What are the common presentations to the Emergency Department in Suva, Fiji? How does this differ from the UK?

Fiji has a population of 900,000 people set over 333 islands. Suva, the capital of Fiji, has a population of 88,691 (Wikipedia, 2018). Colonial War Memorial Hospital (CWMH) is located in Suva and is the only hospital in the capital. The Fijian Ministry of Health and Medical Services identified in their Strategic Plan for 2016-2020 that Fiji faces a crisis of non-communicable diseases (Ministry of Health and Medical Services, 2014).

During my elective placement, it was common to see more than one severe asthma attack a day and multiple diabetic foot complications. Anecdotally, every patient over 40 seemed to by hypertensive or overweight or a history of ischaemic heart disease. TV adverts regularly quoted a statement that "one in three Fijians have diabetes". Fiji also has the world's second highest mortality rate from asthma (Ministry of Health and Medical Services, 2015). Patients also had a low level of health literacy so explaining concepts was challenging e.g. the importance of inhaler use and technique.

Subsequently, I saw a range of patients present with late complications of non-communicable diseases.

How is the emergency department organised and emergency care delivered in the Colonial War Memorial Hospital? How does this compare to the UK?

I have a constructed a crude diagram of CWMH's Emergency Department (see Figure 1). Patients would arrive via the entrance where they would be triaged by a nurse. Basic observations would be taken and then most would move to the waiting room to be seen under 'Fast Track'. This is the equivalent of Minors in a UK Emergency Department. Fast Tract is lead by junior doctors and medical students. There are not enough nurses to work in this area as they are needed in Resus. Resus contains three monitored beds with one resuscitation trolley and three more treatment beds. A trauma bay is also available however often this was filled with overflow patients. HDU was described as a step down from resus but I found this to also be an overflow room with patients equivalent to Majors in a UK Emergency Department. The corridors and resuscitation room were often packed with patients on beds and chairs.

Patients were seen in order of clinical need which meant low-risk patients in fast track would wait over 6 hours to be seen. If an emergency arrived by ambulance then patients were displaced from their bed to make room. It would be difficult to manoeuvre through the department and I struggled to grasp how the nurses kept track of patients. There was one computer at the nurses' station in the resuscitation room to view blood results.

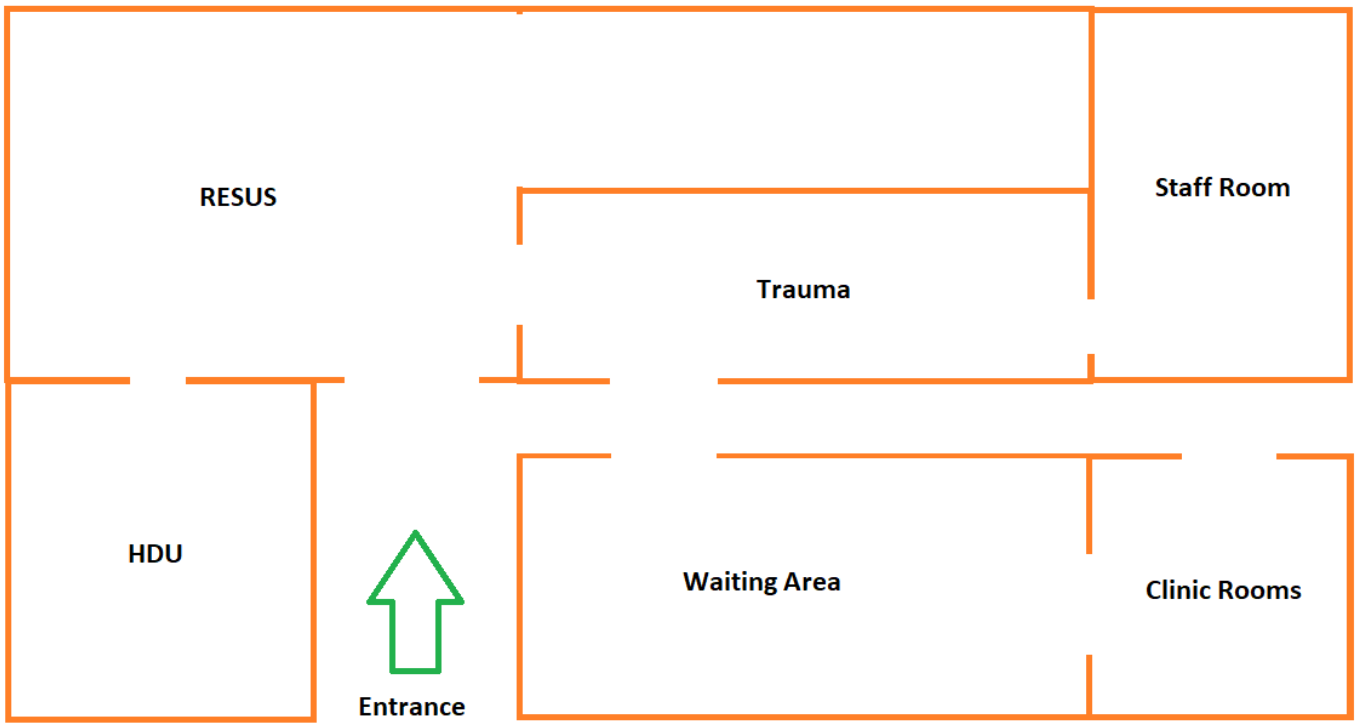

Figure 1 - Colonial War Memorial Hospital's Emergency Department

Doctors and nurses were rotated for 12-hour shifts starting at 8am. A handover would take place then and a ward round at 4pm, before handing over to the night team at 8pm. One consultant or senior doctor provided cover with two registrars and one intern. Medical students were essential to supporting the work of these doctors and attendance (or absence) was noticed.

Doctors from Australian and Indian provided an influence on the Emergency Department via fellowships and visiting placements. This has been fundamental to the establishment of post-graduate Emergency Medicine training in the past five years (Creaton & Holt, 2017).

This is a long way from the UK which has a Royal College of Emergency Medicine that just celebrated 50 years.

As a less economically developed country, what pressure does this place on the emergency department and the level of care provided?

This was the hardest aspect of my elective to come to terms with. I found the lack of resources frustrating and embarrassed that my presence may actually be worsening their resources (e.g. multiple cannula attempts if I failed). The whole system ran on rationing with compromises made on care delivered.

From a basic hygiene level, there was often no paper towels to dry your hands. Alcohol gel was expensive to import so everyone was expected to carry their own. Alcohol wipes were only available if a visiting Australian HCP had brought some. If no alcohol wipes, cotton wool and alcohol gel was used to “sterilise” equipment trays. There was also a bizarre habit of using betadine to sterilise the skin then alcohol gel pre-cannulation. The literature is not strongly supportive of alcohol wipes before IM injection or venepuncture, so this was an odd case of waste in a resource-stricken system.

Due to a lack of cannula adaptors for vacutainers and not wanting to waste syringes, the Fijian med students had a developed a novel way to collect blood. They would allow blood to drip from a freshly inserted cannula into an open blood tube. This created an exposure risk for blood-borne viruses and I was not comfortable undertaking this method.

Cannula dressings were also rare so any cannula was taped in place and could easily be dislodged by the patient. The entire process of cannulating had been impacted by austerity to produce a technique that was effective, but not safe or aseptic.

Drugs often ran out limiting the emergency department’s ability to provide care. Streptokinase had only recently come back in stock. Meanwhile there was no amiodarone so lidocaine was used in both the management of atrial fibrillation and cardiac arrest. This pressure to use sub-optimal drugs was infuriating at times. It also meant that lower levels of analgesia were used to preserve drugs for worse cases.

The cost of importing equipment further rationed clinical care. The defibrillator was chosen because it used paddles, not disposable pads. Only aspirin could be offered as an anti-platelet drug. Spaces cost $30 FJD (£10) so Coca-Cola bottles were used instead. Lancets for blood glucose monitoring were not available, so a needle was often used to prick a finger. All this rationing impacts the clinical decisions a doctor or nurse can make and there is limited scope for them to change the situation.

I found this difficult to watch as I knew these patients would receive a high level of care if we were back in the NHS.

Will this placement improve my clinical skill in a resource-poor environment? Will this give me confidence and experience that I can bring to my FY1 job?

I think this elective placement has ultimately given me an appreciation for the NHS and how incredibly lucky I am. Fijian medical students asked me if I used Kumar and Clarke’s Clinical Medicine. I felt very humbled when I shared that not only did I own a copy, but I had been lectured by Prof Kumar and examined by. I leave this placement with an immense gratitude and a new insight into a completely different healthcare system.

References

Creaton, A. & Holt, J., 2017. Health promotion in Fiji: Is it feasible in the emergency department?. *International Emergency Medicine,* 16 August, Volume 29, pp. 686-691.

Ministry of Health and Medical Services, 2014. *National Strategic Plan 2016-2020.* [Online]
Available at: http://www.health.gov.fj/PDFs/Corporate%20Plan/Strategic%20Plan%202016-2020%20Executive%20Version.pdf

Ministry of Health and Medical Services, 2015. *Asthma.* [Online]
Available at: http://www.health.gov.fj/?page_id=656

Wikipedia, 2018. *Suva.* [Online]
Available at: https://en.wikipedia.org/wiki/Suva