



Global Emergency Care

ANNUAL PORTFOLIO OF THE ACEM GLOBAL EMERGENCY CARE NETWORK

2019 / 2020 PORTFOLIO

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Image of a Highlands Village of Papua New Guinea (PNG)
Cover: JohnCrux
Image from Mount Hagen PNG, location of the triage system development project.

Global Emergency Care Portfolio
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**RETURNING FROM
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The Australasian College for Emergency Medicine (ACEM) acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

In recognition that we are a bi-national College, ACEM acknowledges Māori astangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

INTRODUCTION TO GLOBAL EMERGENCY CARE

Emergency care is an essential part of the health system.

At any moment in time, there are patients all over the world experiencing acute illness and injury. Some will have the option of calling an ambulance, attending a clinic or presenting to an emergency department – but many will not. Globally, there is an enormous unmet need for Emergency Care (EC), especially in settings where there are social, environmental and economic barriers to healthcare access.

As the burden of non-communicable disease and injury in low- and middle-income countries (LMICs) grows, demand for timely and effective EC is increasing. While the challenge is immense, Emergency Medicine (EM) is responding. EM is now recognised as a speciality

discipline in over 65 countries – evidence of the value and impact of EC in both developed and developing settings.

EM sits within the broader field of EC, an integrated platform to deliver time-sensitive healthcare services in the community, during transport and in the hospital. The central focus of EC is reducing preventable morbidity and mortality from acute illness and injury, in part through facilitating access to early operative and critical care when required.

Global Emergency Care (GEC), a relatively novel term, integrates EC with the field of global health. It emphasises the transnational aspects of disease and healthcare, the synthesis of public health and

clinical care, and the pursuit of equity across populations. GEC practice incorporates clinical service provision, capacity building and health systems strengthening for time-sensitive healthcare, and it includes development activities as well as aspects of disaster health, humanitarian assistance and surge response.

Compared to International Emergency Medicine (IEM), GEC is a more inclusive term: it emphasises that EC is team-based and multidisciplinary; is relevant in community settings as well as hospitals, and is essential irrespective of whether EM exists as a specialty medical discipline. It is in this spirit of inclusivity that the Australasian

ACEM'S GEC PARTNERS

ACEM GEC Desk

4 team members: 1 FTE Manager, 0.6 FTE Coordinator, 0.1 Strategic Partnerships, 0.1 Communications

Country/Regional Liaison Representatives (CLRs/RLRs)

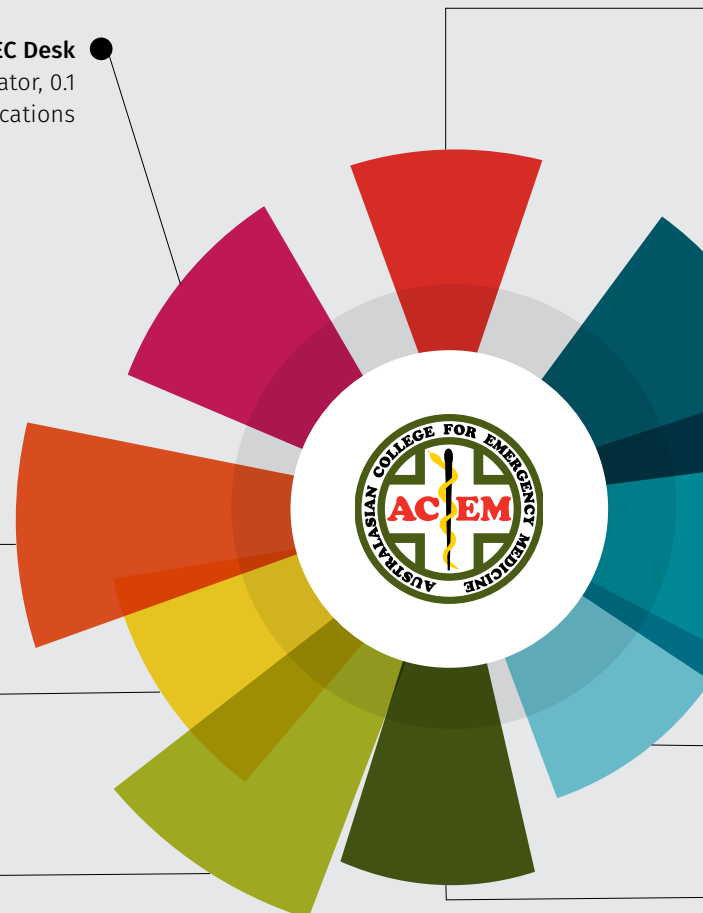
36 representatives in 31 locations act as a point of linkage between local providers of EC and ACEM to facilitate discussions and opportunities to support LMICs countries to deliver safe and effective EC. On average our CLRs have a minimum five-year engagement in the country they liaise with or are diaspora

GEC Network

A network of approximately 500 Fellows and Trainees interested in Global Emergency Care sharing updates and opportunities in GEC. We connect to our Fellows and Trainees in the Field (FIFs and TIFs) undertaking work in GEC independently via this network

In-country Partner Organisations

ACEM partners with local EC providers and educators such as Ministries of Health, Government Hospitals, Universities to support countries in fulfilling their development objectives for EC. ACEM currently holds formal partnerships in Fiji, Mongolia, Myanmar and Papua New Guinea



“No one should die for the lack of access to emergency care, an essential part of universal health coverage.”

College for Emergency Medicine (ACEM) IEM Committee has recently changed its title to the Global Emergency Care Committee (GECCo).

Although GEC has not featured heavily in global health and development priorities, it is estimated that nearly half of deaths and over a third of disability in LMICs could be addressed by the implementation of effective EC systems. This message appears to have been heard by the World Health Assembly, which recently adopted a critical resolution on emergency and trauma care:

“No one should die for the lack of access to emergency care, an essential part of universal health coverage. We have simple, affordable and proven interventions that save lives. All people

around the world should have access to the timely, life-saving care they deserve.” – World Health Organisation (WHO) Director-General Dr Tedros Adhanom Ghebreyesus.

This resolution, 72.16, is indicative of the growing global demand for EC systems improvement. It provides a roadmap for addressing the unmet global need for EC and has created a platform for governments, donors and non-governmental organisations to work collaboratively to achieve universal emergency healthcare coverage.

ACEM is committed to improving the capacity of LMICs to deliver safe and effective emergency care, with a focus on the Indo-Pacific Region. The College seeks to do this by supporting

locally-led EC capacity development: our approach to GEC activities and projects is to promote reciprocal, sustainable and mutually beneficial partnerships; focus on training and education; ensure accountability and value learning and; strive for best-practice in international volunteering for development.

ACEM’s Fellows and trainees have made substantial contributions to GEC over the last two decades. Led by pioneering emergency physicians committed to the global expansion of EM, these efforts have created a strong foundation on which ACEM can work to address global inequity in EC access. The College is actively increasing its investment in GEC activities, both via the ACEM Foundation and the establishment of the GEC Desk.

ACEM is proud to be a leader and collaborator in EC development in the Indo-Pacific and is excited by the growing number of GEC partners in Australia, New Zealand and across the region.

Key contributions from Sarah Körver, Dr Rob Mitchell (FACEM), Dr Georgina Phillips (FACEM)

● Global Emergency Care Committee (GECCo)

15 core members, including one Council of Advocacy, Practice and Partnership (CAPP) Representative and one Community Representative

● Other Medical Colleges and Regional/Global Agencies

ACEM partners with other Colleges The Pacific Community (SPC), The World Health Organisation (WHO), International Federation of Emergency Medicine (IFEM), *et al.*

● International Affiliates

24 applicants for international affiliate membership from LMICs, providing access to ACEM resources and Continuing Professional Development (CPD)

● Volunteer deploying specialists

ACEM partners with volunteer deploying specialist agencies and programs such as AVI and the Australian Volunteers Program to ensure the opportunities we offer in GEC are adhering to best practice in international volunteering for development

● Funding Bodies

Current funders of ACEM GEC projects include the Australian Department of Foreign Affairs and Trade (DFAT), AVI, Australian Aid Program and ACEM Foundation

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GLOBAL EMERGENCY CARE COMMITTEE

The Global Emergency Care Committee (GECCo), formally known as the International Emergency Medicine Committee (IEMC), has been integral to the establishment of GEC as a key pillar of ACEM's body of work. The committee's key objectives are to; advocate for global health; improve the GEC Network, FACEM and trainee engagement in GEC; support capacity building for emergency care in LMICs; and promote and facilitate GEC research.

Dr Colin Banks - Chair

Colin is an Emergency Physician from Townsville. He has been supporting emergency care capacity building in Papua New Guinea (PNG) since 2009. This has predominantly been related to the UPNG Masters program for training emergency physicians. He has been the UPNG external examiner on a number of occasions. He was heavily involved in recent structural modifications to the training program and the introduction of a newer format of exams. He was also instrumental in introducing the Diploma of Emergency Medicine. He is the clinical lead for the emergency care support package component of the Clinical Support Program for Angau Memorial Hospital in Lae and he is involved with the triage implementation project in Mount Hagen and Gerehu General Hospital. He is the ACEM Country Liaison Representative for PNG.

Colin was the chief examiner in Fiji for the first two cohorts of emergency physician final exams, and has done support visits for JCU medical student placements.

He has been a member of the GECCo since its inception in 2015 and chair since March 2019.

Dr Megan Cox- Deputy Chair

Megan is an Emergency Medicine Specialist Clinician and Academic with over 20 years of International EM experience, mostly in sub-Saharan Africa. She worked fulltime in Botswana for six years as the Head of



Emergency Medicine and trained the first local EM Specialists for Botswana. Whilst there she also helped develop the first public ambulance system for the country, locally-based resuscitation courses, established EM research and supervised numerous medical students and physician volunteers from all over the world.

Now back in Sydney, she works part time as a State Retrieval Consultant and EM Specialist for NSW Health. Megan is a Senior Lecturer for the University of Sydney delivering "Resource Limited Critical Care" for the Masters of Medicine Critical Care. She tutors in the Masters of Global Health and mentors students in their international field placements. Megan has over 20 peer reviewed publications, is a journal reviewer for three International EM journals and has recently been appointed Adjunct Associate Professor in EM for the University of Botswana.

Dr Claire E Brolan - Community Representative

Claire is a qualified lawyer (non-practising) and right to health and development academic specialist based at the Centre for Policy Futures, The University of Queensland. Claire has some 60 peer-reviewed and other publications such as *The Lancet et al.*

Claire has experience conducting legal and social advocacy for access to essential medicines and health care and related social services for vulnerable and minority populations in both Queensland and internationally and has worked with leading right to health scholars providing guidance to the European Commission on Sustainable



Development Goal (SDG) 3 (Health and Wellbeing).

Claire completed her PhD and Post-Doctoral studies at the Dalla Lana School of Public Health, University of Toronto. Claire currently sits on the Global Council for Financing the SDGs, hosted by the Prime Minister's Office in the Government of the UAE, and is the Medical Sector Representative on the Queensland Red Cross' International Humanitarian Law Committee. She has recently been appointed to sit on the Academic Advisory Committee to the new Queensland Human Rights Commission.

Dr Jennifer Jamieson

Jennifer is an Emergency Physician and trauma specialist at Monash Health and Alfred Health. She has previously worked with Medecins Sans Frontieres (MSF) at the former Kunduz Trauma Centre in Afghanistan as the emergency and intensive care doctor. During 2015, she undertook a medical education role within the emergency department of Muhimbili National Hospital, Dar es Salaam, Tanzania.

Jennifer has a Masters in Public Health and Tropical Medicine and is currently undertaking a Masters in Trauma. She has been involved in a number of global health projects and organisations, including co-founding the Global Health Gateway and working as faculty for the Global Emergency Care Conference and workshop. Within ACEM's Global Emergency Care Committee, she is involved in communications and assisting with the global health content for *Your ED* magazine.



Dr John Kennedy (“JFK”)

John has been involved in ACEM’s GEC activities since the early days of the College’s engagement in Papua New Guinea. He lived through the exciting times that saw the Special Interest Group develop into a fully-blown Committee and continues to support short course delivery and trainee placements in the Pacific.



Dr Kezia Mansfield – Trainee Representative

Kezia is an Emergency Medicine Advanced Trainee from Sydney with a strong interest in global medicine. She has worked with Médecins Sans Frontières for two projects in the Middle East, focusing on health and advocacy for Syrian refugees. She brings with her a keen interest in promoting global medicine to trainees and representing ACEM trainee issues in the area of Global Emergency Care.



Dr Rob Mitchell

Rob is an Emergency and Retrieval Physician based at the Alfred Hospital Emergency and Trauma Centre in Melbourne. He has a strong interest in global emergency care, having previously completed Australian Volunteers for International Development (AVID) assignments in Papua New Guinea (PNG) and Solomon Islands. Rob is undertaking a PhD focussed on emergency care systems in resource-limited environments, including a triage development project in Mount Hagen, PNG funded by the Australian Government Department of Foreign Affairs & Trade.



In 2014, Rob completed a Churchill Fellowship focussed on postgraduate training in global emergency medicine, and is currently contributing to the University of Sydney’s Resource Limited Critical Care program. He holds a Master of Public Health and Tropical Medicine

and a Postgraduate Certificate of Disaster and Refugee Health from James Cook University.

Dr Mike Nicholls

Mike was fortunate to be born in a developed country that espouses (although may not always practise) equitable access to healthcare for all. Currently based in an urban ED in New Zealand, he has had the privilege of working with his brothers and sisters in the Pacific, particularly Tonga, and in a few other spots around the world. Mike hopes to be able to facilitate the growth of excellent culturally- and resource-appropriate emergency care in areas where this so far has not been possible, all the while maintaining equanimity in the face of inevitable challenges.



Associate Professor Gerard O’Reilly

Gerard works as an Emergency Physician at the Alfred Emergency and Trauma Centre, where he is Head of International Programs. Gerard chairs the annual Alfred-Monash Global Emergency Care Workshop and Conference and is a past chair of the ACEM International Development Fund Committee and GECCo. Gerard represents Monash University (WHO Collaborating centre partner) in the WHO Global Alliance for the Care of the Injured and has partnered with WHO in emergency and trauma care system development activities in Iran and Myanmar. For more than 20 years, he has led multiple emergency response and emergency capacity development programs, including in Afghanistan, Kenya, Indonesia, Sri Lanka, India, Vietnam and Myanmar. He has completed a Master of Public Health, a Master of Biostatistics and a PhD in International Trauma Epidemiology. Gerard is a PhD supervisor in global emergency and trauma care at the Monash School of Public Health and Preventive Medicine and is currently undertaking a NHMRC Professional Research Fellowship at the National Trauma Research Institute.



Dr Georgina Phillips

Georgina has worked at St. Vincent’s Hospital, Melbourne for more than 20 years, with special interest in clinical excellence and research for patients with complex psychosocial issues, such as homelessness, addiction and mental illness.



Since 1996 as an Australian Volunteer emergency doctor in Kiribati, Georgina has had ongoing involvement in the development of emergency medicine, in the Asia-Pacific region. She is currently a visiting EM specialist at the Fiji National University and University of Papua New Guinea, and an honorary professor at the University of Medicine, Yangon in Myanmar. Georgina is the ACEM Country Liaison Representative for the Solomon Islands and Pacific Region, and the co-section editor of the ‘International EM’ section in the Emergency Medicine Australasia journal.

Georgina has held a number of board positions both past and current across ACEM and St Vincent’s. In 2017 she commenced a PhD at Monash University to explore the impact of emergency care capacity development in low resource environments, and since 2018 has lead a regional emergency care project across the Pacific.

Dr Bishan Rajapakse

Bishan is an Emergency Physician who works at the Shellharbour hospital emergency department. He has carried out development work in Sri Lanka between 2006 and 2010, and as part of a PhD program he studied the effectiveness of Train-the-Trainer rural resuscitation program, as a strategy to reduce mortality from self-poisoning. He was also exposed to the early stages of the development of the emergency medicine specialist training program for Sri Lanka during this period. This work was in part accredited as part of his diverse training journey with ACEM. Bishan has a special interest in supporting ACEM trainees in the



involvement of GEC projects that seek sustainable change. He has served on GECCo as Trainee Representative in the past, and is currently serving the committee as a Co-Editor, with Dr Jenny Jaimeson, for the GEC section of the College's quarterly magazine, *Your ED*.

Dr Zafar Smith

Zafar is a Kiwi-born, Papua New Guinea raised, Samoan doctor who works as an emergency physician



in Townsville and Mater Emergency Departments, Australia. He is a senior lecturer with the James Cook University Medical School, with a passion for Indigenous health and international emergency medicine in the Pacific Islands. His Samoan heritage and upbringing in Papua New Guinea inspire him to continually work towards bridging the health inequality gap that exists between Indigenous and non-Indigenous peoples.

Associate Professor David Symmons

David is an Emergency Physician based in Townsville. He previously worked



in a mission hospital in the highlands of PNG from 1994-2002. Since then he has been involved in the development of emergency medicine training in the Pacific region, especially in PNG, Fiji and the Solomon Islands.

David has also for many years been a subject coordinator for James Cook University School of Medicine and Dentistry MB BS subjects in emergency medicine in Yr 3 and Yr 6. David has developed two Masters of Public Health and Tropical Medicine subjects for James Cook University covering Acute Care in a Low Resource Setting.

David has an ongoing interest in medical education and training

Dr Alan Tankel

Alan Tankel has a Scottish science degree, an English medical degree and an Australasian fellowship. He



has lived in Australia for 30 years and has worked in Queensland, Western Australia, Victoria, and New South Wales. He is passionate about developing the specialty of emergency medicine and improving the quality of health care around the world.

Dr Brady Tassicker

Brady is an Emergency Physician based at Northwest Regional Hospital, in Burnie, Tasmania. His international development efforts are predominantly focussed in the Pacific Island nations of Kiribati and Tuvalu. Emergency care is in its infancy in both nations, so the focus has been on doing the core elements well. These contexts have demonstrated the importance of nursing to emergency care, prompting working towards collaborative approaches to nurse education. When in Australia, he is particularly enthusiastic about simulation-based education, and in developing systems to protect against cognitive errors.



Dr Nick Taylor

Nick is a Senior Emergency Specialist and the co-Director of Emergency Medicine Training at the Canberra Hospital. He is the Associate Dean (Teaching and Learning) at the Australian National University Medical School and has a passion for medical education.



He is a joint Country Liaison Representative for Sri Lanka and a member of the ACEM Foundation Committee.

In 2015/16 Nick spent six months based at Teaching Hospital Karapitiya Emergency Treatment Unit in Galle, Sri Lanka where he had the most exciting and rewarding experience

of his career. He was involved in clinical care of patients, education and assisting with the new emergency medicine specialist training program. Since returning he has coordinated and supervised the employment of multiple Sri Lankan registrars in Australia to complete their speciality training, and has ongoing involvement in the teaching and support of Sri Lankan emergency care providers.

He is the creator of Time Critical Medical Education, a free critical care education website and the first online education platform for Sri Lankan critical care.

Karen Eastwood

The Global Emergency Care Desk and GECCo would like to acknowledge the contribution of former GEC Coordinator Karen Eastwood for the pivotal role she played in establishing GEC at the College during her seven year tenure.



Under her stewardship, GECCo launched the Country Liaison Representatives and International Affiliates Programs and established a formal partnership with Fiji National University to support EC development.

It has been a pleasure working with Karen. We thank her for her many years of service and the valuable contribution she has made to the sector.

THE ACEM GLOBAL EMERGENCY CARE DESK

ACEM is making a significant increase in investment in their contribution to the Global Health Sector.

Following the appointment of a Manager of Global Emergency Care, ACEM has established the Global Emergency Care (GEC) Desk as a key focal point for Fellows and trainees interested in learning more about or getting involved in GEC.

The GEC Desk will manage the portfolio of ACEM Supported Projects in GEC and be responsible for establishing partnerships that support locally-led, capacity development of emergency care in low and middle-income countries.

The GEC Desk will become a repository of resources and guidance, for those interested in engaging responsibility in the GEC capacity development and volunteering.

If you would like to learn more about GEC or ACEM's GEC activities and projects please email: gecnetwork@acem.org.au.

Amelia Howard

Amelia Howard is the General Manager of Strategic Partnerships at ACEM. She is a senior manager from a health care and leadership background, with experience within Australia and the UK with a range of organisations within the health care, disability home care and employment and rehabilitation services.

Amelia started her career supporting people to return to work following injury or illness, however developed a passion for leading teams in a range of health-related organisations and programs. Before joining ACEM, Amelia implemented a number of large-scale projects with the National Health Service in the UK, working on a number of change programmes across London.

Amelia is honoured to be working with Fellows of ACEM and partners to support the development of Global Emergency Care.



Sally Reid

Sally Reid is the newly appointed ACEM Global Emergency Care Coordinator, previously having worked in the College's CPD Unit as a CPD Officer.

Sally is an experienced administrator and project manager who has worked across the health, agriculture and community services sectors. Her early career as a scientist and a dietitian has been subsequently combined with working in research; research and development management; administration; advocacy; policy and project management. Sally has worked with a number of 'not-for-profits', community and membership organisations, including Dairy Australia and the National Heart Foundation.

This new role enables Sally to fulfil a long-term goal of working in the Global Health Sector and be involved in the improvement of healthcare and healthcare access in low and middle-income countries.



Sarah Körver

Sarah Körver is the Manager of Global Emergency Care at ACEM. She is a Public Health and International Development professional with more than nine years' experience working closely with governments, development partners and civil society to establish global health programmes, policy and co-ordination of humanitarian response.

Sarah previously worked with the World Health Organisation (WHO) in the Western Pacific and South-East Asia Regions, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and most recently managed the DFAT funded Solomon Islands Graduate Internship Training Supervision and Support Project (SIGISSP) with AVI.

She is looking forward to contributing to the continued growth of College's portfolio of projects in GEC and establishing partnerships that support locally-led capacity development of EC in low and middle-income countries.



Inga Vennell

Inga Vennell is an experienced Editor and Publications Specialist with a demonstrated history of working in the non-profit organization sector. She is the Editor of *Your ED* – the ACEM Magazine, and has a special interest in Global Emergency Care.

She is a strong media and communications professional with a background in Journalism and a Bachelor of Arts (B.A.) focused in Sociology and Literature from Federation University.

She prides herself on giving back to her community, having held a volunteer administrative communication position at the Victorian Homeless Fund (VHF) for over four years.

Inga is looking forward to increasing the readership of *Your ED* and GEC publications, and highlighting the incredible work done by the physicians whose stories she has the privilege of telling.



MAPPING GLOBAL EMERGENCY CARE AT ACEM

This map features ACEM's 2019 portfolio of work in GEC.




ACEM supported activities and projects are a discreet body of work managed by ACEM's GEC desk focused on building capacity in emergency care in LMICs. This work supports locally-led development and adheres to best practice in volunteering for development.

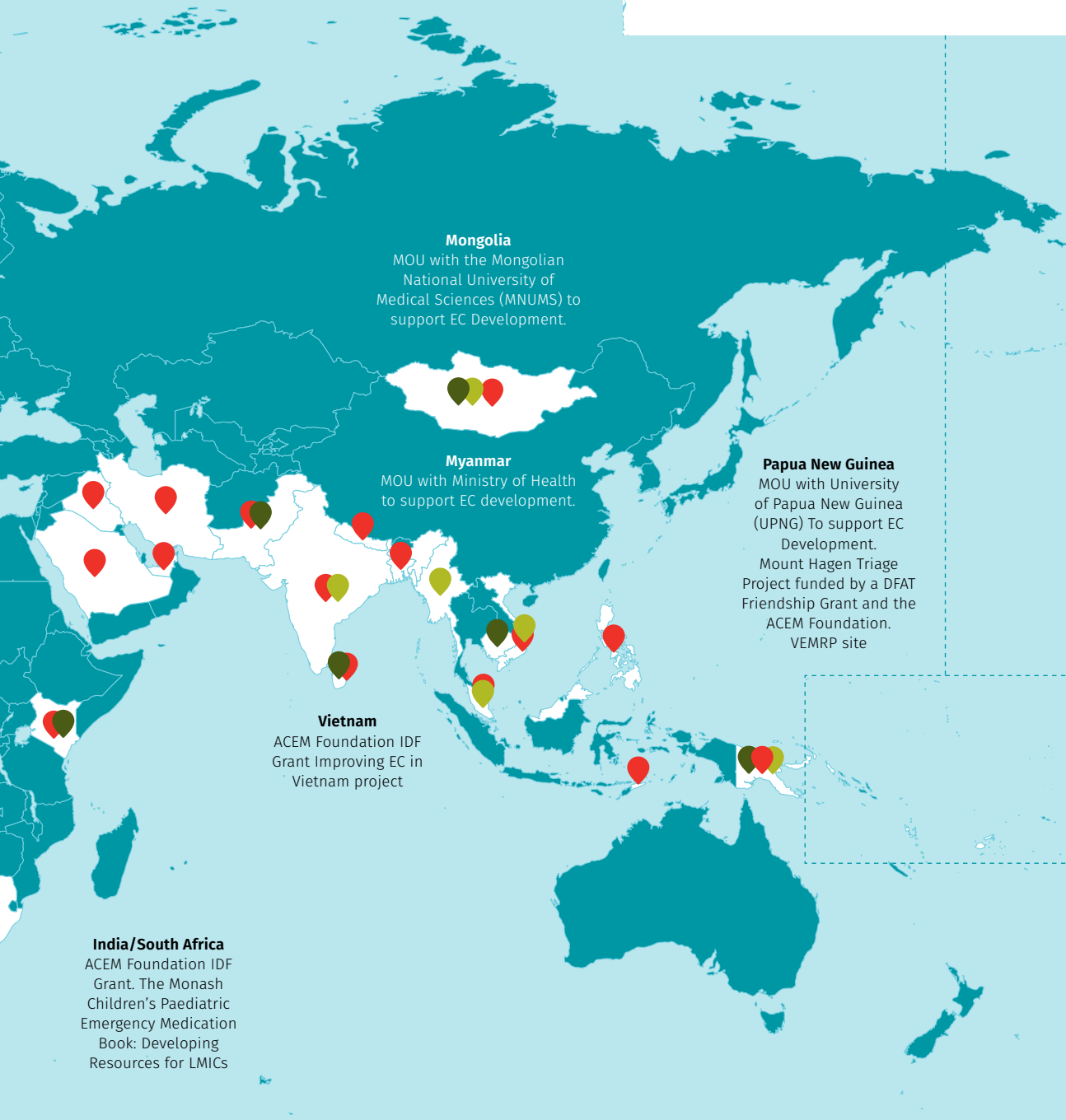
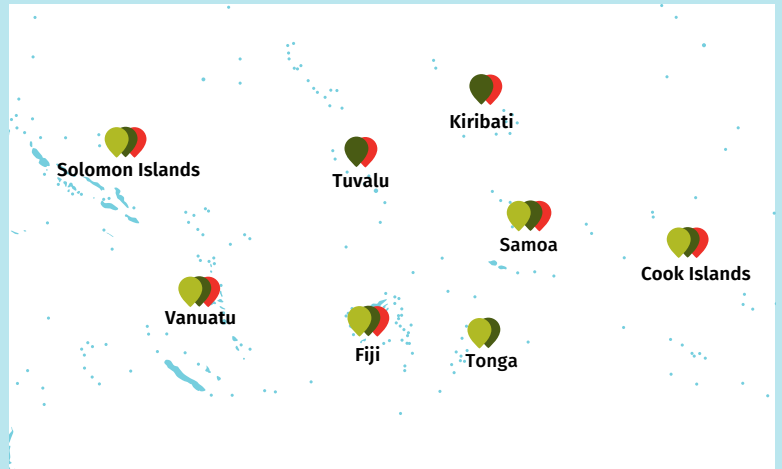
GECCo's 36 country liaison representatives (CLRs) are in 31 locations and act as a point of linkage between local providers of EC and ACEM to facilitate discussions and opportunities to support LMICs countries to deliver safe and effective EC.

Fellows in the field (FIFs)/trainees in the field (TIFs) are individuals supporting GEC activities independently of the College. We link in with our FIFs and TIFs and share information via our GEC Network.

If you are a FIF or TIF and do not see the geographical location of your work reflected on this map please reach out the GEC Desk at GECNetwork@acem.org.au. We would love to hear about your work in GEC.



-  Fellow in the field / trainee in the field (FIF / TIF)
-  County Liaison Representative (CLR)
-  ACEM Supported Project / Activity



Mongolia
MOU with the Mongolian National University of Medical Sciences (MNUMS) to support EC Development.

Myanmar
MOU with Ministry of Health to support EC development.

Vietnam
ACEM Foundation IDF Grant Improving EC in Vietnam project

India/South Africa
ACEM Foundation IDF Grant. The Monash Children's Paediatric Emergency Medication Book: Developing Resources for LMICs

Papua New Guinea
MOU with University of Papua New Guinea (UPNG) To support EC Development.
Mount Hagen Triage Project funded by a DFAT Friendship Grant and the ACEM Foundation.
VEMRP site

Solomon Islands
Solomon Islands Graduate Internship supervision and support project (SIGISSP)
VEMRP Site

Cook Islands
ACEM Certificate Training

Tonga
ACEM Certificate/ Diploma Training

Fiji
MOU with Fiji National University (FNU) to support EC Development

Vanuatu
Visiting Emergency Medicine Registrar Program (VEMRP) Site

Samoa
ACEM Certificate Training

STORIES FROM YOUR ED

The first issue of Your ED, the ACEM Magazine, was released in early 2019 featuring stories from across Australia and New Zealand. It also included a large Global Emergency Care (GEC) section, with contributions from South Sudan, Bangladesh, Vietnam and Papua New Guinea. These stories inspired both FACEMs and trainees, who wrote to the editor expressing how much they enjoyed reading about their fellow physicians' travels and work around the world.

Following its success, Your ED Magazine again featured GEC stories in its second issue, this time coming from Pakistan, Botswana and the Solomon Islands. This range of content has allowed readers to develop a sense of the challenges and rewards that come with working in resource-limited environments.

ACEM SUPPORTED PROJECTS

PAPUA NEW GUINEA

Dr Rob Mitchell wrote about an emergency care strengthening project in the Highlands of Papua New Guinea, interviewing his colleagues, Dr Colin Banks, Dr Scotty Kandelyo and Dr John Junior McKup.

The potholes are a blessing in disguise. They pepper the road between Kagamuga Airport and Mount Hagen town centre, moderating the speed of traffic snaking its way along the Highlands Highway. The drivers of public motor vehicles (PMVs) – minibuses ferrying locals in and out of town – are expert at pothole avoidance. It's an essential skill for motorists in this part of the world.

The potholes – some inconspicuous divots, others vacuous pits – may slow the traffic, but they don't completely mitigate the risk of road trauma. In November, an open truck carrying 26 passengers drove off an embankment 10 kilometres out of town. There were multiple casualties, including several women and children. In the absence of a pre-hospital care system, patients found their way to Mount Hagen Provincial Hospital (MHPH) by whatever means they could – some in other PMVs, many in the trays of utility vehicles incidentally passing the scene.

'It was early in the morning and I saw trauma casualties lying all over the place, some bleeding, some in respiratory distress, with an unknown number still to arrive', says Dr Scotty Kandelyo, Deputy Chief of Emergency Medicine for the Highlands Region of Papua New Guinea.

'It was a mass casualty incident and the day staff had not yet arrived. It was really chaotic. We were overwhelmed and we activated our mass casualty response.'

Scotty was the first emergency physician to be employed at MHPH – the first, in fact, of any public hospital in the lush and remote Highlands region. Having grown up in neighbouring Enga Province, he had a strong desire to return when he completed his specialty training in 2016 through the University of Papua New Guinea.

With Scotty moving on to another role in Port Moresby, Dr John Junior ('JJ') McKup has taken over the mantle as MHPH's lead (and only) emergency physician. JJ may have the figure of rugby player, but he is a softly spoken Highlander who cares deeply about improving healthcare in the region.

'I'm passionate about emergency medicine here, because I am from here', John says. 'I remember when the ED was staffed with the most junior doctors, the misfits and the renegades. There was no system. My people deserve better.'

While most newly graduated emergency physicians elect to stay in Port Moresby, Dr McKup had no hesitation about accepting the challenge of leading MHPH ED: 'It is because here, I can make the most difference.'

A lot has changed at MHPH since Scotty and John's arrival. In 2018, the ED was renovated to improve safety and functionality. The result is a more open department, with four dedicated resuscitation bays and a central fishbowl area. The pastel walls are stark, but they signal a fresh, vibrant ED that is ready to embrace change.

These infrastructure changes have helped facilitate a novel triage and patient flow system, recently implemented with the support of a team from ACEM. The new processes are helping to ensure that all 200 (or so) patients who present to the ED each day receive timely and equitable care.

With these improvements, the signs are very positive for Mount Hagen ED. FACEM Dr Colin Banks, Chair of the ACEM Global Emergency Care Committee (GECCo) and longstanding supporter of EM training and development in Papua New Guinea, is impressed by the progress.

'I first came here in 2009 and there were no staff with emergency training, the department was poorly designed, and the result, not surprisingly, was chaotic. The transition now to a modern design, with trained staff and actual systems, is a huge leap forward', says Colin.

'The future is bright for EM in Papua New Guinea, especially with skilled and capable emergency physicians like Scotty Kandelyo and John McKup leading the way.'

The road ahead may be long, but hopefully the potholes will be few and far between.



Dr Colin Banks, Dr John Junior McKup, Dr Scotty Kandelyo and Dr Rob Mitchell



Dr Donna Mills, Dr Trina Sale, Dr Georgina Phillips and Dr Rose Naesol

THE SOLOMON ISLANDS

Dr Donna Mills, a FACEM who recently returned from a volunteer assignment in the Solomon Islands, wrote of her time exploring this beautiful and vibrant place while making a great contribution to EM.

Welkom lo Hapi Isles. The Solomon Islands is a beautiful archipelago of 1,000 atolls and islands that are home to 700,000 people, who live scattered throughout the nine main provinces from the Shortlands in the west to the remote islands of Temotu in the east. The National Referral Hospital (NRH), in the capital of Honiara, provides care to the 90,000 people living there, as well as providing tertiary-level care for all the provinces. As a developing nation, the Solomon Islands healthcare system and, in particular, the NRH Emergency Department faces many challenges, just one of which is the burden of communicable diseases, such as dengue, malaria and tuberculosis that are seen on a daily basis, where a 'simple' case of epistaxis may actually be dengue.

For the past five months, I have worked alongside Dr Trina Sale (Director) and Dr Patrick Toito'ona (Deputy Director) in the NRH ED as an Emergency Consultant Advisor. My role is part of the Solomon Islands Graduate Intern Supervision and Support Project (SIGISSP), funded by the Australian Government's Aid Program and managed by AVI. Technical support is provided by ACEM.

This project was initially set up at the request of the Solomon Islands Government to assist with the of returning medical graduates. Specific assistance was requested for the NRH ED after a report deemed there no capacity to supervise or train these interns. At the time of review, conducted by ACEM, there were no specialist emergency physicians in the Solomon Islands. Increasing urbanisation and the burden of communicable and non-communicable diseases (NCDs), without the associated development of ED capacity, led to near breaking point for the department. The review identified the following initial priorities: increased leadership capabilities; improved triage procedures; improved patient flow and timeliness of care; and support for training in emergency medicine.

As part of this project, a Solomon Islands Triage Scale was designed and implemented with the assistance of previous SIGISSP volunteers, Dr Rob Mitchell and Lynne Wanafalea.

Working at NRH has been a big learning curve for me. The malaria lab is shut on the weekend. The blood bank is not open overnight. Some doctors travel for hours before and after shifts on public buses or hospital transport to get to and from work. Some of them have no electricity at home.

One case in particular highlighted the significant differences between working in the Solomon Islands and Australia. Just before handover on a Friday afternoon, a taxi pulled up in the ambulance bay. Four young men raced in carrying a sick child. The patient, a five-year-old male, then went into respiratory arrest. Bag-valve-mask (BVM) ventilation was commenced and the patient was then intubated. Collateral history proved difficult as his family and witnesses could not be found. On examination, a large boggy mass was identified behind his left ear with an associated hemotympanum. Pupils were bilaterally dilated and minimally reactive.

There is no CT scanner in Honiara (or the Solomon Islands, for that matter). There is no intensive care unit in the country. Organ donation is not available.

The family explained that the patient had been sleeping in a hammock near people who were playing with a slingshot. He was hit by a stray rock in the back of the head and fell out of the hammock. We taught them how to hand ventilate and advised them that once they had all said their goodbyes, they could stop ventilating their son/brother/cousin. I have since learnt that this 'wantok ventilation' is not uncommon.

The relationships I have built with local colleagues have enriched my personal experiences and, more importantly, allowed me to help work towards goals for local emergency teams. Maintaining relationships with these colleagues has allowed me to see the growth and achievements of the inspiring young doctors and nurses working in the Pacific and that is what keeps me coming back for more!

@ You can read the full stories by Dr Mitchell and Dr Mills at: acem.org.au/Content-Sources/About/Publications/Your-ED.



Photo Dr Hanh Pham

VIETNAM

Dr Hanh Pham, a FACEM working in Brisbane, has led three teams of FACEMs to southern Vietnam over the past three years, with ACEM support and funding.

“An appreciation of karaoke and strong coffee would be an advantage.”

ACEM has supported emergency medicine development in Vietnam through a number of initiatives in recent years. A Vietnamese medical practitioner from Saigon [Ho Chi Minh City] received ACEM sponsorship to attend a EM conference in Melbourne in 2013 and participated in a supervised exchange program at Royal Brisbane and Women’s Hospital in 2016.

Dr Pham’s first visit in 2016 was to Cho Ray Hospital, associated with Ho Chi Minh University Medical School. Cho Ray Hospital is the major referral hospital for 37 southern provinces, including Ho Chi Minh City, and serves a total population of 40 million. Dr Pham met with senior emergency medicine and intensive care unit (ICU) staff and developed a course introducing the principles of basic emergency care. The first course comprised two parts: 2.5 days for multiple medical emergencies, including some public health issues; and 1.5 days for basic trauma care

with hands-on workshop interactions. Approximately 60 enthusiastic doctors from several hospitals around Saigon attended.

The success of this visit led to another visit in 2017 of eight FACEMs to Cho Ray Hospital and a large hospital further south in the Mekong Delta area, Can Tho. The courses were repeated in 2018 at both sites, with 45 candidates attending the two-day basic course in Can Tho and over 100 candidates in Cho Ray for the one-day advanced course and 40 for the workshops.

All participants gave positive feedback and were highly motivated for more courses and further emergency medicine-related opportunities. Dr Pham successfully applied for an International Development Fund Grant with the IEMC in 2017 and uses the funds to continue these significant initiatives.

@ You can read more about Dr Pham’s initiatives at: acem.org.au/Content-Sources/About/Publications



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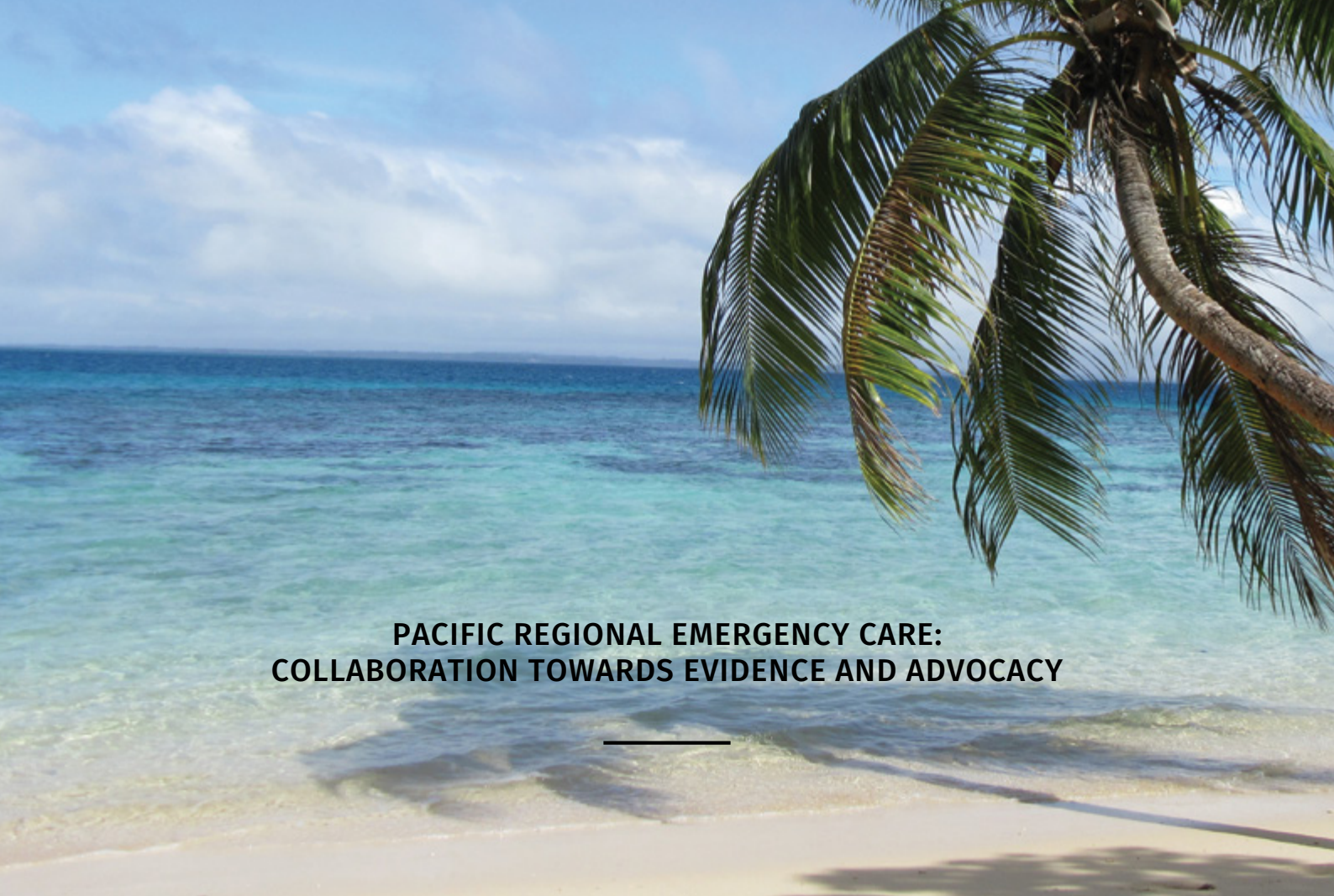


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PACIFIC REGIONAL EMERGENCY CARE: COLLABORATION TOWARDS EVIDENCE AND ADVOCACY

Why should Pacific Island Countries (PICs) pay attention to emergency care (EC)? Of all the critical health issues facing the peoples of the Pacific, notwithstanding the existential threat of climate change, what point is there for PIC governments to think about the EC needs of their populations, or divert resources to building up EC systems? Even more; why should donors to the region prioritise EC above aid programs to combat non-communicable disease, malaria and other infectious diseases, maternal and child mortality or mental illness? Isn't EC a 'luxury item'; a component of health care that might be affordable in affluent countries, but not essential to the developing countries of the Pacific?

These are commonly faced questions to any EC clinician or advocate in the Pacific region. Although some countries, such as Papua New Guinea (PNG) and Fiji have become centres of training and are building the speciality of emergency medicine, many PICs may have one or two trained EC leaders who are expected to provide EC on a daily basis and improve EC systems across their whole country. Some PICs have no one with EC training and therefore struggle to provide a high level of EC or incorporate EC in to their overall health care system.

Many PIC leaders do not understand what EC is, and cannot appreciate how safe and effective EC can address all acute health care needs across the spectrum of illness and injury and through the life course of their people. The majority of donors and global health practitioners understand EC only within the lens of disasters and outbreaks, and the short-term but high-expense visiting

Emergency Medical Teams and other surge response requirements to assist PICs in times of stress. Few health leaders make the link between disaster resilience and routine EC, and even fewer can see how improving EC can contribute to achieving the Sustainable Development Goal (SDG) health targets.

In this light, the recent collaboration between the Pacific Community (SPC: <https://www.spc.int/>), regional EC leaders, Monash University researchers and the Australasian College for Emergency Medicine (ACEM) is both timely and critically important. Through an extensive, multi-phase consensus process, over 200 PIC EC stakeholders provided evidence about the status of EC in their countries and came to a consensus agreement about the priorities and standards for EC development across the Pacific region. Seventeen different PICs were represented; American Samoa, Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Niue, Palau, PNG, Samoa, Solomon Islands, Timor-Leste, Tokelau, Tonga, Tuvalu and Vanuatu. Initiated by the Pacific Community, the project outcomes now provide baseline indicators of EC across the region, and a roadmap for EC development going forwards.

The advocacy infographics are a key outcome of the consensus project, and ACEM has played a huge role in producing these eye-catching documents. Using the colours and designs approved by the Pacific Community, the infographics explain what EC is and why it is important for the health of Pacific peoples. The link between increasingly common disasters and outbreaks in the Pacific and the development of robust pre-hospital and facility-

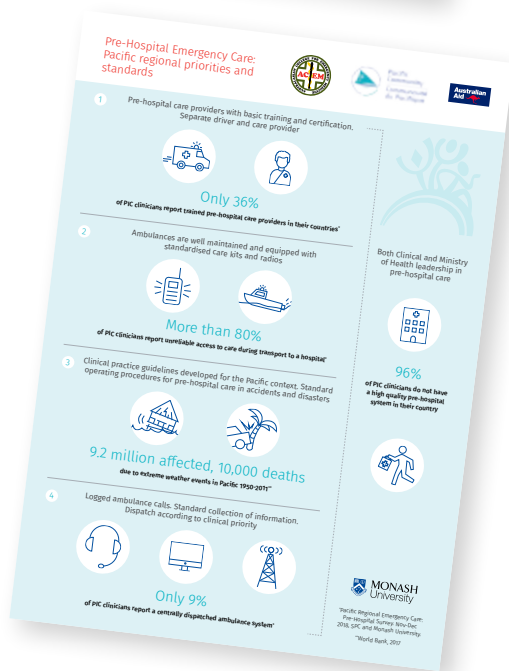
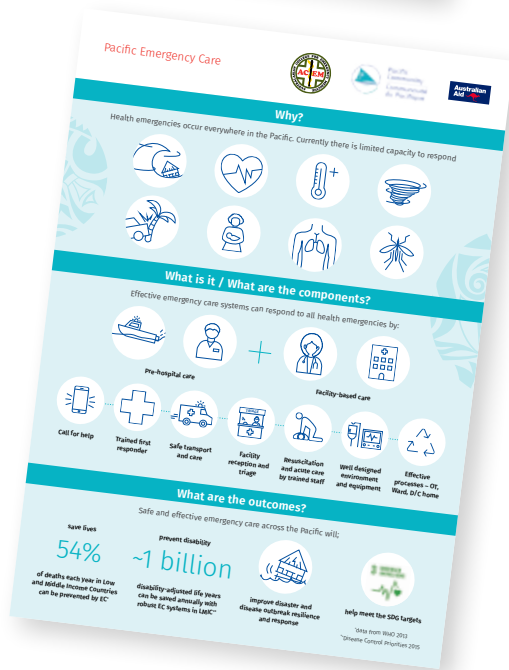
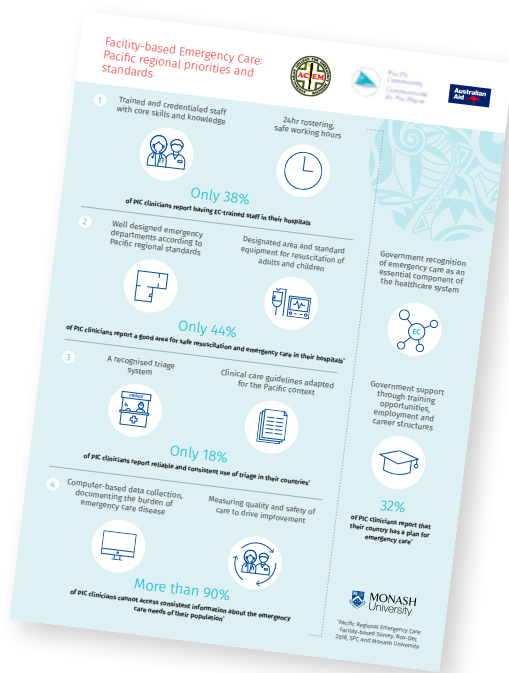


Photo Dr Georgina Phillips

based EC systems is made explicit, and the implications for saving lives, preventing disability and meeting the SDG targets explained. For global consistency, the World Health Organisation EC and Health System tools have been used to provide a clear framework that explains the components of EC. Research data collected through the collaborative process provides compelling evidence about the gaps and consensus standards for pre-hospital and facility-based EC and is matched with each EC system building block; human resources and training, infrastructure and equipment, processes, data and leadership / governance.

This ground-breaking work has reached the penultimate level of health governance and decision-making for the Pacific region. The full report and advocacy infographics were presented to the Permanent Secretaries of Health across 22 PICs at their regional meeting in April 2019. The Pacific regional consensus priorities and standards for EC now sit for consideration and regional endorsement by PIC health leaders; indeed, some individual PICs are already using this roadmap for EC developments at their own national level. These tools now belong to all PIC EC stakeholders, including their colleagues and partners at ACEM, to be used for the advocacy and development of EC across the region. Please feel free to share them widely!

(For more information about the Pacific Regional Emergency Care project, contact Georgina Phillips at Georgina.Phillips@monash.edu)



ACROSS THE GLOBE

The following stories have been submitted by Fellows in the field and trainees in the field – Now affectionately known to us as FIFs & TIFs.

Unlike ACEM Supported projects, these opportunities have been independently sourced. It is exciting to share these impactful stories of Global Emergency Care from our FIFs and TIFs working globally.



SOUTH SUDAN AND BANGLADESH

Dr Evan O'Neill wrote of his time in South Sudan and Bangladesh, working with Médecins Sans Frontières (MSF) in 2017.

I had long aspired to work for MSF, admiring their fierce independence as a leading provider of humanitarian medical aid. They asked if I would work in South Sudan in a place I'd not heard of before – Old Fangak.

Old Fangak has become a population centre for Nuer people displaced by the dangers of civil war. The reasons for its relative security, isolated from roads and surrounded by swampy wetlands, were the same reasons that the local population suffered a multitude of health threats. We would intermittently receive an influx of war wounded, but day-to-day the most common afflictions reflected the conditions, namely malnutrition and infectious diseases. We worked between tents and fixed structures, providing basic emergency, paediatric, maternal and medical care. Though technology was limited, we never wanted for basic supplies such as essential medicines. The profound effect that attention to detail, close monitoring and delivery of simple and relatively cheap interventions could have for the gravely ill children who presented, was a daily inspiration.

Come August 2017, the Rohingya crisis was evolving rapidly as scores of refugees fled ethnic cleansing in Myanmar, into the neighbouring Cox's Bazar Peninsular in Bangladesh. I was offered a role as Medical Activity Manager within a hastily organised team from MSF Barcelona. The humanitarian crisis was escalating daily on a massive scale and required endless late nights, bumpy travels and treks into dense and desperate camps. We would visit camps and provide treatment with what medicines we could procure under bamboo and tarpaulin. These visits allowed us insight into where the greatest needs were as we planned to construct more definitive clinics, along with structures that would enable inpatient care.

The conditions the Rohingya endured brought malnutrition, pneumonia, watery diarrhoea, skin infections and sinister vaccine-preventable infectious disease outbreaks to our clinics. Side by side with the enthusiastic work of local Bangladeshi doctors we did all that we could every day.

@ You can read more of Dr O'Neill's story at:
acem.org.au/Content-Sources/About/Publications



Photo Dr Evan O'Neill, Bangladesh

RURAL PAKISTAN

Dr Farida Khawaja is committed to supporting the growth of EM in Pakistan and finding adaptive solutions for resource-poor contexts.

At a rural hospital in Pakistan, a mother keeps vigil next to her sick daughter. Quietly, she swats away flies. Near her, 100 other children and their mothers share the same circumstance. Among them, six nurses struggle to impart care at the 20-bed paediatric emergency department.

In some parts of rural Pakistan, children under the age of five are not named.

United Nations Human Development Indicators show 78.8 out of 1,000 children born in Pakistan will die a preventable death by age five. Australia suffers 3.7 such deaths per 1,000 births, and New Zealand 5.4. As is the case in many low-income countries, access to reliable emergency care in Pakistan is scarce, contributing to increased morbidity and mortality. In impoverished areas, life-saving interventions are significantly delayed by a lack of first responders, and by the lack of structured emergency care in many of the country's regional and remote areas.

Over the past 15 years significant local and international effort has gone into developing emergency medicine in Pakistan. The aim is to garner support from all sectors of healthcare; public, private, not-for-profit and military. Tireless work by emergency physicians, surgeons and general practitioners to raise awareness of structured

emergency care has raised hopes for the delivery of critical healthcare in Pakistan. One of the groups working towards greater care is the Pakistan Society of Emergency Medicine (PSEM), founded as a platform to discuss current and future challenges of emergency medicine, and to deliver messages on the importance and value of emergency medical care.

In 2018 PSEM played a significant role in the local launch of Emergency Life Support International (ELSi), a not-for-profit two-day course designed in Australia to assess and stabilise common emergency medicine presentations. The Society had identified a need for a basic non-trauma course in Pakistan that would impart a standardised approach to non-trauma conditions such as shock, sepsis, neonatal resuscitation, ischaemic heart disease, diabetes, seizure and poisoning.

Since 2018, four courses have been held locally – run jointly by a group of self-funded FACEMs and local trainee facilitators. The courses have been conducted at major hospitals in Lahore and Islamabad, as well as at district hubs, where the training was given full support by local authorities.

@ Read more about the work of Dr Khawaja at:
acem.org.au/Content-Sources/About/Publications



Creating a world where all people, in all countries, have access to high quality emergency medical care

The World Health Organisation estimates that nearly half of deaths and over a third of disability in low and middle income countries could be addressed by the implementation of effective emergency care. Many countries still have no, or very basic, first line pre-hospital and in hospital emergency care. This means that people suffer devastating impacts from road traffic accidents, workplace injury, infectious illness, heart attacks, stroke and other common problems – things that would be quickly treated in Australia and New Zealand. As a result, people, often children or young adults in the prime of life, die or are debilitated, and not able to work and live a fulfilling and productive life. This also threatens the economic future of an individual, their family, and their community.

The International Federation for Emergency Medicine (IFEM) is dedicated to changing this through leading the development of the highest quality of emergency medical care for all people, in all countries. A predominantly volunteer run organisation, IFEM is made up of emergency medicine professional organisations from 66 countries, from all regions around the world. IFEM comprises of a network of emergency medicine specialist doctors who deliver emergency care in their own countries, and collaborate to improve emergency care across the world through:

- Fostering relationships and knowledge sharing between global emergency care experts and local healthcare providers to fast track better emergency care.
- Advocating with governments and key influencers.
- Through our members, developing and making freely available locally relevant education and standards in multiple languages.
- Rapidly harnessing and sharing clinical and health systems expertise.
- Leading the collaboration and networking among experts and those developing emergency care to support equality in service and care.
- Promoting the creation and growth of the specialty of emergency medicine.

IFEM was founded in 1991, with ACEM being a founding member. The College has maintained strong ties with IFEM, providing support through hosting its secretariat and through Fellows' commitment to the work of IFEM in advancing emergency medicine internationally. Currently, the following FACEMs are members of the IFEM Leadership Group:

Associate Professor Sally McCarthy, Board Member President-elect
Dr Anthony Cross, Board Member Treasurer and Chair Finance Committee
Professor Anthony Lawler, Board Member Regional Representative Australasia
Dr James Kwan, Chair Core Curriculum and Education Committee
Associate Professor Jonathan Knott, Chair Research Committee
Professor Melinda Truesdale, Chair Quality and Safety Special Interest Group
Associate Professor Anthony Joseph, Chair Trauma Special Interest Group

Many more ACEM members contribute through committees, working groups, taskforces or networking at IFEM conferences and other events.

As a federation of grassroots emergency medicine organisations from countries and regions with mature and highly developed emergency care systems, and systems in various stages of development or just starting out, IFEM has unique insight and reach into health systems globally. Members are experts in all facets of emergency care, delivered in all environments, to all ages and types of patients. This enables IFEM to rapidly harness expertise and draw global teams together to work on a project, or any emergency care challenge.

The positive impact IFEM has on people's lives across the globe is only possible because of our members and volunteers who donate their time, expertise, and resources. If you would like to get involved and play a critical role in advancing global emergency medical care then we encourage you to get in touch. Your financial support will also play a critical role in scaling up the work IFEM does.

BOTSWANA

Dr Kago Mokute is an emergency physician working at Princess Marina Hospital in Gaborone, Botswana.

Botswana has a population of just over two million people, smaller than many cities. The capital, Gaborone, has a few hundred thousand people. The country has 30 hospitals, with 28 public and two private hospitals (a third opening soon). Two public referral hospitals (one yet to be opened) and all three private hospitals are in Gaborone. There are only four emergency physicians in Botswana, all of whom are based in Gaborone; two in private practice and two in public hospitals. I am an employee of the University of Botswana at the country's main referral hospital, Princess Marina Hospital, in Gaborone.

We run a joint specialty program with the University of Cape Town, South Africa, in order to meet the huge need for emergency physicians in Botswana. Our registrars spend half of their four-year training program in Botswana, completing the examination of the South African College of Emergency Medicine and their Master of Medicine dissertation.

Recently, at Princess Marina Hospital overcrowding has become a significant problem and has led to some patients waiting more than 24 hours to be seen. Patient flow factors are mainly related to an acute shortage of doctors. Triage is run using a modified version of the South African triage scale.

The biggest day-to-day challenges facing an emergency doctor in Botswana are mostly management-related, the main test is managing a department that I have little control over. The management of public hospitals in Botswana is centralised and doctors on the ground do not have much say around how the hospitals are run. Most of the essential resources are under the control of the central government, be it staff, equipment or medications. In my experience, resources provided are not always reflective of needs and shortages.

If I could advocate for one change in emergency medicine in Botswana, I would aim to decentralise healthcare management and allow EDs more control over their resources.

@ Read more of Dr Mokute's story at:
acem.org.au/Content-Sources/About/Publications

URBAN PAKISTAN

Dr Rizwan Qureshi and Dr Faryal Waqar Dr Qureshi wrote about their experiences delivering emergency training in Urban Pakistan.

On a hot and humid afternoon in Karachi, an unconscious young man was rushed to the ED of a local hospital by a panicking mob of relatives. He had fallen from a ladder after being electrocuted. The senior medical officer on duty rushed to assess the patient.

Much to the dismay of the crowd, he pulled a piece of cotton from his pocket, tapered it between his fingers and gently touched the corners of his patient's eyes, and then turned and gave them the news of his demise. The crowd burst into tears followed by screams of despair. This was a common scenario 15 years ago in Karachi.

Unfortunately, even today the country faces similar challenges in managing time-critical resuscitations across public and private hospitals. The approach for dealing with this type of presentation was, and often still is, unfamiliar to many Pakistani clinicians practising emergency medicine.

FACEMs Dr Rizwan Qureshi and Dr Faryal Waqar are originally from Karachi and Lahore, respectively, two of Pakistan's most densely populated cities. Both cities, Karachi (16 million people) and Lahore (nine million people), have extremely high incidents of trauma, cardiac and paediatric emergency presentations. Pakistan is a country with a population of over 200 million people, with nearly 40 per cent living in cities and towns.

Most cities have limited access to a centralised ambulance service and very few have properly equipped EDs. A typical urban ED manages 600 to 800 presentations a day, a few hundred of these patients travelling more than 100km from extremely poor rural areas to access care. Recognising these limitations, both Rizwan and Faryal wanted to return to Pakistan and help in whatever way they could.

Joined by a team of eight other enthusiastic emergency physicians of Pakistani origin, from both Australia and the United Kingdom, they delivered two- and three-day courses focused on the principles of trauma resuscitation, adult and paediatric resuscitation, ultrasound and communication.

@ Read more about their journey at:
acem.org.au/Content-Sources/About/Publications

WHY GLOBAL EMERGENCY CARE?

'Perhaps the best teacher of 'humanity' in health care.'

Dr Bishan Rajapakse

In life one of my most loved pursuits is travel. I have found that travel itself has been the greatest teacher in life, and I love to learn.

Some of the things that most drew me to Emergency Medicine as a career was the adventure and action that was experienced on the floor, but also the diversity of cultures I was involved with both in patients and staff, as well as the chance to help where and when it counted, and of course to have fun doing so.

For me doing Global Emergency Care (GEC) work was the ultimate mix to combine these passions. Working as a final year medical student on elective in a busy resource limited NYC county hospital ED affiliated with Mt Sinai Medical school, and later at the trauma surgical unit of Colombo National Hospital in Sri Lanka, I learned at an early stage what GEC work had to offer; the chance to travel, contribute and simultaneously gain valuable experience in the practice

of medicine at humanitarian level. These experiences were unpredictably challenging yet simultaneously rewarding.

Fast forward many years later I found myself working within a research collaboration as an ACEM advanced training registrar conducting research aiming to reduce mortality from self-poisoning. I collaborated with local partners to design and test resuscitation training program for resource limited rural doctors using a "Train-the-trainer" system education.

The skills I learned within clinical medicine, research, leadership, and humanity were unparalleled to anything I had experienced before, and the experience has offered me much in my career as an emergency physician working in Australasia. My GEC experience was an opportunity that I cherish and will always be grateful for, and I hope to pay it forward by helping the next generation of medicals student, registrars and consultants to cultivate similar experiences by engaging in the important space of global emergency care.



The ACEM Foundation supports emergency medicine in three key areas through sponsorship, grants, awards and scholarships.

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RETURNING FROM GLOBAL EMERGENCY CARE

Dr Gerard O'Reilly

Before I headed for my first GEC work, with MSF in north -Afghanistan in 1997, my thoughts were concentrated on what my challenges would be.

Mostly, I was determined to bring a toolkit brimming with clinical skills to the setting, and an enthusiasm to impart these. Surely that's what was required of me?

Well, aside from the rapid realisation that my clinical toolkit was in the lower end of the top ten needs whilst in the field (that's a whole other story)...there was an unexpected array of experiences, challenges and emotions that I waded through, over some time, on my return.

The involuntary thoughts and questions circling repeatedly until they dampened included the following:

'They don't / wouldn't / won't understand', referring to MSF people debriefing me in Brussels, then family, friends, colleagues at home...

'What's the point?' of my day job, describing my experiences, being frivolous, having fun.

'You don't realise how good you've got it'. In other words, why is everyone complaining?

'When can I stop talking about my mission and just do another one?'

'Why does travel feel empty without the purpose?'

'Honestly, I know there were bombs and stuff, but I felt very safe!' Meaning, why can't you understand that?

'How do I weave / integrate these experiences into my life?' When it comes to work, marriage, family etc.

Subsequent forays into GEC had progressively softer landings... it pays to stay grounded. Having a home base enhances one's effectiveness and well-being in the field.

Dr Jenny Jamieson

'Oh hey! I haven't seen you in a while - have you been away?'

The fallout after returning home from global health work can be shattering. After returning from working with MSF in Afghanistan, there were many strange corridor conversations with colleagues.

'That sounds like a bit of fun. By the way, you've heard there's a 10-minute delay on all high-sensitivity troponins this morning?'

Inexperienced and unaccustomed, I wondered how to convey the horrors of working in conflict zones with so few resources. I wondered how to broach the notion that despite the austere and unstable environment, it was one of the most rewarding roles I'd taken on.

As a junior registrar in a large tertiary hospital, it was business as usual when I returned to clinical work. Yet, it was impossible to ignore the vast wealth of resources surrounding me and the relative indifference to such privilege.

Many of us returning from global emergency work can predict that this will be an enormous time of transition. As such, it can be useful to surround yourself with people who are genuinely interested in hearing more about your experiences.

Getting involved in further study or involved in global health work back home can feel like embarking on a methadone program compared to field work; however, the long-term benefits can be immensely useful for the future.

Dr Megan Cox

Working internationally for over 20 years means many transitions back to Australia.

My first transition occurred just before starting EM registrar training, and I quickly resumed work in an Australian regional ED. Memories from the developing country setting of gloves being washed and recycled, cardboard splints, drink bottles cut into spacers, revealed some of our surpluses to me. Being young and new to health systems, this experience positively impacted my decision making, resourcefulness and adaptability.

As a brand-new EM Physician, I volunteered with an NGO for six months and the transition back was harsh. I was locuming at the time and was advised to have a month off once I returned. This wise advice assisted, but everything in Australia -culturally, personally and medically seemed so excessive and reverse culture shock hit hard. I'd experienced war's impact on a health system, and it had completely changed me. I bored friends for months lecturing them on Australian entitlement; enrolled in a Masters of International Health and looked for further opportunities to work internationally.

Fast forward 15 years and I have transitioned back again after six years living and working in a developing country, implementing EM into their health system. My generous Australian EM colleagues mentored me back through my first nervous clinical shifts back home and I can have gentler conversations about how I've seen things change. My international EM experiences now allow me to mentor and teach interested health professionals wanting to work internationally. I still recommend people work Internationally but always with effective education, mentoring and reflection at every stage.



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