Society News

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The Spring Seminar Edition

Editorial

Dear Readers,

'For winter's rains and ruins are over, And all the season of snows and sins;

The days dividing lover and lover, The light that loses, the night that wins;

And time remembered is grief forgotten, And frosts are slain and flowers begotten;

And in green underwood and cover, Blossom by blossom the spring begins'

- Algernon Charles Swinburne, 1865 (1837-1909)

As Winter comes to a close, we bid farewell to cough, colds and exacerbations of airway diseases. Spring has hopefully brought warmer weather, much needed rain and new opportunities for you wherever you may be.

In this edition, we take a look at the recent ASEM Spring Seminar, which was held in Launceston and hosted over 100 delegates attended from Australia and New Zealand. The Seminar covered topics such as working in Antartica, Palliative Care, Health and Electronic Media, Quality and Safety in Health Care and Dermatology to name just a few. In this issue, **Dr Marcel Berkhout** and **Dr Peter Roberts** provide some insights into the Seminar– hope you enjoy and consider coming to the next Seminar!

Another special feature in this edition comes from **VEPA, Victorian Emergency Physicians Associations Inc.**, a group of proactive Emergency Physicians that advocate on matters relating to Emergency Medicine and Industrial Relations. As of late, VEPA has been active after a number of media reports relating to the current state of play in Emergency Medicine. I'd like to thank **Dr. Con Georgakas**, who is President of VEPA for providing the article.

Spring is also the season of renewal and thus provides a useful segue to remind you to renew your ASEM membership if you haven't already!

Once again, I invite ASEM members to contribute to the Newsletter. I'd like to thank everyone who has contributed to this edition

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. Amusing cartoons related to Emergency Medicine are also welcome. Failing that, emails to the editor would also be gratefully accepted for inclusion in the Society News.

Please send any articles to **traineevic@asem.org.au**

President's Spring Seminar Report

The Spring Seminar in Launceston was a great success with over 100 delegates attending from Australia and NZ. The Welcome Reception was held at the historic Brickendon Estate, a working farm dating from the 1830's and now being run by the 7th generation of that farming family. It was a beautiful location and the weather was perfect, cool and clear. Delegates were welcomed by conference organizers and the owners. Walking round the lush property, spring was in the air. Lambs with black circles around their eyes looked like old fashioned motor cyclists. Horses grazed in the paddock. Rabbits were in hutches and looking very pleased with themselves. The smithy was fired up and one of the sons was forging a fire grate in the old building. Damper was freshly made and served with treacle in another barn. The tiny church was opened and the old organ remained functional and was played by a young girl. The grain barn dated back 180 years and was on the Heritage list because of its unique design with a dutch gable roof, with the whole barn on stone cone shaped feet, capped off with horizontal discs, to prevent rodents from spoiling precious seed grain. A wood-chopping exhibition was held with the host being a world record holder in his sport.

Oysters and a selection of cheeses were available for a pre-dinner nibble. Dinner was provided from a large mobile BBQ/kitchen and served in another large, beautifully constructed timber barn. The meals was complemented by a fine selection of Tasmanian wines and beers.

The Horizon speech was given by Dr Jeff Ayton, CMO of the Polar Medicine Unit at the Australian Antarctic Division in Kingston, just south of Hobart. Antarctica is the highest, driest and coldest continent. He provided an excellent talk, discussing the history and the challenges of providing medical care in a truly remote location with a single doctor looking after a group of expeditioners with access limited to maybe 4 months every years. Dr Ayton discussed the need for careful selection of those wintering. The doctor generally undergoes a 4 month training course, including basic dentistry and surgical skills. The medical facilities are comprehensive and capacity for digital radiology and pathology are present. Photos of the trip down, both by plane and ship, were a stark reminder of this area's remoteness. He concluded his talk by inviting delegates to consider applying for this position.

Workshops opened the conference next morning and I attended excellent sessions on Advanced Suturing Techniques (Dr Rob Gates, Plastic Surgeon), Health and Electronic Media (Dr Andrew Perry): the future of social media, including Google+, Facebook, LinkedIn and Twitter in EM, Management of commonly mismanaged hand conditions (Dr Nitin Sharma) and Journal Club (Dr Brian Doyle): dabigatran in AF (more expensive, irreversible, 1:200 stroke reduction cf warfarin, renally excreted, with more similar 'trans' to come), hs-troponins (more positives and difficulty of interpreting low positive results).

Lunchtime was the opportunity for the ASEM AGM. Reports from the President and the Treasurer were tendered. All Councillors were re-elected to their positions, and thanked for their contributions. General discussions covered a number of important points: the need for the Society to review its Constitution and the rules under which it operates as a non-profit organisation, improving links with ACRRM and AMPA, and welcoming AMSA members to ASEM. A copy of the minutes will be placed on the ASEM website.

Thursday's programme was a number of lectures on Mental Health and the Emergency Department (Dr Kris Luscombe), Palliative care patients in the ED (Dr Robyn Brogan) and a feisty talk by Prof Bernie Einoder on Sports Injury Updates.

Continued...

President's Spring Seminar Report (cont'd)

Robyn recommended several excellent websites: dhs.tas.gov.au/palliativecare/healthprofessionals; goldstandardsframework.nhs.uk; and recommended Therapeutic Guidelines 2010 v3 on Palliative Care. She talked broadly about achieving a best practice model, starting with training the nursing home staff, then working backwards. This has proved a successful model and could be implemented beyond NW Tasmania. Bernie's pearls included: all first traumatic shoulder/patello-femoral dislocations should be arthroscopically repaired; 'bone bruising' is a fracture of cancellous bone under the intact cartilage and if ignored can lead to avascular necrosis; RICE remains as important as ever; all dislocations should be reduced, then X-rayed; examination remains crucial to diagnosis; all tense effusions should be aspirated as cartilage is avascular and derives its oxygen and nutrient supply from circulating synovial fluid; early referral and review by orthopaedic surgeon no later than 5d later; knee injuries damage (in order) LCL/lat meniscus/ACL/patello-femoral/PCL.

Dr Melanie Underwood was selected as the winner for the best presentation for her paper on '*Therapeutic subclavian artery compression for peripheral vascular stasis*' and won free membership to ASEM for the remainder of this financial year, $500 cash prize and free registration to the SSEM next year, to be held in Port Douglas valued at $1200. Melanie was contacted to congratulate her and to remind her that publication of her abstract was included in the ASEM Newsletter. She was ecstatic and couldn't wait to tell her co-contributors. We look forward to publishing her abstract.

The conference dinner was held at the Launceston Country Club and had a Tasmanian theme. A prize was offered for the best Apple Isle costume and also for the longest apple peel(ed): 232cm! This was keenly contested and there were many peeled apples collected at the end of the evening. Music was provided by a young local band, strongly reminiscent of the bush bands so popular in the 1970's (have a listed to the Bushwackers) and enjoyed by all.

The final day comprised a series of talks from 4 speakers. Prof Alan Wolff is the Director of Medical Services at Wimmera Health Care Group in Horsham, Victoria. He spoke eloquently on the need for Quality and Safety in Health Care, as developed by a stable group of physicians over 20 years to reduce adverse events and improve the quality of care provided to patients. Continuous screening of clinical activities and the incremental changes in practice are then reflected in update clinical pathways, dependent on best practice and adjusted for local resources. He emphasised the importance of clinical and executive leadership, adequate resources, the role of education and the need to develop a quality and safety culture. Some interesting numbers: 10% of admissions have an adverse reaction, 50% receive recommended preventative care/70% receive recommend acute care. Interventions to improve outcomes range between 7-14%, with regular reminders showing the best results.

Dr Richard Lennon spoke on 'Beginning of Life in the ED' and I mention some points: tocolysis (trying to prevent labour) is unwise if there is active PV bleeding, chorioamnionitis, IUGR or cervical dilatation beyond 4cm. Oral nifedipine is now the preferred drug, rather than IV salbutamol (risk of APO) and can be given 60mg every 30 minutes up to 240mg. IM betamethasone 11.4mg remains best practice. Preterm resuscitation is best at 30-40%FIO2.

Dr Ian Hoyle discussed a wide range of dermatology issues and I will mention just a few. Drug eruptions can be any drug/any rash. Icludes OTC's. Remember antibiotics, NSAID's, allopurinol (phototoxic), ACE, BDZ's. SLE can presents as a fungal rash, not responding to topical/oral antifungals. Dermatitis herptiformis in gluten enteropathy. Erythema multiform: minor usual viral, major usually drug eruptions. Psoriasis treated with oral steroids for pruritis can present with erythroderma when treatment is withdrawn. A pathonomonic gyratory rash indicates internal malignancy.

Dr Michael Haybittel spoke on a wide range of ophthalmological presentations. Time critical ones are mentioned here. Third nerve palsy with fixed and dilated pupil and pain indicate an aneurysm of the posterior communicating artery, usually younger patients and require urgent MRI/MRA which, confusingly, can sometimes be reported as normal. Urgent neurosurgical input should be sought. Anterior Ischemic Optic Neuropathy (AION) in the 5-10% group that are arteritic: VA<6/60, pallid swollen disc, history of weight loss/headache/myalgia/jaw claudication, ESR>100, afferent pupillary defect (APD) present, 20-50yo, F>M and require IV methylprednisolone 1gm/d. Blunt trauma with evidence of raised IOP (CT is useful looking for retrobulbar haematoma) requires urgent lateral canthotomy. If suspect retinal detachment and VA remains good than urgent review. If a hyphaema is present, check the IOP; if high (>50) urgent review is indicated. He recommended rootatlas.com for excellent information and an iCare tonometer far ease of use. A Morgan lens should not be left unattended by staff during irrigation to minimise the risk of corneal trauma.

Dr Sue Ieraci discussed end of life care in ED using a number of typical vignettes to explore issues in management. She pointed out that loss of airway control in advanced dementia (recurrent aspiration) indicates the final phase and that PEGs are no consider optimal care. The discussion with family members of this terminal condition needs to be done wherever possible by senior staff. She pointed to via.nih.gov/healthinformation/publications/endoflife as a useful resource.

Dr Marcel Berkhout, ASEM President

ASEM Member Profile: Leon Malzinskas

Dr. Leon Malzinskas
Wonthaggi Hospital (BCRH) Emergency Department, VIC

Dr. Leon Malzinskas became the Senior Medical Officer in the Emergency Department at Wonthaggi Hospital (Bass Coast Regional Health) in July 2008. At that time local GPs were no longer sustain a fee for service A&E model and BCRH quickly had to establish a staffed Emergency Department to meet community and sub-regional needs.

Dr. Malzinskas was an ED HMO at PANCH for 3 years in the mid 1980s before becoming a procedural GP in Wonthaggi in the late 80's with special interests in EM, anaesthetics, obstetrics and sports medicine.

Leon has participated in lots of other clinical interests outside BCRH ED including being :

- A Program Supervisor (2001 – 20070 for Rural and Remote Area placements
- A Supervisor GP Registrars since 2001
- A Designated Aviation Medical Examiner (1996 to 2008)
- SCUBA Diving Medical Certified from 1993 to 2008
- Director and an Instructor of Advanced Paediatric Life Support Courses since 1997
- A Senior Instructor of EMST courses since 1995
- An Instructor of both Monash and Melbourne University medical students
- A Monash Medical School tutor since 2004
- A Medical Officer supporting the Commonwealth Games(2006); Deaflympics (2005 & 2006) and; the Simpson Desert Cycle Challenges (2003, 2004, 2008 & 2009)

Leon married his wife Carmel in 1983 while still studying medicine and they have had four children. Cara was born in Warnambool, studied medicine and is currently in her JRMO year of Paediatric training and hopes to be a rural Paediatrician; Vince was born in Melbourne and is an apprentice chef on Phillip Island, Jack is studying teaching at Ballarat University and Dylan is finishing year 12 and hopes to get into engineering. Now that all the kids are independent, Carmel has taken up a part time position as an integration aid at one of the local primary schools.

His "relaxation" interests outside of Medicine revolve around four wheel driving in remote areas of Australia and endurance cycling. The latter has seen him compete in Simpson Desert Bike Challenges as well as in 2 (unsuccessful) attempts at the Audax Paris Brest Paris Rides which he hopes to again attempt in 2015.

Over the 3 years in his EM job, ED patient attendances seen in ED have increased from about 10,000 to 14,000. From those humble beginnings with 4 HMO's, Leon now supervises 8 HMO's, two interns, an ACEM Registrar doing ED / anaesthetics as well as several other casual senior doctors on weekends.

In recognition of his standing both within and outside the hospital, Leon's job was recently reclassified as DEMS and ADMS – roles that he has clearly been performing with distinction for some time.

Ed: ACEM would like to congratulate Leon on winning the 2011 Rural Workforce Agency Vic Rural Doctors Award for Outstanding service to his community.

ASEM News and Updates

New South Wales

Dear ASEM Member,

This year is passing much too quickly!

The big news in Health is the change from the Department of health to the Ministry of Health. I must admit that when I heard the announcement my thoughts flew to the Monty Python Ministry of Silly Walks. A colleague asked if the Ministry of Health would work in the same way as Harry Potter's Ministry of Magic. However, I have it on good authority that more will change than the Letter Heads. Perhaps this re-organisation is a step in the right direction.

As you might remember, the Minister for Health commissioned an independent review of Cerner FirstNet in June 2011. The results of the review were sent to the Minister in July 2011. There is no further progress to report. I hope that the report does not get lost in the current responsibility shuffle.

The old NSW Health Department supported the recent conference, "Improving the Health Care Experience". During the Master Class conducted by Dr. Dan Smith from the StuderGroup, an efficient electronic medical record system was mentioned. I nearly bit my tongue. I had used that system successfully for about nine years before I was compelled to replace it with FirstNet.

The Spring Seminar in Launceston was a great success. The workshops were well attended. I was able to participate in Advanced Suturing Techniques, Ultrasound Guided Regional Blocks, Management of Hands and Hypothetical-Critical Geriatrics. The presentations all held audience interest and in some cases raised heated controversy. This was particularly evident in discussions regarding end of life and "not for resuscitation" decisions.

The next Spring Seminar on Emergency Medicine will be held in Queensland. ASEM offers vouchers for $100 off the cost of registration to financial members. Could you interest a mate in joining ASEM? The voucher is a "good deal". ASEM is a worthwhile group.

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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Victoria

ASEM is pleased to be supporting again, the 2012 ASEM (Vic) Triathlon

Depending on participating numbers, this Triathlon will again be (fully or very substantially) subsidized by ASEM and its loyal external sponsors.

The triathlon is open to ED teams & individual ED Health practitioners from around Victoria, but interstate ED entries would be very welcome!

The triathlon consists of about 300 metre swim,10km ride and 3km run around St Kilda beach & environs in Melbourne.

Since Epworth ED has won the last 3 events, this is time for other EDs to rally and seriously take them on!

EDs do need to nominate a team co-Ordinator for their ED and register an interest with the ASEM Office on: 9701 5675

Regards
Dr. Rick Lowen, VIC Councilor

1
APRIL
SUNDAY

AUSTRALASIAN SOCIETY FOR EMERGENCY MEDICINE (VIC)

TEAM TRIATHLON 2012

WHERE
ST KILDA FORESHORE

WHAT NOW?
EACH HOSPITAL NEEDS A TEAM MANAGER
FURTHER DETAILS SOON

CONTACT
TIM BAKER
tim.baker@deakin.edu.au

VEPA (Victorian Emergency Physicians Association Inc.) was established about a year ago as an instrument:

- To facilitate addressing issues as determined by its members and other relevant bodies
- To provide advice that fully embraces and describes obligations and entitlements applicable to all VEPA members
- To enhance and recognise the performance of individual VEPA members, by drawing together elements such as performance management and classification structures and ensuring that they are fairly rewarded within the future Agreements;
- Introduce strategies for better communications throughout the VEPA membership and consequently directly involving members and embedding a culture of open, ongoing and direct consultation;
- To improve the standing of VEPA by incorporating elements of the membership responses in future Workplace Agreement formation and implementation strategies.

Its two core elements are that of Advocacy on matters relevant to Emergency Medicine and Workplace Relations.

VEPA is now able to provide Emergency Physician commentary in the media including television, radio and newspaper, where in the past this information was often sought from unrelated parties. VEPA is now a respected source of comment and is capable of responding to queries from all media within their timeframes and deadlines.

VEPA has reviewed much of the available workplace relations data and has reached a series of disturbing conclusions, which revolve around a lack of trust displayed by VEPA members– or perhaps even outright distrust – towards the various Hospital Administrators. Hospitals pay wages to their employees usually depending on working time and/or on results. Individual wage often depends on occupied position in the hospital as well as on education, cumulated experience and seniority. Wages for the same job outside the hospital serve as a conventional or mandatory reference point. Wage levels result from individual and collective negotiations between the hospital employees (and their representatives) and the hospital management. The outcome of negotiations decides wages and this documented in a publicly available document, a Workplace Agreement, registered through Fair Work Australia.

For Emergency Physicians these determinants do not apply. The data provides a clear indication that a hospital's Emergency Physicians are separated from the notion of an industry standard. For most VEPA members nominal wages are stipulated in contracts between them and their respective hospitals. This is because the negotiation process is ruled by a bureaucratic hierarchy (with many levels of low, middle and upper management) who put in motion a hospital-specific policy based on a precursor of not understanding emergency medicine.

Wage and condition differentiation is a widespread phenomenon and different hospitals pay working time rates that are based on unrelated factors that disregard output as a measure. For example, wage rates for the same classification at different hospitals vary from 5% to 40%.

Understanding how Emergency Physicians feel, feeding that vital insight to improve an Emergency Department, encouraging EP ability to influence hospital decision-making, and ensuring there are strong, two-way communication processes in place that sustain healthy and supportive relationships have become less and less a key pivot of the administration of emergency medicine in recent years.

This is no wonder, considering many hospital administrators privately admit their hospital is managed solely within a rigid bureaucratic model aimed at camouflaging the real situation in the Emergency Department and running budgets based on minimums with little regard at genuine outcomes.

VEPA's statement of purpose is to represent the Specialist Emergency Physicians of Victoria within this spectrum and to establish a productive working relationship with other health employee representative bodies.

Further information can found at www.vepa.com.au. Please direct any queries to info@vepa.com.au

Spring Seminar Conference Report

Surprise was a strong feature of the 2011 SSEM. I was surprised to see how big Launceston has become, with a freeway from the airport where my taxi driver took the wrong exit. More surprised when he made a U turn on the exit ramp to correct his error.

The welcome reception saw buses driving down narrow farm tracks between stone buildings like a Bailey's Irish Cream advert. Delegates climbed down from the bus into a field, and spent a moment taking in trestle tables creaking with Pacific Oysters, and Tasmanian brie and venison, before following shrieking children off to feed goats, or watch a sheepdog or blacksmith at work, or axe-men halve a log in six blows.

After Tasmanian Salmon in a rustic barn, for the Horizon Lecture in another shed **Jeff Ayton** described the difficulties of being the doctor on an Antarctic mission. With a week of education on dentistry, a fit emergency doctor can sign up to be the entire medical staff for the winter.

The next morning at workshops, I took a seat behind one of 40 tables with pigs' trotters and suture sets. On the screen was the closed circuit TV picture of **Rob Gates** everting the edges without crushing the skin in beautiful close up. At the edge of the room the hotel staff gathered to see why this conference had called for 80 raw pigs' trotters.

The communication workshop demonstrated how video of routine conversations in the ED could be used to analyse and improve communication.

After the ASEM AGM, my highlight of the afternoon was the Hypothetical Critical Geriatric.

The next morning began in the imposingly grand terraced lecture theatre. **Kris Luscombe** came from Canada to tell us about acute agitation in clipped, efficient style. Think of agitation as a potential emergency with outcomes of death or violence. Rising levels of treatment after re-assurance include extra staff, transfer to a secure location, then either physical or chemical restraint.

Many personality disordered patients have co-morbid bi-polar. Why do they self harm? It allows the sick role, brings partners close, and helps impress others how truly sick they are. Cutting is to punish, to disfigure to avoid sex trauma, can release endorphins, and can help draw themselves out of a dissociative state.

And what are the predictors of violence? Male, aged 15-25, low IQ, low education, and alcohol or drugs.

Robyn Brogan's style in palliative care could not have been more different. After inviting the audience to discuss issues amongst themselves, she somehow gracefully regained their attention. There is a palliative care therapeutic guideline. Google dhhs, palliative care, Tasmania. It has a section on palliative care emergencies like spinal chord compression and SVC obstruction. The formulary has a table of symptoms and drugs. www.dhhs.tas.gov.au

Some nursing homes have 100% mortality in one year. Sixty per cent is common. So they are actually big palliative care institutions. Staff are demoralized. City nursing homes are chosen on availability, not where the GP goes.

There are 4 main disease trajectories. A twelfth have sudden death, and a third have organ failure. These are the groups EDs are built for. But a third have a frailty/dementia trajectory and these are coming more and more to EDs. A quarter have cancer.

Been to an interesting conference in Emergency Medicine?

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

Prof **Berni Einoder** had a theme of prompt management of sporting injuries. Go ahead and reduce dislocations on the field. If there is a fracture, it still needs reduction. RICE gets missed in waiting rooms.

If a joint is so swollen it won't move, drain the joint. The effusion or blood damages the synovial cartilage.

Continued...

Spring Seminar Conference Report (continued)

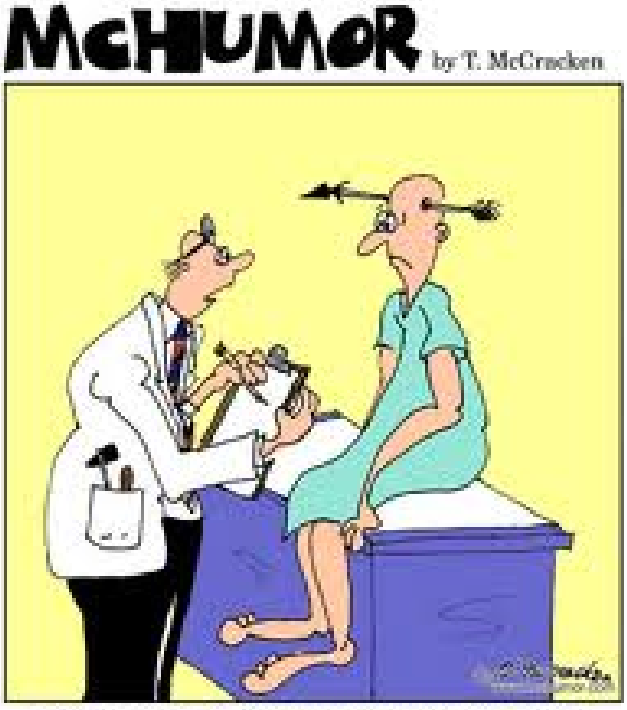
Refer dislocated patella in time to be fixed inside 5 days, and shoulder dislocations recur less if you do arthroscopy after the first one. And most sporting injuries need internal fixation to keep the athlete fit. The Athletes choose the risk over the atrophy.

Dr Alan Wolff justified getting up early after the conference dinner with a rare practical insight into quality and risk. There is lots of monitoring going on with not much action as a result. The National Stroke Audit found only 70% get aspirin after stroke, half get a swallow assessment before feeding.

He had a neat conceptual map of latent failures in management decisions or organizational processes affecting conditions of work background issues like workload and supervision increasing active failures like slips, errors, protocol violation which must get through barriers like time-out or double checking orders to produce an error affecting a patient.

We should be studying adverse events in other health services, and when staff raise issues they need to know that they stay on the agenda until they are resolved. The intervention is the hardest part.

Most interventions in the past were education, audits and reminders, which produce 10%, 7% and 14% improvements respectively. The currently favored interventions are; simplify the task, checklists, protocols, introduce constraints, standardization, and adequate timely information.



Measure the *processes* that have an evidence base to improve *outcomes*.. And culture is only changed by 100 little decisions.

Richard Lennon was his usual informative self. He uses the Kee Pad system do the audience can put their answers to his questions anonymously. Nifedipine orally is the thing for stopping labour; fewer side effects than salbutamol. Use 20mg 30 minutes apart up to 3 doses if still contracting then 20 mg 6th hourly. It was a relief to see how many others didn't know that. Glad wrap is better than towels for keeping premature neonates warm.

Dr Ian Hoyle on emergency dermatology was very visual. Then **Michael Haybittel** had a recommendation for the new i-care tonometer. In angle closure glaucoma, the IOP is 50 to 80 mmHg. Give IV mannitol 20% 1g/kg.

"Macula-on" detachment is the urgent one. They have good visual acuity, flashers and floaters, and should be seen the same or next day. But if the macula is already gone and the visual acuity is poor it is no longer so urgent. And in artery occlusions, all the urgent treatment rarely helps. But look for an associated aortic dissection and check the ESR because it may go with temporal arteritis.

Sue Ieraci got some interaction going in the discussion of end of life in the ED. She pointed out that dementia has a final stage where the patient is immobile, can't communicate, needs help with all ADLs and the swallow is failing. These things mean the patient is at the terminal phase.

Dr. Peter Roberts, NSW Councillor

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

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