Amy Coopes reported on the Australasian College for Emergency Medicine’s *Annual Scientific Meeting* held in Perth from 18 – 22 November 2018, for the *Croakey Conference News Service*.

Croakey is a social journalism project for public health based in Australia.  
http://croakey.org
Contents

Preview article: #ACEM18 to put a spotlight on doctors’ mental health........... 3

Council of Australian Governments under mounting pressure on Closing the Gap................................................................................................................................. 8

Holy Smokes! This is one sick system – talking burnout, at #ACEM18 .......... 16

Impassioned call for doctors to lead on climate change..................................... 34

Healthcare, on the edge with artificial intelligence .............................................. 42

Under increasing pressure in Australia and NZ: how are emergency departments coping? ................................................................................................................ 50

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more ........................................................................................................... 62
Preview article: #ACEM18 to put a spotlight on doctors’ mental health

Amy Coopes writes:

Doctor burnout and medicos’ mental health will be one of the headline issues at the annual scientific meeting of Australian and New Zealand emergency doctors.

Canadian emergency physician Dr Ken Milne will cover some of the occupational health issues facing emergency physicians in a keynote address to the Australasian College for Emergency Medicine conference.

Themed ‘On the Edge’, the ACEM conference promises to pack a punch, presenting the latest in shark bite management, resuscitation science, sepsis and pain relief, with a healthy dose of skepticism, time travel and “clinical inertia”.

The conference comes amid intense discussions about medical cultures in recent weeks, prompted by a senior Australian medical specialist’s recent revelation that he had stayed silent for 30 years about trying to kill himself as an intern.

Professor Steve Robson, President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and a member of the Australian Medical Association Federal Council, described his personal history in an article titled: Learn from me: speak out, seek help, get treatment.
It is absolutely vital that each and every one of us is honest and acknowledges the pressures and strains of our profession; that we see mental health issues not as sources of shame, but as potential occupational hazards that put not only ourselves at risk, but the patients we care for,” Robson wrote in MJA Insight last month.

“I should have spoken up sooner.”

Robson’s article generated an enormous response – including a powerful follow-up revelation by his former colleague Dr Kate Tree that it had been no accident when she knocked on his door all those years ago, interrupting his suicide plans.

What he had assumed for 30 years was a life-saving coincidence, she revealed as a deliberate intervention born out of concern for his mental state.

She wrote:

“Doctors face compassion fatigue, emotional burnout, vicarious trauma and workplace bullying – while working in situations that make it challenging for them to reach out for social support or medical help, in competitive environments that promote rather than discourage maladaptive perfectionism.

We take bright caring young people then subject them to institutional traumatisation and see who survives.”

Better support needed

Meanwhile in Perth next week, Ken Milne, the Chief of Staff at South Huron Hospital Association in Exeter, Ontario, will also focus #ACEM18 delegates on the importance of better support for doctors’ health and wellbeing.

“As an emergency physician, we are on the edge of life and death, but we are also on the edge of being healthy and well,” Milne told the conference organisers ahead of his presentation.

“Our work can take a personal toll, so we need to look after ourselves so we can always be on the top of our game when it comes to looking after our patients.”

Milne is also passionate about skepticism and critical thinking. He is the creator of the knowledge translation project, The Skeptics’ Guide to Emergency Medicine.

Milne describes emergency medicine as one of the few specialities where the statistical cost benefit measure known as Number Needed to Treat (NNT) is one.

“We can help every single person we come into contact with because we are on the edge of the healthcare system,” he said.
Also see his **YouTube alter-ego BatDoc** promoting the conference.

---

**Coming home**

The annual meeting returns to Australia’s west coast after a 15-year hiatus, to celebrate ACEM’s 35th anniversary as a specialty. For convenors Dr Peter Allely and Dr Ian Rodgers, there couldn’t be a more fitting location.

“The College was pretty much formed in Perth, the first president of the College was from Perth, so it’s almost like it’s coming home,” said Allely.

Adds Rodgers: “All of our founding fathers are still with us, every president of the college is still alive and will actually be there at the meeting. It’s going to be quite a reflective occasion.”

Though a bit of good-natured sport about the location – Perth is second only to Honolulu as the most isolated city on Earth – the conference theme hopes to capture something of the essence of what it means to work in emergency medicine.

“Patients that are on the edge of society, physiology that is at the extremes… but ‘on the edge’ also applies a little bit to us and the effects it has on us and how we work,” says Rodgers.

“Although we have put a strong emphasis on science in the meeting, we’ve really tried to bring the science to the fore, you will also see a lot of stuff which is what I call almost postmodern emergency medicine.

“It’s not about patients directly, but the people that are caring for patients, things like physician burnout and wellness.”

**Social conscience**

Other keynotes will range from artificial intelligence and machine learning in the emergency department (Dr Martin Than, NZ), through to the very human dimensions of uncertainty and resilience (Dr Eillyne Seow, Singapore).

Dr Anna Holdgate, senior staff specialist from Sydney’s Liverpool and Sutherland Hospitals, will reflect back on a distinguished three decades in emergency medicine, looking at interventions and approaches that have come and gone (and sometimes come again) in the field.
This theme will be expanded upon by Dr Diana Egerton-Warburton in the Tom Hamilton oration, where she will reflect on how the specialty has evolved beyond the mere training of specialists to embrace a broader advocacy role at both community and political levels.

Close the Gap founder Professor Tom Calma AO will deliver the Foundation lecture – the College’s annual showpiece event, which is open to the public. Former human rights commissioner Gillian Triggs gave last year’s address.

Rodgers said the College prided itself on its social conscience and progressive views, the nature of emergency medicine being “that you see all the bad things that happen in society and the things that go wrong in the health care system”.
In a break with the conference tradition of a politician officially opening proceedings, the team opted for Noongar elder Barry McGuire’s Welcome to Country to be accompanied by something a little different in Perth.

What does it mean to be on the edge?

Emergency physician and acclaimed *Dustfall* author Dr Michelle Johnston will open the conference with a multimedia session themed ‘Stories from the Edge’. Rodgers says this will feature “patients or carers who are on the edge, because of their age or their ethnicity or their socioeconomic situation”.

“It’s intended to be thought-provoking, even provocative, about what emergency medicine is about and why we do it.”

For Johnston, the edge means different things: the emergency department’s place in the hospital and the health system, the populations it serves and the nature of the work and technology.

“There will be a story that perhaps people have not quite heard before, or in the way they’ve heard it told,” says Johnston. “Our story, and how we came to be where we are today.”

In a bid to highlight some of the cutting-edge research coming out of Australian and New Zealand EDs, every morning session of the conference in the main auditorium will begin with one of the best six scientific papers as judged by the conference committee.

These will cover a range of topics, including resuscitation and cardiac arrest management, use of virtual reality and other techniques in reducing distress for children undergoing cannulation or insertion of a nasogastric tube, and the use of arterial fist compression versus tourniquet to stem bleeding from a shark bite, which Rodgers said “couldn’t be more topical” following a recent spate of shark attacks.

Courting the unconventional, there will be two sessions for controversial ideas – a formal Provocative Thinkers session where Rodgers said subjects will include time travel in the ED and deliberate clinical inertia or “the medical art of doing nothing… not intervening because we can, waiting to intervene only if we need to”, as well as an open mic Dangerous Ideas panel.

Organisers expect at least 900 delegates to attend over the five days of the meeting, exceeding last year’s popular Sydney event, with a focus on attracting trainees and junior doctors.
Amy Coopes writes:

As Australian governments prepare to sign off on a new set of Closing the Gap targets, a senior Aboriginal health advocate, Professor Tom Calma AO, has called for meaningful re-engagement with Indigenous communities on the process.

Calma, a Kungarakan and Iwaidja Elder and former social justice and race discrimination commissioner, added his voice to calls for the Council of Australian Governments (COAG) to hit pause on plans to settle a new round of Closing the Gap targets at its next meeting on December 12.

The National Aboriginal Community Controlled Health Organisation (NACCHO) and other peak Aboriginal health bodies have called for an urgent meeting with COAG representatives to determine a framework for reaching agreement on a refreshed Closing the Gap strategy. The Australian Healthcare and Hospitals Association is backing their calls on #RefreshtheCTGRefresh.
Speaking in Perth, where he delivered the Australasian College for Emergency Medicine’s annual Foundation Lecture ahead of two major Indigenous suicide prevention conferences in the city (read our preview here), Calma said Aboriginal and Torres Strait Islander groups had again been locked out of Closing the Gap talks.

“We’ve invested a lot of time and effort as Aboriginal and Torres Strait Islander people in informing the Government about the sort of targets and priority areas that we see should happen,” said Calma in an interview with Croakey at ACEM18.

“That’s gone into bureaucracy but feedback hasn’t come back to us, yet there is going to be a COAG meeting on the 12th of December that is going to determine the future.

“So we don’t have a lot of confidence that ministers haven’t interfered with what we see as the priority areas, (they haven’t seen fit to) negotiate with us, talk with us.”

**Disability and justice targets needed**

Calma said addressing disability and the over-representation of Aboriginal and Torres Strait Islander people in the justice system were two key areas that needed to be addressed in a **refresh of the Close the Gap targets**.

He was scathing about a revolving door of Prime Ministers, frontbenchers and thousands of bureaucrats that had seen a stop-start in funding and consistent policy approaches in Aboriginal affairs, with the appointment of Tony Abbott as Indigenous envoy the latest “ludicrous” development – “another waste of money that’s going to be debited against the Aboriginal expenditure portfolio”.

“All he needs to do is look at the numerous reports that have been done on Aboriginal and Torres Strait Islander education, and issues to address attendance and so forth: those solutions have been offered up for years by the experts, people who are invested in this area,” he said.

“This is where Aboriginal and Torres Strait Islander people get really pissed off, because we are continually investing, we keep on getting asked about what do we need to do, how can we help you, and we invest in this and yet nothing gets heard.”

Calma said this was the case when the original Closing the Gap targets were “unilaterally determined” by governments – one of the reasons, ten years down the track, that little progress had been made towards meeting them.

“While theoretically 10 years have passed, we’ve had so many changes to government policies that it’s meant that there’s been no consistency and level of engagement with Aboriginal and Torres Strait Islander people,” he said.

“The only consistency’s been in Aboriginal and Torres Strait Islander people, who are still there and still working on the issues that impact us.”

**Address and interrogate your bias**

In an engaging and wide-ranging address at the ACEM annual scientific meeting, Calma urged emergency doctors to examine and address the unconscious biases that underpinned their clinical decision-making.

He touched on the high-profile cases of **Ms Dhu, Dr G Yunupingu, Naomi Williams and Mr Ward**, each of whom died due to institutional failings within the justice and health systems.
Calma also spoke about the Northern Territory Intervention and the role of mass media in perpetuating dangerous narratives and stereotypes about Aboriginal and Torres Strait Islander people that contributed to poor health outcomes.

Calma said Indigenous patients had some of the highest rates of discharge against medical advice due to their experiences within and beliefs about the health system, including that you were safer out of hospital than in it, and shared some sobering statistics from the Healing Foundation on intergenerational impacts of trauma.

Calma also echoed recent sentiments from VACCHO acting CEO Trevor Pearce on the impacts of racism, citing work by the Australian Indigenous Doctors’ Association: “It’s a fact, racism is a determinant of health and it’s a major determinant that we have to look at for both mental and physical health.”

Though reductions in smoking had been one of the big success stories in Aboriginal health over the past decade, Calma said general population approaches didn’t tend to work within Indigenous communities, where people were younger (65 percent younger than 30 and 46 percent younger than 20) and died earlier (30 percent dead by 65 vs 9 percent in the broader population).

Human rights-based approaches, incorporating social and cultural determinants of health and led by and for Aboriginal and Torres Strait Islander people, held the answers, Calma said.

“Governments can’t make us healthy, we have to take control of that ourselves,” he said. “It’s all about empowerment and giving direction, support and confidence to people to address their health issues.”

He impressed the importance of advocacy for ACEM and its doctors, “not marching in the streets” but supporting the work of Aboriginal-led advocacy groups on issues like Closing the Gap and justice reinvestment. Calma stressed the importance of cultural competence, and of mentoring Indigenous doctors into the system.

Rather than being passengers in democracy, he urged doctors to participate in movements for change, including a mature reckoning with the past and its ongoing legacies.

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

From Twitter

Amy Coopes @coopesdatat - 15h
Now underway with Tom Calma #ACEM18

Amy Coopes @coopesdatat
With a change of government in the wings, Calma says Aboriginal and Torres Strait Islander peoples must be front and centre #ACEM18

Dr Fiona Lander @fionalander
Tom Calma on the importance of self-determination for indigenous health; this is well recognised by the UN declaration on the rights of indigenous peoples #acem18

Amy Coopes @coopesdatat
Calma says medicine the only higher education discipline where we now see parity for Aboriginal and Torres Strait Islander peoples, with 500+ doctors now - on par with Canada #ACEM18
You can track Croakey’s coverage of the conference here.

Council of Australian Governments under mounting pressure on Closing the Gap

#ACEM18

Amy Coopes
@coopesdetat

Calma reflects on social and emotional wellbeing from an Indigenous perspective. Far beyond the clinical #ACEM18

The social and emotional wellbeing concept recognizes the importance of connections to social, cultural, traditional, family and community of Aboriginal people and Torres Strait Islander people.

Amy Coopes
@coopesdetat

Calma stresses the importance of accepting our history. Massacres took place and occurred in the memory of Aboriginal people still living #ACEM18

Colonial Massacres map

https://658h.unc.edu.au/colonial-massacres-mapa.html

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

Council of Australian Governments under mounting pressure on Closing the Gap

Impact of intergenerational trauma cannot be overestimated. No different to service people suffering PTSD

#ACEM18

Calma speaking about institutional racism and unconscious bias

#ACEM18
Trauma and mental health

As global Indigenous suicide prevention advocates descend on Perth for their second-ever meeting, Calma, a patron of the movement, shared some sobering statistics with ACEM delegates.

No Indigenous family or kinship group in Australia was untouched by suicide, he said, with an estimated 95 percent of the population affected in some way by someone who took their own life.

Three in every four child suicides between 2007-11 were Aboriginal children, with youth rates five times that of the non-Indigenous population. One quarter of Indigenous people aged 15 years and over had been diagnosed with a mental health condition, and 23 percent reported problems accessing health services.
Aboriginal and Torres Strait Islander people were 2.6 times more likely to suffer high to very high levels of psychological distress and were 2.7 times more likely to be hospitalised for non-fatal self harm.

Calma said the status quo “just wasn’t cutting it” in mental health, with greater investment needed.

Governments poured billions into black spot areas on our roads when motor vehicle accidents accounted for less than half the number of deaths attributable to suicide, where mere thousands were spent on prevention.

“To win gold medals we’ll invest big time; to save people’s lives we’ll do a token effort,” he said.
Holy Smokes! This is one sick system – talking burnout, at #ACEM18

Ken Milne, AKA #BatDoc: “I’m not a superhero, even though I dress as one”

Amy Coopes writes:

When three-quarters of people in a profession show signs of burnout, you have a problem that goes far beyond individuals to a system that is sick.

That was one of the central messages of an acclaimed keynote address to emergency doctors on the issue of mental health and wellbeing delivered at the Australasian College for Emergency Medicine’s annual scientific meeting in Perth.

Taking to the stage in his trademark superhero mask and toting a bottle of “liquid courage” – maple syrup – Canadian emergency physician #BatDoc, Dr Ken Milne, offered some deeply personal insights into “life on the edge”: of medicine, of society, and of burnout.

Milne, who is something of a cult figure in the online #FOAMEd community as creator of the popular site The Skeptics Guide to Emergency Medicine, said a unique mix of personal and professional factors made emergency doctors particularly vulnerable to Maslach’s triad of emotional exhaustion, depersonalisation and loss of personal accomplishment.

Half of all medical doctors in the United States showed signs of burnout, according to studies, and among emergency physicians this number was higher still – a whopping 70 percent, he told delegates.
Figures are similar locally, affecting 75 percent of Australian and New Zealand emergency doctors and trainees.

Working on the edge of life and death, with some of society’s most marginalised people, put special pressures on ED staff, said Milne.

The demands of a busy department meant that there was sometimes little space or time to process the death of patient, and when emotions were chronically pushed aside, this put doctors at risk.
Holy Smokes! This is one sick system – talking burnout, at #ACEM18

Milne said that attempting to keep up to date with the latest advances – “like drinking from a fire hydrant” – also contributed, with 3,800 biomedical papers, 75 RCTs and 11 systematic reviews being published in medicine every day.

As early adopters of new technology and techniques, sometimes ED doctors got it wrong and “jumped too soon”, contributing to stress.

But when seven in every ten people in a profession were on the brink, Milne said the question of resilience became somewhat redundant: “The system is the problem. We should stop blaming the individual.”
Drivers of burnout

There was sustained laughter and applause in the auditorium when Milne nominated one of his chief drivers of burnout: the electronic medical record, telling delegates there was nothing healthy about placing a screen between doctors and patients.

Increasingly, he said, doctors were consumed by non-clinical duties, eroding their sense of worth and satisfaction.

In an interview with Croakey, he said:

"Often it’s trying to problem-solve, especially with systemic problems or problems getting access to care."

"I find that I’m often dealing with not what’s the diagnosis, what’s the treatment — I’ve got the diagnosis, I know the treatment — but how can I move them through the system to get the care they need ongoing."

"Sometimes I feel like I’m just advocating and navigating for patients more often than offering a diagnosis and providing a treatment."

Agreeing that it was a question of resources rather than resilience, ACEM president Simon Judkins said the “unseen member of the team is the system, and the system sometimes prevents us from delivering the care that we want to deliver.”
“The system plays a huge part in how we feel, how we manage our patients, our wellbeing,” he said in an interview with Croakey.

“If you put up barriers in front of people that just want to do a good job and prevent them from being the best that they can be then it’s going to lead to an incredible amount of stress and burnout.”

“If we’re investing years of education training to get clinicians to a point where they become specialists, and they work in a system that is then going to burn them out and they don’t want to work in that system after 5 or 10 years, we’re not doing things right.”

Examples like the controversial new public-private Northern Beaches Hospital in Sydney, where staff have been faced with rostering, equipment and medication shortages, were a case in point, he added.

Judkins said:

“Medicine isn’t for profit-making.

We’ve got a fantastic health care system, but if we’re running hospitals in order for an organisation to maximise their profit or reduce their spending, I think that is a significant problem.”

The people that work in that hospital should rightly be frustrated that they expected better. They want to provide great care to patients, and if they’re working in a system which doesn’t allow them to do that they should rightfully be angry.”

Coping styles

The importance of systemic issues was highlighted by research presented at the conference this week by Melanie Jessup and Frances Kinnear into the drivers of burnout among emergency doctors, looking at self-reported stressors and coping styles.

Overwhelmingly, researchers found organisational factors were central to experiences of burnout, with issues ranging from the pedestrian (printers, equipment, rostering), to cultural (communication, poor or no complaints resolution) and systemic (lack of beds, inability to admit, low acuity patients presenting to ED instead of primary care, violence and abuse). Common themes were around relationships, communication and control.

Coping styles among emergency doctors were also a contributor, with more passive (particularly evasive) approaches associated with burnout risk.

Doctors were at higher risk than their nursing or allied health colleagues, and people who were single were also more vulnerable – something to be mindful of when rostering staff at Christmas, Kinnear said.

Other research presented on leadership challenges for ED directors – chief among them access block, overcrowding and managing difficult colleagues – and on the value of clinical scribes in improving productivity, offered important insights into the day to day challenges contributing to burnout in the ED.
Systemic and individual change

Doctors who burned out were at increased risk of depression, substance use, self-harm and suicide, and patient care was obviously at risk, Milne told delegates.

“As long as the number of suicides in the health professions is more than a round number like zero, the number is too high,” he said. “I’m here to say burnout is real, and physician wellness needs to be a priority.”

Though the issue was now gaining traction in countries like Canada, Australia and the United States, Milne said burnout had probably always been there, it was just that the changing face or “humanisation” of medicine – more women, more cultural diversity – meant an end to “old white men telling everyone to suck it up, buttercup.”

While systemic reform was unquestionably part of the equation, Milne said there was plenty individual doctors could do, starting with mindfulness, kindness and avoiding tribalism.

Seeing success as a series of false starts and rolling with the punches had helped in his own circuitous journey into emergency medicine, and the relentless “curveballs” of life, including his father falling critically ill just before he got on a plane to Australia. (Ken Milne Sr had insisted his son go ahead with the trip, and watched a livestream of the talk from his Canadian hospital bed)

Learning to pace yourself – set boundaries, say no, don’t spend beyond your means – was important, as was filling your cup both at work (finding a niche, becoming an expert) and outside (having a confidant and interests beyond medicine).

He acknowledged that stigma, shame and embarrassment prevented people seeking help when they needed it, and that cultural change would take time.
“Being a physician should be something that you do, not something that defines who you are,” he said. “We can have a long and successful and fantastic career… however, we should not be consumed by the practice of emergency medicine.

“I’m not a superhero, even though I dress as one. I’ve worked to the point of physical and emotional exhaustion. I’ve broken down more than once – and that’s ok.”

Milne stressed that when someone asked ‘are you ok’, it was ok to say ‘no I’m not ok, but I will be’.

“Let people know you need help,” he said. “Be vulnerable, it’s not a sign of weakness, it’s a sign of strength.”

---

**Reports from Twitter**

Mark Hohenberg (@MarkHohenberg)

A fascinating #qual study on #burnout in #ED. “If you are unsure of solution then leave”. Culture is changing that it’s acceptable to explore creative careers in medicine aligning to ED or otherwise. @MelanieTan5 made a great video showcasing this: youtu.be/8UpxB0M8SHE #acem18

(Watch the video here, re Creative Careers in Medicine).

Amy Coopes (@coopesdetat)

Teamwork resoundingly came across as a strength #ACEM18
Background

Burnout: ‘...a psychological state resulting from prolonged emotional or psychological stress on the job ... an internal emotional reaction caused by external factors, resulting in loss of identity both interpersonally and socially’ (Maslach et al., 2001)

- Positive work environment: proportionally related to work engagement and professional commitment (Maslach et al., 2009)
- Negative perception or high-tension environment: related to a state of burnout (Maslach et al., 2009)
- Increase episodes of: depression, obesity, drug use; and a decrease in overall quality of care (Agarwala, 2012)
- Diminished quality of life, increased relationship issues, episodes of aggression (Yu et al., 2011)

What is the one thing where possible improvements are actually feasible?

Culture: through the lens of team

- Praise each other more - Staff of the Month/Week
- Support and acknowledge junior staff
- Regular pizza/coffee as a reminder
- Everyone be mindful of communication and with respect; condescending is the worse. Stop focusing on the little things and look at the big picture.
- Ensuring that everyone feels supported after a difficult patient.
- Unsure of a solution. Leave to find a new job!

Relationship: with management

“No support from upper management. Only negative feedback. Poor rostering leading to serious fatigue.”

“I often feel very unsupported by management... that they’re out of touch with what really happens on the floor especially in times of high patient flow/crisis. - I don’t feel that they have our backs. - I don’t feel that any concerns or conversations I may have with management will stay confidential.”

Held in trust
Holy Smokes! This is one sick system – talking burnout, at #ACEM18

JohnBon
@johnubonn

Melanie Jessup #ACEM18 with a picture of the contagion of burnout - a psychological state resulting from prolonged psychologically & emotional stress at work.
@acemonline @JudkinsSimon

You can track Croakey’s coverage of the conference here.
Holy Smokes! This is one sick system – talking burnout, at #ACEM18

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

A/Prof Melanie Jessup presenting on "An exploration of work stressors amongst emergency department staff". Spoke about the importance of teamwork and communication and frustrations with upper management... #ACEM18 #EMFgrant @MetroNorthHHS

Wonderful talks from Melanie Jessup and Francis Kinnear on their research describing workplace stressors, burnout and coping strategies, and how to measure it all so we can work out how to solve it. #ACEM18

Results of the coping styles study. Emotional exhaustion and depersonalisation were significant #ACEM18

Findings on coping styles #ACEM18. More negative/passive styles more closely linked to burnout, especially evasive. Single people more at risk, allied health seem to be doing better and have lessons to offer?
3 main challenges facing ED Directors of all levels of experience: administrative overload; managing difficult colleagues; access block & overcrowding #acem18

Holy Smokes! This is one sick system – talking burnout, at #ACEM18

Leadership challenges for heads of department in #emergencymedicine. Interesting crossover for #geriatric Medicine leaders and managers. Access block leads to pressure for earlier discharge: may not be best for #patients. Shows importance of #collaboration. #ACEM18 @acemonline

What are the leadership challenges that you personally face as a Director of Emergency Medicine?

- Administrative overload
- Aging Population
- Building and developing the ED team
- Delegation
- Effective communication
- Managing younger generation workforce
- Interdepartmental relationships
- Managing complaints
- Overcrowding and Accessblock
- Professional isolation
- Performance management
- Managing staff morale and wellbeing
- Personal time management
- Managing challenging colleagues
- Quality
- Recruiting
- Service provision
- Staffing and Rostering Time

The shared leadership challenges across all panels and experience levels

New Metro
- Constant flow of admin duties
- Bureaucracy
- Need for better resource allocation
- DEMs should be included in top-down implementation
- Lack of admin support and difficulty to delegate tasks
- Need for better resource allocation

New Rural
- Lack of resources to complete administrative work
- DEMs use admin duties to fill the need for administrative work
- Lack of communication between DEMs and senior management

Experienced Metro
- DEMs need additional training to function effectively
- Lack of administrative support
- Need for better resource allocation

Experienced Rural
- DEMs need to coordinate administrative work
- Need for better training and support
- Lack of administrative support

Holy Smokes! This is one sick system – talking burnout, at #ACEM18
Holy Smokes! This is one sick system – talking burnout, at #ACEM18

The shared leadership challenges across all panels and experience levels

**New Metro**
Difficulty when seeing friends or previous colleagues. No more fun. A time sink which can be emotionally draining and conveys administratively. It can also lead to performance management and recruitment impacts.

**New Rural**
More a drain on wellbeing and morale, and also on time and resources. Colleagues seem as challenging sometimes because staff are at different stages of life with differing amounts of experience and different personal situations.

**Experienced Metro**
Managing challenging colleagues in the face of enormous production pressure/shortages, access block and over-crowding. Can be stressful and emotionally draining, especially when there is a need to balance morale. Requirement for feedback tool to enable discussion and reflection facilitated by the SAM. The EAMS Walker model formalises this process.

**Experienced Rural**
Some perform well as leaders, some as paperwork. Managing the differences in expectation as these lectures is a challenge. Need to be enough support and agreed processes around managing senior colleagues. Senior colleagues can be very resistant to being managed.

---

**Mel Venn** @doc_indy - 22h
Huge list of challenges for ED directors! No surprise that the worst are administration, challenging colleagues and access block. Andrew Rixon on research into DEM #ACEM18

---

**Bethany Boulton** @bethany_boulton - 2h
@TheSGEM at #acem18 on burnout & culture in medicine "It should no longer be about middle aged white men saying suck it up" @WRAPEmtweet

---

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

Holy Smokes! This is one sick system – talking burnout, at #ACEM18

Other solutions: pace yourself, this is a marathon not a sprint. Set boundaries and say no. Don’t overspend and get into debt. Become an expert at something - #POCUS, sims. Find a confidant. Have a life outside of medicine #acem18

5 Other Things:
- Pace
- Money
- Expert
- Confidant
- Non-Medical

Tips to avoid burnout. Mindfulness. Pace yourself. Don’t overspend $. Become an expert at something. Find a safe confidant. @TheSGEM #ACEM18 @acemonline

BATDOC I’d add nurture your friends to the list of five (pace, finances etc) #ACEM18

Sonia Twigg @LankyTwig · 2h
@TheSGEM on burnout and physician wellness. Thanks #BatDoc for your energy, enthusiasm, allowing us to see your vulnerability and showing us this is strength. “And always be yourself- unless you can be Batman!” #ACEM18
Holy Smokes! This is one sick system –
talking burnout, at #ACEM18

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

Geoff Couser @GeoffCouser · 2h
Very personal, warm and engaging talk by @TheSGEM at #ACEM18 @acemonline Great to hear the emphasis of burnout being on the system rather than victim blaming. And looking after ourselves along the way.

Amie Beattie @beattie_amie · 2h
Thankyou @TheSGEM - to you and your family- for coming to The Edge to discuss burnout. Your insight into movies, Aussie lingo and physician wellness is fabulous. #acem18

Nicholas Gray @mdewaydavis · 2h
Thank you Dr Ken Milne for an open, honest and inspiring talk. A truly courageous presentation. @TheSGEM #ACEM18

Gareth Wahl @garethwahl · 2h
Thankyou @TheSGEM for your presentation today. Your openness is so respected. You are a true asset for our specialty. #ACEM18

Melanie Rule @rulesrule1 · 2h
Importance message and sharing of vulnerability from Dr Ken Milne @SGEM explaining that even the most high profile & successful amongst us can be on the edge of burnout. Thanks so much for joining us in Perth at #ACEM18 and best wishes to your Dad.

Casey Parker @broomedocs · 2h
Great narrative from @TheSGEM on his personal #burnout story
Wandering around a cold, wet car park wondering where he parked.

We have all had that moment where our brain is overwhelmed and we need to reach out for help
#ACEM18
Holy Smokes! This is one sick system – talking burnout, at #ACEM18

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

Kerina Denny @CritCereTaco
Replying to @bethany_boulton @acemonline and 2 others

I really loved @TheSGEM appreciating CALD and female colleagues, of whom contribute towards the humanisation of our practice. Good for doctors and, most importantly, good for our patients #acem18

JohnBon @johnubornn • 2h
Always be yourself. Unless you can be Batman. Then be Batman @TheSGEM #ACEM18

One of the best keynote talks I’ve ever seen. Thanks for coming to the edge of the world @TheSGEM #ACEM18

peter allely @peterallely

Jacqui Butler @butsy73 • 2h
@TheSGEM just gave one of the best talks on #burnout I have heard! Personal, insightful and strong. #ItsOkNotToBeOk #ACEM18 is a win based solely on this presentation!
Holy Smokes! This is one sick system –
talking burnout, at #ACEM18

PostScript: Ken Milne broadcast his presentation via Facebook Live so his critically ill father, Dr Ken Milne, was able to watch it, back in Canada. See: https://www.facebook.com/TheSGEM/videos/187598105516381/

Holy Smokes! This is one sick system –
talking burnout, at #ACEM18

Amy Coopes writes: When three-quarters of people in a profession show signs of burnout, you have a problem that goes far beyond individuals to a system that is s...
croakey.org
A focus on wellness

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

Holy Smokes! This is one sick system –
talking burnout, at #ACEM18

Andrew Perry @AWalterPerry · 2h
The inaugural ACEM Wellbeing Awards taking centre stage at the ASM this morning. As they should. Congratulations-and thankyou- to Rachel Coutts, Ray-Mund Siauw, St John of God Midlands and Sunshine Coast EDs @acemonline
#ACEM18 @WRAPEMtweet

Alex Markwell @almarkwell · 4h
#ACEM18 Good morning! A bit fresh this morning but stunning outlook from King’s Park. #wellness #ACEM18 @WRAPEMtweet

#ACEM18
You can track Croakey's coverage of the conference here.

Holy Smokes! This is one sick system – talking burnout, at #ACEM18

Bishan Rajapakse @trainthetrainer · 2h
With so much good talk about #wellbeing at #ACEM18, and so many great talks in general - are we taking "time in" for a daily dose of "Vitamin N" (#nature)? anyone keen to share a few images that keep you well? These are from my walk this morning #BeautifulPerth #OnTheEdge
Impassioned call for doctors to lead on climate change

No Time for Games: It’s time to act! Protect children’s health in a changing climate

Professor Kingsley Faulkner AM told the conference: “‘The profession must use its clout, reputation and influence...’”

Amy Coopes writes:

“We are on the precipice of a real disaster unless we as a nation, as a global community, and certainly as a profession speak up on this issue.”

This was the emphatic message that Professor Kingsley Faulkner AM, chair of Doctors for the Environment Australia, delivered to the annual scientific meeting of Australian and New Zealand emergency doctors.

In a spirited and gripping session on climate change and health, Faulkner issued an impassioned call to arms to ED doctors on the moral and ethical imperative of climate change, an issue with significant implications for their work.

Meanwhile, the Australasian College for Emergency Medicine (ACEM) announced that the College would divest from fossil fuels.

This was decided at its October board meeting, following calls from members, recent discussions at the Council of Presidents of Medical Colleges and the lead shown by the Australian Medical Students’ Association, said ACEM President Dr Simon Judkins.

In a session devoted to exploring the scope of the problem for emergency medicine and practical steps for individuals and the profession, Judkins said climate change struck at the heart of health as a human right.
“Demands on healthcare and the costs of running a system won’t be sustainable unless we address this issue urgently,” he said.

No time for games

Faulkner, a former surgeon with a long history in the fight for tobacco control, urged ACEM to join Doctors for the Environment’s new No Time for Games pledge, to be launched at Parliament House on November 27.

The pledge commits health organisations to do more on climate change, and will be accompanied by the release of a report by the same name, originally published in 2015 and updated for this campaign.

In an interview with Croakey after the panel, Faulkner said:

“The profession needs to be more cohesive in its messaging, needs to get its message out more strongly than it has done in the past, and really drive home that this is not only a massive problem, it’s an urgent problem and we cannot delay longer.

Australia has proven that it can punch above its weight in terms of tobacco control legislation, gun control legislation, seatbelt legislation, and in blood alcohol levels.

It can lead the world, it has led the world. We can do the same in climate change if we’re serious.”

In his talk to delegates, Faulkner said climate change was “not only a moral issue, it’s a major health issue and a significant economic issue”, declaring that if doctors won’t speak up, no one will.

“The profession must use its clout, reputation and influence on this issue – it can make a difference.”

Wide-ranging health impacts

Increased heatwaves, bushfires, floods and storm surges, cyclones and droughts would all bring health impacts that would impact EDs, as the system’s frontline caregivers.

Presentations of heat stroke and heat exhaustion, dehydration, burns and smoke inhalation would increase, along with drownings, injuries, and exacerbations to chronic diseases of the heart, lungs and kidneys.

This was already happening, particularly with heat waves, he said, with deaths due to heat in Australia increasing over the last century, and mass casualty events already on the record books.
The heat wave accompanying the 2009 Black Saturday bushfires in Victoria had claimed more than double the number of lives (384 compared with 173 in the firestorm). During that event, there had been 414 presentations to Victorian EDs over a 72 hour period, Faulkner said.

Food security and nutrition would present a growing issue, and patterns of infectious disease, allergens and venomous creatures would all shift as a result of global warming.

Trauma, mental health and ‘solastalgia’ – a sense of loss of place due to environmental destruction – were less obvious but no less insidious health risks, he said.

The air pollution driving climate shifts was already killing hundreds of thousands of people every year – 3,000 in Australia alone – and would present an ongoing burden to health system, with the coat of burning coal estimated at some $2.6 billion per annum.

John Nairn, leader of the Bureau of Meteorology’s heat program, presented some of the science demonstrating that climate change was already upon us and, even with emissions reductions, warming and drying would continue.

Low intensity heatwaves had increased across every part of Australia – most significantly in Perth – and severe or extreme heat events had risen markedly in Adelaide, Melbourne and Darwin.

Though Australia’s inherent climate variability masked some of the shifts, Nairn said the extremes were becoming more extreme, rains were starting later in the season and falling for shorter periods, the Murray-Darling basin was suffering and ranges for our fauna were increasingly restricted.

Every one degree temperature increase boosted the amount of water in the vapour column by seven percent, with increased rainfall already overwhelming unfit-for-purpose infrastructure in our major cities – an issue that was only going to become more acute.

Unimaginable consequences

Health emergencies like thunderstorm asthma, bushfires and heatwaves would become more frequent and more severe, Nairn said, but perhaps more concerning were the as-yet unimaginable consequences of “cascading events” in the new climate.

He said: “You’re going to get surprises.”

Professor Gerry FitzGerald from QUT’s Centre for Disaster and Emergency management cited the findings of the Lancet Commission on Health and Climate Change that the projected course of global warming presented an “unacceptably high and potentially catastrophic risk to human health”; that tackling it could be the greatest global health opportunity of the 21st century; and that the health community had a vital role to play in accelerating progress.

FitzGerald said there would be direct and indirect impacts on health, largely driven by exacerbation of chronic disease, evolution of pathogens and changes to the way allergens were released.

He echoed Faulkner’s sentiments on heat waves, saying they were already the biggest killer in Australia in disaster management terms after pandemics, and were associated with increased mortality, ambulance callouts, and presentations to ED.

He also foreshadowed major social disruption: poverty, displacement and threats to food and water security, as presenting real consequences for doctors and their patients.
Asking ED doctors whether they were content to be “the ambulance at the bottom of the cliff”, FitzGerald said climate change would increase demand on their services, squeeze staffing, supplies and security, as well as direct damage to infrastructure from extreme weather events.

In terms of what they should do, FitzGerald said EDs needed to be prepared for what was coming, in terms of surveillance, planning, equipment and surge capacity.

He said Australian and New Zealand doctors also had an obligation to come to the assistance of our neighbours in the Asia-Pacific, many of whom were far more vulnerable to the effects of warming and less prepared and resourced to respond.

More broadly, he said doctors needed to educate and advocate on behalf of their patients, and speak together, loudly and in concert with other health groups as a credible voice on this issue.

Dr Omar Khorshid, an orthopaedic surgeon and federal councillor with the AMA, echoed these calls.

“This is our space as a profession, and we have a very clear responsibility to act and lead,” said Khorshid, calling for doctors to lead by example, including at their own hospital and health service, and as individuals.

The session debated scores of solutions, ranging from the drafting of an open letter to the government from the College, through to internal environmental awards, greater pressure on suppliers to recycle and reuse, and reducing use of volatile anaesthetic gases that were damaging to the atmosphere.
Other solutions discussed included sustainability targets for health services and reduction of unnecessary tests to decrease the burden of petroleum-based pathology plastic and fuel used for transport and analysis.

As a wealthy profession, individual doctors were encouraged to put their money where their mouth was and support groups like the Climate Council, install solar panels and drive electric (or not at all).

Dr Kimberly Humphrey, representing training doctors, said conversations were key – with peers, with junior staff and with patients.

Humphrey said doctors should be as comfortable talking with their patients about the impacts of climate change as they were about smoking cessation.

With AMA research suggesting about 30 percent of doctors were climate sceptics, or didn’t think medical groups should take a positions, Humphrey said it was just as important to talk to colleagues about the issue as to lobby politicians.

Watch the interview
From Twitter

ACEM @acemonline · 6h
A passionate and provocative talk by Prof Kingsley Faulkner AM: “We have one of the seven wonders of the world, and a rise of 1.5 degrees will destroy 70-90% of the Great Barrier Reef. #ACEM18 #ACEMvolunteers

Dr Kimberly Humphrey @dhumki · 8h
We must embed climate change strongly in the AECM Curriculum, we need our trainees to be solid on this - aware, and informed advocates. #acem18 @acemonline @JuckinsSimon

---

Dr Kimberly Humphrey liked

Casey Parker @broomedocs · 5h
Prof Kingsley Faulkner says: Australia can punch above its weight in advocacy for climate change

Smoking, gun control, seatbelts, alcohol regulation are all examples of Australia leading behaviour change through policy change

#ACEM18

Amy Coopes @coopesdetat · 10h
So what can we do practically leaving this room? Faulkner recommends reading ‘Merchants of Doubt’ to try and understand what we are up against with the climate debate. Overtones of the tobacco lobby, huge influence of the fossil fuel industry in Australia #ACEM18

---

Casey Parker @broomedocs · 5h
Extreme weather events occur in Australia with serious impact on the health and provision of healthcare even in rich countries

#ACEM18

---

Dr Kimberly Humphrey @dhumki · 7h
John Nunn - the science of climate change is the same science that keeps planes in the air and mobile phones working. It is remarkable it is challenged as frequently as it is @acemonline #acem18

---

Impassioned call for doctors to lead on climate change

#ACEM18
Pretty good models of climate change matching the observations. #ACEM18

EM physicians are the canaries in the coal mine for climate change. We need to combat the noise in this post truth world and get the message across - Alex Tzannes #acem18 @JuckinsSimon @acemonline

#climatechange #ThisIsOurLane - in Australia where we have strong gun control policies and poor climate change policies! @ACRRM @RuralDoctorsAus @AusConservation @climatecouncil @farmingforever

We'll be tweeting from the climate change session through to lunch at #ACEM18. The new #ThisIsOurLane?
Impassioned call for doctors to lead on climate change

Dr Kimberly Humphrey @drhumki • 8h
Yes. I've had colleagues at #acem18 say they will be going to a more 'serious' session then the climate change panel today. What could be more serious? This is an emergency. We are facing extinction. @acemonline

Clare Skinner @clairi
Doctors are rich and powerful. We need to be part of finding a political solution to mitigate and prevent further damage from climate change. Fantastic panel. #ACEM18
Healthcare, on the edge with artificial intelligence

One of the stand-out images from #ACEM18. But why? Read on...

Amy Coopes writes:

Bots mining the data records of millions of patients to refine your diagnosis; voice-to-text intelligent electronic medical records that build a file, suggest tests, and offer differentials while you see a patient in real-time; even a ‘digital doctor’ that can – with the help of a few simple devices plugged into a smartphone – run an entire consult right down to the dispatch of a script to the nearest pharmacy.

It sounds like the stuff of science-fiction, but these are all capabilities coming onto the market right now in health care, where big data, processing power and data science technology are presenting an “exponential convergence” that promises to transform medicine, emergency doctors heard at a recent summit in Perth.
Dr Martin Than, director of research at New Zealand’s Christchurch Emergency Department, captivated delegates to the 35th annual scientific meeting of the Australasian College for Emergency Medicine with his keynote ‘On the Edge of Artificial Intelligence’, which explored the potential of big data, machine learning and deep learning in patient care.

As a discipline defined by “the art of making rapid, vital decisions with incomplete information” on the frontlines of health, emergency medicine stood to reap significant benefits from advances in AI, Than said.

Rather than replacing the doctor, he said augmenting clinical practice with smart technologies would offer physicians more time with their patients, allowing greater focus on the people and humanity at the core of their work.

It would also increase job satisfaction by decreasing routine tasks and elucidate data signals that were, at present, opaque.

**Beware of biases**

As with every new development, Than cautioned against the ‘hype cycle’ in AI, and said doctors needed to be vigilant about remaining patient-centred and to be aware of the biases inherent in and entrenched by these technologies, including human prejudices programmed into their algorithms and within the data fed into their learning.

Though Than didn’t explore this in his talk, so-called ‘black box’ machine learning models rolled out in the United States criminal justice system have been shown to be biased against racial minorities.

Than’s AlMed article has some interesting commentary on bias in healthcare AI and why it’s such an issue, and there are other important perspectives here and here.

This in-depth piece on the problems plaguing IBM’s much-touted Watson supercomputer in medicine is also worth a look, as is Siddhartha Mukherjee’s longread in the New Yorker, ‘AI versus MD’.

As a profession constantly engaged in the process of weighing up probabilities, Than said emergency medicine’s engagement with machine learning and big data seemed logical, outlining roles for AI at several points in the patient journey.
Far from a futuristic fever dream, Than said AI was already being rolled out in health, walking the audience through a host of apps and platforms already being trialled or in use.

Examples included Stanford’s **Patients Like Me** big data project, pooling information from millions of patient encounters to refine diagnostics: a “clinical informatics consult” utilising “pattern recognition on an enormous scale”.

Microsoft’s **EmpowerMD** project was another – an intelligent medical records system that transcribed and sifted data gathered in a patient consult in real-time, singling out important themes, differential diagnoses and investigations for the doctor as they spoke.

By feeding back which suggestions the doctor had accepted for integration into the record at the end of the consult to the platform, EmpowerMD evolved with every new encounter, Than said.

From his native New Zealand, Than shared some work at the forefront of AI, including EMR-interfacing apps for use by clinicians at the bedside by local company **Smudge Apps**, which has developed a similar system for NZ Police to use out on the job. Than said the **OnDuty suite**, which includes an **award-winning app** designed for use in domestic and family violence callouts, was enormously popular with officers.

Captivating the audience were **Soul Machines’** deep learning project **BabyX** and the **Digital Doctor Healthcare Assistant** – a virtual physician who was, with the assistance of a smartphone-compatible stethoscope, thermometer and pulse oximeter, able to run a consult and examination from start to finish, right through to signing off a script and transmitting it to the nearest pharmacy for collection.

The Digital Doctor, a freakish facsimile of a human, thanks to the involvement of Oscar-winning Planet of the Apes, Avatar and King Kong visual effects guru Mark Sagar, was even able to interpret facial expressions by a patient and offer reassurance.

Such technology had great potential for rural and remote areas, particularly in developing countries like India, where availability of health care was poor but most people had access to reliable high-speed broadband, Than said.
You can track Croakey's coverage of the conference here.

Healthcare, on the edge with artificial intelligence

#ACEM18
Machine learning had already made significant inroads in specialties like radiology and dermatology – two disciplines predicated on carefully honed pattern recognition – and Than said it had also seen successes in fields like critical care medicine (heavily rooted in and reliant on data outputs) and medical administration (looking at indicators such as length of stay and readmission).

All of these had structured data in common; by contrast, the vast majority (80 percent) of medical data was unstructured and, at present, much more complex to navigate, he added.

Data science startups like Kaggle and Harvard-based Experfy were available to crunch large medical datasets, and Than said some were able to work on this information within a host-controlled sandbox so that sensitive patient data remained onsite.

He acknowledged that privacy, confidentiality and ethical conundrums needed to be addressed as technologies advanced but said he did believe these barriers could and would be addressed.

Machine learning was far from perfect, he cautioned.

Machines were as yet unable to differentiate a blueberry muffin from a chihuahua – something even a four-year-old human could do – and mistakenly identified Manet’s 1856 masterpiece, Olympia, as a burrito.

Veracity matters

Like other sectors on the cusp of big data integration, Than said there were major challenges for health. He characterised these as ‘The 5 Vs’ – volume, velocity, variety, veracity and value — of which he said veracity was probably the most significant.

While it was lagging parts of the healthcare sector such as risk analytics, lifestyle management and monitoring, imaging and diagnostics and drug discovery, Than said emergency medicine was slowly catching up in AI terms.
In response to the “stampede” of tech giants like Apple and Google into the space and proliferation of proposals, the British government had drafted an NHS code of conduct for AI and other data-driven technology, and Than said Australia and New Zealand needed something similar.

Most important, he said, was the maxim conjungere ad solvendum, ‘connect before solving’. This didn’t mean connection to technology, but the step that came before: interrogating the purpose, intention and benefit of a technology before rolling it out.

Failure to connect at this fundamental level was what underpinned the deep unpopularity of the detested electronic medical record, identified earlier in the conference as a key ingredient in physician burnout, Than said. No doubt a criticism, on this logic, that could also be levelled at the Australian Government’s troubled My Health Record project.

---

**From Twitter**

Dr Michael Than takes us deep into a fascinating future with his keynote address, "On the edge of Artificial Intelligence".

#ACEM18 #ACEMvolunteers

This is all a bit Black Mirror to me.

@acemonline #ACEM18
You can track Croakey’s coverage of the conference here.

Healthcare, on the edge with artificial intelligence

#ACEM18

Great talk from Martin Than, but I fear it’s a collection of stuff not bound by a philosophy of what we’re trying to ultimately achieve. We need to understand AI and develop an ethos

@acemonline #ACEM18

Martin Than asking us “Why AI?” Perhaps to “bring more humanity back to our interactions”? #ACEM18 @acemonline

Dr Martin Than takes to the stage and opens his talk about NZ's dangerous animal - keas

#ACEM18
You can track Croakey's coverage of the conference here.

Healthcare, on the edge with artificial intelligence

Dr Martin Than asks us to imagine - an introduction to big words like; Big Data, AI, machine learning, deep learning and natural language processing. It’s still BabyX and can’t tell the difference between a chihuahua & a blueberry muffin but it’s time to get ready... #ACEM18

Some examples of machine learning with Dr Than #ACEM18

- Linear regression
- Logistic regression
- Linear Discriminant analysis
- Classification and regression trees
- Naïve Bayes
- K-nearest neighbors
- Learning Vector Quantization
- Support vector machine
- LASSO
- Gradient Boosting
- Artificial neural network
Under increasing pressure in Australia and NZ: how are emergency departments coping?

Debating wins and challenges in tackling access block. Photograph by Amy Coopes.

Amy Coopes writes:

Time-based targets had significantly reduced overcrowding in Australian and New Zealand emergency departments (ED) over the past decade, saving thousands of lives, an emergency medicine conference was told recently.

However, the effectiveness of these targets had plateaued and major equity issues remained, particularly for mental health patients, the conference heard.

It’s been 10 years since a landmark summit brought together groups, including the Federal Government, Australian Medical Association and Australasian College for Emergency Medicine, to discuss a crisis in ED waiting times and crowding – an issue known as access block.

The 2008 Access Block Solutions Summit saw the rollout of time-based targets modelled on the NHS four-hour rule (known locally as the National Emergency Access Target or NEAT), which sets a limit on how long someone should wait in an ED before being admitted, transferred or discharged.
Critics of the policy question its value in improving patient outcomes and caution that it may actually compromise patient safety and care, pointing to the Mid Staffordshire experience in the UK.

But the rollout of targets had significantly improved flows through Australian and New Zealand EDs in the decade since the access block crisis talks, delegates to the recent ACEM annual scientific meeting heard.

This was despite exponential increases in demand and a 20-30 percent surge in emergency workloads.

‘Unequivocal evidence of discrimination’

Drew Richardson, a professor at ANU and senior staff specialist at Canberra Hospital, reflected on how much had changed in Australian emergency medicine over the past 10 years, with the number of accredited EDs almost doubling and demand skyrocketing, along with presentations and admissions.

Even the most conservative estimates suggested that workloads had increased by 20-30 percent, and this did not factor in new hospitals, he said.

Despite this, Richardson said there had been a sustained decrease in access block since 2008 everywhere – except NSW, which had gone backwards. The greatest improvements had been seen early in the so-called NEAT era, and though things had been relatively stable, they had started to worsen again in recent years.

Overall, he estimated that one-third of the workload in ED remained caring for inpatients who had been admitted but were awaiting beds.

As far as delays were concerned, Richardson said 24-hour stays in the ED – something for which there was “never any clinical justification” – remained an issue in every state except Victoria, but there were significant disparities for mental health patients.

Though mental health presentations comprised just nine percent of all ED patients, they accounted for almost 30 percent of access block cases and they were almost twice as likely to wait eight hours in ED for a bed and five times more likely to spend 24 hours in the ED.
“This is unequivocal evidence of discrimination against a particular patient group,” said Richardson. “Hospitals have a major problem with equity of access.”

An attendee from Consumers of Mental Health WA said more “inreach” services into EDs could help with these lengthy stays, and Richardson agreed this was an important model, but not one that was widely embraced.

**Gains in New Zealand**

In New Zealand, where a six-hour target was introduced in 2009, ED mortality had halved and there had been dramatic improvements to access block, Dr Peter Jones from Auckland University and Auckland City Hospital told delegates.

Similar to Australia, however, he said improvements had plateaued, with early, easy gains coming up against cultural and attitudinal barriers.

Instead of focusing on what the target was intended to achieve, Jones said there was now a perception of targets for targets sake, and backlash by staff gaming the system or finding workarounds.

Movement of patients to a short-stay or observation unit within the ED as the deadline approached was one popular approach, and Richardson confirmed that this was also a phenomenon in Australia, where 11-13 percent of all presentations were now managed in such a unit.

Instead of being aligned to departmental or hospital imperatives, Jones said the target needed to be “rebranded” to focus on patients, quality of care and equity of access.

Dr Andrew Staib, from Brisbane’s Princess Alexandra Hospital, said a whole-of-hospital response was required in order for targets to succeed, with buy-in from executive, inpatient teams, policy and budget staff as well as the ED, and an understanding of local demographics and culture.

Princess Alexandra has seen a dramatic turnaround from one of Australia’s worst-performing EDs to one of its best, and Staib said this had been achieved incrementally, targeting the highest-volume and turnover units first and choosing priority patients.

Staib said length of stay was a rudimentary proxy for patient outcomes and the time for easy wins had passed, with a need to fundamentally rethink how things were done, using granular, digitised, real-time indicators to measure patient care.

Whether time-based targets were effective or appropriate was hotly debated when the floor was opened for questions.

Some argued for a separation of elective and emergency streams in hospitals, others said night staffing was a real issue, with patients presenting later and later to ED, when day staff had gone home and registrars were running wards.

Those who supported targets said they had the potential to force improvement of systemic issues, while others advocated a move towards more meaningful patient-based metrics and a return to the question of what was important and needed to be achieved.

Dr Sally McCarthy, president-elect of the International Federation for Emergency Medicine, said it was “crazy” to debate numbers when this offered no information about the experiences of patients.
She also advocated stricter consequences for delays, arguing that someone’s job should be on the line in the event of 12 and 24-hour stays.

**Busting myths**

David Mountain, head of emergency at Sir Charles Gairdner Hospital and an associate professor at the University of Western Australia, delivered a robust defence of the evidence supporting time-based targets and shot down some of the most common myths.

Rather than worsening patient outcomes, Mountain said studies had overwhelmingly shown that time-based targets were beneficial for patients, with decreases in ED and inpatient mortality ranging from 0.13-0.6 percent and an estimated 2,500-5,000 lives saved every year.

There were no significant increases in reattendance, readmission or adverse events; hospital length of stay and occupancy was reduced, as were “did not wait” events, where people left ED before they were seen by a doctor, he said.

By contrast, there was a vast body of evidence demonstrating harm to patients from overcrowding, including delirium, pressure sores, incorrect or delayed administration of medications, antibiotics and analgesia, and increased mortality, as well as prolonged stays, delays to definitive care, aggression and impacts to staff morale.

Severe overcrowding increased overall hospital costs by 3-5 percent, which translated to roughly $20 million for a large tertiary centre, Mountain said, and this didn’t account for opportunity costs, lost activity and poorer outcomes.

On the question of cost, Mountain said it was something of a furphy that it was cheaper for patients to be seen by a GP rather than in the ED, particularly in an era of spiralling out of pocket costs.

A GP consult would bill, on average $35-100, compared with $35-250 in the ED, but Mountain said 60-80 percent of ED costs were fixed, no matter the complexity of the presentation or the time required for its investigation and diagnosis, and the bill was picked up by taxpayers. If available, a GP might be cheaper, but not by much, he said.

This is of interest given recent Australian Bureau of Statistics data showing that people living in areas of most socio-economic disadvantage, and in outer regional, remote and very remote areas were more likely to visit ED than their least disadvantaged, urban counterparts.

These same populations were more likely to report visiting an ED because a GP was not available, and some 18 percent of all ED attendees said they felt a GP could have treated the condition they had presented to emergency for.

Mountain echoed comments from the other speakers about the waning effectiveness of time-based targets, and warned that there had been an over-reliance on them as a quick fix without substantive steps to address the capacity crisis.

Targets were imposed from above without commensurate resourcing for their realisation, there were not enough inpatient beds, and community resources were also inadequate or in some cases had been reduced. Expanding EDs was not the answer – if anything, this just resulted in more crowding, he said – cautioning that running hospitals at or above capacity actually made them less efficient, not more.

Resolving these issues, rather than rolling out more phone lines, walk-in clinics and urgent care services, is where solutions lay, Mountain said.
Under increasing pressure in Australia and NZ: how are emergency departments coping?

And more reports from Twitter
You can track Croakey's coverage of the conference here.

Under increasing pressure in Australia and NZ: how are emergency departments coping?

Amy Coopes @coopesdetat · Nov 19
David Mountain says the access block summit had a major impact and he hopes the recent mental health summit will have a similar effect. You can read our coverage of that here #ACEM18:

National summit calls for urgent action on mental ...
Marie McInerney writes: Australia’s health system is croakey.org

Amy Coopes @coopesdetat · Nov 19
Dramatic and immediate effect from time-based targets #ACEM18

Amy Coopes @coopesdetat · Nov 19
Now hearing from Drew Richardson on whether things are better or worse in Australia 10 years on from the Access Block summit #ACEM18

Amy Coopes @coopesdetat · Nov 19
10-year data shows number waiting exactly the same, but things so far as access block go are better. Demand is the huge story - it has skyrocketed #ACEM18
You can track Croakey’s coverage of the conference here.

Under increasing pressure in Australia and NZ: how are emergency departments coping?

#ACEM18

Amy Coopes @coopesdetat · Nov 19
Everywhere is better than 2008, apart from NSW which has gone backwards
#ACEM18

Correlation is not Causation
- The Access Block Solutions Summit was the venue for Access Block, which is parts of the
- Acute care is the area of most interest
- The peak performance was early in the year
- NSW is the only jurisdiction to be significantly
- 24 hour stays remain on the increase

Amy Coopes @coopesdetat · Nov 19
‘Hospitals have a major problem with equity of access’, especially around mental health. Never a clinical justification for a 24h stay, says Richardson
#ACEM18

The State of the Nation
- Acute Block and 4 hour stays improved after winter 2008
- 4 hour stays have started to worsen in the last few years
- Access Block remains significantly better than it was
- About 10% of our workload remains emergency
- We achieved this with 20-30% increase in demand
- Hospitals have a major problem with equity in this space
- Especially around mental health
- 24 hour stays are never justified

Amy Coopes @coopesdetat · Nov 19
Peter Jones will now be presenting the data for NZ #ACEM18

Amy Coopes @coopesdetat · Nov 19
Halving of mortality in the ED, dramatic improvements in access block in NZ following introduction of targets, says Jones #ACEM18

56
Under increasing pressure in Australia and NZ: how are emergency departments coping?

Amy Coopes @coopesdetat · Nov 19
Things are no longer improving now though, they are getting worse, Jones says #ACEM18

Amy Coopes @coopesdetat · Nov 19
Why are things going backwards? Target for the sake of it, losing sight of what is important, says Jones. Leads to people gaming the system. Quick wins have been won quickly and we have now hit a glass ceiling of culture and attitude #ACEM18

Amy Coopes @coopesdetat · Nov 19
Jones describes use of observation/short stay units to dodge targets, move people approaching the deadline #ACEM18

Amy Coopes @coopesdetat · Nov 19
Jones advocates rebranding the target to make it more focused on patients and quality rather than department imperatives. Can bring an equity focus #ACEM18

Amy Coopes @coopesdetat · Nov 19
Staib’s Princess Alexandra Hospital is number one in Australia for ED length of stay #ACEM18

Amy Coopes @coopesdetat · Nov 19
What does ‘whole of hospital’ mean and what are our priorities? #ACEM18
Under increasing pressure in Australia and NZ: how are emergency departments coping?

#ACEM18

---

Amy Coopes @coopesdetat · Nov 19
Staib talking about value of real time data dashboards #ACEM18

Amy Coopes @coopesdetat · Nov 19
We still don’t really understand what parts of the interface are important to patient outcomes. We need granular, digitised, real-time indicators that are more nuanced than length of stay. Time for easy wins has passed and we need to think about and do things differently #ACEM18

Amy Coopes @coopesdetat · Nov 19
We’ll now have a panel with all the speakers on where to now #ACEM18

Amy Coopes @coopesdetat · Nov 19
Question: how does elective surgery impact on access block? Mountain says smoothing elective lists to allow discharge over the weekend has been shown to make a difference to flow gluts #ACEM18

Amy Coopes @coopesdetat · Nov 19
Counterpoint from NSW - smoothing works well in US literature because they average 65% occupancy, low hanging fruit. When you have 95% occupancy, constantly, gains are difficult. Best hospitals have separate emergency and elective streams - should be the norm #ACEM18

Amy Coopes @coopesdetat · Nov 19
Another perspective: people are presenting later in the day, wards staff have gone home for the night. We need better night staffing - most Australian hospitals are run by registrars at night and that’s dangerous #ACEM18

Amy Coopes @coopesdetat · Nov 19
Is a 4 or 6 hour target better, if we are committed to targets? Probably similar and not much evidence one way or another #ACEM18
Discussions via Twitter

Amy Coopes @coopesdetat · Nov 19
Will be tweeting from the session this afternoon on access block, should be an interesting and robust discussion of health system issues #ACEM18

Amy Coopes @coopesdetat · Nov 19
Mental health patients five times more likely to spend 24 hours in ED: ‘This is unequivocal evidence of discrimination against a particular patient group’ - Richardson #ACEM18

Skye Kinder @skye_kinder

Replied to @coopesdetat

Interesting. What did they attribute to cause of wait time? From my end (on the ward) we tend to see wait times related to being concurrently substance-effected, or nil appropriate bed available e.g needs high dependency but only low dependency bed vacant

Dr Jill Tomlinson @jilltomlinson

Replied to @skye_kinder @coopesdetat

From my end it’s bed shortage. Includes patients remaining on surgical wards for days after an emergency plastic surgical repair because “no beds”.

Renata @ReniPaj

Replied to @coopesdetat

How much of this is related to service provision?
You can track Croakey's coverage of the conference here.

Under increasing pressure in Australia and NZ: how are emergency departments coping?

#ACEM18

Jude Alford
@CoffeeShoesDogs

Continuous rather than discrete targets may avoid the admission spikes at 3:50 hrs. And the further gaming leading to a spike at 22-23:00 hrs thanks to the 24hr KPI.

#ACEM18 #accessblock

Amy Coopes
@coopesdetat

Is a 4 or 6 hour target better, if we are committed to targets? Probably similar and not much evidence one way or another #ACEM18

Show this thread

Amy Coopes
@coopesdetat · Nov 19

Sally McCarthy says it's crazy to debate 4,6h, average LOS. Sounds good but rubbish when you look at what's happening to patients. Need targets at the other end with consequences - 12h stay should see someone fired, let alone 24h #ACEM18

Tanya
@GongGasGirl

Replying to @coopesdetat

How about targets which relate to outcome? Measured in terms of mortality and morbidity?

Amy Coopes
@coopesdetat · Nov 19

Replying to @GongGasGirl

Which ones would be most meaningful/would you choose? Would these be relevant to every site? These are interesting questions

Tanya
@GongGasGirl · Nov 20

We need to measure things which matter... For pts with fractured NOF for eg ....increasing time to theatre is directly related to poor outcome. There's no point rushing someone from ED to the ward for them to just lay there for days waiting. Need a whole of hospital metric.
You can track Croakey’s coverage of the conference here.

Under increasing pressure in Australia and NZ: how are emergency departments coping?

Tanya
@GongGasGirl

Replying to @coopesdetat

Folk will say there is evidence that increasing stay in ED is assoc with poor outcomes ... that's true ... but need to drill down to what's important. Bring it back to the medicine.

Kyle Sheldrick
@K_Sheldrick

Replying to @coopesdetat

One of the things that really shitted me was when ED was full and we were told to discharge patients, having patients I could discharge with the right support, and not getting it!
Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

Doctors’ mental health and professional burnout, the importance of medical leadership in galvanising climate action, governmental deafness on Aboriginal and Torres Strait Islander health, the increasing burden on emergency departments, and the use of artificial intelligence in healthcare.

These were among the stories from the 35th annual scientific meeting of the Australasian College for Emergency Medicine.

As the tweets below indicate, other hot topics at the conference included aged care, women in medicine, global health, wellness at work and cultural safety. And sharks.

Also, see the selfies and Twitter analytics towards the end of the post.
Aged care

Carolyn Hullick @DrCarolinH · 2h
To care for those who once cared for is one of the highest honours: a beautiful thought for Geriatric Emergency Medicine. Thank you @talk2nemat @GeriatricEDNews #acem18 Our session is underway.

Mark Hohenberg @MarkHohenberg · 9h
A/Prof Glenn Arendts gives an important talk on recognition of #pain in the older person in #ED. Time to analgesia is longer in older persons and much longer in cognitively impaired. This contributes to #delirium burden & worse outcomes: "must assess pain". #ACEM18 @MarieDAlford

Older age and analgesia response

Age is an independent risk factor for delay in analgesia

Planning for death

- 40% of patients do not have capacity to make decisions at the end of life
- In 2014 only 14% of Australians had an Advance Care Plan/Directive
- In 2015, in patients older than 65 presenting to the ED
  - 26% of those from ACF had an ACD
  - 0% of those from the community had an ACD
  - 70% of people would like to die at home, but only 10% do
You can track Croakey’s coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more #ACEM18

Sophie Wallace @DrSophieWallace · 6h
Fantastic discussion about provision of end of life care by Prof Anna Holdgate. Death is inevitable and we only die once - have the conversation with your loved ones about how they want to do it. Do it before they’re sick in ED at 3am. #ACEM18

Communication

- Talk to the family
  - “When a family says their father wants to live I try not to ignore it. I just say, ‘Of course he does, we all want to live, but would he want to live like this?’ People imagine they’re going to live the way they did before they got sick, but that’s not our choice right now”
- Talk to the patient (it makes you look human)

Mark Hohenberg @MarkHohenberg · 7h
A/Prof Anna Holdgate speaks to discomfort in managing #palliativecare in #ED. Collaboration and shared decision making with colleagues in and outside of hospital can help address this: primary & secondary care + nursing & allied health. #ACEM18 @anzsgm @ANZSPM @RACGP @GeriSoc

Managing death in the ED

- Australian Emergency Physician survey 2014:
  - 84% felt uncomfortable providing care to the dying
  - 84% felt ED is not the right place to die
  - 64% felt futile treatment is frequently provided in ED – as limitations of care are not clearly documented
- Yet more and more people are presenting to the ED at the end of life

EOL Essentials @EOLessentials · 4h
@DrCarolyneH FYI our new ‘Emergency Department End-of-Life Care’ module will be released Dec & includes ‘The possibilities of #endolife in ED’ & ‘How to have conversations on the future & advance care planning’ #ACEM2018 #ACEM18 endolifeessentials.com.au

Carolyn Hullick @DrCarolynH
Withdrawing care versus good, supportive care. Language is important. How do we make sure the conversations happen well every time in ED #acem2018 @talk2nemat
Diagnostic error

Jonathan Cheah @joncheah · Nov 18
@DrCarmelCrock in MR1 at #acem18 introducing the talk on diagnostic error. Years ago more emphasis on medication errors than diagnostic error.

Jonathan Cheah @joncheah · 23h
@DrCarmelCrock describes another definition for diagnosis error; rather than emphasis on just missed/delayed/wrong... now included the failure to communicate a timely explanation to the patient. Emphasizing on patient voices now #acem18

Definition
- New definition of diagnostic error (delayed/missed/wrong)

EM Visions for the future
- Trainees and FACEMs given time to seek feedback on diagnosis “diagnostic calibration”
- Re envisioning the role of the consultant as diagnostic “safety net”
- Improved decision support at bedside (eg sepsis)
- Re designing our ED space and ED work for the critical work of diagnosis
Cultural safety and Indigenous health

Bihan Rajapakse @trainthetrainer · 1h
Dr Paula Edgill & Daniela Sabbioni - sharing their wisdom of being Indigenous people and doctors: “respect” and “empowerment” are vital to our Indigenous patients. #ACEM18 @acemonline @nic_liesis

Culture for Aboriginal community

• Culture is a source of strength, resilience, happiness, identity and confidence

Facets of Aboriginal culture that empowers Aboriginal people:
- Kinship and family;
- Holistic approach: Social and Emotional Well-being
- Connection to land/country
- Traditional healing
- Spirituality:
Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

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

**ACEM @acemonline** - 2h
Protective Factors: Land #ACEM18 @nic_liestis

Protective Factors: Land

- Connection to Land, Culture, Spirituality and Ancestry
- “We don’t own the land, the land owns us. The land is my mother, my mother is the land. Land is the starting point to where it all began. It’s like picking up a piece of dirt and saying this is where I started and this is where I’ll go. The land is our food, our culture, our spirit and identity.” - Knight ATSIC.
- “Removed from our lands we are literally removed from ourselves.”

**ACEM @acemonline** - 2h
Culture & Health; Cultural Safety #ACEM18 @nic_liestis

Cultural Safety

- Respect of differences and understanding diversity
- Understanding of own beliefs, values and perceptions, understand ourself first then others
- Communication skills
- Understanding beliefs and values
- Inclusive in practice at all levels
- Collaboration and complementary practices
- Equality holding and governance
- Advocacy at all levels

Culture & Health

- Culture & culture is central to health & wellbeing
- Temporality of life and culture, is both projective and reflective
- Individuals & culture, social inclusion through culture, social inclusion vs. social exclusion, culture and the standards of adherence to treatment & follow up
- The impact of protective & health promoting strategies & options on health outcomes depends on cultural appropriateness
- Cultures have objectives that are different understandings and are not to be followed

**ACEM @acemonline** - 1h
Indicators of lack of cultural safety #ACEM18 @nic_liestis

Indicators of lack of cultural safety

- ‘Denial’ of suggestions that there is not a problem
- Low utilization of available services
- Low compliance/adherence referrals or prescribed interventions
- Reticence in interactions (engagement)
- Emotional responses- disengagement, anger, withdrawal

**Sonia Twigg @LankyTwigg** - 32m
Noongar women sharing their knowledge; Dr Paula Edgill @Derbar1Yerrigan @DanielsSabbioni Kerri Colegate, Aboriginal Health Coordinator, SJOG Midlands & Cheryl Taylor. Aboriginal doctors and ED staff needed and an important part of creating a culturally safe ED & workplace #ACEM18
You can track Croakey's coverage of the conference here.

Global focus

Michael Downes @ToxTalks · 16h
Dr Hanh Pham arrived in Germany as a 9 yr old refugee, subsequently came to Oz, became a doctor and @acemonline fellow, returned to Vietnam to run critical care workshops for ED staff with IDF grant, great talk, great story #acem18

Bishan Rajapakse @trainthetrainer · 10h
ACEM International Scholars bring back inspiring stories, challenges and report on the progress of developing EM in their home countries; PNG, Botswana, Nepal, Myanmar & Sri Lanka. Legends! #ACEM18 @acemonline #DevelopingEM
Gender and diversity

ACEM @acemonline · 22h

"0/10 of ACEM Board members are women. It’s not just about having a policy, but a change of culture. Now comes time for ACEM to support and advocate for females in Emergency Medicine." Dr Kim Hansen in the Health Practitioner Inclusion & Welfare session #ACEM18 #ACEMvolunteers

Dr Kimberly Humphrey @drhumid · Nov 18

@hansendisease talking on the Advancing Women in EM and the evidence for why need the new @acemonline Women in EM section. So glad this is happening - it's been a long time coming. #ACEM18
You can track Croakey’s coverage of the conference here.

Dr Kimberly Humphrey @drhumki · Nov 18
As we know, there are no women on the @acemonline board. Good to see that the College is open to changing the status quo and recognising this is not acceptable #womeninEM #ACEM18

Alex Markwell @almarkwell · 23h
@hansendisease has outlined the powerful argument for a women in emergency medicine section in ACEM Congratulations to @claski and Kim for their hard work and looking forward to the networking event tomorrow 5pm @acemonline @JudkinsSimon #ACEM18

Melanie Rule @rulesrule1 · 23h
Promoting women in Emergency Medicine. @hansendisease shares some of the challenges in gender equity and ways that we can do better. #ACEM18 #FemInEM @acemonline

Dr Kimberly Humphrey @drhumki · 23h
Being a woman in EM is like playing a video game on the hardest setting @hansendisease - and for culturally diverse women even more so. #ACEM18
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

#ACEM18

#ACEM18

Croakey

"Conference News Service"
Clinical matters

ACEM @acemonline · Nov 18
“Back in my day, we didn’t have clinical decision rules, we just made clinical decisions”. A. Prof Anna Holdgate picks apart the evidence that has shaped practice over the decades! #ACEM18 #ACEMVolunteers

Andrew Perry @AWalterPerry · Nov 18
AProf Anna Holdgate raises the vexed issue of health care professionals’ use of clinical photography. Benefits of technology have not been matched with the necessary safeguards. She recommends the @ama_media guide on this topic
#acem18
ama.com.au/article/clinic...

Jonathan Cheah @joncheah · 23h
Stephen Gourley cautions about just fully extrapolating airlines systems of safety into medical systems and not all system 1 thinking is bad. #acem18
Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more #ACEM18
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

#ACEM18
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more #ACEM18
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more #ACEM18

Dr. Simon Craig (@DrSimonCraig) and Dr. Stephen Macdonald (@spimacdonald) opening the day presenting their research at #ACEM18 #ACEMVolunteers

Great overview of recent research in cardiac arrest by Prof Judith Finn #ACEM18

Dr Amith Shetty discusses the technological innovations advancing the management of sepsis through cutting edge screening algorithms, clinical predictors and neural networks at #ACEM18 #ACEMVolunteers @Docshetty

Dr Gholina Watkins explaining the importance of the AECM Clinical Trials Network in improving Australian EM research #ACEM18 #ACEMVolunteers
You can track Croakey’s coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

Emergency Care Institute @eci_nswaci · 1h
Steven MacDonald: Embedding emergency research in clinical practice is very important - a lot of work still to be done to ensure this #acem18 Clinical Trials Network.

ACEM @acemonline · 20h
A framework for the governance of restrictive interventions in acute settings needs to be developed as there are currently no state-wide standardised process in place.

One of A/Prof Johnathan Knotts many recommendations on restrictive interventions

#ACEM18 #ACEMVolunteers

Philip Brooks @dphilipbrooks · 10h
... and just because they know (and use) the name of an analgesic, it doesn’t brand them a junkie. @First_do_noharm still making me think about language, prejudice inequality and simple human kindness ahead of my clinical shift tomorrow #ACEM18

Jonathan Cheah @joncheah
“Drug seeker” is a term usually used with little compassion. These people are often marginalized and suffer from social inequality. Maybe we should use the term “relief seekers” @First_do_noharm #ACEM18
Shark encounters

ACEM @acemonline · 21h
FACEM Dr Nick Taylor being interviewed by at @Channel10AU’s @vashacoppola at #ACEM18 on first aid techniques following shark attacks @nickeroyat @daviddiamondSC You can hear about his study at 3.30pm this afternoon in MR 1 & 2

Lauren Sharp @laurensharp_au · 15h
Some game-changing advice in lower limb trauma thanks to research by Dr Nick Taylor and his team at #ACEM18

NEXT STEPS

• Education campaign via first aid providers and surfing/coastal peak bodies

1. PUSH HARD HALFWAY BETWEEN HIPS ANDバラ

2. Pull yourself up and out of water

Drag the cursor over the area you want to capture.
Wellness at work

Kim Hansen @hansendisease · 5h
@rulesrule1 presents at #ACEM18 on meaningful change for Wellness: use the greater purpose, act inclusively, measure and share impact. @WRAPEmuseum @acemonline @bethany_boulton @almarkwell
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

**Organisational Strategies**

- Safe staffing quotas
- Adequate resources & workflow
- Fatigue management
- Best roster practices
- Access to leave
- Just culture for errors & complaints
- Celebrate successes
- Promoting meaningful work
- Autonomy & flexibility

**Bethany Boulton @bethany_boulton - 5h**

@rulesrule1 organisational strategies to improve physician health @acemonline
@almarkwell @andeeljohnston @andrew dean61 #acem18

**Bethany Boulton @bethany_boulton - 5h**

@rulesrule1 on making meaningful change:
1. Gather your wellness troops
2. Create a vision for wellness (write it down & get leadership endorsement)
3. Target initiatives at individual, team and organisational levels @almarkwell
@andrew dean61 @andeeljohnston @acemonline #acem18

**Kim Hansen @hansendisease - 2h**

Another candidate for best slide at #ACEM18 @acemonline from @rulesrule1 @WRAPEMTweet wins the "most phones out in 10 seconds" award from today's #Wellness session. @peterally @AWalterPerry

<table>
<thead>
<tr>
<th>Maladaptive</th>
<th>Coping Strategies</th>
<th>Adaptive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeine/Sugar</td>
<td>Sleep hygiene</td>
<td></td>
</tr>
<tr>
<td>Sleep debt</td>
<td>Rest &amp; recovery</td>
<td></td>
</tr>
<tr>
<td>Taking work home</td>
<td>Boundaries</td>
<td></td>
</tr>
<tr>
<td>Alcohol or Substance use</td>
<td>Transitions &amp; Rituals</td>
<td></td>
</tr>
<tr>
<td>Dark humour</td>
<td>Nutrition/Meal breaks</td>
<td></td>
</tr>
<tr>
<td>Cynicism</td>
<td>Attitudes - positivity, optimism</td>
<td></td>
</tr>
<tr>
<td>Working through breaks</td>
<td>Gratitude</td>
<td></td>
</tr>
<tr>
<td>Attendance when sick</td>
<td>Flexibility</td>
<td></td>
</tr>
<tr>
<td>Absence when not sick</td>
<td>Acceptance</td>
<td></td>
</tr>
<tr>
<td>Denial</td>
<td>Mindfulness</td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>Self-reflection</td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td>Connection</td>
<td></td>
</tr>
<tr>
<td>Avoid seeking help</td>
<td>Finding meaning &amp; purpose</td>
<td></td>
</tr>
</tbody>
</table>

Croakey "Conference News Service"
You can track Croakey's coverage of the conference here.

Minh Le Cong @ketaminh · 5h
Hey @TheSGEM! Burnout relevant stuff from latest Mja. All the best for your talk today #ACEM18 : ping @coopesdetat

Sonia Twigg @LankyTwig · 22h
Neil Cunningham. We know our juniors work in a low trust, low empathy environment and do not feel empowered to speak up. St V’s developed an anonymous reporting method for bullying and are changing culture with quiet, respectful peer to peer conversations about behaviour #ACEM18

Bethany Boulton @bethany_boulton · 5h
@rulesrule1 The behaviour you walk past is the behaviour you accept. Civility saves lives! @acemonline @almarkwell @andrewdean61 @andeejohnston #acem18

hellomynameisDeanne @drdeannechui · 31m
At dinner last night. #ACEM18 My best ever #pearl
Use VERBS to feedback. People CAN change observed behaviours.
Not ADJECTIVES. Ppl can't change descriptors/how you perceive them.
Eg: "You only see 1 patient per 5 hours, I wonder how we can support you?"
NOT
"You're lazy."

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more #ACEM18
Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

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

_Bishan Rajapakse @trainthatrainer · 10h_  
Looking forward to the “Interactive Wellness” forum at #ACEM18 today. Thanks 🙏 @Eletherius for sharing a 2min meditation yesterday on the grass. Sitting again Pre-lunch 12:30pm, for 2 mins—anyone else interested in sitting together? @TheSGEM @acemonline mindfulness wellbeing

_Bethany Boulton @bethany_boulton · 5h_  
@andrewdean61 leading FACEMs in a brief mindfulness exercise at #acem18 @almarkwell @rulesrule1 @andeejohnston @acemonline @WRAPEMtweet

_ACEM @acemonline · 52m_  
FACEM Dr Neil Cunningham of @StVincentsMelb talks about the ethos program, with the aim of building an even better workplace culture by providing staff with the opportunity to reflect on appropriate behaviours in the workplace #ACEM18
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

#ACEM18

Croakey

"Conference News Service"
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

CPR

 ACEM @acemonline · 17h
Dr Paul Bailey takes to the stage to talk about High Performance, High Impact CPR #ACEM18

 ACEM @acemonline
Great message from Dr Bailey and Noah, a cardiac arrest survivor, about the importance of CPR #ACEM18

Michelle @dr_mikki · 17h
Paul Bailey makes the point about out of hospital cardiac arrest survivors by bringing in survivor Noah. Chase the 1% improvements and it makes a big difference #acem18
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

ACEM @acemonline · 17h
Survivors of cardiac arrest do well, Dr Bailey tells #ACEM18

Tony Kambourakis @DrTonyKam · 17h
Andrew Coggins describes COACHED cognitive aid to defibrillation – useful in 1st 10mins of CPR, especially established shockable rhythm. #acem18

Croakey
“Conference News Service”
Time travel

Centre for Clinical Research in Emergency Medicine @CCREM2 · 2h
Professor Daniel Fatovich on time travel in the ED. Very provocative! #ACEM18 @acemonline

Melanie Rule @rulesrule1 · 2h
The time paradox of Emergency Medicine. While other specialties are defined by anatomy, EM is defined by urgency & time. But is time a wrong measurement that undervalues our role in relieving suffering. Prof Daniel Fatovich talks time travel in the ED. #ACEM18 @acemonline

Casey Parker @broomedocs · 2h
Professor Daniel Fatovich invokes the theory of relativity to explain how teaching in the ED allows us to travel back and forth in time

#ACEM18

Expertise is transferred by time travel of senior docs back to their trainees state

President's address

ACEM @acemonline · 33m
President @JuddsSimon takes to the stage at #ACEM18
Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

#ACEM18

You can track Croakey's coverage of the conference here.
Professional development and training

Dr Andrew Rixon explores leadership at #ACEM18

Common issues keep recurring in root cause analysis relating to supervision of juniors #ACEM18

Major Contributors
- Availability of Senior Clinician
- Workload
- Rostering/Skill Mix
- Conflicting Priorities
- Lack of Senior Clinician Review or Input
- Escalation of care
- Appropriate level of care
- Culture involving Senior Clinicians
- Effectiveness of supervision

How do we get our employers to recognise the value of FACEMs working alongside trainees for learning and assessment? At present it is viewed as inefficiency and the value of bedside teaching of the next generation is not recognised. @Eleytherius @acemonline #ACEM18
Awards

Jen Williams @DrJenWilliams · 8h
Another outstanding achievement from a Griffith_University grad. #ACEM18

Suneth Jayasekara @DrSuneth
Congratulations to Sunshine Coast emergency trainee Dr Adam Douglas on winning the prize for the highest mark for the college primary exam! @SHealthnews

Bronwyn Bebee @quietlyEvolving · 3m
ACEM well-being awards. What a great idea. My vote will be for the first ED that installs nap-pods in their ED. With naps and caffeine we can achieve anything. #ACEM18 #wellbeing @acemonline

ACEM @acemonline · 3m
Congrats Dr Rachel Coutts #ACEM18

ACEM @acemonline · 2m
Congrats Dr Raymund Slaauw #ACEM18
You can track Croakey’s coverage of the conference here.
Selfies and snaps

Andrew Perry @AWalterPerry - 20h
Some serious attendance at the #acem18 session on ACEM’s new Fellowship exam. As there should be for something that is so high stakes for the candidates, departments and our patients! Moderated superbly by @DonYTJeew. @acemonline

ACEM @acemonline - 4h
Great discussion happening at lunch about the need for improved diversity at ACEM #ACEM18 with @claski @drhumki @johnubonn

ACEM @acemonline - 15h
One of the highlights of Day 1, Laura Raiti @LauraRaiti lights up the room at #ACEM18
Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

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

Andy Cadin @AndyCadin · 8h
Interested in pre-hospital and retrieval medicine? RFDS recruiting now for our bases in NSW. Come along to our booth for a chat about what’s involved and what we offer or catch us out and about. #ACEM18 @acemonline @RoyalFlyingDoc

Andrew Perry @AWalterPerry · 5m
Tour of WA’s retrieval and rescue services continues at the @RoyalFlyingDoc WA Coordination centre and the Emergency Rescue Helicopter Service. Good to see how other systems work. #acem18 – at Jandakot Airport (JAD)
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

#ACEM18
You can track Croakey's coverage of the conference here.
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

#ACEM18

---

**ACEM @acemonline • 21h**

More photos from lunch at #ACEM18

---

**ACEM @acemonline • 18h**

Professor Tom Calma AO interviewed by @coopesdetat ahead of the ACEM Foundation Lecture tonight at #ACEM18 You can hear him at 5pm in the Riverside Theatre. Don’t miss it @nickrolyat

---

**ACEM @acemonline • 3m**

Autograph please! @Eleytherius signs copies of her book, Dustfall, for @hansendisease @TheSGEM #ACEM18
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 - aged care, women in medicine, all the tweets, selfies, and more

Melanie Rule @rulerule1 · 20h
We have burst into song in the Fellowship exam interactive session at #ACEM18. The wonderfully talented @LauraRaiti shines again.
#TheGreatestShowman

Mel Venn @doc_indy · 20h
Team Alice Springs doing some impressive chair-dancing in the break in the exam session #ACEM18
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

#ACEM18

— Nick Taylor @nikkoryat - 20h
Canberra Hospital ED regs circa 2001/2. Dodgy back then... even worse now @hallpaintings... love #acem18 catching up with colleagues!

— Ken Miline @TheSGEM - Nov 18
Is there a doctor on board?
- of course, we are the RFDS @RoyalFlyingDoc @AndyCaldin @acemonline #acem18 #batdoc

— Melissa Sweet @croakeyblog - 19h
Interesting juxtaposition. #BatDoc meets @CroakeyNews... aka @TheSGEM speaking with @coopescietat at #ACEM18 youtu.be/oK4rYVcoM

Croakey
“Conference News Service”
You can track Croakey's coverage of the conference here.

Wrapping #ACEM18 – aged care, women in medicine, all the tweets, selfies, and more

Clare Skinner @claski · 20m
Caught the tweeters tweeting. Thanks hard-working AECM comms team
#acem18

ACEM @acemonline · 10h
ACEM President @JudkinsSimon with all our wonderful volunteers. Thank you to all of them #ACEM18 @JudkinsSimon @TheSGEM

ACEM @acemonline · 2h
Here is @WRAPEmTweet mixing it with @TheSGEM a.k.a BatDoc at #ACEM18 @bethany_boulton @almarkwell
Wrapping up

Watch our playlist of video interviews with Dr Simon Judkins, Professor Kingsley Faulkner, BatDoc Ken Milne and Professor Tom Calma AO. As of 28 November, 1,118 viewers had watched these videos in total via the Periscope app.

Symplur analytics for the period of Croakey’s coverage show there were 1,226 participants on Twitter using the hashtag, sending 8,170 tweets, and creating just over 43.5 million Twitter impressions. Read the entire Twitter transcript.

Thanks to Amy Coopes for not only stellar reporting but also fronting the other side of the camera for an interview by Dr Ken Milne, aka Bat Doc.

Croakey Conference News Service

- Reporting by Amy Coopes
- Editing by Melissa Sweet
- Layout and design by Mitchell Ward