

# Doyle's Informal Orientation to the Australian Emergency Department

*For American docs coming to Australia*

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## Part I:

There are many potential differences US trained Emergency Physicians encounter when adjusting to the Australian Emergency Department. The following are my biased observations... People may disagree with what I have written. I hope you find this helpful.

Since this paper is meant for orientation purposes, I have obviously emphasized the differences. Don't be intimidated by what I have included below! The human bodies are still the same, and there are **far more similarities than differences!** No one is expecting anybody to jump right in and be very efficient, and when in doubt, you can always ask questions!

## Friendly and Less Formal

One thing that you will immediately notice is that the Australian culture seems to be a lot less formal and friendlier. You will be known by your first name from all of the nurses and even the patients. Don't ever try to call yourself, "Dr. XYZ." Many Australians will probably forgive you thinking that there is a cultural difference, whereas others might think you are pompous, arrogant, or pretentious. These character traits are really looked down upon by most Australians. (Most Australian "heroes" are humble in nature.) I always introduce myself and "Hi... I'm Brian Doyle... one of the doctors. They usually refer back to me as "Brian." Of course, the above observations are generalizations and you will see local variations and exceptions. Likewise, it is customary to refer to patients by their first name, but I still refer to older patients as Mr. or Mrs. XYZ.

There is not much of the social hierarchy between doctors and nurses that exists in some areas of the USA. Nurses will banter back with the doctors as though they are your colleagues and refer to you by your first name. This is not to say that there is not mutual respect or that they don't do their job. You can ask them to do things and follow orders just as you would in the USA. Overall, the nurses I have worked with have been fantastic!

Dress is also less formal. The typical ED dress is “smart casual.” Nice button-down shirt and slacks. It is unusual to see an ED doc wear a tie, but I have on occasion. On weekends, it is not unusual to see the registrars or junior staff in blue jeans. I have even seen some of the nurses and doctors wear shorts. I have NEVER seen an ED doctor wear a white coat. I wore my white coat my first day working in Australia until a nurse came up to me and said “I would take that off mate... the patients might mistake you for a butcher!” Scrubs became mandatory at some hospitals during the SARS epidemic and so have remained. I personally don’t have a problem with anyone wearing their own scrubs in the ED (I prefer them myself when in the USA) but you will need to ask what the local preference is.

## **Part II:**

### **Free Emergency Department Care**

In general, the government provides free health care to all of its citizens... i.e., nationalized health care. There are some private hospitals in Australia and people can purchase private “health cover,” but most people go through the “public” system. It is my belief that the overall delivery of health care in Australia is actually better than the USA. However there are individual features of the US system that are probably better (i.e., invasive cardiology).

All citizens have Medicare (regardless of age). Emergency Department care is free. Some GPs (general practioners... this is the preferred term for what is called family practioners) in the community may charge a fee over and above what Medicare will reimburse. Patients have to “pay the gap.” A minority of GPs will “bulk-bill” and only charge what Medicare will reimburse. It is getting more difficult to find GPs in Australia who will bulk bill. As one might imagine, this does create some conflict because, “Why would I want to pay to see my GP when I can go to the ED for free?” Therefore some GP type patients do present to the Emergency Department, but this is what triage is for... There is no EMTALA in Australia, but it is uncommon to see a patient denied admission to the ED. But, I have heard some triage nurses suggest to patients that it would be best if they saw their GP for minor complaints.

The advantage of free Emergency Department care is that the patients seem to be less demanding and they don’t seem to mind waiting as much as their American counterparts... perhaps this is more of a cultural phenomenon. It is easier to get patients in and out quicker. Since they are not paying \$200 to walk through the door, I don’t feel as obligated to put on a big show... (I hope you know what I mean.)

The other advantage of free ED care is that you can ask people to come back to the Emergency Department the following day for a quick check. I do this often for burns, cellulitis, and abdominal pain that I send home. I also tell patients to come back and “see me tomorrow” for a quick recheck if I am a little worried about something. Obviously this is a bit foreign to the American system, but I like it! There are no major expectations on the part of the patients, and they seem to be very grateful for the follow-up. If they are

OK, I send them away usually within two minutes and my notes are VERY brief (see about documentation below). Obviously, I select which patients I want to come back... as you can imagine there are some patients (fibromyalgia anyone??) which are best to get back to their GP urgently.

## **Free Care and Incentive for Service**

Unlike the USA, you will not see EDs advertising on billboards to “come to our state of the art Emergency Department.” The ED is NOT run on a business model. There is no economic incentive to be quick or efficient. You do not get paid more for seeing more patients. To the contrary, more patients imply utilization of more resources. As you might imagine, this creates a less efficient system. Don’t get me wrong... the system is no where near as bad as the typical Veterans’ hospital in the USA, but you will notice some inefficiency. **Examples** would include:

No ED secretary to answer phones (this one can drive me nuts at times...). I generally don’t answer any phone primarily unless I am **not** doing something else (which is rare) and eventually one of the nursing or other staff answers the phone. It is really not efficient to have the nurses answer the phones either, but this level of efficiency has not quite entered into the EDs where I have worked.

At times you will need to fill out forms and slips (i.e. x-ray slips) and walk them around to the x-ray department. Rather than get extremely annoyed by this, you should think of this as “mental break time...” Trust me; you will not change the system overnight.

There are many Australian ED’s that expect the doctors to draw all of the blood and put in all of their own IVs! Fortunately, the hospital where I currently work is an exception. I rarely have to put in an IV, although the nurses are usually quite reluctant to place one in a child. Since I have “deskilled” at putting in IVs, I usually ask one of the junior doctors to put one in for me as a courtesy... they usually look at me funny and then oblige- this doesn’t come up often. You may find the nurses ask you to put in urinary catheters in male patients (the term “foley” is not used in Australia) although I seem to always get out of this one...

## **Part III:**

### **Relaxed Working Environment**

Australians do not define themselves by their work. In general they do not look up to or emulate the worker who puts in a lot of extra time or hours. They think of this person as a bit misguided. This is not to say that the Australians don’t have a pretty good work ethic, rather they have what I perceive to be a better understanding of the priorities in life. It is understood that one should have a life outside of the Emergency Department.

The “**sickie**” should be a question on the exam to become an Australian Citizen. Australians think of sick-days as a “right” rather than some extreme notion that we have

in the USA. If an Australian has a bad cold, he or she will call in sick. This is expected. If you show up to work with a bad cold, they wonder what the hell you are doing going to work. I have told many an Australian about American doctors walking around with their own IV pole to keep hydrated during an illness... and they think we are nuts. Perhaps we are!?! However, there are times that sick days are abused a bit, but many supervisors do not cry foul since they are as likely to be as guilty at times.. While I was working at a moderate size ED in Victoria, we once had five nurses call in sick the day after “Ken’s famous cocktail party.” But this is an exception. Most “casual sickies” would not be expected to inconvenience the other staff that has to work.

### **More on relaxed working environment...**

You will notice the pace to be a lot more relaxed compared to the typical American ED. Doctors are expected to be able to leave the department for a quick bite to eat and to use the bathroom when needed. I generally see just less than two patients an hour (depending on the acuity). You will notice that the ED seems to have more doctor coverage than what you would see in the USA. There is definitely less running around than you are probably accustomed to... enjoy it... But obviously step up the pace when things get busy or if you have multiple sick patients. You will need to be careful in the beginning about seeing “too many” patients while the junior doctors sit back and watch you run around. You will be supervising the junior doctors and may need to very politely ask if they were going to see the next patient, etc. Don’t be surprised when the other doctors take a lunch break and return 20 or 30 minutes later... but 30 minutes is a bit long. I usually leave for 10 minutes maximum, but this is me...

There are only 38 Emergency Nurse Practitioners in the whole of Australia... They seem to be about 20 years behind the US on this one... As far as I am aware, there are no Physician Assistants. Osteopathic doctors are not really recognized as traditional medical practitioners (like the USA) in Australia. They seem to operate more like chiropractors down here.

### **Documentation**

Hand-written and short! You are not billing based on your documentation in Australia. There are no templated or dictated charts either... thought to be too expensive. Therefore, the documentation is probably what existed in the USA 20 years ago. Notes are very short, problem focused (don’t have to worry about 15 aspects of the review of systems etc...) Put enough to convey the encounter to maximize communication and patient care. Forget all of the silly things that we do for billing in the USA. Are you relieved?!?!

## **Part IV:**

### **Rationalization of resources**

The public seem to understand that the public system has limited resources and is “willing” to be inconvenienced at times. This is likely one of the cultural aspects that allows the public health system to function without becoming bankrupt. (*This is the reason why I don't think public health care would function well in the USA- too many unreal expectations. “I want my fries now, I want them hot, and I don't want to pay for them!” – am I being too cynical?*) They don't seem to be too unhappy when they see an intern or demand to see the consultant. (BTW the term “attending” does not exist in Australia... you will be called a “consultant.”)

Patients often wait a long time on non-urgent operative lists for things such as joint replacement or cholecystectomy. They also wait a while to see a specialist... Good luck seeing a neurologist, urologist, dermatologist, unless it is very urgent. It might be months for the next routine neurology appointment to become available. But if you speak to the specialist directly and think it is urgent, they will sometimes see the patient quite soon... usually the next day.

Most Emergency Departments do NOT have 24 hour routine radiography... this includes regular radiographs. At my hospital, after 8:00pm, there is no radiographer, but one may be called in for urgent x-rays. All non-urgent x-rays that present after-hours are asked to return the following day at 8:00am for their ankle, wrist, or whatever film. I have yet to find a patient who was not understanding and fine with returning. You can get any x-ray, ultrasound, or CT scan urgently if it is needed, but you would be surprised at how infrequent this really occurs. But some of this is also a reflection of the lack of reliance upon technology or advanced imaging...

Many EDs are fortunate to have some good orderlies or “attendants” (USA term “tech's”) that will put on back-slabs (splints), get crutches, etc.

## Part V:

### Advanced Training in Emergency Medicine

In Australia, **medical school** is for six years commencing after high school.

After this, they do **basic training** for two years; an internship year and then at least one more year before they can apply to the *Australasian College for Emergency Medicine* for advanced training. Unlike the USA, training is much more individualized and must be undertaken at multiple different hospitals.

The next step is at least one year of **provisional training** during which time they must spend 12 months in an accredited ED. (ACEM determines which EDs in Australia can train emergency trainees and for how long; 6, 12, or 24 months.) From this point onwards, the trainee is referred to as an emergency “registrar” similar to an emergency resident in the USA. During this provisional training, they must pass the **primary exam**. This exam is similar to USMLE step 1 and a major pain in @%^\*. There are four sections; anatomy, pathology, pharmacology, and physiology.

After provisional training comes **advanced training**. This is *at least* four years long, but is often years longer depending on the motivation and commitment of the registrar. Often they take “time-off” and get paid quite well doing other things that are not recognized as contributing to their 48 month commitment. (Like being a doctor in Antarctica...) Of the 48 months, 30 months must be in an accredited ED (but 6 months must be done in an urban district or a regional/rural hospital) and 18 months are off service... most registrars will do some anesthetics and other rotations. There is a **minimum pediatric requirement** and a “4:10.” The 4:10 is a major hurdle in training in EM. It is the research requirement and the college takes this very seriously. I had to perform research, present it at a national conference, and have it formally adjudicated before I could even consider having my USA ABEM qualifications recognized by ACEM. Many trainees actually publish research in a peer reviewed journal.

After all of the above requirements are met, they take the **fellowship exam**. I believe the pass rate for the fellowship exam is about 60% (but I could be wrong.) I do know that it is very common for people to fail the exam on multiple attempts.

My belief is that the average new FACEM is actually more experienced than the average new ABEM graduate. But after a couple of years, the end product is really the same and boils down to the individual. In some ways the training in the USA is better since it seems to be more comprehensive with formal training in many different environments (surgical, pediatric ICU, ultrasound, EMS, toxicology, etc) but in many ways the FACEM may also be more well rounded. They will often spend at least 6 months in anesthetics, during which time they start all of the large IVs and manage entire operative cases on their own (with back-up of course...) playing around with inhalation anesthetics etc.(hopefully, not on themselves...)

### **FACEMs... to reiterate**

A fully qualified emergency physician in Australia is referred to as a FACEM... Faculty of the Australasian College for Emergency Medicine. ACEM, the Australasian College, administers the fellowship examination (much like ABEM does in the USA, but ABEM is not part of ACEP). The Australians are not really sure what to call a US trained ABEM graduate, so they call us FACEPs. Even though this may not really be correct, it is easier not to try to correct them. Just call yourself a FACEP! (I'm sure that ACEP would understand given the circumstances...)

### **More on FACEMs and ED Cover**

There are only about 1000 FACEMs in all of Australasia. The USA has about 20,000 emergency physicians. This is much fewer per capita than the USA. There are not enough to provide 24-hour coverage of all of their EDs. Therefore, it is very common for Emergency Registrars to be the most qualified doctor in the ED after hours. If you are lucky, a FACEM will be on call. It is an unusual experience being on-call again, but what

can you do? If you are called in, it is usually for something quite fun... like putting in a couple of chest tubes and intubating a trauma patient.

## **Part VI:**

### **Utilization of technology**

Australians tend to rely more upon the clinical exam rather than advanced imaging. I have yet to see anyone in the Emergency Department order a CT scan to rule out appendicitis except after they have been seen by the surgeon. And most surgeons would rather take a patient straight to “theatre” (no... not a movie theatre... the operating theatre!) and take out their appendix rather than get a CT. I usually call the surgeon to see a patient with abdominal pain rather than order the CT scan. However, I don’t think I have changed my practice much for head CTs as compared to the USA.

It is not often that I get emergent ultrasounds (especially after hours) but I will get them if I think they are emergently indicated. After hours, low risk rule-out ectopics, and rule out DVTs generally come back the next day. Many EDs have ultrasound machines now... but ultrasound is not really considered part of the core curriculum for EPs like it is in the USA. They may actually be amazed by your ultrasound skills... (assuming you have these skills...)

## **Part VII:**

### **Snakes, spiders, shark bites, manta rays, killer jellyfish!!**

A lot is made in the American press about the dangerous animals in Australia. The reality is that the Australians are more fearful of the animals in the USA (killer bears and moose that will stomp you to death!) and gun-toting rednecks. The last recorded death from a snake bite in Tasmania was from a Tiger snake in 1966! You will quickly find that it is safer in Australia (especially Tasmania) when it comes to crime and wild animals. Much of what is written about Australia involves a lot of sensationalism... but heck... sensationalism sells!

There are three species of snakes in Tasmania (tiger, copperhead, and whip snake) and they are all poisonous. Takes the guess work out of the equation! They are very timid and usually run away unless they are provoked by drunk 25 y/o white males. The species are all elapids... not crotalids like the USA. This means they are primarily neurotoxic rather than tissue toxic. You cannot rely upon local findings and local symptoms to determine envenomation. You must rely upon labs and systemic symptoms. Constriction bands are used to prevent lymphatic flow in the prehospital setting and there are few other things that you can read about. In almost three years of working in Australia I have never had to give antivenin. Bites are VERY rare in Tasmania. I have perhaps seen 2 or 3 possible envenomations that turned out to be either dry bites or not bites at all.

Perhaps more dangerous is the “Jack-jumper” ant. They cause anaphylaxis just like our bee stings in the USA and are treated the same. Give adrenalin (epinephrine) and lots of it! I see a case every few months.

The most dangerous activity in Australia is driving your car. Not snakes, spiders, manta rays, killer jelly fish....

**Bottom line: Don't be intimidated!**

As I have already mentioned, I have highlighted the differences. The reality is that there are **far more similarities!** Just practice the best medicine you already know and things will be fine.

And have fun!!! It's sure the Australians will!!!

Brian