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Emergency Care: a worldwide perspective

The International Federation for Emergency's (IFEM's) Vision statement reads "A world where all people, in all countries, have access to high-quality emergency care". Few people would disagree with the statement but from where I sit right now, listening to colleagues all over the world either as thumbnails on my screen or with my privilege of attending the world's major Emergency Medicine (EM) conferences, we're all a bit tired. Tired of our crowded and chaotic departments. Whether the root cause of poor patient flow is due to the volume "in", the "middle bit" (processing) or the "out" varies, but the pandemic has proven very good at exposing the cracks in fragile systems.

I'm not going to discuss the more extreme situations: very rural community hospitals, those with no ED where the out-patient department combines the roles of primary care and a section set aside for very sick patients, or the tragic state of war-torn countries. Let's talk about hospitals with something called an Emergency Department (ED) in a relatively normal state of affairs. It may be worth noting to UK readership that in many countries EDs exist mainly in cities, and inequality of public versus private hospital care exists in stark and depressing polarity. This last decade has seen a worldwide massive growth in a proper facility at the "front door" of hospitals and in recognising EM as a speciality. I feel the positive buzz from young doctors who have chosen this new career, but in a recent snap-survey of Presidents of 41 national societies all reported over-crowding and physician fatigue.

WHAT'S THE DIFFERENTIAL DIAGNOSIS?

I wish to stress that the following are often found simultaneously in any one country or in complex combination "syndrome" leading to EM poorliness.

1. We are too dependable.

In countries with a fully established model of a hospital "front door" staffed by trained professionals the ED brand is highly valued by the public but that's as much a blessing as a curse. We are victims of our own success. Who's heard these sentiments? "We should be here as a safety net for the patient, not a safety valve of the system". "We are A&E: anything and everything". "We are the only speciality defined by our walls, not what we do". This spills over into bed management strategies, hospitals cramming in urgent elective cases or non-urgent (profitable) elective surgery to take bed capacity over 85%, assuming that "ED will cope". Over-capacity is the enemy of efficient working.

2. No-one understands us.

In contrast, in countries who are young in the journey of the speciality, for example a decade or less (by the way that's an awful lot of countries in Latin America, Africa, Europe and Asia) the problem lies with *lack* of brand identity. The health services invest too little into staffing and equipping the ED properly, and hospital specialists are hostile as they perceive Emergency Physicians as "stealing" their patients (can you imagine that in the UK!).

3. We have caused a new problem.

In some countries the ED is a victim of its own success by creating "unexpected survivors" only to discover that critical care bed capacity cannot match this success and patients are kept literally, for days in the ED.

4. We are a pressure valve.

As a final common default to a worried patient, troubles in other parts of the healthcare system, particularly primary care (the "in") have an impact. Combined with access block to community care (the "out") and you witness the current crisis in Australasia, Canada and the USA. Healthcare systems are complex systems. There's a science to this, but politicians and health managers perpetuate the idea that specific fixes will pay off. After 20 years of failing to fix emergency patient flow in the UK, perhaps we need hydraulic engineers to truly change the course of this river.

LASTLY, A BIT ABOUT IFEM

"President of the world then, hey?" teased friends and colleagues as I took the weighty mantle of IFEM President in June 2022 at IFEM's annual International Conference of Emergency Medicine in Melbourne (this year's ICEM conference is in Amsterdam in June, folks! – do come

and join in). This was closely followed by "so what does IFEM do?" Answer: For 31 years IFEM has promoted our speciality at global level (eg working with the World Health Organisation) and member level (over 70 regional and national members including the Royal College of Emergency Medicine as a founding member).

That might sound a bit ethereal but many countries lack a single, strong professional organisation like RCEM to support its emergency physicians (EPs) and nurses. Others are at the beginning of a journey, their young EPs discovering the thrills and the stresses of becoming an overnight regional leader and pioneer. IFEM's website www.ifem.cc provide core resources, a community of practice (via its committees and special interest groups) and has a new program of online education. Many countries, indeed several on our doorstep in Europe, need help persuading governments to recognise EM as a speciality. IFEM advocates on their behalf.

IFEM needs to move with the times to remain useful as a Federation to its member organisations. It is fantastic to see the regional societies growing from strength to strength in the last decade in Latin America (FLAME), Africa (AFEM), Asia (ASEM), Australasia (ACEM) and Europe (EuSEM), indeed with a fellow Brit (Dr Jim Connolly) as President.

RCEM continues to support global emergency care through a dedicated committee and much outreach work such as in India and other countries. The training and examinations are highly respected. I especially would like to thank Mr Gordon Miles, Dr Katherine Henderson, immediate Past President and Dr Adrian Boyle for their enduring support to IFEM, and to me in my role. My learning curve for the sheer diversity of the presidential role is steep. The privilege of holding a supportive and strategic position connecting with colleagues around the world and the opportunity to actually influence the health of the world's population – what's not to love!

Dr Ffion Davies, President, International Federation for Emergency Medicine, Consultant Emergency Physician, University Hospitals of Leicester NHS Trust, February 2023

Clinical Educators in Emergency Departments - where are we now and where do we want to get to?

How much real-time Emergency Medicine education is happening when numerous patients wait more than twelve hours in the department. How much training happens when patient safety is an issue and patients are now being "examined" and managed on chairs or trolleys in corridors? A degree of educational pragmatism has evolved simply as a virtue of the situations we are forced to work in.

Emergency Department workforce shortages and the volume of patients leave little time for the seniors in charge to explore thinking processes around decision-making with staff. It is no wonder that many clinicians may struggle with the uncertainties of the "grey cases" who present to our Emergency Departments. It is no surprise that with this level of cognitive load, clinicians of any seniority or background may be consumed by anxiety over their decision-making or clinical abilities.

Every day should be a learning day, but the last 6 months has felt immeasurably difficult, to the extent that those teachable moments have been overpowered by other events. In the midst of this, how do we take time to value our patients, ourselves and our future workforce? Why in 2023 does job-planning for dedicated ring -fenced **direct clinical care** time for Consultants and the senior workforce to specifically educate and train seem so difficult?

CLINICAL EDUCATORS IN THE EMERGENCY DEPARTMENT (CEED)

The CEED pilot study was born out through recognition of issues around staff retention, wellbeing and burn out in Emergency Medicine. This was highlighted by the 2017 Securing the Future workforce for emergency departments strategy.[1] In 2018, 54 of the most challenged Trusts in England, as rated by GMC training survey, were funded by HEE to provide development and training of multidisciplinary staff using clinical educators. 90% of the work of the clinical educator was designed to be within the clinical environment. This role was in addition to the education provided by seniors within their Supporting Professional Activity (SPA) job plans and to continue with shop floor training and assessments. The pilot ended in December 2020 and highlighted many benefits for clinicians and trainers. The conclusions from the learners speak for themselves with 78% (388/493) more confident in their clinical abilities; 49.9% (246/493) showing positive impact on well-being and 92.5% (456/493) indicating they would prefer to work in a Trust with clinical educators.[2]

The handbook for CEED (which can be found on the RCEM website) was produced as part of the project in January 2021. This includes many of the practical aspects for delivery, including obtaining feedback as evidence of return of investment and a business case template. This is essential reading material for all speciality tutors in EM.

The conclusion supports the appointment of clinical educators within NHS Emergency Departments.[3] The recommendation is for a minimum of 8 hours a week of CEED time.

CEED WHERE ARE WE NOW?

As the COVID-19 pandemic begins to lift, our working environments and conditions have immeasurably altered. The RCEM 2021 curriculum demands more real time clinical scrutiny and direct observation of practice from supervisors. Each Extended Supervise Learning Event (ESLE) takes a considerable number of hours of trainer time. If done properly with in-depth feedback it provides a valuable learning experience. With increasing numbers of doctors and allied health professionals needing supervision and

training, CEED enables the trainers to share the workload of supervision amongst the team.

Some EDs in England have been able to access HEE covid training recovery funding to support the CEED role within their department. CEED is recognised to be a

valuable role for clinical shopfloor education in EM and so an ideal way to support training recovery. Ongoing recovery funding is unlikely and so alternative methods for funding CEED must be found.

Unfortunately, due to the pandemic and the ensuing workload expansion there has not yet been the opportunity for RCEM to reassess the current position of the CEED role within training EDs across all four nations.

Soft intelligence around future proofing and sustainability of CEED gathered via survey monkey, twitter and numerous 1:1 conversations are summarised below.

Speciality Tutors note the CEED role has helped in improving GMC survey results. Poor GMC survey results can be helpful in securing Trust funding for this role. Clinical educators provide a bespoke learning opportunity, allowing clinicians to match training to personal learning gaps. One Tutor notes "assessments in the clinical environment are done properly, clinicians are no longer just having to number crunch or feel like they are on a conveyer belt gaining superficial assessments or feeling undervalued. Hopefully in regaining the sense of value, we can try to retain staff." Another speciality tutor notes "we just don't have enough eyes to watch every new trainee. Patient safety is paramount but it becomes so difficult with a four month change around." CEED acts as a quality control measure, ensuring that clinicians are observed in practice which helps with early identification of those needing additional support or signposting for mentorship or coaching and patient safety.

CEED WHERE DO WE WANT TO GET TO?

CEED educators can be used to specifically provide 1:1 supervision for supported return to training trainees during their supernumerary and enhanced supervision phase of return. They can also support international medical graduates new to the NHS to assist with a more supported transition into NHS working.

Easy to capture, timely feedback to the learner is essential to the maintenance of the role and to justify ongoing support and the benefits. Timely feedback is however difficult to sustain and needs a regular prompt after the learning episode to ensure feedback capture becomes standard practise.

Incorporating the CEED role in EM job plans can be helpful when recruiting new Consultants and can be used to retain senior Consultants/ SAS grades who wish to retire. The role can enhance the value of staying in EM for those who have experienced or are at risk of burnout. The role will enable clinicians to make an immensely valuable contribution supporting others, bringing their decades of experience into play. It will likely help with the retention of EM workforce by bringing job satisfaction, reward, and sustainability.

In 2023-2024 the RCEM Training Standards Committee will continue to promote and monitor the introduction of the CEED role for a minimum of 8 hours per week as a benchmark of quality standards for all Training EDs.

Maya Naravi
Vice President RCEM (Exams and Training)

Tamsin Dunn
Quality Lead RCEM Training Standards Committee

(ENDNOTES)

1 https://www.gmworkforcefutures.org.uk/media/1024/emergency_department_workforce_plan_-_111017_final3.pdf
2 https://doi.org/10.1136/emermed-2020-210122
3 Clinical Educators in Emergency Departments (CEED) | RCEM

"Have you been sexually harassed at work?"

This is the question we asked to the audience at the RCEM Annual Scientific Conference in October 2022.

YES – said two thirds of the people in the room.

"I was told by a consultant, when I said a baby was cute, that he would put a baby in me'

"I made a drug error as an F1, my registrar invited me back to his room to discuss it."

"A senior member of staff…known to be inappropriate to female staff members…is still allowed to work in the trust…due to staff shortages."

"The sexualisation of women in itself is sexual harassment - women being red-carded in an OSCE because they were wearing a short - sleeved shirt and their bra strap slipped off their shoulders"

"sexual harassment of female seniors to male juniors – have also seen that."

Although it shocked some members of the audience, it came as no surprise to the committee members of the women's SIG and I wonder whether it triggers you as the reader.

Sexism and sexual harassment are illegal under the Equality Act of 2010 section 26 (1)

Harassment

(1) A person (A) harasses another (B) if
- (a) A engages in unwanted conduct related to a relevant protected characteristic, and
- (b) the conduct has the purpose or effect of
  - (i) violating B's dignity, or
  - (ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

(2) A also harasses B if
- (a) A engages in unwanted conduct of a sexual nature, and
- (b) the conduct has the purpose or effect referred to in subsection (1)(b).

(3) A also harasses B if
- (a) A or another person engages in unwanted conduct of a sexual nature or that is related to gender reassignment or sex,
- (b) the conduct has the purpose or effect referred to in subsection (1)(b), and
- (c) because of B's rejection of or submission to the conduct, A treats B less favourably than A would treat B if B had not rejected or submitted to the conduct.

Clearly rape and sexual assault are also illegal under the Sexual Offences Act 2021.

So, given that sexism and sexual harassment are illegal, we asked our audience:

WHY DOES IT STILL HAPPEN?

A common theme that ran through these discussions was that of power and patriarchy. The Oxford definition of patriarchy is:

'A society, system or country that is ruled or controlled by men.'

However, the author, journalist, comedian and feminist Caitlin Moran gives us a modern day interpretation of the patriarchy in her book 'More than a Woman' (2)

"Old, Stale and confining ideas about what it is to be a man or woman (that are hurting men just as much as they are hurting women)."

The patriarchy frowns on the father who wants to be present for their child for the long to life term commitment of parenting, rather than the 2 weeks of statutory parental leave. The patriarchy uses toxic and gendered insults such as 'man up;' or 'you run like a girl.' It powers the few and disadvantages the many.

The perpetrator is often someone in a position of power who benefits from the protection of a patriarchal system (men and women) such as a consultant over the survivor (junior doctor or nurse). This often strikes fear into the junior colleague about speaking out and challenging the behaviour.

The Sexism in Medicine (3) report published by the BMA showed that 44% of women respondents and 34% of men respondents who had experienced or witnessed issues of sexism and/or sexual harassment did not raise it. 63% stated they believed no action would be taken if they did; other reasons included a fear of negative impact on their careers and relationships with colleagues. We still exist in a patriarchal culture that cultivates this behaviour and often is more powerful then the threat of any law to prosecute powerful perpetrators.

What is more insidious than a toxic culture that outwits the law is an apathy in the reporting system.

The survey found that only 18% of women felt appropriate action was taken after reporting sexism and sexual harassment while 34% felt no action was taken at all. Men seemed to be more successful at complaining as 48% reported satisfaction with the outcome vs 12.5%. It seems that the practice of sexism and sexual harassment at work is endemic so what is the point in raising it as an issue?

The Surviving in Scrubs (4) campaign have carefully published 136 testimonies (to the date when this article was written) of sexual harassment, sexism and sexual assault in the work place.

That is 136 testimonies too many.

Even with the success of the MeToo campaign, high profile and powerful individuals (mostly men) may still avoid prosecution. Medicine remains a patriarchal playground for hierarchy, where unsociable behaviour is regularly excused because it is endemic and committed by powerful characters abusing their position and the trust of their employees. Such behaviours go unchallenged and can even be championed creating a toxic environment, discouraging reporting and making colleagues feel silently threatened.

The reporting system itself is failing survivors. In the wider society only 3% of cases of rape will ever go to trial. No wonder perpetrators get away with it – because the system and culture allow them to thrive.

WHERE DO WE GO FROM HERE?

Are you indignant, shocked, curious or a total denier?

Unfortunately if you are a denier – much like anti-vaxers or climate change deniers, no amount of evidence or testimonies will change your mind and henceforth you will always be part of the problem.

NOT you ? Well then…

First of all, start with self-reflection and really ask yourself how your own gender/ sexuality/ race plays into your everyday lived experience and can obscure the reality. For example, if as a man you have felt safe at work and on the streets of your neighbourhood does sexual harassment exist in your experience? And if you've never encountered it, does it mean it's not a problem? And if it is a problem, how much is it your problem if you are not personally affected by it?

The answer?

Sexual harassment is everyone's problem. If you are not a perpetrator do you partake in some of the "banter"? do you bear witness but look the other way? Or are you oblivious to the work environment as felt by your colleagues and walk on by – not even a passive bystander?

The Women's SIG will be leading on a campaign against sexism, sexual harassment and sexual assault in our work place. Stay tuned to find out more and become a champion and ally.

But the TIME IS NOW. Start by asking your colleagues about their experience and ask in a way that is non-judgemental and safe for them to answer (not in the middle of resus with an audience at hand).

Reflect on your own behaviour in the past and honestly ask how you may have contributed – even down to the "banter" at handover that you think is harmless.

If you are challenged, put the shame away, listen, say sorry and learn. The person you have offended will feel much worse than you.

Are you a cis-gendered white man in a leadership position? Be an ally and lead by example and MAKE IT YOUR AGENDA, not a woman's. Women are just as capable of sexual harassment. Sexual harassment of anyone is unforgivable and destroys lives.

Champions and allies will always be vilified by a patriarchal system. But it is the right thing to do and RCEM as a collective are here to support you through this journey.

Through the article I have chosen to use the word survivor over victim when speaking about people who have been subjected to sexism, sexual harassment, assault and rape. Through my experience of working with survivors of torture (including sexual torture) and survivors of rape – the structure of language is important in order to empower those who have been wronged and take away the power of the perpetrator.

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1 Equality Act 2010 (internet) Part 2 Chapter 2: section 26 Harassment. [accessed 23rd November 2022]. Available from (https://www.legislation.gov.uk/ukpga/2010/15/section/26)
2 Moran, C 2020, More Than a Woman, Ebury Press, part of Penguin Random House Publishing, London
3 Sexism in Medicine: British Medical Association, published August 2022 Available from: https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/gender-equality-in-medicine/sexism-in-medicine-report
4 Surviving in Scrubs (Dr Becky Cox & Dr Chelcie Jewitt). Available at https://survivinginscrubsorg.wordpress.com/the-campaign