Amy Coopes reported on the Australasian College for Emergency Medicine’s Annual Scientific Meeting held in Sydney from 19 – 23 November 2017 for the Croakey Conference News Service.

#ACEM17

Croakey is a social journalism project for health based in Australia.
http://croakey.org
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An emergency medicine conference in Sydney heard about the need to reduce “unacceptable” waiting times for people presenting to emergency departments with mental health problems.

The 34th annual scientific meeting of the Australasian College for Emergency Medicine (ACEM) also put the spotlight on access block more generally, as well as gender equality and inclusive workplaces. Professor Gillian Triggs delivered the ACEM Foundation Lecture: *Health Care for Australia’s vulnerable populations; how we can do better?*

In the article below previewing conference discussions, Associate Professor Sally McCarthy, Chair of the ACEM ASM 2017 Organising Committee, writes that many people who present to emergency departments with mental health problems are waiting far longer than is desirable.

Data from ACEM’s 2016 Annual Site Census suggest that of all mental health presentations to the emergency department, the majority wait more than eight hours following assessment for an inpatient admission.

She writes:

> **Sadly, patients presenting to emergency departments with mental health concerns have unacceptable lengths of stay following triage and assessment. The emergency department is inappropriate for the ongoing care of this patient group.**

> **The highly stimulating emergency department environment and design can contribute to further distress and agitation which may increase the risk of behavioural disturbance.**

The conference themes are ‘*Impossible is just a perspective*’ and ‘*Getting the balance right*, and discussions will cover policy, clinical governance and oversight, principles and practice standards, leading evidence, best practice, and patient and community expectations. (See beneath this post for selfies and snaps from pre-conference workshops.)
Sally McCarthy writes:

Emergency departments in Australia and New Zealand are the front door to the health system for those who are acutely unwell or injured. Many of us have waited anxiously in an emergency department late at night with a sick child or with someone who has suffered an acute injury, which may be minor or life threatening. Emergency departments treat all patients based on the severity of the presenting problem rather than socio-economic or health insurance status.

Demand for care in emergency departments reflects changes in the health system and the broader community. If funding for mental health services is reduced, for example, emergency departments are likely to see more mental health patients, or if there is a drug epidemic such as “ice”, we will see more “ice” or other drug users. In the recent winter, many patients were suffering from the effects of the flu which varied from mild to seriously life threatening. On busy weekends, a significant number of patients seen in emergency departments will be affected by alcohol.

Demand for healthcare in Australasia continues to grow. And, like many other countries, Australia and New Zealand’s populations are ageing and living with chronic diseases and cancer, which can be managed by modern medicine. The increase in the prevalence of chronic diseases, and the invariable complications of both the diseases and treatment, have added to the demand on acute care resources which are often only able to be provided in emergency departments.

Emergency Medicine physicians usually work only in emergency departments and provide specialist supervision and care seven days per week. They have specialist skills both in resuscitation and diagnosis in the acute phase of illness and injury, as well as a diverse set of procedural and technical skills. They are also deeply committed to the work involved in emergency care and in providing timely, appropriate and high quality care to all of our patients.

Over 800 members of our College, the Australasian College for Emergency Medicine (ACEM), met in Sydney at the Annual Scientific Meeting. Many topics and relevant research in areas relevant to Emergency Medicine were discussed, such as advances in resuscitation and management of clinical conditions, emergency department design and function, and the treatment of some groups, such as mental health patients and illicit drug users.

Focus on access block

There will also be discussion about one of the biggest challenges facing emergency departments, which is “overcrowding”. This phenomenon is also known “access block” and it occurs when patients who are to be admitted to hospital stay in the emergency department for long periods because there aren’t enough available beds on the wards for these patients.

Access block leads to increasing pressure on emergency department staff and long waits for patient and undermines the quality of care that we can provide. Evidence consistently demonstrates that access block leads to increased risk of complications, medical and drug errors, death and increased costs to the health care system.

Access block has historically been seen as ‘an emergency department only problem’; however, it is symptomatic of a health system in crisis where inpatient capacity cannot meet demand. Hence, access block requires a “whole of system” response.
ACEM believes strategies must be adopted to improve the flow of patients into and through hospitals. These include hospitals identifying system-wide process solutions that are tailored to their local needs and the realistic setting of targets for whole of hospital performance.

If you can prevent people coming to the emergency department in the first place, by preventing illness and injury, even better. It is unfair for the patients who use emergency departments and for the staff who work in them to have so much of the pressure in the health system directed at this one point.

Long waits for vulnerable patients

One of the most vulnerable groups to be caught up in this predicament are patients presenting with mental health issues.

ACEM’s policy position is to treat all patients presenting to the emergency department with an acute mental illness with the same dignity and respect afforded to patients presenting with any other condition requiring emergency medical care.

Sadly, patients presenting to emergency departments with mental health concerns have unacceptable lengths of stay following triage and assessment. The emergency department is inappropriate for the ongoing care of this patient group. The highly stimulating emergency department environment and design can contribute to further distress and agitation which may increase the risk of behavioural disturbance.

Data from ACEM’s 2016 Annual Site Census suggest that of all mental health presentations to the emergency department, the majority wait more than eight hours following assessment for an inpatient admission. ACEM is currently piloting research in emergency departments to estimate the prevalence of mental health access block.

Preliminary data suggests that approximately one-third of patients with an acute mental illness wait more than eight hours in the emergency department, with some of these patients waiting much longer.

ACEM believes there are a number of strategies that can be adopted to address these issues, including identifying care pathways in hospitals and the community.

The development of innovative service models that provide access to emergency care for mental health patients, along with safe assessment rooms and improving the safety of staffing models, emergency department design, adequacy of facilities and bed capacity, are measures governments can adopt so patients presenting to the emergency department with acute mental illness receive the best possible care.

Responding to aggression and violence

The increased use of crystal methamphetamine, or “ice”, results in patients affected by this drug presenting to emergency departments and often they are acutely psychotic. Their care can present a number of challenges to the function of emergency departments, including the safety of staff, the patients and carers.

Experienced hospital security personnel with excellent communication skills, an aptitude for learning, and a positive ‘customer service attitude’ are an important emergency department resource to prevent and respond to aggression and violence.
As a member-based organisation, it is incumbent on ACEM to look after those on the frontline of emergency care. We acknowledge emergency physicians and emergency medicine trainees in Australia and New Zealand are confronting these issues while experiencing emotional exhaustion, and a diminished sense of personal accomplishment and even burnout.

ACEM has an ongoing commitment to improve the working lives of the emergency medicine workforce through its membership support, policy and advocacy and education.

Patient care is at the heart of emergency medicine. Emergency physicians and emergency medicine trainees who are enjoying a sustained and satisfying career will be more able to meet the needs of their Australian and New Zealand patients.

It’s this vision of optimal patient care being delivered by a sustainable emergency medicine workforce that is driving ACEM’s efforts in this area.

**Associate Professor Sally McCarthy is Chair of the ACEM ASM 2017 Organising Committee. A senior specialist emergency physician at the Prince of Wales Hospital in Sydney, she is a former ACEM President.**

ACEM is the peak body for emergency medicine in Australia and New Zealand, responsible for the training and education of emergency physicians and advancement of professional standards in emergency medicine.

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**Selfies and snaps from pre-conference workshops**

[Image of a selfie from a pre-conference workshop with text overlay: Leadership and Self-Awareness]
You can track Croakey's coverage of the conference here.

Emergency medicine conference to put focus on access block and vulnerable populations

#ACEM17

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"Leadership is about making others better as a result of your presence and making sure that impact lasts in your absence."
You can track Croakey's coverage of the conference here.

Emergency medicine conference to put focus on access block and vulnerable populations

#ACEM17

Aidan Baron @aLittleMedic • Nov 17

So cool to finally meet @peppermint_frog at #ACEM17!

We totally needed out scanning oesophagus's with @kylebaker888 😄

#Sono #POCUS

Aidan Baron @aLittleMedic • Nov 17

“The more patients you have to see, the less individually you end up seeing them.”

- @peppermint_frog on the pressure in ED

#ACEM17
Emergency medicine conference to put focus on access block and vulnerable populations

You can track Croakey's coverage of the conference here.

AIU @AIUMedEd · 23h
World class educators upskilling Australia's emergency physicians in cardiac ultrasound
@kylebaker888 Justin Bowra & Ruth Ramm

AIU @AIUMedEd · 23h
Justin Bowra @alttimedic and Jenni Sanderson at #ACEM17 Echo workshop

Kellie D'Orsa @ultrasound skill · 3h
#ACEM17
You can track Croakey's coverage of the conference here.

Emergency medicine conference to put focus on access block and vulnerable populations

#ACEM17

ACEM Events @acemevents · 2h
Should we have a separate ED for geriatric patients?

What are the arguments for and against this, and what does the data from studies surrounding this issue demonstrate? #ACEM17

ACEM Events @acemevents · 2h
How can we prevent missing a diagnosis of delirium in the ED?
The discussion continues at AGESIM. #ACEM17

ACEM Events @acemevents · 2h
Participants discuss a feasible approach to managing geriatric patients with delirium at AGESIM. #ACEM17

ACEM Events @acemevents · 4h
What are the kinds of elder abuse and how can we identify it in the ED? #ACEM17
You can track Croakey’s coverage of the conference here.

Emergency medicine conference to put focus on access block and vulnerable populations.
Human rights lawyer Professor Gillian Triggs received a standing ovation after delivering a rousing lecture about Australia’s disrespect for human rights to an Australasian College for Emergency Medicine (ACEM) conference.

Her calls for health professionals to speak up and advocate for human rights and health rights were timely, as the situation on Manus Island grows ever more dire, pressure mounts for national youth justice reform, and further evidence emerges of the detrimental health impacts for LGBTI people of the marriage equality survey process.

Also watch this interview with Triggs, where she describes the marriage equality survey as a “painful and inappropriate process”, although the results were an “outstanding success for participatory democracy”.

Amy Coopes writes:

In a post-truth world of alternative facts and ideologies, health care workers are more obliged than ever to speak loudly for what they believe in and know to be true, Professor Gillian Triggs told the conference, describing health as a fundamental human right.
Triggs, former president of the Australian Human Rights Commission, received a standing ovation for her keynote address: *Health Care for Australia’s Vulnerable Populations: How can we do better.*

Traversing considerable terrain, ranging from the Northern Territory Intervention to Children Overboard, Manus Island and marriage equality, Triggs said the credibility and frontline experience of doctors made them essential allies in the human rights movement.

Understanding health as a “fundamental part of human rights and the right to a life in dignity” was important because it underscored its connection to social justice and to functional democracy, she said.

International law understood health as, not just the absence of disease, but as complete physical, mental and social wellbeing – an ideal that Triggs said we were falling short on for too many vulnerable groups, including Indigenous people, rural and remote communities, the elderly and those who were uninsured or disconnected from the system.

Truly universal care would encompass much more than the medical needs of our most disadvantaged groups, and also recognise the many and varied determinants of wellbeing including, housing, employment and legal security.

“We might have a better opportunity at social cohesion were we all able to access our universal right to health,” said Triggs.
Human rights challenged

Triggs said the tragedy of Australia’s “isolationist and exceptionalist” stance on human rights was that health, and many other essential human freedoms, were not enshrined in or protected by domestic law.

Australia existed in the world’s only region without a human rights treaty and, quite simply, didn’t speak the language, Triggs said.

In the era of H.V. ‘Doc’ Evatt, Triggs said Australia had once been a leader in international human rights law, but was now the world’s only democracy without a Bill of Rights and had ratified just three global instruments into domestic law – the international conventions on elimination of racial discrimination, discrimination against women, and on the rights of persons with disabilities. The rights of the child were a notable omission.

As Human Rights Commission president, Triggs said that left her in the “parlous” situation of having to protest human rights abuses to the Australian Government that, as far as they were concerned, were not defined as thus under domestic law.
It was with some irony that Triggs noted that the fiercest opponents of Australia recognising its international human rights obligations were suddenly scrambling for protection of religious freedom under the International Covenant on Civil and Political Rights in the marriage equality debate – a “muddled” situation.

This was a strawman given Australia’s constitution already enshrined protections for religion, said Triggs, adding that “this government does not support fundamental human rights principles except when they want to placate” the conservative flank of their own party.

**Cries of ‘shame’**

Triggs stressed the importance of language in rights debates, recalling the 2001 Children Overboard scandal for which, ultimately, “not a shred of evidence” was found.

“It didn’t matter, the damage was done. The language was there,” said Triggs, noting a similar effect from stunts like Pauline Hanson’s recent entrance to the Senate wearing a burqa. “These are ways of demeaning people.”

She admitted being “astonished” by the “shocking” derision with which the government spoke about asylum-seekers and said her own experiences visiting detainees in Australian facilities in the Pacific had illustrated for her that we cannot, and must not, turn our backs on the most vulnerable.

Delegates erupted into applause when Triggs said the International Criminal Court was considering bringing a case against Australian government ministers for crimes against humanity over their punitive asylum-seeker policies, and there were cries of ‘shame’ when she pointed out that the billions spent on offshore detention had come from the country’s humanitarian budget.

Rather than denouncing Australia’s ascension to the UN Human Rights Council – not an election, she noted, as it was a dead rubber with two countries running for two vacant seats – Triggs said she viewed it as a good thing.

“It’s an opportunity for us to persuade but also be persuaded to meet the standards we’ve signed up to,” she said.

There were moments of levity, as she lamented her lack of coordination evidenced in the preceding dance break for delegates and said she preferred not to be introduced as Emeritus Professor because in Latin emeritus meant “has-been – and I’m not done yet.”
Credibility matters

Triggs paid tribute to the doctors she had worked alongside gathering evidence and testimony from offshore detainees, saying they brought a credibility to the process and the findings.

She said we were living through a very difficult period in our history where advocacy – even and especially for risk-averse people like doctors – was more important than ever before.

In the face of a growing tolerance for alternative facts and ideologies, and a rejection of evidence-based inquiries and reports, Triggs said it was imperative that “as professionals with full knowledge of the facts, we need to stand up for what we know to be right.”

“My view now is that have we have a clear obligation to push back and to get the facts on the record, even if it attracts a certain degree of public opprobrium,” she said.
Emergency medicine doctors applaud "compelling" presentation by Gillian Triggs on human rights

Hearing from the audience

Geoff Couser @GeoffCouser · 16h
Professor Gillian Triggs not holding back from the very start. Love it.
@acemevents #ACEM17

Rob Mitchell @robdmitchell · 15h
RePLYing to @coopedetat
So rare to hear the words chagrin, opprobrium and obfuscation in a single plenary at a medical conference. A compelling and erudite speech #ACEM2017

Eric Richman @DoctorRichman
To hear @GillianTriggs speak at #ACEM17 is to fall in love with ideas, what an agent of change looks like, to know what a good human is.

Rob Mitchell @robdmitchell
Congratulations and thanks to @acemFoundation and @acemonline for inviting Gillian Triggs to speak - a compelling and erudite presentation #ACEM17
You can track Croakey's coverage of the conference here.

Emergency medicine doctors applaud “compelling” presentation by Gillian Triggs on human rights

Watch this interview
Professor Gillian Triggs discusses marriage equality and other human rights issues.
In the hospital system, efforts to address bullying and discrimination must start at the top

Amy Coopes writes:

Hospital executives need to be held to account for “hostile” work environments and cultures of bullying and discrimination that affect the wellbeing of staff, according to the new president of the Australasian College for Emergency Medicine (ACEM).

The hospital system needed to “change significantly”, and executives should shift their focus to supporting and caring for people, Dr Simon Judkins said in an interview with Croakey at the ACEM Annual Scientific Meeting in Sydney.

His comments followed the presentation of an ACEM survey showing that about half of the respondents (55.7 per cent of women and 45 per cent of men) reported experiencing bullying, discrimination, harassment and sexual harassment in the workplace.

Judkins, who is also the Deputy Director of Emergency Medicine at Austin Health, said:

- The hospital system is about people… it’s not about widgets and it’s not about key performance indicators, it’s about looking after patients and looking after staff.

- I’ve had multiple examples from visiting various health networks that there is a problem out there, about bullying and discrimination and not supporting their staff.

- Some of these environments that our emergency physicians and trainees are working in would be described as being hostile... that's a really sad thing to see when you're meant to be working in an industry that cares about people. It's called a healthcare industry for a reason, and we certainly don't see that.
So part of my work as president will be standing up and calling out that behaviour and going beyond the incidences of bullying in the emergency department or within the surgical unit, but actually holding the administration to account – because that’s where the rot starts and that’s where we need to change the culture.

If we’re only addressing it at the coal face but we still have an executive that... doesn’t understand how to treat people, then you are never going to get that change.”

Internal change also needed

However, Judkins acknowledged that the College also had its own work to do, as demonstrated by a presentation highlighting that all ten members of its board are men (women account for 32 percent of the emergency medicine workforce).

Judkins, who described himself as a privileged white guy, admitted it was “very hard to look in the mirror” when the new all-male board posed for photos, and change was certainly needed. One of his first conversations as president was “how will we make sure the next president is female?”

He said “having the dialogue” was where this would begin, and recognising that if ED teams led by women had better outcomes, so too would the College.

“It’s not just a gender equity issue that we need to address but it’s also racial diversity and racial equity, we need to look at all of those issues,” he told Croakey.

“Disgraceful”

In a plenary presentation on Tuesday, registrar Dr Jenny Jamieson said it was “nothing short of disgraceful” that ACEM’s newly-elected board was 100 percent men.

Her presentation – described by colleagues as “brave and fearless” – pointed to macro and microinequalities perpetuating a problematic culture in emergency medicine.

These came from colleagues (questioning the judgment of a female doctor when they wouldn’t do the same to a male counterpart), from patients (assuming any female in scrubs is a nurse), and indeed from female doctors-in-training themselves, she said.

As a result of social conditioning and unconscious bias, Jamieson said women were more polite, apologetic, hesitant and less likely to interrupt. They were also less likely, as the result of “deeply-held beliefs and norms” about work-life balance and family, to be seen as suitable for leadership, she said.

Jamieson busted what she described as the meritocracy myth – held time and again as justification for preferencing a man over a woman for a role – arguing that the metrics of ‘merit’ did not exist in a vacuum but were largely predetermined by men.

Often used as a “proxy for being objective”, meritocracy was only as good as the values, cultures and leaders it espoused, she added, arguing that it was actually standing in the way of addressing the real impediments to gender equity in medicine.

“Everyone hates this topic because women fear being marked with an asterix, and men fear being overlooked for jobs,” Jamieson told delegates.

She called for a culture change at ACEM to attract, retain, and foster female leaders, describing one-year contracts as a major contributor and noting that, even though it was illegal, asking female trainees about their family intentions was still a feature of job interviews in the speciality.
Judkins and board member Didier Palmer both related anecdotes of female colleagues being afraid to reveal their pregnancy because of the perceived repercussions, and Judkins said it was everyone’s responsibility to shift this culture.

“People are much more important than rosters or any other thing,” he said. “This is your life; that’s work.”

Palmer echoed Jamieson’s sentiments, declaring that the “merit principle is rubbish”.

When hiring, he said CVs were now burnished to such a degree that “what you’re looking for is the X factor – and for most people that’s just you in a mirror.”

**Workplace bullying and harassment findings**

Palmer described things as “palpably not” equal on gender at ACEM, with just 35 percent of College Fellows being female, and also noting that a 2016 review conducted after the Royal Australasian College of Surgeons sexism furore had revealed that 50 percent of ED docs had experienced bullying, discrimination or sexual harassment.

The headline findings of the ACEM review were presented at a conference session chaired by Judkins and other members of the College’s working group on discrimination, bullying and sexual or other harassment, or DBSH.

The survey, which had a 44 percent response rate from across the membership (some 2,121 people), found 49.8 percent of ACEM respondents had been subject to DBSH in the workplace, with the breakdown as following:

- five percent had been bullied
- seven percent had experienced discrimination
- one percent had been harassed
- two percent had been sexually harassed
Levels overall were much higher among female fellows and trainees, at 55.7 percent overall vs 45 percent for men, and by subgroup (with males for comparison):

- discrimination 26.1 percent (17.8 percent)
- bullying 38.2 percent (31.3 percent)
- harassment 15.2 percent (10.4 percent)
- sexual harassment 12.2 percent (1.5 percent)

Of note, Judkins said more than 70 percent of DBSH incidents happened within the ED, and males and fellows were overwhelmingly the perpetrators. Half of all respondents said they believed reporting these behaviours would have negative consequences for them, and majority felt there were improper reporting mechanisms and that the incident, if reported, was not resolved to their satisfaction.

Rates of DBSH were particularly higher among respondents born in non-English speaking countries, with a marked gap on discrimination.

This issue was highlighted in a presentation of a separate review convened to examine accusations of racial bias in the College’s 2016 exams, where a group of 30 unsuccessful ‘non-Caucasian’ candidates alleged a pass rate of 6.8 percent versus 88 percent in the broader cohort as evidence of discrimination.

Though the review ultimately rejected that claim (all findings and reports available here), the chair Professor Ron Paterson and other members of the expert advisory group did recommend that ACEM issue an apology for “unintended systemic racial discrimination” and improve support for failed candidates, expressing concern for their health and wellbeing.

That apology was delivered by outgoing College President Tony Lawler in his valedictory address on Tuesday.

Shahina Braganza, one of the working group’s members, said she had been “incredibly confronted by the data from this survey”, though ACEM past president Sally McCarthy said she hadn’t been surprised, describing medicine as a mirror on the society in which it operates.

**Drivers of disparity**

Coleen MacKinnon, a corporate consultant on gender equity and the Male Champions of Change movement, offered some fascinating insights into the drivers and determinants of gender disparity.

Children internalised gender biases from a young age, she said, with girls beginning to question their worth compared with boys when they were just six and 50 percent losing interest in STEM subjects by eight.

A ‘confidence gap’ existed where fewer women presented for promotions because their self-imposed threshold for meeting the position criteria was 80 percent, compared with 40 percent for men. Women would start an interview declaring their shortcomings, while men emphasised their strengths, MacKinnon said.

Assertive behaviour was seen as a strength for men (increasing their score on performance evaluations by 14 percent), while the same behaviour in a woman was viewed as a drawback, resulting in 10 percent lower scores.
Reform options

On DBSH, McCarthy said the group would move forward with a draft action plan to be put to the membership, examining potential remedies across five target areas: culture change and leadership; governance; education and training; complaint management and advocacy.

Quotas and targets would be among ideas considered, as well as an interactive online complaints portal and increased advocacy on workplace issues contributing to cultural problems, including access block and ED overcrowding.

Judkins said tackling cultural issues in emergency medicine had the potential to send waves through the whole health system, with the ED at the epicentre of not only the hospital but also connected to many other parts of the health system, as well as being at its public-facing frontlines.

“We can be leaders not only in our hospitals, but in our communities as well.”

Judkins stressed that a concern for social justice was at the heart of emergency medicine, as “our doors never close… we treat whoever needs our help”, and many of those presenting to emergency departments struggled to access healthcare in any other way.

---

Tweet reports

Jenny Jamieson

Amy Coopes (@coopersdetat)

Hearing from emergency doc Jenny Jamieson #ACEM17

“the global gender gap will take 100 years to close, compared with 83 last year.”

- World Economic Forum, Nov 1st 2017

Tony Kambourakis (@DrTonyKam)

Dr Jenny Jamieson ED reg at @AlfredHealth speaking on gender equality - ‘You can’t be what you can’t see’ #ACEM17
In the hospital system, efforts to address bullying and discrimination must start at the top.

Gender disparities in @acemonline. The 'trickle up' doesn't exist, says Jamieson. Board is 100% male - 'nothing short of disgraceful' #ACEM17

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In the hospital system, efforts to address bullying and discrimination must start at the top

Simon Judkins

Laura Raiti
Follow

An inspiring presidential address from @JudkinsSimon "EM is about social justice, fairness and equality" #ACEM17
In the hospital system, efforts to address bullying and discrimination must start at the top.

@JudkinsSimon: As new @acemonline president, I want to focus on social justice, equality, justice & fairness #ACEM17

In the hospital system, efforts to address bullying and discrimination must start at the top.

Amy Coopes @coopesdetat · Nov 20
Seeing our patients not as fodder, not as widgets in a production line, will go a long way to addressing these problems as well, says @JudkinsSimon #ACEM17

Amy Coopes @coopesdetat · Nov 20
DBSH Working Group: The College is in a unique position to change culture in EDs and wider hospital settings #ACEM17

Amy Coopes @coopesdetat · Nov 20
Replies to @coopesdetat @JudkinsSimon
We can be leaders not only in our hospitals but in our communities as well, says @JudkinsSimon #ACEM17

Amy Coopes @coopesdetat · Nov 20
Pres @JudkinsSimon says gender revolution in EM has the capacity to drive system-wide culture change, seeing huge numbers of trainee doctors and connected to all other disciplines #ACEM17
In the hospital system, efforts to address bullying and discrimination must start at the top.

Didier Palmer

Didier Palmer, a leader in the hospital system, said, "Fostering a culture that values different perspectives and challenges us is key to addressing bullying and discrimination." He believes that changes must begin at the highest levels to create long-lasting solutions.

Other tweets:

- "It's about recruiting a fair workforce where people are happy and give better patient care," Palmer continued.
- "I laid my gender credentials on the table," one participant said, recalling an incident where a school that had only admitted women for over 50 years bragged about their achievements.
- "Didier Palmer is doing a PhD in gender studies. He told us about the talk and said 'Why the hell are you doing that talk, you're a man'. He says he got defensive," another tweet noted.
- "To create the right culture, you need to identify staff who are not nice, and mentor them to niceness, or get them out," said Michael Edmonds.
- "Didier Palmer's whole talk is basically an advertisement to go work for him in Darwin. Great to see a DEM acknowledging their role in workplace culture," Jessica Forbes commented.
- Amy Coopes, another attendee, tweeted: "I'm open to the idea of merit, but until men are actually promoted on merit I see absolutely no reason why women should have to be. In fact, I believe we will only have true equality when there are as many mediocre women in positions of power as there currently are mediocre men. And if you'd like to see just how mediocre things can get, look no further than our new federal cabinet."
In the hospital system, efforts to address bullying and discrimination must start at the top

#ACEM17

"Conference News Service"
In the hospital system, efforts to address bullying and discrimination must start at the top

#ACEM17

Coleen MacKinnon

Biases a way of making quick decisions, born out of social conditioning. Parents, coaches, teachers, media, culture and society drivers @CMacKinnonAUS #ACEM17

Gender pay gap in Australia remains at 17%, sexism an issue across every industry, childcare arrangements mean disproportionate ratio of women in part-time work: @CMacKinnonAUS #ACEM17
In the hospital system, efforts to address bullying and discrimination must start at the top.

Benefits for men of gender equity include better sex - 'and if that doesn't interest the men in the room I don't know what will' says @CMacKinnonAUS #ACEM17

The corporate landscape in Australia on gender equality: @CMacKinnonAUS #ACEM17
You can track Croakey’s coverage of the conference here.

In the hospital system, efforts to address bullying and discrimination must start at the top.

#ACEM17
In the hospital system, efforts to address bullying and discrimination must start at the top.

Hearing from the audience

Jessica Forbes @jorbesy · Nov 20
“Need to change the culture so that it’s normal for trainees to speak up & speak out” - @JuddkinsSimon Hear, heart 🤗 #ACEM17

Jack Lego @jacklego92 · Nov 20
Looking in mirror - too much XY-factor, and not enough XX-factor! #ACEM17

Amy Coopes @coopesdetat
It was very hard to look in the mirror as the new all-male board posed for photos said @JuddkinsSimon. We certainly need change #ACEM17

Amy Coopes @coopesdetat · Nov 20
Biases will never be removed, we just have the conversation about them and introduce interrupters like anonymising CVs says @CMacKinnonAUS. Until we have a level playing field initiatives like targets may be of value #ACEM17

Andrew Walby @awalby
Learning how to stop ACEM being pale, male and stale. #acem17
In the hospital system, efforts to address bullying and discrimination must start at the top.

You can track Croakey’s coverage of the conference here.

Congratulations @drjennyjam - a very brave and fearless presentation. #inspirational #acem17 @acemevents

Great to hear @drjennyjam challenging the status quo - ACEM and EM can do more to achieve gender equity - need culture change and systems change #ACEM17

@angelaschiewa - great session on gender balance - other annoying questions I get asked as a female doctor/ working mum - "Don't you miss your kids?" And "who is looking after your kids?" and if I go to present at conference "how can you be away from your kids?" #ACEM17

Additionally, the organisation needs to acknowledge the benefits and normative to do so. I hope @acemonline really does #acem17

Having chaired an NGO board it's actually not hard to achieve gender equality on boards - identify, encourage, appoint. @acemonline @acemevents should do likewise #ACEM17

#ACEM17 Fellowship examination is the end result of a long process of training. Should so much focus be on exam/examiners? Or should ACEM do more to tackle bias during training?
You can track Croakey’s coverage of the conference here.

In the hospital system, efforts to address bullying and discrimination must start at the top.

Watch the interview with ACEM’s Dr Simon Judkins.
Disasters, conflicts and climate change are escalating threats to global health security

As disasters escalate within Australia, our region, and globally, how prepared are our health systems to cope, and what challenges might we face?

These were recurring questions at the annual scientific meeting of the Australasian College for Emergency Medicine (ACEM).

In a meaty program tackling some of the biggest issues for emergency medicine, sessions ranged from climate change-driven disasters and public health emergencies like thunderstorm asthma, through to lessons from the 2014 West Africa Ebola outbreak.

In the first of two articles on these topics for the Croakey Conference News Service, Amy Coopes writes that the targeting of health facilities and staff is another critical challenge for global health security, with the World Health Organization (WHO) documenting almost 1,100 of these attacks over a 3.5 year period.

In the video interview beneath the article below, the WHO's Dr Rick Brennan also describes the development of new collaborative models to restore health services to countries experiencing protracted conflict, such as Yemen.
Amy Coopes writes:

The World Health Organization (WHO) is facing “unprecedented” demand globally for crisis responses, according to Dr Rick Brennan, an emergency physician from Australia who is director of emergency operations at the WHO.

He said the WHO was currently dealing with nine top-tier incidents – well above the projected trend of one every few years – with four new events emerging this year alone, in Bangladesh, the Democratic Republic of the Congo, Ethiopia and Somalia.

Crises in Syria, Iraq, South Sudan, northern Nigeria and Yemen had been going for some time and were continuing to pose challenges, he said.

The data he presented was staggering: more than 200 new disease outbreaks every year, 200 million people affected by natural or technological disasters and 65 million people displaced globally – 80 percent due to conflict.

He said 1,500 new pathogens had emerged, with major outbreaks in recent years of SARS, H1N1, MERS, Ebola and Zika.

Climate change was already contributing to this picture, Brennan said, giving the example of the Darfur conflict, which was largely driven by drought.

New approaches needed

With the conflict in Syria now running longer than World War Two, and the average displacement period for refugees globally at seven years, Brennan said business as usual in the relief and development sector was no longer an option.

The protracted nature of conflicts presented a major challenge in the delivery of health care, with the traditional method of rush in, deliver aid, rush out being outdated and ineffective, and donor fatigue a constant issue, he said.

Because they endured for so long, contemporary conflicts also presented multi-factorial health challenges far beyond simple trauma, with major outbreaks of cholera, lassa fever, malaria and yellow fever in Yemen this year alone.

The modern context also posed unique threats for health workers, Brennan said, with facilities and staff increasingly targeted. Between 2014 and 2017, there had been more than 1,000 such attacks, claiming 1,500 lives.

Funding, lack of local capacity, state fragility and insecurity and bureaucratic bottlenecks were also issues in the delivery of health, he said.

In recognition of the major risk to global health security of protracted conflicts, Brennan said the World Bank had put unprecedented new funding on the table for a pilot in Yemen on a new relief delivery model which, if successful, would be rolled out in other top-tier contexts. This pilot was a partnership with the World Food Programme, WHO and UNICEF.

In a bid to stay ahead of the curve, Brennan outlined the WHO’s global event-based surveillance system, which reviewed about 3,000 signals a month and actioned rapid risk assessment on those deemed to be of significance to public health at a national, regional and international level.

This, and other measures, including a new global health security agenda to replace the old international health regulations, had assumed greater importance following the 2014 West Africa Ebola outbreak.
He said 85 countries had signed onto the new agenda and 47 had tested their national systems, with after-action reviews in 10 countries where outbreaks had occurred.

“Ebola really was a watershed in how we think about global health security,” Brennan told delegates.

The event had exposed “very limited capacity at a country, regional and global level to prevent outbreaks, prepare for them and respond effectively,” he said.

The “real heroes”

Brennan described national health workers on the frontlines as the “real heroes of the day”, facing a risk of contracting the deadly haemorrhagic disease 32 times greater than the rest of the population, as well as collapse of local health systems due to the pressure, with implications for malaria and other chronic conditions.

Ultimately, 898 health care workers contracted Ebola during the response and there were 518 deaths: 50 percent of these occurred in nurses and 12 percent among doctors. The vast majority of these were locals, with just 18 cases among international workers and three or four deaths.

Brennan said weak local health systems and a delay by the WHO in recognising and responding to the outbreak had been factors in its spread, with 28,000 cases and 11,500 deaths by the end of the event.

Fear, rumours and misunderstanding among local communities had also contributed to this “perfect storm” of outbreak escalation, he added. Engagement of civil society including religious and women’s groups had been essential in addressing this.

UNMEER, which Brennan described as the world’s first public health emergency response, faced considerable logistical challenges, having to build 72 medical centres, deploy 50 foreign teams and 27 mobile laboratories as well as 280 burial teams.

He said 5,500 WHO staff were trained and 1.42 million pieces of personal protective equipment (PPE) were delivered.
Vehicles, accommodation and other sites posed an infection risk. Medevac with biocontainment capacity and a willing end destination were challenges, and in the end Brennan said no country was willing to accept evacuated African locals, only foreign staff.

“We really were building the ship as we were sailing it,” said Brennan of the Ebola response.

- Stay tuned for a second article on disaster preparedness, which will examine gaps in Australia’s capability, and lessons from thunderstorm asthma outbreaks in Victoria and NSW.
Disasters, conflicts and climate change are escalating threats to global health security

Tweet reports

Global health security challenges

Amy Coopes @coopesdetat · 24h
Currently @WHO responding to 9 top-tier emergencies worldwide. Projected 1 every 2 years -- 4 new ones this year - Bangladesh, Congo, Ethiopia & Somalia. Syria, Iraq, South Sudan, northern Nigeria ongoing #ACEM17

Amy Coopes @coopesdetat · 24h
Brennan says climate change already having effects, points to Darfur conflict as largely driven by drought. 1500 new pathogens identified. SARS, MERs, H1N1, Ebola, Zika. State fragility, esp Middle East & Africa. Unprecedented levels of travel #ACEM17

Amy Coopes @coopesdetat · 24h
Well over 200 outbreaks globally per year, can cross borders. 200m+ affected by disasters every year, 65m+ displaced. 80% conflict-driven. 'Unprecedented' demand says Brennan #ACEM17

Eric Richman @DoctorRichman · 24h
#ACEM17 the grade 3 crisis was expected to be once every 3 years when described. Currently 9 ongoing

anne creaton @annecreaton · 23h
Syrian conflict has lasted longer than WW2 Rick Brennan #acem17

Protracted Nature of Conflict

- Modern-day conflicts are long-term
  - Ave displacement = 7 yrs
- Humanitarian model insufficient to ensure access to health care
- Development actors largely absent

ACEM17

Croakey “Conference News Service”
Disasters, conflicts and climate change are escalating threats to global health security.

#ACEM17

Tough operating conditions for health in conflict. Now targets, > 1,000 attacks

#ACEM17
Disasters, conflicts and climate change are escalating threats to global health security #ACEM17

Lessons from Ebola

Amy Coopes @coopesdetat · 24h
Brennan on the international health regulations - not taken seriously by many countries pre-Ebola #ACEM17

Croakey “Conference News Service”
Disasters, conflicts and climate change are escalating threats to global health security.

Without PPE health facilities can be amplifiers for infectious disease outbreaks

#acem17

Amy Cooper • @coopesdata • Nov 19
Medvac a challenge - had to have relevant biocontainment capacity as well as finding a country, government, hospital that would receive these evacs. Only expats were ultimately accepted. 27 people evacuated, 18 confirmed dx and 9 as precaution ACEM17

Amy Cooper • @coopesdata • Nov 19
One of the success stories - accelerated development of new products. 3 x PCR rapid dx tests, new vaccine advanced, says Brennan ACEM17

Amy Cooper • @coopesdata • Nov 19
1.42 million pieces of PPE brought in by the WHO, had to apply not just in HC facilities but vehicles, accommodation and other places that became infection risks ACEM17

Amy Cooper • @coopesdata • Nov 19
5,500 WHO staff trained in Ebola during the response. Had to develop a range of protocols to guide the response, says Brennan ACEM17
You can track Croakey's coverage of the conference here.

Disasters, conflicts and climate change are escalating threats to global health security

New responses and models

Amy Coopes @coopesdatat · Nov 19
Ultimately 72 Ebola centres built, 50 foreign teams delivered, 27 mobile laboratories, 280 burial teams. Cuban and African Union medical brigades. US, UK, France deployed military personnel #ACEM17

Amy Coopes @coopesdatat · Nov 19
How do you attract international workers to this scenario? Had to be trained, build 50-70 treatment centres from scratch, ensure access to care and medical evacuation for staff #ACEM17

Amy Coopes @coopesdatat · Nov 19
Real heroes of day national health workers on the frontlines. 32x more likely to catch Ebola than general population, more than 50% of health centres stopped functioning with implications for malaria and other conditions #ACEM17

Amy Coopes @coopesdatat · Nov 19
World’s first public health emergency response - UNMEER. Identified 5,500 bed gap, need for 30 extra medical teams, 230 more burial teams, 1,800 more staff and 17 more labs #ACEM17

Melody @peppermint_frog · Nov 19
Rick Brennan talks about Ebola outbreak in 2014 at #ACEM17. Compelling stuff... and really puts our local ED problems in perspective.

Amy Coopes @coopesdatat · 23h
On Ebola response #ACEM17

Jenny Jamieson @drjennyjam
Replying to @coopesdatat @WHO
Still struggle to understand how call for action by MSF & other humanitarian agencies was not a "signal." Slow patchy response, took months.

Amy Coopes @coopesdatat · 23h
On Ebola response #ACEM17

Jenny Jamieson @drjennyjam
Replying to @coopesdatat @WHO
Yes... first "signal" was in Guinea in March. Repeated calls by many humanitarian agencies - took months for WHO to respond to this.

New responses and models

Amy Coopes @coopesdatat · 23h
Brennan says growing trend of public health emergency operations centres at a national level - network of these established in 2012. >200 partners meeting in Geneva this week #ACEM17
Disasters, conflicts and climate change are escalating threats to global health security

Rick Brennan also presented during a session on wellbeing for emergency workers

You can track Croakey's coverage of the conference here.
Our emergency response and health systems are not prepared for the increasing toll of disasters

An emergency medicine conference in Sydney recently heard that disasters, conflicts and other public health emergencies are presenting growing threats to global health security, as reported at Croakey.

The Australasian College for Emergency Medicine (ACEM) conference also heard that Australian emergency response and health systems are woefully unprepared to cope with natural disasters and other public health emergencies, as Amy Coopes reports below for the Croakey Conference News Service.

Amy Coopes writes:

A flurry of natural disasters and public health crises had revealed a woeful lack of preparedness in Australia’s emergency response and health systems, the ACEM conference was told.

Presenters reviewed some of the lessons from events ranging from Black Saturday and the Queensland floods to last year’s Victoria thunderstorm asthma event.

Dr Kavita Varshney, from Sydney’s Westmead Hospital, presented a study showing an exponential increase in disasters worldwide, with Australia seeing some of the worst cataclysms on record in the past decade, exposing vast deficiencies in its preparedness.
Apart from the 1996 Port Arthur massacre, which had been met with a swift response by the Federal Government, Varshney said her study found that the implementation of reforms recommended by disaster reviews tended to be delayed.

Identifying gaps in response efforts

Paul Barnes from the Australian Strategic Policy Institute (ASPI) told the conference health care responses were critical to the national security effort but there were dots – local, state and federal – that had not yet been joined.

Preparedness had not been tested at a state, intrastate and national coordination level, particularly to a scenario involving an improvised explosive device, said Barnes, arguing that capability gaps could not be seen without activating the “whole of service chain”.

Barnes said Australia did not run enough realistic real-time simulations of crisis response, pointing to the 2016 Exercise Sydney emergency response drill testing readiness for a mass casualty event in the city when a jumbo jet carrying 500 people went down in the harbour.

There was a “certain degree of non-realism involved” said Barnes of the exercise, which ASPI reviewed for stakeholders.

For example, participants reported fire-fighters carrying five or six cardboard people under each arm, and it was held on the weekend, meaning CBD traffic flows were unrealistic. Despite it being a jumbo jet scenario, no search and rescue capacity of the harbour was tested, he added.

Looking at health specifically, he said it was important to acknowledge that staff were often the targets of secondary devices in so-called ‘hot zones’, and that health facilities were no longer sanctuaries but targets, with a need to plan accordingly, especially in the event of an ongoing attack.
There was also an important role for public health systems to go into “emergency mode” to engage and reassure the community in these scenarios, he added.

Barnes said it was imperative that COAG look at emergency medical responses to major crises and the broader recovery cycle.

He noted that the overhaul of Home Affairs into a super portfolio led by Peter Dutton meant it was presently uncertain how health fitted into the government’s thinking on national security.

He did say there was appetite in the Federal Government to address this issue, it was just a matter of lobbying the right officials.

**Thunderstorm asthma**

Victoria’s emergency response system came under scrutiny last year during the state-wide thunderstorm asthma event, when 9,000 presentations flooded the system and nine people lost their lives.

Simon Craig, from Austin Health, surveyed 357 staff working that night and presented his findings to the conference.

More than half (247) said they felt teams did well despite the circumstances, but a third (107) reported running out or needing more medication, and a quarter (92) felt a code brown should have been called.
Staff reported wanting to stay back but being denied overtime by hospital executives, nurses suffering asthma attacks stopping for puffer breaks in the corridors between patients and a lack of timely and effective communications between the health department, hospitals and paramedics.

Others said electronic medical record-keeping became laborious and time-consuming, as did the normal triage procedures. Equipment and supplies, workload management and distribution, and space in the ED were identified as institutional issues.

Victorian Inspector-General of Emergency Management Tony Pearce – whose position was created in response to the Black Saturday fires and Victorian floods – reviewed the event, and the Andrews government announced the rollout of a real-time monitoring system to track emergency demand and fast-track responses in when a crisis unfolds, in response to his report.

**Regional experience**

Shane Curran, from Wagga Wagga Base Hospital, shared the NSW regional centre’s long experience with thunderstorm asthma, and lessons learned stretching back to an event in 1996 where 397 patients presented in a single night (40 patients being the norm).

The hospital now had oxygen outlets in the emergency waiting room and an ‘asthma-only’ section of the ED for surges, as well as contingency orders for equipment.

They had developed a special triage protocol and the ED would activate its disaster management plan, if put on alert by Public Health during dangerous conditions, once two or three people presented with shortness of breath.

Technological advances also meant that, instead of looking out the window to see if hay-cutters were wearing masks, Charles Sturt University had developed an algorithm to predict dangerous conditions based on pollen counts and meteorological data.
They even provided an opt-in alert service to community members vulnerable to the condition, Curran said.

“Thunderstorm asthma’s not new, and we think that these events are predictable in our district,” he said.

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**Tweet reports**

Dr Kavita Varshney

**Amy Coopes** @coopesdetat · Nov 19
Now hearing from Kavita Varshney on Australasian disasters of national significance #ACEM17

**Disaster Selection:**
- 105 disasters conformed to CRED Criteria
- Further 5 disasters added on basis of legislative criteria
- Further 16 disasters added on basis of economic criteria
- 69 disasters filtered due to lack of national significance
- 57 disasters included in final analysis

**Amy Coopes** @coopesdetat · Nov 19
Disasters included in Varshney’s study #ACEM17

**Amy Coopes** @coopesdetat · Nov 19
Replying to @coopesdetat
In past 10 years some of the worst disasters recorded - Black Saturday, Queensland floods. Revealed vast deficiencies in disaster preparedness, say Varshney #ACEM17

**Amy Coopes** @coopesdetat · Nov 19
Delays in required reform identified after these disasters, says Varshney (apart from Port Arthur, which had a prompt response from government) #ACEM17

**Amy Coopes** @coopesdetat · Nov 19
On Black Saturday and Queensland floods, Varshney says inquiries found woeful lack of preparedness, despite warning signs #ACEM17

**Amy Coopes** @coopesdetat · Nov 19
Varshney talking through some of the events which prompted legislative reform - Granville, Port Arthur #ACEM17
You can track Croakey's coverage of the conference here.

Paul Barnes

Amy Coopes @coopesdetat · Nov 19
Health care responses are critical to the national security effort, says Barnes. But dots (local, state, federal) that have not yet been joined together #ACEM17

Amy Coopes @coopesdetat · Nov 19
COAG needs to look at emergency medical responses to emergent phenomena and broader cycle of recovery. Barnes notes massive changes to Home Affairs portfolio, and uncertain how health will fit into this matrix #ACEM17

Amy Coopes @coopesdetat · Nov 19
First responders will deal with issues of emergent harm; but the focus then shifts to helping community return to normality #ACEM17

Amy Coopes @coopesdetat · Nov 19
Role for our public health systems to go into 'emergency mode' in terms of community engagement and reassurance in these scenarios, says Barnes #ACEM17

Amy Coopes @coopesdetat · Nov 19
Health care facilities are no longer sanctuaries but soft targets. Need to plan accordingly, especially for an ongoing attack, says Barnes #ACEM17

Amy Coopes @coopesdetat · Nov 19
Barnes talking about hot zones and secondary devices, with health care workers often the targets as they are first responders #ACEM17

Amy Coopes @coopesdetat · Nov 19
Need to action whole-of-service chain to understand where there are capability gaps. Also should identify ideal capability, test actual, and then fund gaps, says Barnes #ACEM17

Amy Coopes @coopesdetat · Nov 19
If an IED or weapon was involved, if we haven’t tested full EM system at state, intrastate and federal co-ordination level we may be found lacking, says Barnes #ACEM17

Amy Coopes @coopesdetat · Nov 19
We don’t do enough realistic real-time simulations of how things will operate, says Barnes. August 2016 ‘Sydney X’ one such scenario #ACEM17

Amy Coopes @coopesdetat · Nov 19
Scenario was an aeroplane coming down close to the harbour, but didn’t test search and rescue, eg. Like ‘playing doctors and nurses’ rather than real-world #ACEM17
You can track Croakey’s coverage of the conference here.

Our emergency response and health systems are not prepared for the increasing toll of disasters #ACEM17

Tony Pearce

Eg firefighters carrying 5 or 6 victims under each arm. Amusing anecdote, but not a test of capability, says Barnes. Test done on weekend - traffic scenario unrealistic #ACEM17

Sydney X tested health response to a mass casualty urban scenario. 500 ‘confute persons’. Certain degree of non-realism involved #ACEM17

In Australia we are obsessed with police investigation of disaster. We must shift to a functionality and community recovery mindset #ACEM17

Homeland security and disaster resilience
(from the Australian Government to Local Councils)

Dr Paul Barnes & Dr Anthony Bergho
Australian Strategic Policy Institute

Tony Pearce speaking on Black Saturday and other reviews #ACEM17

Black Saturday followed by Victoria floods, both inquiries found grave shortcomings in emergency management and that ‘more of the same’ would not suffice, says Pearce #ACEM17
You can track Croakey's coverage of the conference here.

Our emergency response and health systems are not prepared for the increasing toll of disasters #ACEM17

Simon Craig

Amy Coopes @coopesdetat · Nov 19

Pearce’s role was created in response to these inquiries, and his role is to foster continuous improvement in the EM system and assure the govt & community on Victoria’s systems #ACEM17

Amy Coopes @coopesdetat · Nov 19

Craig’s team did an anonymous web-based survey on the event in the ensuing days of health workers involved #ACEM17

Amy Coopes @coopesdetat · Nov 19

9000 presentations across state, minimal warning, many hospitals affected, says Craig #ACEM17

Amy Coopes @coopesdetat · Nov 19

Findings of the survey #ACEM17

![Most common themes (24% of total)](image)

- Did well, despite circumstances 247
- Ran out / needed more medication 107
- Patient care positive comments 93
- Code brown activation should have occurred 92
- Triage positive comments 83
- Medical staff called in 83
- Staffing - adequate 73
- Need more training 70

Amy Coopes @coopesdetat · Nov 19

Stories of staff wanting to stay back to help but being denied overtime by hospital execs #ACEM17

Amy Coopes @coopesdetat · Nov 19

Hospitals identified equipment and supplies, workload management/distribution as issues. Space in the ED to actually see patients. Controversy over whether Code Brown should have been called to mobilise resources outside the ED #ACEM17

Amy Coopes @coopesdetat · Nov 19

Some of the feedback - should have gone onto paper records as EMR was laborious, lack of timely and effective comms between health dept, hospitals, paramedics #ACEM17
You can track Croakey's coverage of the conference here.

Our emergency response and health systems are not prepared for the increasing toll of disasters

#ACEM17

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**Aidan Baron @aLittleMedic · Nov 19**

Feedback from Thunderstorm Asthma 2016 in Victoria

Simon Craig at #ACEM17

Documentation

“Patient records should have gone on to paper notes as our EMR is so painfully inefficient. They should have kept these notes, drug charts and vital sign charts with them throughout their journey which would have eased communication substantially. This is the essence of disaster management and was not performed well.”

- Metropolitan public hospital, medical staff

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**Jack Lego @jacklego92 · Nov 19**

Fascinating to look back at Melb’s thunderstorm asthma event with Dr Simon Craig at #ACEM17; recall hearing of it unfolding at #ACEM16 from Queenstown!

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**Jack Lego @jacklego92 · Nov 19**

Stories of code browns not being called despite requests during thunderstorm asthma event and usual flow/hospital policy not sufficient to deal with the disaster’s magnitude. #ACEM17

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**Aidan Baron @aLittleMedic · Nov 19**

Learnings from thunderstorm Asthma 2016 Victoria.

Craig at #ACEM17

Code Brown?

“A code brown was denied by executives despite experienced emergency consultants begging for the code to be called. This would have enabled for better allocation of resources.”

- Metropolitan public hospital, nursing staff
You can track Croakey's coverage of the conference here.

Our emergency response and health systems are not prepared for the increasing toll of disasters

#ACEM17

Shane Curran

Melanie Rule @rulerule1 · Nov 19
Wagga Hospital has been dealing with thunderstorm asthma for many years, long before Melbourne made it high profile. Shane Curran at #acem17

Amy Coopes @coopesdstat · Nov 19
Thunderstorm asthma's not new, we think these events are predictable in our district, says Curran. Sounds like Wagga’s the pioneer in this area! #ACEM17

Tony Kambourakis @DrTonyKarn · Nov 19
Shane Curran - new ED in Wagga has oxygen outlets in waiting room. Innovative thunderstorm asthma disaster planning. #ACEM17

Will Birkett @willbirkett · Nov 19
Thunderstorm asthma not a new phenomenon, weather related asthma in Wagga from ryegrass for decades #ACEM17

Aidan Baron @aLittleMedic · Nov 19
During a thunderstorm Asthma event we divide the ED into an asthma side and a business as usual side.
You can track Croakey's coverage of the conference here.

Our emergency response and health systems are not prepared for the increasing toll of disasters

#ACEM17

Croakey
"Conference News Service"
Hearing from the audience

Aidan Baron @aLittleMedic · Nov 19
Healthcare has been left out of discussions in many cases planning for crisis and disaster.
We need to openly step forwards.
#ACEM17

Aidan Baron @aLittleMedic · Nov 19
Current thoughts by all speakers at #ACEM17
We are FAR behind in preparing Australia for crisis and disaster
A long way to go to resilience.

Melanie Rule @rulesrule1 · Nov 19
It’s not just a perception. Disasters have actually become more common since the 1980’s. Varshney presents timeline of disasters at #acem17

Aidan Baron @aLittleMedic · Nov 19
Common theme from #ACEM17
must empower emergency departments to declare a disaster
Exec leadership of hospitals cannot have power to block
An applause-winning question: Is it time to re-think the way we do emergency medicine?

Amy Coopes writes:

In an era of specialisation, emergency doctors are a disruptive force holding a mirror up to the hospital system and demonstrating new ways of working and truly patient-centred care.

But this comes at a cost to both the physician and the profession.

Those were the messages at the heart of a series of thought-provoking lectures by Bankstown Hospital’s Dr Sue Ieraci at the Australasian College for Emergency Medicine’s annual scientific congress.

Ieraci, an emergency specialist with more than three decades’ experience in the public hospital system, was lauded for her candid assessment of the profession, highlighting some of the privileges and pitfalls of working in the ED.

In a talk titled *Creation or Evolution? From Shelley to Darwin and Back*, Ieraci detailed emergency medicine’s transformation from House of God chaos to a professionalised, sought-after specialty.

But this journey had not been without its problems, she said, likening the question to one of Frankenstein versus Prometheus versus Darwin. Where the former were about creation, Ieraci said the latter was about evolution – a process not driven by perfection but survival.
In the imperfect evolution of emergency medicine, she asked whether it was possible that they had “created a monster”, taking the most rewarding work in acute medicine for themselves and receiving resentment, access block and the tyranny of KPIs (key performance indicators) in return.

“Havers, not have-nots”

There was much to celebrate about being an ED physician, Ieraci told delegates. She described emergency medicine as a “disruptive force, working in new ways”, with vertical rather than horizontal hierarchies and patient-driven access.

ED doctors were generalists in a specialist era, she said, and “havers, not have-nots”, with the highest incidence of “fixes” per day and ongoing learning a feature of daily practice.

The work was challenging, with a high and mounting patient volume of increasingly complex and variable presentations, as well as the psychosocial demands of working under pressure and scrutiny, and losing patients.

But it was structural issues that made emergency medicine stressful, said Ieraci, pointing to data from an annual workplace survey of ED doctors showing that the three most common day-to-day stressors were overcrowding, access block and conflict with other teams.

The auditorium erupted in applause as Ieraci said the rest of the hospital should not be dictating practice to the ED nor viewing it as a dumping ground for patients, arguing there was no such thing as “too sick to be admitted”.

Ieraci said the ED’s job was not to process work for other teams or community providers, to carry risk for the entire hospital or to conduct non-time dependent workups. ED resources should be considered as precious as those of the ICU, she argued.

For doctors, Ieraci said it was important to resist the temptation to investigate “people who look like you and I, but have a symptom”, again prompting applause as she advocated public health “prophylaxis” – educating the public on how to deal with minor issues and where to go for such presentations.
The wellness industry was working against the health system in this regard, she added, engendering unrealistic expectations of wellbeing and encouraging punters to demand investigation of every symptom.

**Taking control**

Rather than people with the simplest solutions waiting the longest in ED – a flu patient, for example, who simply needed rest and fluid – Ieraci called for greater capacity to retriage and the ability to counsel, reassure and send such people on their way.

She also advocated better seasonal management of resources, including fever and paediatric clinics for referral and treatment of such patients during peak periods.

Ieraci’s talks were so popular that she had to declare several times that she wasn’t running for election to the College or anywhere else.
Ieraci said a sense of control was key to satisfaction in any job, and this was sometimes lacking for ED staff, with unrealistic demands that they never laugh, gossip or let off steam.

Because respecting very ill patients and stressed or grieving families was paramount, it was essential that there be private spaces for staff to have a moment’s such reprieve, she said.

She urged her colleagues to embrace the art of saying No, and shared some of her secrets to going the distance as an emergency doc: creating, writing, traveling, teaching, learning, protesting, campaigning, talking, sharing and nourishing your inner child.

Ieraci also strongly advocated mentoring and caring for vulnerable junior doctors, who were most susceptible to burnout, and modelling of good behaviour by senior specialists.

The grass wasn’t always greener on the other side, she reflected. It was green where you watered it, requiring nurturing, attention and care.
You can track Croakey's coverage of the conference here.

An applause-winning question: Is it time to re-think the way we do emergency medicine?

#ACEM17

Tweet reports

From House of God to modern EM: Sue Ieraci #ACEM17

Australasian Emergency Medicine
- Have we created a monster, and are we being punished for being perceived as "playing GOD"?
- Has our creation evolved beyond our control?
- Should we have foreseen it? (Prometheus)
- Can (and should) we re-create it?

Shelley

Have we created a monster? Has EM evolved beyond our control. Can we recreate it? Ieraci #acem17
An applause-winning question: Is it time to re-think the way we do emergency medicine?

#ACEM17 Sue Ieraci: maybe EM is more like Prometheus... and these are the eagles that are attacking us every day...

An applause-winning question: Is it time to re-think the way we do emergency medicine?
An applause-winning question: Is it time to re-think the way we do emergency medicine? #ACEM17
You can track Croakey’s coverage of the conference here.

An applause-winning question: Is it time to re-think the way we do emergency medicine?

Eric Richman
@DoctorRichman

#ACEM17 leraci: need to change the way we do things and need to be able to tell people that they don’t have a time dependent health problem

Melody
@peppermint_frog

#acem17 Sue leraci on “taking control” in our workplace. Ooh, the last one is controversial...

Our specialty

- Remember and consistently teach and model the nature of our specialism – every day
- Acting in patients’ best interests doesn’t mean being “helpers” for other teams
- Communicate horizontally with other consultants
- SCRAP THE SCRUBS!
An applause-winning question: Is it time to re-think the way we do emergency medicine?

You can track Croakey's coverage of the conference here.

"Having control over how you do your work is an important part of job satisfaction" - Dr Sue Ieraci speaking about how to take control in the workplace #ACEM17

Amy Coopes @coopesdetat · 11h
What makes ED work stressful? Not the work itself, but frustrations and conflict says @sue_ieraci #ACEM17

Amy Coopes @coopesdetat · Nov 19
EM must be experts in interpersonal communication and negotiation, says Ieraci. Wellbeing and sustainability - self-care - must be imperative for ED docs #ACEM17

Amy Coopes @coopesdetat · Nov 19
How can we provide a good patient service if we burn out good staff? How can we recreate and reimagine emergency medicine as a specialty worth belonging to? #ACEM17

Bishan Rajapakse @trainthetrainer
Removing stigma & empowering vulnerability => re-thinking norms on being emotional &/or sensitive. Sue Ieraci #wellbeing #ACEM17 @acem17
You can track Croakey's coverage of the conference here.

An applause-winning question: Is it time to re-think the way we do emergency medicine?

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**Hearing from the audience**

**Melody @peppermint_frog**

#acem17 There is so much gold in Sue Ieraci's lecture on Taking Control... but (if I've got this right!) the common theme is we should be respecting and valuing our profession, skill set and knowledge.

---

**Melody @peppermint_frog**

Sue Ieraci at #acem17 - *"We can't have our trainees go out to battle and come back scarred."* Wise words.

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**anne creaton @annecreaton**

Feel like I'm in therapy. Problems have been acknowledged. Time for empowerment. Thanks #acem17
An applause-winning question: Is it time to re-think the way we do emergency medicine?
A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

Some of the #ACEM17 conference tweeps

The management of snakebite, an update on the Choosing Wisely initiative, contested views on voluntary assisted dying, and the need to improve care of the elderly and diagnosis of injuries caused by family violence – such was the diversity of topics covered during the recent Australasian College for Emergency Medicine conference.

The Twitter wrap below aims to give a snapshot from #ACEM17. To find out more details about any of the presentations mentioned below, please check the program.

Warm thanks to all #ACEM17 conference tweeps for helping to share the news. There were more than 40 million Twitter impressions for the conference hashtag, and 1,401 participants on Twitter.
You can track Croakey’s coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

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Amy Coopes @coopesdstat · Nov 19
Opening remarks from @DaveGillespieMP. A doctor for the first 33 years of his life, 12 of them in various EDs #ACEM17

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Amy Coopes @coopesdstat · Nov 19
New Rural Health Commissioner’s number 1 job will be to expand rural generalist training - ‘being generalists is the new black’: @DaveGillespieMP #ACEM17

---

Amy Coopes @coopesdstat · Nov 19
Maldistribution goes across medical and allied health says @DaveGillespieMP. Rural areas ‘begging’ for dentists, pharmacists #ACEM17

---

Amy Coopes @coopesdstat · Nov 19
Rural and remote, private sector now needs more attention in terms of training places, says @DaveGillespieMP #ACEM17

---

Amy Coopes @coopesdstat · Nov 19
All specialties now face an oversupply by 2030 thanks to lifting of medical school places cap. Now need to think about levers, brakes: @DaveGillespieMP #ACEM17

---

Amy Coopes @coopesdstat · Nov 19
Gillespie says we still have a distribution problem in medical workforce but shortages are no longer an issue, per se #ACEM17

---

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

#ACEM17
Improving resuscitation outcomes

Amy Coopes @coopesdetat · Nov 19
Now underway with the opening plenary - Wicked Problems in Emergency. First up, Finnish doctor Maaret Castren #ACEM17

Victor Lee @EM_viee · 11h
Castrén challenges us all to take a systems approach to resuscitation not just training individuals #acem17

Prof. Peter Cameron @prof_cameron · 11h
Maaret Castren emphasising the importance of the community response and engagement as well as team work in OHCA survival #ACEM17

Michael Edmonds @drmedmonds · 23h
Replying to @coopesdetat
Crowd-sourced first responders with CPR skills already a thing with apps like @GoodSamApp #ACEM17

Amy Coopes @coopesdetat · 23h
How about CPR in developing countries where there aren’t even ambulances? Castren says layperson intervention can still be essential, even when further links down the chain of survival are broken/don’t exist #ACEM17

Amy Coopes @coopesdetat · 23h
How do we improve a layperson skill base across a nation? Castren says everyone needs instruction in telephone CPR, register to be dispatched with an AED to nearby emergency #ACEM17
You can track Croakey's coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from ACEM17

Amy Coopes @coopesdatat 23h
Cardiac arrest deaths in the EU equivalent to two jumbo jets crashing every day says Castren. Yet poorly researched, funded #ACEM17

Eric Richman @DoctorRichman 23h
#ACEM17 Castren: if you put a good clinician against a bad person, the system will win almost every time

Jack Lego @jacklego92 23h
Healthcare professionals hesitate to initiate CPR due to lack of confidence and fear they will do more harm than good, says Prof Maaret Castren at #ACEM17

Amy Coopes @coopesdatat 23h
Excellence is not a skill, it’s an attitude, says Castren #ACEM17

Michael Edmonds @drmedmonds 23h
It’s more about attitudes than skills, more about system than individuals, and about changing human behaviour - Castren on improving CPR outcomes #ACEM17

Alexander Kochi @SenseiKochi 23h
“If you always do what you’ve always done, you’ll always get what you’ve always got” - Maaret Castren #changethegame #ACEM17

Amy Coopes @coopesdatat 23h
Research shows health care professionals hesitate to initiate CPR because they worry about harming a (dead) patient, says Castren #ACEM17

Amy Coopes @coopesdatat 23h
We have to realise that the professionals are not good at cardiac arrest says Castren. We need to make it easy for those who don’t see it often to do a good job #ACEM17

Amy Coopes @coopesdatat 23h
Too many silos: layperson, professional, ICU, firefighters, dispatchers. We need to look at this to thrive for a culture of excellence, doing something beyond the ordinary, says Castren #ACEM17

Amy Coopes @coopesdatat 23h
Attitudes, not skills, vital to this question, says Castren. Systems, not individuals #ACEM17
You can track Croakey's coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

Amy Coopes @coopesdetat · Nov 19
Castren talking about development of an app where a mobile phone can connect to a public defib and give emergency dispatch information about the rhythm. Amazing #ACEM17

Amy Coopes @coopesdetat · Nov 19
Castren also talks about needing to improve prognostication to relieve burden on ICU, which accounts for 70% of cardiac arrest costs #ACEM17

Amy Coopes @coopesdetat · Nov 19
Cardiac arrest centres absolutely needed says Castren. Very good survival rates. Very strict protocols - PCIs, hypothermia #ACEM17

Amy Coopes @coopesdetat · 23h
Stavanger resus meeting, 2.5h climb. But look at the view! Castren urges delegates to join her on such a journey rethinking cardiac arrest #ACEM17

ACEM Events @acemevents · 9h
“Cardiac arrest is often looked at as somebody else’s problem but it really is everybody’s problem... we have to work together... to figure out new ways” - Professor Maaret Castren took us through said new ways at this morning’s plenary - “beyond our wildest imagining”. #ACEM17
Diverse presentations

Telemedicine, pressures on and processes in emergency departments, the impact of national targets, and violence in emergency departments are among the topics covered below.

**Amy Coopes** @coopesdatat - 10h
Now hearing from Branko Celler on big data, telemedicine and wearable technology #ACEM17

**Kim Hansen** @doctor__dora - 10h
Big data can rescue the health expenditure blow out - Celler presents 6:1 ROI, 50% decrease in expenditure for wearable technology and telehealth. #ACEM17

**Amy Coopes** @coopesdatat - 10h
Savings on home monitoring telehealth over one year. 46.3% reduction in health system use, hospital admissions - 53% fewer hospital reductions, 67.8% shorter length of stay, 40% reduction in mortality #ACEM17

**anne creaton** @annecreaton - 10h
Why aren’t we doing this more? #ACEM17

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A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

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**Summary of Impact of Telemonitoring**

- **Rate of expenditure on medical services fell by 46.3%**
  - Savings over the first year was 23.5%
- **Rate of unscheduled admissions to hospital fell by 53.2%**
  - Reduced number of admissions over one year 23.8%
- **Rate of length of stay fell by 67.9%**
  - Reduced length of stay over first year 33.8% (7.5 days)
- **Mortality was reduced by > 40%**
- > 83% user acceptance and use of telemonitoring technology
- > 89% of clinicians would recommend telemonitoring services to other patients
You can track Croakey's coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17
You can track Croakey's coverage of the conference here. A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

**ACEM Events** @acemevents • 3h
Things to remember: “one sip of a corrosive can kill a toddler” - toxicologist Dr Alan Gault on how to manage corrosive injury. #ACEM17

**ACEM Events** @acemevents • Nov 20
Dr Pouryahya examining the extent of violence in the emergency department. Of 244 abusive incidents reported, 10% involved physical abuse incidents. #acem17

**peter allely** @peterallely • Nov 19
Policy response to ED overcrowding is largely the blame game: Blame the patient. Blame the gov. Blame primary care. #ACEM17

**ACEM Events** @acemevents • Nov 20
Now verified with research - implementing the 4 hour ED rule in WA did improve patient flow and access but had a negative effect on staff stress and morale. Presentation by Roberto Forero and Shizar Nahidi. #acem17

**EpidemicAmy** @EpidemicAmy • 5h
Hmmm... Dr Forero describes 4 hr target results in decreased % with long los in WA and Qld and decreased mortality rate in WA but increases mortality in QLD. Hmmm... what happened in the Qld hospitals? Other things likely impacting mortality require control. #ACEM17

**ACEM Events** @acemevents • 8h
Improving ED length of stay across Australia - Nicola Man and Roberto Forero take a look at data from implementation of the National Target #ACEM17
A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

You can track Croakey's coverage of the conference here.

**Summary**
- With NEAT implementation, there was:
  - Decrease in EDLOS and in access block in NSW & QLD but not ACT
  - Increase in short-stay admissions in NSW, ACT & QLD
    » Can facilitate ED flow but can also be used to "stop the clock"
  - No evidence for deleterious patient outcome
    » Decrease in time to be seen and DNW in NSW
  - Unplanned ED re-attendance did not change significantly in all 3 jurisdictions

**ACEM Events @acemevents - Nov 20**
"Stop thinking about abstracted flows and start thinking about the people" - RNSH Medical Director Dr Phillip Hoyle on how to run a hospital using compassion and physics concepts. #ACEM17

**Melanie Rule @rulesrule1 - 8h**
Scribes in the ED. Katie Walker describes benefits such as increased productivity for senior staff, patient & physician support. #ACEM17

**ACEM Events @acemevents - 8h**
Each patient requires at least 30 minutes of clerical data entry by the doc. Scribes can provide real time documentation, request admissions, seeking information. "I can focus on my clinical decision making, rather than getting distracted by my clerical duties" #ACEM17

**Croakey Conference News Service**
You can track Croakey’s coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

### Complexity of care

- **Level 1**: Nurse-run, “Primary Care Assessment”
- **Level 2**: “Medical practitioner on call or available via telehealth at least during duty hours”
- **Level 3**: “Medical practitioner available 24 hours (not inclusive on call)”

### Further Details:

- **Amy Coopes** @coopesdetat · 8h
  - Nearly 200 EDs in NSW, says Mane. Most along the coast, a few major rural centres. Most patients across the state expect the same level of care, though most EDs are L1-3 (lowest level) and they see 25% of all presentations #ACEM17
  - Critically ill patients seen a lot less often by staff of smaller EDs – an MI every 5 years, a cardiac arrest every 10. How do they maintain their skills and knowledge? #ACEM17

### ACEM Events

- **Update in paediatric research #5**
  - Outpatient intravenous antibiotic therapy is at least as good as intravenous antibiotics administered in hospital for management of moderate to severe cellulitis in paediatric patients. #acem17

- **Update in paediatric research #4**
  - 50% of ED physicians who participated in a workshop to develop skills for challenging the instructions of their seniors DID NOT challenge incorrect dosage and infusion instructions given to them by a known confederate in their workplace. #acem17
You can track Croakey's coverage of the conference here.

#ACEM17

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17
Choosing Wisely matters

Amy Coopes @coopesdetat · Nov 19
Next up Rachel Hardy-Holbrook from @NPSMedicineWise Choosing Wisely
#ACEM17

Amy Coopes @coopesdetat · Nov 19
These are the Choosing Wisely recommendations in emergency medicine
#ACEM17

1. Avoid requesting computed tomography (CT) imaging of kidneys, ureters and bladder (KUB) in otherwise healthy emergency department patients, aged <50 years, with a known history of kidney stones, presenting with symptoms and signs consistent with uncomplicated renal colic.

2. Avoid coagulation studies in emergency department patients unless there is a clearly defined specific clinical indication, such as for monitoring of anticoagulants, in patients with suspected severe liver disease, coagulopathy, or in the assessment of snakebite envenomation.

3. Avoid blood cultures in patients who are not systemically septic, who have a clear source of infection and in whom a direct specimen for culture (e.g. urine, wound swab, sputum, cerebrospinal fluid, or joint aspirate) is possible.

4. For emergency department patients approaching end-of-life, ensure clinicians, patients and families have a common understanding of the goals of care.

5. Don’t request imaging of the cervical spine in trauma patients, unless indicated by a validated clinical decision rule.

6. Don’t request computed tomography (CT) head scans in patients with a head injury, unless indicated by a validated clinical decision rule.

Amy Coopes @coopesdetat · Nov 19
96% of specialists now agree they have a responsibility for reducing
#toomuchmedicine says Hardy-Holbrook. 61% of patients agree this is an important issue, but the same proportion also think doctors should do every available test (decrease of 13% y-o-y) #ACEM17
You can track Croakey's coverage of the conference here.

Amy Coopes @coopsdcstat · Nov 19
Hardy-Holbrook says 80% of colleges have now signed up to Choosing Wisely and its recommendations have flowed through to MBS Review #ACEM17

Geoff Couser @GeoffCouser · Nov 19
reasons for ordering unnecessary tests #ACEM17 @ChooseWiselyAU @acemonline

Clinician responses - specialists

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

Eric Richman @DoctorRichman · Nov 20
#ACEM17 Great study: choosingwisely #CT in altered mental state in poisoning. Strong work by Joash Arnold. Need large prospective trial.

Utility of computed tomography imaging of the brain in a poisoned population presenting to the emergency department with an altered mental state

J Arnold1, R Meek2,3 and A Gaudins1,3
1 Monash Emergency Research Collaborative, School of Clinical Sciences at Monash Health, Monash University
2 Emergency Physician, Department of Emergency Medicine, Monash Health
3 Monash Clinical Toxicology Service, Monash Emergency, Monash Dandenong Hospital

Background: Patients with poisoning frequently present to emergency departments (ED). When altered mental state (AMS) is present, CT scan of the brain (CTB) is commonly performed to exclude intracranial pathology. Little evidence exists to support this practice.

Objectives: Primary: Determine the incidence of abnormal CTB in adult patients with poisoning who presented with AMS. Secondary: Determine the number of patients who had previous CTB for any reason.

Method: Retrospective review of eligible patients presenting to the three Monash Health EDs between Jan 2014 and Dec 2016. Inclusion: final discharge diagnosis of poisoning, GCS<15 on presentation, CTB performed. Exclusion: known history or clinical evidence of head trauma. Abnormal CTB was defined as any acute intracranial pathology. Performance of previous CTB at any Monash Health facility was noted.

Results: Of 5926 patients with poisoning and GCS<15 on presentation, 1068 (18%) had CTB ordered. Of these, 512 were excluded (evidence of trauma, CTB not performed), leaving 556 for analysis. Mean age was 44 years (95 CI: 42-45) and 341 (61%) were male. Abnormal CTB was detected for one (0.2%) patient. This was a new infant concurrent with opioid overdose. Of the total, 296 (53%) had at least one prior CTB (range 2-31) performed.

Conclusion: Abnormal CTB in adult patients presenting with AMS from poisoning was rare. Of concern, more than half the patients had a previous CTB performed. Development of a clinical decision rule regarding CTB may better balance benefits versus risks for this population.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

Croakey

Conference News Service

80
Focus on mental health

**ACEM Events** @acemevents · Nov 20

Challenges in emergency mental health care taking place in C2.2. The first speaker was Mahesh Dornbagolla talking about barriers to optimal care for psychiatric patients in the ED. #ACEM17

### Staff barriers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>agreed/ strongly agreed n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-psychiatric staff lack of knowledge and experience</td>
<td>26 (25.0)</td>
</tr>
<tr>
<td>Non-psychiatric staff attitudes</td>
<td>18 (17.3)</td>
</tr>
<tr>
<td>Avoidance of patient presentation types</td>
<td>17 (16.3)</td>
</tr>
<tr>
<td>Interdisciplinary rejection of care responsibilities</td>
<td>14 (13.5)</td>
</tr>
<tr>
<td>Language and jargon barriers between staffing groups</td>
<td>8 (7.7)</td>
</tr>
<tr>
<td>Lack of cultural understanding</td>
<td>2 (1.9)</td>
</tr>
<tr>
<td>Human resource supply and skill mix</td>
<td>2 (1.9)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>87</td>
</tr>
</tbody>
</table>

### Patient barriers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>agreed/ strongly agreed n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effects of dual diagnosis</td>
<td>27 (26.0)</td>
</tr>
<tr>
<td>Difficulties differentiating b/w psychiatric issues &amp; social disorganisation</td>
<td>26 (25.0)</td>
</tr>
<tr>
<td>Presentation issues complicating an accurate history or diagnosis</td>
<td>23 (22.1)</td>
</tr>
<tr>
<td>Impact of comorbidities on assessment/management</td>
<td>22 (21.2)</td>
</tr>
<tr>
<td>Patient stereotypes</td>
<td>19 (18.3)</td>
</tr>
<tr>
<td>Patient intoxication</td>
<td>15 (14.4)</td>
</tr>
<tr>
<td>Patient aggression</td>
<td>9 (8.7)</td>
</tr>
<tr>
<td>Frequent attendance</td>
<td>8 (7.7)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>149</td>
</tr>
</tbody>
</table>

You can track Croakey’s coverage of the conference here.

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Stacy Carter @stacymcarter · Nov 20

Thanks #acem17 for inviting me to speak about @wiserhealthcare today & thx for ?s & feedback. ICYM this is our website with contacts.

Wiser Healthcare

Wiser Healthcare is a research collaboration that aims to conduct research that will reduce overdiagnosis and overtreatment in Australia and around the world. wiserhealthcare.org.au
You can track Croakey's coverage of the conference here.

Great student presentation by M Dombagolla on barriers to optimal care for mental health pts presenting to ED #ACEM17. Space, time, and non-psych staff knowledge, attitudes and confidence most prevalent for 124 mental health pts @SocraticEM

#ACEM17 suicide risk prediction take home message.

- The use of any predictive test or clinician judgment for future suicide or suicidal behaviour is not accurate enough for clinical use
- ...regardless of the way the test is derived
- ...even in the highest risk populations
- Low prevalence imposes an absolute ceiling on PPV
- ED physicians need to learn a new way to allocate after-care for suicidal populations

Factors in psych care that lead to increased violence - the physical environment is key @acernevents #ACEM17
Snake bite management

Michael Edmonds @drmedmonds - 4h
23 deaths from snakebite in 10 years in Australian Snakebite Project. Early CPR is most important intervention in collapse to improve survival - @geoff_isbister #ACEM17

Michael Edmonds @drmedmonds - 4h
Snakebite VDK still not used properly. 50% done unnecessarily and then antivenom given inappropriately in some - @geoff_isbister #ACEM17

Melanie Rule @rulerule1 - 4h
Early CPR in collapse due to snake bite is the most important first aid measure. Need to educate the public. @geoff_isbister #ACEM17

Michael Edmonds @drmedmonds - 4h
The one slide summary from @geoff_isbister #ACEM17

Update on early treatment

- Antivenom Type
  - Antivenom type: Polyvalent O/R Brown + 10% Toxin
  - VDK - 'expensive "red good list"'
- Antivenom Dose
  - 1 vial for all snake envenoming
- Redosing
  - Initial dose sufficient, don't re-dose
- Timing
  - Early antivenom crucial for Irreversible effects
  - Mortality
  - Neurotoxicity
Focus on improving care

Presentations covered learning from coroners’ reports, reducing errors, the need to improve care of the elderly, opioid prescribing, and recognition and intervention for women presenting with injuries from family violence, as well as global perspectives.
You can track Croakey’s coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

#ACEM17
You can track Croakey's coverage of the conference here.

Amy Coopes @coopesdetat · 8h
Dx, Ix errors most common says @doctor_dora of @EmergMedER data. Fractures, AMI and aortic dissection top 3 #ACEM17

Amy Coopes @coopesdetat · 8h
What can we do minimise procedural errors? Start at the top - train the trainer, supervise supervisors, use other eyes in our department. Train within and between departments #ACEM17

Amy Coopes @coopesdetat · 8h
EDs are chaotic places, says Chan, leading to suboptimal performance. Most patients consenting, compliant, awake but also clinically compromised, in pain, communication difficulties #ACEM17

Amy Coopes @coopesdetat · 8h
Thomas Chan from the Austin in Melbourne, now presenting on procedural errors in EM from the EMER database #ACEM17

Amy Coopes @coopesdetat · 8h
Specialisation of institutions also means loss of skills more broadly, says Chan. Patient profile - more elderly, more obese - presents issues #ACEM17

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17
You can track Croakey’s coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

#ACEM17
Dr @almarkwell discussing evaluation of Australia’s only 24/7 #socialwork service in an #emergencydepartment #ACEM17 #EMFgrant #RBWH @MetroNorthHHS @qldhealthnews emergencyfoundation.org.au/2017/05/17/aus...

Social Work in ED
• Well-established
• Extended hours + on-call service
• Some variation in roles

Angela Chiew @angelachiewa · Nov 19
@acemevents Greene: we have now become the drug dealers, in scrubs, with prescription pads. We need to look at our opioid prescribing practices. #ACEM17

Opioids
• Opioids cause greatest number of “drug” deaths
• ↑ unintentional deaths: prescription opioids

Role of ED in “prescription opioid epidemic”:
• Complex, multi-factorial causes
• Close relationship between supply + harm
• Prescribers = drug dealers?
• Little evidence for efficacy in extended Rx of non-cancer pain

Multifactorial solutions:
— Review prescribing practices
— Community naloxone programs save lives
You can track Croakey's coverage of the conference here.
Important questions

- In the last year have you been hit / slapped / hurt by someone (at home)?
  - By who?
- Are you frightened of anyone (at home)?
- Are you safe to go home?
- Would you like some help with this?

ED presentations

- Acute pain without visible injuries
- Chronic pain +/- evidence of tissue injury
- Repeated presentations
  - Minor injuries
  - Non-specific complaints – medical or gynaecological
  - Mental Health presentations without specific / obvious triggers
- Delayed presentation after injury
- Noncompliance with treatment, missed appointments

EpidemicAmy @EpidemicAmy · Nov 19
Fernando Pisani updates #acem17 . .41 women killed this year so far from domestic violence. Recognition of victims ED can help. 1 in 3 women presenting likely to be affected by DV. time for screening? GCUH leading QLD study on screening.

AIU @AIUMedEd · Nov 19
Incontinence during strangulation signals intent to kill. If patients report this - you MUST act immediately.

#IPV #ACEM17 #IPViolence

Anoxic progression

- 6 sec: Unconsciousness
- ≥15 sec: Urinary incontinence
- ≥ 30 sec: Faecal incontinence
- 60 – 150 sec: Death
- “Point of no return” is unknown
A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

You can track Croakey's coverage of the conference here.

AIDU @AIUMedEd · Nov 19
Strangulation is a common mechanism in intimate partner violence
Can use ultrasound to assess neck bruises & rule in vascular injury
#ACEM17

Aidan Baron @aLittleMedic · Nov 19
50% of intimate partner and domestic violence injuries are to the head/neck.
Remember to Check the teeth for blunt trauma

ACEM Events @acemevents · Nov 19
Prof Shane Darke highlighting why we need to look beyond toxicity when it comes to adverse health events in methamphetamine use. #ACEM17

Paul van Overbeeke @ultrasoundme · Nov 19
Welcome to the busiest ED in the WORLD 🗺️: 1500pts/day 😳!!
#HamadGeneralQatar #ACEM17
Voluntary assisted dying

Dr Karen Hitchcock @doctorhitchcock takes to the stage at ASM to talk about
The Right to Die or the Right to Kill
#acem17

If a young person kills themselves, we call it a tragedy. If an older person kills themselves, we call it an argument for #VAD - @doctorhitchcock #ACEM17

Hitchcock likens death as a prescription for refractory depression to lobotomies. Doctors can be as crazy and misguided as anyone else - how can we leave such a decision in their hands? #ACEM17

What is unbearable suffering and how should we as a society do about it? There are far more questions than answers, says @doctorhitchcock #ACEM17
You can track Croakey's coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

Amy Coopes @coopesdetat · Nov 19
Despite our country’s vast collective wealth we hear the constant cry that our health and welfare systems are unsustainable, care of the elderly and those with a disability, care for the dying or training about it - @doctorhitchcock #ACEM17

Amy Coopes @coopesdetat · Nov 19
You’re all better off dead, we say, rather than trying to improve the lot of the dying, addressing our feelings of disgust and discomfort at dependence - @doctorhitchcock #ACEM17

Amy Coopes @coopesdetat · Nov 19
Knowing one is dying can be excruciating, the terror of non-existence looming. For #VAD advocates Nembutal is a way of seizing control in the one area of their life they cannot control, and these reforms benefit the privileged, says @doctorhitchcock #ACEM17

Amy Coopes @coopesdetat · Nov 19
Patients tell me they want to die, and my response to that is why. Not often pain but grief, despair, feeling meaningless, worthless or that they are a burden. Physical suffering at the end of life is rarely untreatable - @doctorhitchcock #ACEM17

Amy Coopes @coopesdetat · Nov 19
To kill an unconscious dying person relieves the family, not the patient. Families remember the death, but there are many influences on whether this is ‘good’ or ‘bad’ that won’t be solved by a ‘clean kill’ - @doctorhitchcock #ACEM17

Amy Coopes @coopesdetat · Nov 19
What about the people with no family, no loved ones? Doctrine of double effect is a bedrock of medicine – we don’t treat life, says @doctorhitchcock #ACEM17

Amy Coopes @coopesdetat · Nov 19
Euthanasia makes terrific TV, says @doctorhitchcock. But is death the only solution? #ACEM17

Amy Coopes @coopesdetat · Nov 19
‘I think the debate has fallen into euphemism or euphemasia’ - reframed as expansion of a layperson’s rights to die rather than a doctor’s right to kill: @doctorhitchcock #ACEM17

Amy Coopes @coopesdetat · Nov 19
Concept of power differentials too often overlooked in debate, says @doctorhitchcock. Doctors wield power over their patients #ACEM17

Amy Coopes @coopesdetat · Nov 19
Language is very important in shaping thought, so we should call it for what it is, says @doctorhitchcock of the #VAD debate #ACEM17
Dr Karen Hitchcock also presented on “the power of the pen”.

Professor John Dwyer

Amy Coopes @coopesdetat · Nov 19
Dwyer is President of Friends of Science in Medicine. Laments ‘extraordinary penetration’ of pseudoscience into the public sphere and our medical schools #ACEM17

Amy Coopes @coopesdetat · Nov 19
On the TGA, Dwyer says ‘industry self-regulation, and conflict of interest given TGA funded by the very people it’s supposed to regulate’ #ACEM17

Amy Coopes @coopesdetat · Nov 19
Export of TCM even built into Australia’s FTA with China, adds Dwyer #ACEM17

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Regulatory matters

Dr Joanna Flynn: Medical Board decision on review of doctor recertification to be announced 28 November. Will not be called ‘revalidation’ and will be different to the UK model. #ACEM17

As mentioned by Dr Joanna Flynn at #ACEM17 last week. @acemevents @acemonline

AHPRA @AHPRA
The Medical Board announces a new ProfessionalPerformance Framework to ensure that all registered medical practitioners practise competently and ethically throughout their working lives. #patientsafety...
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You can track Croakey's coverage of the conference [here](#).

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Changing of the guard

AECM Events @acemevents · Nov 18
Standing ovation for Professor Tony Lawler in his last official duties as President at the AGM and awards ceremony. Now Immediate Past President #acem17

Laura Raiti @LauraRaiti · Nov 20
A wonderful presidential address from the AECM immediate past president "I have loved this job" @DrALawler #ACEM17
A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

You can track Croakey's coverage of the conference here.

Congratulations @JudkinsSimon, now ACEM President. We look forward to your leadership.

Should we change our name from ACEM to ANZCEM? Immediate Past President Tony Lawler and NZ CAP representative John Bonning explain the rationale, process and implications at #acem2017 @acemonline
Professional development matters

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

You can track Croakey's coverage of the conference here.

Will Birkett @willbirkett · Nov 20
ACEM working towards the development of a nationally standardised diploma of prehospital and retrieval medicine #PHRM #ACEM17

ACEM Events @acemevents · Nov 20
FACEM Dr Mark Elcock outlines the work to achieve a nationally recognised Diploma of PHRM #ACEM17

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Amy Coopes @coopesdetat · 9h
Explosion in number of mandatory training modules - now more than 30, says Gourley. People rarely complete all, or enjoy them. And it costs a lot of money - writing, maintaining, policing #ACEM17

Amy Coopes @coopesdetat · 9h
The bureaucrat ratio in health #ACEM17 cc @DrEricLevi

Amy Coopes @coopesdetat · 9h
Gourley says areas where there is a heap of evidence doesn’t translate to behaviour change - eg blood safety, hand hygiene #ACEM17

Amy Coopes @coopesdetat · 9h
Gourley says information doesn’t change behaviour. Cites the obesity crisis as evidence. ‘Ludicrous’ to think mandatory modules change behaviour - so why do we do them? #ACEM17

Amy Coopes @coopesdetat · 9h
Mandatory modules are causing bureaucratic and paperwork overload. What is the evidence for learning in this way? Counter to education theory - lowest knowledge-retention method #ACEM17
You can track Croakey's coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

**Amy Coopes** @coopesdietat · 9h
Some wisdom from Gourley #ACEM17

**ACEM Events** @acemeevents · Nov 20
Is teamwork and communication the same in resuscitation training scenarios as the real situation? Recent research out of Royal Melbourne Hospital says yes! #acem17

**ACEM Events** @acemeevents · Nov 19
"Mentoring is a series of progressive conversations that empower the mentee, not just coffee chats." #ACEM17

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Selfies

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“Conference News Service”
Feedback from participants

**Geoff Couser** @GeoffCouser · Nov 20

Congratulations to #ACEM17 for hosting sessions with outside experts - the whole point of conferences: to challenge and to hear new information. If I just wanted clinical info I'd read a paper at home.

**Chris Trothwys** @ElCapitanED · Nov 20

Finished the Plenary “Getting the balance right: Leadership.” Great speakers, great insight. I’m feeling inspired by the mentors in my speciality who have demonstrated patient advocacy, quality and grace - even under enormous pressure. 😊 #ACEM17

**anne creaton** @annecreaton · Nov 20

We need more general physicians. We need to work with them more. It is so lovely and so rare to be able to directly interact with inpatient consultant colleagues #acem17

**Melody** @peppermint_frog · Nov 22

Heading home now after a great conference - congrats and thanks to the organisers of #ACEM17 👏👏👏
You can track Croakey's coverage of the conference here.

Discussion at #acem17 about what keeps us in ED... for me, a big part of this is my lovely lovely team. So fortunate to work with a bunch of amazing ppl everyday - ED peeps rock! :-D

Further evidence that @acemonline docs aren't like the rest, nor their conferences... #ACEM17

A reminder to those at ACEM that those of us who come out here from the UK are amazed how good the staffing is, your staff retention, training, skills... It isn't perfect, but don't do yourselves down.

Twitter impact

Read the full #ACEM17 transcript via Symplur.
You can track Croakey’s coverage of the conference here.

A great big Twitter wrap of the latest news and views in emergency medicine – from #ACEM17

Croakey Conference News Service

• Reporting by Amy Coopes
• Editing by Melissa Sweet
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