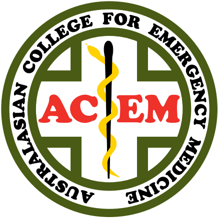


Australasian College for Emergency Medicine

acem.org.au

Emergency Medicine – Building Our Future Summit

Report

September 2024

1. Introduction

On 30 August 2023, in the year of the 40th anniversary of the foundation of the Australasian College for Emergency Medicine (ACEM), the College convened the Emergency Medicine – Building Our Future Summit to start conversations about the role and scope of emergency medicine – now, and into the future.

The practice of emergency medicine today is significantly different from when ACEM was founded in 1983, and there are vital questions to be answered. How is the scope of the specialty, and the role of emergency physicians, changing? What are the skills and training necessary to deliver effective and compassionate emergency care in increasingly complex healthcare contexts? What is needed to create sustainable and satisfying careers in emergency medicine?

The Summit brought ACEM Board members, councillors and committee chairs together in person, along with hundreds of members and trainees who joined proceedings online. Short presentations about key topics, representing the specialty's 'growing pains' were delivered, generating rich discussion. Afterwards, a survey seeking further input and feedback on the issues raised was circulated. Information from the summit and survey was collated and examined.

Reflecting the breadth of the ACEM community, input was varied, however key themes emerged.

- Commitment to the acute, generalist, clinical core of the specialty
- Strong dedication to serving the community and meeting the needs of people who seek emergency care
- Recognition of the diverse career options now available to emergency physicians, and the challenges and opportunities that supporting breadth of practice presents for the College
- Reflection on the critical role of emergency medicine in healthcare systems, and pride that emergency physicians are increasingly assuming sector-wide leadership roles
- Identification of three areas for core focus: resuscitation, decision-making and leadership
- Support for ACEM to continue to advocate for improved healthcare systems, structures and resources necessary to provide high-quality and humanistic emergency care

This report provides a high-level overview of findings from the survey that members and trainees were invited to complete following the Summit. Participants were asked to consider the role and scope of emergency medicine in relation to clinical service delivery across a range of practice areas and models-of-care, as well as College policy and advocacy activities. Outcomes from the Summit have also been summarised in the April 2024 edition of *Emergency Medicine Australasia*.

Emergency medicine is now a well-established specialty, that is fully embedded in healthcare systems across Australia and Aotearoa New Zealand, and the College should feel very proud of this considerable achievement. Reflecting this mature status, it is time for ACEM to set clearer organisational priorities. A careful balance must be found, to ensure the health needs of patients and carers are met, while also recognising the professional needs of emergency physicians.

Information from the Summit, including the data contained in this report, will be used to set advocacy priorities, to guide development of the 2025-2027 ACEM strategy, and will influence the next review of the FACEM Training Program. ACEM will continue to listen, and evolve, to meet the increasingly complex health needs of communities, and to support emergency physicians, trainees and others delivering emergency care to enjoy diverse and sustainable careers.

Dr Clare Skinner
Immediate Past President

© Australasian College for Emergency Medicine
September 2024

2. What did the Summit cover

Discussions at the Summit focused on the challenges and opportunities faced by the specialty, and the College, and centred on three themes:

- Changing processes and models-of-care
- Changing peoples and populations
- Changing roles and contexts

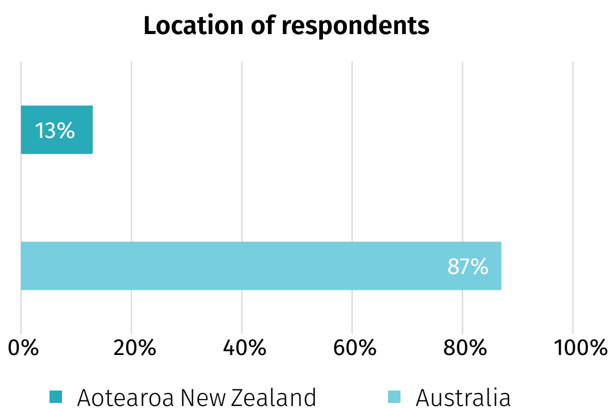
View the video recordings from the Summit here.

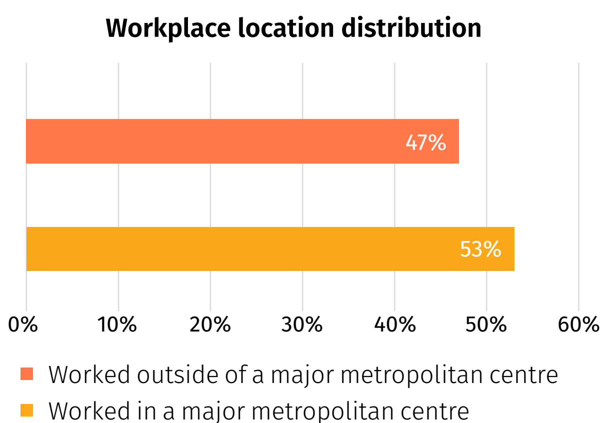
3. What data did we collect

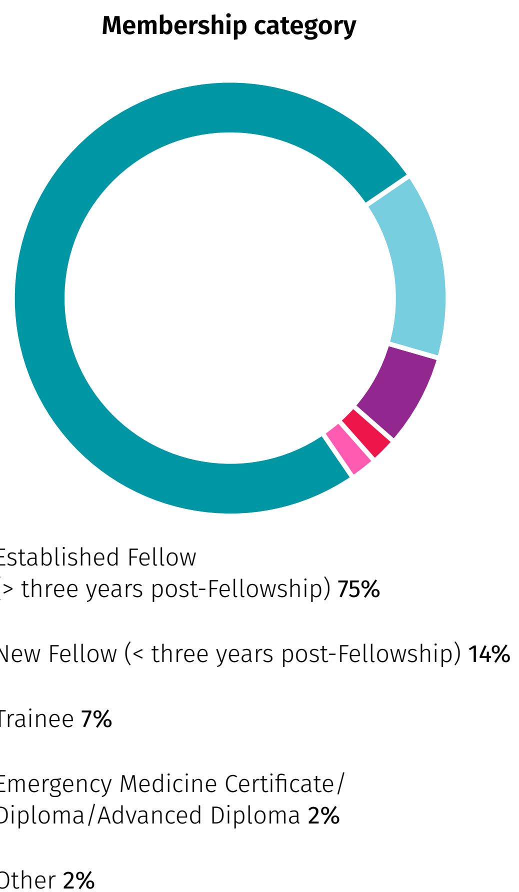
All members and trainees who attended the Summit, in person or online, were invited to complete this survey. Members who were not able to participate on the day were invited to view video recordings of the Summit and/or complete the survey in their own time.

The survey was open from September 2023 – February 2024.

A total 264 member responses were analysed.







4. How to interpret the data

Participants were asked to consider the role of emergency medicine in relation to a range of practice areas and models-of-care. Specifically, participants were asked to consider:

4.1 What is the scope of emergency medicine?

Data has been presented in the following categories:

- CORE – skills that should be fundamental to emergency medicine
- EXTENDED – skills that augment or enhance the practice of emergency medicine
- EXTRA – skills that lie outside emergency medicine practice, but allow emergency medicine physicians to influence emergency care systems and service delivery
- NOT IN SCOPE – skills that lie outside emergency medicine practice and are more effectively performed by others

4.2 What is the role of emergency medicine?

Data has been presented in the categories of:

- LEAD – emergency physicians are experts in these areas with a central and critical role
- SUPPORT – emergency physicians have interests and knowledge in these areas, but others are key stakeholders with greater expertise
- EXTRA – some emergency physicians have interests and knowledge in these areas, but are not regarded as major stakeholders
- NO ROLE – emergency physicians do not have a clear role

5. Feedback on Changing Processes and Models-Of-Care

The panel session on Changing processes and models-of-care focussed on how emergency doctors undertake their role, the rapidly changing ways emergency care is delivered, and impacts on the scope of practice required by emergency physicians. Topics covered were *clinical procedures and resuscitation, trauma, ultrasound, observation medicine, virtual care* and *urgent care*.

Regarding the scope of emergency medicine, on average most respondents completing the survey believed that:

- Resuscitation, trauma, clinical procedures, observation medicine, private emergency medicine should be considered as **CORE** skills, with resuscitation, trauma, and clinical procedures the highest ranked.
- Pre-hospital and retrieval medicine, and ultrasound should be considered as **EXTENDED** skills.
- Hospital in the home, urgent care, and virtual care should be considered as **EXTRA** skills.

Scope of emergency medicine	Core	Extended	Extra	Not in scope
Clinical procedures	90.2%	7.3%	0%	0.9%
Hospital in the home	2.7%	23.4%	47.8%	26.1%
Observation medicine	48.0%	28.5%	18.7%	2.4%
Pre-hospital and retrieval medicine	38.7%	48.7%	10.8%	0.9%
Private emergency medicine	37.0%	27.9%	27.0%	6.3%
Resuscitation	100.0%	0%	0%	0%
Trauma	93.4%	5.7%	0.9%	0%
Ultrasound	37.4%	44.7%	8.9%	0.9%
Urgent care	20.3%	17.9%	42.3%	15.4%
Virtual care	8.1%	35.0%	40.6%	9.8%

A total of 111 – 123 responses were received. Note that responses for some topics do not add up to 100 per cent as respondents were able to select an additional response – It's complicated – which is captured in the Additional Feedback section.

Regarding the role of emergency medicine, on average most respondents completing the survey believed that:

- The College should be playing a **LEAD** role in clinical procedures, observation medicine, pre-hospital and retrieval medicine, private emergency medicine, resuscitation, and trauma – with resuscitation, trauma, and clinical procedures the highest ranked.
- The College should be playing a **SUPPORT** role in the areas of hospital in the home, ultrasound, urgent care, and virtual care.

Role of emergency medicine	Lead	Support	Extra	No role
Clinical procedures	72.7%	15.7%	0%	0%
Hospital in the home	1.8%	39.7%	35.1%	21.6%
Observation medicine	47.1%	32.2%	12.4%	3.3%
Pre-hospital and retrieval medicine	53.2%	33.3%	12.6%	0%
Private emergency medicine	56.8%	17.1%	16.2%	5.4%
Resuscitation	98.4%	0%	0%	0%
Trauma	86.2%	11.4%	0%	0%
Ultrasound	33.3%	40.0%	15.0%	0.8%
Urgent care	17.2%	33.6%	32.8%	11.5%
Virtual care	21.5%	39.7%	24.0%	8.3%

A total of 111 – 123 responses were received. Note that responses for some topics do not add up to 100 per cent as respondents were able to select an additional response – It's complicated – which is captured in the Additional Feedback section.

6. Feedback on Changing Peoples and Populations

The panel session on *Changing peoples and populations* discussed the changing demography of people seeking emergency care, and the resulting effects on emergency department case mix. Topics covered were *paediatric emergency medicine, geriatric emergency medicine, mental health and addiction, toxicology,* and *health equity for marginalised peoples*.

Regarding the scope of emergency medicine, on average most respondents completing the survey believed that all the topics covered should be considered as **CORE** skills – with paediatric emergency medicine, geriatric emergency medicine, and toxicology the highest ranked.

Scope of emergency medicine	Core	Extended	Extra	Not in scope
Alcohol and other drugs	46.1%	32.2%	16.5%	3.5%
Diversity and inclusion	42.4%	21.6%	20.7%	14.4%
End-of-life care	49.2%	35.3%	12.1%	1.7%
Geriatric emergency medicine	94.0%	4.3%	0.9%	0%
Health equity for marginalised peoples	37.4%	34.8%	12.2%	13.0%
Mental health	56.9%	29.3%	9.5%	2.6%
Paediatric emergency medicine	94.0%	3.4%	0.9%	0%
Toxicology	72.2%	20.9%	4.3%	0%

A total of 111 – 116 responses were received. Note that responses for some topics do not add up to 100 per cent as respondents were able to select an additional response – It's complicated – which is captured in the Additional Feedback section.

Regarding the role of emergency medicine, on average most respondents completing the survey believed that:

- The College should be playing a **LEAD** role in paediatric emergency medicine, geriatric emergency medicine, toxicology, as well as diversity and inclusion.
- The College should be playing a **SUPPORT** role in alcohol and other drugs, end-of-life care, health equity for marginalised peoples, and mental health.

Role of emergency medicine	Lead	Support	Extra	No role
Alcohol and other drugs	25.0%	50.9%	19.0%	1.7%
Diversity and inclusion	38.8%	30.6%	18.9%	9.9%
End-of-life care	20.7%	61.2%	11.2%	2.6%
Geriatric emergency medicine	87.0%	11.2%	0.9%	0%
Health equity for marginalised peoples	31.0%	37.9%	14.7%	6.9%
Mental health	22.4%	62.1%	9.5%	2.6%
Paediatric emergency medicine	90.5%	6.9%	0.9%	0%
Toxicology	75.0%	17.2%	6.0%	0%

A total of 111 – 116 responses were received. Note that responses for some topics do not add up to 100 per cent as respondents were able to select an additional response – It's complicated – which is captured in the Additional Feedback section.

7. Feedback on Changing Roles and Contexts

The panel session on *Changing roles and contexts* explored some of the broader roles now performed by emergency physicians across health services and systems. Topics covered were *population and public health, global emergency care, improving health outcomes through research and data, emergency physicians as medical educators and lifelong learners,* and *emergency physicians as healthcare managers and leaders*.

Regarding the scope of emergency medicine, on average most respondents completing the survey believed that:

- Leadership, medical education, and resource stewardship should be considered as CORE skills.
- Healthcare management, research and data, population and public health, and global emergency care should be considered as EXTENDED skills.
- Climate change adaptation and mitigation should be considered as an EXTRA skill.

Scope of emergency medicine	Core	Extended	Extra	Not in scope
Climate change adaptation and mitigation	13.5%	21.6%	36.0%	28.0%
Global emergency care	14.4%	40.5%	39.7%	4.5%
Healthcare management	23.4%	58.6%	17.1%	0%
Leadership	70.0%	22.7%	6.4%	0%
Medical education	59.5%	30.6%	8.1%	0.9%
Population and public health	18.9%	41.5%	29.7%	8.1%
Research and data	34.2%	43.2%	22.6%	0%
Resource stewardship	37.3%	31.8%	27.3%	2.7%

A total of 110 – 111 responses were received. Note that responses for some topics do not add up to 100 per cent as respondents were able to select an additional response – It's complicated – which is captured in the Additional Feedback section.

Regarding the role of emergency medicine, on average most respondents completing the survey believed that:

- The College should be playing a LEAD role in leadership, medical education, as well as research and data.
- The College should be playing a SUPPORT role in population and public health, healthcare management, resource stewardship, and global emergency care.
- The College should be playing an EXTRA role regarding climate change adaptation and mitigation.

Role of emergency medicine	Lead	Support	Extra	No role
Climate change adaptation and mitigation	14.4%	25.2%	33.4%	26.1%
Global emergency care	26.1%	34.2%	33.4%	6.3%
Healthcare management	34.6%	50.0%	12.7%	1.8%
Leadership	75.5%	20.0%	4.6%	0%
Medical education	60.4%	33.3%	6.3%	0%
Population and public health	6.3%	56.8%	25.2%	9.0%
Research and data	42.3%	40.6%	17.1%	0%
Resource stewardship	37.8%	39.7%	18.9%	2.7%

A total of 110 – 111 responses were received. Note that responses for some topics do not add up to 100 per cent as respondents were able to select an additional response – It's complicated – which is captured in the Additional Feedback section.

8. Additional feedback

Participants were also given the opportunity to provide on additional questions, with responses broken down into key themes.

What other topics do you believe need further consideration or development by ACEM? Please outline the role and scope of emergency medicine regarding these activities.

Key themes

Definition/roles of emergency medicine (n=12)

- Require clearer boundary/ limit (n=6)
  - *We need to set clear limits on what we as FACEMs/emergency doctors do, and not be the backup "everything for everyone all the time" default for the hospital and community.*
  - *ED seems to have become the back stop for many things. I think we need to be clear that we are NOT the solution to the failing of primary care*
- ED ownership on core skills (n=3)
  - *A stronger stance in ED ownership, that EM lead all critical care and procedures that occur in ED*
  - *Subspecialisation needs to be looked at. How will this be credentialed etc.*
- Patient needs to be prioritised over definitive roles of EM (n=3)
  - *Rather than stepping back, I think we need to up and lean in. There was a lot of chatter about 'learning to say NO'... I also struggle with the 'Lanes' analogy. I do not see a patient focus in 'what is our lane'*
  - *Maintaining generalism across our speciality. We MUST maintain a general scope including ALL patient age groups and types of presentations including in rural and regional settings*

Advocacy on improving ED overcrowding and patient safety (n=10)

- Appropriate treatment areas in ED
  - *I am very disappointed that this is not mentioned so far. I am expected to see people in corridors and waiting rooms with no privacy or dignity and not enough nurses to supply the over ratio care, so please include corridors and appropriate clinical treatment areas as a scope issue.*
- Access block issues and solutions
  - *We are really struggling with bed access, staffing, moral injury, waiting times, and shift work. This is what I want ACEM to address most.*
  - *I believe emergency physicians are best suited to influence flow within hospital systems and should take a leadership role within larger systems both public and private to improve flow*
- Highlight positive perceptions of EM care
  - *We also need to nuance the messaging around access block... The average hospital will have an admission rate of 15-20%. So while access block does negatively impact us, we end up fully caring for 80%+ of the people who come through our doors for their whole treatment journey. This messaging is being lost.*
  - *How we are treated and viewed by the rest of the hospital and community – perception of care we deliver*

Rural and remote medicine and advocacy (n=9)

- Importance of rural medicine exposure and training
  - *Rural and remote medicine, I think needs to be specifically mentioned as well as Aboriginal and Torres Strait Islanders. I know it was implied in the categories, however it needs specific attention*
  - *Development of rural faculty and improving the gap between rural/regional medicine and urban medicine.*
  - *Rurality confers additional roles and scopes to emergency medicine practice.*
  - *Inclusion of some type of rural medicine exposure for six months*
- Improving the rural, regional and remote workforce
  - *I am concerned about the current status with locum doctors and locum agencies in the rural workforce space… perhaps on a state or national level governments need to do more to incentivise taking permanent roles in regional areas.*

Other potential skills/scopes in addition to EM core skills (n=9)

- Medical administration/ health education (n=3)
  - *There are other roles and scope of emergency medicine by advocating for patients needs, addressing ethical consideration in the emergency situation, patient education, improving patient health literacy, collaboration with other medical specialities for comprehensive patient care…*
  - *Inter hospital transfers / other pre-hospital options like FACEMs working Telehealth with ambulance crews to avoid admissions*
- Non-clinical skills (n=2)
  - *Professionalism / Communication – Teaching and training in clinical communication skills is poorly taught and a common feature of candidates who fail examinations…*
- EM care beyond the ED setting (n=2)
  - *Thinking about different ways of practice our speciality – do we need to be mainly based in an ED? Who could be provided with better care, decreased costs, decreased pressure on our hospitals and decreased carbon emissions but intervening in their journey before they need to physically come to ED (i.e. better links between GPs and Virtual ED, ED sprint models to provide care in the community, etc.)*
- Other (n=2)
  - *Hyperbaric medicine. Potentially and extended scope.*
  - *An appropriate training program would be good for PEM similar to the EMC/EMD for general emergency medicine, for doctors who want to work as CMOs in paediatric only EDs, and for FACEMs who want a little extra training but not the full PEM subspecialist training program.*

Sustainable emergency medicine/workforce (n=6)

- Role of non-specialist medical practitioners
  - *I think the narrative around EMCDAD and CMO's needs to be emphasised as the President said- we are the College FOR Emergency Medicine rather than the College for Emergency Physicians.*
- Supporting later-career FACEMs
  - *I think we need to look at supporting and how we manage our aging FACEMs and how we can best keep utilising their knowledge and experience. We're going to have a lot more coming up to retirement age soon (given the age of the college)*
- Providing more workforce options
  - *Workforce options including diversification, part time work*
- Advocate for system-level change
  - *Need to advocate for system level change to remove things that harm our workforce eg four-hour target doesn't work and it results in high degrees of avoidable fatigue and resultant poor behaviour.*

Improving trainee support (n=3)

- Improving supervision capability
  - *In other Colleges there are more consultants than trainees by a large margin with the amount of trainees matching the expected attrition rate. If we changed our staffing profiles to consultant run rather than consultant led we could supervise and teach trainees better*
  - *How do we support medical students in a busy [department] where pressures are ++ and we should be able to show them the satisfying (rather than the frustrating) side of EM*
- Training sustainability
  - *More attention needs to be given to the education of trainees to ensure appropriate exposure to procedures and the diversity of EM. Currently the sheer volume of trainees required to staff night shifts around the country means that each trainee has limited opportunities to perform well supervised procedures, or receive appropriate education. Additionally, the imbalance between training numbers of FACEM job availability demoralising to trainees.*

Research support and evidence-based EM (n=3)

- *That ACEM recommends a certain amount of FTE to a dedicated research director at each site*
- *There are a lot of state based protocols and guidelines as well as some non-affiliated repositories of information. Many other colleges and societies own their guidelines and...it would be good to own the management of these.*
- *Advocates for dedicated research grants in core areas*

© Australasian College for Emergency Medicine

Do you have any other suggestions or feedback for the College?

Key themes

Summit is a valuable initiative; appreciative of College work (n=11)

- *Thank you to the organisers for a really well run and well themed event. It was great to see a broad range of speakers and to have the chance to discuss issues that we all think about a lot. It was nice to just be in the same room and talk about how we can hopefully make things better for our community, our trainees and ourselves.*
- *Thanks for starting this conversation. It's an important one. I think we have the skill set needed for healthcare reform and I think we should be talking much more and forming an idea of what good looks like given our relative helicopter perspective.*
- *Keep up the good work and advocacy!*

Stick to core EM and steer clear from political and social justice issues (n=12)

- *The fact that the social justice issues and politics and woke agenda dominates contributes to the low priority of clinical care. ACEM appears to have given up, let access block cause a working environment in ED that is terrible. An OH&S risk, medico legal risk, a personal professional career risk, to work in modern EDs. Treatment in a corridor or in a waiting room promotes short cuts and sub standard care.*
- *The college needs to focus on the bread and butter, and stop taking lead on political issues without consulting the wide FACEM/trainee community. Before broadsweeping political/controversial statements are released, all members should have a survey sent to them to gauge the actual opinions of the group.*
- *Stick to fixing its core business and do not get involved in socio-political issues where the College has no particular expertise nor credibility. Suggest the College restricts its advocacy for issues that are Core to the role of Emergency Medicine, and refrains from commenting on issues of a political/social nature, for which it has minimal expertise, and little public credibility.*
- *I have made the difficult decision to leave emergency medicine, having qualified as a specialist in 1999, as of next year. Quite frankly, the college has lost its way. The practice of emergency medicine, and the day to day work of an emergency physician, is increasingly marginalised by a view, actively encouraged by the college and an increasing number of the fellows it produces, that we are not a medical speciality with a defined scope of practice, but the social safety net of society.*
- *ACEM should be careful when moving into/commenting upon domains and issues that cannot reasonably be seen as 'emergency medicine' – particularly those that are political or ideological in nature. For example, the ACEM position of 'Yes' for the Voice referendum demonstrated the College adopting a perspective and position significantly discordant with the Australian population it serves. I believe that reflected poorly on the College. I also suspect that the College Voice position also failed to appropriately reflect the views of its Fellows – which is a prime responsibility. This must be avoided moving forward.*

Role and professionalism of emergency medicine (n=11)

- Clearer scope of EM
  - *If the College represents its fellows a core role should be to tighten the definition of emergency medicine to what the role of an emergency physician is and strongly lobby for appropriately resourced environments to practice emergency medicine*
  - *Part of the ED overload, poor patient outcomes/experiences and lack of staff wellness, are due to Emergency Medicine not actively reducing it's scope. When we prop up a failing primary care system, we delay sustainable solutions from emerging. In doing so, we strain our staff and discourage new trainees joining our specialty.*
- Current system is unsustainable and requires reforms
  - *Emergency medicine has become the workhorse for the hospital. This is increasingly demanded due to inpatient bed scarcity, funding models and the open door nature of the emergency department. With increasing demand procedures are becoming more difficult to accommodate and we should be insisting inpatient teams take more of this work on. Mental health is poorly managed in emergency. This model needs redefining. Virtual care is cannibalising our workforce and we need to plan for this moving forward.*
  - *Our scope now falls outside of traditional EDs largely because our scope IN EDs has become so unbearable. We have taken on board mental health, ultrasound, inpatient medicine and primary care – and we're giving up resusc, procedures to compensate – unsustainable – how many ED practitioners are full time public now? Does ACEM actually represent us anymore?*
- Strong leadership and advocacy
  - *We need strong EM representation in quality and safety and leadership in healthcare organisations, so that discussions at an executive level are grounded in work-as-done rather than work-as-imagined, and so that emergency medicine is seen as the heart (or 'central processing unit') of the entire system rather than as a troublesome after thought!*
  - *We need to talk as much about resuscitating sick emergency care patients as we do about advocacy and resource allocation at college level. The latter two have taken us away from our core focus of making sick patients better.*
- Branding of emergency medicine
  - *There also needs to be advertisement about the skills of Emergency Physicians. The general public know what a surgeon, cardiologist, etc. does. Do they really know what an Emergency Physician does?*

Preparedness for aging population demands (n=3)

- *The aging population will be the biggest challenge to the sustainability of the acute healthcare system that modern medicine has faced. Rapid action is required to ensure adequate preparedness of EDs, ED clinicians and the broader healthcare system*

Advocate for improving ED resources (n=3)

- *Please focus on training emergency medicine specialists and maintaining skills and standards among current specialists. Please continue to advocate for adequate resourcing for the emergency department.*

Regional, rural and remote workforce and training term (n=3)

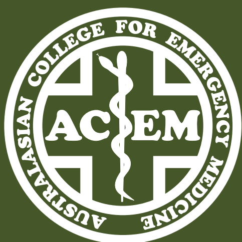
- *CMOs with experience can easily demand hourly rates higher than FACEMs get in regional areas, without the training and knowledge of a FACEM. What exactly is our representation on this matter.*
- *Clear learning objectives/rationale for non-tertiary terms need to be developed to ensure these terms are adequately preparing trainees for practice as new FACEMs.*
- *I am excited by the prospect of some core rural time in the future for trainees and by the idea of this pilot program that was alluded to for sites without FACEMs or with less FACEM coverage. Excited to learn more!!*

Suggestions for the FACEM Training Program (n=3)

- *I have been watching the training program in Australia for the past 20 years and do feel that the examination model needs to change. We need a workforce of the future and I routinely work with many capable candidates who for one reason or the other cannot pass the exit exam hurdle and are therefore relegated to CMO jobs for the rest of their lives. I do believe an alternate exam model would allow them to succeed.*
- *The PEM program needs serious revision. PEM trainees are able to graduate without actually having FACEM level adult skills.*
- *Care should be taken to ensure that ACEM lobbies for increased workplace recognition of this role, provides adequate clerical and administrative support to DEMTs*

Other (n=1 for the respective theme as follows)

- *ED is 24-7 business. It makes no sense to me that FACEMs go home at midnight when trainees take over. We are just creating a class system which is unfair. Suggest to Get FACEMs to work 24-7.*
- *We need to start talking about research of various natures (not limited to clinical trials) – having a leadership group that knows how to provide research support for everyone.*
- *I think ACEM needs to invest more heavily in leadership development. Senior FACEMs are paying top dollar to RACMA (Royal Australasian College of Medical Administrators) and receiving what has been described as a second rate product, because it is not aimed at who this group of FACEMs actually is – that is Senior middle management in the complex hospital system. We could fill this space far more effectively, and our members who are looking for more deserve better that they are purchasing from other sources.*
- *I'd like to see our training program and our ongoing CPD program incorporate mandatory simulation to cover HALO procedures [High Acuity, Low occurrence procedures]... I think we have a great opportunity to really ensure that our FACEMs are truly capable of performing our core skills.*
- *Support increased independence for the Aotearoa NZ branch of ACEM, often included as if it is a state of Australia.*
- *The College needs to advocate for EPs especially older emergency physicians – and find roles for their skills as one gets older and for transition to retirement so we don't lose their skills and experience.*



Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au