

Runner-up — *Medical practitioner category*

# Empowering clinicians to address the global challenge of trauma: an example from Myanmar



Investment in clinicians and in hospitals can trigger wholesale change in thinking about health systems

**N**o one had thought to resuscitate him; shocked, hypoxic and drowsy as he was. This Myanmar Delta fisherman had been left alone with his obstructed airway and bleeding, bilateral compound femoral fractures. Hours earlier, he'd fallen from his boat and under the blades of the outboard motor. Dragged out of the water by his comrades, he didn't receive any first aid and the local clinic care was woefully inadequate. Even at the national trauma hospital in Yangon, the fisherman lay unattended and neglected in the emergency receiving area.

He didn't receive essential trauma care until we arrived: a team of doctors training to be Myanmar's first emergency specialists and me, as their tutor. He needed simple airway support, oxygen, intravenous fluids for shock, pressure and immobilisation for his fractures, antibiotics and some pain relief. Not complicated, not expensive, but perhaps too late.

Fast forward 2 years, for that was in 2013, and I'm impressed by the rapid response to another trauma patient. She's been hit by a car and has severe facial injuries and a tense, swollen abdomen. This time I'm an observer at the Myanmar hospital, visiting my former students who are now leading the care. The team have assembled around the patient in the dedicated resuscitation space of the newly renovated emergency department. She receives simple but effective interventions that stabilise her until the surgeons, called urgently to assist, can take her to theatre.

These are stories of trauma and clinical care. In Myanmar, injuries, primarily from road traffic accidents, remain the leading cause of morbidity and the second highest cause of death. Like other low-income countries, the burden of trauma falls heavily on the young and productive. In Myanmar, and elsewhere, death and disability from trauma have long been unacknowledged by local and global health authorities whose focus is on Millennium Development Goals priorities.

Clinical care of injured patients in low-income countries is substandard or absent. Health systems are weak and underfunded. Crowded, dirty hospitals are perceived as places of death and infection; people don't trust them to provide emergency care. For donors and

funders, hospitals are unsustainable drains on limited resources. An Australian Government aid official told me recently that hospitals are "expensive luxuries" that are not on any global health agenda.

Yet, my experience in Myanmar suggests that investment in clinicians and in hospitals, as critical places of care, can trigger wholesale change in thinking about health systems and health advocacy. Further, given future Sustainable Development Goals targets that aim to reduce death from road traffic accidents, much more attention to clinical care, hospitals and clinicians will be required.

What has been behind the transformation taking place in Myanmar? The examples given above are of life-saving improvements in emergency care, but it's more than that. In Myanmar, the program that is reducing death and disability from trauma — and any other acute and urgent condition — has expanded from training staff to hospital renovation, introducing acute care systems (such as pre-hospital care and triage), changing legislation and educating the public. Where and how were the seeds sown for this type of change?

One starting point, and perhaps a symbol of the importance of empowering clinicians, is the Primary Trauma Care (PTC) course. Introduced in Yangon in 2009 in the aftermath of Cyclone Nargis, PTC is a 2-day course that aims to train front-line staff with the skills, knowledge and attitude for preventing death and disability in the seriously injured patient. Designed specifically for underdeveloped and low-resource areas, PTC exists under the auspices of a non-for-profit Foundation based in Oxford, United Kingdom (<http://www.primarytraumacare.org>). It's free, adaptable to any context and empowers local clinicians to teach the PTC principles in their own environments. First launched in Fiji in 1997, the course is now being taught in over 70 countries and is thriving in parts of Africa, the Middle East and Central America. In the Pacific region (where I've also taught), PTC is known as a "gospel message"; it is bringing new vision, new language and new actions to previously limited clinical environments.

After our inaugural PTC course in Myanmar, a young orthopaedic doctor went back to his rural district hospital and mobilised his colleagues and hospital



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administrators. He sourced funding to renovate and equip a room in the old hospital “receiving area” to provide a safe and effective environment to care for emergency trauma victims. He taught his staff the PTC principles and practised teamwork through simulated trauma scenarios. Six years later, this doctor is now a leader of emergency medicine in the country. He’s meeting government authorities to discuss the national roll-out of acute and trauma care standards, participating in workshops to introduce a coordinated pre-hospital system, making plans for road safety and injury prevention campaigns, and providing good quality clinical care in his well designed, functional emergency department. This doctor was part of our team who tried to save the life of the Myanmar Delta fisherman.

*“Public health needs clinical service in order to provide an effective health system and prevent unnecessary death and disability”*

The work to establish these clinical and health system improvements in Myanmar has been substantial, and not just about a short trauma skills course. Supported mostly through a network of volunteers from Australia and Hong Kong, Myanmar doctors and nurses have been trained and empowered to provide better clinical care in superior clinical environments and become national leaders in acute health care.

These Myanmar clinicians already had the vision and drive for change. The PTC course has been a catalyst to realise their desire for improvement. It is a tool that starts with the clinical, then inspires broader thinking about environments and systems of care, and then even the health status of the population. This “clinical to public health” cascade has brought about substantial health improvements in other national contexts. For trauma, the front-line clinicians dealing with injuries agitated for seatbelts, speed limits and helmets.

Investment in clinicians and their hospitals is a priority in order to achieve the right balance between clinical medicine and public health for an effective response to the global challenge of trauma.

Clinicians have often been the “outsiders” in the global health discourse. In low-income countries, they are exhausted and overwhelmed by the service provision needs of their communities. Working their guts out day after day, they often view public health authorities with suspicion. Likewise, the authorities perceive clinicians as somehow less worthy, excluding them from funding sources and health improvement programs. This is a false and harmful division. Public health needs clinical service in order to provide an effective health system and prevent unnecessary death and disability. People need hospitals that they can trust to deliver safe and effective clinical care in order to inculcate confidence in their health system for times of increased need. As the Myanmar example shows, given support, a network and a few simple tools (like the PTC), clinicians can address the global challenge of trauma and become the strongest advocates for public health and health systems improvements.

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