Society News

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A Changing of the Guard

Editorial

Dear Readers,

It is with great pleasure that I write my first editorial as the new Editor of the Quarterly Newsletter for the Australasian Society for Emergency Medicine (ASEM).

I would like to take this opportunity to thank **Dr Marcel Berkhout** for his contributions during his time as Editor of the ASEM Newsletter. Marcel will continue to serve ASEM this year in his role as President. Thank you for all of your hard work Marcel!

The ASEM Newsletter currently serves as a vehicle for members of the Society to keep informed of current events relating to Emergency Medicine on a state, national and international front. In 2011, ASEM hopes to further expand the role of the Newsletter, this includes but is not limited to:

- Continuing to provide members with the opportunity to publish articles of interest related to Emergency Medicine;
- Inclusion of medical students to the current ASEM readership and membership; and
- Providing members the opportunity to publish research related to Emergency Medicine.

Prior to continuing further, I would like to take this opportunity, on behalf of the ASEM, to send our thoughts and best wishes to those affected by the natural disasters that have occurred here and overseas in recent times– namely those affected by floods in Queensland and Victoria and those affected by earthquakes in Christchurch, New Zealand and Japan. We send our thanks to those who have worked tirelessly to help those affected and help these areas rebuild, slowly but surely. Your efforts are greatly appreciated.

In recent news, ASEM welcomes **Ms Georgina Lee** who has recently been appointed as our new Office Manager. Georgina comes into the job with a strong background in private hospitals and aged care. When not working, Georgina loves spending time away with her family and husband Nick - at the country retreat in Rushworth where they can just relax, fish or jet ski. When at work, you can contact Georgina via email on **asemadmin@bigpond.com**

Lastly, I'd like to thank everyone who has contributed to this edition– I look forward to working with you in future.

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.

ASEM reserves the right to edit all articles, letters and images submitted for publication as seen fit by the Editor of the Newsletter.

ASEM State Councilor News and Updates

South Australia

Current issues in SA are ED overcrowding (as it seems is a problem almost everywhere) despite significant government investment in primary care centres in and around Adelaide.

More specifically, issues have arisen around the legality of detention under 'Duty of care'. A recent directive from SA Health states:

"*There are several pieces of legislation that provide lawful authority for the purposes of providing medical treatment even where the patient refuses or is unable to consent to the proposed treatment. The relevant provisions are found in the following Acts:*

1. *Mental Health Act 2009*
2. *Consent to Medical Treatment and Palliative Care Act 1995*
3. *Guardianship and Administration Act 1993*

If staff believe that it is necessary to detain a patient for the protection of that patient and/or the community, they should explore the statutory options available to them and must not make a ***'duty of care order'***. In law there is no such thing as an order based on a duty of care. If staff believe that it is necessary to provide medical treatment even where the patient refuses or is unable to consent to the proposed treatment one of the statutory criteria must be met"

Currently we believe that we are not covered legally if we detain, restrain, +/- sedate patients who present as 'drunk and difficult' (?head injured, ? medically unwell etc.) where medical assessment (such as to allow assessment of fitness to be discharged to police custody) is not possible without restraint. We are currently requiring police presence in ED (not only for those patients brought detained by police) to facilitate assessment of these patient prior to medical decision as to whether detention is appropriate. A history of mental illness/ presentation consistent with mental illness allows use of 'from 1' (Detention under the Mental Health Act). The Consent to Medical Treatment and Palliative Care Act applies to management of potential life threat due to treatable medical cause.

I gather that the law is variable across states in Australia. This is one area where standardization of the law would be helpful. Comments from other councilors/members in other states would be welcomed.

Dr. Joy Treasure, SA Councilor

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New South Wales

Dear ASEM (NSW) Member,

I am safely back from leave. My husband and I had planned a leisurely cruise down the Nile. We arrived in Cairo just in time to be caught up in the riots. Needless to say, we did not get to cruise down the Nile. However, the burning buildings, the tanks, the armoured cars and the rioters made interesting viewing.

Good news! The Certificate in Emergency Medicine pilot course conducted by the Australasian College for Emergency Medicine will be completed in April 2011. The College is busy training Fellows to act as supervising doctors for those who want to do the Certificate.

As you might remember, ASEM members have expressed concerns regarding the use of Cerner FirstNet as the electronic medical record system currently being rolled out in Emergency Departments in NSW. These concerns have been passed on to Professor Jon Patrick, Health Information Technologies Research Laboratory, Sydney University. His report can be found at http://sydney.edu.au/engineering/it 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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NSW needing locums again.

On Sunday March 27the front page of the major Sydney newspaper carried the Headline; "Fly-in doctor farce".

The subheading was "Hospitals pay $6000 for Kiwi weekend warriors."

The body of the story reveals that these doctors fly in on Friday, work over the weekend and fly home on Monday. The highest rate quoted in the article for non-specialist pay was $100 per hour. So, somehow these doctors are doing 60 hours work in three days or the big figure refers to specialist rates.

Either way, these are highly trained and experienced doctors prepared to travel to wherever they are needed, work nights and weekends dealing with life and death issues. It seems like the going rate in a market place.

Many New South Wales emergency doctors and patients alike are very grateful for the help. New Zealanders and interstate colleagues are filling gaps caused where long-term employment packages are not generous enough to generate competent applicants.

Dr. Peter Roberts, NSW Councilor

ASEM State Councilor News and Updates...cont'd

Victoria

ASEM (Victoria) 2011 Triatholon

Event organisers want to apologise to would-be Vic ED participants, that this years ASEM (Vic) triathlon has been postponed till 2012. Whilst this decision will disappoint many, it does give all EDs longer to train for next years triathlon - in order to pip 3 times Triathlon winners - Epworth ED. Attendees at last year's triathlon wanting to view photographs taken at the time, are reminded that these can be downloaded from: www.bedbrokers.com.au.

Potential key contact persons from EDs wishing to participate in the 2012 Vic ASEM triathlon - should again register their interest with Tim Baker via: tim.baker@deakin.edu.au.

Dr Rick Lowen, VIC Councilor

Other News

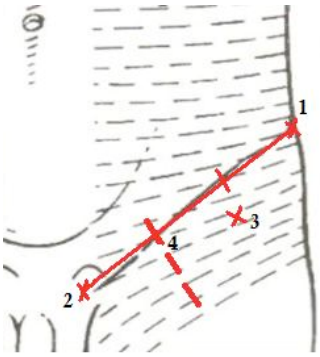
Peripheral Hospitals Emergency Medicine Conference (PHEMC) is a charity devoted to teaching and learning in emergency medicine. For this year's Spring Seminar in Emergency Medicine in Launceston 27 -30 September, they would like to make one scholarship available to a member of ASEM, in the form of free registration. To apply, write less than 500 words of refection on you own emergency medicine practice and email denby.confmagic@bigpond.com Applications close at the end of June.

ASEM Clinical Pearl– Autumn

Fascia Iliaca Block

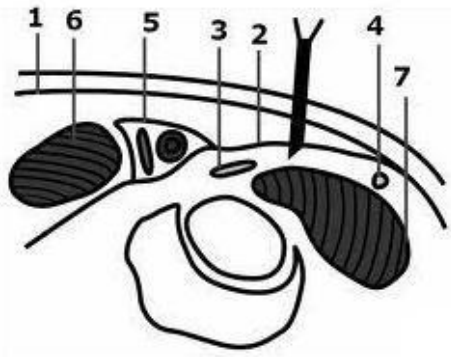
The fascia iliaca block is a nerve block used in the Austin Emergency Department in Heidelberg, Victoria for any patient presenting with a hip fracture. This provides a means for achieving adequate analgesia for the patient, better facilitating their care needs up until their eventual operation. Compared to a femoral nerve block, the fascia iliaca block can provide more reliable and complete local anaesthesia for patients with hip fractures as it targets both the femoral nerve and the lateral femoral cutaneous nerve.

As pictured below, the puncture site is determined by drawing a line from the ASIS to the pubic tubercle. At the junction of the middle and lateral third of the line, the site for injection is marked 2cm below this junction (Figure 1). Prior to injection, the position of the femoral artery should be confirmed by palpation for safety. After anaesthetizing the skin with bupivacaine, an 18G needle is inserted as an introducer. A lumbar puncture needle is then inserted through the introducer. Two pops should be felt on descent (the first– fascia lata, the second– fascia iliaca, as demonstrated in Figure 2). After aspirating, slowly infiltrate the full volume of bupivacaine 0.25% (30ml). Consider a reduced dose for the frail or elderly patient.



1. Anterior superior iliac spine
2. Pubic Tubercle
3. Puncture site
4. Femoral artery

Figure 1: Surface landmarks



1. Fascia Lata
2. Fascia Iliaca
3. Femoral nerve
4. Lateral femoral cutaneous nerve
5. Femoral canal (with artery and vein)
6. Pectineal ligament
7. Psoas

Figure 2: Structures traversed in fascia iliaca block

ASEM Councilor Profiles

Dr Gayle Marie McInerney (ASEM Councilor, NSW, pictured below left)

I graduated in Medicine from the University of Sydney in 1968. I was employed as a "Casualty Supervisor" in 1971 and then a "Casualty Coordinator " in 1974. In 1984 I was appointed as an Emergency Department Director.

I have been a member of the Australasian Society for Emergency Medicine since 1981. I am also a Foundation Fellow of the Australasian College for Emergency Medicine.

Over the years, I have been a member of many Health Department and local committees concerned with Emergency Medicine. In 2002, I received the Order of Australia Medal for services in the development of Emergency Medicine strategies

In recent years, I have been interested in teaching. I have been a Clinical Lecturer for Sydney University and the University of NSW. I am also a Student Supervisor for the University of Notre Dame. I am also undertaking the College course to enable me to supervise doctors in Emergency Medicine Certificate training.

I am married with four children and nine grand children. They keep me busy.

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Dr Adam Janson (ASEM Treasurer, Victoria, pictured right)

After 25 years of medical practise I find myself as the Associate Director of Emergency Services at Cabrini Hospital in Melbourne. I have been there since working on the design over 10 years ago now. Daily I work with a large number of staff and interact with all sorts of clinicians, administrators, volunteers and let us not forget the patients!

When I started in Emergency Medicine (1986 Prince Henry's Intern Casualty Rotation where I met my wife– thanks Alan Y), a large proportion of the work was done by non-specialists and I would encourage all emergency doctors, regardless of specialisation, to maintain a high level of clinical credibility with colleagues and peers.

I have worked in salaried positions in both public and private hospitals, as well in true fee for service private practise, you know the type, if you have a quiet day shuffling charts but not seeing patients, or the patient doesn't pay their bill because they didn't feel they received a reasonable service. Then, you don't get paid. I did that fairly early in my career and I guess that attitude remains with me now.

I also enjoy travelling and have spent a number of holiday periods over the years working in the tourist industry as a ship's doctor, tour manager as well as a tour doctor. I have been lucky enough to visit many unique places including Antarctica, Transylvania, Africa, Japan as well as other salubrious and some less salubrious ports in South East Asia and the South Pacific.

My wife Kathleen and two sons seem to put up with me – which of course is very good for me! In recent times I have been looking into how we can better manage patients who do not need all the services of an Emergency Department and hospital. If you have any ideas please feel free to contact me.

I joined ASEM a few years ago to try and help maintain an organization that represented all Emergency Doctors and after a few years, fell into the treasurers role. We are still around and relevant.

I am happy to be contacted by email or Facebook. Otherwise try my email on adamjanson@optusnet.com.au .

Update– National Health Reform Agenda

On Sunday 13 February 2011, the Council of Australian Governments agreed to a revised health reform package.

First Ministers signed a new Heads of Agreement on National Health Reform <http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/docs/communique_attachment_20110213.pdf>, which will form the basis of a new National Health Reform Agreement and will replace the National Health and Hospitals Network Agreement.

Under the Heads of Agreement:

- States will remain managers of the public hospital system and will continue to negotiate service level agreements with health services and hospitals.
- The Commonwealth will increase its contribution to efficient growth funding for hospitals to 45 per cent from 1 July 2014, increasing to 50 per cent from 1 July 2017. There will be no transfer of State GST to the Commonwealth under this financing arrangement.
- The Commonwealth guarantees that its additional funding will be no less than $16.4 billion between 2014-2015 and 2019-2020.
- States and the Commonwealth will contribute funding for health services and hospitals into a single, independent national pool, to be operational from 1 July 2012.
- The Commonwealth and States will continue to develop a national approach to activity based funding, to be introduced from 1 July 2012.
- States will continue to play a significant role in the delivery of primary health care services - there will be no transfer of primary care services to the Commonwealth.
- The Commonwealth will bring forward the establishment of more Medicare Locals and these entities will plan and support face-to-face GP services outside normal hours.
- The Commonwealth and States will work together on system wide policy and State-wide planning for GP and primary health care services.

The Agreement also states that further reforms in mental health, dental health and aged care will be pursued over the coming three years. Specifically, the funding and policy responsibility for Home and Community Care Services (HACC) will be transferred to the Commonwealth in all states except WA and Victoria. It has been agreed that a further discussion on HACC will take place at the next COAG meeting. The Heads of Agreement noted that potential changes in responsibilities for HACC services for Victoria and WA will consider the different models currently in operation and the importance of maintaining existing service delivery strengths.

A revised National Partnership Agreement on Improving Public Hospital Services was also agreed. This Agreement retains the performance targets for elective surgery and emergency departments as well as funding for new subacute beds. As a result, new targets have commenced for 2011 and include:

- A new emergency department four hour target for category 1 patients, an
- A set of interim elective surgery targets for patients being seen within the clinically recommended time.

An Expert Panel will be established to provide advice on the appropriate implementation of these targets. The Expert Panel will provide its first report to COAG prior to 1 July 2011. Victoria will prepare an interim implementation plan to secure payment of funds from Commonwealth, noting that the implementation could be subject to change following COAG consideration of the Panel's advice.

Furthermore, a portion of reward funding will be brought forward as facilitation funding to support meeting the targets.

The new National Health Reform Agreement is to be agreed by 1 July 2011. Many details will need to be worked through over the next few months to finalise the new National Health Reform Agreement. The Department of Health will continue to play a key role in this process and will maintain active involvement with health services and stakeholders in the implementation process.

Source: Fran Thorn - Secretary DHS (Vic) 16 Feb 2011

Trainees' Section

In this edition, we are pleased to have **Dr. Andrew Perry**, Chair of the Trainee Committee for the Australian College of Emergency Medicine, provide the following update on issues affecting Trainees.

Andrew is a 3rd year Advanced Trainee, currently working at the Women's and Children's Hospital in Adelaide, S.A. His long term interests include trauma, retrieval, medical education and emergency department management.

He joined the ACEM Trainee Committee in November 2008 as the South Australian Representative and has since become Committee Chair in November 2010. He sits on the ACEM Board of Education, Council and the Accreditation Committee. Andrew has a number of side interests including medico-politics (he is former National Chair of the AMA's Council of Doctors in Training), business (paid consultancies to a locum agency and medical indemnity provider) and medical assistance at large events (paid doctor for a primarily paramedic-based event medical aid company). This has resulted in working part-time for almost all of the last 4 years since joining the emergency medicine training program.

The Road Ahead: Issues affecting Emergency Medicine Trainees in 2011

It is an interesting (and dare I say exciting) time to be involved in Emergency Medicine from a trainee point of view given recent developments both within and outside the college. These include the implementation of a national time-based access target for emergency departments (the so-called 4 hour rule) and the significant remodelling of ACEM's educational programs with the rolling out of a non-specialist pathway and a large-scale curriculum reform project.

Trainees - as the doctors who will be affected for the longest duration by these changes – have taken a keen interest in these changes and have provided extensive input into the debate, largely through ACEM's Trainee Committee which has a representative from each state and territory in Australia and from NZ. There are trainees on the majority of the college's committees which have allowed trainees to have direct input into most significant developments and the college President and Censor-in-Chief participate in Trainee Committee meetings.

These changes are largely viewed as positive, although as always there are aspects that are seen as more positive than others, and in many cases the attractiveness and success of the proposed changes will be in how they are implemented. For instance, trainees are frustrated by emergency department overcrowding and acknowledge that a time-based access target can help address that matter, but are aware of the shortcomings that were exposed of such a system when implemented in the UK. In particular trainees do not want emergency medicine doctors to be viewed as "glorified triage nurses" because they do not have the time to adequately work up and commence treatment on a patient because of an arbitrary target. It is possible that a modified time-based access target may end up satisfying everyone if flexibility is built in to allow good clinical decisions to be made, and the objective of such a system i.e. driving change in the whole of hospital and beyond, is pursued rigorously.. A close eye is being kept on the experiences in WA where this target has been in place for almost 2 years and across the Tasman where NZ has recently implemented a 6 Hour rule with the trainee representatives from this region regularly reporting on their progress at each trainee committee meeting.

An additional development is ACEM's roll-out of the Non-Specialist pathway in emergency medicine. Several years in the making, this program is now coming close to producing its first graduates from the Certificate pathway with the pilot due to conclude in the next 2 months.

Trainees were initially not overly enthusiastic about this program because of a concern that College resources were diverted away from ACEM trainees to this non-specialist pathway. The trainee view has now warmed considerably due to a number of developments including the inclusion late last year of a trainee on the Non-Specialist Working Party (which at the last ACEM Council meeting in March became a Committee in its own right that will report to Board of Education). Other welcome aspects include agreement from the outset that the considerable resources developed to support the non-specialist pathway candidates will be made available to ACEM trainees as well once they are finalised, which is likely to be the middle of this year. These resources include a large amount of online multimedia educational modules which this author feels would be of immense benefit to provisional and junior advanced trainees and the supervisor course which while targeted at those people who will be supervising non-specialist candidates has been acknowledged to be of equal benefit to supervisors of any emergency medicine trainee regardless of which pathway they are on.

Continued next page...

Trainees' Section (Continued)

The final development that has the potential for significant benefit to all trainees of ACEM is the election promise made by the Labour government in the federal election last year whereby the commonwealth would provide several million dollars to facilitate the roll out of the non-specialist pathway through such measures as funding dedicated clinical supervision time and secretariat support in emergency departments across Australia. At the time this article is being written ACEM is in the final stages of negotiating the ultimate outcome of this pledge with the Commonwealth Department of Health and Ageing. It is hoped that a future edition of this publication will contain full details of the agreement as it is likely that all members of ASEM as well as ACEM will be (positively) affected by this arrangement. From a trainee point of view this funding is very much welcomed as it will address our concern about adequate resources being available for all trainees and candidates. The funding will enable ACEM to take on additional secretariat support staff, provide Emergency Departments around Australia with improved access to educational supervision by FACEMs, and will enable further development of educational resources for both specialist trainees and non-specialist pathway candidates.

It remains to be seen precisely how the non-specialist pathway and ACEM pathway will articulate with the trainee view being that members of each pathway should be able to move from one pathway to the other with adequate recognition of prior learning. This equivalency has been largely addressed for those trainees moving from the non-specialist pathway to the ACEM pathway and it is hoped that the same can be done for ACEM trainees who for whatever reason decide that the non-specialist pathway is more suitable for them.

The college is also engaging in a curriculum reform project through the Training and Assessment Review Working Group (TARWG) which as its name suggests will likely see a large number of changes occur to all stages of training and methods of assessment leading to an ACEM Fellowship. The proposed changes are still being finalised internally and will then go out externally for a period of consultation and comment. Trainees have been involved with this process through having two representatives on TARWG and through providing a written submission to the college on the proposed changes.

As Trainee Committee Chair I am more than happy to be contacted by trainees of either pathway in regards to issues, questions or suggestions relating to training matters.

Dr Andrew Perry

Chair, ACEM Trainee Committee

andrewwalterperry@gmail.com

0403 464 067

Medical Students' Corner

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 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

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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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Dr Robyn Carey, NZ
Dr Cassandra Host, WA
Dr Joe-Anthony Rotella, VIC (DiT)

Scientific Meetings... more on www.asem.org.au

5th Annual Update in Paediatric Emergencies, Noosa, Queensland, 16th-18th April. Contact www.colloquium.com.au

Sports Medicine for the Primary Care Physician Barcelona, Spain, 16th-21st April. Contact www.congres-medical-congress.com

Paediatric Emergency Medicine Sarasota, Florida, 18th-22nd April. Contact www.ams4cme.com

The Emirates Critical Care Conference 2011. Dubai, UAE, 21st-23rd April. Contact infodubai@infomedevents.ae

8th Annual Critical Care Symposium Oldham, Lancashire, 28th-29th April. Contact www.critcaresymposium.co.uk

High Risk Emergency Medicine Las Vegas, Nevada, 2nd-3rd May. Contact www.ceme.org

EMU 2011 Toronto, Canada, 5th-7th May. Contact www.emupdate.ca

17th World Congress on Disaster and Emergency Medicine Beijing, China, 31st May– 3rd June. Contact www.wcdem2011.org

4th Annual Update in Altitude and Expedition Medicine Cusco, Peru, 20th June– 1st July. Contact: www.mote.net.au

The International Federation for Emergency Medicine Symposium on Resuscitation San Miguel de Allende, Mexico, 22nd-24th June. Contact www.ifemsymposium2011.com

Sports Medicine at Sea Alaska Cruise, United States. Contact www.cmxtravel.com

6th Asian ACEM Conference for Emergency Medicine Bangkok, Thailand, 4th-6th July 2011 .Contact www.acem2011.org