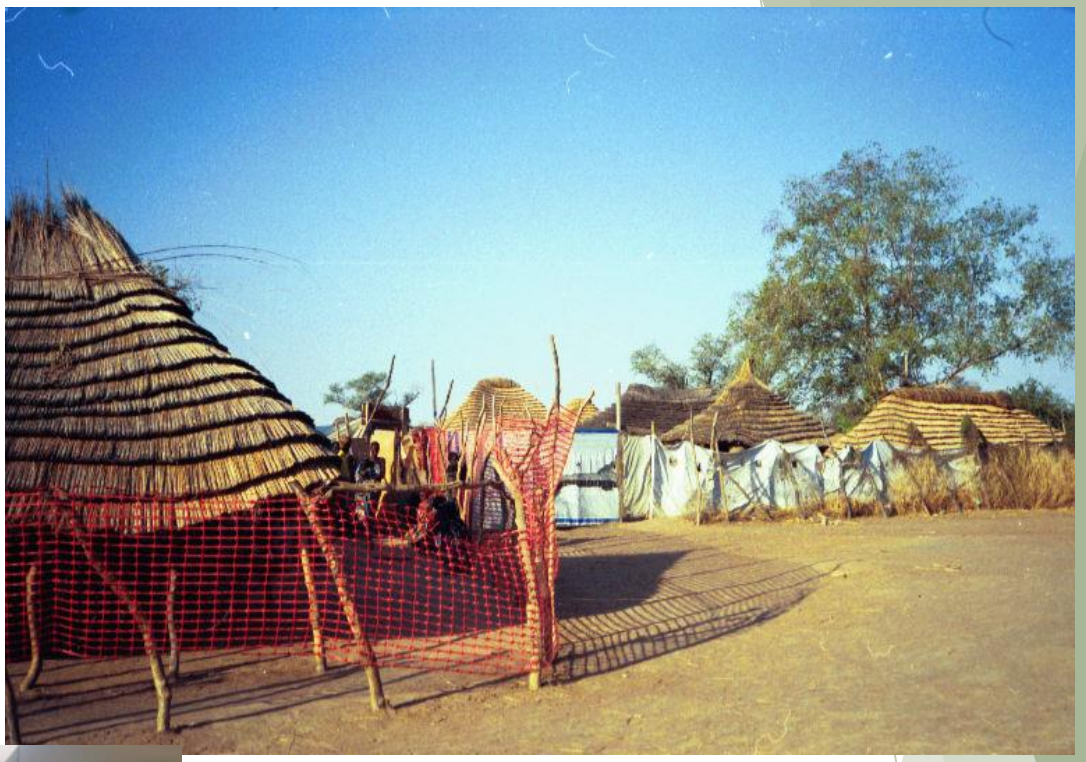
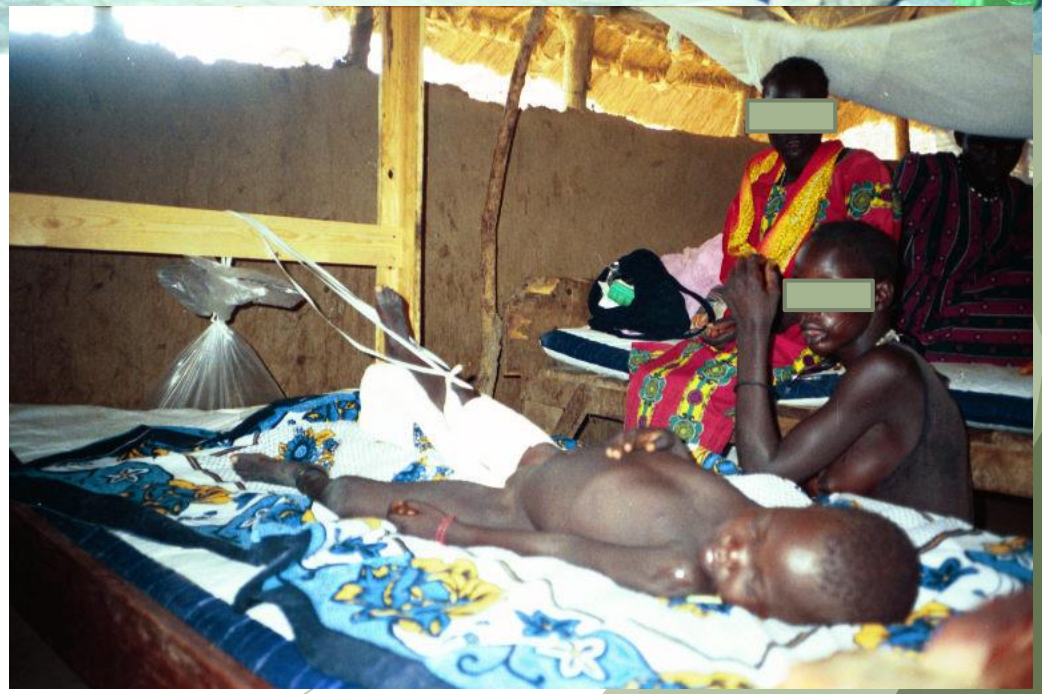
Dr Megan Cox
My IEM history & lessons learnt

- Since 1996 IEM Work in Solomon Islands, South Sudan, Tanzania, Kenya, Uganda and Botswana.
- Currently EM physician South East NSW Area Health/ NSW State Retrieval Consultant
- 2018 designing a unit of study called "Critical Care in Low Resource settings" for University of Sydney

MSF South Sudan





Lessons learnt working in Humanitarian aid

- Work in area of huge need, usually with experienced workers
- Insurance, Airfare, Accommodation provided, Logistical and Security Back up
- Formalized Protocols, Guidelines of the NGO- orientation and debriefing
- Concentrate only on providing acute medical care
- Complex emergencies, war, famine, insecurity -- remote and little clinical back up
- Primary Accountability to your NGO- they determine where, who and what
- Need to complete monthly reports
- Fatigue of dealing with essentially preventable diseases e.g. famine, malaria
- No long term clinical missions- emphasis on dealing with current crisis and emergencies

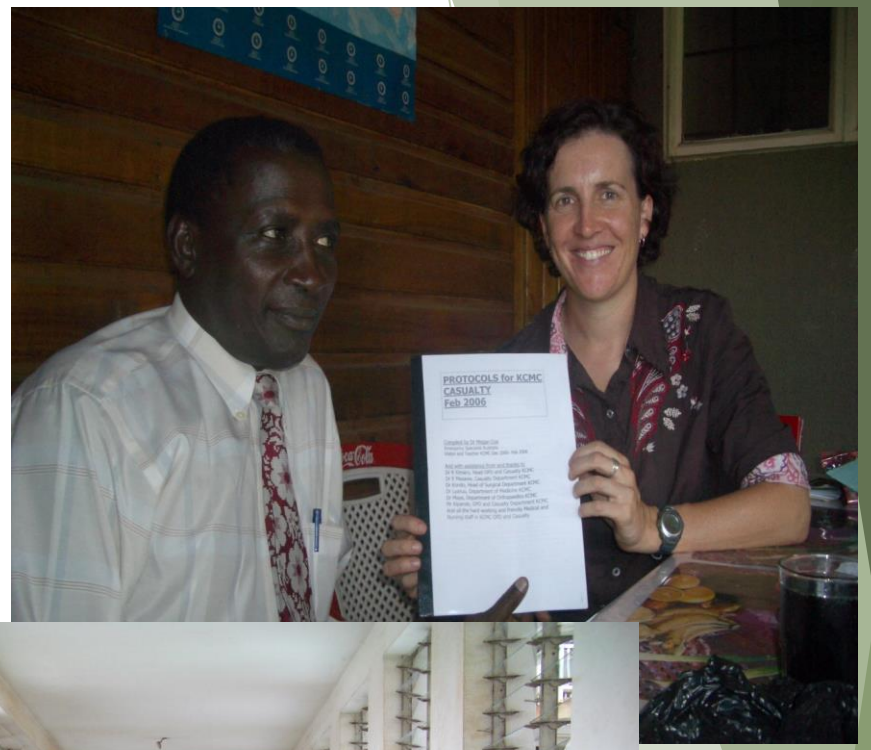
KCMC Tanzania

Major Referral Hospital North Eastern Tanzania
500+ beds teaching University Hospital

- Requested to visit by KCMC Director and medical missionary friends
- Unpaid, self sponsored 3 months every year for 3 years, work visa waived through KCMC, required registration

Educational opportunities

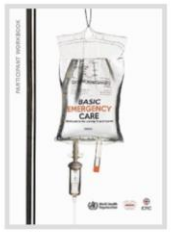
- Introduced “emergency care “
- Opportunity to teach and mentor medical students in the “Casuality” for 8 weeks
- Introduced EM concept “ABCs”
- Taught ECGS and radiology to other doctors in the hospital



Lessons learnt regarding LMIC EM education

Don't re-invent the wheel- there are lots of LMIC EM resources

Basic emergency care: approach to the acutely ill and injured: participant workbook



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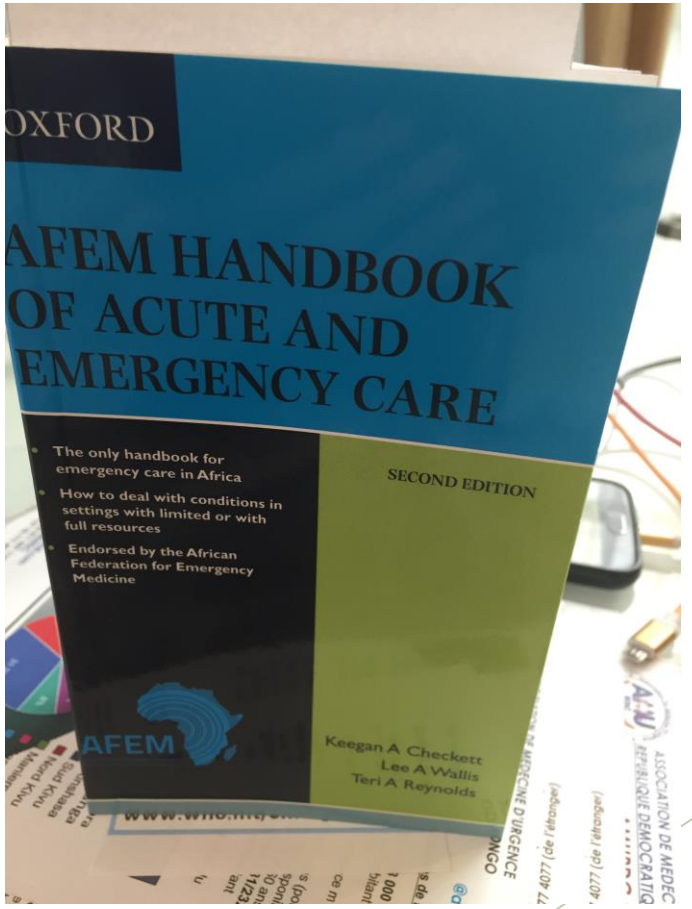

EM foundation Kenya guidelines
https://www.emergencymedicinekenya.org/
AFEM guidelines and curriculum
https://afem.africa/resources/
EM Guidance from UCT http://www.emct.info/em-guidance.html
BadEM https://badem.co.za/

Lessons learnt on ST EM volunteering

- Hospital skeptical of EM practices – death of prominent woman from in the ED --- relatives and medical superintendent demanded a post mortem, little hospital support
- No extra resources for ED in 3 years of visits
- No regular ED staff- every year different doctors, students and nursing staff
- No impact on health educational model, strategies in the Hospital

EM Advocacy requires constant work/ discussions on how EM "value adds" to a health system

with

- Government ministries, Health, Finance, Labor, (Immigration)
- Universities, educational providers, (private and public)
- Pre hospital providers (public and private)
- Hospital manager and HoDs
- Medical colleagues (don't forget pathology, radiology, forensics)
- Nursing colleagues
- Allied health colleagues (e.g. Physiotherapy, Pharmacy, medical records)

University of Botswana

Created an EM culture – staff, resources and multi disciplinary care

University of Botswana – over 6 years of fulltime work

- Implemented and developed **undergraduate EM** in the medical school
- Led and developed the **postgraduate hybrid EM program** (with South Africa)
- Mentored and trained EM registrars , medical officers, nurses and ambulance assistants at main teaching hospital PMH
- Involved in setting up **short course training** (BLS, ACLS, PALS, USS, Trauma)
- Involved in development of **triage** system for PMH and the first public **pre-hospital system** for Botswana
- Developed disaster response for the country
- **EM Examiner** for the EM College of South Africa Fellowship exam
- Recruited 4 fulltime staff for EM department , interviewed 8 applicants in 6 years
- Supervised over 50 short term EM volunteers (medical students, registrars and consultants) working at PMH

Lessons learnt about managing Global EM volunteers

- Over 300 email enquiries for “volunteering” in 6 years
- Mostly from Junior doctors (<PGY3),EM registrars and consultants wanting to visit, work or start a partnership
- Requests for working 1 week to 12 months *(3 months only feasible)*
- Requests for funding flights, accommodation, holiday recommendations, salary!!
- Required significant time answering emails, skype and phone calls requests→ 10% actual volunteer rate
- Over 50 great volunteers worked clinically 4-10 weeks

OFTEN in the first email questions

- Asked about research projects- no knowledge of current research needs, ethics review or data collection issues
- offered to bring courses (BLS, APLS etc..) or equipment (oximeters, mannikins etc.) no knowledge of current courses or equipment available
- asked if they could avoid compulsory medical registration in Botswana- (takes 3 days and paperwork) LMICs often have major country issues of clinical governance and health quality
- Didn’t usually ask about visa issues, safety briefing or post exposure prophylaxis despite visitor visa 90 days only and 23% population HIV positive, TB major health issues

Established a sustainable ED teaching culture

EM research lessons learnt

Examples of My LOCAL research projects I like to start

- Which HIV positive patients should I advocate for ICU admission when there are only 8 ICU beds in the hospital?
- How many and what are the common paediatric presentations in my ED a month so I can continually advocate for a separate ED for paeds?
- What are the main causes of my LMIC teaching hospitals' ED access block ?

Current Global health research priorities in Botswana with funding

- HIV ++++++++
- TB ++++++
- Oncology ++++
- Non Communicable diseases eg Diabetes, CVD +++
- Medical education ++

EM Research lessons learnt– benefits and challenges

- Local EM Research Leads to evidence based EM culture and training
- EM clinicians need abilities to critical analyze literature
- **EM Research** development and publications in Trauma, Toxicology etc for Botswana
- **Masters of EM theses** (compulsory part of EM specialty training in Botswana)
- Research in EM training can cause significant conflict with studies and clinical time…
- Need collaborations and assistance with epidemiologists, biostatistics
- Many interested in research – but not EM research or ….“ research vultures “
- Careful with datasets and ”ownership of data”

?Future directions for LMIC EM

Educ Health (Abingdon). 2017 Sep-Dec;30(3):203-210. doi: 10.4103/efh.EfH_72_17.

Developing and implementing a global emergency medicine course: Lessons learned from Rwanda.

Yi S[1], Umuhire OF[2], Uwamahoro D[2], Guptill M[2], Cattermole GN[2].

Author information

Abstract

BACKGROUND: There is a growing demand by medical trainees for meaningful, short-term global emergency medicine (EM) experiences. EM programs in high-income countries (HICs) have forged opportunities for their trainees to access this experience in low-and middle-income countries (LMICs). However, few programs in LMICs have created and managed such courses. As more LMICs establish EM programs, these settings are ideal for developing courses beneficial for all participants. We describe our experience of creating and implementing a short-term global EM course in Rwanda.

Major lesson learnt regarding IEM