IN INTERNATIONAL EMERGENCY MEDICINE

Changing my perspective: How the development of emergency medicine in Sri Lanka can inform the Australasian experience

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Abstract

When compared to an Australasian ED, the two major differences in the emergency medicine practice at Teaching Hospital Karapitiya are which patients are selected at triage and how those selected present. These differences have caused me to reflect on emergency medicine practice in Australasia and wonder if this practice is sustainable.

Key words: Australasian College for Emergency Medicine, developing emergency medicine, international, registrar training, Sri Lanka.

A 55-year-old man complaining of severe central chest pain presents to the triage desk of a tertiary referral hospital’s ED. He is rapidly and accurately triaged by trained nursing staff then immediately transferred to a monitored bed, where his acute myocardial infarction is diagnosed and expertly treated. This is a scenario, which is commonplace in developed nations with established emergency medicine (EM) systems, but in this case, his care is being provided by the team at the Teaching Hospital Karapitiya (THK), Galle, Sri Lanka.

THK is the major referral centre for southern Sri Lanka having over 1800 beds and seeing 900 000 outpatients per annum. It hosts a sophisticated emergency treatment unit (ETU), a unit that is the only one in the country, which to all visual and functional appearances is equivalent to an ED of any major developed nation.

During my 6 months in THK ETU, providing training and support, I have learnt an enormous amount from my wonderful colleagues but also spent some time thinking about how my experience here provides a different perspective on my own EM practice in Australasia.

Background

The usual way a critically unwell patient, such as the aforementioned man, would receive treatment in Sri Lanka, is by taking a private car or tuk tuk (three wheeled taxi) to the outpatients’ department. Here, he would be met by a junior medical officer (MO). The MO would provide a brief assessment and then divert the patient on an unsupervised trolley to a general medical ward or to the small casualty ward (often four beds or so) depending on the probable initial diagnosis. It is not uncommon that patients may arrest at some stage in transit or on arrival, where they can access no advanced life support measures. Prolonged treatment delays are an unfortunate part of this system.

Spurred on by the tragedy of the 2004 Boxing Day tsunami, passionate advocates for improving this system have worked tirelessly towards the development of the THK ETU, a wonderful example of a collaboration between governments and health practitioners of developing and developed nations.¹²

Passionate advocates have also succeeded in developing an EM specialist training programme (EMMD) administered by the Sri Lankan Post Graduate Institute of Medicine, which commenced in 2013. The registrars of this programme are some of the most committed, enthusiastic and industrious I have had the pleasure to work with. They are the burgeoning forefront of EM in Sri Lanka and will eventually fill the 100 or so new ETUs, based on the THK model of care, which the Sri Lankan government plans to roll out over the next 10–20 years. This roll out is a huge and daunting undertaking. The challenges in providing sufficient high level supervision, equipment and training when resources are severely limited and the first EM specialists

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Key findings

• Sri Lanka is embarking on an exciting phase of emergency medicine expansion.
• Collaboration between Sri Lanka and international experts has been a key part of the development of emergency medicine to this stage.
• Continuing partnerships with established emergency medicine systems will be important for the future of Sri Lanka’s emergency medicine systems.
• The future of emergency medicine in Australasia may be informed by this Sri Lankan experience.
EMMD registrars and faculty following the inaugural trial fellowship exam.

are still 2 years from completion of training cannot be underestimated.

The THK ETU system

Emergency medicine practice at THK ETU has important differences from that which is commonplace in Australasian EDs. The comparison of these two systems has allowed me to take a new perspective on the challenges facing EM practice and training in Australasia.

At THK, all patients who are admitted – either by their own judgement or that of an external referrer – arrive at triage. This is approximately 250–300 patients per day, similar to the number presenting to a major Australasian ED. Anyone who meets the triage criteria (a strict interpretation of category 1–3 of the Australasian Triage Scale) is brought directly into ETU. Everybody else is seen by the secondary doctor triage, an ETU MO, who then diverts the patient onto an inpatient ward or occasionally a clinic for their likely provisional diagnosis. The triage MO can also return patients into ETU if required.

For example, a patient with dyspnoea but normal observations will go to the general medical ward; a patient with abdominal pain but no signs of surgical emergency will go to the general surgery ward; a patient with a simple broken arm goes to orthopaedics; and a patient with a sore throat might go to the general medicine clinic.

If the patient gets very sick immediately on the ward, they return him or her to the ETU – I have seen one or two returns only in my time here. The system seems to be accurate in this initial sieve.

ETU therefore sees around 50–80 patients a day. There is no waiting room. All patients are placed onto a bed and seen immediately. At peak times, a moderately unwell patient may wait for 5–10 min. Resuscitation patients are given immediate and high level care by motivated and well-trained teams. No one is discharged from ETU; all are admitted. In my experience, almost 100% need admission.

In THK ETU, the resuscitation bay is a constant whirl of critically unstable patients with multisystem illnesses. Here, making a diagnosis is rarely the problem. Patients present late; they are often non compliant with prescribed medications and commonly have limited or no access to ongoing higher level intervention. Our patient with the myocardial infarction from the introduction is likely to have three blocked coronary arteries and progress into a highly unstable condition even with treatment.

At THK ETU, I have been able to focus my involvement as an educator and supervisor onto the skills required to assess and to manage these unwell and unstable patients.

The ETU staff I work with have excellent resuscitation and critical care skills and knowledge. The triaging system allows these doctors and nurses to continuously upgrade their skills, with frequent exposure and repetition as they focus their practice on only the sickest group of patients.

The Australasian ED

The relative surplus of resources in the developed world has allowed, even demanded, that EDs provide timely and high standard care to all who present, regardless of the severity of their condition.

The emergency physician in Sri Lanka has to be a sick patient expert. The emergency physician in Australasia is often predominately a diagnostician for the mildly unwell undifferentiated patient, despite, I suspect, still believing their skills are predominately intended for the critically ill.

The classic presenting complaint of illness still exists in underdeveloped Sri Lanka, but in a developed world of primary and secondary prevention, asymptomatic screening tests and very early presentations, the Australasian emergency physician is now dependent on algorithms, Bayesian reasoning and coercive communication skills in order to make diagnoses and admit patients. They spend a huge amount of time and resource ruling out serious illness from minor complaints in order to discharge more rapidly, so they can see the next patient who is lining up in the waiting room. The Australasian ED staff sort and differentiate so thoroughly and so often that their inpatient colleagues, who have now been largely screened from this primary sort for over 30 years, are often unwilling or even unable to do further sorting.

The expectation that EDs in Australasia will continue to treat everyone who presents has led to workplaces of high stress, high staff burnout rates and lower job satisfaction as the staff struggle to deal with a daily increasing patient load. Into the future, continuing to expect to provide high level care to all patients may be an unrealistic goal. Attempting to train the future emergency physicians of Australasia to gain all of the knowledge and skills required to treat virtually any illness, at the high standard that the speciality of EM, and the public expect, is an increasingly difficult proposition. The recently declining success rate at the ACEM Fellowship examinations may attest to this.

Consider the Australasian emergency medicine trainee who spends 5 years battling huge patient numbers,
minor complaints and heavy supervision burdens while queuing for their sporadic exposure to the resuscitation bay. Most would now consider themselves lucky if by the end of their training they have gained sufficient exposure to patients with critical illness to feel comfortable managing those same patients independently as a specialist.

**Changing my perspective**

Before I came to Sri Lanka and the THK ETU, I was convinced that EDs should provide timely and high standard care to every patient, at all hours, regardless of severity or circumstance. I saw it as a moral obligation that this should continue to occur and was initially surprised by the system of care I encountered here.

I wonder now if, for emergency medicine in Australasia, it is time to relinquish some of our patients and ask our hospital and community colleagues to share some of the acute care burden. If it is time to focus our energies on training our staff to become experts in those with time critical illness and acknowledge that we cannot possibly continue to treat everyone with any illness at all times to the same standards that others might expect or provide.

The challenge for emergency medicine’s future in Sri Lanka is to use available limited resources to expand the successful model of emergency medicine care piloted at THK ETU into a nationwide system, which provides expert and timely care to those most in need. The challenge for emergency medicine in Australasia is to continue to provide expert and timely care to those most in need, without sacrificing the progression and development of the knowledge and skills, which make this speciality so special.

Sri Lankan emergency medicine registrars will shortly be looking for placements for 12–24 months in Australasia, Singapore and the UK in order to complete their training. They are highly competent and adaptable and would be an asset to any department. In return, there could be no better rotation than THK ETU for an Australasian registrar to gain much needed exposure to critical illness.

There are multiple possibilities for EM specialists to provide mentoring and support in a volunteer capacity in Sri Lanka. For further information contact me or visit www.srilankaemergency.wordpress.com to become an online mentor.

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**Competing interests**

None declared.

**References**
