

# IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM



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## In this Edition

### **PNG**

John Kennedy and his team of ELS instructors are pioneering the export of this well established Australian course. They report on the launch in PNG.

### **South Africa**

“Emergency Medicine in the Developing World” conference was the impressive outcome of a huge amount of work by the Cape Town group led by Lee Wallis.

### **India**

“EMCON 2007” was the ninth Indian EM conference and progress is being made towards specialty recognition. Chris Curry offered some perspectives on how this might be achieved in different environments.

### **Sri Lanka**

EM is at a beginning in Sri Lanka. Bishan Rajapakse reports on the situation, and on the inaugural congress of the Sri Lankan Society for Critical Care and Emergency Medicine (SSCCEM).

### **France**

Sandy Inglis reports on changes under way in a country with a different emphasis on the delivery of emergency care.

### **Qatar**

Lisa Bell seeks advice on assisting development in a Middle East country.

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## Papua New Guinea

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### Emergency Life Support International (ELSI)

Launch in Port Moresby, September 2007 [www.elscourse.com.au](http://www.elscourse.com.au)

### John Kennedy

#### Pap

A modification of the Emergency Life Support (ELS) course was launched in September 2007 in association with the Annual Symposium of the Medical Society of Papua New Guinea.

Modification of the ELS course content, lectures and skill stations, to enhance its usefulness in a developing environment was undertaken with assistance from a PNG emergency trainee and several emergency physicians with experience in PNG. The PNG version of the well-established Australian course reflects local disease patterns and the realities of the provision of care in a resource poor environment. The course has a “train-the-trainer” component with the aim of making an international ELS course autonomous within a decade. The course skill stations are heavily reliant on the use of teaching mannequins.

#### *Lectures for the International course*

Introduction  
Asthma  
Acute Coronary Syndromes  
Altered Level of Consciousness/Seizures  
Poisoning/Overdose  
Shock – sepsis/hypovolaemia  
Malaria

#### *Skill Stations for the International course*

Introduction  
Basic Airway/Intubation  
Advanced Airway  
ECG/Arrhythmia  
Basic Life Support/ACLS  
IV Therapy  
Sick Child

#### Faculty

A faculty of seven Australian emergency physicians (EPs) and one PNG emergency trainee conducted the course. The Australian course national coordinator provided logistic and organisational assistance. All of the EPs are FACEMs with significant experience in emergency medicine teaching. The faculty members were not paid for their time and covered the cost of their airfares and accommodation using their personal study leave entitlements.

John Kennedy, PNG course convenor.

Ms Sandra Guider, CEO ELS Inc., PNG course coordinator.

Phil Hungerford, Chairman ELS Committee of Management.

Chris Trethewy, Nick Ryan, Kate Porges, Pip Keir, Mark Miller.

Alfred Raka, emergency trainee, Port Moresby General Hospital

#### Participants

A group of 24 doctors attended the pilot course as trainees. This cohort of doctors included many of the most senior critical care doctors in PNG including PNG’s only specialist emergency physician, a senior anaesthetist, a consultant surgeon and several advanced trainees in emergency medicine. Two of the participants were from Honiara in the Solomon Islands. The participants were not charged a course fee.

Robert Ko

Medical Officer-ED  
PMGH

Name	Position	Institution
Yongoe Kambue	EM SMO	Lae
Lucas Samof	Anaesthetist SMO	Alotau Hospital
Charlie Tuharus	Surgeon SMO	Wewak Hospital
Jonathon Leslie	Anaesthetist SMO	Port Moresby General Hospital
Sam Yockopua	EM trainee	PMGH
Moses Lester	EM trainee	PMGH
Wala Marjen	EM traineeEM EM TraineeTrainee	PMGH
Desmond Aisi	EM trainee	PMGH
John Tsiperau	EM trainee	PMGH
Julius Plinduo	EM trainee	Rabaul (Nonga Hospital)
Taita Kila	EM trainee	PMGH
Kenton Sade	EM trainee	Honiara, Solomon Islands
Fletcher Kakai	EM trainee	Honiara, Solomon Islands
Waimbe Wahumu	Medical Officer-ED	PMGH
Robert Ko	Medical Officer-ED	PMGH
Alex Peawi	EM trainee (prospective)	Madang (Modilon Hospital)
Dennis Lee	EM trainee (prospective)	Alotau Hospital
Greg Tokabilula	Anaesthetic trainee (prospective)	Alotau Hospital
Raymond Korimbo	Anaesthetic trainee (prospective)	PMGH
Leslie Kawa	Medical registrar	PMGH
Joe Kimbu	Paediatrics registrar	PMGH
Jonah Kurubi	Paediatrics registrar	PMGH
Angela Senginami	O&G registrar	PMGH
Antonia Kumbia	O&G registrar	PMGH

### Future Courses

The next course will follow the Annual Symposium of the Medical Society of PNG at Rabaul in September 2008. Julius Plinduo (EM trainee, Rabaul) will assist with logistics and planning.

#### Local instructors

Yongoe Kambue (emergency physician, Lae), Lucas Samof (anaesthetist, Alotau) and Sam Yockopua (senior emergency registrar, Port Moresby) have agreed to be instructors for the proposed course in Rabaul in 2008. In addition, a further two PNG doctors (Alfred Raka, Port Moresby and Vincent Atua, Madang) will have completed the course by then and will be able to contribute to the PNG instructor pool.

We envisage running the course with three PNG and three Australian instructors for a number of years before devolving the course to the control of the PNG emergency medicine community and assisting only as required.

### Feedback

- “The course is just fantastic and it has sharpened my hands-on skills and properly aligned my approach to managing emergency cases”
- “I learned to be systematic in my approach so I don’t miss out on the important findings to save a dying patient”
- “All MOs should do this course”
- “Please bring the course to the Solomon Islands”



## The Emergency Life Support Course (ELS) Inc.

[www.elscourse.com.au](http://www.elscourse.com.au) .

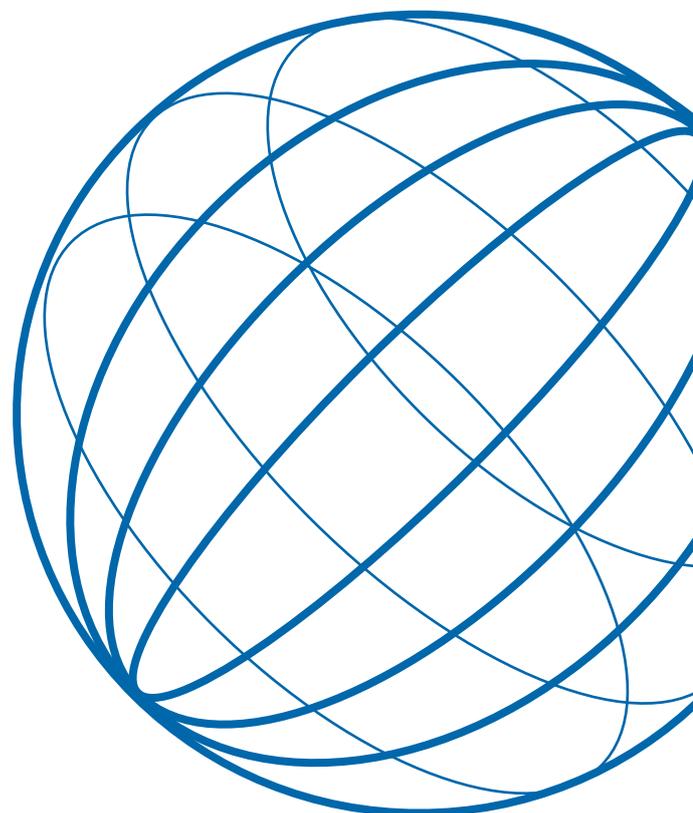
The ELS Course is a comprehensive two-day course that teaches the skills and knowledge needed to effectively care for the critically ill. The course was developed by a group of Australian emergency physicians and is based in Tamworth, New South Wales, Australia.

The course is a mix of lectures and skill stations similar in structure to the Advanced Trauma Life Support (ATLS) course but covering medical emergencies rather than trauma. It was designed to fill that obvious gap – trauma is a big problem but it is not the only problem. Non-specialist doctors especially in smaller and rural centres are expected to look after very sick people with little training. ELS aims to give them a systematic approach for the assessment and management of the critically ill.

The principles taught in the ELS Course are universal in nature and as applicable in the developing world as in Australia. Courses are run by a faculty of specialist emergency physicians who donate their time and expertise for free. The ELS Course is a well-established and highly effective educational tool with long experience in delivering training to rural and remote health professionals in Australia. Since 1997 the course has been conducted 119 times in centres across Australia and New Zealand and has reached over 2000 non-specialist doctors, the majority of whom have been rural practitioners.

### ELS Course Committee of Management

- Phil Hungerford, Chairperson
- Greg McDonald, Treasurer
- Ms Sandra Guider, CEO
- Michael Bastick, Andrew Bezzina, Terry George, Geof Marshall, John Pasco, Kate Porges, Stephen Walker,



## South Africa

# Emergency Medicine in the Developing World Cape Town 4-6 October 2007

[www.emssa2007.co.za](http://www.emssa2007.co.za)

This conference was presented under the auspices of the Emergency Medicine Society of South Africa (EMSSA) by an organizing committee from the University of Cape Town and Stellenbosch University. The chair was Professor Lee Wallis, Head of the Division of Emergency Medicine at these Universities.

The conference attracted more than 600 delegates from 44 countries:

Argentina	Ghana	Namibia	Sweden
Australia	Gibraltar	Netherlands	Switzerland
Azerbaijan	Italy	New Zealand	Sudan
Botswana	India	Nigeria	Tanzania
Cameroon	Japan	Norway	Thailand
Canada	Jordan	Poland	Trinidad & Tobago
Chad	Kenya	Qatar	United Kingdom
China	Korea	Senegal	USA
Cuba	Macedonia	Sri Lanka	Vietnam
Ethiopia	Malawi	Singapore	Zambia
Germany	Malaysia	South Africa	Zimbabwe

For comparison, the International Federation for Emergency Medicine (IFEM) has 31 member countries (as at October 2007):

Argentina*	(European Society)	Mexico	Sri Lanka*
Australia	Hong Kong	Netherlands*	Sweden
Bahrain	Hungary	New Zealand	Taiwan
Brazil*	India*	Poland	Thailand
Canada	Ireland	Papua New Guinea	Trinidad
China	Israel	Singapore	Turkey
Colombia	Korea	South Africa	United Kingdom
Czech	Madagascar*	Spain*	USA – ACEP, AAEM

\* = affiliate member

There were 86 invited speakers for a three day program that ran in five streams outside the plenary sessions. There were 43 delegates from Australia and New Zealand, with presenters including:

Peter Cameron	EM in Australia. Patient safety and how to assess it. Trauma registries and quality of care.
Megan Cox	EM in Tanzania
Chris Curry	Creating something from nothing. EM in Papua New Guinea.
Kavi Haji	EM in Kurdistan
Sandy Inglis	EM in France

Tamsin Jones	The role of emergency nurses in training programs in the developing world
Gerard O'Reilly	India – developing and measuring a trauma system
Rob Pitt	Paediatric EM interactive workshop
Bishan Rajapakse	EM in Sri Lanka. Teaching EM in the developing world.
Simon Young	Teaching paediatric resuscitation skills in a developing country.
APLS training	improves knowledge, skills and confidence in a developing country.

A DVD of the EMSSA conference presentations, including audio recordings from the main plenary venue, is available for sale. Cost including postage & packaging is R120 (overseas). The presentations will also be made available on the website: [www.emssa2007.co.za](http://www.emssa2007.co.za)

For details please email Belinda Chapman, Conference Co-ordinator, UCT Conference Management Centre.  
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## Division of Emergency Medicine University of Cape Town and Stellenbosch University

Division of Emergency Medicine  
University of Cape Town and Stellenbosch University

Even though Emergency Departments had existed in South Africa for at least two decades, EM was not recognized as a separate specialty until the Division of Emergency Medicine was formed in Cape Town in 2001.

The initial function of the Division was to provide formal structured teaching in the discipline of EM. An informal teaching program was started which led to the registration of a Master of Philosophy (M Phil) degree at the University of Cape Town (UCT) in the same year.

During this time the Emergency Medicine Society of South Africa (EMSSA) submitted documentation to the Health Professions Council of SA (HPCSA) for registration of EM as a specialty. The specialty was recognized by the HPCSA in March 2003 and subsequently the College of Emergency Medicine was founded by the Colleges of Medicine of South Africa.

By the end of 2003 the Universities of Cape Town and Stellenbosch joined forces to offer a joint Master of Medicine (M.Med) in EM. The first ten students registered for this degree in January 2004 and the first graduates are expected within the next 12 months. Several students have already graduated with the M Phil degree.

Following the popularity of the M Med and M Phil degrees a Master of Science degree has also been introduced at UCT and plans to register an MD are under way.

To date a total of fifty postgraduate students have registered for the M Med, making UCT the largest emergency physician training centre in South Africa.

For more detail visit us on our website [www.emergencymed.co.za](http://www.emergencymed.co.za)

Lee Wallis, Head of Division of EM

## India

### EEMCON 2007 Emergency Medicine Conference Chennai 16-18 November 2007 [www.emcon2007chennai.com](http://www.emcon2007chennai.com)

This was the ninth annual conference of the Society for Emergency Medicine in India (SEMI). EMCON meetings are supported by the American Academy for Emergency Medicine in India (AAEMI) and by Harvard Medical International. Australians have been involved since EMCON 2005 in Vellore.

EMCON 2007 was conducted at the Sri Ramachandra University in Chennai (previously Madras) in Tamil Nadu.

Australian contributors included

Tony Brown: "Anaphylaxis".

Tony also co-adjudicated 44 poster presentations with Tamara Thomas (USA).

Peter Cameron: "Role of Factor VII in trauma"

Chris Curry: "Perspectives on developing Emergency Medicine as a specialty"

Joe Epstein: "The 21st Century – a new paradigm for disaster medicine"

Sally McCarthy: "Minimizing clinical errors in the Emergency Department" (presented by Chris Curry)

On Friday 16th there were several Workshops conducted by AAEMI.

#### American Academy for Emergency Medicine in India (AAEMI)

[www.aaemi.org](http://www.aaemi.org)

From the Home Page:-

"A group of Emergency Medicine physicians of Indian descent met in Pittsburgh, Pennsylvania in February 2001 to launch the American Academy for Emergency Medicine in India. This organization is dedicated to promoting Emergency Medicine in India. These physicians came together because of a common interest: to help the people of India, especially those in dire need of emergency care.

Many physicians in the USA were working individually to help medical care in India, sometimes prompted by a death in the family or among close friends due to inadequate emergency services in India. It became obvious that if they combined resources, knowledge, expertise and interests, they would accomplish so much more than they could have working alone.

The motto of AAEMI is Care, Compassion and Education. The Mission of AAEMI is to

- promote Emergency Medicine as a specialty in India
- enhance the quality of emergency medical care
- raise public awareness of the scope of emergency medical services
- enhance and optimize Emergency and Disaster Preparedness and Response in India

Since 2001 AAEMI has grown and the vision for improving emergency services is being realized in many different areas. Within a few months after its formation AAEMI physicians were invited as faculty to EMCON 2001, the 3rd annual conference on Emergency Medicine hosted by SEMI, the Society for Emergency Medicine in India. SEMI is the single nationally recognized body for the promotion of Academic Emergency Medicine in India. With common ideals and vision for the future of Emergency Medicine in India, AAEMI and SEMI started an enduring partnership. Over the years, as both organizations grew, this team has conducted Emergency Medicine conferences in major cities all over India, attended by thousands of local physicians.

AAEMI members, many of whom are first and second generation Indians, understand what an honor and privilege it is to be able to give something back to India after years of service in America. The work of AAEMI has also drawn a large group of Western emergency physicians into its membership. These physicians have dedicated their lives and careers to developing Emergency Medicine on the International front through education, residency training, advocacy with the Deans of Medical Schools and the Indian Government as well as the Medical Council of India."

2007 AAEMI Officers:

President: Lingappa Amernath

Vice-President: Vijay Akkapeddi

Secretary / Treasurer: George Abraham

Immediate Past President: Indrani A. Sheridan

The Board of Directors  
Kumar Alagappan, Anita Bhavnani, Rajesh Gupta,  
Kiran Pandit, Krishan Kumar, Lynda Daniel, Kinjal  
Sethuraman, Girish Kapur

AAEMI has more than 100 members. Membership is open to everyone. The only requirement is that you wish to help India.

### Harvard Medical International

The HMI view is that every citizen of the world should have access to high quality health care in their own region. HMI works with academic and health care organizations internationally to build high quality academic medical infrastructure around the world while providing resources for academic exchange, teaching and research.

### Sri Ramachandra University

Sri Ramachandra Educational & Health Trust, a non-profit organization, was founded in 1985. The

visionary of this Trust is Shri N.P.V. Ramasamy Udayar. The members of the Trust are eminent industrialists, philanthropists, educationists and professionals from various fields

Sri Ramachandra Medical College & Research Institute is a Deemed University, an autonomous body primarily dedicated to the purposes of medical education, research and health care. Sri Ramachandra Hospital is a 1050 bedded teaching hospital which was commissioned in 1988. The general wards cater to the needs of thousands of villagers from several hundred villages in the neighborhood.

In addition to the free teaching beds, 300 private beds are utilised by all the specialties and particularly the advanced specialty services including cardiology, cardio thoracic surgery, neurology, neurosurgery, nephrology, transplant services and advanced trauma orthopaedic services.

## Perspectives on developing Emergency Medicine as a specialty Emergency Medicine Conference (EMCON) November 2007, Chennai, India Chris Curry

I was recently in South Africa. India had just made a big impression there in the Twenty/20 cricket. Another event that made a big impression was a conference, "Emergency Medicine in the Developing World". There were delegates from 44 countries. As Gautam Bodiwala, President of the International Federation for Emergency Medicine, has said in a recent editorial, EM is rapidly becoming a global specialty.

India is at a beginning. How does one begin? We all know that every country has its own peculiarities. But in the development of emergency medicine we all have more that is common than is peculiar. I spent ten years in New Zealand building EM, and I have been contributing over 7 years to the development of EM in Papua New Guinea. In New Zealand I borrowed from Australia, who had learned from the UK, USA and Canada. PNG is now selectively borrowing from Australia.

We can learn from how things have happened in other places, extracting what might be useful for our

own circumstances. So I want to offer some selected observations, and invite you to see if there are any parallels with what is happening in India and if there is anything you can make use of. I am going to talk of Beginnings, Australia, NZ, PNG, IFEM, IEMSIG and Lessons.

### Beginnings

My first exposure to Emergency Medicine was as a student in 1978 at the Kenyatta National Hospital in Nairobi. The most junior doctors did the best they could with a huge workload without any guidance. In 1979 as a new graduate at the Royal Perth Hospital in Western Australia I started in a busy Emergency Department supervised by a retired anaesthetist where the most senior doctor on the floor was in his second year post graduation from medical school (PGY2). There were aspects I really enjoyed: it was hospital, generalist, unpredictable, often exhausting, sometimes terrifying, and, from time to time, exciting and enormously satisfying. But there was no career pathway to continue doing it.

In the UK in 1962 an Orthopedic surgeon, Harry Platt, had recommended that EDs, then called “Casualties” (as indeed they were), should have a senior doctor in charge. In 1965 these newly appointed directors, mainly orthopaedic surgeons, established the Casualty Surgeons Association. In 1982 the Royal Colleges of Physicians and Surgeons of Edinburgh in Scotland established the first specialty exams for Emergency Medicine in the UK.

I went to the UK in 1982. At Southampton General Hospital, a major teaching hospital, the “Accident and Emergency” was directed by a general practitioner who looked after minor injuries. The work was done by PGY2 doctors. It was clear that doctor incompetence contributed to the “accidents” in the department. There was one registrar on the new training scheme, which was viewed by other specialty trainees as rather pathetic. Surely no-one who took themselves seriously in medicine would do it.

### **Australia**

In Australia the first “Casualty” to get a director was at Geelong in Victoria in 1967. In the 1970s new directors ganged together in local societies. By 1981 there were sufficient numbers to establish an Australian Society for Emergency Medicine, expanded to Australasian to include New Zealand. The Society determined that the way to progress training in Emergency Medicine was to establish an independent autonomous College, modeled on the Colleges of the well established specialties of surgery, medicine and others. The Australasian College for Emergency Medicine was founded in 1984 with a fellowship of 70 directors of Casualties and A&Es, who charged themselves with the task of building Emergency Medicine as a specialty. The first President, Tom Hamilton, was a Scotsman in Western Australia and a former surgeon. The College conducted the first exit exams in 1986, from which eight new specialists were added to the fellowship.

All this happened because there were doctors working in Emergency Departments who saw the staggering inadequacies of having the least trained, least competent, least supervised junior doctors attending the most unstable, least differentiated patients in the hospital, while senior staff from the in-patient specialties leveled relentless criticism at them. This was a time when anyone more senior than PGY2 who wanted to work in a “Casualty” was regarded as incompetent for anything worthwhile, as a failure, as treading water until retirement, or as mad. These misfits were the first champions.

It was with the emergence of the first doctors claiming specialty status by training and examination that

the battle for recognition by colleagues in other specialties could really get under way. From their efforts would eventually come the evidence that Emergency Medicine deserved to be fully recognized by the several layers of medical governance and by the national body, the National Specialist Qualifications Advisory Council. This was an effort from the ground up. It took 10 years. A seminal paper of the time was an editorial in the Medical Journal of Australia in 1989 by Peter Cameron and Joe Epstein, the second President and also a former surgeon. It was titled “Emergency Medicine – no longer a casualty”. It took until 1993 to convince the National Specialist Qualifications Advisory Council.

### **New Zealand**

In 1986 I went from the UK to Christchurch in New Zealand. I was dismayed to find conditions in the “A&E” worse there than in Australia and the UK, and in some respects worse than in Kenya. How could they treat their cricketers so badly? That year I also discovered the new Australasian College for Emergency Medicine. In 1989 I completed the requirements for fellowship. I became the first FACEM by training in NZ, the first to be recognized as a specialist, by Christchurch Hospital, and I got to work on several fronts. A key tool in getting started was that paper “Emergency Medicine – no longer a casualty”.

By default I became the NZ representative at College on the training body, called the Board of Censors, and on the management body, the Council. As the poor cousin from New Zealand I was able to bring back developments by our bigger and stronger neighbour, Australia. These included training programs, a system of triage, standards for staffing of EDs, standards for transport of patients, and much else.

In 1993 the New Zealand Medical Journal published a Leading Article I had penned (we still used pens then), “Emergency Medicine – a new specialty”. I had, of course, borrowed from Peter Cameron and Joe Epstein. I quote:

“With the development of expertise, EDs have undergone fundamental changes in the last ten years. In the resuscitation room specialists co-ordinate a multidisciplinary team in the management of multisystem major trauma. Life saving interventions are initiated immediately. Patients receive quality intensive therapy until a bed in an ICU is available. Myocardium is saved by the early commencement of thrombolysis. Safety and efficiency considerations make the ED a logical location for soft tissue repairs, urgent procedures warranting conscious sedation, joint enlocations and lumbar puncture. Avoidable mortality and morbidity are reduced by having expertise immediately available, on site. Efficiencies are gained

by the judicious ordering of appropriate investigations, and management strategies are initiated expeditiously. Costs are contained by reducing unnecessary hospital admissions. For example, in the area of toxicology there has been a major shift from inpatient to short term ED management. Substantial improvements in pre-hospital care are achieved by the involvement of specialists. Major incident and disaster preparedness becomes a reality rather than remaining an idea.

The final paragraph read:

“In areas of resuscitation, differential diagnosis, initiation of appropriate investigation and management, and in the appropriate disposal of their patients, specialists are bringing emergency care up to parity with the inpatient services of longer established specialties. Their ability to act as gatekeepers, while dealing efficiently with the expanding range of illness and injury that can be managed without hospital admission, will become increasingly important in the new health environment.”

That was 1993. It took another two years to persuade the Medical Council and the Government of NZ that Emergency Medicine was worthy of full recognition as a specialty. By 1997 there were 70 New Zealand doctors on the ACEM training program, and the movement was under way. Now, a decade further on, there are 111 specialists there.

How was specialty recognition achieved? In Australia and New Zealand it was built from the ground floor of EDs and through the energies of the fellowship. Hospital administrators were persuaded to employ doctors more capable than PGY2. The College, the ‘union’ for this movement, established a training program demonstrably as rigorous as that of other specialties. It produced graduates who knew that they would have to fight for recognition. These pioneers engaged the medical community on every front, in hospitals, in local, state and national bodies, in interdisciplinary courses, in medical schools, in pre-hospital care, and in many other arenas of acute care. They established a journal. It was only when it became beyond argument that these up-start emergency medicine people were functioning as specialists, and were being recognized by peers and hospitals as specialists, and after multiple attempts, that Emergency Medicine was recognized by the national authorities.

### **Papua New Guinea (PNG)**

Papua New Guinea provides a dramatic contrast. But, while there is much that is very different, in the business of delivering acute care there is much that is common. PNG lies immediately north of Australia, its closest neighbour. From World War 1 to 1975 it was under Australian administration. It lies at the opposite

end of the world spectrum by many measures of infrastructure, economics and standard of living.

There is one medical school in PNG and specialty training is conducted by the Postgraduate Committee of the School of Medicine and Health Sciences of the University of PNG. Graduates of specialty training are awarded a Master of Medicine.

PNG is now largely independent in the training of doctors for the major specialties. In 1996 the Postgraduate Committee recognized the need to improve the capacity to deliver care to the acutely ill and injured and established a Master of Medicine for Emergency Medicine. Without expertise PNG nationals were unable to provide leadership so the plan lay on the table. In 2000 the National Department of Health and the Ministry of Health identified Emergency Medicine as a priority in their 2001-2010 National Health Plan. The Australian Agency for International Development was asked to assist in launching the program, and in 2002 AusAID funded an emergency physician in residence and visits by others. Emergency physician support has continued since. So this is a program built from the top down, with input from an established neighbour.

The first trainee was awarded his Masters diploma in April 2007. There are now 17 trainees on the program and there are two trainees from the neighbouring independent state of the Solomon Islands. Other Pacific Island nations may join the program in the future.

### ***Capacity building:***

The emergency medicine trainees are building credibility by building capacity to respond to acute illness and injury, particularly in rural areas, through several courses:-

### ***Primary Trauma Care***

The Primary Trauma Care course was developed for environments with limited resources. It is now established in 35 developing countries. In PNG it was introduced in 2002 by emergency physicians. It has been well received by provincial hospitals because it can be delivered very simply. There are now a number of PNG instructors with the capacity to run courses independently.

### ***Snakebite Management***

Snakebite is a major cause of avoidable mortality in PNG. There are parts of the country where there are more deaths from snakebite than from malaria, and that is in malaria endemic regions. A course has been developed by an Australian toxinologist, David Williams, and a New Zealand emergency physician, Simon Jensen, and is now being disseminated widely.

### ***Diploma of Emergency Medicine***

In PNG 80% of the population is rural, and most health care is provided by community health workers, nurses and health extension officers. The Divine Word University, a Catholic Church funded institution, has established a postgraduate Diploma of Emergency Medicine for these providers. The course has been developed and delivered by an Australian EM trainee, Sandra Rennie, with a PNG EM trainee, Vincent Atua. The first cohort will graduate in March 2008.

### ***Emergency Life Support***

The newest contribution to capacity building is an Emergency Life Support course. The Australasian Society for Emergency Medicine developed a course for rural and remote Australia and has been running it for 10 years. Led by John Kennedy, this has now been further developed for the particular circumstances and conditions of PNG. It was launched in September 2007.

### **International Federation for Emergency Medicine (IFEM)**

The International Federation for Emergency Medicine was founded in 1989. Its mission is to promote international interchange, understanding and co-operation among physicians practicing Emergency Medicine. The current President is Gautam Bodiwala from the UK, the vice-president is Peter Cameron of Australia, and the Secretariat is now established in Australia.

The IFEM has defined Emergency Medicine as “a field of practice based on the knowledge and skills required for the prevention, diagnosis, and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of episodic undifferentiated physical and behavioural disorders; it further encompasses an understanding of the development of pre-hospital and in-hospital medical systems and the skills necessary for this development”. In my advocating for emergency medicine I have used this definition countless times.

Organisations with EM training programs now number 24, and there are 7 affiliate members. India has just become an affiliate member. In our region countries with training programs include China, Hong Kong, Korea, Papua New Guinea, Singapore, Taiwan and Thailand. These are countries that India could look at, before it finds itself the last major country without an organised capacity to respond to the acutely ill and injured.

### **International Emergency Medicine Special Interest Group (IEMSIG)**

The International Emergency Medicine Special Interest Group of ACEM was established in 2004 in response to the expanding involvement of FACEMs in the development of Emergency Medicine in

other countries, notably in the Asia/Pacific region. Australians and New Zealanders are isolated peoples and they like to travel. There are now contacts of various shapes and sizes with nearly 50 countries

### **Lessons**

What have we learned? In getting started there are many uncertainties. I offer you a Trimurti of pointers.

#### 1. *For creation: (Brahma)*

##### 1. Champions

Major changes are achieved by pioneers prepared to champion a cause. For Emergency Medicine this may be best done by a director of an Emergency Department with a recognised specialty qualification, such as in surgery. The second level to find a champion is in a hospital department, and most commonly this has been, again, in surgery.

##### 2. Organize a ‘union’

A body politic, a group with one purpose, needs an organization to represent it. In India it might be useful to do this by institution, by city, and by state, as well as at a national level.

##### 3. Administrator support

It can take a major effort to gain the support of administrators. Pursue it relentlessly, at all levels, from hospital to Government.

##### 4. Bottom up development

In ANZ the ground swell came from the floor of EDs. The pioneers had to change the minds of hospital staff, administrators, then medical councils, health departments and governments. This may be how you will need to do it in India. You may have to build the momentum from EDs before the Medical Council of India will pay attention to you.

##### 5. Top down development

Top down development is possible where there are examples to emulate. This is what happened in PNG, who saw the ANZ example. If the Medical Council of India can be persuaded to look at what is happening around the world, they might be persuaded to establish EM as a recognized specialty.

##### 6. Endurance and Energy

Progress is made by a group prepared to cope with poor recognition. They persevere because they know what they are doing is right. So you will need to be summoning your energy. There needs to be engagement with all facets of the delivery of acute care, expanding from the ED to hospital committees, undergraduate and postgraduate training and courses, pre-hospital care and retrieval, disaster preparedness, and so on.

2. *To prosper: (Lakshmi)*

## 7. Use benchmarking

Benchmarking is the process of making gains by comparing yourselves with others doing better and campaigning to do at least as well, if not still better. One site can provide a lead for others to follow and to surpass.

## 8. Borrow from others

Borrow from others, and unscrupulously plagiarize other peoples work. Emergency physicians applaud that. It is what the IFEM, IEMSIG, AAEMI and other international organizations exist for.

## 9. Take advantage of local events

There are situations that can be capitalized upon. Mass casualty incidents, disasters, an emergency suffered by a VIP (a minister of health is useful), bad outcomes in EDs (such as to a relative of a minister of health), can all focus attention on the need to build capacity to respond to acute illness and injury.

## 10. Take advantage of local interest

Sometimes a particular local focus, such as disaster preparedness or a regional trauma system, can be the way in to promote Emergency Medicine. In PNG active volcanoes are an impetus. In India an expanding road system with spiraling road trauma demands attention, not only at the roadside but also on reception in hospitals.

## 11. Recognize local appropriateness

Different environments require their own approach. The PNG training program is very different from the Australasian and even more different from the US programs. The way Emergency Medicine is done in one country cannot be transferred directly to another. India must develop its own way of providing care to the acutely ill and injured.

## 12. Link Emergency Medicine to local Primary Care and Public Health initiatives

Prevention is included in the IFEM definition of EM. Teach that, while we are advocates for Public Health, these measures will not eliminate the need for a capacity to respond to acute illness and injury.

3. *To surmount obstacles: (Ganesh)*

## 13. Educate everybody

There is a need to keep on saying what Emergency Medicine is, to everybody. Medical colleagues, administrators, government agencies, the general public need to be told time and again. A recurring theme in developing environments is disinterest, scorn, contempt, antagonism, obstruction from colleagues,

administrators, leaders. This can only be overcome by taking every opportunity to educate. This campaign has to be on multiple fronts.

14. Organise an independent training program  
Independence is important. Dependence on established colleges constrained the development of Emergency Medicine in the UK, while an independent college in ANZ promoted it. In India there are numbers of independent Universities who could set up their own programs. These could collaborate to develop uniform standards. Here in Tamil Nadu there are three of India's top ten medical colleges, in CMC Vellore, Madras Medical College and Stanley Medical College. There is nowhere better to build an emergency medicine movement.

## 15. Become instructors

A potent way to influence colleagues and junior doctors is to be instructors for ATLS, ACLS, APLS and other courses. From there you can advise that doing courses is not sufficient alone and does not equate to specialist training.

## 16. Look for sustainability

Sustainability needs to be built for the training program, for job prospects and for career development. Realism is required in recognizing the limitations of local resources. At the same time, you can be certain that supply of trained emergency physicians will increase the demand for them.

## 17. Prioritise the direction of effort.

Resources are always limited, so the most effective use must be made of them. For example, effort put into training the trainers will have a greater long term impact than providing service.

## 18. Overcome roadblocks

The journey has many roadblocks. Some you can overcome yourself, some you need help to overcome, some you need others to overcome for you, some you can go around, some you can wait out, while others (a few) are insurmountable and you simply have to go back to base-camp and take an entirely different route.

Finally, go for it. And keep on going for it. India takes prides in its capacity to achieve. Indians are great innovators. A country that is mastering nuclear technology and information technology can also build a system that can provide basic care to the acutely ill and injured.

## Conclusion

Our aim should be to ensure that most people have access to basic acute care. It requires commitment

and faith to develop a capacity to do this. But you can create something from nothing when your cause is right, which it is, and you have the will. The will you must find for yourselves. It is you who must find a way through the Indian ways of doing things. The journey will need resolve, patience, persistence and perseverance. Progress can be by fits and starts. There can be long periods of apparent stagnation or impasse. Then there can be sudden movements. Revolutions can happen and you have to be ready to take advantage of them. But mainly, progress is made by a series of small increments, a multitude of small steps. So be prepared for a long campaign. The greatest journeys are made one step at a time. Keep in mind - it has already been demonstrated in several countries - the Emergency Medicine journey is a winner.

You too can be winners. Your cricketers will be proud of you.

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of ACEM Newsletters

[www.acem.org.au](http://www.acem.org.au)

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Primary Trauma Care course

[www.primarytraumacare.org](http://www.primarytraumacare.org)

Email [admin@primarytraumacare.org](mailto:admin@primarytraumacare.org)

Emergency Life Support course

[www.elscourse.com.au](http://www.elscourse.com.au)

Email [elscourse@bigpond.com](mailto:elscourse@bigpond.com)



## Sri Lanka

# The development of Emergency Medicine in Sri Lanka and The First Annual Congress of SSCCEM

**Bishan Rajapakse**

Sri Lanka is a small island about the size of the republic of Ireland with a population of 19 million. Despite being a relatively poor developing nation with a per capita annual income of US \$1,350 it has impressive social and health indicators with low infant mortality at 11.2 / 1000 live births and an average life expectancy of 73 years.

Systems are developed to a high degree in the established specialties of medicine, surgery, paediatrics and obstetrics, but development in systems of emergency care are lacking in comparison. Emergency Medicine in Sri Lanka is underdeveloped according to a classification presented by Alagappan et al. 2005 [1]. It scores higher in two categories because of an existing inter-hospital ambulance network and well developed trauma systems in some hospitals (Figures 1a and 1b). Assessing the level of development in Sri Lanka is obfuscated by a huge variation in emergency services across the island between urban and rural settings, and there are large differences between hospitals within these settings.

Figures 1a) – International classification of patient care systems

Comparison of patient care systems		<b>Sri Lanka</b>		
	Country class			
	Underdeveloped	Developing	Mature	Middle East countries
Emergency physicians	Housestaff, other doctors	Some EM residency trained	All EM residency trained	GPs, some residency trained
Emergency department director	Other specialty	EM physician	EM-certified physician	Some EM
Prehospital care	Private car, taxi	BLS or EMT ambulance	Paramedic or doctor	Varies by area
Transfer system	No	No	Yes	No
Trauma system	No	No	Yes	No

*Abbreviations: BLS, basic life support; EM, emergency medicine; EMT, emergency medical technician.*

•Developed in some of the larger sized hospitals in the City Centres

•Often Ambulance only service between hospitals  
•No paramedics

NB - **Table** - Alagappan et al (2005) Emerg Med Clin N Am 23 (2005) 1-10

Classification system first described by Arnold JL, Ann Emerg Med 1999;33:97-103.

Fig1b) Comparison of emergency specialty systems



Comparison of emergency medicine specialty systems				
Sri Lanka	Country class			
	Underdeveloped	Developing	Mature	Middle East countries
National EM organization	No	Yes	Yes	Some
EM residency training	No	Yes	Yes	Some
EM board certification	No	Yes/no	Yes	No
Official specialty status	No	Yes	Yes	Some

*Abbreviation: EM, emergency medicine.*

[1]. Alagappan K, Holliman CJ: History of the development of international emergency medicine. Emerg Med Clin North Am 2005, 23(1):1-10.

**A case presentation** illustrates some of the challenges:

A 36 year old woman intentionally ingested 100mls of dimethoate, a particularly toxic organophosphorus (OP) insecticide, in a suicide attempt following a domestic dispute. She was found vomiting by her family within half an hour of ingestion and was taken in a 3 wheeler taxi to the nearest small rural hospital staffed by one doctor and 2 nurses. She received basic treatment with IV fluid administration, gastrointestinal decontamination and atropine. She was then taken to the nearest secondary hospital in an ambulance staffed with a driver only. Advanced airway management is rarely practiced at first point of medical contact and patients are quickly transferred to the nearest secondary referral centre for further emergency treatment and ongoing management. Time from ingestion to arrival at the secondary hospital was 2 ½ hours.

On arrive she was seen by a “medical admitting officer” in the “medical outpatients department” (OPD) located at the front of the hospital where all patients from the community present. The MO is typically a non-specialist doctor of variable seniority who decides whether a patient should be admitted for treatment on the ward or discharged home. These doctors do not have the benefit of observing the patient over time or of ordering investigations so consequently most of the symptomatic patients are admitted. Very limited treatment can be instituted in the OPD and even basic emergency equipment is not located there. Our patient was quickly assessed as being severely unwell, with lung secretions, tachypnoea, hypotension and a low GCS, requiring a hospital admission. Therefore she was sent to a busy medical ward for her emergency care (Figure 2).



Figure 2  
The medical ward

## **Systems of Emergency Care in Sri Lankan Hospitals**

The scenario above illustrates the standard system of emergency care in hospitals that do not have either an Emergency Treatment Unit (ETU) or a Preliminary Care Unit (PCU).

### ***Emergency Treatment Units (ETUs)***

Because of the delay to treatment with the above model “Emergency Treatment Units” have started to appear within some of the larger hospitals over the last 20 years. These usually have 4-5 beds equipped with monitoring and resuscitation equipment and can receive critically ill patients before they go to a ward. ETU doctors usually do not have a role in the decision of admission or discharge as all patients moved to an ETU will inevitably be admitted to a ward.

### ***Preliminary Care Units (PCUs)***

In the mid 1990s a number of “Preliminary Care Units” were set up. At this time the system of emergency care available was predominantly through the “OPD + Ward” model although a handful of larger hospitals also had ETUs. However, many of the ETUs were not adequately staffed or supervised to see and treat the large numbers of patients with subacute illness. The result was high rates of direct admission to crowded wards and delayed initial treatment. The PCUs were set up with 15-30 beds where critically ill patients could be resuscitated and admitted for further treatment, and patients with subacute illness could be differentiated into those who needed treatment and admission, and those who were fit for discharge after treatment. These units require the doctor from the admitting specialty to see patients in PCU, resulting in more judicious admissions to the ward. They therefore function more like contemporary emergency departments.

## **Development of Emergency Medicine**

Hospital development of emergency medicine began with the creation of a dedicated accident service at the National Hospital of Sri Lanka in Colombo in the late 1960s. ETUs started appearing in some hospitals over the last 20 years, and PCUs were developed from the mid 1990s onwards.

Following the Tsunami in December 2004 a lot of foreign aid came in to the country for emergency medical care, mainly focusing on disaster management, but it also led to hospital development projects. One such project sponsored by the Government of Victoria in Australia plans to develop a fully functional emergency department at the Karapitya Hospital in Galle.

A significant development has been the formation in December 2006 of a “Trauma Secretariat” as a branch of the Ministry of Health. It has a role in coordinating pre-hospital and trauma care services. Another important development has been collaboration between the Ministry and the Sri Lankan Medical Association (SLMA) to create a steering committee to look at the reorganization of outpatient services. This was formed in May 2007.

There has also been progress in pre-hospital care with the collaboration of the National Hospital and the Colombo Municipal Council to form an ambulance service backed up with paramedics. This has resulted in an ambulance service that covers part of the Colombo city limits. However there is still no national service. The introduction in 2006 of a degree course for paramedics by the newly formed Faculty for Allied Health Sciences at the University of Peradeniya will be a great contribution to the further development of pre-hospital care in Sri Lanka.

## **Emergency Medicine Training**

Emergency Medicine is not available as an area for postgraduate training, however there has been progress recently. The interest in Critical Care and Emergency Medicine training was recognized by a group of doctors from other specialties. This led to the formation of the Sri Lankan Society of Critical Care and Emergency Medicine (SSCCEM).

In terms of postgraduate training, there are plans to collaborate with the Postgraduate Institute of Medicine (PGIM) in developing a diploma course in Emergency Medicine in the near future.

## **The Sri Lanka Society of Critical Care and Emergency Medicine (SSCCEM)**

Since its inception in 2002 the SSCCEM has become the national academic society for Emergency Medicine in Sri Lanka. The society has led local teaching initiatives in resuscitation and critical care which have included

paediatric resuscitation workshops and the publication of educational and policy information such as a booklet on "Minimum Standards for Intensive Care". The SSCCEM has developed links with fellows of the Australasian College of Emergency Medicine (ACEM). In November 2006 they held a Seminar in association with the Ceylon College of Physicians Annual Scientific Meeting. This was followed by a Resuscitation Workshop (which was a modified ELS course) conducted by Australian emergency physicians Shane Curran and Gim Tan from New South Wales and Victoria respectively.

## First Annual Scientific Congress of SSCCEM

The Sri Lankan Society of Critical Care and Emergency Medicine held a First Annual Scientific Congress in Kandy in November 2007. The meeting included 2 days of pre-congress workshops followed by an educational program consisting of separate symposia on emergency care by various traditional specialties. The speaker list included eminent local speakers and international guests from UK, Australia and India.

### Pre Congress Workshops

There were several workshops on offer ranging from interpretation of acid/base in critical care to paediatric ventilation. I attended the workshop on Pre-hospital Emergency Care that was run by South Australian Paramedics Abroad (SAPA). This is a volunteer organization that has been supporting the University of Peradeniya in Sri Lanka with their paramedic training course for the last 2 years.



The pre-hospital emergency care course was in general received very well by its participants. My personal highlights were the practical nature of the course including the placement of spinal immobilisation and extrication devices, as well as the total involvement of the group in a realistic disaster scenario in the final session (photographs above).



The workshop covered a wide range of topics in pre hospital emergency care from principles of extrication and patient transport, to land mine injuries, trauma systems, triaging, and disaster management. The course was attended predominantly by nurses who were interested in expanding their skills to incorporate paramedic work. However, there were almost an equal number of doctors who attended the course from around the island, many of whom were interested in pre-hospital care and disaster management.

### The Scientific Sessions

The opening evening started with a very visual presentation of the history and development of the SSCCEM by the outgoing president, Professor Chula Goonesekera. This was followed by three talks on emergency medicine in Sri Lanka. The speakers were Professor Peter Cameron from the Alfred in Melbourne, Dr Karaliedde a Sri Lankan anaesthetist and toxicologist now practicing at the London Poison Centre, and Dr Buthpitiya a local surgeon and clinical lecturer attached to the University of Peradeniya. They all expressed slightly differing approaches to emergency medicine which brought to the fore some of the challenges that Sri Lanka might face in development of the specialty, but these talks paved the way for some healthy discussions. There was also a lively display of traditional drumming and dance, including fire dancing.

The academic sessions started the following morning and ran for the subsequent 2 days. There was a range of symposia on aspects of delivering emergency care

organized by the different specialties. These included sessions by the anaesthetists, including a talk by Dr Karaliedde on chemical and biological warfare, by the paediatricians on paediatric ventilation strategies, and by the College of Physicians on toxicological emergencies, led by Professor Andrew Dawson.

One of the more interesting sessions from an emergency medicine perspective was the symposium on road traffic accidents, organized by the College of Surgeons on the final day of the conference. It generated a lot of discussion about the current systems of delivering emergency care in Sri Lanka.



### Summary

The conference was a great success on the whole. Possible areas for improvement could have been to try and increase the amount of original research presented. This is a challenge for emergency medicine as a specialty the world over. Also, whilst the conference was well attended, we could aim to have more delegates in future sessions as most of the lectures had the capacity for further delegates to attend. This reflects in part on just how new emergency medicine is in Sri Lanka, and I'm sure we'll see greater attendances as the specialty emerges and develops further. All in all, the conference would have acted as a great stimulant for the further development of emergency medicine. The conference organizing committee and the past president of the SSCCEM Professor Chula Goonesekera should all be commended for their efforts.

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## France

### Emergency Medicine in France

#### Sandy Inglis

I presented this talk at a conference in Cape Town, South Africa, in October 2007. The conference was entitled Emergency Medicine in the Developing World. One entire stream of the conference on the first day was devoted to Emergency Medicine in various countries around the world and I had the slightly trying job of presenting as the final speaker of nineteen! The other slightly unusual thing about my situation was that I was the only presenter speaking about Emergency Medicine in a country who had not actually worked in EM in that country. I had however spent a year living in France renovating an old house in a village and had the fortune of visiting the local Emergency Department and was given a couple of fantastic tours and explanations about the department and their EM practise.

#### 31 August 1997, Princess Diana dies in Paris Crash

"Diana, Princess of Wales, has died after a car crash in Paris. She was taken to the hospital in the early hours of Sunday morning where surgeons tried for two hours to save her life, but she died at 0300 British Standard Time. The Princess's Mercedes car was apparently being pursued at high speed by photographers on motorbikes when it hit a pillar and smashed into a wall. Mr Al Fayed and the chauffeur died at the scene but the Princess and her bodyguard were cut from the wreckage and rushed to hospital."

#### "Rushed To Hospital"?

This probably is the biggest difference between Emergency Medicine in France and Emergency Medicine in the USA, England and Australasia. To "stay and play" or to "scoop and run".

Princess Diana, sitting in the back right hand seat, Dodi in the back left seat, Henri Paul driving and Reese-Jones, Diana's bodyguard in the front right seat, left the Ritz at about 0020 hrs on 31 August 1997. Reese-Jones in the front right seat was the only seat belted passenger. They were driving at 60-80 mph, being pursued by the paparazzi. On entering the Alma tunnel they apparently veered into the right hand lane, clipping (so rumour has it) a small white Fiat Uno and

then proceeded to swerve across the tunnel, collided with a wall, and finally a pillar at 0024 hrs. Within one minute the paparazzi were at the scene and within three minutes a Doctor Mailliez stopped at the scene, having been passing in the opposite direction. Within five minutes two ambulances and doctors were on the scene. A further 52 minutes from crash time later the ambulance left the scene with Diana on board and 97 minutes after the crash time they arrived at the Hospital de la Salpetriere. In summary, they spent 47 minutes at the scene and took nearly 45 minutes to reach the hospital. In getting there they passed two lesser hospitals as they were keen to take her to a major trauma centre. There are various theories as to why they took so long, 45 minutes, to reach a hospital that was only 5-6 km away. They did stop to give adrenaline but apparently drove slowly because they were extremely concerned about exercising complete spinal precautions. Princess Diana underwent at least two hours of surgery and repair of her torn pulmonary vein, but arrested, had open CPR, defibrillation, and died at about 0400 hrs.

According to the autopsy Princess Diana died of internal bleeding as the result of injury to the pulmonary vein. This type of injury does not lead to rapid loss of blood but can only be stopped by surgery. Injuries of this type do not typically end in the death of a patient if the injured person arrives at a hospital within 15-20 minutes of the accident.

French physician Frederick Mailliez, who was the first medical professional to arrive at the scene, was quoted by the Telegraph as saying that "Diana had looked pretty fine. I thought this woman had a chance", and Chris Barnard (performer of the first heart transplant) had this to say: "Princess Diana could have been saved if she had reached hospital on time". So this then is probably the main difference between Emergency Medicine in France and many other countries. They tend to "stay and play" and we tend to "scoop and run".

### **Emergency Medicine in Niort**

I visited the Emergency Department in our local city called Niort. The town has a population of 65,000 with a catchment of 200,000. They have about 42,000 presentations per year and see about 120-125 patients per day of which about 20 per day are paediatric. They have a 40% adult admission rate and 20% paediatric admission rate. All specialties are provided for except neurosurgery, plastics, paediatric and cardiac surgery.

They have 14 ED doctors, most of whom have qualified by doing a Diploma over four years. The training

includes runs in most specialties including Emergency Medicine, as well as time in the ambulances, called SMUR. The doctors work an average 48 hours per week and make between 40,000 and 80,000 Euros per year. They do about five nights per month and on the weekends do 24 hour shifts from 0830 to 0830 hrs. In true French style they have a canteen which is open 24 hours and free meals are provided for staff at work. They also have on call rooms to put up their feet if they get a moment over night.

Within the ED doctors carry out their own intubations, although they do have specialised anaesthetic nurses to help them. They have a fully equipped observation ward which is staffed with two doctors in the morning and one in the evening. On a shift doctors are allocated to one of three areas. These are the telephone triage system, involvement with the ambulances (SMUR), or allocation to the floor of the Emergency Department. The ED seemed to be structured around three "pods", each of which is staffed with its own team of doctors, nurses and auxiliary staff. During a day shift there are four doctors, while at night there is one doctor with two interns.

**Development of Emergency Medicine in France**  
Historically Emergency Medicine in France has been dedicated to pre-hospital care and this remains a huge part of their practise. The sort of things that are carried out at the scene include rapid sequence induction and intubation, the placement of intercostal catheters, large IV lines, thoracotomy and, more recently, even FAST scanning. However Emergency Medicine is not recognised as an independent specialty. The practice of EM includes both hospital and pre-hospital care and more recently these two parts have merged to form the Society for Emergency Medicine in France. The ultimate aim is for specialist recognition, as in Australasia.

There is now a European Society for Emergency Medicine which is developing a curriculum for EM training. They envisage a five year programme with a minimum of three years in an Emergency Department. They are aiming more for a hospital based specialty which will include pre-hospital Emergency Medicine. The curriculum is symptom based and they plan to have it up and running in late 2007.

### **Pre-hospital Emergency Care**

Amazingly, there is a two-tiered pre-hospital emergency care system in France, with two dispatch centres. One is based out of the Fire Department and is a basic life support service which dispatches very basic ambulances (VSAB) and the second provides advanced

life support and has doctor staffed ambulances (SMUR). Some hospitals, like the one in Niort, provide medical control, telephone triage and ambulance dispatch, and this is called the SAMU. The telephone number for emergency medical services in France is 15.

The main differences in Emergency Medicine are primarily that it is not yet recognised as a specialty in its own right (but hopefully this will change soon) and secondly, that the French tend to “stay and play” whereas we are more likely to “scoop and run”. A concerted effort to develop hospital Emergency Medicine to the same level as pre-hospital Emergency Medicine may make this one of the finest systems in the world.

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## Letter to the Editor

*Dear IEMSIG members,*

*I have recently arrived in Qatar and am working for Hamad Medical Corporation (HMC) for 2 years.*

*Although Qatar does not yet have an Emergency Medicine postgraduate fellowship it is very keen to look into it's development.*

*HMC is in the process of developing an international level hospital and training facility for its doctors and already has links into ALS, EMST and other areas of emergency training.*

*I would be very keen to hear from anyone within the IEMSIG who might have ideas or experience into how they have been able to assist with the development of Emergency Training programmes in other countries.*

*The Director who I am going to be working with is full of enthusiasm and it would be fantastic to be able to help to develop a programme with them while I am here, even if it is just the beginnings. Weill Cornell also has a university here and I am*

*trying, without much success unfortunately at the moment, to make inroads with them to see what can be developed through them, so any one with contacts there also would be great.*

*In short, advice from anyone would be greatly appreciated!*

*Kindest regards,  
Lisa Bell  
scottandlisa@gmail.com*