



IEMNet News

Newsletter of the International Emergency Medicine Network of ACEM

Teaching, trauma, and TB in Madang

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*This page: traditional house of the
Sepik people, Papua New Guinea
Cover: a local at the Goroka Tribal
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Message from the Editor

Welcome to this edition of the IEMNet Newsletter. In this edition there are pieces on various projects and collaborations involving FACEMs in Kiribati, Samoa, Kenya, Fiji and Papua New Guinea. There are also reports from ACEM scholarship recipients from Myanmar who attended last year's ASM in Queenstown, and a piece from the outgoing chair of ACEM's International Emergency Medicine Committee—Gerard O'Reilly.

I hope you find this edition of interest.

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Reflections and visions from a retired Chair...

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Chair International Emergency Medicine 2009-2014

Chair International Emergency Medicine Committee
2014-2016

Looking back... Australasian emergency physicians have been actively engaged in global emergency care capacity development for more than a decade.

2004 marked an important year in ACEM's organisational links to international emergency care, with the establishment of the ACEM International Emergency Medicine Special Interest Group (IEMSIG). Associate Professor Dr Chris Curry championed this development and was the first Chair of the IEMSIG and Chief Editor of the time-honoured IEM mouthpiece, the IEMSIG Newsletter (now the IEMNet News).

I had the privilege of taking on the role of Chair of IEMSIG from Chris in 2009. In the period of 2009 to 2014, with an expanding leadership of myself, Chris Curry and Dr Georgina Phillips, and with the strong support of now multiple ACEM CEOs, Presidents and IEMSIG Secretariats, the expansion of ACEM's leadership in international emergency care was signposted by some key events. The International Scholarship, enabling emergency care champions from low resource countries to attend the annual ACEM Annual Scientific Meeting (ASM), was consolidated and expanded. The ASM, in turn, provided a consistent forum for global emergency care advocacy with its dedicated annual sessions for International Emergency Medicine, including presentations by the International Scholars. Similarly, in 2011, the International Development Fund Grant was established, providing annual funding support for emergency care capacity development programs in low resource countries. A dedicated International Development Fund Committee was tasked with the initial development and execution of the necessary selection process. Subsequently, the ACEM Foundation has been established, with International Emergency Care being one of its three pillars. The ACEM Foundation now provides ACEM oversight to the International Scholarship, the International Development Fund Grant, and a suite of other grants related to its other pillars (Indigenous Emergency Medicine and Emergency Medicine Research).

Importantly, FACEM-led emergency care capacity development blossomed in parallel to ACEM's growing regional role. The development of emergency medicine as a specialty progressed rapidly in Papua New Guinea (PNG), Myanmar, Nepal and Sri Lanka. In addition to an increasing role in emergency and disaster response (e.g. Medecins San Frontieres), FACEMs and EM trainees, were globally active in increasing numbers and for longer periods of time, delivering long term emergency care capacity-development programs in PNG, Botswana, Timor Leste, Myanmar and Fiji.

2015 saw the inauguration of the International Emergency Medicine Committee (IEMC), marking the full maturation of ACEM's global vision. With its regular committee membership, plus the representation of FACEMs working long-term in overseas posts, and a comprehensive and appropriately ambitious Terms of Reference, the IEMC continues towards its goals, facilitated by a series of committee working groups and wide regional networks of locally trained emergency physicians.

Looking forward...

There is still much work to be done. In the vast majority of the world, people do not have access to the bare essentials of emergency care. Pre-hospital care is largely absent, as is triage. What emergency care exists, is usually only delivered in large, inaccessible hospitals, by health providers untrained in emergency care. With a bunch of processes and funding options now bedded

down, my own view of the challenge for those engaged in global emergency care, including ACEM, can be summarised as three main priorities:

1. Capacity-building

...of those leading and delivering global emergency care programs. It is not enough to just turn up. Local stakeholders (i.e. patients requiring emergency care and local health providers delivering emergency care) deserve better. Global Emergency Care (GEC) providers (i.e. FACEMs and ACEM advanced trainees) need to maximise their opportunities to be appropriately trained, undertaking available opportunities to develop the necessary knowledge and skills to deliver emergency care capacity-development programs in limited-resource environments. And learning opportunities need to be accessible, including dedicated workshops and mentored field experience.

2. Learning the lessons

Working with local stakeholders, lessons learnt from the delivery of emergency care capacity development programs need to be identified, heeded and disseminated. The conduct of a comprehensive research agenda is key to ensuring that knowledge is acquired in a robust, valid and contextually relevant and appropriate way.

3. Align goals and activities

Every effort should be made to align program objectives with global goals (e.g. World Health Organization, Sustainable Development Goals). Alignment of other bodies (including potential funders) with agreed global emergency care goals requires strong advocacy and linkages across a range of networks (in-country partners, Australasian health bodies, governments). Key messages are that emergency care system development is a solution (not a problem) for attaining the Sustainable Development Goals. Similarly, the antidote for the recurrent need for international emergency disaster response actions is local disaster resilience. Disaster resilience requires emergency care system development.

Personally, moving on from the role as IEMC Chair (while remaining an active IEMC member) will allow me to concentrate more on the ongoing international emergency and trauma care programs I have the privilege of being involved in. The Alfred Hospital, including the National Trauma Research Institute and the Emergency and Trauma Centre, provides unmatched support for international programs. Working alongside many trauma and emergency doctors, nurses and managers, I look forward to a continuing participation in the Alfred's work with partners in Myanmar, India, Sri Lanka, Tanzania and the WHO and the annual International Emergency Care Workshop and Symposium.

Finally, I wish to thank all of those who have supported me in my previous role as Chair, both in Australasia and beyond. I look forward to continuing to work with you in your tireless efforts to improve emergency care everywhere •



Teaching, trauma, and TB in Madang, PNG

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A pretty town on the north coast of Papua New Guinea: Madang sits flanked by offshore volcanoes on one side and rugged mountain ranges on the other. Many traditional cultures of the province and nearby highland areas are still very much a part of everyday life. Mud covered skin, animal bones, shells, feathers and leaves are all painstakingly put together for costumes so vibrant it makes your head spin.

The people you meet and the stories they share while on a placement like this are something that anyone would treasure for a lifetime.

Madang province is home to 530,146 people and with Modilon Hospital as the main and only referral centre for the 43 health centres and 173 functioning aid posts, the emergency department is kept busy.

The challenges the department faces and the interesting experiences of the previous nine ACEM trainees who have worked in Madang as part of the Visiting Clinical Lecture program, since its inception in 2010, have been recounted in previous editions of IEMNet News and EMA.

What did I learn quickly?

I learnt that bush knives slice through bones like butter and that they are picked up by some children even before they can walk. I learnt that a billum (local string bag) could contain anything from a baby, to a kus kus (like a possum), to a preciously wrapped but very battered patient record book (the only form of medical record keeping). I learnt that banana leaves make pretty good stretchers for trauma patients and that out of date IV fluid bottles make excellent spacers.

What took longer to learn?

How to find that knife edge balance between respectfully watching, learning, absorbing and, at an appropriate moment, offering a small exchange, a morsel of personal experience in what was a fun but

chaotic shared learning environment. Despite the title of the role being the somewhat grand 'Visiting Clinical Lecturer', I often felt that a typo was in order and it should have read 'Visiting Clinical Learner' for my term as I felt I had more to learn than I could ever offer.

Over the six months I spent in Madang, both with Divine Word University and in the emergency department at Modilon Hospital, I grew to love teaching. I started wet lab practical sessions for suturing and cannulation skills with the fourth year HEO students, using pig skin (donated by the local supermarket) when it was available, ripe bananas when it was not, and foam woggles when the bananas were not ripe enough. I created spot quizzes with pieces of medical kit for the second years to guess the item and its use, as well as setting up a 'guess the blood volumes' in a consult room in ED on a quiet day for the fourth years. Using (very) fake blood (cherry flavoured juice drink) on sheets, soaked gauze, in kidney dishes, and a bowl, the students had to guess the amount of blood loss for an imaginary patient as part of a PPH teaching session.

To fill the time it would take to fix the inevitable electrical computer or projector problem before my second year lectures I made worksheets

for the students to fill in (they seemed to love them and they got great feedback). The worksheets would have diagrams, missing words, questions or puzzles and the idea was to recap the previous lectures learning objectives as well as introducing the new ones for the current lecture. Anything they couldn't fill in at the start they could fill in afterwards.

Lowlights

I found the confines of wearing a facemask in the department (due to the new arrival of multi-drug resistant TB) hard, but with not even a vague hint of somewhere to isolate patients and a large fan facilitating the flight of little mycobacteria on their journey around the department, it was a necessary evil.

Highlights

Finding out students had changed their holiday plans to be able to spend time in the department as word of the foreign doctor teaching had spread through the dormitories. The people you meet and the stories they share while on a placement like this are something that anyone would treasure for a lifetime. I feel very lucky to have been the final trainee to work in the VCL program as we have known it and am excited for the introduction of the new Visiting Emergency Registrar program which takes its place.



Safety

PNG has a somewhat notorious reputation but AVI are security conscious and take your safety very seriously. Be prepared to not walk anywhere after dusk and to only use security transport (provided by AVI) if you need to go somewhere in the evening. The lodge accommodation has 24-hour security guards and razor wire fencing disguised by friendly smiles and beautiful gardens. Not walking around settlements at any time and not walking anywhere after dusk means most problems are avoided. I felt safe enough to walk the short distance to and from the hospital in the day and had no safety problems during my six month stay.

Developing as an ED doctor

We all face different sorts of challenges every day in the emergency department but I believe the range of challenges I experienced during my time in PNG has helped me develop as a doctor in new ways. Both exploring different approaches, and learning to approach things differently. The lack of resources required me to think of strategies outside the box and reminded me how to keep things in perspective. I hope my time in Madang has helped me become better at managing those times when tasks explode around you like fireworks, and developed my ability to teach and support colleagues alongside my medical practice, despite the frequent stressors we are faced with in ED.

Thank you!

I would like to thank AVI for their support of this placement, Dr Atua for his constant help, Dr Georgina Phillips for being there as 'phone a friend', as well as Dr Shane Tan for being a legendary DEMENT •

The range of challenges I experienced during my time in PNG has helped me develop as a doctor in new ways.





Building bonds in emergency medicine

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In August 2016, a team of six doctors and four nurses from Canberra Hospital's emergency department arrived in Samoa for a 10-day trip. All the participants hoped that the expedition would lead to the creation of a strong bond between the two emergency departments in each nation. The initiative had been raised by one of the Canberra nursing staff, who—having lived in Samoa for two years—fell in love with the island and decided that a visit by an Australian emergency team would be of benefit to everyone. Excited by the prospect of learning in an international setting, the Canberra team had come together and independently raised the required funds to cover the cost of the trip.

We were amazed at the warmth and generous welcome of the Samoan hospital staff and felt immediately at home.

Samoa's general hospital emergency department treats approximately 80-100 patients a day, with many lower triage acuity patients being transferred to clinic-based treatment. The work is demanding for the emergency staff, with two doctors and four nurses managing this patient load on a daily basis. Waiting times are long and any mistakes in triage can potentially be costly, as delayed time to doctor assessments—and the fact the emergency department is on a separate campus—can result in significant patient deterioration prior to arrival.

Samoa's health challenges revolve heavily around the management of chronic diseases—predominantly diabetes and heart disease—and their complications. These challenges can be made significantly worse due to the existing culture of late presentation for medical care. Road traumas are a very present risk with highly relaxed traffic safety regulations. Just prior to our arrival, a major accident involving a wooden-bodied bus resulted in significant trauma that quickly overwhelmed the facilities available on the island.

One of the Canberra registrars also learnt why dog bites are a frequent presentation, after a morning's run was 'encouraged' by a pack of local strays!

We had three goals:

First, to identify the areas in which Samoa's emergency medicine would benefit most from a visiting team of senior practitioners.

Second, to set up a strong working relationship with Samoa's emergency department, which will hopefully allow many future opportunities for collaboration between the two departments.

Third, to share knowledge and experience in order to strengthen practices into the future.

We were invited to attend the medical school and spent a valuable afternoon teaching University of Samoa medical students BLS and ALS for adults and children. Despite limited resources and at first appearing to be intimidated, the students soon settled into a comfortable relationship and made excellent use of the nursing and medical expertise in the room. The team is keen to be involved in the future with the medical students at University of Samoa and see this as an excellent resource from which to build capacity for a Samoan health workforce.

We were amazed at the warmth and generous welcome of the Samoan hospital staff and felt immediately at home and welcomed in the wonderful way that is distinct to Samoan culture. This eased any anxieties at the potential reception of an outside team coming to offer teaching, a reception that was further aided by the intent of the Canberra staff to learn as much as they could about practising medicine in Samoa, while attempting to share as much knowledge as possible. By the end of day one the ice was broken, made evident by the frequent bouts of laughter breaking out amongst the groups as they revised their CPR skills.

The Samoans were very forward about the areas of training they felt they would benefit from most. These included advanced sepsis, trauma, and cardio-respiratory arrest. In the limited time that we had, the team's focus was to strongly target the early recognition of deteriorating patients and help establish solid guidelines for the staff to work from when confronted with patients in extremis. To address this, the nursing staff ran workshops on triage processes focusing on reducing the time to acute care, and the importance of vital observation. The nursing and medical staff ran scenarios and case-based learning on basic and advanced life support, trauma, sepsis and the deteriorating patient in both adult and paediatric settings.

The few moments of downtime available to us were eagerly spent enjoying the beauty that Samoa has in spades, the beaches being a favourite for all.

The education was delivered to a diverse group of practitioners with skill levels ranging from medical and nursing students, up to consultant level doctors and advanced nursing practitioners. This proved a great challenge to us as there were cultural challenges in teaching mixed nursing and medical teams and the skill level of practitioners varied greatly.

It was a joy to see the naturally reserved Samoans grow in their confidence and enthusiasm as they quickly adapted to any situation, frequently peppering intense scenarios with great humour and an ever present good-nature. We were also distinctly impressed by the work ethic that was present throughout the Samoan students and staff at all levels. They were virtually tireless in their enthusiasm to learn more.

The few moments of downtime available to us were eagerly spent enjoying the ample beauty that Samoa has to offer. The beaches were a favourite for all.

The challenges of health care on a small island remain clear to see. Limited resources and the lure of practising medicine in larger centres internationally, where hours are less and pay is greater, is further compounded by a scarcity of senior clinicians to guide those who are hungry for knowledge. Public health initiatives remain critically important, with high rates of diabetes, obesity and renal failure, poor trauma response systems and the need to improve both vaccination status and child/maternal mortality.

The Canberra team, exhausted at the end of an intense teaching week, left reassured by the Samoan hospital staff and students that the teaching had been valuable. Both groups looked forward to working together in the future and to further strengthen the shared vision that unites medical colleagues regardless of where they call home •

The team leader of Canberra Hospital's Samoa Project is Dr Suzanne Smallbane (suzanne.smallbane@act.gov.au)





Report for ACEM scholarship

Associate Professor Khine Shwe Wah
& Dr Thynn Thynn Win

On behalf of Myanmar emergency medicine specialists, we would like to express our heartfelt thanks to the ACEM Foundation for the opportunity to attend ASM 2016 in Queenstown.

We arrived in Auckland on the 16th of November and we visited the emergency departments of three hospitals: North Shore, Auckland City Hospital, and Starship Children's Hospital.

Each hospital has its own ED design, ED systems, trauma-based systems and model of ED care. Among these hospitals, there was one particular thing that surprised us. In Starship Children's Hospital we saw a different style of triage placement and staffing. We also noticed that the role of nurse practitioner is a key role in that hospital, which is not the same as the other hospitals. In North Shore Hospital, we saw their detailed program in training a doctor to become an emergency specialist. In Auckland City Hospital, we learnt how to conduct simulation teaching.

We arrived at Queenstown the day before the opening date of the conference.

It was an honour to receive the scholarship on stage on the first day and be welcomed by ACEM President, Professor Anthony Lawler. We felt excited to attend the welcome reception at Skyline and also enjoyed an evening of spectacular scenery and a cultural performance showcasing traditional Maori song and dance.

Every morning, we attended the 'Plenary Session Live Feed' before the conference. Although both of us are anaesthetists, we got a lot of valuable knowledge from 'Incrementalised approaches to Hypoxemia and Intubation in emergency airways' presented by Professor Richard Levitan.

On the second day, we got a chance to attend the IEM Network country updates forum. There we met with other Australian volunteers, who are keen to work and try to develop emergency medicine in developing countries. We also realised that these other countries experienced many of the challenges as well. We enjoyed hearing a range of topics regarding safety, paediatrics, paediatric controversies, education in the ED, adult trauma and international emergency medicine.

During lunch time, we had the opportunity to meet with other international doctors and share experiences and information that was helpful and encouraging.

We would like to once again thank the ACEM Foundation for the opportunity to attend ASM 2016 in Queenstown •



The 'c' word—culture

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Picture a busy shift in your emergency department. Bed block is a problem—it always is—and your emergency department is at 180 per cent of capacity with admitted patients. You have an 'escalation policy', which basically means the admitted patients are put in some extra beds outside. And you have two barouches available to see all acute presentations. Six undifferentiated patients turn up simultaneously. No problem, your well-functioning triage system will ensure that your sick patients can be prioritised to be able to use those beds. Now subtract the triage system.

Many of the direct instructions you need to give during a resuscitation cannot be expressed in the local language at all.

All six patients are in your small acute assessment area, all hoping to be seen. Now visualise your approach.

I don't know precisely what you imagined, but my suspicion is that you would do some sort of a brief assessment of all the patients crowding around you, to prioritise them yourself, and allocate the sickest/most needy to the beds. Perhaps you could use the beds to examine patients, and then move them back onto a seat. I'm guessing that you made the same assumption I did—that decisions about who gets access to the two available beds should be made by the hospital staff, and that you are able to ask a patient to get off the bed once they are on it.

It is always the assumptions that you don't realise you are making that get you into trouble. This was my experience on this particular day. The most mobile (and therefore least unwell) of the patients climbed up onto the barouche and lay down. When I asked him to get off so someone else could use it who was more needy, the entire room went silent, and accusing stares from the staff and the patients alike made it apparent to me just how wrong I was. There had been hints of this over the past few months. My attempts to move our high-care patients from the outdoor observation area to a bed closer to the nurses' station indoors were universally resisted by staff and patients alike.

The second hint: We use a whiteboard to track which patient is in which bed. But it was incredibly common to find that patients were in different beds to what was recorded on the

whiteboard. These movements were not being arranged by the nurses; instead the patients were deciding where they would most like to be.

This particular event happened eight months into my placement in Kiribati, a Pacific Island nation straddling the equator. It gave me cause to reflect on the all-pervasive impact of culture onto health care delivery, as well as my own cultural arrogance in assuming my way was the right way. Health care systems are incredibly complex, taking into account many different aspects of behaviour, infrastructure, environment, disease and available resources. Change any one of those inputs, and the 'ideal' system (meaning best performing under those conditions) would—out of necessity—have to change. Could an Australian style emergency department truly function well over here—with different beds specialised for different purposes, and staff having control of patient flow? Perhaps, but what compromises to design and function, as well as staff behaviours, would have to be made to facilitate it?

Acceptable work practices is another confronting issue. Absenteeism is common through the Pacific, and I frequently hear expats bemoan the challenges this creates. Certainly the rostering here is like no rostering I have seen elsewhere—they have a first on call for the nightshift and a back-up to be called-in if the relevant person doesn't show up. But sometimes the back-up also falls through. Turning up to work over an hour late is normal and accepted. The western work-ethic would not tolerate that, and there

would be significant repercussions. But if a ministry has spent many hundreds of thousands of dollars training someone, would they really then fire them? Also the staff are massively underpaid in comparison to neighbouring countries—so how could you punish someone without them actually moving elsewhere for better pay and conditions?

Most doctors conceive of themselves as diagnosing and treating patients. But what proportion of your patients do you make a definitive diagnosis on really? We do mostly risk assessment and risk management, rather than diagnosis and treatment. And the level of appropriate risk is entirely culturally determined—a fact which has to contribute to the challenges many immigrant doctors face on arrival in Australia. Certainly I struggle every day with the diagnostic uncertainty that local resources force upon me, and the compromises I make in patients' care. If you only have a single sheet of ECG paper left, what criteria do you use to decide who to perform the ECG on? If you have a shocked child in status epilepticus with failed venous access, and the only intraosseous needle in the hospital has damaged packaging, do you use it anyway?

Where two different cultures interface, it gets even harder. There is a small expatriate community in Kiribati. To end up in a place like this, you need a fairly adventurous spirit, and a broad world view. You need a willingness to live under the conditions faced by the locals. That works perfectly well until you are sick, and facing the types of outcomes the locals face, at which



time people's acceptance of local standards evaporates and first world healthcare standards become expected. This is rational, and I fully accept the desire of expats to get the outcomes they would expect at home. But how should their desires affect my professional responsibilities? I am employed by the Ministry of Health. Is it truly appropriate for me to provide a different level of care to a particular subgroup of patients, purely on the basis of their skin colour? From the way I phrased the question, I suspect that you can guess my answer—but it is not an answer which is designed to endear me to the expat community.

At the same time, I also believe it is appropriate for the critically unwell expatriates to be medevaced—it improves their outcomes, saves precious local health care resources for the locals, and the evacuation teams inevitably bring me a welcome cache of hard-to-obtain supplies, so everybody wins. But past experience has shown my colleagues have missed critical referrals for evacuation, or else arranged unnecessary evacuation. They also find the interaction with the medical evacuation teams difficult—a difficulty I suspect is mutual. So I find myself in the situation of providing special care to the expatriate community because my skills are best suited for the role. But I surround myself with many barriers. I make it clear to staff that I can be called in for all people who are seriously unwell, and I provide expatriates with the best care I can while feeling a profound sense of unease at my own hypocrisy.

One of my areas of interest at home is teamwork and communication during a resuscitation. This can be difficult to get right in the best of circumstances. But how do you adapt this to a culture where all decision making is consensus based?

Where, in a single resuscitation, four different languages are being used between different staff members? I knew I had been finding it difficult, but I really only understood why when one of the very good emergency nurses here explained to me that many of the direct instructions you need to give during a resuscitation cannot be expressed in the local language at all.

Manifestations of non-specific illness is the other major challenge. People here present with 'emptiness'. I have asked many colleagues to explain this to me. I still do not truly have a good understanding of precisely what emptiness feels like. Some days I'm convinced it is presyncope. Other days I think it must be nausea. In fact, I suspect it is a locally unique sensation, felt as a symptom of being non-specifically unwell. In Solomon Islands, this was often 'whole body weakness'—whereas here that symptom is almost always due to hypokalaemia (incredibly common, and not related to diuretics like it might be at home).

I don't for one moment pretend the challenges I have been facing are unique—all who venture forth to work in different environments face these challenges and others more profound. And I do not pretend to have any answers to the many questions I have posed.

But one thing remains a constant across all cultures. 'Dizziness' is still the least rewarding of presentations to assess •

Brady first lived and worked in Kiribati with his partner Michelle in 2003 for 12 months as Australian Volunteers—he returned to Kiribati last year with his family as an employee of the Ministry of Health with funding sourced from a DFAT program called 'Strengthening Specialised Clinical Services in the Pacific'.

Emergency medicine diploma training in Nairobi, Kenya

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Kenya, a developing sub-Saharan nation with a population of some 46 million, faces many healthcare problems which are common to most parts of Africa. Trauma, severe untreated chronic illness and severe infections are routine presentations to healthcare providers. What is also routine is a lack of access to basic emergency care.

The Kenyan medical system does not currently recognise emergency medicine as a medical specialty. There is widespread recognition that emergency care needs to be improved, however there seems to be difficulty developing a coordinated national plan to achieve this.

Access to emergency medicine is through 'Outpatient Departments', with patients self presenting by foot, wheelbarrow, motorbike, car or taxi (and very rarely by ambulance).

Triage systems usually exist in larger hospitals only. Outpatient departments

are commonly staffed by 'clinical officers', similar to nurse practitioners. The hospitals that have an 'Accident & Emergency' (A&E) centre are usually staffed by very junior doctors with little or no emergency medicine training. Patients requiring admission are managed from the point of referral in A&E by inpatient teams, again mostly very junior doctors.

The country has a mix of government hospitals and health centres and remarkable array of private and non-government hospitals (including some at tertiary level). Rural government health centres and regional hospitals ultimately refer to government tertiary hospitals (of which there are two in Kenya).

The Aga Khan University Hospital Nairobi is a private tertiary hospital which has made a decision to provide a high standard of emergency care. The hospital sponsored one doctor (Benjamin Wachira) through an emergency medicine fellowship in South

Africa, with the aim of installing a qualified emergency physician in the A&E to further develop emergency care.

To date, this has been a great success story, and Dr Wachira has managed to fashion the A&E into something very similar to an Australasian-style ED in a short period of time. He also regularly provides training in ATLS, APLS, ACLS, ALSO and POCUS. He has established the Emergency Medicine Kenya Foundation (www.emergencymedicinakenya.org)—have

Yes, 'hakuna matata' really is Swahili for 'no worries'.

a look!) which provides a network and teaching platform/organisation for practitioners with an interest in emergency medicine. He has also assumed management of the hospital code blue system, with all code blues run by a team from the A&E.

His most ambitious project to date has been the establishment of an 18-month training program for selected candidates to write the South African Diploma of Primary Emergency Care. The program started in January this year, with six diploma candidates. Candidates attend a full day training session each week following a curriculum similar to an ACEM Fellowship preparation study program. Candidates spend the majority of their time in A&E, but also have short rotations through ICU, anaesthetics, paediatrics and obstetrics/gynaecology.

As Dr Wachira has many portfolios, responsibilities and is a research addict, he finds himself extremely stretched to provide adequate 'on the floor' teaching and supervision.

I have been assisting him to deliver the weekly Diploma training sessions and on the floor teaching to all doctors for a fortnight at a time, twice yearly.

The Diploma training sessions consist of informal reviews of the topics for the week, the use of manikin where appropriate, and discussing previous exam questions. The sessions were also a venue for questions on any aspect of emergency care, or to clear up any issues from interesting cases

seen during the week. Bedside teaching was very rewarding, with both medical and nursing staff

very enthusiastic to receive some outside support.

The A&E has a daily census of about 150 to 200, with a 5-10 per cent admission rate, reflected by a large amount of 'family medicine' cases, as there is no well-developed system of primary care in Kenya. The A&E has nine cubicles dedicated to primary care patients, six cubicles for 'observation' patients (similar to 'main floor' patients in an Australasian ED) and two resuscitation cubicles. There are no admissions under A&E and no short stay units.

Patients take a ticket, are registered, triaged (Canadian Triage System), financial eligibility established, and then allocated to a doctor. The patient acuity and medical staffing does not lend itself to team based care.

Unwell patients commonly arrive by ambulance (which may or may not have staff trained in healthcare) with absolutely no warning. A buzzer is rung outside the A&E,

and staff will go and inspect the patient. Presentations range from the inappropriate (I need a sling for my arm), wrong location (direct admit to ward/cath lab/ICU etc), to the truly frightening: young hypertensive renal failure with encephalopathy; trauma from being trampled by an elephant; life threatening sepsis; and gunshot wound to the chest, etc).

It is a consistent challenge to instill and maintain an ED 'attitude' in the department. Management of the A&E patients was traditionally left to the inpatient teams, and there is commonly a reticence for A&E staff to 'own' their unwell patients. Adding to this challenge is the 'poaching' of well-trained and enthusiastic emergency nurses by Western nations. They were largely replaced by ward nurses, leaving the A&E with a shortfall of nurses confident in emergency nursing of the unwell patient. Similarly, the majority of doctors in A&E (not on the Diploma program) are ward based, and have little training in emergency care, apart from departmental teaching sessions. On floor FACEM presence makes a world of difference, as all staff thrive with close bedside support and teaching, resulting in prompt and appropriate patient management.

Bedside teaching with the non-diploma doctors was very rewarding, and within a week or so of support they were rationalising investigations (e.g. clear clinical pneumonia does not need a CTPA, all headaches do not require an MRI). Even more rewarding was encouraging and supporting them and the Diploma candidates in core EM business, e.g. procedural sedation, fracture & joint reductions, cardioversions etc, which was normally left to inpatient teams.

The real satisfaction was dealing with the Diploma candidates. In only six months I had noticed a marked difference in their approach to the emergency patient. Histories and examinations were focused, likely differentials were considered and rational investigations ordered, with good management and disposition plans. Importantly, life threatening conditions were identified and treated early. I could see them developing from junior RMO to mid-registrar level in a very short space of time.

The plan for the training program is to run it every 18 months, with the possibility of concurrent courses rather than consecutive. After graduation, some doctors will be offered jobs at Aga Khan A&E, and others will go to whichever hospitals or regional centres they apply for. Those staying at Aga Khan will be actively involved in subsequent training programs and the management of the department. Those going elsewhere will provide their individual A&E/ outpatient department with the first ever doctor formally trained in emergency medicine.

Distant and lofty goals include establishing this Diploma training program in public hospitals, the recognition of emergency medicine as a medical specialty, the establishment of a Kenyan emergency medicine faculty or college, a Kenyan EM Fellowship, and ultimately saving the lives and reducing morbidity of Kenyan emergency medicine patients.

At the time of writing, Dr Wachira had just met with his hospital executive, who expressed an interest in the hospital supporting an EM residency (Fellowship) from 2018. *From little things, big things grow...*

Interested? Nairobi is safe and malaria free, Uber is reliable and internet coverage is good. Cable TV tends to show Mexican soap operas dubbed in English (very entertaining). People are friendly, everyone speaks English (all primary school lessons are in English starting from grade 3 or 4), but a few words of Swahili are always appreciated and yes, 'hakuna matata' really is Swahili for 'no worries'.

Dr Wachira would love for you (a FACEM or senior registrar) to attend for a week or two of bedside teaching. Monday to Friday 8 to 5 is a good regime. Flying your partner over when you've finished to go on Safari (another Swahili word) is a great way to finish your time.

We are currently investigating a six-month advanced training term (non-ED for ACEM accreditation purposes). Pay, or more specifically a lack of pay is the sticking point.

If you would consider a teaching trip, please email me via lourensant@ramsayhealth.com.au •

Since writing, Emergency Medicine has been recognised as a medical specialty in Kenya, but there remain many challenges to its expansion.

The first six emergency physicians for Fiji

Dr Anne Creaton, FACEM
acreaton@hotmail.com
Dr Melanie McCann, FACEM

December 2016 saw the graduation of the first six emergency physicians for Fiji—the first cohort to have completed the Masters of Emergency Medicine at Fiji National University (FNU). The ceremony celebrated their considerable academic achievements: four years of work, study, exams and research.

FIJI

In addition to their academic achievements, they have played a considerable role in the development of emergency care in the Suva area and beyond: Developing emergency services at Fiji's major referral hospital, Colonial War Memorial Hospital, conducting outreach to surrounding facilities, providing education, advice, resuscitation and retrieval of the critically ill.

As is the case for most pioneers, their journey can only be imagined by those who follow them. This group worked extremely long hours, often as the only doctor in the ED, then enthusiastically attended teaching sessions, when protected teaching time was a far-off dream. Only a few years ago, it was a fight to get sheets for the beds. Their requests for drugs and equipment were declined. The reason given was that they were 'not a department'. Government scholarships to study were suddenly withdrawn. Time was spent teaching nurses new skills, only to have those nurses rotated to different departments. Morale nosedived, fracturing the team. However, despite the setbacks, they kept studying, knowing their efforts were making a difference to patients.

In addition to work and study, they committed themselves to their portfolios, growing specific areas of emergency care. The fruits of their labour include: annual short courses; outreach education to smaller health facilities; a trauma call process, an asthma clinic, functioning critical care equipment and an ultrasound machine. So how did they get there and what of the future?

The structure of the Masters at FNU has the exit exams at the end of the third year, leaving the fourth year for completion of a research project and development of leadership skills.

So how do you graduate leaders, where there are no local emergency physicians to follow?

While teachers and mentors are accepted requirements of medical specialty development, what of coaches? While the role of coaching has expanded into many other areas, it remains relatively unexplored in medicine, as noted by Atul Gawande in the article 'Personal Best: Top Athletes and Singers Have Coaches, Should You?'

Could a coach assist with the translation of skills and knowledge into practice, preventing the drop off we often see following attendance at short courses, for example? If competencies assess performance against agreed benchmarks, could coaching provide continuous quality improvement? Acquiring leadership skills may benefit from a coaching approach. Long-term investment is required, similar to mentoring but requiring more intensive input from the coach.

Should we be looking for coaches to develop international emergency medicine as well as teachers and mentors?

A focus on leadership and emergency medicine specialty development was required to assist the first cohort of graduates in Fiji and to help signpost the way forward. It began with the regional leadership course organised by Dr Georgina Phillips in June 2016 and continued with Dr Anne Creaton and Dr Melanie McCann running weekly sessions.

The six final year Masters students were tasked with researching and presenting on a specific topic every week, which then stimulated discussion amongst the whole group. Some of the areas covered included: what followers want from leaders; leadership styles (including servant leadership); the specific challenges of leadership; organisational values and culture; creating a vision that works; strategy; advocacy; innovation; change management; and the communication secrets of great leaders. There were lessons from Aristotle on modes of persuasion and exercises on 'what is a champion?' and how do you become one. The group was encouraged to think deeply about themselves now and about the types of leaders they wanted to become. This unique cohort knew that they would, of necessity, be stepping into leadership roles immediately and they actively embraced these sessions.

This structured program was challenging to prepare and deliver, as these are not topics usually taught in our own ACEM training. Deciding what were the crucial elements to be covered, how best to do this and finding resources to support the learning, required considerable time and effort. However, when working in the field of international EM, it is crucial to do what is needed, not remain in your own comfort zone.

Another important aspect of preparing this group for leadership was to provide opportunities for role modelling. Medical training has been likened to an apprenticeship and we learn much by observing the behaviours of those more senior than ourselves. Thus, having an ED consultant conducting daily teaching ward rounds, spending time 'on the floor', providing supervision and assistance with cases and attending meetings was integral to the program. The trainees were also encouraged to make links with local consultant leaders from other specialties.

As the end of 2016 approached, the focus shifted to assisting these young leaders to develop a road map for the future of emergency medicine in Fiji. This included helping the trainees write documents to submit to the Ministry of Health explaining the importance of emergency physicians in Fiji and detailing their many roles, including clinical work, teaching, management, clinical support activities, research and public health. The ED Clinical Services Network met in November, bringing together key medical and nursing staff from the emergency departments of Fiji's three divisional hospitals to plan the way ahead together. This meeting was led by the group about to graduate. A Clinical Services Plan was formulated, outlining the immediate scope of duties for the new 2017 emergency specialists at the divisional hospital, primary and secondary health care level. Furthermore, specific recommendations for the future of emergency care in Fiji and the measures needed to facilitate these were drafted. Final teaching sessions for the year included work-shopping the process of setting up a professional society for emergency physicians in Fiji.

More than mentoring or teaching, the final year of the Masters program required coaching. The word coach originally referred to horse drawn carriages, then buses that would 'get people where they wanted to go'. That meaning was translated into the sporting arena and then more broadly, with the idea that a coach is a person who will develop specific skill sets, provide structured support, anticipate setbacks, monitor progress and bolster confidence to help a person towards an end result. We are immensely proud of the first six emergency physicians in Fiji who, by their very hard work, have already made such a great difference to so many people. We wish them well as emerging leaders •



End of an era—and a fresh start

Dr Georgina Phillips, FACEM
The Visiting Clinical Lecturer Program 2010-2016

The partnership involving Australasian College for Emergency Medicine (ACEM), Divine Word University (DWU), and Australian Volunteers International (AVI) comes to an end, but a new, bright version of the Madang trainee rotation is launched!

Background

The Visiting Clinical Lecturer Program (VCLP)—a placement of Australasian advanced trainees in emergency medicine (EM) to teach at the Divine Word University (DWU) and provide emergency care and clinical supervision at the local Modilon Hospital—commenced in Madang, Papua New Guinea (PNG) in 2010. Over the years, 10 advanced trainees have spent three to six months each living and working in Madang under the VCLP and have had this experience accredited towards their ACEM training. Many trainees and Fellows have participated through short and long term visits to support the program, and several have reflected on their experiences through articles published over the years in the IEMNet News (or formerly IEMSIG).

With the most recent trainee—Dr Rebecca Heath—completing her six months Madang VCLP placement in January 2017, the current iteration of the VCLP as a partnership with DWU has come to an end. But that’s not the end of the story!

This article is to pay tribute to the VCLP and people who supported it, and to launch, with great excitement, the new ‘improved’ version of the Visiting Emergency Registrar Program (VEMRP).

Structure of the VCLP

Between 2010 and 2013, I coordinated the VCLP placements in liaison with DWU partners and Dr Vincent Atua, the senior EM specialist at the Modilon Hospital. All participating doctors worked as volunteers and self-funded their travel and other expenses. DWU provided secure accommodation on the university campus and for some of the longer term VCLs, a small stipend. At DWU, VCL doctors worked under the direction of the Health Faculty Dean, Head of Rural Health Department and Clinical Unit Coordinator in EM.

In 2014, ACEM partnered with Australian Volunteers International (AVI), who took on the VCLP and supported our trainee placements under the Australian Government funded ‘Australian Volunteers for International Development’ (AVID) program. We worked together; with ACEM recruiting suitable advanced trainees, AVI mobilising and supporting, and DWU accommodating and supervising them (along with Dr Atua at the hospital).

The trainees who had their time accredited by ACEM worked under a ground-breaking model whereby they were jointly supervised by Dr Atua in-country, and a FACEM remotely. The ACEM model of recognising a local expert—in this case, a PNG trained emergency physician, as an appropriate supervisor of Australasian EM trainees—has garnered much respect and replication by other professional medical bodies.

People

There has been a longstanding relationship between FACEMs and DWU, beginning perhaps with FACEM Dr Sandra Rennie, from Western Australia (a trainee in the mid-2000s) who, under the guidance of FACEM Associate Professor Dr Chris Curry, helped develop a Diploma of EM, which continues to run today. I spent six months on sabbatical with the Health Faculty at DWU in 2009, which was the initial trigger for the VCLP. Two key people kick-started the program in 2010: FACEM Dr John F Kennedy as an inaugural supervisor to then trainee Dr Katryna Denning. Katryna has since returned to support the program as a FACEM in 2015, illustrating the value of these kinds of short term opportunities to engender longer term commitment. Other VCLs over the years: Dr Danielle Wood, Dr Hannah Macguire, Dr Tom Wallis and Amanda Appleton in 2011; Dr Becky Box and Dr Jocelyn Kaege in 2012; Dr Brendan Morrissey and Dr Meg McKinnon in 2013; and in Partnership with AVI, Dr Rob Mitchell in 2014, Dr Johanna Doherty and Dr Philippa Flinn in 2015, and Dr Rebecca Heath in 2016.



Activities

The overarching aims of the VCLP have been to improve capacity for emergency care through both supporting health education and clinical service in PNG and provide an opportunity and experience in international EM for Australasian clinicians.

The VCLPs focussed on the training of Health Extension Officers (HEOs), who are core clinicians for rural and remote areas of PNG and therefore serve the great majority of the population. Teaching was based both on campus and in the ED, alongside clinical ED work supervised by Dr Atua, and Dr Taita Kila, another PNG EM specialist to work in Madang.

The VCLs did much more than innovate interactive EM teaching and assessment for HEOs. All of them contributed to the life of the hospital and University through clinical work, educational activities, quality improvement projects, rural and community clinics, the formation of many personal and professional friendships, and networks that will last beyond the life of the VCLP.

Outcomes

Without doubt, the VCLP has delivered benefits for all stakeholders. At each visit to Madang, I received positive feedback about the trainees, their enthusiasm and contribution to the teaching. AVI are delighted with the calibre of our ACEM trainees, profiling them widely amongst their own communication networks.

Each VCL has experienced moments of appreciation and gratitude from their students, hospital and university colleagues. They have all worked with energy and respect, leaving behind a legacy of teaching and clinical EM resources. All VCLs have been challenged and rewarded by their experience in Madang, many going on to further involvement in international EM (IEM) activities.

Certainly, one of the lasting legacies of the VCLP has been to move ACEM into an appreciation of the value of such IEM placements as core learning in EM. Through its popularity and longevity, the Madang VCLP model has triggered

One of the lasting legacies of the VCLP has been to move ACEM into an appreciation of the value of such IEM placements as core learning in EM.

work at the College to embed 'International EM' or 'Global Emergency Care' experiences into recognised trainee placements. The VCLP has set multiple precedents now; of structured international EM training in a low resource environment, of the possibility of local clinicians supervising Australasian trainees and of partnerships between organisations and across borders.

The end of an era

Now is a good time to pause in our relationship with DWU. The University has formed a partnership in Italy to commence training of 'rural doctors', a program of unknown quality which has mixed support from our PNG medical colleagues. The future of training for the essential HEO workforce is unclear, and the role of the VCLP into the future also ambiguous.

ACEM has an ongoing commitment to health education and clinical support towards safe and effective emergency care in PNG. We have strengthened our relationship with our medical colleagues in Madang (and elsewhere around PNG) and re-aligned our focus to clinical EM care and EM education at the Modilon Hospital. Our relationship with DWU remains open and positive.

Acknowledgements

All the people whose names have appeared already deserve warm thanks and acknowledgement. In addition, at DWU, Fr Jan Czuba, Br Brendan Neilly, Fr Garret Roche, Linda Fitina, Angela Kakau, Dr Pascal Michon, Dr Clement Manineng, Roselyn Semin, Dr Samia Hadier, Bob Simon, Dr Billy Selve and Dr Betty Koka (staff past and present) all played an important supportive role over the years. Dr Vincent Atua, the CEO of the Modilon Hospital, and Christine Gawi have been consistently supportive, along with the many hospital medical and nursing staff who have generously hosted and worked alongside the VCLs.

At AVI, the PNG in-country managers, Tracey John (former) and Rebecca Walker (current) have been critical. Similarly, at ACEM, Sarah Smith (former) and now Fatima Mehmedbegovic (current) have worked hard to embed the VCLP into College structures and maintain the formal partnership with AVI •

ACEM Foundation Awards & scholarships 2016

The International Development Fund Grant 2016

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

In 2016, the ACEM Foundation awarded four International Development Fund Grants.

Dr Brady Tassicker received \$15,521 for his project '*Specialised Training Program for Emergency Nurses in Tungaru Central Hospital*' in Tawara, Kiribati. **Dr Anna Davis** received \$3,203 for her project '*Workshop on Leadership, Crisis Resource Management and Communications Skills in Emergency Medicine for Registrars in Emergency Medicine*' in Sri Lanka. **Dr Alan Tankel** received \$4000 for his project '*Provision of Emergency Life Support International (ELSI) and Serious Injury/Illness in Remote Environments (SIREN) Course*' in Tonga. **Dr Hanh Pham** received \$7,279 for her project '*Improving Emergency Care in Vietnam, EM Short Course*'.

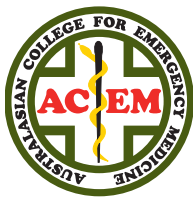
The International Scholarship 2016

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 2016, **Dr Thynn Thynn Win** (Myanmar), **Dr Bobby Welsh** (Papua New Guinea), **Dr Khine Shwe Wah** (Myanmar), **Dr Ram Prasad Neupane** (Nepal), and **Dr Ganbold Lundeg** (Mongolia) received scholarships •



Dr Thynn Thynn Win, Dr Bobby Wellsh, Dr Khine Shwe Wah, ACEM President Professor Anthony Lawler, Dr Ram Prasad Neupane, and Dr Ganbold Lundeg



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