EMSSA newsletter

July 2015

Feedback from conferences

Drs Smith and Hardcastle give some feedback from recent international conference experiences. Above picture shows Prof Lee Wallis preparing for ICEM 2016

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An EM mindset

Dr Steve Carroll from the popular emdocs.net blog writes about how emergency physicians are experts at the differential diagnosis

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Welcome to another edition of the annual newsletter of the Emergency Medicine Society of South Africa. Since our last edition we have enjoyed two exciting collaborative conferences in South Africa: WADEM/EMSSA 2015 and the Integrated Acute care symposium held jointly with the Trauma Society of South Africa in 2014. Currently, our committee members and the local organizing committee are very busy preparing for the biggest event that South African Emergency Medicine has ever seen: ICEM 2016, to be held in Cape Town in April 2016.

Emergency Medicine as a specialty is gaining momentum in South Africa, and EMSSA its subgroups and special interest groups are at the forefront of developing locally appropriate resources and guidelines for those working in emergency medicine in resource limited settings. We are also in the process of developing funding options for those who wish to pursue research opportunities, but are not working in the context of academic organizations and so do not have access to the tradition resources or academic funding.

Our ongoing commitment to the development of emergency ultrasound training in South Africa has led to several courses running over the last year, with a total of almost 2000 people now trained in level one emergency ultrasound.

Our nursing subgroup, ENSSA is particularly active and collaborations with nursing training organization in SA and in Africa are aimed at developing the improvement and recognition of emergency nursing as a specific and vital skill set.

One of the reasons EM is so great as a specialty is because it emphasizes collaboration and connection with so many different people. I would love to hear from you with any feedback, questions or comments regarding any of the articles. Please email me at annebsmith@gmail.com or connect via twitter @annestir. You can also contact me if you are not yet an EMSSA member and would like to get involved.

Looking forward to hearing from you!

Anne

' Emergency medicine is the most interesting fifteen minutes of every other specialty' – Dan Sandberg, Sweden 2014

Looking for more information about EMSSA and what we do? Interested in the EMSSA practice guidelines?

Visit us as www.emssa.org.za

The Integrated Acute Care Symposium November 2014

Prof Tim Hardcastle

Over the weekend of the 14th to the 16th of November 2014 the first combined EMSSA-Trauma Society of SA Acute Care Symposium was presented in Durban at the " Durban Holocaust centre".

The meeting was arranged by the KZN-Acute Care Consortium, representing the three professional societies for emergency care (EMSSA, TSSA and ECSSA). The program was split equally between emergency medical topics on the Saturday and trauma-related topics on the Sunday, including the Second Annual Etienne Theron Trauma Lecture presented by Prof Jacques Goosen.

The preceding Friday the 14th was a day of short-courses at various disparate venues, namely an AIME course at the Netcare training centre; a Drager Ventilation Workshop at IALCH; and the Emergency Ultrasound course held at the Howard College of UKZN. All of these were very well attended.

The two days at the Durban holocaust Centre were attended by approximately 170 people each day, including medical and EMS students, nurses, doctors and specialists in emergency medicine and trauma surgery/critical care. Throughout the program the focus was on continuity of care and holistic care, from the prehospital scene to emergency and definitive care, eventually ending with a thoughtful talk on rehabilitation post trauma.

Looking more specifically at the Trauma Program on the Sunday: The day commenced with an enlightening and at times light-hearted look at leadership in medicine with Prof Goosen highlighting the good and bad learning experiences of his life in trauma surgery: crisis management and error avoidance being the focus of his message.

This was followed by an entertaining pre-hospital care session addressing the rural versus the urban scenario and a call from a retrieval specialist for development of formal retrieval programs in this country with Gary Paul, Caleb Wang and Matthew gunning keeping the audience's attention.

The following session moved to the Emergency Department with Tim Hardcastle expounding the minimum care requirements and highlighting that fancy equipment is not the be-all and end-all of care. This issue was placed in context by Elizabeth Lutge and Nirvasha Moodley from the Department of Health detailing the trauma burden to the KZN community.

David Skinner gave an entertaining and myth-busting lecture on Acute Kidney Injury and John Bruce showed the role and timing of calling out the trauma surgeon for major trauma cases. Ben Grey gave an orthopaedic overview of trauma and reminded the audience that the broken bone needs fixing less urgently than the physiology of the patient, with lactate levels serving as a useful surrogate in this decision-making process.

The operative care session followed after lunch with entertaining and bloody videos proving the points raised by Andy Nicol around chest trauma surgery, followed by an alternative view on the stabbed heart from George Oosthuizen – namely the ones arriving alive have generally earned their right to a thoracotomy.

The inimitable Prof Dave Muckart followed on with an overview of the "Guinea-pig Club" (the team fixing the faces of burned pilots from World War 2) and modern maxilla-facial trauma care and a second lecture on the concepts of Critical Care in trauma practice, being all about oxygenation and mitochondrial resuscitation! Interspaced between his two talks Rene Grobler, the Milpark Trauma Coordinator, gave an overview of the ongoing role of the Trauma Nurse in the holistic care of trauma victims from admission to discharge. Nikki Allort, President of the Burns society followed on from the talk the previous day on initial burn care to describe modern definitive burn care and this led into the talk by Virginia Wilson (Head of Netcare Rehab and President-elect of the Rehab doctors society) looking at rehab as a "missing link" in South Africa to societal restoration and reintegration.

Damian Clarke ended off the day with an overview of how electronic medical records could be easily designed and cost-effectively used to produce not only research data, but real-world information useful to plan trauma systems and public health / prevention programs. After the sessions closed the TSSA AGM followed and Dr George Oosthuizen was elected as the new TSSA President and Prof Andy Nicol as VP. Mande Toubkin will be TSSA Treasurer and Petra Brysiewicz becomes the TSSA secretary. Dr Hardcastle is IPP

ex officio. Five other TSSA Council members were elected.

The feedback after the meeting has been generally positive and the feeling was expressed that this type of "update talk" meeting was more beneficial to the " average practitioner" than lots of research presentations.

Dr Anne Smith

2014's Acute care symposium in Durban was a two day update arranged by the local KZN-Acute care consortium, held in an historic building near the famous Durban waterfront. Attendance was excellent and included a wide variety of local EM providers.

Saturday the 15th November was coordinated by EMSSA and the focus largely on medical topics, while Sunday was 'trauma day'.

Expert emergency physicians from all over the country gave short, thoughtful and insightful talks on relevant and common emergencies topics. The 20 minute time limit set for all talks meant that even those of us with very short attention spans were able to concentrate and absorb the knowledge!

Dr Darryl 'Snakeman' Wood gave an overview of the management of snake bites in the EC and Dr Melanie Stander highlighted the importance of getting the basics right with acutely poisoned patients. Dr Sean Gottschalk inspired and amazed us with his tales of emergency medicine in austere environment (think base camp on Mount Everest!).

Dr Lara Goldstein and Prof Mike Wells from WITS both gave excellent talks which challenged current knowledge and practice – on novel anticoagulant therapies and cardiac ultrasound respectively.

It was encouraging to note the high quality talks given by EMS pre hospital providers from both the public and private sectors, as well as emergency nursing staff contributing to the program. Non academic topics such as debriefing and quality assurance in emergency medicine were also covered.

The executive committee of EMSSA met during this meeting and the annual EMSSA AGM was also held to update members of developments. A fantastic speakers' dinner was arranged by our KZN hosts, and took place in the uShaka Marine world aquarium – a totally different experience at night!

This symposium certainly proved that KZN and Durban have a lot to contribute to the South African and global emergency medicine stage and was thoroughly enjoyed by all. Although a small gathering of people, the presence of FOAMed was felt, with live tweeting spreading information and sparking discussions around the world.

Photos left: Speakers dinner at uShaka marine world with Drs Gottschalk, Smith, Postma and Stander

Pre symposium ultrasound workshop with Dr Hein Lamprecht

Middle column: Ultrasound faculty from all across the country

Above: Dr Wood speaking on snakebite management

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1 October 2015
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Emergency nursing matters

Tanya Heyns, Ilse van Eeden, Rene Grobler and Petra Brysiewicz (@nursesennsa)

We as emergency nurses regard ourselves as an integral part of the emergency care team. As our roles are evolving our focus should include curative as well as preventative interventions. As members of the executive committee of ENSSA we have identified three focus areas for the current committee, namely 1) education and training, 2) injury prevention and 3) encouraging dialogue among emergency nurses through social media.

We envision the advancement of emergency nursing as a specialty in South Africa that will be recognised locally and internationally. Representing the voice of emergency nurses, we collaborate with emergency nurses, the South African Nursing Council, Academy of Nursing of South Africa (ANSA) and the Forum of University Nursing Deans of South Africa (FUNDISA) to negotiate and clarify the role and competencies of emergency nurses. In addition, as part of the AFEM nurses group we are leading several innovations to develop emergency nursing in Africa. An emergency nursing course was also developed for Tanzanian nurses, which include a 'train the trainer' component regarded as vital to enhance the sustainability of such a course.

Obtaining Seed Funding from EMSSA made it possible to present a "Candle Safe" project at two primary schools situated in resource poor communities. Approximately 1100 foundation phase learners (of which more than 50% use candles on a daily basis) were actively involved in a learning event which focused on the prevention of burns. A second injury prevention project was conducted through a collaborative initiative involving undergraduate students from the University of Pretoria, Department of Nursing Science and the Trauma Programme Managers of the Netcare private hospital group. The aim was to develop booklets regarding injury prevention topics applicable to the South African context for children six years and younger. Twelve booklets were developed of which the four best booklets were chosen for publication. The rationale for including undergraduate students was to raise awareness regarding emergency nursing as a specialty and potentially recruiting these nurses for the future.

The ENSSA social media sites (Facebook, Twitter and Blog) are being revived in an effort to promote dialogue among emergency nurses. Monthly topics have been identified and we invite all emergency nurses to share their practice wisdom and voice their opinion regarding these topics. Furthermore, to celebrate the unique contributions of emergency nurses in the emergency care environment, we invite you to share stories of everyday practice that made a difference in the lives of patients, their families (significant others) and/or your colleagues.

Above: **Students and administrative support staff assisting Foundation Phase Learners to decorate their "Candle Safe Bottles"**

Winning four Trauma Injury Prevention booklets by the undergraduate students from the University of Pretoria

Masters of the undifferentiated patient

Dr Steve Carroll (@EMBasic)

Edited by Drs Alex Koyfman and Manpreet Singh. First appeared on emdocs.net and reprinted here with permission.

During medical school, I was working with a very personable anesthesiologist who was incredibly helpful in helping me accomplish my goal of getting as many intubations as was physically possible during my short 2 week rotation. I told him upfront that I wanted to go into emergency medicine for which he was slightly disappointed given my enthusiasm for airways. He told me "I thought about EM but they are the jack of all trades but master of none. I wanted a specialty where I could really master a skill set."
This comment stuck with me for a while (and fortunately didn't dissuade me from pursuing EM) but it took a few years before I could come up with a reply. My reply is this – first, what's wrong with being a jack of all trades? What's wrong with being the "MacGyver" of medicine, the doctor who is prepared to see any patient at any time? Second, we are the master of something – we are the masters of the undifferentiated patient. In no other specialty would you be expected to acutely manage (and possibly resuscitate) anyone who comes to you for care – young or old, surgical or medical, sick or not sick.

As an Emergency Medicine Physician you should be proud of the fact that you can deal with literally anything that comes through the door. Would an Internal Medicine doctor be expected to see a septic child? Would a general surgeon be expected to diagnose and initially manage an ectopic pregnancy? Would you expect a primary care doctor to run a major resuscitation in their

office? The answers to all of these are a firm "NO" but those three scenarios could be the first hour of your shift. When talking about how to get into the EM mindset, I think of it as a few discrete stages – what you do before you arrive to a shift, what you do on shift, and what you do after a shift. Some of this will be about building your EM mindset while some of it will be about how to maximize your physical and mental performance.

Before your shift

A commitment to lifelong learning

A commitment to practicing in EM is a commitment to lifelong learning and thinking about medicine a lot. Before you even set foot in an Emergency Department there is so much preparation that should go into your everyday practice. This means keeping up with the latest studies, literature, and expert opinion. This has been made easier with blogs, podcasts, electronic journals, and the entirety of the FOAMed world but it still takes time and effort. You have to figure out what learning style works for you and commit yourself to doing it on a consistent basis. If you aren't committed to doing this, you will never get into the EM mindset that you will need to be a well-functioning EM physician.

Mental preparation for each shift

You have to figure out how you will mentally prepare for each shift. Maybe this involves a medical podcast or two as you drive into work. Maybe it means blasting the radio and singing at the top of your lungs. Perhaps you like to pray or do some sort of self-affirmation as you walk into your shift. This may sound like New Age touchy feely hogwash but the bottom line is that you need some sort of way to stay positive, stay happy, and stay motivated while doing this job. Regretting coming into work each day will leave you miserable and wanting something else.

On shift

Rule out (but not necessarily test for) all life/limb/eyesight threatening emergencies

This is frequently the hardest concept for EM trainees to grasp and it is something that we are all working to develop and fine tune – even if you have been in practice for years or decades. It is hard to find that balance between being concerned about everything and being concerned about nothing. The temptation for new EM people is to either order lots of tests or order almost no tests. Keep in mind that a good history and physical will frequently give you enough data to rule out a deadly diagnosis without performing a whole bunch of tests. While this "gestalt" or "gut feeling" takes time to develop, you should be aware of your thought process behind each patient. Listen to your supervisors when they share their own thought process. Make sure to make it known to your supervisor that you have considered all of the possible deadly diagnoses. If you don't think you need to test for it, that's fine but be prepared to explain why. When I am on shift I like to tell residents: "Sick patients need lots of tests. Not sick patients need a good history and physical and targeted testing to make sure they aren't sick".

Recognize your biases

We all have biases. To deny that fact is to deny that you are human. In this context, I am not referring to those biases based on things such as race or nationality (you shouldn't have those) but instead those biases about certain patients that creep up in our subconscious without us realizing it. Perhaps you don't like dealing with chronic pain patients. Maybe you can't stand parents that bring their well-appearing child into the ED. Perhaps you don't like dealing with the tidal wave of asymptomatic hypertension that is flooding our EDs on a daily basis. These biases can color our patient interactions in a negative way and they lead to us missing bad things. Instead of burying them or denying them, acknowledge them and make a plan to move on. When you find yourself groaning when you pick up a chart after seeing the chief complaint, take a second to reset and commit to doing the best that you can for your patient. Maybe it will be a difficult patient interaction, maybe it won't but if you come into the room with a bad attitude you will fail. Remember that part about treating every patient that comes through your doors?
I'll share a quick story. I was working at a busy community ED, single coverage overnight shift when I picked up a chart of a middle-aged female with chronic pain due to fibromyalgia. I groaned a little but I caught myself. Before I went into the room, I committed to helping her out as much as I could. I came into the room cheerful and did my usual history and physical. When that was over the patient said "Doctor, I'll be honest, all I need is some Toradol and I will feel so much better"... Sure enough, after one dose of Toradol, the patient felt much better (evidence-based medicine be damned) and she was happily discharged. Here I was prepared for requests for mega-doses of opioids and a difficult patient encounter but she turned out to be the nicest patient I had on that shift. So don't let your preconceived notions taint your patient encounters because no one wins when that happens.

Recognize your physiology and do something about it

There is no possible way that you can form a good differential diagnosis if all you can think of is your full bladder. If you find yourself not doing well on a shift, ask yourself three questions:
Do I need to use the bathroom
Am I thirsty or hungry
Am I stressed or overwhelmed?
If the answer is yes to questions 1 or 2, then fix them as soon as possible. The myriad of idiotic hospital rules against consuming food on shift can make these tasks problematic so find a way around that. If you are feeling stressed, then sit down, take a few deep breaths, and find one task that you can accomplish to get

you back on track. This will help you from feeling like you are losing control.

Don't assume that patients came to you for tests

Believe it or not, most patients are more interested in your educated opinion as to whether they are sick or not rather than what a slew of tests show. Young parents just want to know that their child running around the room with a fever is going to be okay. The worried family in the next bed just wants to make sure that their patriarch isn't having a heart attack. In EM, you will be in the reassurance business much more than you will be in the resuscitation business. Don't roll your eyes at those parents – tell them that their child will be just fine and that they are doing a good job.

EM is a team sport

Committing to a career in EM is committing to being a team player. Those who are not team players are not around for very long. Running an ED is an exercise in collaboration starting from the housekeeping staff all the way to the very top. It is very easy to get stressed out and take it out on your staff. If that happens, recognize it and prevent it from happening. Whenever possible, let your nurses know your plan. Say please and thank you. Listen to the input from your nurses and acknowledge it. If you don't agree with their suggested course of action, explain why in a calm and professional way. If you screw up and lose your cool, apologize. We've all been there and people are forgiving if you acknowledge your mistakes. Finally, after you take care of a sick patient and at the end of the shift, go around and thank everyone for their help in a sincere way.

EM is about being an advocate for your patients

During a lecture in my third year of medical school, after an incorrect answer from a classmate, a cardiologist exclaimed "For the first two years of your education it was all about you. Well guess what, it's not about you anymore, it's about the patient!" While I don't agree with the manner in which he used this phrase to belittle an incorrect answer, the last part certainly stuck with me. Most importantly, it means that you hold yourself to a high intellectual and educational standard. Next, it means advocating for your patient. You will be calling other doctors at all hours of the night to ask them to do work. Most of the time, your consultants will be professional, collegial, and nice. Sometimes you will need to fight for what you think your patient needs. Keep it calm and keep it professional but never lose sight of the fact that you are an advocate for your patient.

You will have bad outcomes

Bad outcomes are a fact of life in EM. Some of them you can't prevent, you'll think some of them could have been prevented, and there will be ones where you just plain screwed up. This is a high stakes job with constant interruptions and a million ways that things can go wrong. It's amazing that we get it right as often as we do. Find a way to mentally process these bad outcomes without being self-destructive. A good EM doctor is always critiquing themselves to figure out how they can do better the next time. However, they don't let bad outcomes consume them and bring them down. You will beat yourself up over your mistakes and that's ok but give yourself some sort of time limit. A few days is ok – a few months isn't. I'm not saying to forget about your mistakes forever (that will probably be impossible to do) but rather move on in a productive way. Talk with a trusted mentor, colleague, spouse, partner, or friend about these patients to help you decompress and gain perspective.

After the shift

Have something else besides medicine in your life

I can't stress this enough. You cannot be an effective EM doctor if all you have is EM. While I will admit that having "something else" during medical school and residency is difficult, it is still possible. Some people like to skydive, others like to knit. Some people like to run ultra-marathons, some like to read books. Whatever it is – find something outside of medicine that you enjoy or you will burn out.

Find some sort of physical activity that you enjoy and do it

Do not fall into the trap of "I just ran around the ED for 12 hours, that is all the exercise I need". Even if you have a sky high metabolism and are still the same weight as you were in high school, you need to do some sort of physical activity. It doesn't have to consume hours of your day but it needs to be something you do on a regular basis for your physical and mental health.

Realize that you have the best job in the world

If you don't think this more days out of the week than not, then you may want to find another line of work. Realize how lucky you are to have a job that

challenges you on a daily basis and is never the same day twice. You get to go into the ED, make a whole lot of people feel better, and go home (without a pager!). Figure out a way to stay healthy and mentally well so you can have a long career in EM.

UPCOMING CONFERENCES

If the articles in this newsletter have inspired you to travel to an Emergency medicine conference, why not consider one of these? If you do attend, let us know about your experiences – you could find yourself writing for the next newsletter!

MEMC VIIIth Mediterranean Emergency medicine congress: September 5-9 2015 Rome, Italy. www.emcongress.org/2015l

Developing EM annual conference 2015: September 13-17 2015. Havana Cuba www.developingem.com

International Congress on Disaster and Emergency medicine: November 26 – 29 2015 Istanbul, Turkey www.afetveaciltip2015/org/en/cfm

ESEM 2015: December 6-10 2015 Abu Dhabi, UAE www.esem.ae

ICEM 2016, Cape Town South Africa. 18 – 21 April 2016 www.icem2016.org

smacc dub: Transforming critical care Dublin, Ireland 13-16 June 2016 www.smacc.net.au

WCDEM/ EMSSA 2015 Cape Town

Dr Anne Smith

Again highlighting the importance of worldwide collaboration and - cooperation, EMSSA acted as co-hosts for this years 19th annual World Conference for Disaster and Emergency Medicine.

Plenary speakers this year were all of excellent standard and included large organizations such as Gift of the Givers and the WHO. The recent Ebola outbreak in central Africa was very much a 'hot topic', with several plenary sessions and individual speakers focusing on lessons learned as well as research arising from the epidemic.

Some highlights included:

- Prof Lee Wallis speaking on the recent evacuation of South African citizens from Nigeria following a building collapse – a massive operation which required cooperation from armed forces and emergency medicine in both countries.
- A dedicated peadiatric day which covered topics such as the peadiatric airway in EM, seizures, acute gastroenteritis and shock in children.
- PECSA held a consensus meeting and clarified their purpose and plans for the upcoming month
- The election of the new president elect for AFEM, Dr Heike Geduld
- The first annual AfJEM innovation competition, with winners demonstrating creative solutions in resource limited settings. The winner, Emmanuel Acheampong, a nurse from Ghana, demonstrated what can be done without simple equipment such as ECG electrodes. Other top 3 ideas included an innovative shoulder sling and a homemade mucosal atomization device.
- Excellent quality abstract submissions ranging with a pre hospital and disaster medicine focus .
- The changing role of EMS in emergency medicine and specifically disaster medicine and how providers need to adapt their roles as the situation changes.
- A strong FOAMed presence with a total of 2144 tweets and over 2 million impressions created over the week.
- Delegates from 58 countries across the world!

A message from our president:

Dr Melanie Stander

Emergency Medicine is a specialty of action, pushing the boundaries and innovation. With this privilege of providing our patients with the best emergency medical care possible comes the commitment that we also need to be their fiercest advocates and allies. Accountability in the form of clinical governance and patient safety are fundamental components of emergency practice today and in the future.

Emergency Medicine is currently in its second decade of growth and development in South Africa. There are now five national recognised postgraduate training programmes. There are dedicated undergraduate training modules for medical students, the Masters in Emergency Medicine is well established for postgraduate training and the first doctoral students have already qualified. There are also numerous other degree and diploma courses offered which aid in building and maintaining a strong emergency medicine academic presence in the country. Consultants in emergency medicine have also been pivotal in improving the provision of emergency medical care both on provincial and national levels.

The Emergency Medicine Society of South Africa remains committed to improving and developing the practice of emergency medical care in South Africa and beyond our borders.

Contact us via email or get in touch via twitter!

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