

IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM



Volume 8 | Issue 1 | August 2012

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Editorial

2012 has seen a lot of FACEM activity and EM development in Asia, the South Pacific and in Africa. As the IEMSIG expands ACEM has dedicated ongoing administrative support to help grow International EM development into the future.

Myanmar

The historical agreement between the Myanmar Ministry of Health, ACEM, IFEM and RACS, along with EM, surgery and anaesthesia specialists from Hong Kong, to establish EM as a specialty was formalised in March 2012. It was followed by the Myanmar Emergency Medicine Introductory Course (MEMIC) in June. There is a review of the Myanmar project in this edition.

This 3 phase project will be ongoing over the next 5 years and a Myanmar EM Interest Group (MEMIG) has been created. If you are interested in assisting in this project or you would like further information you are welcome to submit expressions of interest to IEMSIG@acem.org.au.

Fiji and the South Pacific

There has been quite a lot of activity in the South Pacific and EM development in this region is moving forward. Georgina Phillips along with other FACEMs attended a recent 'Strengthening Specialised Clinical Services in the Pacific' (SSCSiP) in Fiji. Georgina's report is included in this edition.

EM as a specialty continues to be developed and supported in PNG and the Solomon Islands.

As part of ongoing support for Pacific Island EM development the IEMSIG has created the Pacific Islands EM Interest Group (PIEMIG) and is calling for expressions of interest from trainees and fellows wanting to assist. Please submit your expressions of interest to IEMSIG@acem.org.au.

In Timor Leste, Botswana and Tanzania, EM development is supported by FACEMs living in-country. In Sri Lanka, support of EM development in Galle continues, and Emergency Life Care courses are being introduced.

The IEMSIG Newsletter has been accessed by the first EM trainees in Myanmar and in Nepal. This is a great step forward in spreading the word of EM developments. FACEM initiatives and experiences are now shared worldwide.

Changes to the IEMSIG Administrator

Sarah Smith joins the IEMSIG as Administrator and has already begun collating current FACEM activities around the world and developing the IEMSIG administrative processes to support growth and development of the IEMSIG in the years to come. As well as general administrative support, Sarah is responsible for assisting with collating and editing the IEMSIG Newsletter as Assistant Editor along with Chris Curry who will continue in the role as Editor. Chris and Sarah would like to invite trainees and fellows to submit articles on International EM developments and experiences abroad for future IEMSIG Newsletter issues.

Sarah is keen to support ACEM trainees and fellows in their training and development of International Emergency Medicine and is available every Wednesday to answer your questions. Please email Sarah at IEMSIG@acem.org.au.

Accredited Training Time

Opportunities exist for trainees to receive accredited training time overseas in Madang, PNG, in Gaborone, Botswana and through MSF. If you are interested in developing your EM experience overseas and are looking for something unique please contact Sarah at IEMSIG@acem.org.au for further information.

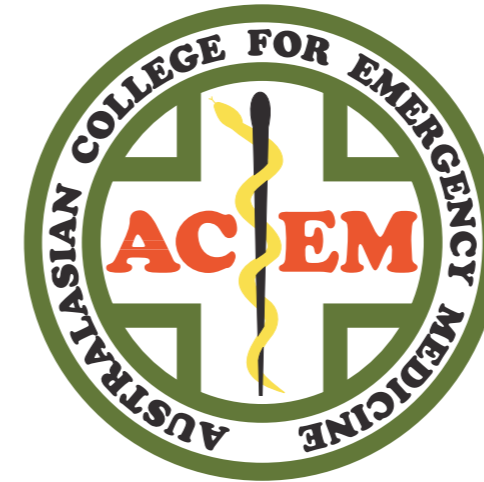
National Archives

IEMSIG is pleased to announce that the IEMSIG Newsletter is now available through the National Archives at the National Library of Australia.

By Sarah Smith and Chris Curry

ACEM NEWS

Notice of the recipients of the inaugural (2011) ACEM International Development Fund (IDF) grants



Notice of the recipients of the inaugural (2011) ACEM International Development Fund (IDF) grants

The 2011 IDF Grant IDF has been awarded to:

Setthy Ung – Primary Trauma Care (PTC) in Cambodia, and

Georgina Phillips – ED nurse training in PNG

The IEMSIG would like to congratulate Setthy and Georgina and look forward to receiving an update on their progress.

UPCOMING EVENTS

2012 International Emergency Care Symposium 21st September 2012 – The Alfred Hospital Melbourne

Join experts, both international and Australian presenting key themes of IEC and sharing in a wealth of experience.

Key topics will include:

- The state of emergency care in the various corners of the globe
- Lessons from emergency care capacity and specialty development
- The role of Australia and New Zealand in regional emergency care development
- Global emergency trauma care: lessons learnt
- Emergency public health: the refugee camp
- International disaster response: the role of the emergency care provider
- IEC: Writing a funding proposal
- IEC: Opportunities for emergency trainees
- Research in IEC

See the IEMSIG notice board on the college website for further details: http://www.acem.org.au/media/docs/Alfred_IEC_Symposium_Sep_2012.pdf

African Conference on Emergency Medicine 30 October to 1 November 2012 – Ghana

The African Federation in Emergency Medicine proudly presents the first African Conference on Emergency Medicine to be held at the Accra International Convention Centre in Ghana.

For more information visit: www.afcem2012.com

IEMSIG Annual General Meeting

19 November 2012 – Hobart

Once again the IEMSIG will be hosting a number of international delegates from around the globe at ACEMs Annual Scientific Meeting in November 2012. IEMSIG members are invited to attend.

Papua New Guinea

Report from PNG – Madang and Port Moresby, May 2012

Georgina Phillips
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Background

EM has been developing in PNG for ten years with the assistance and support of a large number of FACEMs and leadership of local EM clinicians. There are now four PNG emergency physicians (MMedEM) based in Port Moresby, one in Madang and one shortly to be stationed in Mt Hagen. FACEMs recently have assisted with short courses, peer support and MMedEM trainee exam and research preparation. Their visits have received some financial support through the HECS program (Health Education and Clinical Services program of AusAID)

Divine Word University trains HEOs with a 4 year Rural Health Bachelor Degree. Clinical teaching in the key disciplines occurs at Modilon Hospital in Madang, where the local emergency physician provides significant leadership and support. A Visiting Clinical Lecturer Program (VCLP) commenced in 2010 involving volunteer FACEMs and senior Australasian EM registrars visiting DWU to teach HEOs, ED residents and registrars and build capacity for emergency care at the Modilon Hospital.

Aims

The aims of this 3 week visit to PNG were to:

In Madang

- Visit DWU and meet with University and Health Faculty leaders in order to receive feedback and review the VCLP, as well as explore ongoing opportunities for capacity-building in emergency care
- Meet and provide support for the current visiting EM registrar (Dr Becky Box) who is volunteering for 3 months and therefore having her time in

Madang accredited towards her ACEM fellowship training

- Provide peer and professional support to Dr Vincent Atua (MMedEM), Director of the ED at Modilon Hospital and local supervisor to Dr Box
- Provide ongoing teaching, training and emergency care capacity building for HEO students and ED clinicians, in particular the EM registrars, at Modilon Hospital

In Port Moresby

- Visit the Port Moresby General Hospital (PMGH) ED, review clinical functioning and in particular, review the new (un-opened) ED and review progress and design issues
- Provide peer and professional support to the MMedEM leaders; Drs Sam Yockopua (Chief EM Officer, NDOH), Sonny Kibob (Coordinator ED, PMGH), Desmond Aisi, Taita Kila and Julius Plinduo (soon to be based in Mt Hagen)
- Provide ongoing teaching and capacity building support for ED clinicians, EM residents and registrars based in the ED at PMGH
- Provide focussed exam preparation and research assistance, as needed, for senior MMedEM trainees: Drs John Tsiperou (final year) and Alex Peawi (research year)
- Meet and support MMedEM trainees at various stages of training
- Meet with HECS and UPNG SM&HS (School of Medicine and Health Sciences) leaders to discuss the status of EM in PNG, as well as health training at DWU and other areas of potential liaison and support (including emergency nurse capacity building).

Comments

EM in PNG is progressing well, with increasing numbers of MMedEM emergency physicians and a large cohort of bright, enthusiastic trainees. Imminent changes such as the move to the new ED at PMGH and having an emergency physician stationed at Mt Hagen to lead emergency care improvements in the Highlands will trigger another phase of development. FACEM support with senior professional development, exam and research preparation and ED teaching provides critical assistance, and ongoing regular FACEM visits will be important. Having the first MMedEM final exam candidates from Solomon Islands in 2012 provides additional reason for FACEMs to visit and prepare candidates through the second half of the year.

Clinical practice in EM in the ED at PMGH is hampered by the current absence of an ultrasound machine, despite two machines having been previously donated specifically to the ED (one from the St. Vincent's Pacific Health Fund). Both ultrasound machines are kept for use in the PMGH Radiology Department. Bedside ultrasound can diagnose life

threatening haemorrhage in minutes compared to the hours of delay usually incurred through organising a formal ultrasound in a remote department. It would be useful for the ED to regain one of its ultrasound machines as soon as possible.

ED nursing capacity building needs to occur alongside the growth in EM. Educational exchange visits between PMGH and SVHM ED nurses to coincide with the move to the new ED is planned. Critical tasks such as triage will need specific attention.

In Madang, clinical and emergency skills and knowledge teaching for HEOs will require ongoing support due to limited local capacity at DWU. The ED at Modilon Hospital is currently in a position of strength through the leadership of Dr Atua and presence of enthusiastic ED registrars and residents and committed ED nurses. Visiting and ED registrars provide valuable assistance to both the University and Modilon Hospital, and enhanced support through the VCLP will be important.

Thanks to the PNG EM community, DWU leadership and staff and UPNG SMHS and HECS staff for their very warm welcome and ongoing friendship.



Snakebite Research in PNG

Simon Jensen
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(Simon is medical director of the Charles Campbell Toxinology Centre, School of Medicine and Health Sciences (SMHS) at the University of PNG (UPNG) and of the Australian Venom Research Unit (AVRU)-UPNG Snakebite Research Project.)

Snakebite with envenomation is a significant medical problem worldwide, leading to many deaths, perhaps as many as 125,000 per year, with several times that number maimed by the results of the bite and/or subsequent surgery, necessary or not. Initial management of this injury is the responsibility of medical and nursing staff working in emergency departments, though in many countries snakebite is considered a surgical problem.

It is only relatively recently that “snakebite” was officially recognised by the World Health Organisation (WHO) as a Neglected Tropical Disease (NTD) (http://www.who.int/neglected_diseases/diseases/snakebites/en/index.html). The exact number of victims, worldwide, is elusive because snakebite is not a reportable injury in the vast majority of countries.

Thanks to the efforts and enthusiasm of a small team of dedicated people, led by Australian herpetologist, David Williams, the current Snakebite Research Project (SRP), a collaboration between the Australian Venom Research Unit (AVRU) of the University of Melbourne (UoM) and the School of Medicine & Health Sciences (SMHS) at the University of Papua New Guinea (UPNG) commenced in 2000. The project has many facets, including studies of snake systematics, venom composition, first aid training projects, clinical research into optimal management and collecting patient data from hospitals and health centres throughout most of Papua New Guinea to build a better epidemiological profile. The data collected so far indicates that, despite the purchase of Australian Commonwealth Serum Laboratory (CSL) snake antivenoms by the PNG government, there are probably at least 200 deaths per year following an estimated 3500 snakebites per year.

David and I jointly developed a comprehensive Snakebite Management Course in 2004, and we have run this course, in several forms in several centres in PNG since then, as one attempt to improve the mortality figures. While courses were run during the first few years with the assistance of lecturers from the UK and Australia, a small but increasing number of PNG national doctors and scientists have been involved in delivering the course, as well as being involved in associated research. In 2008 our efforts attracted the attention of the WHO Regional Office for the Western Pacific, and we were invited to assist the Cambodian Ministry of Health in assessing the extent of snakebite problems there and devising a strategy to address the issues. In 2009 we taught the first Snakebite Management Courses specifically developed for Cambodian doctors and health workers in Phnom Penh and Siem Reap, proving that expertise developed in PNG can be exported to the world.

The latest important achievement of the research group has been to develop, with the significant assistance of a government-funded research institute and antivenom manufacturer in Costa Rica, the Instituto Clodomiro Picado (ICP), a PNG taipan-specific whole IgG equine antivenom. In pre-clinical trials it has been proven to be equivalent to, or better than, the CSL monovalent product, according to a number of objective criteria. This work, published in PLoS NTD (<http://www.plosntds.org/article/info%3Adoi%2F10.1371%2Fjournal.pntd.0001144>) and the Journal of Proteomics (<http://www.sciencedirect.com/science/article/pii/S1874391912000231>) represents the development of the first new snake antivenom intended for human use in Australasia for more than 50 years. It is also expected to cost the PNG government a tenth of the cost of the current CSL product. Additionally, it is hoped that technology transfer will allow this product to be produced in PNG, as well as this part of the SRP acting as a platform for training young scientists graduating from the UPNG.

In 2011 the National Health and Medical Research Council of Australia (NHMRC - www.nhmrc.gov.au)



for the first time made Global Health a special initiative area for Australian residents involved in research outside of Australia. Following a detailed application the AVRU-UPNG SRP was awarded in late 2011 a significant grant to enable us to run a Double Blinded Randomised Controlled Trial (DBRCT) of the new taipan antivenom against the current CSL monovalent taipan antivenom. This will be first ever RCT of any CSL antivenom against an alternative product. The grant is the second largest NHMRC grant awarded to the University of Melbourne in 2011 and the largest single grant ever awarded for antivenom research by the NHMRC.

Our trials of the new antivenom are being run in two stages – first, a small safety and dose-finding study, and secondly the DBRCT of the new product against the current CSL monovalent antivenom.

Supporting this NHMRC grant, the PNG Office of Higher Education has allocated our research group a large grant (by PNG standards) as co-funding for the project. This generosity has made it possible to establish a new Clinical Research Laboratory – the Charles Campbell Toxinology Centre – at the UPNG Medical School. Construction of this new facility was completed in May 2012. The Centre will employ up to 16 PNG doctors, nurses and allied health workers during the clinical trials. Other projects commencing later in 2012 will build this workforce to a total of 20 personnel. The Centre is being equipped with state-of-the-art haemostasis, haematology and biochemistry analysers to enable us to conduct exacting investigations in snakebite patients, supporting the latest point-of-care (POC)

bedside analysers, which we will be using in the Port Moresby General Hospital Emergency Department where the clinical trials are taking place. Trial patients will be cared for with the aid of new state-of-the-art monitoring and life support equipment. Also, a new immuno-diagnosis platform, developed by a collaborator in Australia, will be used to detect quantitatively measure plasma levels of specific taipan venom toxins.

The PNG taipan antivenom clinical trials project is strongly supported by the management of Port Moresby General Hospital (PMGH), the Director of the newly constructed Emergency Department, the Executive of the UPNG Medical School and both the UPNG Ethics Committee and the National Medical Research Advisory Committee (MRAC).

It is hoped that the trials will not only yield a positive result for the new antivenom, but that they will significantly benefit the development of medical science in PNG by training staff involved in the trials in various capacities.

Also, a new Memorandum of Agreement (MoA) has been established between the UPNG and the UoM for the next 5 years, encompassing both research and teaching.

Mounting a double-blinded, randomised controlled trial in PNG is an enormous challenge. A number of visiting toxinology experts, emergency physicians, and others are lending support to the project.

Anyone interested in hearing more about our work is most welcome to contact Simon Jensen at simondjensen@hotmail.com.

Working In Papua New Guinea - A trainee's personal perspective

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I am the third ACEM trainee who has had the amazing opportunity to volunteer at Modilon Hospital, Madang, Papua New Guinea. This is a level two hospital and the main hospital for Madang Province.

Rather than re-state the general experience and opportunity that is available to an Australasian EM trainee when working in PNG, I want to share two individual patient stories and a perspective of my time at Modilon.

For a more general overview you can refer to my predecessor Katryna Denning's article in the December 2010 issue of the IEMSIG Newsletter.

MR CK

This 21 year old male was brought in by family members with GCS 6 and hypotension. What could be gathered from the history - language and cultural barriers aside - revealed he was a previously healthy male with one day of fevers, headache and confusion.

Decision was made to intubate, a rarity in Modilon due to inadequate facilities. A monitor from ICU magically appeared, prior to this I was under the impression there was no monitor available. It revealed a narrow complex sinus rhythm, his radial pulse was only just palpable. No 12 lead ECG was available. Nil response to two litres of crystalloid and 50% dextrose, given empirically as there was no BSL machine to confirm the level. Within five minutes he became bradycardic and then proceeded to asystole. CPR was commenced, five cycles were administered including five x 1mg adrenaline. No output returned and he was declared dead.

I have been brief with the above details, so that I could focus on the aftermath, which affected me the most. The father came in and both gracefully and humbly thanked all staff who had been involved in the resuscitation, in his own 'tok place' (language). I was feeling slightly choked up as I walked outside to the lab to chase the pathology results and went past his wailing wife. This was compounded by the fact that when I entered the lab there was no-one there (at 13.30hrs) and the blood from our urgent resuscitation was sitting on the bench unprocessed. On my return to the department I expressed my disbelief to a colleague at the lack of pathology processing, who without blinking an eyelid said "I am not surprised."

The small voice inside that I had been suppressing was now screaming out, how can you seem so unaffected? A man our age has just died and available investigations were not performed. I was further perplexed by the fact that I knew this particular national colleague had lost her own husband only 12 months previously, through unjust circumstances. Somewhat dumbfounded I said nothing more, but a few minutes later witnessed the same colleague walk past the back door where the deceased patient's wife was mourning, with tears welling up in her eyes. It was at that point I realized the limitations to my own understanding of the complexities underlying the health system in PNG and the situations that our national colleagues face on a daily basis.

Later, after I insisted that pathology run his bloods, I found out that Mr CK's potassium was 7.7 and creatinine > 264 (the lab didn't read higher than this).

Provisional diagnosis was hyperkalemic cardiac arrest secondary to acute renal failure as a complication of cerebral malaria.

MRS S

This woman presented to the ED with recurrent abdominal pain. This was her third presentation and her health care book labelled her with "Chronic Abdominal Pain," which was a frequent occurrence despite lack of any previous proper assessment or investigations.

On proper history and assessment, this patient had 'cyclic' presentations and amenorrhea since the C-section delivery of her baby 11 months previously. Examination revealed a soft but diffusely tender lower abdomen. Bedside USS revealed a heterogeneous large mass, perhaps within the uterine cavity (the walls of the uterus were hard to appreciate), with the fundus of the uterus clearly visible but pushed superiorly and to the side by this mass. PV exam revealed a 'pursed' looking cervix.

On consultation with the O&G registrar (a national who is actually on the EM training program in PNG) I explained the findings, saying "I am not sure, but can you get cervical stenosis or closure post failed vaginal delivery due to inflammation and scarring?" His response to my question was "either that or maybe her cervix was inadvertently closed during C-section.." Not surprisingly, the findings in theatre

supported his diagnosis. The patient now has retrograde endometriosis.

On her previous two presentations to the ED no history of her menses had been taken. Her management on each occasion was simply oral antibiotics and discharge home, an all too frequent management plan for a wide range of presentations.

A personal perspective

The complaints of Australian trainees regarding lack of supervision pale in comparison. I now have a much greater appreciation for the training scheme and the high standards and requirements that it sets.

I came away from PNG with more questions than answers, but I also came away with a strong sense of responsibility. The inadequacies in the health system are far more than just a lack of adequate resources, which has hopefully been demonstrated in the narratives above.

What makes two countries, two different races of people, separated by less than 20km, so very different?

It is often far too easy to place the blame on someone else and distance ourselves from the harsh reality that exists so close to our own borders. Too often I have heard others say, it's their own fault, they/their government have put them there, why should we donate or care when they won't help themselves.

In many ways I understand the argument; PNG is a relatively wealthy country. It is only by working alongside the nationals, appreciating their difficulties on a daily basis that it becomes impossible to ignore.

In my first few weeks in PNG it became apparent that the work ethic amongst the nationals varied extensively. Initially I couldn't work out why some of them were so lackadaisical in their approach. I quickly realized that the lack of accountability within the

health infrastructure was responsible. There were no consequences for not doing your job properly. After a while I began to wonder what drove the smaller group of nationals who are extremely dedicated and hardworking and I wondered how many of my colleagues back home would continue to be so dedicated in the face of such adversity.

As I have progressed through my career as a doctor, both my own and my family and friends' image of myself has changed. No longer am I the little girl that so badly wanted to be a doctor. Now I am "The Doctor."

With that name comes a degree of responsibility. As a doctor, people value our opinions and we are often given an immediate level of respect by fellow community members, whether deserved or not. With this respect also comes power, which I believe as a professional body we can band together to create a voice which speaks out for the individual right of all humans to a basic level of health care.

It is exciting for me, just starting out on my career, to see that here within this group I have many other like-minded colleagues who are advocating for the same.

I would like to thank both Georgina Phillips and John Kennedy, who introduced me to the possibility of doing 3 months in PNG as part of my training in emergency medicine. I would also like to thank Vincent Atua as my onsite supervisor and Divine Word University for hosting me.

I also hope that through this article I can encourage other trainees to do the same. The experience is invaluable. The PNG nationals are stoic and the clinical findings will impress. The requirement to work without all of the resources that are only a finger tip away at home means you develop and expand on your ability to think 'outside the box'.

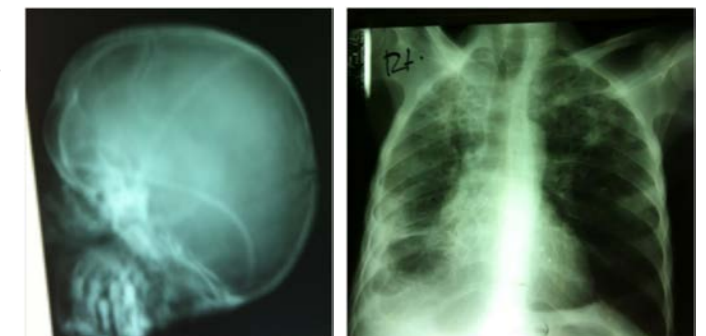
I had the privilege to work along-side amazing and dedicated national doctors and health extension officers (HEOs).



MODILON HOSPITAL

During my time in Modilon, (having only done two previous USS courses with Gold-Coast USS group) I diagnosed:

- Free fluid in ruptured ectopic (including visualization of ectopic)
- Intra-hepatic abscess
- Iatrogenically closed cervix
- Massive hepatosplenomegally
- Intra-uterine Foetal death
- Confirmation of IUFG



Above: Separated skull sutures in raised intracranial pressure due to TB meningitis. Right: An 'everyday' Xray

Pacific Islands

Solomon Islands Update

Andrew Bezzina
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May 2012 marked the planting of another seed for emergency medicine in the South Pacific. The first Emergency Life Support and the first Serious Illness in Remote Environments (SIREn) courses were delivered in Honiara, Solomon Islands. Each course is run over two days.

The team of instructors included 2 Solomon Islanders (Dr. Kenton Ratu Sade and Dr. Fletcher Kakai) and Dr. Vincent Atua from Madang in PNG as well as 5 Australians (Greg McDonald, Conrad Loten, Mark Miller and Brady Tassicker with Andrew Bezzina as Convener).

The ELS course was attended by 20 doctors and delivered in the main conference facility at the National Referral Hospital in Honiara. It was a highly enjoyable and rewarding experience for the instructors and is not only the first time this course has been held in the Solomons' but also the first time faculty has been provided by a PNG emergency physician going outside PNG. The involvement of local instructors and inclusion of the local hospital administration in the course opening has provided a significant level of moral

support to the Solomon Islands emergency clinicians.

The course was well received and the formal feedback from attendees was very positive, with requests for a regular rotation of the course. The possibility of a second yearly event is being considered.

The SIREn course was held in a different facility at the hospital with attendance by 25 nurses. This was likewise successful but all the more so for the capacity to have many of the lectures delivered in Pidgin by the local contingent and Dr. Atua. As with the SIREn course in 2011 in Mt Hagen in PNG, it was seriously oversubscribed (the course is designed for 18 attendees) but the faculty, helped by a receptive audience and the emergency physician's usual aplomb in the face of chaos, were able to accommodate the large numbers and still provide a valuable learning experience (either that or the attendees were being overly polite).

The faculty have taken home the many lessons learned and will use these to consider future modifications that may enhance the course for local delivery.

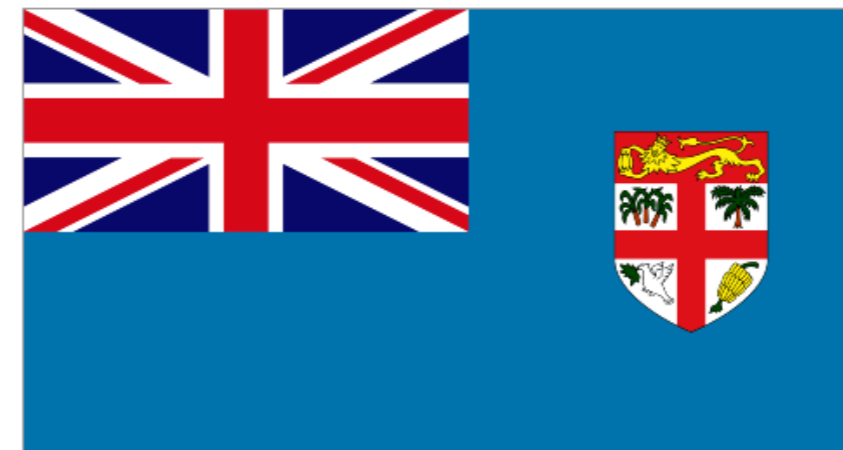


Above: The First Solomon Islands ELS Course Right: Dr Kenton Ratu Sade taking a skill station.

Strengthening Specialised Clinical Services in the Pacific (SSCSiP)

A Technical Meeting of Pacific Specialist Clinicians, Nurses & Biomedical Engineers. April, Nadi, Fiji

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Background

The Strengthening Specialised Clinical Services in the Pacific (SSCSiP) program is an AusAID initiative being implemented by the Fiji School of Medicine (FSMed). Developed over 2010 and commencing in 2011, the overarching rationale of the program is to assist Pacific island Countries (PICs) to achieve better planning and improved local capacity to meet secondary and tertiary health needs in an appropriate manner consistent with primary and preventative health care priorities.

A loose association of FACEMs organised through the IEMSIG network attended the Stakeholder Reference Group meeting held in Fiji in August 2011, where all 14 PICs (not including PNG – which receives its own stand alone AusAID health program) were represented. Despite some mixed feedback from organisers and participants about our presence at that meeting, the profile of emergency medicine (EM) and capacity building for emergency care was raised and it was clear that significant need and interest existed amongst PICs. As a result, EM has been included as part of the SSCSiP framework, and some emergency care capacity building projects have already occurred as a result of this process – some directly funded by SSCSiP.

Follow-up meetings in November 2011 also promoted EM as an important discipline to be developed in the region. These were the Pacific Islands Project meeting

held by the Royal Australasian College of Surgeons (RACS) International Projects Management Committee, and a meeting organised through the University of NSW to discuss the contribution of the ANZ colleges and specialists to strengthening clinical and other health services in the Pacific. ACEM IEMSIG was represented at both these meetings through formal presentations.

Purpose of the meeting

This Technical Meeting of Pacific Specialist Clinicians, Nurses and Biomedical Engineers was the first of its kind organised by SSCSiPs, with the intention of bringing together key clinical disciplines (including EM) to discuss and agree upon priorities for both service delivery and capacity building. Issues covered included specialist societies, formal and short course training, service providers, clinical consults, ANZ college support, professional development and locums. Information from the meeting will be used by the SSCSiPs program to assist with future activities. FACEMs Enasio Morris and Georgina Phillips represented IEMSIG and ACEM as part of the EM discipline and Dr Phillips was invited to make a formal presentation to the meeting on "How can Australian and New Zealand colleges help the Pacific Island Countries: opportunities for collaboration."

For EM, consolidation was also a key priority of the meeting. Many emergency care capacity building activities have occurred in the PICs (often initiated by FACEMs) without corresponding educational opportunities. Since an academic program in EM has commenced at the FSMed, this meeting provided an opportunity for clear information sharing and to commence a collaborative approach, with many relevant stakeholders sitting around the table for the first time.

Events/discussions/activities

The meeting was held over 2 ½ days with some opportunities for social networking in between formal presentations and discussions. Formal presentations from various disciplines were followed by craft group discussions around the issues listed above. Participants were seated by discipline.

The EM table comprised the 2 IEMSIG / ACEM representatives (Drs Morris and Phillips) and a Tongan doctor experienced in emergency care (Dr Saale Lemesio). Other invitees were the Director of EM training at FSMed Professor Craig Adams, two USA emergency physicians involved in a consortium engaged by FSMed to support curriculum development and clinical teaching in Fiji (A/Prof Michelle Daniel – Brown Uni, A/Prof Rohith Malya – Texas Uni) and Prof Gary Browne, a FACEM from Sydney Uni / Notre Dame Uni working on curriculum for FSMed. Also included were two local doctors (from Fiji; Vivek Arnold Lal, and Samoa; Mika Ah Kuoi) who have commenced the new Post-graduate Diploma in EM launched this year at FSMed.

The most relevant discussion areas for EM participants were around expanding the South Pacific Society for EM and techniques to do this, how the ACEM can be more engaged and supportive of emergency care developments in the region and what would be required, and what the teaching and learning needs are (of doctors and nurses) to improve emergency care skills in the Pacific.

As a result of the formal presentation to the participants about Emergency Care developments in the Pacific, two PICs expressed interest in activities for their environment; Samoa and Palau. Samoa would like input into their systems for emergency care and perhaps some kind of audit, and Palau are re-prioritising their health care needs and requested assistance upgrading emergency care systems. Both will submit a formal request with clearly stated aims, objectives, terms of reference and expected outcomes to either SSCSiPs or Dr Phillips, who will then pass it

out to the IEMSIG group.

Key relationships were established and enhanced between EM representatives and other participants. In Fiji, Dr Ratu Vereniki Raiwalui has taken on responsibility for the clinical development of EM – which means he is in close liaison with the FSMed team about clinical teaching and supervision and he is also responsible for working with the other specialty disciplines in the establishment of the MMedEM which will require their engagement and cooperation. He is interested in establishing a good working relationship with ACEM, sharing resources for curriculum, assessment and Continuing Professional Development. Dr Vereniki will be the clinician taking responsibility for recruiting a longer term FACEM based in Fiji if possible. Despite receiving significant service and support from the USA consortium, there is still a close tie with Australasia and a great desire from PI clinicians to have Australasian clinicians doing high level teaching, service provision and support. Born and trained in Fiji, Dr Enasio Morris has extensive regional networks which will be useful in establishing ongoing FACEM engagement and FSMed collaboration.

Recommendations made to SSCSiP from the EM discipline

The final day of the meeting was for each specialist group to present their key recommendations to the other participants and the SSCSiPs program managers. Dr Morris presented recommendations on behalf of the EM group around these themes:

- Provide support for post-graduate medical training at FSMed and the clinical supervision and training component
- Enhance cooperation and collaboration between all relevant EM bodies in the region
- Develop and establish emergency nurse training and educational opportunities
- Engage MMedEM PNG specialists
- Continue, support and expand emergency care capacity-building activities throughout PICs as requested.
- Continue and expand relevant basic short courses (eg; PTC, SIREn) and make them accessible to as many staff as possible (nurses, ambulance drivers, other first responders) in as many PICs as possible – and make them regular (eg. every year)
- Same principle for relevant advanced short courses for doctors (eg; EMST, ELS, CCrISP, ACLS).

Myanmar Emergency Medicine Introductory Course – MEMIC June 2012

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Background

The Myanmar Ministry of Health (MoH), Myanmar Medical Association (MMA) and academic and clinical leaders have committed to the development of emergency care in Myanmar with a 3 phase program involving international partners. The EM development program includes the rapid training of junior specialists for emergency medicine (EM), the establishment of formal specialty training and the introduction of EM systems including pre-hospital and emergency nursing care.

The Myanmar Emergency Medicine Introductory Course (MEMIC) is the initial component of the Phase 1 Post-graduate Diploma in EM awarded by the University of Medicine 1 in Yangon. Aims of the MEMIC included introducing the concepts, competencies and practice of EM, core EM skills and knowledge as well as introducing EM systems, leadership and teamwork.

Supporters, Instructors and participants

Emergency physicians, surgeons and anaesthetists from Hong Kong and Australia designed, wrote and delivered the MEMIC from 2nd - 8th June 2012. The FACEMs were Georgina Phillips, Chris Curry, Phil Hungerford, Antony Chenhall, Michael Augello and Kerry Hoggett. The course received funding from the Australian Ambassador's Direct Aid program and was supported through the Royal Australasian College for Surgeons.

Participants had been recruited from a range of surgical and medical specialties as junior specialists prepared to become the first cohort of emergency physicians for Myanmar and drive future EM developments.

Course events and feedback

MEMIC adopted adult learning principles adapted to a low resource environment. A range of lectures, skill



stations, facilitated discussion and group workshops were utilised to cover both clinical and EM systems topics. Overarching themes embedded through the course included leadership, communication, teamwork and teaching. Significant time was spent on critical issues such as disasters, pre-hospital systems, ED design and triage in recognition of the EM readiness required for the South East Asia (SEA) games in December 2013.

Participants overwhelmingly gave positive feedback and showed substantial improvements in knowledge of and commitment to EM. Novel teaching styles modelled by the MEMIC instructors were appreciated.

The Myanmar Minister for Health attended the

Opening Ceremony and the Australian Ambassador visited during the course. There was interest from local and Australian media. Several strategic meetings and activities occurred during the course between international and local partners.

Future activities and support

Future short and long term visits from MEMIC instructors are planned, including expert clinical supervision and training based in the ED at Yangon General Hospital. International and local partners will work together to ensure the Post-graduate Diploma in EM requirements are met and the initial cohort of Myanmar emergency physicians will be ready to deliver emergency care.

“Utuan, Utuan” – Little by little in Timor Leste

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“Little by little” describes the process of evolution of emergency medicine (EM) at the Hospital National Guido Valadares (HNGV) in Dili in East Timor. We have limited resources, adequate chaos and no shortage of interesting, challenging and fascinating patients. The ED sees in excess of 55,000 patients a year with over 50% being paediatric presentations. The rough casemix of paediatric presentations would be pneumonia, dengue, gastroenteritis, asthma, trauma and malnutrition related. Adult presentations are most commonly hypertension related, tuberculosis, renal colic, general surgical complaints and trauma. The local quirks are definitely vast numbers of dramatically hypertensive adults, a high number of renal colic cases and a vast amount of paediatric asthma as well as stiff opposition from “Aimoruk Timorese” - as traditional medicine is alive and thriving in East Timor.

The less common presentations in my time here so far have been several cases of clinical tetanus, many interesting snake bites by the poorly understood local green viper, tuberculous meningitis and the more extreme dengue haemorrhagic fever presentations.

The ED is a hectic place with a bizarre combination of languages spoken often within the same patient encounter as we attempt to communicate with each

other. The department is staffed mainly by Timorese and Cuban doctors with some occasional exceptions. In a given day and often within a given sentence you can encounter Tetun, Spanish, Bahasa Indonesian, Portuguese and English. In fact the lingua franca is generally a combination of these. This is definitely challenging, sometimes funny and occasionally dangerous with some celebrated disasters along the way.

The history of engagement with the department started in 2009 with an AUSAID sponsored scoping mission done by Georgina Phillips and Sr Kath Bowman from St Vincent’s in Melbourne. There followed funding for an emergency physician position at the HNGV through the AusAID ATLASS program (Australian Timor-Leste program of Assistance for Specialist Services), managed by the Royal Australasian College of Surgeons (RACS). Antony Chenhall worked here for 12 months in 2009 – 2010 and is fondly remembered. There is also a nursing development programme being run by St John of God at HNGV which funded four ED nurses to travel to Australia in 2011 and they spent four weeks at both St Vincent’s ED in Melbourne and St John of God in Ballarat.

The medical landscape in East Timor is about to undergo a dramatic change with the influx of one

thousand (yes - 1000) Cuban trained Timorese doctors over the next 2-3 years. This represents a massive challenge for any system and will be a difficult phenomenon to manage but will also hopefully provide some great opportunities in terms of improving access to healthcare especially for those in the districts. At the moment, something as simple as managing hypertension is really quite difficult – but with a dramatically expanded health workforce hopefully the capacity to cater for chronic non communicable health problems will be improved.

In terms of EM, a major positive development has been a local doctor putting his hand up to specialise in EM. He is likely to pass through the now well

established PNG pathway and spend some time in PNG and hopefully Australia during his training.

The need to improve emergency care in East Timor is obvious and the way ahead is not without challenges and obstacles. Some of the challenges are philosophical – the syndromal approach to emergency medicine versus a diagnostic paradigm which relies on waiting for laboratory results which sometimes arrive. Medical triage versus diagnosis, treatment and then referral. There are many different medical cultures in play here and time will tell which triumphs. There will be a lot of opportunities and a great need in the future for many shoulders to be put to the wheel here and it is a fascinating and diverse place in which to work.

The ETC Mentoring Project at Teaching Hospital Karapitiya in Sri Lanka

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Following the Indian Ocean tsunami in late 2004 the Victorian Government responded to the request of Teaching Hospital Karapitiya (THK), the major hospital in the heavily affected Southern Province, to support disaster preparedness and emergency and trauma care through the construction of an Emergency Trauma Centre (ETC). During the construction of the ETC, teams of predominantly emergency physicians and emergency nurses from The Alfred in Melbourne provided on-site, patient-based emergency and trauma care training in Galle, with some support from AusAID.

In March 2011 the ETC was opened for business, taking its first emergency patients. Since then the Sri Lanka Ministry of Health has continued to increase the staffing to the new facility to the point that all three floors are operational. The ground floor is the Emergency Treatment Unit (ETU) with more than 20 beds and 4 resuscitation bays. The first floor houses 4 operating theatres plus recovery, and an 8-bed ICU. The second floor is a short stay ward. Whilst a proposed model of care was developed for the new facility at its inception, the potential to integrate emergency and trauma care across the whole facility

is only now being realised. To support the staff of THK in the upsizing of emergency and trauma care to a fully fledged Level 1 Trauma Centre, the Alfred Trauma and Emergency Services, with the support of the Victorian Government have now commenced the ETC Mentoring Project.

The Project aims to assist THK in its efforts to optimize the functions of the ETC, namely the delivery of a high level of emergency and trauma care. To achieve this, it is intended that the activity of all levels of the facility will be integrated, with the full implementation of admission and discharge guidelines, nursing triage and a trauma quality improvement program. Between 1 August 2012 and 30 June 2013, more than 20 senior trauma clinicians from The Alfred, including medical, nursing and management representatives of the ED, operating theatres, ICU, trauma ward and radiology, will spend a total of 10 weeks working at THK alongside local staff.

With the first intake for the newly commenced MD in Emergency Medicine in 2012, the Mentoring Project will prove timely for THK and its skilled emergency medical and nursing staff. They will take a lead role in the training of future emergency physicians in Sri Lanka.

Emergency Life Care (ELC) course – Sri Lanka

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In early August 2012, 9 emergency doctors (8 FACEMs and one intrepid registrar) are travelling to Sri Lanka to help deliver the first Emergency Life Care course in Sri Lanka.

The Emergency Life Care course is designed along similar principles to the Australasian Emergency Life Support (ELS) course but with some educational outcomes tailored for Sri Lanka (particularly poisoning and envenomation).

An initial course will be delivered with mainly Australasian faculty as a train the trainer course, followed immediately by a course delivered by Sri Lankan faculty with the FACEMs acting as facilitators. In the event of further ELC courses the possibility exists for FACEMs to assist in each course delivery.

Some of the faculty will then deliver lectures at a symposium facilitated by the Sri Lankan Society of Critical care and Emergency Medicine <http://www.sscem.com/>.

This course will be run in Kandy at the University of Peridiniya skills lab with some equipment originally donated through ACEM's International Development Fund.

Emergency medicine has now been recognised by the Institute of Medicine in Sri Lanka as a specialty. Candidates are required to complete the Diploma of Emergency Medicine first, for which completion of an ELC course is mandatory. The first selection examination for EM advanced training is in August this year.

Emergency Medicine does not exist as we understand it in Sri Lanka. Most patients present to the outpatients department of a hospital (some with 3,000 presentations per day) and are subsequently then referred to either an inpatient unit, clinic or if needing some resuscitation to the emergency "room" - and in many instances it is in fact a room.

In the pilot ELC course run for senior medical staff in November last year, the ELC course was identified as ideal for doctors working in the outpatient units of hospitals, usually with no senior back up readily available.

An initial plan to run a course a few years ago with Australian faculty was hampered by the domestic political situation within Sri Lanka. This has now settled and there are a number of FACEMs assisting with emergency medicine in Sri Lanka, both currently and in the past.

The original involvement stemmed post tsunami via a request from the Ceylon College of Physicians to ACEM for some speakers at its annual conference. Six FACEMs participated in that.

The Alfred Hospital in Melbourne has visiting teams to the Emergency Treatment Unit at Galle (the building of which was funded by AusAID).

A team from south west Sydney visit every year and provide education at both society meetings and in satellite events.

Any educational efforts in Sri Lanka are always oversubscribed. Anyone wishing any more information can contact Shane Curran

Africa

Developing EM in Botswana

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In March 2010 I read an article on Emergency Medicine in Botswana published in IEMSIG, which started me thinking about an overseas career move. Just over 2 years later I am part of the School of Medicine at the University of Botswana and updating IEMSIG as to what has happened and the future prospects.

The University of Botswana has a new Faculty of Health Sciences building and the Medicine faculty are familiarizing themselves with their impressive surroundings. New Faculty members join every month and this has meant the completed curriculum for 4th and 5th Medical students. The University plans that no local students will be sent out of Botswana for undergraduate medical studies from 2014. More importantly Botswana will have the first ever graduation of doctors trained in country in 2014.

The postgraduate medical programs available for local doctors are also increasing. Pathology Masters and PhDs have been approved as University courses this year. Current training programs of emergency medicine, family medicine, paediatrics, internal medicine and anaesthetics have trainees at all stages. South Africa provides rotations short term in training areas not yet developed in Botswana. (e.g. ICU and ENT)

Our 7 emergency medicine trainees are busy formulating research topics for their theses; studying for exams or preparing themselves for various rotations. The recent second year rotation in surgery had very positive feedback from both sides. The hospital administration has commented on the improved standard of care in the "A and E".

We have high hopes for the 5 residents sitting their EM primary exam in August.

The main teaching hospital has no shortage of medical pathology and clinical signs. The ED ultrasound is put to great use each clinical shift. The medical officers are introduced to new ED guidelines each month at our monthly Morbidity and Mortality meetings. HIV is still the overwhelming medical issue here. There are research collaborations involving ultrasound, trauma and pre-hospital medicine. These great changes have been made possible by the current 3 full time EM faculty and many EM physician volunteers over the last 2 years from all over the world.

Gaborone is a great introduction to African living - safe accommodation, wireless internet, large variety of shops and schools. There are animal watching and sight - seeing opportunities starting in the city and extending out in all directions. Johannesburg is a 60-minute flight, 4-hour drive away and the South African College of Emergency Medicine (not yet 10 years old) is a solid ally.

The University of Botswana is recruiting for more emergency physicians at a Lecturer or Professor position. Contracts are for 2 years and the details are available at http://www.ub.bw/staff_vacancies.cfm?id=1923&pid=226

Short term volunteers are very welcome- a minimum of 6 weeks is preferred- please email myself at mcox2050@gmail.com or Ngaire Caruso at ngaire.caruso@gmail.com for more details.

“Pole pole ndio mwendo” - Slowly slowly is a good motion in Tanzania.

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This Swahili proverb sums up life and health in remote North West Tanzania where we live. Murgwanza Designated District Hospital (MDDH) is a 200 bed hospital that serves a population of around 400,000. It is in the Ngara District of Tanzania, which borders both Rwanda and Burundi. It was one of the main hospitals for refugees during the Rwandan genocide of the Hutus against the Tutsi. It is in the region of Kagera which has an under five mortality of around 120/1000 children compared to the national average of 81/1000. Malaria, pneumonia and diarrhoea remain the top 3 killers, with malnutrition seen in 50% of those children. Most people are subsistence farmers and earn less than a dollar a day.

With only 7 Clinical Officers (3 year trained medical staff), 1 Assistant Medical Officer (further 2 year training post Clinical Officer) and 1 doctor (5 year University degree) as well as nurses (one, two, and three years training), the hospital sees around 25,000 patients/year. The hospital runs an HIV/ TB clinic with over 1000 clients registered. While I have been assisting the hospital my husband Nigel has been working at the Murgwanza School of Nursing, which conducts a two-year certificate course.

In a snapshot of the last few months I have treated tetanus, typhoid, brucellosis, malaria, pneumonia, rheumatic heart disease as well as the usual pneumonia and diarrhoea. With HIV at 5% there are usually three to four patients with HIV on the wards, half with concurrent TB. Diabetes, and cardiovascular disease are on the rise. The main trauma seen is from piki piki (motorcycles), panga (machete) and occasionally bombing (grenade) injuries. MDDH is relatively “well” resourced for a remote hospital, yet compared to Australia it is still very limited and many die because of this. Patients come to the hospital late, after visiting the local healers, and resuscitation is often slowly given or not at all, contributing to the mortality.

What difference has it made being an emergency physician and nurse here?

As we work we are trying to mentor “good practice and medicine” and change behaviour through example and repetitive reinforcement. Training in Tanzania is considered not “worthwhile” unless the workers go off site and get paid. In a hospital short of staff (and money) this makes provision of services difficult. Yet through bedside training (compared to classroom teaching) we are now seeing patients put on oxygen, fluid resuscitation commenced before theatre and vital signs being done. Recognition of seriously ill patients is improving. There is now running water on the wards and doctors and nurses are washing hands! Asthma patients are getting salbutamol inhalers through homemade spacers.

Having been used to the fast pace of emergency departments in Australia, these changes may seem small and slow (and indeed they do to us at times) but the changes need to be fully integrated into the system to be sustainable independent of us, and that takes time. This year the Tanzanian Government has introduced Quality Improvement Initiatives, which are helping to consolidate ideas we have been putting forward, including the use of triage.

Lateral thinking, patience despite frustrations and challenges, teaching on the run, and the ability to work long hours are all skills I have learned as an emergency physician and have found essential here in this African setting.

What opportunities are there in Tanzania?

With the doctor and money shortage here, all volunteer doctors are welcome. However from an emergency medicine point of view Muhimbili Hospital in Dar Es Salaam and KCMC (Kilimanjaro Christian Medical Centre) in Moshi are the biggest centres of training and are trying to set up “Accident and Emergency” Departments. Muhimbili has recently set up its own Emergency Training Program

with an emphasis on trauma. However with immigration requirements tightening, getting Hospital Specific Registration and a two-year volunteer visa can be a costly and a lengthy process.

In a place where death is accepted as the norm and where every family has had at least one member die young, each patient that survives despite the limited resources is a joy that makes the daily frustrations of training and continually reinforcing good care worthwhile.

Previously at the Royal Adelaide Hospital, 2001 – 2009, Rosanne is in her 3rd year at Murgwanza Hospital and is currently the Acting Medical Officer in Charge. Ed

