



IEMNet News

Newsletter of the International Emergency Medicine Network of ACEM

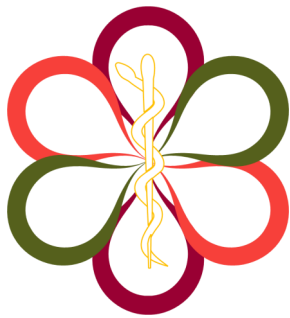
October 2016, Volume 2: Issue 1

Sri Lanka

The Dawn of EM

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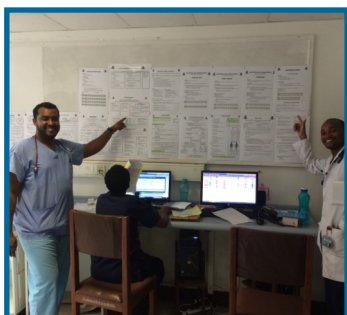
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Message from the Chair



Gerard O'Reilly

Chair, International Emergency
Medicine Committee

**Try filling
those shoes...
the passing of
the baton**

**Chris Curry retires as inaugural
Editor of the International
Emergency Medicine Network
News.**



Chris Curry

Fore-runner to the current International Emergency Medicine Network (IEM-Net) and the International Emergency Medicine Committee (IEMC), the International Emergency Medicine Special Interest Group (IEMSIG) was the first incarnation of the passion and activity of FACEMs and ACEM trainees in the field of International Emergency Medicine. Its inaugural Chair, from its inception in 2004, was Chris Curry.

Until now, Chris has also been the Chief Editor of the IEMSIG Newsletter, more recently re-badged as the IEMNet News. The Newsletter was first published in September 2004 as Volume One, Issue One, featuring articles and opportunities from emergency care programs in the Solomon Islands, Papua New Guinea, Afghanistan and the Advance Paediatric Life Support Course in the Asia-Pacific region. 23 issues later, the Newsletter continues to be an inspirational and colourful array of the personal stories, courage and work of Australasian emergency care champions across the world,

supported by FACEMs with a passion for international emergency medicine. For 12 years, this publication has been the pulse and the oxygen of the IEM network. It has been the glue holding the network together and the vehicle for updating the network. Our Newsletter has been the inspiration for many emergency doctors leaving Australasia to help start or join emergency care capacity development projects in our Asia-Pacific region, and beyond, to Africa, the Middle East, Europe and anywhere where support for improving emergency care has been sought.

Undoubtedly, without it (and without Chris Curry steering the ship), projects across the Asia-Pacific, including the most advanced emergency development projects in PNG, Nepal, and Myanmar, would not have yet reached their current heights. In fact, there is an intangible but real link between the activity of the IEM Newsletter and improvements in the delivery of emergency care, particularly in the Asia-Pacific region.

Chris, as editor, has embraced a broad and deep understanding of the global reach of emergency care capacity development. His personal and professional networks are expansive. His inclusiveness and relentless positive encouragement of FACEMs, trainees and other clinicians to get involved, reflect and write about their experience has created the wonderful publication that we now rely on to learn about each other's valuable work in the field.

So please join me in thanking Chris Curry for his wonderful efforts to create, lead and be the inaugural Chief Editor of the ACEM International Emergency Medicine Network News.

ACEM's International Emergency Medicine Committee

Dr Colin Banks



Colin has been supporting emergency medicine in PNG since 2009 with regular short visits. It has been predominantly with the emergency physician training program but also with emergency department systems and delivery of trauma courses. He was heavily involved with the recent restructuring of the program and is a regular examiner. In 2015, he became involved with the training program in Fiji as the Chief Examiner for the first wave of local emergency physicians.

Prof George Braitberg



George has been practicing emergency medicine and toxicology since 1988. He is Professor of Emergency Medicine, University of Melbourne

and Director of Emergency Medicine, Royal Melbourne Hospital. He is a Fellow of the American College of Medical Toxicology and ACEM, a board member of St Johns Ambulance Victoria and Barwon Health and a part time medical advisor to Ambulance Victoria. He holds a Master of Bioethics and is completing a Masters of Health Services Management. His research interests include toxicology, pre-hospital care and health system redesign.

Dr Ngaire Caruso



Ngaire is an Emergency Physician currently working at Fiona Stanley Hospital in Perth. Previous international medical experience includes three years in Botswana, developing and implementing the first emergency medicine training programme in the country. Ngaire has also volunteered with Médecins Sans Frontières in Uganda, Ethiopia and Thailand.

Dr Megan Cox

Megan became interested in International EM while working in the Solomon Islands in 1995. Since completing her Fellowship in 2001 she has worked in Southern Sudan,

Tanzania, Kenya and Uganda. For over 4 years now she has worked full-time in Botswana, training the first local EM registrars and managing a busy referral ED in Gaborone.



Dr Anne Creaton

Anne studied medicine in the UK, and moved to Australia in 1999, where she

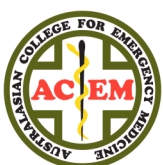


was awarded a Fellowship in 2007.

She is interested in education, pre-hospital/retrieval and disaster medicine, and has been involved in capacity building with Thai emergency physicians between 2006-8.

In 2013, Anne developed the Diploma and Masters of EM in Fiji in with Fiji National University.

Anne is currently enrolled in a Masters of Public Health and is also working



part-time in Fiji as well as part-time in Melbourne.

Dr Chris Curry



Chris has played a leading role in the development of emergency medicine training in Papua New Guinea, Nepal and Myanmar.

He was the foundation chair of the International Emergency Medicine Special Interest Group (IEMSIG), and was editor of the IEMSIG/IEMNet Newsletter for a decade (2004-2015).

Dr Sandy Inglis



Sandy heads the ED at Edendale Hospital in Kwa-Zulu Natal (KZN), South Africa. Sandy is South African born but spent most of his career in Australasia. A hunger for developing global EM and adventure has seen him

working in PNG, Antarctica, the Tuamotus and, for the last few years, in KZN where EM is embryonic and raw. His passions include developing EM, teaching and all things clinical.

Dr Anthony Joseph

Tony is an Associate Professor at the University of Sydney and a Senior Emergency Physician and Trauma Director at Royal North Shore Hospital in Sydney.



He has been involved in teaching courses in Emergency, Trauma and Ultrasound skills in India, Myanmar and Vietnam over the last 10 years.

Dr John Kennedy



John is an emergency physician and DMT at Sydney's Royal North Shore Hospital. He has been involved in the

development and dissemination of training courses and other support for ED clinicians in the Pacific since 2007. He enjoys working for the IEMC - the most entertaining of all ACEM Committees!

Dr Gerard O'Reilly

Gerard is an emergency physician and Head of International Programs at the National Trauma Research Institute, Alfred Hospital in Melbourne, Australia. He has worked with Médecins Sans Frontières (MSF) in north Afghanistan (1997-8) and a Somali refugee camp in Kenya (2002), and has participated in emergency responses in Timor Leste



(1999) and post-tsunami Aceh (2005).

Gerard has led emergency and trauma capacity development programs in Asia, including in Sri Lanka (2007-13), India (2009), Myanmar (2013) and Vietnam (2013-4), and has participated as faculty for trauma care training in China (2008, 2010-11) and Papua New Guinea (2004-9), where he was an Advanced Trauma Life Support Instructor. He has also served as faculty for the World Health Organization (WHO), delivering courses on trauma quality improvement programmes in Ethiopia (2011) and Iran (2013, 2015).



ACEM's International Emergency Medicine Committee

Gerard is Chair of ACEM's International Emergency Medicine Committee, a Board Member of the ACEM Foundation, and is a member of the WHO Global Alliance for the Care of the Injured (GACI) Trauma Registry Working Group.

Dr Georgina Phillips



Georgina is based in Melbourne and is currently the Deputy Chair of the IEMC. Before commencing her EM training, she worked for 2 years as an Australian volunteer in the remote Pacific nation of Kiribati. Since then she has been involved in capacity development activities around the Pacific, (particularly PNG, Solomon Islands and more recently Fiji) and in Myanmar. Georgina is also on the board of the Primary Trauma Care (PTC) Foundation and an experienced PTC instructor around the Asia/Pacific region.

Dr Bishan Rajapakse

Bishan is an Emergency Medicine advanced trainee with a [passion for international Emergency Medicine](#). He spent 4 years in Sri Lanka researching organophosphate poisoning, and introducing a "[train the trainer](#)" system of resuscitation education for

rural Sri Lankan doctors which led to a [PhD in knowledge translation](#).



Bishan is also a [medical blogger](#), who has written for [Life in the Fast Lane](#) on topics related to international EM, and helps coordinate a Facebook usergroup on [International Emergency Medicine](#).

Dr Sean Scott



Sean is an Australian trained emergency physician and intensivist practicing critical care from rural African retrieval to ECMO for transplants. Sean works to bridge the gap that often exists between the emergency department and the ICU in a variety of international contexts. He works clinically as a staff specialist at St Vincent's Hospital in Sydney.

In 2006 he completed his Diploma of

Tropical Medicine and Hygiene and has since worked with Partners in Health (PIH) and the Lesotho Flying Doctors Service (LFDS) in Southern Africa. He has also worked as an emergency physician, intensivist and medical educator in Italy.

Sean has an interest in international critical care education and is a strong believer in #FOAMed. He is the director of critical care simulation at the Don Harrison patient safety simulation centre and is deputy supervisor of intensive care training at St. Vincent's Hospital in Sydney. He is currently a faculty member for the Dutch emergency medicine masterclass series (www.mnsha.nl). Sean also runs workshops in critical care ultrasound and teaches adult and pediatric life support in Australia and South Africa.

Dr Rosanne Skalicky



Rosanne is currently working in Myanmar, where she has been the international emergency consultant advisor for the national development of emergency medicine. To date, this has included the successful graduation of two post-graduate Diploma EM programs and the commencement in 2015 of the 3-year Masters EM specialty program. Rosanne was awarded the title of Honorary Professor



of Emergency Medicine by the University of Medicine 1, Yangon, Myanmar, in June 2016.

From 2010 - 2012 Rosanne worked in a 200-bed district hospital in rural Tanzania, where in 2012 she became doctor-in-charge in response to local leadership problems. She was awarded a certificate of appreciation for contributions to the regional viral haemorrhagic fever mass casualty plan, involving a tri-country simulation exercise, led by East African community health committee.

Dr Alan Tankel

Alan has had a longstanding interest in international emergency medicine. He has been involved in organising and delivering Emergency Life Support courses in the Pacific region and in



Asia and has represented ACEM at international meetings including Strengthening Specialised Clinical Services in the Pacific (SSCSIP) and the Global Health Symposium.

Dr Brady Tassicker

Brady has been active within the Pacific Islands for many years. It began with a one year placement in Kiribati in 2003. Thereafter followed shorter engagements in Papua New Guinea, Solomon Islands and Vanuatu,



including as an Emergency Life Support International (ELSI) instructor. The wheel has come full circle (or perhaps the canoe has tacked), and he once again finds himself living in Kiribati for 2016.

Dr Gina Watkins

Gina's interest in international EM development began with involvement in the early Fair Trade movement as a student. She has worked on medical development projects in Botswana, Nepal and the Philippines. Gina is currently Director of EM Research at Sutherland Hospital, Sydney.



Dr Matthew Wright

Matthew studied medicine at the University of Adelaide and did his

internship in Sydney in 1994. He did a range of medical jobs during the late 90s but ultimately it was when he was living and working in Alice Springs that he managed to find a way forwards to combine his passions for travel, social justice and excitement by specialising in emergency medicine and going on to develop an interest in EM in developing country settings.

Matthew did a Masters of Public Health at the University of Sydney and then a Masters of Tropical Medicine in Barcelona. He was an Australian



Volunteer in the Solomon Islands in 2004. He has a long term connection with East Timor having worked there in 1999 and then again through the AUSAID funded project at the National Referral Hospital in 2012. Matthew now works at Flinders Medical Centre in SA and has started a project called "Team Flinders." This involves an annual visit by ED Doctors and Nurses to the ED at the National Referral Hospital in Honiara (Solomon Islands) for teaching, training and clinical work.



Message from the Editor



Matthew Wright

Editor, IEMNet Newsletter

Is access to simple & effective emergency care not a fundamental human right?

I am delighted to be taking over as the editor of the IEMNet Newsletter. While acknowledging the fantastic contribution of Chris Curry over many years and the daunting prospect of attempting to fill his shoes, I look forward to the challenge of the role and to hearing first hand of exciting developments in international emergency medicine.

While by its very nature the Newsletter will continue to provide country by country updates, I would love to include more articles from our colleagues in developing countries, our emergency nursing colleagues, and trainees in emergency medicine who are making significant contributions around the globe.

There have been some impressive achievements in countries within our region in the development of the specialty of emergency medicine, from Myanmar and Sri Lanka, to Papua New Guinea and Fiji. These achievements have been outlined in this edition, as well as previous editions of the Newsletter.

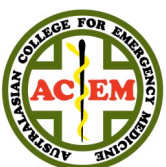
Despite these successes, an enormous challenge remains to improve access to basic emergency care for millions of people around the world, and reduce the unacceptable number of preventable deaths that continue to occur due to a lack of adequate emergency care.

Is access to simple and effective emergency care not a fundamental human right?

And just like Randolph Hearst, Rupert Murdoch and Chris Curry before me – I need copy.

Please feel free to contact me with comments, letters to the editor, ideas for articles or to contribute in any way.

IEMNetNewseditor@acem.org.au



Awards and Scholarships

The International Development Fund Grant 2015

The International Development Fund Grant aims to promote the development of emergency care in the developing world through teaching, training, and capacity building.

In 2015, the [ACEM Foundation](#) awarded two International Development Fund Grants. Dr Loren Sher received \$9,000 for her project, '*Reference manual for Initial Emergency Care course - Mongolia*'. Associate Professor David Smart received \$21,000 for his project, '*Establishment of sustainable Emergency Life Support International (ELSi) and Serious Injury/Illness in Remote Environments (SIREn) Courses in Fiji*'.



Dr Loren Sher & Immediate Past-President Dr Anthony Cross.

The International Scholarship 2015

The [ACEM Foundation](#) International Scholarship is awarded to doctors and other health professionals from developing nations to support them in attending the ACEM Annual Scientific Meeting (ASM).

The scholars present at the ASM to increase awareness and support for emergency medicine in developing countries. In 2015, Dr Nay Naing Htun (Myanmar), Dr Tin Kyaw (Myanmar), Dr Rabin Bhandari (Nepal), and Dr Hendry Sawe (Tanzania) received scholarships.



Dr Hendry Sawe, Dr Nay Naing Htun, Immediate Past-President Dr Anthony Cross, Dr Rabin Bhandari & Dr Tin Kyaw



ACEM
Foundation

SRI LANKA

Sri Lanka Update

Nick Taylor

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Emergency medicine (EM) in Sri Lanka is currently in a very exciting period of development. The first batch of trainees in the Doctor of Medicine (MD) in EM (administered by the Board of Emergency Medicine, Post Graduate Institute of Medicine) sat their fellowship exam in September 2016, and the government has committed, via a World Bank grant, to rapidly expand the successful Emergency Treatment Unit (ETU) model at Teaching Hospital Karapitiya (THK) in Galle, to multiple other centres across the country.

Additionally, the Sri Lankan Society of Critical Care and Emergency Medicine (SSCCEM) included an inaugural parallel nursing conference as part of its ASM in October 2015. The DevelopingEM conference (FACEMs Mark Newcombe and Sanj Fernando) is to be held in Colombo in December, there has been successful training of a local teaching faculty for the highly regarded Emergency Life Care (ELC) course (FACEM Shane Curran and others) and there is early planning for a pre-hospital care system.

From October 2015 to April 2016, I was privileged to spend my sabbatical at the THK in beautiful Galle, Sri Lanka. During my time, I was involved in on the floor 'doctoring', teaching and capacity development as well as a broader role in the post graduate EM training program.

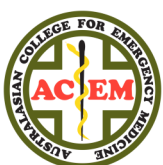
THK ETU

Developed as part of a partnership with the Alfred Hospital (FACEM Gerard O'Reilly and others) via a Victorian Government and AusAid funded program, THK ETU is utopia for EM in Sri Lanka. It has a large acute area and a well stocked 4 bed resus and delivers high level care to the 50-70 Cat 1-2/3 patients it sees daily. It is staffed by medical officers (from intern to PGY 10+ on a 4 year rotation) and



The ETU team at THK in Galle.

supervised by general physicians with an ED interest. It has well trained RN and EN nurses. Working here clinically was a delight as the case mix and acuity coupled with professionalism and enthusiasm of the staff made for a perfect combination. Daily cases were a mix of often severe trauma, multiple organ dysfunction as part of dengue and leptospirosis and managing a huge number of cardiovascular emergencies. Arriving in resus for the morning round usually involved seeing 3 ventilated patients (1 ICH or head injury, 1 cardiogenic shock and 1 tropical disease) and 1 patient about to fail CPAP! Most equipment was available including an excellent ultrasound machine which was never out of use, but there was a complete lack of the disposables which we take for granted. THK had one 'blue bougie' which had been in constant use for 5 years! We introduced new airway protocols, ran a huge amount of in-house training and began a Quality Assurance (QA) program, which is currently auditing streptokinase risk benefit on AMI to attempt to provide an evidence base to support investment in r-TPA at a national level.



EMMD

There are now three 'batches' of registrars in the MD in Emergency Medicine (EMMD) specialist training program, all of whom are committed and enthusiastic advocates for emergency medicine. They rotate around multiple terms for their 3 years of core training time attempting to glean as much ED relevant knowledge as possible by working in the 'casualty ward' as part of their rotation. They have a Primary and Fellowship exam modelled on the UK and Australasia and, after the fellowship exam in 3rd year, doctors are required to complete 1 year as a fellow and 1 year in a suitable overseas ED placement to attain fellowship. The first consultant emergency physicians will thus be available to commence work in late 2018. The current plan at a national level is to roll out these trainees across the more established ETUs and slowly spread them country wide. There is an ambitious plan to copy the THK model of ETU and build (or modify) ETUs and casualty wards in over 100 hospitals to provide structural and organisational support for this developing specialty.



Ranj, Nick and Srilal

My involvement in this program was at a national level, helping with formal education provision and planning for the future with the EM Board of Study, as well as writing, running and marking the first practice fellowship exam. At a local level the most important role I could offer was mentoring for the 3rd years who rotated down to THK ETU. It was wonderful to work alongside these pioneering doctors, who signed up to EM training having never seen an ED or a specialist emergency physician in action.

WHAT NEXT?

The next few years are crucial for emergency medicine's development, with one of the most important roles being to provide support for the EM Board (all of whom are non ED specialists with full time busy careers), and mentoring for the registrars.

Sri Lanka is a fabulous place to experience a tropical lifestyle with your family. Please contact me if you are interested in spending time as a volunteer or visit my blog <https://taylorsinsrilanka.wordpress.com/> to see what this amazing country offers.



FACEM Anna Davis also spent 3 months volunteering at THK ETU in August 2016.

For those who want to give support in other ways, please email me about becoming an online mentor on www.srilankaemergency.wordpress.com, Sri Lanka's first (and only!), FOAMED website, which now hosts scores of amazing EM cases – the registrars and ED staff using and posting on this site would love to hear from you!



BOTSWANA

Botswana calling

Jamie Hendrie
MBBS, FACEM, MD

If you are looking for an African Experience in Emergency Medicine (EM), then Botswana has a lot to offer. Safe, clean, and wisely governed by President Khama, Gaborone is leaping forward. Funded by diamond and copper mines, the population now enjoys over 80% literacy, up from 4% 50 years ago. The Botswana government, helped by many international funds, is tackling the HIV epidemic, which afflicts 23% of the population. Already 200,000 of the 2.3 million population are on anti-retroviral treatment (ART). With a government decision pending for treatment on diagnosis rather than by CD4 count, the number of patients on ART seems set to swell to 400,000, setting the stage for '1st world' level treatment: truly a leading light in Africa.



Getting the lab organised Michiel Van Veelan, Changi Baikai, Megan Cox, Jamie Hendrie

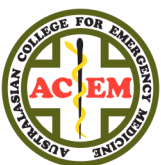
From an EM perspective, I worked in Princess Marina Hospital 'A&E' as it is still called. Princess Marina is the largest government-run hospital in Botswana and takes referrals from most of the country, particularly the impoverished. An enormous hospital, it is

arranged in blocks along 2 open corridors. It is chock-a-block full of patients, battling to cope with its burgeoning workload. The A&E keeps pretty busy. Its patient population is young, few over 50. Not surprisingly, HIV and TB and their various manifestations constitute an important part of the workload. Haemoglobin levels of 30 and 40 gm/L were commonplace. Transfusion is not considered unless the level is less than 60! Awareness of risk of cross infection was quite high, with gloves and 60-micron masks readily available, which helped alleviate one of my worries. There is a new ultrasound machine and plenty of opportunity to use it, particularly in 1st trimester bleeding, another common presentation. There is moderate trauma workload.



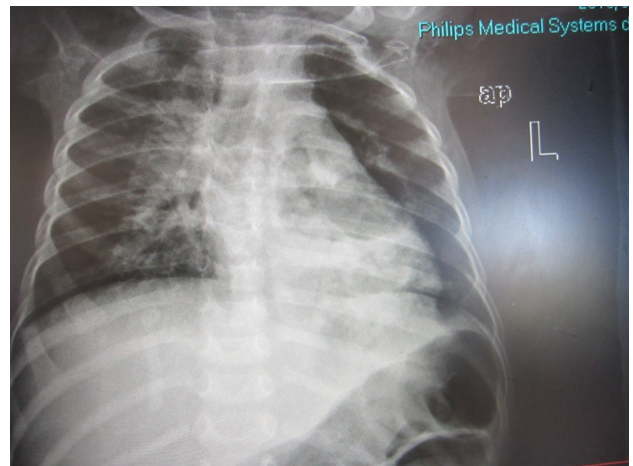
Teaching Airway skills

There is an active education program, vigorously promoted by FACEM Megan Cox, run through the University of Botswana. Several EM trainees are approaching their South African EM Fellowship exam, and will hopefully provide the 1st wave of 'Nationals' improving emergency care in Botswana. The University boasts a swish, luxurious new medical school, with extensive teaching space. Simulation workshops in EM are provided to medical students, who relish this practical exposure to intubation, CPR and acute care management scenarios. There is a weekly resident education tutorial. I was pleased to contribute to all of the programs.





Great Placard HIV prevention campaign



Cavitating TB in 2yo



Good Labs



Anatomical reduction achieved - challenging!

Gaborone offers a good range of restaurants, Western-style shopping malls and the more traditional Main Mall, complete with colourful hawkers selling their wares. There are a number of game parks within easy driving distance and, of course, the Okavango Delta beckons to the north.

Those interested in joining Megan Cox and her team, or just spending a month or two, can contact Megan at mcox2050@gmail.com. One word of warning – you will have to be fully registered. This is tedious but doable; it does set a good standard. A warm welcome is assured.



MYANMAR

Balancing Progress – Myanmar Emergency development

Rosanne Skalicky

The development of emergency medicine in Myanmar has been a relatively rapid one that was initially spurred on by the need for improved response to disasters like cyclone Nargis, and the need for a co-ordinated emergency service for international gatherings, like the Southeast Asian Games. However, the momentum that has kept it moving forward is the recognition of the benefits of improved emergency health care by both the government and the community. This momentum, like a snowball, continues to move forward and get bigger.

In 2012, 18 pioneer doctors started the journey, followed by a further 8 doctors in 2014. Now, in 2016 there are 51 Masters of Emergency Medicine students, (1st and 2nd year), and 13 Diploma of Emergency nursing students. In August 2015, 52 candidates commenced the Diploma of Primary Emergency Care which is a one-year program aimed to equip them to provide acute care at the district hospital level.

Despite this rapid expansion in student numbers, the number of full-time emergency consultants delivering clinical service and teaching is only 14 nationally, from the first two Diploma EM courses. The number of government specialist emergency nurses is only 2.

The question arises -how do you balance the production of high quality emergency doctors and nurses with the national need and expectation for emergency doctors now?

Over the next 1-2 years there is an expectation that the doors to EM training will extend beyond the University of Medicine 1 to the University of Medicine 2 and Mandalay University.

The momentum of the development of emergency medicine reaches beyond just training doctors and

nurses, to leading infrastructure change in hospitals nationally and the development of a pre-hospital emergency service.

How do the same number of people do it all?

Myanmar has been opening its borders for a number of years but with the election of a new government the push from internationals to come and help is increasing.

Is all help good help?

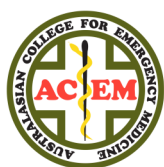
The challenge to the leaders and to emergency doctors and nurses as emergency medicine development moves forward is how fast is a good speed forward? And how do you balance quality with quantity?

The emergency department resuscitation room of Yangon General Hospital now sees on average 180 cases per week. The acuity of these category one patients is often on the extreme side due to late presentation, lack of pre-hospital care and untreated chronic disease. Injury and trauma still are leading causes of death and morbidity, with severe head injury a common presentation.

The up side of this work it that it is gaining the respect of the community as lives are being saved and a higher quality of service is being provided. In January 2015 according to the ED audit, less than 15 myocardial infarcts per month were being referred to the CCU but now there are greater than 30 per week.

Recently we had a visiting trauma team from Australia facilitate team training and focus students on trauma systems. Within days of their arrival one of the cases they supervised was blunt chest trauma with cardiac tamponade secondary to road trauma. The patient was treated in the resus room and underwent successful repair to the heart and later walked out of the hospital a well man! As the team was chatting to the cardiac surgeon about this case prior to OT, the cardiac surgeon responded that he had already managed 3 similar cases in the past month, all with successful outcomes. These are 4 cases that, in years prior to the commencement of triage and specific emergency care, would have had different outcomes.

A few months ago a fisherman was referred to YGH after trying to kill a fish by biting off it's head. Unfortunately the fish had other ideas and slid down



his throat causing a partial obstruction to the man's airway. By the time of arrival to YGH his airway was almost completely obstructed necessitating cricothyroidotomy and urgent surgery.

An older lady presented with signs and symptoms that appeared to be a stroke. After a normal CT head and further examination of the patient that appeared not entirely consistent with this, a bedside ultrasound by an emergency candidate was performed. This second year student identified a dissecting aortic aneurysm arising from the aortic root and down to the suprarenal section of the abdominal aorta. Rather than thrombolysis for a stroke (this has just commenced in 2016) the patient was instead admitted and managed by the cardiovascular unit. A great result!

These are obviously cases that are story worthy, yet behind these few cases are hundreds of others where similarly, the outcome has changed due to improved emergency care.

There is a momentum for more contemporary methods of training and assessment in the university, and curriculum reform is the current buzz phrase. Not only are the universities looking at renewal of the undergraduate curriculum to a more integrated approach, but also postgraduate training is looking at better assessment methods and teaching. Emergency training both for doctors and nurses is emerging as a leader in medical education reform. The emergency doctors and nurses are spearheading skills training, and now run a skills intensive course for the interns in collaboration with the other departments for 500 – 600 students per year. Our postgraduate assessment methods and training are now being imitated in other specialties and indeed other universities.

There is no doubt that emergency development in Myanmar is progressing rapidly. Some liken it to a fast train. Others here liken it to leap frogging. Regardless of the picture, the challenge ahead for both local EM and international EM is how to balance progress between quantity and maintaining quality, so that the good reputation of EM continues and we don't burn out those doctors and nurses who are leading this development.



SOLOMON ISLANDS

Team Flinders in the Solomon Islands – I have a Dream...

Matthew Wright

Charlatan7@yahoo.com

In May 2015 a group of 10 Doctors and Nurses from Flinders Medical Centre (FMC) ED cast off the oppressive yoke of four hour targets, obstructive inpatient teams, CT scanning clopidogrel survivors, less than 24 hour turnaround times for laboratory tests and endless supplies of single use items and ventured to the ED at the National Referral Hospital (NRH) in Honiara.

The original connection with the Solomons began when my partner and I spent time there in 2004 in one of the provinces as volunteers. I returned to Honiara in 2014 and spent 10 days in the ED at the National Referral Hospital to see how things had changed and to scope out the possibility of our ED establishing a relationship with theirs. The ED at the NRH had no shortage of challenges and I wondered if there was any way that we could support them in even the smallest of ways.

When I returned to Flinders I promoted the idea of an initial trip to Honiara for a mixed group of doctors and nurses from our ED for a combination of clinical work and hopefully teaching. A little bit like the fishing trip from the movie “One Flew over the Cuckoo’s Nest”, some brave souls signed up. We raised some money in advance to subsidise travel, which included a quiz night, and then headed off.

The team for our initial visit consisted of 3 FACEMs, 3 ED registrars and 4 of our ED nurses. During our time in Honiara we did a combination of clinical work and teaching. Our nurses put most of the NRH’s ED nurses through BLS training and we put their doctors through quite a bit of simulation teaching using an ALSi iPad based system that we had taken with us. We felt the local doctors enjoyed the fidelity of the sims as well as having some dedicated teaching time off of the floor. Two of the FACEMs also spent time teaching the ED Doctors some Ultrasound skills as

the ED had received a donated U/S machine in the year prior.

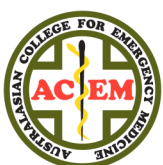
Other highlights were our group going away to an island for a weekend, and a karaoke world series championship, with FMC ED vs NRH ED staff on one of our final nights. The Australians were way out of tune.

Overall we were very happy with our first visit. All of our team had spent time in a very different ED from our own, seen some fascinating clinical medicine, done a little to help the staff at the NRH and made some great friends. It was also a great team building exercise for us, and to have done a trip like this with some of our registrars, added a unique dimension to it. We came away with a lot of enthusiasm to try and make the Solomons trip an annual event and had a lot of ideas about things we could do and try next time.

In June 2016 “Team Flinders – the second coming” headed off to the Solomons for another visit. Unfortunately I missed this year’s trip as I was otherwise occupied in Australia. This time 8 doctors and nurses from FMC ED headed back to Honiara with a lot of donated items and equipment that we felt would be useful based on our first trip.



Team Flinders in the Solomon Islands



Amongst the donations were 2 otoscopes and a donated ALSi iPad simulation trainer which was presented to the staff at the NRH ED.

The highlights of this year's visit were:

- The team were impressed with the ways that the staff at the NRH ED had reconfigured their department in terms of developing a new dedicated paediatric area.
- Our nursing staff, led by Sam Cosgrove, took around 40 of their nursing staff through Resus4kids.
- The FACEMs and our registrar did clinical work with teaching on the floor, as well as some dedicated teaching time for their doctors.
- The team also met Lyn Wanafaela who is an Australian ED nurse who has recently started in the ED in an AVI/ACEM role.
- It was great to see some old friends.

There is something universal about the life of doctors and nurses who choose to work in EDs. The dream or the vision of an endeavor like this is – ‘what if every ED in Australia and New Zealand had an ongoing relationship with an ED in a developing country’?

Working in emergency departments can be a long hard road, and nowhere is that more true than in developing countries where the case load is large, the resources are limited, the pay isn't great, the physical working environment is tough and your capacity to do things is often limited (e.g. at the NRH there is no ICU, no CT and you usually don't get that critical lab result on your patient for at least 24 hours, if at all).

There is enormous goodwill in Australasian EDs, and to tap into that to support the emergency doctors and nurses who are providing care in hospitals throughout our region in low resource settings is a worthwhile endeavor. I believe there is also a lot in this type of relationship for us too. The problems back home mostly pale into insignificance when you see some of the challenges of other people's working environments.

So, the next time you are at work, have a look around. There is a good chance that many of the doctors and nurses that you are on shift with are from somewhere other than Australia or NZ, and that

could be the start of something.

Team Flinders is already planning for 2017 and Honiara – we are hoping to put together enough people and money for 2 visits and have some ideas how we can add more structure to our teaching. We would also love to be able to fundraise enough to look at purchasing some additional equipment for their ED.



TANZANIA

Karibu Tanzania!

Jennifer Jamieson

MBBS, BBiomedSc, MPHTM

ACEM Advanced Trainee

Trapped in my little Forester, I found myself enveloped in the traffic chaos of Dar es Salaam. Cars snaking backwards in a horrendous gridlock, blaring their horns, whilst motorbike taxis (“boda bodas”) were madly careening their way through traffic, and hawkers shouted out with today’s copy of “The Citizen” to sell to frustrated drivers stuck in yet another drawn-out jam. And in amongst the dense humidity comes the waft of street-side barbeques selling beef kebabs (“mishkaki”) next to stalls overflowing with fresh pineapple, papaya and passionfruit.

Like many interested in international emergency medicine (IEM), it didn’t take long before I was lured back to another overseas project. Conscious of prolonging my training time again, I nonetheless embarked on the next adventure at Muhimbili National Hospital in Dar es Salaam, Tanzania. I was met with many warm “Karibu Tanzania” greetings (“Welcome to Tanzania!”).

Emergency Medicine in Tanzania

The spectrum of emergency medicine (EM) across sub-Saharan Africa is as diverse as the region itself. South African EM is notably advanced, with the specialty established since 2003. Many South African metropolitan areas have fully functioning EM systems, pre-hospital and retrieval care, and clear referral pathways. This is in sharp contrast to the rest of the continent where EM is still in its infancy and little EM infrastructure exists. However, many African countries are starting to recognise and develop EM as a specialty. Despite this, the majority of existing EM resources in sub-Saharan Africa are overstretched and over-burdened.

EM in Tanzania has been around since 2009 when the first specialty training program started as a 3-year Masters of Emergency Medicine. There have now been several years of graduates and the

program continues to grow at Muhimbili National Hospital, attracting doctors from across the country and region. Many of the EM residents graduate from their training at Muhimbili and return to smaller rural hospitals to take up Head of Department leadership positions in order to pioneer the growth of EM across the country.

Muhimbili National Hospital, Dar es Salaam

Muhimbili is currently the only hospital in Tanzania which has formal EM training capacity. A 1500-bed

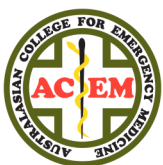


hospital, with a busy emergency medicine department and a diverse casemix, Muhimbili is a truly remarkable place for Tanzanian trainees to embark on their residency training. Like many countries in sub-Saharan Africa, Tanzania is also susceptible to the ‘double burden’ of disease - that is the burden of communicable diseases such as malaria, dengue and cholera, as well as the rising burden of non-communicable diseases such as cardiovascular disease, obstetric complications and trauma.

Local healthcare challenges

Muhimbili national hospital is reasonably well resourced compared to many other rural and regional public hospitals in the country. However it remains liable to shortages in medication supplies and difficulties with maintenance of essential equipment such as ultrasound machines.

As the national public hospital, there are many referrals from rural and regional health centres. Yet, due to a lacking pre-hospital system, there are frequent delays in the referral of critically-ill patients. Many seriously ill patients will arrive at Muhimbili with end-organ failure. As such, there is an enormous



amount of community-driven fear surrounding referral to Muhimbili. Local healers or witch-doctors, who are frequently sought for health advice and prescriptions, may also contribute to the delay in seeking appropriate medical treatment.



Tanzania has also sought to assist individuals living with albinism. Cultural beliefs have traditionally attributed magical powers to people with albinism, hence albino body parts are frequently believed to bring wealth and fortune. Violence and murders against people with albinism are driven by traditional witchdoctors and carried out by contract killers, particularly in rural areas, causing many to flee to Dar es Salaam. Globally albinism is rare, affecting only 1 in 20,000. However, in Sub-Saharan Africa it is more common, affecting approximately 1 in 1429 in Tanzania, more than any other nation.

Fortunately, there are now more organisations helping those living with albinism in Tanzania. They help promote education around albinism through films and documentaries; ensure access to medical treatment; and provide simple preventative strategies such as supplying wide-brimmed hats and sunscreen to those living with albinism.

Health-system strengthening

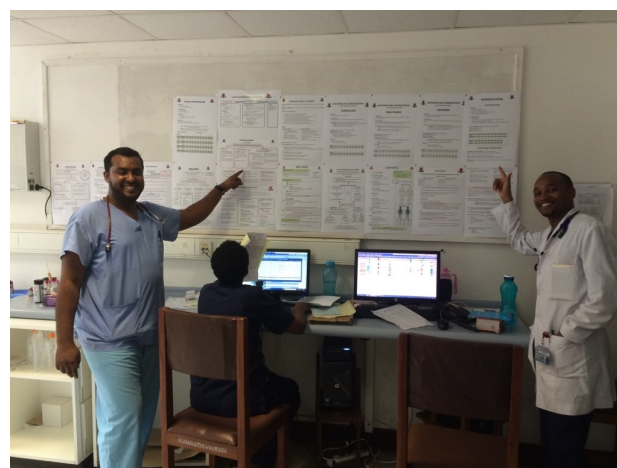
During my time working at Muhimbili, my role was mainly focused on health-system strengthening. In conjunction with the EM residents, I worked on developing a new set of protocols for the department. I spent time assisting with various educational activities, including simulation, exams, research projects and lectures. This included mentoring the residents on how to teach junior staff effectively by giving them opportunities to lecture

junior staff at other hospitals in Dar es Salaam.

Mass casualties and disasters are not infrequent in the city of Dar. During last year, a cholera outbreak occurred in Tanzania after the influx of refugees from Burundi. Disease epidemics and disasters are a true test of health system capability, therefore we also coordinated a large-scale disaster drill for the Muhimbili emergency staff. Emergency providers from other hospitals were invited along to observe the drill. We utilized over 30 medical students to act as patients and tested the coordination, triage, decontamination strategies and management of a mass casualty response at Muhimbili.

The future

This is an exciting time in Africa as we witness the growth of emergency medicine as a specialty in response to the demand for acute care services. The 2016 International Conference for Emergency Medicine (ICEM) in Cape Town highlighted the interest in developing and growing EM across many different countries in the continent. The African Federation of Emergency Medicine (AFEM) has developed an enormous pool of open-access resources specific for African EM.



Tanzania will remain an example of how emergency medicine can be effectively implemented, and many countries across Africa will look to Muhimbili for leadership in this domain.

Jennifer Jamieson spent 12 months in Tanzania as a volunteer. 6 months of this time was accredited towards her training as a special skills post. This opportunity was organised through her own connections.



Review of EM training in Fiji

Dennis Lee

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Fiji is a small country made up of close to 300 islands located in the South Pacific. It has a population of almost 900 000, of which most are living on the two largest islands, Viti Levu and Vanua Levu. Fiji's largest referral hospital, the Colonial War Memorial Hospital (CWMH), is located in Suva City on Viti Levu. CWMH is one of the three referral hospitals for the country and provides specialist services, including Emergency Medicine.

Fiji has been training health care workers for the region since the late 1800's. Emergency Medicine (EM) however, is a recent development. For several years there had been a local vision to establish EM in Fiji, but formal training only began in 2012 with the Diploma in EM course from the Fiji National University (FNU). In 2013 the country had its first Emergency Physician (EP), Dr Anne Creaton FACEM. Dr Creaton would prove to be major force in the establishment of EM in the country. From her three years in Fiji and with support from visiting FACEMs, a formal Specialist Training programme in the form of a Masters degree with FNU was refined and developed and continues to run. It will produce its first specialists in early 2017.

Diploma training was initially spread out over several hospitals at the time and managed by Dr. Craig Adams, then Professor of Medical Education at FNU. He was supported by visiting EP's from the USA. In fact since then, the Diploma has trained doctors from all across the Pacific including Samoa, Federated States of Micronesia, Solomon Islands and Kiribati. The Diploma takes 9 months and is compulsory before people enter the Masters.

In 2013, Under Dr Creaton's direction, the CWMH became the primary centre of EM training for doctors. 2013 also saw the largest intake of new trainees thus far in to the programme – six young

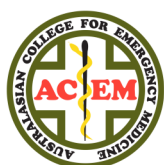
Fijian doctors entered the Diploma course. The following year, these trainees advanced to become the first intakes for the three-year Masters training programme. In 2015 these now senior trainees sat and passed their Clinical Expertise exams. Now in 2016 they are in their final year completing their research requirement as well as being guided in the areas of leadership and administration.

EM has continued to develop in other ways as well. In 2013, the CWMH opened its new Emergency Department which includes physiological monitors, defibrillators and an Ultrasound machine. In 2013 work had also been started by one of the now-senior trainees on development of a clinical pathway for Asthma management in the ED. That pathway is now on the verge of becoming a national guideline. In early 2015, another trainee in the same cohort, began work on a system of trauma care for the CWMH aimed at improving efficiency and promoting a multidisciplinary approach. Today that system has completely revolutionised how trauma is managed at the CWMH.

Two very recent developments of note are the Pacific Mentoring Programme and the regional EM Leadership Workshop. The Pacific Mentoring Programme emerged from a collaboration of several FACEMs who have been involved with the Fiji program, and aims to bring together doctors in the Pacific still developing as Emergency specialists together with more experienced senior FACEMs for the purpose of a mentoring relationship. The website can be found at <http://www.empacificmentor.com/>.

An EM Leadership Workshop was held in June 2016 and ran over three days. The workshop aimed to share ideas and strengthen relations between regional leaders of EM. Participants were brought in from Papua New Guinea, the Solomon Islands, Kiribati, Samoa and Tonga as well as Fiji. These leaders are often working in isolation from each other and one of the aims of this workshop is to strengthen links between these leaders, enhancing the EM support network.

I am the most recent addition to the EM team in Fiji. I am an Emergency Physician trained in Papua New Guinea (PNG) where I had been managing the EM training program in 2015. What started as a curious exploration of EM training in the Pacific very quickly turned into something more and in March this year I



started as Assistant Professor at FNU. Settling into the work and Fiji in general has been a great experience for me. There are similarities between Fiji and PNG but there are also differences. The hospital resource constraints for example, are a familiar thing. One notable difference is the case-mix. The prevalence of heart disease and renal failure and their complications in Fiji amazed me. Furthermore trauma was only a small portion of that case mix, very unlike what I was used to in PNG.



Dennis Lee at the EM Leadership Workshop

In this article are only a few examples of what has been going on in this corner of world. But without a doubt, over the last three years, EM has grown rapidly in Fiji. Growth will continue but the need for assistance and support is ever present. There are a huge number of people that have contributed to bringing EM in Fiji and the Pacific to where it is today. Although I have only mentioned a few names, I would like to take this opportunity to thank every one of you: Your generosity and compassion have not been in vain. If there is anyone else who would like to know more, I can be contacted on dennis.lee@fnu.ac.fj and I will be more than happy to chat.



FIJI

Pacific Emergency Medicine Leadership Workshop

Georgina Phillips

23rd – 25th June 2016, Suva FIJI

Emergency Medicine (EM) in the Pacific has taken a momentous step forward with the first ever regional Leadership Workshop held in Fiji in June this year. New and experienced EM leaders from around the Pacific Islands met to learn from each other, build skills and knowledge for effective leadership and create a regional peer-support network.

Funded through the Strengthening Specialised Clinical Services in the Pacific (SSCSiP) Australian

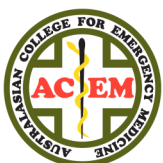
government program, the Fiji National University and the St. Vincent's Pacific Health Fund, representatives from Papua New Guinea, Kiribati, Solomon Islands, Samoa, Tonga and Fiji attended the workshop. These talented EM clinicians gained a deeper understanding and increased confidence for leadership tasks as a result of the three day program, with many departing for their home countries re-invigorated and with practical ideas for improving emergency care in their own environments. They will support each other through the new 'Pacific EM Network', formed as a result of this meeting.

ACEM provided their Leadership Framework and associated resources towards the workshop program, and Australian emergency physicians (FACEMs) generously donated their time and travel as facilitators and participants.



Back (L ->R): Bobby Wellsh (PNG), Garry Wilkes (FACEM), Tanebu Tong (Kiribati), Kelera Tabuaniqili (Fiji), Raymond St John (Fiji), Georgina Phillips (FACEM), Pai AirdHill Enosa (Samoa), Moana Tupou (Tonga), Donna Mills (FACEM), Trina Sale (Solomon Is), Sinead Kado (SSCSiPs, Fiji), Shivani Shailin (Fiji)

Front (L ->R): Hector Fuentes (FACEM), Lavinesh Raj (Fiji), Brady Tassicker (FACEM, Kiribati), Vincent Atua (PNG), Dennis Lee (Fiji / PNG), Arveen Maharaj (Fiji)







IEMNet News

Newsletter of the International Emergency Medicine Network of ACEM



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