

IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM



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Editorial

The second half of 2011 saw the bringing together of a lot of activity in the realm of international emergency medicine:

International Development Fund Committee (IDFC)

This Committee of ACEM Council had its first meeting on 5th September 2011 at ACEM HQ in Melbourne. Subsequently the group has been working on the mechanism to promote and award grants from the International Development Fund (IDF) of ACEM. The IDF currently stands at \$500,000, from which grants to \$30,000 per year will be awarded.

Committee members are

Gerard O’Reilly (chair), Peter Aitken, Chris Curry, Craig Hore, John Kennedy, Andrew Maclean, Chris May (hon.tres, ex officio), Robyn Parker, Georgina Phillips, Guy Sansom, Gim Tan, Brady Tassicker, Jules Willcocks, Matthew Wright.

The IDFC will soon be putting out a call for applications for grants from the IDF, hopefully in late December for decisions in early 2012.

Strategic Planning Workshop

An ACEM Strategic Planning Workshop was held in Sydney prior to the Annual Scientific Meeting. Proposals for the development of ACEM involvement in international EM were presented. While the principles received favourable support, the shape in which ACEM will expand its engagement in IEM requires further evolution and will be receiving more attention.

Fiji and the Pacific Islands

There have been several meetings relating to developments in Fiji and the Pacific Islands.

In August two meetings were held in Fiji - the Stakeholder Reference Group meeting for the Strengthening Specialized Clinical Services in the Pacific program (SSCSIP), and the annual meeting of the Pasifika Medical Association (PMA) and the Fiji Medical Association (FMA).

These were attended by Jules Willcocks, Georgina Phillips, Peter Wirth, James Fordyce, Brady Tassicker, Enasio Morris, and Shailesh Dass.

Subsequently there have been discussions relating to:

- 1) ACEM assistance towards the development and launch of a Diploma in EM at the Fiji School of Medicine
- 2) liaison between ACEM, the PMA and its funding body, Health Specialists Ltd.

Both are areas in evolution, with discussions on-going.

In November Georgina Phillips presented a summary of EM involvement in the Pacific to the RACS International Projects Management Committee. This Committee co-ordinates the delivery of the Pacific Islands Project (PIP) of AusAID.

In December a meeting entitled "Contributions of ANZ Specialists in strengthening clinical and other health services in the Pacific - an informal consultation" was held in Sydney under the auspices of the University of NSW. Peter Wirth and Georgina Phillips presented an ACEM viewpoint. A report by John Kennedy is published in this issue.

EM in Nepal

Following a visit to ACEM by an executive delegation in February, the Institute of Medicine at Tribhuvan University Teaching Hospital has launched a specialist training program towards a Doctor of Medicine, Emergency Medicine. Professor Pratap Prasad presented at the ACEM ASM in Sydney, and seeks FACEM support in building this program. Anyone interested is invited to contact the Editor (chris@chriscurry.com.au).

Trainee Update

Interest continues to rise in having international experience accredited towards training. Andrew Perry and Bishan Rajapakse are actively involved with ACEM in progressing this front.

ACEM guest international speakers

ACEM supported the visit of four speakers from developing countries to the ASM in Sydney. These were Pratap Prasad (Nepal), Zaw Wai Soe (Myanmar), Fletcher Kakai (Solomon Islands) and Moana Tupou (Tonga). Articles are published in this issue.

Sue Thompson, immediate past secretary of the International Section of ACEP, described an IEM fellowship program under way at Christiana Hospital in Christiana, Delaware.

IEMSIG Annual Meeting, Sydney

The IEMSIG meeting was conducted over a full afternoon, and again surpassed expectations in interest shown and contributions made. More than 80 delegates attended the IEM stream (despite the high quality of competing streams), and 30 enjoyed a harbour cruise dinner organised by Jules Willcocks. Speakers who have submitted to this issue of IEMSIG Newsletter are Rob Douglas, Georgina Phillips, Tony Eliseo, Will Davies, Pratap Prasad, Moana Tupou, Fletcher Kakai, Bishan Rajapakse.

Chris Curry. chris@chriscurry.com.au

IEMSIG Secretariat:
Hydie Pallier, Administrative Officer
hydie.pallier@acem.org.au

Improving trauma care in India: a recommendation for the implementation of ATLS training for ED medical officers.

Rob Douglas
rabs01@hotmail.com

Background

Trauma is major cause of morbidity and mortality in India. The Advanced Trauma Life Support (ATLS) programme teaches a standardised method for the initial assessment and management of trauma patients, and has been adopted by more than 50 countries worldwide.

Aim

We sought to assess the theoretical knowledge of ATLS principles among Emergency Department (ED) Medical Officers (MOs) in Salem, Tamil Nadu, India, and from the Royal Adelaide Hospital, Adelaide, South Australia.

Methods

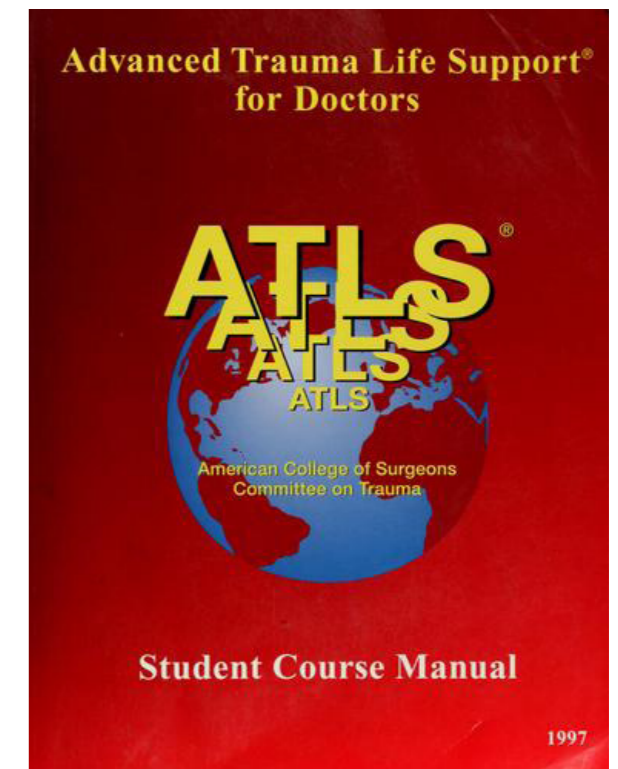
All MOs answered a trauma management quiz based on ATLS-type questions. Quiz scores were compared between Senior and Junior MO groups for each country, and within each professional group between countries. Categorical data were analysed using Chi 2. An a value less than 0.05 was deemed to be statistically significant.

Results

We discovered significant differences in the theoretical knowledge between ED MOs from Salem compared to colleagues in Adelaide. Our results demonstrated the clear positive influence of completion of an ATLS programme upon the obtaining of a passing grade in the trauma quiz. We failed to determine a link between self-rated time spent working in trauma and an ability to pass the quiz.

Conclusions

Our study demonstrated the positive influence of completion of an ATLS-type programme on the score obtained in the trauma management quiz. As previously published works have demonstrated



an improvement in the care of injured patients following completion of an ATLS programme, we recommend that such programmes be urgently integrated into the training of Indian Medical Officers and/or Medical Students, and suggest that ATLS should be viewed as an integral part of ED MO trauma training.

Further reading

Improving trauma care in India: a recommendation for the implementation of ATLS training for emergency department medical officers. Douglas RJ, Vasanthi B, Giles AJA, Anand Kumar G. *Int J Emerg Med*, 2010; 3:27-32

Further recommendations for trauma training of Indian medical officers and medical students. Douglas RJ, Mezzini TM, Anand Kumar G, Giles AJA. *World J Emerg Med*, 2011; 2: 85

Papua New Guinea

Capacity building in Emergency Care: an example from Madang, PNG.

Georgina Phillips
drgeorgina@gmail.com



Background

Divine Word University (DWU) is an emerging national university of Papua New Guinea (PNG) based in the provincial capital of Madang, providing training for all Health Extension Officers (HEOs) through a Bachelor degree program. Theoretical teaching on campus and clinical teaching at the nearby Modilon Hospital are limited due to significant human and educational resource constraints. HEOs form the backbone of clinical healthcare delivery in PNG, by servicing rural hospitals and health centres throughout the nation, as clinicians, public health officers and health centre managers.

Aim

This paper aims to describe the first year of a visiting clinical lecturer program whereby Australasian emergency physicians (EPs) and emergency registrars (ERs) deliver clinical and theoretical teaching to HEO students in order to assist capacity in the DWU and Modilon Hospital setting.

Methods

Volunteer EPs and ERs are sourced through key Australian EP facilitators familiar with Madang, PNG and prepared with comprehensive pre-departure briefing and pre-prepared educational tools. Visits vary in length from 2 weeks to 3 months, and include the possibility of accredited training for advanced ERs through the Australasian College for Emergency Medicine (ACEM). DWU provide secure accommodation and assistance with travel and visa logistics. Key tasks for visiting lecturers include delivering campus-based theoretical teaching on emergency medicine (EM) topics, structured and opportunistic bed-side tutorials and clinical teaching and assistance with emergency department (ED) care and professional development support for local EM clinicians.

Discussion

Program evaluation has relied on qualitative feedback which has been positive from all stakeholders. Objective measures of clinical skill improvement as a result of EP and ER teaching are unavailable. Visiting lecturers gain teaching skills and particular insights into the challenges of emergency healthcare delivery in a resource constrained setting. Local educators and clinicians receive much needed assistance and support as well as learning new teaching skills. Students receive increased interactive learning opportunities. The challenges for ongoing sustainability of the program include increased pressure on accommodation and uncertainty regarding future local human resources.

Conclusion

The example from Madang, PNG provides a model for capacity building in emergency care through focussing on clinical healthcare provider education as well as direct ED support in a resource constrained setting. By engaging Australasian EM clinicians and recognising such work through ACEM accreditation, this program acts as an example of collaborative assistance which can be replicated throughout the region.

Emergency Medicine in a remote Highland region of Papua New Guinea

Will Davies
Senior Medical Officer, Oil Search Limited PNG
willdavies72@hotmail.com

Introduction

As a FACEM working in the Southern Highlands Province of PNG one faces a completely different set of challenges than those faced by one's colleagues in Australia.

The different challenges reflect the fact that despite being close neighbours (Western Province PNG being 4km from Saibai Island in the Torres Strait Islands) they are very different countries. The geography of PNG defines many of its challenges. With an area of 500,000 sqkm, the country is 1/15th of the area of Australia. The populous, agriculturally productive and resource rich Highlands Provinces are in a rugged spine of mountains that runs across the middle of the country. This is also where the majority of the population live. There are three road systems in the country that do not communicate with each other, so the majority of rapid population movement is by air. Local transport is mainly on foot on narrow tracks, often through dense jungle.

The population demographics also differ greatly from Australia as demonstrated by Figure 1.

The combination of challenging logistics, heavy burden of treatable infectious diseases and limited resources mean the rapid clinical diagnosis and treatment of infection is crucial to good outcome from emergency presentations.

In the resource limited environment, access to advanced and even basic, diagnostic adjuncts is a rare luxury. There are three CT scanners in PNG, but one seems to be permanently out of commission. Access to the others is very limited and the image quality woefully poor for those of us who have experienced 64 slice helical CT technology in Australia. Concerns over the absence of antibiotics, adrenaline or oxygen are more common than worrying about "bed-block", "ramping" or whatever political decree is crippling the working environment in the Australia.

Emergency Medicine is a new specialty to PNG. The training is via a Master of Medicine, Emergency Medicine (MMed EM) course that is run in Port Moresby. Dr Sam Yockopua is the driving force, supported by members of the IEMSIG who visit to teach and lecture. The course successfully graduated 3 more specialists in November 2011, effectively doubling the number of domestic ED specialists in PNG. Congratulations are due to all involved.

There is no national retrieval service in PNG and the task of transferring patients from remote outposts to the central health care facilities falls to faith based organisations and the private sector.

DEMOGRAPHICS	
PNG	AUSTRALIA
• Population: Approx 6 600000	• Population 22 065670
• 12.5% urban living	• 89% urban living
• Life Expectancy Male 58.7yrs	• Life Expectancy Male 79.2yrs
• Life Expectancy Female 63yrs	• Life Expectancy Female 83.7yrs
• Maternal mortality ratio 733:100000 live births	• Maternal mortality ratio 6:100 000 live births
• Infant Mortality 56.7:1000 live births	• Infant Mortality 4.1:1000 live births
• Leading cause of death: Infectious diseases	• Leading cause of death: Ischaemic heart disease

WHO Country Profiles 2010.

Figure 1: demographic comparison of populations of Australia and Papua New Guinea

Oil Search Health Service and Oil Search Health Foundation

Oil Search Limited is a Papua New Guinea company that has been involved in oil and gas exploration since 1929. Due to the remote nature of the work they have developed a comprehensive health service, including acute medicine, retrieval and public health, that provides health care to its employees and members of the local communities in the Southern Highlands, Hela and Gulf Provinces. The company also provides support to local government and faith based clinics giving them access to diagnostics, higher levels of care and a retrieval service.

Recent adjustments to the core structure of the company's health service have led to a partial split of the public health unit (PHU), which has been approached by the Global Fund to Fight AIDS, TB and Malaria to act as primary recipient of grants and ensure delivery of public health programs to the whole of PNG. The public health unit now comes under the auspices of the Oil Search Health Foundation although it remains core to the overall Health Service Governance. As part of the restructure, the health service field laboratory has become a predominantly research based asset and bedside diagnostics have been introduced to the clinics.

The acute health service has remained under the funding and auspices of oil production and provides support to the PHU. The acute health service employs 7 Papua New Guinean doctors, 16 nurses, 5 health extension officers, 4 expat clinical nurse educators/retrieval first responders, 2 managers and 2 expat doctors. The expat doctors are myself in an "in country" role and an occupational health specialist based in Sydney. The health service provides acute care and brief inpatient services to local community members on a referral basis. The service performed 152 retrievals during 2011 to 31st October. 69% were local community members. The service sees approx. 25,000 patients per year in the 6 clinics.

Senior Medical Officer Role

The SMO role is varied and complex. It includes clinical leadership and governance of the acute health service, the provision of medical education and professional development to the PNG doctors and policy and guideline development within the service. The role also encompasses acting as first responder to category 1 retrievals and coordination and planning of disaster response. Within the PHU the role includes liaison with government agencies, acting as a technical advisor on acute medical problems and overseeing operational and academic research undertaken in the field in collaboration with James Cook University, Townsville.



The upside to working here is that it is constantly varied and fascinating and there are opportunities to be involved in the strengthening and development of a rapidly evolving health care system. There is the chance to acquire new clinical skills and see clinical conditions that are usually only read about. There is generous time off at home, even though the pressure of being on call 24/7, 365 days a year can be trying.

However, the downside is long hours, typically 06.00 to 18.00 with 2-3 hrs evening paperwork 7 days a week, 21 days on 21 days off, with long periods away from home and family. The potential for losing clinical skills appropriate for practicing in Australia means that I have to do some locums to remain current. This erodes the benefit of time off.

Interesting Presentations

20 cases of paediatric pneumonia admitted per month. Admission criteria are in keeping with WHO 'severe' or 'very severe' pneumonia.

40 cases malaria diagnosed and treated per month.

5 cases of leprosy diagnosed and treated in 2011.

1 cholera outbreak tackled

1 typhoid case in a food handler managed.

3 shotgun blasts to chest 2011.

3 chest stabbings in 2011.

14 limb amputations or partial amputations 2011.

14 snake bites with 2 fatalities.

1 air crash attended with all survivors successfully retrieved.

Cases not seen so far: Situational crisis, nursing home referral for assessment for higher care, 3 year history of back pain for investigation or patient worried about own health.

Summary

It is a privilege and honour to get the opportunity to work in the remote highlands area of PNG. I cannot encourage members of the IEMSIG enough to engage in any clinical opportunities they may be offered in the challenging and remarkable country that is Papua New Guinea.

An Emergency Medicine course delivered in Kuching, Malaysia: time to build bridges and explore.

Tony Eliseo
tony.eliseo@health.sa.gov.au



In March 2011, six emergency specialists from the Royal Adelaide Hospital were invited to deliver an emergency medicine course in Kuching, Malaysia. One of the six emergency specialists was born in Kuching and after obtaining his FACEM and working in Australia was keen to return to Kuching to deliver an emergency medicine course.

Kuching is a beautiful city on the banks of the Sarawak River on the island of Borneo. It is the fourth largest city in Malaysia with approximately 1 million residents.

As there is already an emergency medicine specialist training program in Malaysia our purpose was to augment the local specialists to be able to deliver an emergency medicine course especially focused on emergency medicine skills. We used the local specialists to deliver some parts of the course as well as to feedback to us on how the course was going on a daily basis. This allowed daily fine tuning and improvements.

The process of delivering the course in Kuching commenced 9 months prior with much communication between ourselves and Dr Chan (an emergency specialist in Kuching). This allowed for key aims and objectives to be determined as well as sorting out much of the logistics of delivering the course.

The course was delivered over 3 days with each day being themed. The themes were emergency adult medicine, emergency paediatrics and trauma. We presented lectures, scenarios and skills stations as a means to teach the various skills. The lectures gave information which was to be used in the scenarios and skills stations. The scenarios were based on ACLS, APLS and trauma vignettes. The skills which were taught included ultrasound (FAST and venous access), intraosseous access, ECG sessions, chest drains and airway management (basic maneuvers through to surgical cricothyriodotomy).

The participants included emergency medicine trainees, junior house officers (working in varied hospital environments, eg tertiary referral centres through to solo practitioners with little emergency medicine experience in very remote areas), emergency nurses and emergency physicians assistants.

The feedback from the participants was excellent with lectures, scenarios and skills stations scoring very highly by all participants. The local emergency specialists who were present throughout the course were also able to feedback on a daily basis and at the end of the course. Due to the support and positive feedback we are in the process of updating the course for our next visit in April 2012.

If anyone is interested in reading and seeing more of the course please visit our website: Ausemed.com



Strengthening Emergency Services at Tribhuvan University Teaching Hospital in Kathmandu

Pratap Prasad
Head of Department, GP&EM
tejnpd@yahoo.com

Emergency services commenced at Tribhuvan University Teaching Hospital (TUTH) in 1985. The ED was run by medical officers from various departments. It was later realized that there was a need for a holistic approach to the care of patients and the coordination of services. Hence, the responsibility was transferred to General Practice specialists (MD GP). For the last 25 years the Department of General Practice and Emergency Medicine has been running the ED in coordination with all the departments

Nepal's MD GP program has the primary curricular goal "to provide comprehensive and effective management of common health problems including timely emergency care and life-saving surgical and obstetrical intervention".

Until September 2011 there was no specialty training in EM. Converting small time emergency rooms to fully operational modern day Emergency Departments will be a process of evolution, which will take time (as it does anywhere).

The ED at TUTH sees 34,000 patients per year, of which 13.5% are admitted, 60% under medicine and 20% under surgery. A broad range of cases attending the ED require primary health care rather than being emergencies.

Readily identifiable areas for improvement include:

- TUTH's rule is that no patient shall spend more than six hours in the ED; the reality is that a patient may spend up to 5 days there
- Staff keeps on repeatedly seeing the same patients over and over again in our morning, evening and night rounds, along with the new patients
- Admission from ED to ward beds starts only after 5 pm
- Hospitalization is a "prized entity" rather than the patient's right, due to beds not being made available on wards



EM Faculty: Yagya Shakya, Ramesh Maharjan, Yogendra Shakya, Ramesh Acharya, Pratap Prasad

- Political pressure, social obligations and intra-staff lobbying all come into play to get a patient admitted
- Once a patient comes to TUTH's ED, it is not easy to say "you ought to go somewhere else because we don't have a bed to admit you". These people have come to us from afar and trust in TUTH
- Lab reports and radiological investigations can keep a patient waiting in the ED for extended periods
- Timely consultations and definitive decisions for patient disposition are uncommon
- Lack of EM faculty in the ED is a major problem impeding its growth and development
- Social and culture factors contribute to ED overcrowding

It is due to these factors that our ED wears the look of a burgeoning fish market.



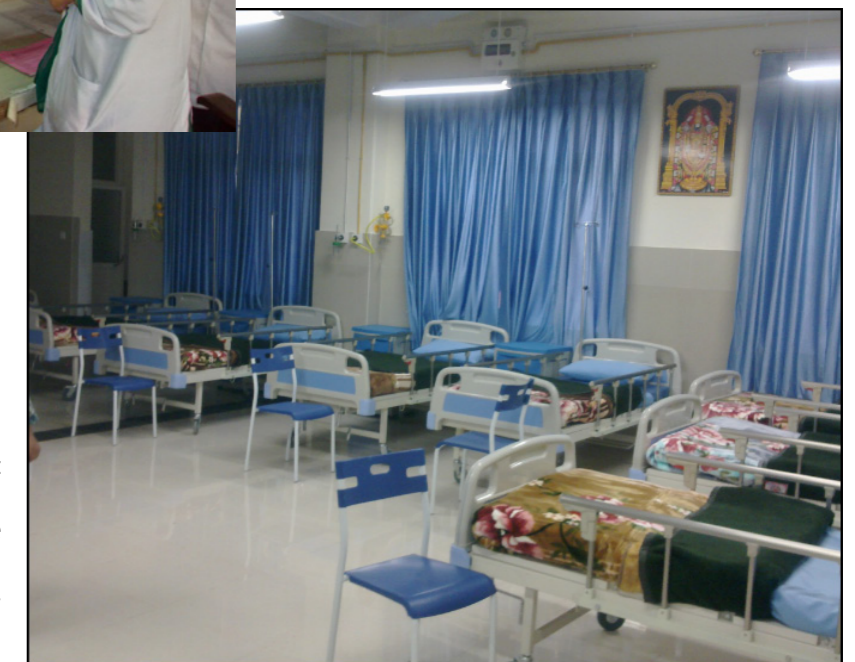
The old ED at Tribhuvan University Teaching Hospital - a 'burgeoning fish market'.

Ways forward:

- Triage
- Increasing the availability of beds in the wards
- Prioritization of emergency admissions by all departments
- Authorization of ED faculty to admit patients requiring a hospital bed
- Proper, timely and efficient consultations, admissions and discharges by inpatient teams

The ED is about to move into a new building. The new ED has allocation of specific areas: Triage, Resuscitation, Trolley, Walking, Minor Surgery/plaster/pelvic exam, Isolation, Disaster preparedness set-up, Observation Ward. It is hoped these can contribute to improvements in the patient 'journey'.

A strong EM training program has now been established, for Doctor of Medicine in Emergency Medicine, to produce fully trained specialists. This has come about through collaboration with ACEM and IFEM.



The new ED: specific allocation has been made for a range of areas including Triage, Resuscitation, Minor Surgery and an Observation Ward.

Pacific Islands

Emergency Medicine in Tonga: an emerging discipline

Moana Tupou
Medical Officer in Charge, General Outpatient/Emergency Department, Vaiola Hospital
dr.matamoana@gmail.com

Emergency Medicine as a recognised discipline in Tonga is still in its infancy at the present time. In collaboration with local and international stakeholders, Tonga will be able to take its first steps to the next level of Emergency Medicine.

The Kingdom of Tonga is a collection of islands spread over roughly 800 square kilometres of Pacific Ocean with a population of approximately 104,000. About 70% of the populace reside on the main island of Tongatapu (the capital of Nuku'alofa is here) with the remainder spread throughout the other island groups of Ha'apai, Vava'u, Niuafou'u, and Niuatoputapu.

Up to the present time, the hospital general outpatients department caters for the majority of consultations in the Kingdom. This is for two main reasons: the hospital provides healthcare and medications free of charge; and there are

a very limited number of private clinics available. Within this department is a single emergency room which is used for approximately 1000 emergency cases annually. The new department which will boast an emergency section is estimated to be functional by April 2012. This new department is part of the Japan-funded Vaiola Hospital renovation project.

The department is staffed with four medical officers, three health officers, and 15 nursing staff. These staff work on a shift basis with three eight-hour shifts per day, seven days a week. A typical day and evening shift will be staffed with one medical officer, one health officer, and four nursing staff and see between 100 and 200 general consultations over the 16 hours, but may be closer to 300 during peak periods, as well as any emergency cases. The night shift is staffed by one medical officer and two nurses only, so if there is any major



General Outpatient/ Emergency Dept staff, including the Nursing sister in Charge, the Ambulance Officer (driver), and a couple of Health Officers



An Ambulance Training Course for nurses, ambulance drivers, police, fire, and Red Cross. Three trainers are from the South Australian Ambulance Service.

incident or multiple emergency cases at the same time, help must be called from the inpatient wards. A typical night shift has between 15 and 30 consultations.

The current department was not set up as an emergency department, but rather a general outpatient consultation department. However, since about the year 2000 there have been a number of changes in an effort to upgrade emergency services. Previously, there was a small room only for emergencies which could only hold one bed and four staff. There is now a much larger room which can hold two beds, but only has adequate resuscitation equipment for one patient at a time. In addition to this, a room was renovated by the Rotary Club providing an area for triage. Previously, there was no formal triage process, but with help from emergency nurses from Australia and New Zealand a standard triage process was designed and taught to the local nurses using the five-category Australian Triage Score. Whereas before patients were initially seen by a records clerk, they are now seen by the triage nurse and then by the clinician in a timely fashion.

The ambulance service is also directed by the department. There are three drivers who have been trained in basic life

support and safe lifting and transport techniques in order to assist the nurse when responding to a callout. Previously the ambulance used drivers from the ministry pool which were not rostered specifically to the ambulance. This caused unnecessary delays in responding to callouts. For the past half year the ambulance with its assigned officer is within the emergency area at all times ready for deployment within minutes.

However, only one ambulance may be dispatched at a time, but this is not usually a problem as it is uncommon to have simultaneous callouts and distances are short. There are currently no paramedics, although it is planned to eventually have paramedic training. There are already offers of short-term attachments with paramedic services for the ambulance drivers from Australia.

There are plans in 2012 to have more formal training programmes for both nursing and medical staff in emergency medicine topics with the assistance of both local vision and international collaboration. This will help upgrade emergency services provided by the main hospital in Tonga and make Emergency Medicine a recognised discipline as well as becoming a viable career path for clinicians.

Emergency Medicine in the Solomon Islands

Fletcher Kakai
fletcherkakai@gmail.com

Emergency Medicine in the Solomon Islands is a completely a new field of practise which has been slowly evolving over recent years. An organised development of the discipline started in 2004 when Dr Kenton Sade was the Director of the Emergency Department at the National Referral Hospital (NRH) in Honiara.

Emergency medicine in the Solomon Islands was initially practiced during World War II, where the war hospital was known as Base Number 9 (current site now NRH). The Emergency and Outpatient services were provided by expatriate doctors and joined by local doctors in the 1980s. Two local interested doctors in emergency medicine went on emergency attachments at St Vincents Hospital, Sydney in 1994 and 2004 but did not continue into formal EM training.

The geographical scatteredness of the islands of a land area of 28,969 sq km over a sea area of 1,632,964 sq km presents Emergency Medicine a real challenge. The current population is 515,870 people in 9 provinces, with 52% in coastal villages and with very poor road access to inland villages. 70% of the population lives within 3km from a health facility - which is likely to be non-functional. Therefore, sea transport is the main transport system, but this is very unreliable. The NRH in Honiara is the only major hospital in the country with an Emergency Department (ED), with posted staff but substandard equipment. Gizo and Kilu'ufi hospitals in Western and Malaita provinces respectively have infrastructures for EDs but these are still unestablished. Thus, medical evacuation within the Solomon Islands is a costly exercise.

The NRH ED has to cater for the Honiara population of 64,602, Guadalcanal population of 93,613, and all referrals from the 9 provinces of all ages regardless of the severity of the cases.

On a daily basis we see on average 3 - 5 major emergencies such as trauma, asthma, convulsions, AMI (triage cat 1 - 3), and 50 - 70 outpatients (triage cat 4 - 5). In a month about 100 emergencies and more than 1000 outpatient cases usually present to the ED.

The ED was built in the late 1980's by the Taiwanese Government and was renovated in 2009 by the Australian Government through AusAid.

Despite the costly renovation, the emergency equipment in place is very basic.

In the department there are 3 beds in the resuscitation room, 1 bed in the minor theatre for trauma resuscitations, 8 beds in the acute ward (which can be increased to 14 beds with trolleys), and a flexible sub-acute bay for day cases. The ambulance service is directly under the ED but most times the driver alone does the retrievals. A 2 way radio network is established nationwide for emergency consultations with nurses on the islands.

Currently, there are 8 doctors on 8 hours shifts and 4 EM trainees with the University Papua New Guinea. There are 2 emergency nurses, 19 registered nurses and 9 registered nurse assistants on 8 hourly shifts.

There have been improvements, including the major renovation (2008/2009), and an increase in number of doctors (from 2 to 12) and nurses. In terms of training, 4 doctors are doing the Masters of Medicine in EM (MMed EM) and are trained PTC instructors, and doctors have attended EMST and ELS courses. There have been 5 PTC courses conducted locally.

Future improvements lie with organising short courses for registrars (EMST, ELS, APLS), rolling out more PTC courses in the country, and with the first qualified emergency physician expected in 2012. There is a need also to upgrade the current equipment, ambulance service, communication network, Kilu'ufi & Gizo EDs, and to establish a mass casualty plan.



The new triage station at Honiara.

International Emergency Medicine – a Trainee's Perspective

Bishan Rajapakse
bishan.rajapakse@gmail.com

This article is a summary of the presentation made at the IEMSIG meeting at the ACEM ASM 2011. See slides at <http://www.slideshare.net/bishanrajapakse/international-em-trainee-update-nov-2011a>

There is growing enthusiasm amongst Emergency Medicine (EM) trainees to be involved in international work and when possible to get part of this time accredited for training. Challenges encountered include a lack of knowledge of international training opportunities, and how to get these activities accredited by ACEM.

The solution lies in education and promoting awareness amongst trainees about the resources available. These include trainee- focused articles in the IEMSIG Newsletter, and the newer breed of web based information sharing tools such as medical blogs like "Life in the Fast Lane" (LITFL), and social media like "International Emergency Medicine Australasia" Facebook groups, and local meet-ups such as the "Global Health Drinks" forum that operates in NSW. These focus on dissemination of information as well as providing valuable opportunities for networking and collaboration.

Resources for Trainees interested in International Work

IEMSIG Newsletter

<http://www.acem.org.au/infocentre.aspx?docId=1194>

This is probably the single most useful resource for a trainee wanting to embark on international work. Edited by Chris Curry, it has been published on line twice a year since the first issue in September 2004. It contains a number of articles over the years that are dedicated to the activities of trainees, some of whom have had their activities accredited for training.

IEM Websites & Social Media

There are now other resources available that extend the goals of the newsletter, recognizing the trend of the modern trainee towards using more social and user-friendly platforms of knowledge sharing, networking and collaboration, as offered by medical websites and social media.

Life in the Fast lane – International EM section
<http://lifeinthefastlane.com/education/international-em/>

"Life in the Fast Lane" (LITFL) is a popular medical blog that is viewed by many trainees both for both recreation and learning, as it provides much content geared towards the ACEM training syllabus, and it shares a database web-links to other educational sites. It was co-founded by Mike Cadogan (who recently received ACEM's Teaching Excellence award for 2011) and advanced trainee and technophile Chris Nickson, who heeded the call for a section of the website to be devoted towards IEM. There is a platform that helps promote connection between IEM enthusiasts, provides easy access to the IEMSIG Newsletters, creates a global directory of IEM resources (including online links, contacts and conferences), and compiles an easy access multi-media database of stories from people who have done overseas work (called "postcards from the edge").



"International Emergency Medicine Australasia" – Facebook group
<http://www.facebook.com/groups/international.em/>

This unofficial Facebook group was started around the same time as the LITFL IEM section, early in 2011. Founded by this author, the vision was to take advantage of a social media platform that was already popular amongst both ACEM trainees and many ACEM fellows to help connect people with the same interests. The goal was to provide a forum for more interaction, to support an online community that could help promote and foster IEM ventures in the real ('non virtual') world.

The Facebook group platform isn't a place where one can read articles like many websites or blogs, rather it is a place where members are presented with links to articles or ideas, and they can contribute by liking or making comments, thereby interacting with such information in a way that can enliven the message behind the text in some way. There is a "wall" upon which statements or comments, known as "wall posts", can be contributed by any member. Such posts can contain links to interesting IEM web articles, or links to networks that support IEM ventures. They can also contain anything to do with IEM that a member feels relevant, including a short personal statement. Because the wall contains "bite sized" pieces of text it is short, snappy and interactive. Posts also have the name and picture of the contributor tagged to the statement creating a more personal form of online interaction. For those who are shy to contribute there is the added opportunity for positive feedback that is offered by the feature showing that you "like" any statement or post by clicking on the "like" button.

The group encourages everyone to write an introductory statement about what experience they have had doing international work, or what experiences they are looking to have in the future, what they hope to get out of the group or contribute.

Examples include links to interesting publications, updates about IEM conferences (such as live summaries of the EMSSA South African conference in Cape Town), links to the ACEM 2011 conference in Sydney this year, links to other IEM networks (such as EPI, which will be explained below), and links to IEMSIG activities.

At the time of writing, the group has over 100 members ranging from Sweden to Sri Lanka. They are predominantly ACEM trainees and fellows, and so it has an "Australasian focus", but membership extends to medical students, nurses, and paramedics or anyone interested in improving global health through IEM. If you are reading this, and have never joined a Facebook group before, why not click on the link above and become part of our community? Click and share your story or aspirations with us today!

Emergency Physician International (EPI)
<http://epinternational.ning.com/>

The goal of this group is to foster a community that has the "desire as to save lives when every second counts, no matter the conditions" and do this by increasing global access to acute care through the

development of EM. EPI has over 1,300 members from 60 countries and has at least 10 special interest groups, eg "Emergency Medicine India", "Nordic EM" or "Wilderness Austere Medicine". There is also an online magazine, currently in its 6th issue, containing articles contributing towards a theme, eg EM in Asia, in Issue #4.



Local "Meet ups" – Global Health Drinks
www.globalhealthdrinks.org

This is a Sydney based initiative that provides a meeting place with as focus to encourage and inspire Australian doctors to use their skills to serve in less developed countries through clinical work, public health or research. The forum provides 4 gatherings per year, each with a theme with 2-3 presenters who have done international work, allowing interaction in a relaxed and friendly environment.

ACEM perspectives on supporting IEM and Trainees

The college is increasing its engagement with, and expanding the infrastructure for, IEM. Andrew Perry, chair of the Trainee Committee, is involved. ACEM is currently considering mechanisms by which it can more formally support both fellow and trainee involvements, with more definite announcements likely in 2012.

Accreditation of international work for ACEM Training

The IEMSIG Newsletter contains stories of trainees who have done international work and had their time accredited for training, in Vol 3, Issue 1 -2006, and Vol 6, Issue 2, 2010. Alison Moore and Marian Lee describe a strategy for gaining prospective accreditation for an MSF mission in Africa, and Katryna Denning describes an accredited term in PNG. Georgina Phillips expanded on the PNG opportunity at the ACEM ASM in Sydney, in her talk "Capacity building in emergency care: an example from Madang, PNG".

Conclusion - a new era of IEM for trainees and fellows

There are now new forums of information sharing and collaboration that may benefit trainees and fellows in the field of IEM. Some of the online resources are developing so rapidly that perhaps there is a "widening gap" between what resources are available and what resources are currently being used. It is hoped this article might help bridge the gap by providing a framework for some resources that may be of use.

Perhaps today's trainee, whilst less experienced and accomplished in doing the work of IEM, is likely to be more proficient with the online tools of tomorrow. These tools could help raise awareness and maintain important relationships, thus helping more senior colleagues in the common goal of promoting IEM and increasing global access to emergency health care.

As always I appreciate your feedback and comments and I look forward to reading them online, or perhaps discussing them with you in person at a local IEM meet up near you in the future!

MEETING REPORT

"Contributions of ANZ Specialists in strengthening clinical and other health services in the Pacific – an informal consultation"

John Kennedy
jfkennedy@nscchahs.health.nsw.gov.au

Introduction

This meeting was held in Sydney on 1st December 2011. In essence, this was a "mapping and dialogue event" for all of the specialist Colleges organised by Richard Taylor, Professor of Public Health, UNSW – and probably the first time that representatives of the various craft groups have got together to ponder Pacific development assistance.

It involved fairly senior representatives from the Colleges of Surgery (including orthopaedics, ophthalmology), Physicians, O&G, Anaesthetics, Pathology, Psychiatry, Public Health...and Emergency Medicine. Essentially each College got up and told everyone what they were doing in the Pacific and there was lots of discussion. There were also representatives of two funding agencies, SSCSIP (Strengthening Specialised Clinical Services in the Pacific) and Pasifika Medical Association. There was no-one from AusAID – who knew about the meeting and were apparently a bit spooked and worried they'll be inundated with funding requests!

Colleges and Players positions and profiles

Most Colleges have a fairly tertiary care focus (e.g. fixing cleft palates or setting up endoscopy services in Fiji) rather than a strictly educational and/or capacity building approach. IEM is possibly a bit more the latter. One comment from the meeting that betrayed the tertiary focus was: "children are dying of diarrhoeal diseases out there – we need to urgently get trained paediatricians into those centres to save lives"...a comment that generated considerable dissent!

The major focus of most groups is on Fiji +/- smaller Pacific island nations. Some pointed questions were raised about this, as PNG has 75% of the population of the Pacific.

- RACS – have it all well sorted out and are critical to IEM because they hold the AusAID purse-strings. The surgeons' focus is on service provision (e.g. team deployments) rather than capacity building. The Big Man of RACS, David Watters, is a legend.
- RACP – perhaps surprisingly, are only a little more advanced at a College level than ACEM. They now have an International Committee with a Pacific sub-committee, formal TORs etc, but it is early days in formalizing their international activities at College level.

- o Some physicians are running very nice tight, focused projects – e.g a group of NZ cardiologists did an echo on almost every child in Tonga, identified all those with early rheumatic valve disease and put them on an intermittent penicillin prevention regime.

- Public Health – have a curious lack of engagement. They are developing training courses – e.g. short courses in Public Health – that could be valuable for individuals doing IEM work or if ACEM goes down the International Fellowship road. As a result of the meeting the PH people have undertaken to try to strengthen the PH team at UPNG.

- Ophthalmology – as everyone knows, these people have an awesome track record of fixing lots of eyes and teaching local staff.

- Orthopaedics – fabulous service provision, well-organised. They have identified teams for each country, fly over there once a year and do operations. Self-confessed "not so good at building capacity" – but very good at going and doing.

- o At one point they gave Diploma-level recognition to Pacific trainees who had their MMed from Fiji. It all backfired from a "capacity building" viewpoint when Queensland started putting those people in remote areas as orthopods.

- o "Orthopaedic Outreach" has an annual budget of \$100,000 from the Australian Orthopaedic Association (and, on top of this, gets AusAID/Pacific Island Project funding for each mission).

- o They fund 5 Aus/NZ registrars each year (\$2000 each) to do placements in the Pacific/Asia.

- Anaesthetists – send lecturers to the Fiji School of Medicine, are involved in lots of curriculum development and have a big involvement in the Primary Trauma Care (PTC) course and the Essential Pain Management course.

- o They send 2 Fellows a year (used to be more junior registrars but the work is a bit scary) for three month terms to the Pacific/PNG/Timor to work & assist locals in exam preparation (and pay them \$12,000 for the 3 months!).
 - SSCSIP (Strengthening Specialised Clinical Services in the Pacific). Based in Fiji. Funded by AusAID. Controls all of the funding for placements, courses etc etc, for the Pacific (but not PNG – which falls into a different catchment) – though money is via the Pacific Islands Project (PIP) and managed by RACS. Well-meaning people – keen to help, and to do things right.
 - Pasifika Medical Association. A NZ NGO heavily involved in NZ-aid funded programs in the “East Pacific”.
- Quo Vadis?
For ACEM/IEMSIG (and all of the Colleges) the recurring theme of the meeting was that it would be good to get our acts together and in particular address the need for formal structures and communication pathways for reception of external requests and dissemination of information and efforts.
- There is a need to develop links between ACEM and the other Colleges and Players to promote dialogue and coordination, and to develop focus areas and avoid service duplication. There was an undercurrent of tension at the meeting about “mixed messages”, “loose cannons” and “unclear pathways”.
- For ACEM/IEMSIG I think the messages from this forum were (this is mostly my extrapolation):
- There are a lot of great efforts by individual FACEMs in many areas of assistance (and in many regions and nations)...but it is probably time for Australasian IEM to fall under the mantle of the College.
 - There needs to be one “conduit” (group or person) rather than a bunch of individuals ostensibly representing their craft group. The imprimatur of the College should be considered important for anyone purporting to speak for EM.
 - There needs to be more structure within IEMSIG, which needs to become a College Committee – possibly region-specific sub-groups under the main body, eg. an Asia-Pacific sub-committee, an “other nations” sub-committee, the IDF sub-committee etc.
 - There need to be staff, time and money for coordinator roles.
 - It may be of use for ACEM/IEMSIG to look to defining the role Australasian EM should play. Many Colleges have identified and articulated their niche. Where do we offer the most value? Where do we not duplicate the work of others? What can we offer that is “special”?
- For example, we might document and promulgate ACEM’s roles as including:
1. Assistance with development of EM in other countries
 - Curriculum development/dissemination
 - Specialist training
 - o Placements, scholarships, sponsorship
 - o Lecture/tutor assistance, exam preparation
 - Continuing Professional Development (CPD) assistance for MMedEM graduates
 - Offer “associate membership” to MMedEM graduates? – need to maintain CPD but get kudos, journal, web access, whatever
 2. Special Areas belonging to EM
 - Triage – implementation and training. (By the way – why are we flogging the Australasian Triage Score, ATS? Why not the WHO IMCI/IMAI 3-tiered triage system?)
 - ED design and EM systems
 - Pre-hospital systems
 - Disaster preparedness and response
 - Others?
 3. Short courses
 - PTC, ELSi etc
 - Support for Developing World doctors to come to Australian courses/conferences
 4. Service provision - local provision of care
 - Visiting FACEMs
 - Registrar secondment/rotation – many comments about this at the meeting. The previously regular “Pacific rotations” are sorely missed. Maybe ACEM could try to establish a few Special Skills Category A rotations
 - Remote second opinion and advisory role?
 - IT/internet/data support
 5. Support for FACEMs and Trainees undertaking OS work
 - Include aspects of “Global Health” (= “International Health”) in the ACEM Fellowship curriculum – training EPs to function in a global context
 - Liaison with RACS, AusAID, etc. on behalf of applicants
 - The International Development Fund (IDF)
 - Support for public health courses and pre-deployment safety courses

Letters to the Editor

“FACEMs are well suited to working in southern Africa.”

Sandy Inglis
isinglis@gmail.com

Sitting here next to the great Okavango River in Caprivi in the far north of Namibia, listening to hippo grunt and fish eagles call, it is easy to forget all the trials and tribulations of being a FACEM. We work in a tough environment; unpredictable, shift-work, access block, obstructive colleagues, burn-out, to name a few.

I have had the amazing fortune to spend the last year as a Chief Medical Officer (CMO) in a rural hospital in remote Kwazulu-Natal in South Africa.

It dawned on me during this year that as FACEMs we are fantastically trained and suited, better than any other specialty, to adapt to the variety and rigors of being a doctor in a remote or rural hospital. We are generalists by nature, but better than this, we possess special skills that make us comfortable in a wide range of situations; trauma, airway management, critically ill medical patients, paediatrics and procedures.

More than this, we are adaptable and thanks to our broad training base and time in various specialties, we are amenable to learning new skills and can become rapidly competent (like we have embraced ultrasound scanning). We have all diagnosed ectopics, abscesses, torted testes, tendon lacerations and gangrenous feet and so understand the anatomy and pathophysiology of these types of problems and can become rapidly competent in their management given the opportunity and correct environment.

The “see one, do one, teach one” adage in South Africa is alive and well and it is fantastic how rapidly competent one can become if one has to! I suspect that specialists from other areas would find the adaptation to a generalist hospital very difficult and would find themselves hugely lacking in skills and/or confidence to adapt to this open field of play after their narrow specialist environments.

I did my undergraduate degree in South Africa which may have given me a head start but all my further training was in the UK and then the FACEM in Australasia. So really I am coming from much the same medical environment as most Australasian FACEMs and my experience in South Africa could be perfectly handled by any other FACEM.

I arrived fresh from my consultant position in Christchurch to CMO in a 190 bed rural hospital in KZN; three hours from the nearest referral hospital and CT scanner; no specialists at all; about 12 doctors, mainly ‘com-serve’ (3rd year out), and some GP trainees from UK.

My life-savers were the medical director (ex UK and been there for 25 years) and a South African medical officer in his late thirties, both of whom barked at nothing, were generous with support and are the reason these rural hospitals survive.

Within weeks of my arrival I knew a lot more about HIV and TB and all their complications, was infinitely more comfortable in Labour Ward, was incising and draining abscesses prolifically and had amassed a dozen or so C-sections and a couple of vacuum extractions, tendon repairs, chest drains, multiple ketamine sedations and spinal anaesthetics.

By the end of my 13 months or so I had done more than 40 C-sections, a few ectopics, a few limb amputations, some torted testes and many debridements. Added to this I had run the male medical and surgical ward and was in charge of the “ED” (of course!). I had attended an excellent course on HIV and TB, a rural doctor’s conference in Swaziland and an orthopaedic workshop. We had grand ward rounds four days per week and medical education every Friday morning. I won’t start on the beaches, game reserves, mountains, culture and family experience.

What I’m trying to convey in a somewhat convoluted fashion is this: FACEMs are exceptionally well trained specialists; our work is tough and sometimes we burn out. We are also perfectly suited to work in rural environments both in Australasia and abroad. Rural hospitals (particularly in South Africa) desperately need you and your skills. You will be an incredible asset. You will learn new skills and operative procedures fast and will enjoy an unparalleled life-experience.

For some more insight please see
inglisinafrica.blogspot.com

And for the NGO that will sort out all your admin, see
www.ahp.za.



“A trainee at Nyakibale Hospital in Uganda.”

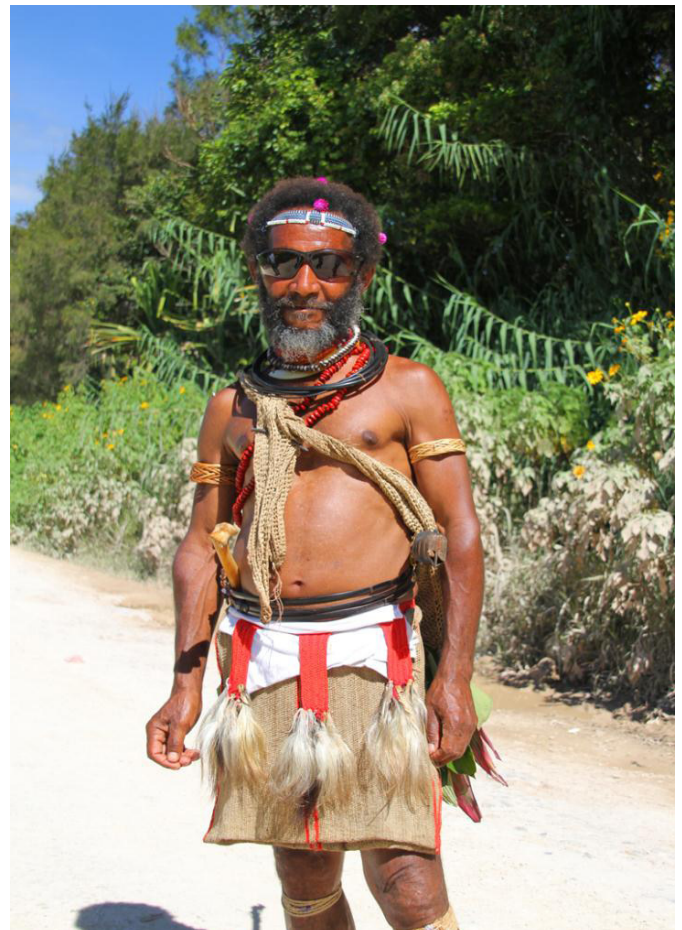
Rubina Bunwaree
rubinabunwaree@doctors.org.uk

Last year I decided to take 6 months off from the busy world of Melbourne Emergency Medicine to do something a little bit different. I needed a break, I needed a change. I knew I wanted to use the skills I had acquired through my training, I was keen on teaching and I was eager to travel to my continent of birth. The perfect opportunity presented itself while flicking through the IEMSIG Newsletter.

In September 2010 I packed my bags and headed to the Nyakibale Hospital located in the Rukungiri District in South Western Uganda. The program I was involved in was dedicated to provide sustainable medical assistance in the developing world. The organization, the Global Emergency Care Collaborative was set up by a group of American Emergency Physicians in an attempt to improve access to Emergency Medicine by training nurses to become

Emergency Nurse Practitioners (ENP). The program started in 2009 and a set curriculum was taught to 6 nurses of varying experience. The first ENPs graduated in mid 2010 and they were now responsible to act as tutors for the new recruits. My role, as one of the visiting doctors, was to supervise the care provided by the ENPs and ENP students to patients, to participate in formal tutorial-style teaching and bedside teaching in the department and to teach procedural skills needed in the ED.

Our resources as expected were limited but adequate. My experience in Nyakibale was fascinating, at times tragic but mostly incredibly gratifying and I would encourage all emergency trainees to join in the effort of providing this universal right of basic healthcare for all.



Lukim yu bihain (see you later!)