

IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM



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In this Edition

Sri Lanka

An inaugural Emergency Medicine Symposium was conducted with the Annual Meeting of the Ceylon College of Physicians in September. Peter Cameron, past president of ACEM, led a contingent to contribute to this launch. They also visited Galle, developing the connections for a continuing involvement.

Bishan Rajapakse describes the undertaking of research in toxicology in a poisoning environment very different from Australasia.

PNG

The input towards a sustainable EM training program in PNG continues to build. Chris Curry presents a summary of all the components to this venture - past, present and future.

Fiji

James Taylor reports on the evolving partnership between the Sandringham Hospital in Melbourne and Fiji. The first training program for triage has been launched.

Laos, Kurdistan and PNG

Letters to the Editor provide insight into the challenges and advances of emergency medicine in places with Australasian connections.

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Sri Lanka

Report from Sri Lanka — an emergency medicine symposium and a visit to Galle

Peter Cameron

The EM Symposium in Colombo

Following the tsunami and subsequent aid/reconstruction within Sri Lanka, there has been increasing interest from the local medical fraternity regarding emergency medicine as a specialty.

In this context, Aled Williams and Mark Fitzgerald had some initial discussions with Dr Ragunathan (Ragu), President of the Ceylon College of Physicians, regarding the possibility of holding a symposium introducing the concept in Sri Lanka. Ragu was very supportive and asked the Australasian group to put together a half day symposium at the Annual meeting of the College. Expressions of interest were invited from IEMSIG and five speakers were included for this initial symposium. There was some disquiet from potential speakers because of the possibility of civilian violence (from Tamil resistance) which resulted in last minute changes to the program.

Five talks were given at the symposium on 28th September 2006:

Emergency Medicine in Australia – Peter Cameron

Trauma Care – Gerard O'Reilly

Respiratory Emergencies – Shane Curran

The Disturbed Patient – Gerard O'Reilly (for Jonathan Knott)

Emergency XRays – Gim Tan

(of interest, a physician from UK was added to our symposium to talk on rashes!)

There were about 350 physicians at the meeting and it was very well received. I invited those interested in developing emergency medicine back to an informal discussion afterwards. There were over 30 people in a small room and (unusually for the cultural group) they had a very animated discussion regarding future actions to develop the specialty.

There is a Society for emergency and critical care doctors with 300 members that was formed 2 years ago, Dr Chula Goonasekera is the president. No formal recognition or training scheme exists for ICU or Emergency doctors. The overwhelming desire of many of the middle grade doctors was to have access

to basic training in emergency and critical care. Chula is organising a seminar on 11th November to begin this activity. It is hoped that more regular training sessions can be developed to ensure basic skills along the lines of ELS. He was very keen to have outside help and both Shane and Gim were keen to assist (anyone else should let us know if interested).

It is clear that it will take some time before the specialty is recognised within Sri Lanka however there are a significant number of enthusiasts and the right people are aware of the gaps in emergency medical service provision. Dr Rezvi Sheriff, Chair of the Board of Studies, with the influence to develop distinct medical disciplines, chaired our symposium and appeared quite supportive. Although he did mention his experience with emergency medicine in Brisbane 20 years ago!

The conclusion from the interest group was that we should immediately start on basic skills training. The development of new models of care incorporating emergency medicine will take some time, including the development of new facilities. However the need for new models of care will become more apparent as skills develop.

Whilst in Colombo, we visited the National Trauma Hospital, where only trauma is managed and all cases are managed by surgeons alone. Considering the facilities, the staff did an excellent job, however it was unclear whether the service model would be sustainable into the future. The present Director was there by default as no one had applied for the position. Certainly outside of Colombo, this model of care would not be sustainable.

Visit to Galle

From Colombo, we went on to Galle, which was severely affected by the Tsunami.

The Victorian State Government has an aid agreement with the Galle Hospital to rebuild and refurbish the emergency/critical care areas (there is no emergency department at present). As part of this, The Alfred

Hospital is training emergency nurses and doctors over an 18 month period in emergency medicine, to develop a service model to fit the new facility. It is hoped that this will act as a pilot for the rest of Sri Lanka.

The President of the Galle Medical Association, Dr Galkatiya (a surgeon), Ragu and others were very supportive of the emergency medicine concept and volunteered the positives that this development would bring.

In Galle we repeated the symposium to an audience of about 300 people. Again, there was enthusiasm for the EM concept.

The facilities in the hospitals are quite basic and we should not underestimate the resource limitations when describing the way we do emergency medicine. The general rule of 90% benefit from 10% of the cost should be emphasised when promoting emergency medicine in countries such as Sri Lanka. It is also important to make the point that we are the specialists in creating systems of care and creating order out of chaos. Sri Lanka has

an excellent record in public health initiatives and is receptive to the philosophy of developing public health and systems of care. One significant restraint on the evolution of the speciality will be the present lack of private medicine for EM practitioners. This appears to be a significant driver for most specialties, because of the very poor wages in the public system.

On the upside, there are many Sri Lankans with Australasian connections and training who are very enthusiastic, we can certainly use these connections over the next few years.

Those interested in participating in the development of EM in Sri Lanka should contact Gerard O'Reilly, Mark Fitzgerald, Chris Curry or myself for further information

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Editor's Note:

Shane Curran and Gim Tan are returning to Sri Lanka in November 2006 to continue an input to the developments now under way.

"Poisoning in Paradise — an Emergency Medicine registrar's experience in Sri Lanka

Bishan Rajapakse



I am a New Zealand registrar currently in my second year of advanced training in Emergency Medicine and am presently spending a research year here in Sri Lanka. Whilst I was born in Sri Lanka, I left at a very young age and have never lived here, so last year I made a decision to come back for a period of time to learn about the country of my origin. Before leaving, the director of emergency medicine training for the Wellington ED, Paul Quigley, put me in touch with the South Asian Clinical Toxicology Research Collaboration (SACTRC), and out of this arose a unique opportunity for me to train in clinical

toxicology in Sri Lanka. I have currently completed just over six months of working with SACTRC and it's been a fascinating experience! I've learnt a lot in this time from seeing a multitude of different types of poisoning, many of which I wouldn't have been exposed to back home, such as organophosphates, as well as the usual suspects that we are used to seeing in Australasia!

The Poisoning Problem

Sri Lanka is a tropical island just south of India which has roughly the same land area as Tasmania

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(64,740 sq km versus 68,332 sq km) and is estimated to have a current population of 20 million. The coastline consists almost entirely of beach; the land is abundant with coconut trees and lush green foliage, the wildlife plentiful and often mixes into daily life, and the country's civilization has a history of ancient kingdoms dating back as far as the 4th century BC.

Currently poisoning is a major health problem and accounts for approximately 80,000 hospital admissions and 3000 deaths each year, and is the third leading cause of death on the island (1). The poisoning is mostly deliberate self harm, and it occurs predominantly in young adults. Organophosphorus and carbamate pesticide poisons are taken most frequently which is not surprising as agriculture is an important sector of Sri Lanka's economy and individuals in rural areas commonly have easy access to dangerous pesticides.

The case fatality for self poisoning in the developing world is commonly 10-20%, but for a particular pesticide it may be as high as 50-70%. This contrasts dramatically with the less than 0.3% case fatality ratio normally found for self-poisoning from all causes in the west(2).

The causes of this comparatively higher rate of death from poisoning are multifactorial ranging from the high toxicity of the agents used (such as organophosphorus pesticides and paraquat), problems with the transport of patients, a paucity of health care workers in terms of meeting the demands of patient volume, lack of facilities and available antidotes for treatment of the pesticides.

Poisoning and Emergency Care

The most common deadly poisons taken are organophosphorus and carbamate pesticides, paraquat and yellow oleander seeds. Emergency care and timely resuscitation along with appropriate antidote therapy, when available, is still the mainstay of treatment for these patients. Thus for an emergency trainee this is very interesting work, and clinical exposure is very high. I have been involved with much resuscitation of acutely poisoned patients and at times have been challenged, having to cope with more limited resources than what I have been used to in the Emergency departments of Australasia.

Hospitals in most cities and towns in the country, apart from a handful of the larger centres, do not have conventional Australasian "emergency departments", and the system of emergency care is quite different. These hospitals have a basic "outpatients department", and emergency care is delivered on the ward itself,

which can be a less than ideal resuscitation setting with low staff to patient ratios. The access to ICU beds is also limited and sometimes patients may even need to be kept ventilated on the ward.

The emergency response services are also set up differently. Ambulances with trained paramedics, are currently only available in the larger cities. Thus in rural areas where most acute poisoning occurs, patients will be brought to the nearest hospital by friends or family members. If this a small peripheral hospital they may receive only basic resuscitation and decontamination, before being transferred via ambulance to a district or general hospital.

These two areas of "emergency response" and "emergency care" of poisoning victims have great potential to be improved ultimately leading to more lives being saved. It is encouraging to see such development already occurring in different areas throughout the country with the existence of a "critical care society", the introduction of paramedic training courses, and the recent invitation of the International Emergency Medicine Special Interest Group (IEMSIG) by the President of the Ceylon College of Physicians to talk on Emergency medicine at the Ceylon College of Physicians conference in September 2006. In my opinion this was a great success as there were many enthusiastic Sri Lankan doctors present who expressed interest or engaged in healthy discussion about the emerging field of Emergency Medicine.

The South Asian Clinical Toxicology Research Collaboration (SACTRC)

SACTRC is the organization I am currently working with. It is a research collaboration which is based in and administered from Sri Lanka but has active collaborators from many other countries, and provides infrastructure and intellectual support to a number of research projects related to acute poisoning.

There is an active program of support and training for postgraduate students and it is funded by competitive research grants including the "Welcome trust" and the "National Health and Medical Research Council (NHMRC)" of Australia.

There are a number of clinical trials being conducted on pesticide poisoning in Sri Lanka by this group at present. In 2002 they set up a cohort study in the North Central Province of Sri Lanka that sought to follow 10,000 acutely self poisoned patients prospectively. As of June 2006, already 11420 patients had been recruited, of whom more than 8000 had ingested pesticides. Patients from this same cohort have been involved in many trials looking at different aspects of poisoning, such as

RCT's investigating the benefits of activated charcoal decontamination, and the effectiveness of oximes as an antidote in OP poisoned patients

Some of the achievements of such research have been a reduction in mortality rates seen at certain district hospitals, following development and institution of treatment protocols.

My personal research consists of three areas 1) the use of a bedside acetylcholinesterase testing kit in the management of OP insecticide poisoning, 2) antidote therapy where I hope to help conduct a phase 2 trial looking at diazepam treatment in OP's, and 3) education and changing behavior in clinical practice. I am currently enrolled in a research Masters degree at the Australian National University in Canberra and hope to put this research towards the degree. I have already analysed data from the SACTRC cohort to look at the use of red blood cell acetylcholinesterase as a predictor of intubation in OP poisoned patients, the results of which I

good guidance and support from my seniors. I am also pleased that the Australasian College for Emergency Medicine recognizes flexibility and diversity in training, which is something that sets it apart from many other colleges. I am currently getting 6 months of training accredited as "special training" in Toxicology.

I believe that there is a lot to be gained from working in another country, particularly a developing country, but there is also something to be offered back to that country at the same time if that work is structured appropriately in a collaborative setting.

If there are other trainees who are interested in working in Sri Lanka with SACTRC, especially if they were interested in carrying out research towards a PhD or Masters, I would encourage them to look at the SACTRC website (www.sactrc.org) and get in touch with our program director Professor Andrew Dawson. Alternatively I would be more than happy to answer any queries via my email (bishan.rajapakse@gmail.com).



presented as a poster at the ACEM winter symposium this year, and was accredited for my 4.10 research project.

Whilst I have been working in Sri Lanka I have been under the supervision of two Australian clinical toxicologists Professor Andrew Dawson, program director of SACTRC, originally from Newcastle, Australia, but currently living in Peradeniya Sri Lanka, and Professor Nick Buckley (Canberra, Australia) who oversee these research projects. I have also been under the supervision of local physicians at the district and general hospitals where I have been involved with clinical work.

The exposure to clinical toxicology here has been amazing, where I can easily see up to 20 acute poison admissions in a week, not to mention the other interesting medicine that comes your way when working in a peripheral hospital in Sri Lanka such as snakebites, dengue, TB and malaria.

Opportunities for EM trainees in Sri Lanka

This opportunity of coming and working here was driven by my own motivation, but I also owe a lot to

In summary

Studying Toxicology in Sri Lanka has been an enlightening experience allowing me the chance to be involved with some interesting medicine, work with some amazing clinicians and researchers, get involved with local teaching and training programs, and not least offered me an opportunity to learn about another country.

I would like to acknowledge the help and support of all my supervisors, as well as the Sri Lankan hospital staff and patients whose cooperation has been invaluable.

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The Emergency Medicine program in PNG – capacity building for general acute care

Chris Curry

Presented to the 42nd Medical Symposium, Divine Word University, Madang
September 4-8 2006.

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History

The Postgraduate Committee of the School of Medicine and Health Sciences decided in 1996 that there was a need for the development of an enhanced capacity to care for the acutely ill and injured in PNG. The Master of Medicine program for Emergency Medicine was established that year.

Emergency Medicine had been recognized only recently elsewhere, by Australia in 1993 and by New Zealand in 1995. So in 1996 this was a prescient decision, with foresight, and I think a bold one.

The proposed program then lay dormant because there was no-one in PNG to lead it. Meanwhile, the Ministry and Department of Health were preparing a National Plan for 2001-2010, and emergency medicine was identified as a priority for development.

So AusAID, through the agency Medical Officer, Nurse, Allied Health Project (MONAHP), supported a visit by two emergency physicians from Townsville, Niall Small and Peter Aitken, to advise on how the M.Med EM could be mobilized. They recommended the funding of an emergency physician in residence. In 2002 Carolyn Annerud, who had been working in Townsville, took on this challenge. She was supported by Kate Porges, and seven other visiting emergency physicians. The engine was started.

But MONAHP was scheduled for closure at the end of the year. The engine was running, but we weren't going to be given wheels. I was asked by the Executive Dean, Mathias Sapuri, if I could get the machine moving. The momentum was picked up by the School of Medicine with a Senior Lecturer position, with support from a much smaller agency established by AusAID, the Medical School Support Project. A core group of myself, Carolyn Annerud, Simon Jensen, David Symmons and Marian Lee, committed to the project. The main thrusts were:

- launching the M.Med EM
- teaching medical students
- consulting and teaching in the Emergency Department at PMGH,
- launching research
- supporting nurses training

Where are we in 2006, four years after those initial discussions in the Executive Dean's Office ?

The M.Med EM program

The M.Med EM program has been developed.

The program is entered in PGY 5, is a minimum of four years, and must be completed within six years:

Year 1	Surgery, Common Core Curriculum, Part 1 in Surgery
4 months	Medicine, Anaesthesia, Paediatrics, Obstetrics and Gynaecology,
1 month	Ophthalmology, ENT
Diplomas	Anaesthesia, Child Health, Gynae and Obstetrics
Rotations	Townsville Public Health, Administration, others, eg research, subject to approval
Research	Project submission
Final	Examinations across surgery, medicine, anaesthesia, paed, O&G

M.Med EM trainees

There are 14 trainees on the program (at September 2006):

Year 4	Yongoe Kambue DA (PMGH)
Year 3	Sam Yockopua DA, Marcella Seve DA (QLD) Vincent Atua DA (Madang) Alfred Raka DA, Moses Lester (PMGH)
Year 2	Desmond Aisi, Wala Marjen (PMGH) Sonny Kibob (Mt Hagen) Julius Plinduo (Rabaul)
Year 1	John Tsiperau, Taita Kila (PMGH) Daryl Robert (Goroka) Kenton Sade (Honiara)

The main goal of building capacity to provide acute care has driven developments in teaching trauma care and snakebite management, and in providing training for HEOs and nurses:

1. Teaching Primary Trauma Care

This is the first major plank in building capacity to provide acute care. The EMST course has provided a foundation for this. Contributing emergency physicians include Andrew Dent, David Eddey, Gerard O'Reilly, David Symmons

The PTC course

The PTC course was prepared by EMST/ATLS instructors who appreciated that there was a need for a basic course for wide distribution. In 1996 the primary authors, Douglas Wilkinson (UK) and Marcus Skinner (Aust.), wrote:

“The PTC team works in conjunction with local medical health educational systems to train doctors, nurses and health care providers to treat the severely injured patient quickly and systematically using what equipment is available to improve the early management of trauma at the district hospital”

It is now conducted in 35 countries. In 2005 there were courses in Samoa, India, Pakistan, Iran, Lesotho, Rwanda, Malawi, Mozambique, Chile.

www.primarytraumacare.org

In PNG course participants include Health Centre workers, HEOs, ED nurses, ATOs, interns and RMOs. Most Health Centre providers have not previously received any ongoing training. In many hospitals ATOs provide all airway management.

Primary Trauma Care courses 2005

February	Mt Hagen	Lester, Kibob, Jensen,
March		Madang Atua, Didei, Curry,
May	Goroka	Lester, Kibob, Dala, Symmons,
	Lae	Kambue, Symmons,
June	Mt Hagen	Lester, Kibob, Hodge,
	Rabaul	Plinduo, Todhunter,
July	Madang	Atua, Didei, Gunja,
	Kimbe	Kambue
August		Port Moresby Yockopua, Raka, Aisi, Marjen , Inglis, Rennie,
September	Goroka	Kambue, Yockopua, Atua, Lester, Kibob, Rennie,
November	Lae	Kambue, Chenhall,
	Rabaul	Plinduo, Chenhall,

Primary Trauma Care courses 2006

February	Mt Hagen	Kibob, Symmons
	Goroka	Dala, Robert, Symmons
March		POM Yockopua, Raka, Lester, Marjen, Aisi, Tsiperau, Kila, Curry
	Rabaul	Plinduo, Curry
April	Alotau	Samof, Yaubihi, Seta, Lee
June	Madang	Atua, Rennie, Kruk
	POM	Kambue, Raka, Lester, Aisi, Marjen, Kila, Curry
August		Rabaul Plinduo, Grainger
	Goroka	Kambue, Jensen
	Alotau	Samof, Yaubihi, Seta, Tokwabilula, Jensen
September	Kimbe	Seneca, Spillane

PTC Instructor course

In May 2006, five M.Med EM trainees undertook the PTC Instructor course in Melbourne. They were Yongoe Kambue, Vincent Atua, Kenton Sade, Sam Yockopua, Marcella Seve. The next step will be an Instructors Course in PNG, we hope in 2007. In June and August 2006, Yongoe Kambue directed PTC courses in Port Moresby and Goroka. He is the first PNG national to direct an international medical course.

2. Snakebite Course

The second major plank in capacity building to provide acute care is the Snakebite course.

This is extremely important. There are places in PNG where more people die from snakebite than from malaria. So far courses have been conducted in POM and Madang. In 2006 courses were conducted in Madang in August and in Port Moresby in September.

These courses are the product of a huge amount of work by David Williams and Simon Jensen in particular. The training provided is specific to PNG snakes and circumstances. It is aimed at providers at all levels of care, from First Aid to Aid Post, Health Centre, District Hospital, Provincial Hospital and Tertiary Centre. The hope is that the distribution of this course will be expanded.

Snakebite Book

So substantial is the work that the authors have written a book. The authors are David Williams, Simon Jensen, Bill Nimorakiotakis and Ken Winkel. (Available from AVRU)

3. Diploma of Emergency Medicine

The third and most recent plank in capacity building to provide acute care is the Diploma of Emergency Medicine at Divine Word University and Modilon Hospital. This is the brainchild of Billy Selve, Dean of the Faculty of Health Sciences.

It contains Units in Management of

- Trauma,
- Medical and Surgical Emergencies,
- Paediatric Emergencies,
- Reproductive Emergencies

It includes residential sessions and workplace directed study and application

Sandra Rennie, a senior registrar in emergency medicine in Western Australia, is the major contributor to course development. The first residential week was conducted in June 2006. Chris Kruk, emergency medicine educator from Fremantle, assisted in the first residential week on trauma.

PNG visitors

Visitors to PNG in support of the emergency medicine program and its courses now number more than thirty:

- 2000 Peter Aitken, Niall Small
- 2002 Carolyn Annerud, Mike Galvin, Greg Treston, Simon Young, Peter Barnett, Aled Williams, Steve Dunjey, Chris Curry, Kate Porges
- 2003 Chris Curry, Carolyn Annerud, Simon Jensen, Andrew Dent, David Symmons, Marian Lee, Bryan Walpole
- 2004 Chris Curry, Carolyn Annerud, Simon Jensen, David Symmons, David Eddey, Gerard O'Reilly, Jack Hodge, Marian Lee, Chris Hall
- 2005 Chris Hall, Rachel Hoyle, Simon Jensen, Chris Curry, Carolyn Annerud, David Symmons, Gerard O'Reilly, Jack Hodge, Ric Todhunter, Antony Chenhall, Bill Nimo, Naren Gunja, Sandy Inglis, Paul Spillane, Sandra Rennie, Basia Lis
- 2006 David Symmons, Chris Curry, Chris Hall, Brady Tassicker, Marian Lee, Fay Ferguson, Sandra Rennie, Chris Kruk, Paul Hui, Gerard O'Reilly, Stephen Grainger, Simon Jensen, Bill Nimo, Paul Spillane, Sally McCarthy, Andrew Dent

The Future

Building

The establishment of a specialty training program takes at least ten years. The emergence of the first graduate (hopefully this year) will be a milestone, and a beginning for the second phase, which is the generation of more graduates, until there are sufficient numbers for the program to be self sustaining.

I know something about this process. In 1989 I was the first graduate in New Zealand from the new Australasian College for Emergency Medicine (ACEM) program. I had not had mentors. I then had to start building the specialty. It was another four years before the next New Zealander completed the program. It was only when I had worked on this development for ten years that I felt it would be self sustaining. Now, ten years after that, there are more than 75 emergency medicine graduates in New Zealand.

The potential is for PNG to proceed more rapidly than that, with trainees on schedule to graduate every year from 2006 onwards.

I need to emphasise the value of support and guidance in this process. It is extremely difficult to develop your own specialty on your own. The continuation of input from visiting emergency physicians will impact substantially on how well the program does in the future. The now established specialties (surgery, medicine, paediatrics, O&G etc) had full time support for many years.

Funding and support

One of the ongoing challenges for the EM program is funding. MONAHP funding lasted one year, UPNG funding 18 months. The Medical School Support Project of AusAID funding has been limited and is declining. The Australasian College for Emergency Medicine (ACEM) has provided funding for four years, and is now changing the way it supports International Emergency Medicine. MONAHP Trust Fund support has been con-

cluded. The visitors themselves make substantial personal contributions. Further funding is needed to ensure continuity and hence survival of this program.

A key to the future is the support of provincial hospitals. Trainees need moral support; they also need jobs and funded training opportunities. The future of the program lies with the Chief Executive Officers (CEOs) and Directors of Medical Services (DMS) of provincial hospitals as well as with the Department of Health.

We have learned from experience elsewhere that capacity building for acute care is fundamental to a health system. We know also that it takes conviction, commitment and perseverance to build it. With those qualities in the trainees, they will succeed.

Where will graduates go?

The first intention for the M.Med EM program, from ten years ago, was to produce doctors equipped to improve the delivery of care to the acutely ill and injured primarily in emergency departments. In 2002 a Five Year Plan was prepared for the program, authored by the resident emergency physician Carolyn Annerud, and Sir Isi Kevau. The Plan identified 14 hospitals as needing an emergency doctor. Those with development now in progress are Moresby, Lae, Mt Hagen, Goroka, Madang and Rabaul. There are beginnings in Alotau, Kimbe, Wewak. Those yet to become involved are Vanimo, Daru, Manus, Buka, and Kavieng.

S. M.Med EM Graduates, numbers and years (Five Year Plan 2002)

	2002	2003	2004	2005	2006	2007	2008	2009	2010
PORT MORESBY	Expatriates/rotations/visitors				1	3	3	3	3
LAE					1	1	1	1	1
MT HAGEN						1	1	1	1
MADANG						1	1	1	1
GOROKA							1	1	1
RABAU							1	1	1
ALOTAU							1	1	1
WEWAK								1	1
VANIMO								1	1
DARU								1	1
MANUS									1
BUKA									1
KIMBE									1
KAVIENG									1

What will graduates do?

They will do more than provide leadership to emergency departments. They will:

- provide leadership for undergraduate and postgraduate emergency medicine training, at the School of Medicine and at Divine Word University.
- contribute to
 - disaster preparedness and response
 - pre-hospital training and care,
 - research,
 - administration,
 - prevention (prevention is included in the International Federation for Emergency Medicine (IFEM) definition of EM)
 - public health (in Australia an increasing number of emergency physicians are training in public health. Much acute illness and injury arises because of failures in public health)

Hospital Generalists

This leads to the concept of 'generalists' in the PNG Health System. Currently there is no active vocational training program for hospital generalists. In the past expat. specialists developed specialty training programs, but the generalists who were the District Medical Officers and Medical Superintendents of district and provincial hospitals did not establish training programs. Now PNG specialists are training specialists, but there are no trained generalists training generalists. This has produced a workforce pyramid that is top-heavy (that is, specialist-heavy) and loaded on Port Moresby. With 85% of the population rural, the majority of people need generalists to meet their basic health care needs.

The M.Med EM program provides the basis for a generalist program. It includes rotations through all the major disciplines, so trainees learn something of the entirety of each discipline. With additional training in administration and public health, graduates would be well equipped for a hospital generalist role. There are many hospitals in PNG that will not get the full hand of major specialists. These hospitals, including many on the list of 14, could be well served by vocationally trained generalists. And from the M.Med EM base these doctors could also become well equipped to serve as Directors of Medical Services and as Chief Executive Officers.

International Leadership

The M.Med EM is already attracting interest internationally. There is a trainee in Honiara, Kenton Sade. Further afield, the PNG model is contributing directly to developments in Nepal and there is interest from as far as South Africa. The Diploma in Emergency Medicine is also gaining attention. Billy Selve has been invited to present at a Conference in South Africa in 2007 on Emergency Medicine in the Developing World. There is genuine potential for PNG to provide an improved service to its people, and to gain international recognition in doing so.

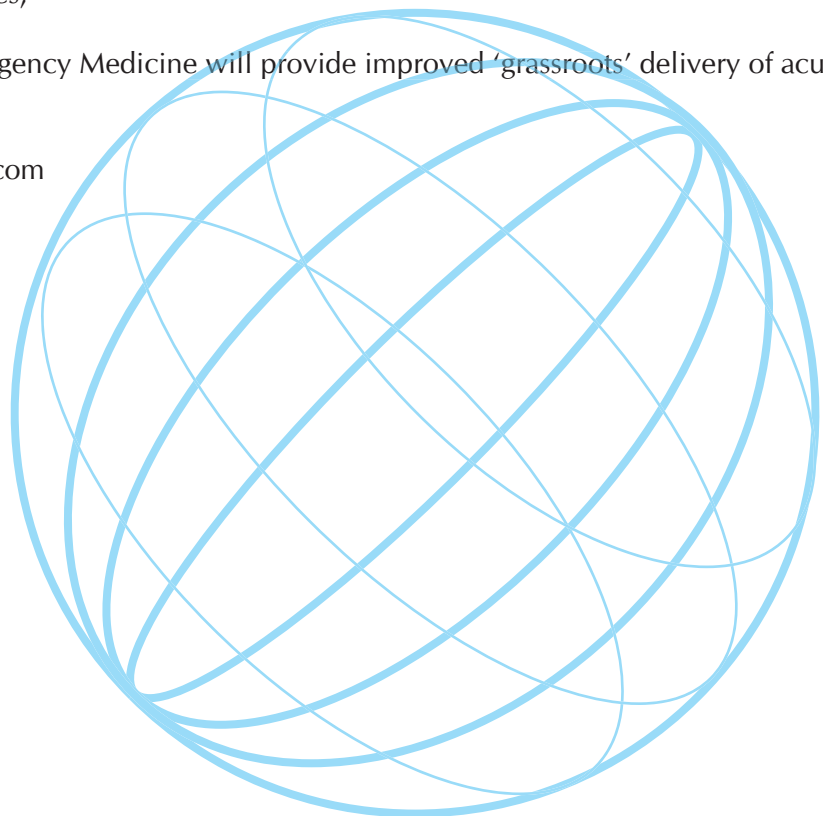
In Summary:

M.Med EM graduates will contribute widely:

- major emergency departments
- University of PNG, School of Medicine
- generalists in provincial and district hospitals
- Divine Word University, Diploma of EM
- directors and instructors of courses,

HEOs and nurses with Diploma of Emergency Medicine will provide improved 'grassroots' delivery of acute care.

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FIJI

CentEast Health Service Fiji and Sandringham Hospital Melbourne Partnership

James Taylor

Overview

Sandringham Hospital was invited by the Fijian Ministry of Health in 2004 to collaborate with the CentEast Health Services in Fiji. The partnership was set up under the auspices of the Fiji Health Sector Improvement Program, which is coordinated by JTA International, a private contractor responsible for the distribution of AusAID to the Pacific region. The first contact was made by Drs Peter Wirth and Michael Walsh (Bayside Health CEO) in 2000.

The CentEast region includes the capital Suva, the eastern side of the main island and the islands to the East. The regional population is 300 000 - 40% of the entire population of Fiji. The major health facility of Fiji is the Colonial War Memorial Hospital (CWM) in Suva. It is a 500 bed facility with CCU and ICU, linked with the Fiji School of Medicine. It supports 2 community hospitals (including a maternity facility at Nausori) and a number of Health Centres providing primary care, general practice and outpatient clinics.

Aim

The aim of the Partnership is the enhancement of the emergency services, home based care and antenatal clinics at CWM and regional hospitals and health centres. The desired outcomes are improved emergency services at CWM and decentralisation of non urgent cases to the regional health centres.

Areas for Partnership

- emergency services
- education in triage and basic life support
- layout of CWM ED
- provision of equipment
- home based care (especially diabetic care)
- assistance in service design and education
- antenatal services
- restructuring clinics

Visits by the Sandringham Team

There have been three visits by the Sandringham and District Memorial Hospital (SDMH) team to

Suva. The first, in May 2005, was a scoping mission to establish the partnership and identify the areas of interest. It included James Taylor, Bruce Greaves (from SDMH ED), Peter Wirth (SDMH ED and representing AUSeMED), Peter Longmore (retired SDMH obstetrician with experience in Fiji). The second in July 2005 concentrated on a collaborative development for the triage program. The third visit, September 2006, was the first major educational project for the partnership – the first of the triage program. Dr Wirth was able to further the partnership in home based care and antenatal clinics.

The fourth visit is planned for Nov 27th 2006 and includes the second triage team and further scoping for home based care with the inclusion of a podiatry representative from CGMC.

Partnership Parameters

From the Bayside perspective, it involves Sandringham Hospital staff in a voluntary capacity. From the CentEast perspective, it involves the Sandringham Hospital staff and others under the institutional banner. Funding for the visits (part or full) will be from FHSIP grants.

Opportunities for extending the Partnership in 2007 It has become apparent that many opportunities exist in Fiji for philanthropic ventures, and that the good reputation of the "Sandringham Team" can realise many benefits to the country at low cost. These include:

- **Podiatry training**

As an extension of the home based care program, we have been fortunate to have received the assistance of the podiatry team at CGMC. They have had extensive experience in the Pacific in the 1990s, and have a training package suitable for implementation to all regions of Fiji.

- **Introduction of public defibrillators to Fiji**

Dr Wirth has been able to arrange the donation of automatic defibrillators to the Nadi and Suva airports in Oct 2006. SDMH will be asked to provide training. This has received Ministerial support in Fiji. There is good indication that this will spread to other institutions in Fiji and other Pacific Nations. It is a major boost to tourism in the area.

- **Neck care program.**

Dr Wirth has been able to secure the support of the Fiji Rugby Union to assist with the introduction of neck care and cervical spine immobilisation programs for rugby fields. This will have generalised benefits to road trauma at a later date.

The Triage Training Program

Report on the visit to Fiji, 11-15 September 2006

James Taylor

Team

Julie Smith RN, Robyn Powell RN, Nicole Robinson RN, Peter Wirth, James Taylor

This was the third visit by the SDMH team to Suva and was the first major educational project for the partnership. Additional objectives included enhancing ED services, advising on ED design, collaborating on the home based care program, updating on the antenatal clinic program and donating equipment.

The objectives of the Triage Education Program were to train 20-25 nurses from CWM and regional health centres, to identify future trainers for the program and to obtain feedback on the educational material.

Learning Objectives

- Understand the CentEast Triage Scale
- Understand and implement ABCD assessment
- Describe the role and responsibilities of the triage nurse
- Prioritise care of patients who present to triage
- Commence appropriate initial management
- Accurately document patient history and primary assessment
- Understand the importance of reassessment and re-evaluation of patients waiting to be seen

CentEast Triage Scale

<i>category</i>	<i>description</i>	<i>treatment time</i>
category 1	emergency	immediate care
category 2	urgent	within 30 minutes
category 3	semi urgent	within 2 hours
category 4	same day	within 4 hours
category 5	next day	can be seen in 24 hours

Program format

The teaching program involved presentations by the team, small group scenario workshops, and triage tuition in the A&E and GOPD of the CWM Hospital. All participants received a program handbook and pocket reference cards. Reference posters were provided for the 2 departments.

Program performance

Participants

In all, 27 Nurses and 2 Doctors were trained over 3 days. Six participants were from the regional centres; 12 from A&E and GOPD; 3 from paediatric outpatients; there were representatives from ICU, CCU, specialist OP, burns and other units. The majority of A&E and GOPD nurses were readily trained and showed expertise in the understanding and practise of triage. A number would make effective trainers. Many of the non-A&E participants (including those from the health centres) also demonstrated competence. A couple of the Health Centres will be self-sufficient in training further staff.

Evaluation

Evaluation was performed using a feedback proforma and MCQ/true-false questionnaire. There were 23 forms received: a 79% response rate. The overall feedback of the course and content was very supportive; the majority of participants gave maximum scores (5/5), skewing the results favourably (see below).

Feedback comments included:

- important workshop – very successful
- need to involve doctors
- need for public awareness of triage
- importance of using triage boxes for patient folders
- need to involve all nurses in A&E and GOPD
- training has boosted confidence and skills
- gratitude to Cent East for providing education

Participant Assessment Quiz

The mean, median and modal score was 8/10 (range 6-10). Questions relating to core learning objectives were universally answered correctly. Two questions requiring experience (and value judgements) were more difficult. The quiz had not been trialled beforehand; further evaluation of its utility is required. The sourcing of other assessment tools would be beneficial.

James Taylor: j.taylor@sdmh.org.au

Upcoming Conferences

Emergency Medicine Society of South Africa

EMSSA Inaugural International Emergency Medicine Conference Emergency Medicine in the Developing World

October 6th & 7th, 2007
Southern Sun Cape Sun Hotel
Cape Town, South Africa

[Conference Secretariat Information]
Phone: +27 (0) 21 4066407
Fax: +27 (0) 21 4486263

Hello and welcome

to the beautiful city of Cape Town. On behalf of the Emergency Medicine Society of South Africa and the local organising committee, I am proud to announce registrations for EMSSAs inaugural international conference are now open.

This conference will offer delegates a unique double opportunity: the scientific content will be of the highest calibre, with invited experts from all corners of the globe; at the same time, the consensus groupings will aim to develop answers to some of the more pressing issues facing the development of the specialty in resource poor areas.

I am delighted to announce that we have currently attracted, amongst other speakers:

- Dr Silvio Aguilera, President, Sociedad Argentina de Emergencias
- Prof Billy Selve, Dean of Health Sciences, Madang, Papua New Guinea
- Prof Elizabeth Molyneaux, Head of Paediatrics, Malawi
- Prof Suresh David, Head of Emergency Medicine, Vellore, India
- Prof Owen Lewis, Head of Family Medicine, Dharan, Nepal
- Assoc. Prof Chris Curry, Emergency Physician, Australia
- Prof Jerome Hoffman, Emergency Physician, UCLA
- Prof Ken Boffard, President Trauma Society of South Africa
- Prof Timothy Hodgetts, Head of Emergency Medicine, UK Defence Medical Services
- Prof Kevin Mackway-Jones, Faculty Professor of Emergency Medicine, Manchester, UK
- Dr Amul Mattu, Emergency Physician, Maryland
- Dr Bob Corder, Emergency Physician, Maryland
- Prof Ken Boffard, Johannesburg

The setting for this conference is world known for its stunning scenery, and friendly peoples. Come and join us in the Rainbow Nation, and experience true Cape hospitality at a world class scientific conference.

I look forward to seeing you in October 2007.

Lee
Professor Lee A Wallis
(Conference Chair)

Emergency Medicine Society of South Africa

Vice Chairman: Dr Clive Balfour
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Letters to the Editor

Road Trauma in Laos

Dear Ed,

There is a HUGE problem here in Laos with road accidents. This results from the combination of:

- roads with large potholes- so people drive around them, not on the 'correct' side of the road;
- almost no roads with white line markings- and so people do not understand lane discipline;
- the mixture of vehicles going at different speeds- push bikes, motor bikes, tuk-tuks and then four wheel drive vehicles with bull bars, huge long haul trucks and buses- local and tourist.

These factors make it really difficult to drive, and often lethal.

Put all of that onto winding roads liable to subsidence, landslides, flooding etc, clouds of choking dust obscuring the view, poorly lit streets in the city and a significant proportion of the driving population being under 15yrs and many being inexperienced and having licences for which they have not had any training and you have a deadly mixture.

Factor in that probably a good 50% of the motor bike riders have no helmets even though they should by law; that there are very few helmets available for children; that up to 5 get on one motorbike, including babies in arms.

Now there are some real road improvements happening on a few major roads. One might think this is a good thing but I have my doubts as everyone goes faster- no road markings, or stop signs etc in most areas.

When we called the ambulance to pick up someone who had come off a motorbike in town - there was no reply! So she ended up going to hospital in a tuk-tuk that was not long enough for her to lie down in, with her head cradled in someone's lap - no collars, hard or soft, of course!!!

One of my enduring memories from this amazing place is the ICU at one of the hospitals. It was a large room with beds all around the outer walls filled with silent, immobile, young men - mostly unconscious - victims of head injury post RTA. These were the lucky ones who made it to hospital - many don't.

ANYTHING you can do to help this situation is so very worthwhile. This is a lovely place with many warm and friendly people - they call it the land of smiles - do come and visit!!

Good wishes,
Dr Andrea Eastman Ramirez
andrea.mary.ramirez@gmail.com

EM in Kurdistan, and an invitation

Dear Ed,

My name is Kavi Haji, I'm a FACEM to be, when hopefully I finish the last 3 months of my training in Emergency Medicine soon!! I'm also training in Intensive Care Medicine. Currently I'm very busy studying for the fellowship exam.

I thank you for your interest in my work in Kurdistan, northern Iraq. I visited in October this year. My stay was unfortunately not very long but certainly rewarding.

I was fortunate to be given the chance to work first hand with Kurdish doctors, ranging from junior staff and students to highly qualified specialists. The area that I mainly focused on was critical care medicine.

Regrettably, I noted that the health system is well behind, there is a deficiency in training especially in acute care medicine. The staffs are lost in that chaotic system where people find it difficult, yet are not resistant, to working outside their comfort zone. This is mainly because of lack of familiarity with modern medicine and a lack of leadership.

Trauma, infectious diseases and poor post-operative care are the highest causes for mortality and major morbidity, which are mostly preventable. The victims by and large are children and young adults.

I was pleased to see the enthusiasm amongst the majority of their doctors. It was demonstrated by their facilitating my work over there, willingness to learn, welcoming new ideas to change or improve their practice, not to mention their kind hospitality. My contribution included:

- Teaching formally in lecture format and informally at the bedside. The lectures mainly involved resuscitation, trauma assessment and management, fluid and electrolytes management.
- Clinical work in their ICU, management of critically ill postoperative patients with regard to ABC assessment and management, prevention and treatment of infections and daily patient care and monitoring.
- Management of trauma.
- Visiting the emergency hospital and teaching on the run.

Continued p16

I certainly enjoyed the work thoroughly and it was extremely satisfying. I am planning to go back with my husband Darsim Haji in 2007, hopefully with a team. We extend an invitation to anyone who would like to join us on next year's trip.

Kind regards,
Kavi Haji
kevee@bigpond.com

Optimism for PNG

Dear Ed.

In September the Medical Society of Papua New Guinea hosted the 42nd Annual Medical Symposium in Madang, PNG. Over 500 delegates from PNG, Australia, New Zealand and other Pacific nations participated in a stimulating conference covering a wide spectrum of professional medical disciplines.

The quality, breadth and depth of research presented was outstanding. Collaborative works between organisations within PNG and across international boundaries showed the benefits of bringing different perspectives together. While the research and presentations often revealed complex problems and sobering statistics, Papua New Guinean health workers from all fields contributed to a sophisticated, insightful and passionate discussion.

Whilst this information is not news to some, it will come as a surprise to many Australians who have been fed a diet of negative stereotypes by a paternalistic government and sensationalist media. Our "failing" and "dysfunctional" neighbours seem only newsworthy when there is disaster, corruption or bad governance to report.

In health, PNG is successfully developing thoughtful, passionate and holistic clinicians, administrators and researchers: people well equipped for the challenges ahead. Indeed, Australians have much to learn from and with our Pacific neighbours. Congratulations, PNG on 31 years of independence.

Yours sincerely,
Georgina Phillips
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