ALOTAU 5-6 April 2006

Primary Trauma Care Course
Alotau Hospital

Director Marian Lee FACEM

Participants 40

Day 1

Facilities: the LCD projector worked well except for not being able to talk to my laptop. Fortunately, I had the PowerPoint presentations on a CD-rom.

The conference room was large enough to accommodate 40 people, 6 manikins and a table for refreshments. It was cool and shaded.

Program:

The first day started well. The only problem was the initial IT problem between my laptop and the LCD. I had sent a draft of the program to Dr Noel Yaubihi prior to my arrival. I split them into 2-hour blocks. He worked on them to accommodate the workings of the hospital and released as many staff as he could. Consequently, 40 people attended and we started at around 830am.

The initial presentations aimed to introduce the principles. During the teamwork presentation, participants were keen to voice their lack of teams to handle emergencies. This came from those in the ED as well as the other wards. The structured approach was introduced.

Skills practice after morning tea increased the level of participation. We had 4 baby manikins and 2 adult manikins to practice cervical immobilization and airway assessment and management. There was one broken rigid cervical collar owned by the surgeon so we discussed methods of immobilization using local resources – IV fluids, taping, and sandbags. Dr Yaubihi, Dr Seta the surgeon and Dr Samof the anaesthetist presented the theory and we all participated in the practice sessions. Dr Yaubihi showed how he suctioned patients when he was working at the army barracks in Taurama.

Dr Yaubihi used the lunchtime session to give out the multiple choice questions and asked people to work in groups. The faculty milled around and helped with some of the interpretation of the question. Most of the participants did not leave until the last 20mins to get a bite as lunch was suppose to be provided but did not arrive.

After lunch, Dr Yaubihi had to attend to his DMS duties and I gave the presentation on Breathing. Subsequently, Dr Seta presented the skills of treating tension pneumothorax and insertion of intercostal chest tube. Dr Seta and myself had to present the concept of the open pneumothorax/sucking wound in different ways as there were many puzzled looks and questions. We finally settled everyone's queries with a few drawings and a great teaching prop – see photo.

Dr Seta owns this teaching prop for insertion of intercostal tube and other chest injuries. It was constructed out of the back of a chair and fitted onto a stand by a carpenter who is now a medical doctor practising elsewhere. As evident in the photo, there is a sternum and a vertebral column. It is the cleverest prop that I have ever seen.

The skills sessions were: a x-ray session on my laptop, 2 cervical spine immobilization and 2 log-rolling of a volunteer.

The circulation session brought out the concern for IV fluids. IV fluids of any type are a scarce commodity. There was much relief when N/S was the recommended initial fluid. They have their own blood bank and the blood bank person was there for the 2 days. People used to be happy to donate and to receive bloods but more recently, there has been a decline in the availability of blood due to AIDS. Not many are willing to donate and even less is willing to receive. Pathology is available 24 hours.

In the last session on disability and exposure, the reasons why they are needed were emphasized. The day ended with a presentation of photos of the priorities and sequence of what was imparted today.

The participants enjoyed the scenario especially the summary scenario where Dr Samof volunteered to be an intoxicated man walking home who was hit by a car outside the hospital. There was much hilarity especially when he was rolling off the table. It was a shame that I was too busy trying to make sure they did not drop him to grab my camera.

The “faculty” retired after the long day, aiming to do more hands-on activities tomorrow.

DAY 2

Dr Seta did all the presentations listed. (He told one of the participants that he was up till 4am, preparing). He did the presentations with great style. He is quite humorous and obviously has the respect of all those present. He was happy to admit that he has not seen many pelvic trauma. We did part of the discussion of severe pelvic traumas together. As they had minimal equipment, I suggested the use of a readily available bedsheet to wrap around a suspected open-book pelvic fracture. The idea caught on and lap-laps and other potential ‘pelvic wraps” were postulated and discussed. We also discussed alternatives to underwater seal drains – not many are available in the hospital. I showed what we did at PMGH with Orchy 2 litre bottles. A number of comments by Dr Seta were memorable but the best are included below.

He encouraged participants to change their thinking. He asked them to think beyond their normal roles. He says everyone should learn to approach patients in the structured ABCDe approach, as it will save a life, regardless of whether this is in the labour ward, ED or OT. He wanted everyone to be brave enough to act at a time of crisis. Dr Samof and Dr Yaubihi seconded this. He also pointed out that drilling more than one hole to drain an extradural haematoma will save a life and it did not matter if it takes four holes to save the patient.

The pregnant trauma patient presentation was easy to present. They were familiar with the anatomical changes if not the physiological changes. Nearly everyone knew the

fundal heights for specific gestations. The paediatric presentation was done with the manikins.

Dr Samof was keen to use the afternoon from 3-5 to run scenarios. It was enjoyed greatly by all. Eight teams practised one scenario. Not all teams had manikins. Some created 'manikins' using back-packs and boxes to log-roll and expose – see photos.

Somewhere during this busy day, we went through the MCQs - conducted by the Surg Reg – Dr Esther Apuahe. We clarified a number of points. The whole group gave people who disagreed a 'hearing'. Everyone listened politely then stood up to offer their reasons for their opinion. It was a very polite and respectful process. The MCQ in question goes through this process as many times as required until everyone agrees on the best answer.

Dr Yaubihi gave every participant an evaluation form to assess the program and the presenters. These were collected and given back to him. None of the other faculties has had a look due to the busyness. No doubt, he will provide us with the final opinions.

The day ended with everyone receiving a certificate from Alotau hospital for attending the PTC course. I had the honour of presenting it to each participant.

We also had a group photo taken. The day started and finished with a prayer and ended at 530pm.

Marian Lee
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