!

Secondly, another timely reminder is to remember to wash your hands! Whilst as doctors, we are all dedicated to patient care, we ultimately must take care of ourselves to be the best we can for those who depend on us– both at work and at home.

The second edition of the ASEM newsletter reports back on some of the areas ASEM had decided to pursue since the publication of the last newsletter.

Of note, ASEM has begun communicating with AMSA, the peak organisation representing medical students across Australia. A position has been offered for a student member to sit on ASEM council as well as working together on promoting Emergency Medicine as an interesting specialty that offers broad clinical experience, variety and work-life balance. AMSA has been very receptive to forming a relationship with ASEM and we hope that together, the two groups can have a productive partnership.

Cerner First-Net is currently being reviewed by the NSW Department of Health with regards to its effectiveness and its implementation. As Cerner now has commenced in Victoria, with roll outs at Austin and Peninsula Health, ASEM will await the final report with great interest. Whilst it is generally agreed that an electronic health system will offer opportunities to provide care for patients in a whole new way, care must be taken to ensure the systems implemented are usable, effective and ultimately safe for patient care.

Once again, I invite ASEM members to contribute to the Newsletter. I'd like to thank everyone who has contributed to this edition, in particular, Dr Peter Roberts, who has written a number of the articles in this Newsletter– thanks Peter!

Happy Reading!

Dr. Joe-Anthony Rotella

## Inside this issue:



## Contributions

Contributions are actively sought from all ASEM members. These could encompass talks attended, significant issues both on local or national scale, worthwhile websites and can be in any form from a letter to the editor to a more formal article. Failing that, emails to the editor would also be gratefully accepted for inclusion in the Society News.

# President's Report

As the end of the financial year gathers, the Society hopes that you all will add ASEM to the list of your renewals. We remain committed to the practice of Emergency Medicine in all its iterations and hope to attract a new set of members from the pool of recent graduates, who may be looking at Emergency Medicine as their area of choice. In addition, we hope to introduce medical students to ASEM through a collaboration with AMSA. Council is also looking to strengthen our cross -Tasman ties with a more regular conversation with AMPA, as well as interested FACEMs.

The quarterly newsletter has seen its first edition by our new Editor, Dr. Joe Rotella and contributions from members are encouraged. Well done, Joe. It takes a fair bit of effort to complete each new one, and the newsletter remains a valued part of your subscription.

The website is updated regularly, and I encourage you to have a look on a regular basis to see what the Society is up to. Council teleconference minutes are added each time. Zoe Russell co-ordinates the website for us and continues to update and improve it to make it more relevant to our membership.

I think ASEM's future requires we reach out to junior doctors, who will became the clinicians of the future. In order to do so, we need to remain relevant and will need to consider using the social media now widely used, in addition to the website alone. I had a look at the AMSA website and found Twitter, Facebook and RSS feeds prominently featured as communication tools. I think that you have noticed the widespread use amongst your colleagues, family and children. I have only recently fallen over LinkedIn and am wondering how this might be useful. This will be a future train of discussion.

The Society could not function without its office support, and Georgie Lee has taken over from Maree Mohamed in a seamless fashion.

The topic of 'end of life' care is in the news, with the latest Medical Journal of Australia (*Vol 194, no 11*) looking at the impact and cost of medical care in the last months of life. It is featured in talkback radio, and a consumer group in Queensland is close to presenting a position paper to government. It is a topic worthy of community debate and will need to recognise the conflicting demands of the various stakeholders. With our ageing population, this issue will continue to become more important. And the baby boomer generation will no doubt have its point of view as it starts to utilise these services. Keep an ear, and an eye, out and you will be surprised how often this is mentioned. ASEM should be part of this discussion.

As always, the SSEM will be very popular and I encourage you to arrange your leave and come along to one of the best CME opportunities on the calendar. You are most welcome at the concurrent AGM for the Society to have your voice, and vote, heard!

The annual RVEEH Eye and ENT course is back: follow the link on the website for details (*Ed: A sign-up form is included at the back of this newsletter*). The Society is a proud sponsor and Dr. Carmel Crock is especially keen to provide places to ASEM members, limited to 60 places for each of the days. It is an excellent chance to gain hands on experience with the help of patient volunteers.

ASEM will continue to provide best paper prizes at conferences around the country and these are appreciated by conference organizers and, of course, the prize winners. It may be the only way in which an original piece of research will be recognised.

**Dr. Marcel Berkhout, ASEM President**

# ASEM News and Updates

## National

*Heat Wave Contingency Planning*

Dr Rick Lowen (ASEM Honorary Secretary) represented ASEM at a teleconference discussing health issues relating to heat waves. The teleconference was chaired by Price Waterhouse Cooper, who has been commissioned by the Government to collect information on various aspects relating to the issue and present recommendations to COAG.

Dr Lowen discussed the following points:

- The health impact of heat waves is enormous in terms of lives lost as well as the burden of illnesses suffered and the consequence of the both on hospital emergency departments (EDs), ambulances services and mortuary/Coronial services
- The demographic group most at risk are the elderly - many of whom are residents of aged care facilities
- The key trigger to plummeting mortality in heat waves appears to be as short as 2 consecutive extreme heat days (>40°C) WITHOUT overnight cooling off (<25°C)
- Such extreme heat days (if predicted) should be declared as "Extreme Heat Emergencies" under existing State Emergency Management legislations
- Detailed heat wave emergency plans should be developed by DOHs who should act as lead "combatting" agencies during declared "Extreme Heat Emergencies"
- Such plans should, like the Californian heat wave contingency plan, cover all aspects of heat wave emergencies from the health perspective including mitigation, planning, activation, response, recovery and debrief.
- Much has been done already since 2009 on the planning side of things in regards to the issuance by DOHs of: Heat Wave alerts; heat wave information sheets ;and to variable but rudimentary levels - the development by Municipal Councils of registers of the aged vulnerable, as well as systems of telephonic contacts of same during heat waves
- Since the prevention of overheating during heat waves relies so heavily on the integrity and surge capacity of the electricity grid (which failed in 2009), contingencies need to be in place to designate safe cool places where the at risk (but well) could gather. Large shopping centres (with independent power generators) would seem an ideal choice but their participation would require discussion with government and integration into local heat wave plans. Safe cool areas could be professionally supported under existing State emergency arrangements by first aid agencies such as Red Cross or St Johns
- Strategies to prevent overburdening of emergency departments should, in my opinion, include the establishment of pre-hospital treatment or "Rehydration" centres at which milder cases of heat stress and dehydration of cases (not requiring hospitalization), could be attended by medical, nursing and paramedic teams. Arrangements for this also exist under most State emergency medical plans e.g. SHERP (Vic) though the establishment of these runs counter intuitively to the day to day philosophy of ambulance services to LOAD, GO and unload at EDs
- Little has so far been done by the Commonwealth's DH&A for days of declared heat emergencies in terms of addressing building design issues, mandating increased staffing levels, monitoring ambulant temperatures in NHs, possible resident evacuation fro NHs with power outs, reviewing resident fluid and medication requirement in aged care facilities. Simple initiatives to manage temperature control in aged care facilities such as opening windows at night, using curtains to screen direct sun from resident's rooms, use of fire doors to maintain "cool" areas etc. which were tried at some facilities during the 2009 heat wave and worked well

ASEM will report on the eventual study report.

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*ASEM joins forces with AMSA*

ASEM has been in communication with the Australian Medical Students' Association (AMSA) with regards to involving medical students with an interest in Emergency Medicine in the Society's activities. AMSA is the peak organisation representing medical students across Australia.

ASEM has offered complimentary ASEM student membership to all members of AMSA, a position for a student member on ASEM Council in addition to working with AMSA to promote Emergency Medicine as well as identify issues relating to Emergency Medicine that affect medical students now and as future graduates. The response from AMSA thus far has been quite favourable and we look forward to reporting back in future about the outcome of ongoing discussions.

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# ASEM News and Updates...cont'd

## National

The Australasian College for Emergency Medicine plans to roll out the Emergency Medicine Certificate (EMC) course in late July 2011. EMC candidates should approach a supervisor who can sign the application form for the candidate to enter into the course. Hospitals that have EMC supervisors are listed on the ACEM website, www.acem.org.au

## New South Wales

Dear ASEM Member (NSW),

Winter is approaching! Below is an extract from a letter dated sent by Dr Tim Smyth, Deputy Director-General Health Systems Quality Performance and Innovation.

*"Although there is not usually a significant rise in numbers of patients requiring hospital services during winter, NSW hospitals traditionally see an increased Length of Stay (LOS) for selected groups of patients, particularly those with chronic illness such as cardiac and respiratory conditions. For this reason, managing planned and unplanned seasonal variations, such as during winter, is an important part of predictive planning. As with previous years, NSW Department of Health requires Health Services to document clear strategies to manage demand across the winter period. There is also a requirement to consider the potential impact that seasonal influenza may have on Emergency Departments and ICU bed usage, which leads to increased capacity pressures on the health system."*

I am very interested in the report that states that there is "not usually a significant rise in the number of patients requiring hospital services during winter." This does not seem to reflect actual Emergency Department experience. There has certainly been an impact of "seasonal influenza" in past years.

FirstNet is still a concern. The NSW Health Department has recently launched the "Second wave" of the Personally Controlled Electronic Health Record. This is a major project to electronically link medical information from all hospital departments, General Practice and Community Health Services. The concept is admirable. However, the system depends on receiving data from FirstNet. As has been previously discussed, this data is not universally reliable even when an attempt is made to utilize FirstNet as an electronic record.

A further comment on FirstNet by Professor Jon Patrick- *"Since my last report on FirstNet I have received new information from doctors around the state on the use of FirstNet. This is caused me to review my initial recommendations for the worse'*

The available document can be found at item 3.12 at the address: http://sydney.edu.au/engineering/it/. Professor Patrick can be contacted at jon.patrick@sydney.edu.au

The Spring Seminar on Emergency Medicine will be held in Launceston, Tasmania (Sept 27th to Sept 30th 2011). ASEM offers a voucher for $100 off the cost of registration to ASEM members who are financial after July 2011.The voucher must be presented to SSEM at the time of registration.

If you have any issues to raise via ASEM, please contact me at gayle_mcinerney@wsahs.nsw.gov.au

Regards
**Dr. Gayle McInerney, NSW Councilor**

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*Regarding FirstNet*

The Minister for Health and the NSW Department of Health have commissioned an independent review of the Cerner FirstNet system and the effectiveness of its implementation. The purpose of this review is to assess the criticisms raised and advise the Minister on the continued use of the Cerner FirstNet system as a core component of the electronic medical record. The Review will report back to the Review Steering Committee and will be completed in July 2011.

*Source: Independent Review of Cerner FirstNet ED System. June 2011. Health System Quality, Performance & Inovation Division eHealth & ICT Strategy Branch, NSW Health*

# Congratulations to Dr. Anne D'Arcy OAM

ASEM would like to congratulate Dr .Anne D'Arcy on receiving an OAM in the general division of services to Emergency Medicine during this year's Queens Birthday Honours. Anne was an early member of ASEM and ASEM would like to recognise her achievement and congratulate her on this immense honour.

Whilst retired, Dr. D'Arcy is still involved in Emergency Medicine but instead of running the Department, she contributes selflessly as a volunteer at St Vincent's Hospital Emergency Department in Melbourne, Victoria. Her efforts were recently recognised in an article in the Age, which can be found at www.theage.com.au/victoria/retired-doctor-keeps-on-giving-20110612-1fz8e.html#ixzz1QSlt3SUa

The following bio is taken from the RMH archive and can be found at: www.mh.org.au/royal_melbourne_hospital/anne-d-arcy/w1/i1021218/

Dr. Anne D'Arcy was Director of the RMH Emergency Department from 1978 to 1995, and had a distinguished career in accident and emergency services both in Australia and overseas.

Her career achievements included being a Foundation Fellow of the Australasian College for Emergency Medicine (ACEM), a Fellow of the Royal Australian College of General Practitioners (RACGP), and receiving the prestigious Women's Achiever Award from the Women Chiefs of Enterprise in 1992.

Anne Francis D'Arcy was born in Melbourne on 16 June 1938, and was educated at Loreto Covent, Toorak, matriculating with Honours in 1955. She completed her medical studies at the University of Melbourne in 1961. She spent two years working as a junior doctor at St Vincent's Hospital, Melbourne, before going to Kuala Lumpur in Malaysia for three years, as a doctor and lecturer. She returned to Melbourne in 1967 and worked as a sessional medical officer in casualty departments at the Royal Children's Hospital, Preston and Northcote Community Hospital (PANCH) and the Queen Victoria Hospital, as well as taking general practice sessions.

In 1976, Dr D'Arcy became Director of Casualty Services at PANCH, and the following year was made Director of Emergency Services at Dandenong and District Hospital. She then became Director of Emergency Services at The Royal Melbourne Hospital in 1978, at a time when she was the only full-time specialist physician, and emergency medicine had not emerged as an important specialty in hospitals. She was also a Senior Associate in the Department of Medicine, Melbourne University.

Other roles included: Area Medical Coordinator, Health Department, Victoria (1991-95); Vice President, Australasian Society for Emergency Medicine (ASEM) (1982-85), and Vice President, ACEM (1984-89), and President of the Association of Casualty Supervisors of Victorian Hospitals, later known as the Victorian Emergency Department Association. She was also a member of the RACGP's Emergency Medicine Subcommittee.

She was a short-term consultant with the World Health Organization, on Trauma and Emergency Care in Malaysia in 1986, and in 1987, represented ACEM at meetings in the US with the Society of Teachers of Emergency Medicine and the University Association of Emergency Medicine.

After retiring from her position at RMH in 1995, Dr D'Arcy for eight weeks was the medical officer on the ship Aurora Australia on a trip to Antarctica. At other times, she was a District Medical Officer at Derby Hospital, Western Australia, with Royal Flying Doctor Service and remote area clinics; and relieving in Emergency Departments at Mildura Base Hospital, Queen Elizabeth Medical Centre and The Valley Private Hospital.

Dr D'Arcy married Mr J Quay in 1964 and had three children: John, Julie and Justin.

*Source: Dr Anne D'Arcy*

# Opinion– Education Emergency?

How on earth did we get into this mess?

All over Australia and New Zealand, if you have an operation, it is done by someone with a degree in the field or directly supervised. If you see a GP, they have specific training in the field. But if you have a medical emergency, it is Russian Roulette randomness outside the major centres. And most medical emergencies are treated outside the major centres.

Some of the doctors you meet are experienced, knowledgeable, up to date with their continuing medical education, and have sought out work experiences and educational resources to keep them functioning at a level that gives patients wonderful outcomes. And sometimes you meet Bozo the incompetent. Short of employing specialists for every job on every shift, the hospital just doesn't have a practical way of knowing if the doctor is up to the task. There are diplomas in obstetrics and paediatrics and other specialties, but so far, not in emergency medicine.

But there are some bright spots on the horizon. In New Zealand, there are accident medical practitioners and MOSSes. These have specific training and an employer can see if they are qualified or not. And the Australian College of Rural and Remote Medicine certifies some people as being competent to treat undifferentiated emergencies. In Queensland, holding this certification can lead to a higher rate of pay. In NSW, the Hospital Skills Program seeks to provide some continuing education for long-term non-specialist doctors working in public hospitals.

For a long time, ACEM resisted having a second tier of emergency doctor. Be specialist or nothing. But now they are beginning their certificate and diploma programs. Who knows if the development of alternative pathways they didn't control changed the institution's mind. But they have now set up some serious education for junior doctors; with on-line material, a detailed syllabus, and requirements to complete the (ASEM developed) ELS course, as well as anaesthetics and critical care terms for the diploma.

Of course, to really be safe as the senior in an emergency department, ready to manage the team as well as the patient, and deal with whatever turns up, needs much more experience and education. Universities might step in to fill this role, with masters degrees that can formalise a qualification while a non-specialist doctor gains ongoing experience.

If it all comes out in this way, certain positions will need grandfather arrangements, but it won't be another college. This is modular, continuous, respectful of prior learning, and general. College fellowship is "all or nothing", cutting edge, peak level, and specialist.

Hopefully, eventually, medical boards will insist on ongoing continuing medical education and employers will insist on qualifications. It could easily go the other way, with employers seeing the tsunami of interns as a chance to force young doctors to accept working in an unsupervised uneducated fog of risk, replaced by limitless colleagues if they trip. Let us hope the medical community uses the sudden appearance of job applicants to produce quality rather than cost savings.

**Dr. Peter Roberts, NSW Councilor**

**What do <u>you</u> think about the state of education in Emergency Medicine?**

**Send your thoughts to traineevic@asem.org.au.**

**Best responses will published in our next newsletter**

# ACEM11

## Educating for our future

## Australasian College for Emergency Medicine 28th Annual Scientific Meeting

The organising committee of the 28th Annual Scientific Meeting of the Australasian College for Emergency Medicine in Sydney extends a warm invitation to you to attend a memorable event to be held in **November 2011**.

The theme of the meeting is ***'Educating for our Future'*** and keynote speakers; Professor Ronald Harden, Dr Susan Promes and Victoria Brazil are internationally recognised for their expertise and contributions to the field of medical education. In addition, we have a large number of prominent local speakers who will lead meeting streams that are of major interest to delegates.

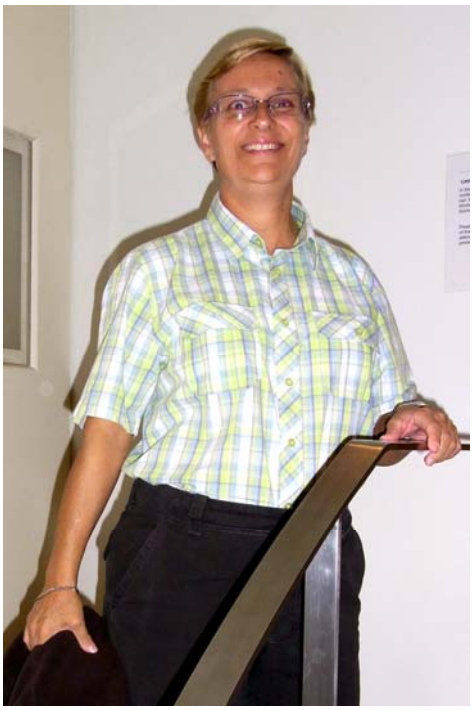
A highlight and a first to this year's program is the SimWars competition allowing four emergency trainee teams the chance to compete against each other in a simulated clinical environment with live audience participation.

As well as a stimulating program ASM 2011 will also feature an exciting social program with opportunities for delegates to network and socialise at one of our many functions such as the gala dinner being held at the iconic Luna Park.

The ASM 2011 will be held at the Sydney Convention and Exhibition Centre and is an opportunity to experience the wonders and sights of Sydney and engage in our local friendly hospitality.

**For more information, including the program at a glance and to register visit www.acem2011.com or contact the meeting secretariat on +61 2 9213 4063 or info@acem2011.com.**

# ASEM Councilor Profile: Glenda Wilson



For those who don't know me or the Royal Flying Doctor Service of Australia, in particular Western Operations, the Section that employs me, I will start with some facts.

My name is Glenda Wilson and I am an Emergency Physician (staff specialist - Clinical Training) and until recently Senior Medical Officer at RFDS, Jandakot Base in Perth. As our workload ( and yours, I expect) increases I have gladly handed over the position of SMO to a colleague and taken up the newly created training position, as well as continue to take part in the Jandakot doctors' roster. The latter I share with 21 other full and part time doctors who have a very varied but broad clinical experience, encompassing Emergency Medicine, anesthesia, procedural rural general practice, and critical care including pediatrics and obstetric skills.

Western Australia is the largest state in Australia, covering approximately 2.5 million square kilometers. Its population is close to 2 million, but more than 80 % live in the capital city, Perth. Regarding health care, WA's main problem is that the above results in ALL tertiary medical facilities being located in Perth with none outside the metropolitan area. For example, outside of Perth the next nearest place with ICU staff and facilities, interventional cardiology or surgical subspecialties, is Adelaide (or Darwin, if you happen to get sick in the "Top End" ie the Kimberley). Darwin, however, has no neurosurgical, cardiothoracic or spinal facilities. Neonatal facilities are likewise limited.

The RFDS, Western Operations, has bases with RFDS doctors, flight nurses, our own pilots and administrators in Perth (at Jandakot Airport where our 24 hr Operations Centre is located) , and the remote towns of Kalgoorlie, Meekatharra, Port Hedland and Derby. In 2010 RFDS ( WOPS) carried out over 7500 retrievals by turboprop, jet, helicopter, road and sea. Most patients were referred from hospitals (district and/or regional) to larger centres, more than half to Perth. There were a smaller number of primary ( vs secondary) retrievals taking patients from areas where there is no doctor to regional or tertiary centers. These patients came from locations such as remote nursing posts, mine sites, cattle stations and indigenous communities. We also handled more than 40 000 calls for medical advice from remote areas, and increasingly, rural areas closer to Perth. The latter reflects the nation wide difficulty finding and maintaining procedural GPs in rural communities. The RFDS's workload at our regular GP clinics from our country bases has therefore also increased.

Changes in Medicine as well as in our society, such as the ageing population, has resulted in a huge increase in the number of critically ill patients RFDS is asked to transfer, from around 15% when I started twenty years ago, to now almost 50% of our patient workload. But then, twenty years ago, before my first flight on my own (other than flight nurse and pilot), Dr Stephen Langford, our Director of Medical Services, had said to me " it's just like ICU in a telephone box - one that moves !"

So how did I come to start working for the RFDS in WA, and why have I stayed with the Service that long ? That is another story - so WATCH THIS SPACE !!

**Dr. Glenda Wilson, WA Councilor**

# Conference Reports

**Evidence Review, Terrigal, NSW**

March 2011

The evidence review seems to be firmly in place on the calendar in March at Terrigal, NSW. The serious, detailed review of evidence has proved popular and the event is growing. Or maybe it is the beautiful beachside hotel at the end of Sydney summer.

Rod Bishop kicked off with facts to replace the dogma about AF. Digoxin and magnesium have no effect on rhythm and are not much chop at rate control. Calcium channel blockers slow down better. Amiodarone and Sotolol seem to work at cardioversion and Flecainide may be faster. But DC shock is the thing that really works. ED cardioversion gets more people home in sinus rhythm than the anticoagulate and admit group. Biphasic, 100 joules, paddles at the front and back. But there is no data for or against a time limit like 48 hours for "don't cardiovert without anticoagulation and TOE". In chronic AF, it is anticoagulate and rate control for all.

But he was most interesting on thrombolysis in stroke. He looked at the various trials and reckons combining the big trials, the number needed to treat is 19. It helps up to 4.5 hours but it is risky on warfarin even if the INR is OK.

Richard Paoloni looked at fluid resuscitation. Saline still comes out well in critically-ill patients, and early fluids and inotropes help in septic shock but we still don't know to what end-point. Saline does well in head injury, too. Especially if you prevent a single episode of MAP < 70 because that worsens outcome. The only issue with saline is this hyperchloraemic acidosis. But it doesn't happen if you give less than 30 ml/kg and it is not killing people: the outcomes in this group trend to the better. Maybe this mild acidosis peri-injury is helpful in oxygen delivery to the tissues. Hypertonic saline is no help.

As for blood; having a massive transfusion policy helps even though nobody knows the best ratio of blood products. Hypotensive resuscitation is good in pre-hospital penetrating trauma but if you work in ED, aim for systolic above 100. And if they are burnt, use Ringer's.

Chris Trethewy looked at trauma centers, and it does seem that having a few major ones reduces mortality compared to the NSW style of having a lot of smaller ones.

How tough was the gig for Robert Edwards! He had to look at the evidence behind ultrasound rather than show off great pictures like everybody else does. Well, you get more complete blocks if you use ultrasound for nerve blocks. And for venous access, it lets you get 50% success in 0.3cm vessels. (Just occasionally you puncture the artery instead.) And we are using it (in order) for FAST, vascular access, AAA, rule out tamponade, confirm asystole, pleural effusion, ascites, nerve blocks and abscess drainage.

Most of us reckon we can treat asthma. And according to Steve Doherty, the evidence is we are correct. If it is severe, use early IV Salbutamol, Atrovent, IV steroids. And use an objective measure like spirometry and an asthma plan.

Stephen Asha looked at this question of maybe using D-dimer to screen for dissection…Nope, not ready for prime time.

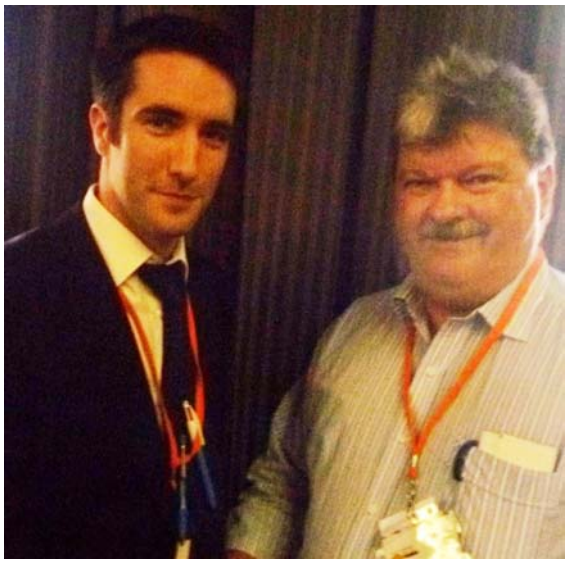
**Dr. Peter Roberts, NSW Councilor**

**Been to an interesting conference in Emergency Medicine?**

**Send your review to traineevic@asem.org.au.**

# Trainees' Section

**Trainee Prize goes South from Queensland Meeting**



ASEM again has been proud to be able to partner the college at the Autumn Symposium 2011 of the Queensland Faculty of ACEM and be able to present the prize for the best trainee presentation.

As in previous years, this meeting attracted emergency medicine clinical staff from both within Queensland and from the other states and New Zealand as well. The meeting over two days covered a range of plenary and workshop based programs. Of major interest to the gathered EM staff was the debate on "My Ramping Rules" which covered a variety of views of how metropolitan, non-metropolitan departments cope with this ever increasing issue. Also on the panel were the Queensland Ambulance Service as well a senior member of Queensland Health executive. The panel certainly engaged in a most vigorous discussion but I am not sure if any solutions were concluded. The workshops covered a variety of topics including an ultrasound workshop, dental emergency workshop, a nursing workshop and a fellowship exam preparation workshop.

There was a significant political acknowledgement of the importance of this meeting with the new Queensland Minister of Health attending to present the latest round of research grant awards from the Queensland Emergency Medicine Research Foundation.

There were eight trainee presentations this year and the trainee prize this year went to a Monash Medical Centre – Clayton trainee, **Christopher Groombridge** (*Ed:* Pictured above on the left with Dr. Brandon, ASEM QLD Councilor). Christopher Groombridge's paper on *Comparison of central venous pressure and venous oxygen saturation from venous catheters placed in either the superior vena cava or via a femoral vein, in an adult intensive care population: The numbers are not interchangeable* was a unanimous choice of the judges who were very impressed with the high standard of Christopher's paper. Christopher's prize was an award of $250 in addition to a complimentary membership of ASEM for the 11/12 financial year.

**Dr. Ian Brandon, QLD Councilor**

# ASEM Comic's Corner

This month, ASEM Comic's Corner takes a humorous look at transcription errors in medical records– think twice next time you write your notes!

- 'The patient has been depressed ever since she began seeing me in 1993'
- 'Discharge status: Alive but without permission'
- 'Patient had waffles for breakfast and anorexia for lunch'
- 'The patient was to have a bowel resection. However, he took a job as a stock-broker instead'
- 'Patient has two teenage children but no other abnormalities'
- 'The skin was moist and dry'
- 'Rectal examination revealed an enlarged thyroid'

# Medical Students' Corner

**Are you interested in Emergency Medicine?**

ASEM would love to hear from any keen medical student with an interest in Emergency Medicine. We would like to know how ASEM could help cultivate your interest in this exciting specialty. Whether it's an informative PowerPoint, a blog to ask questions or something else entirely, send your ideas to traineevic@asem.org.au– Best idea gets a prize!

**Attention all Medical Students!**

Are you a medical student studying in Australia or New Zealand? Are you interested in Emergency Medicine? Then this offer is for you!

ASEM is proud to announce **COMPLIMENTARY** electronic membership to the Society for any medical student studying in Australia or New Zealand!

How?
1. Go to www.asem.org.au
2. Click 'Join Us'
3. Fill out the Annual Subscription form and ensure the box marked 'Student' is ticked
4. Send your form to ASEM, Reply Paid, PO Box 627, Noble Park Vic, 3174

After joining, you will receive a certificate of membership, free access to the Members Only section of the ASEM website as well as an electronic copy of the ASEM Quarterly Newsletter. In future, ASEM aims to offer a host of student-focused resources including information about training, career options, clinical tips and tricks, and competitions.

Dr. Joe-Anthony Rotella is the Victorian Trainee Representative for ASEM and can be contacted at traineevic@asem.org.au if you have any suggestions, questions or ideas

Newsletter of the Australasian Society for Emergency Medicine

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## ASEM Website

After a few technical glitches, the ASEM website is back up and running at www.asem.org.au

Please visit the website for updates on Council events, ELS courses, and news from the states, territories and NZ.

A very useful Links page is being developed by Diane Campbell and members are encouraged to submit suggestions for new links.

Newsletter collated and edited by Dr Joe-Anthony Rotella

**Email:** traineevic@asem.org.au

## ASEM Councilors

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The Royal Victorian Eye & Ear Hospital
caring in every sense

# EYE AND ENT EMERGENCY SEMINAR

The Royal Victorian Eye & Ear Hospital is again offering an Eye and ENT Emergency Workshop for A.C.E.M. Trainees and Fellows and A.S.E.M. members. **The seminar will run over 2 days Thursday 1st and Friday 2nd September 2011**. In addition, there will be an optional practice examination on Eye / ENT emergencies (VAQs and SAQs) for pre fellowship trainees.

The Seminar will offer the opportunity for participants to draw upon the expertise of our colleagues in Ophthalmology and ENT surgery as their specialties relate to our practice of Emergency Medicine. **It is accredited for 0.5 MOPS points per hour by ACEM.**

**Topics for the Eye Emergency Day will include** – Ophthalmic History Taking, Corneal Emergencies, Eye Trauma and Sudden Loss of Vision and:
**Topics for the ENT Emergency Day will include** – The ENT Examination, Otological Emergencies, Epistaxis, Airway Emergencies and Faciomaxillary Trauma.

Participants may register for either or both days. The number of places at both days is limited to 40 in order to allow for the practical demonstration of the use of a slit lamp involving clinical cases and ENT practical workshop.

**RSVP by Friday 5th August 2011. Please phone to confirm your placement prior to sending payment.** Confirmation of placements will be mailed or emailed along with a timetable for each day. **Please complete details on the reply slip below. Payments can be made by credit card, cheque or money order.**

**For further enquiries please contact:**
Loredana De Simone on 9929 8941 or loredana.desimone@eyeandear.org.au
Dr Carmel Crock on 0449 508 828 or carmel.crock@eyeandear.org.au

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Royal Victorian Eye & Ear Hospital
Attention: Loredana De Simone
C/- Medical Workforce and Support Unit
Locked Bag 8
East Melbourne Vic 8002

**Name:** .....

**Address:** .....

**Email address:** .....

**Contact phone number /mobile:** .....

**Hospital:** .....

**I wish to attend**
- ☐ both Eye & ENT Days $275.00
- ☐ Eye Emergency workshop only $190.00
- ☐ ENT Emergency Day only $165.00
- ☐ Practice VAQs & SAQs no additional charge (Registrants only)

**Payment options:** Cheque ☐ Money order ☐ Master card ☐ Visa ☐

**Cheque/money order to be made payable to the Royal Victorian Eye & Ear Hospital**

Card number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiry date ____/____

Name on card: ..... Signature .....

**ASEM Members can refer to the ASEM website for further details about the seminar**