

IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM



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In this Edition

Kurdistan

Kavi Haji describes the difficulties faced in delivering health care in the north of Iraq and outlines the contribution she and husband Darsim Haji have been making.

Laos

Kham Saysana reports from his long service leave on early input into the development of EM in Laos, and seeks advice on EM training programs and support.

PNG

Sandra Rennie has made a major volunteer contribution in building a Diploma of EM and is rewarded with the first graduates. She invites expressions of interest in contributing to further development.

Sri Lanka

Two leading Sri Lankan teachers have visited Australia to train for the Emergency Life Support International course. Plans are developing to launch the course in May 2009.

India

Suresh David celebrates news that the Medical Council of India is recognizing EM as a specialty

UK

Gautam Bodiwala advises of the establishment of The College of Emergency Medicine in London.

Africa

Peter Hodkinson calls for contributors with interest and experience in building emergency care capacity in the developing world.

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Kurdistan

A Contribution to Kurdistan

Kavi Haji

Kurdistan is an ancient mountainous land and is the home of the Kurds. Following the First World War politics divided Kurdistan and Kurds became minorities in five different countries. North Iraq is the southern part of Kurdistan. It is well known for its wealth in soil, water and most importantly oil.

North Iraq was subjected to decades of hardship including persecution, genocide, poisonous gas, and economic sanctions from both the UN and the Iraqi regime. After the Gulf War in 1991 the incursion of the Iraqi army into Kurdistan led to the exodus of one million Kurds into the surrounding countries.

With the establishment of a No Fly Zone and the Oil for Food program the situation improved markedly, however in an uneven manner. Rebuilding infrastructure especially in the areas of health and education is a major task the region is left with, beside the other serious challenges such as security, terrorism and threats from the neighbouring countries.

Emergency medicine as a specialty does not exist in Kurdistan. There are rather global health issues in the region that have to be addressed accordingly. Large scale trauma and infectious diseases still claim lives on a daily basis. Water borne infections like cholera are re-emerging. Since 1991 there have been three outbreaks of cholera. The latest outbreak was a major public health issue in late 2007.

There are rising deaths from snakebites and scorpion stings due to a large number of people returning to their homes in remote rural areas and working on their farms. The likely contributors to deaths are a combination of delayed presentation, shortage of antivenom supply and possibly lack of first aid provision. Also, sadly, Kurdistan continues to suffer from the physical, psychological, economic and social impact of land mines. There are still tens of millions of land mines in the mountains of Kurdistan. They were laid by the Iraqi army during the Iraq - Iran war.

There are substantial deficiencies in the delivery of health care. There is no proper emergency system in place. Pre-hospital care is not available in any form or shape. There is a noticeable lack of nursing care and limited quality of medical services in general. Like any other underdeveloped country there is a significant mismatch between demand and supply which is exacerbated by the growing internal migration from the South to the relatively stable and peaceful North, which is imposing a big burden on the system.

Our contribution

My husband Darsim Haji and I have made regular visits as two independent emergency physicians over the last two years. We have contributed to relief work and teaching in some of Kurdistan's big teaching hospitals. Since there is no well-defined emergency care, the work has extended beyond the Emergency Department into the Intensive Care Unit and Operating Rooms and the wards.

The work included:

1. Teaching and training both medical and nursing staff. Teaching was focused on areas of major deficiency, which included resuscitation, BLS, ACLS, trauma assessment and management and critical care. It covered different patient categories including adults, obstetrics and paediatrics. The teaching was in the form of lectures, workshops, bedside and small group teaching.
2. Clinical work in fields of trauma, medical and obstetrics emergencies.
3. Basic critical care management and development of monitoring charts in ICU.
4. Raising awareness of the importance of infection control and putting simple but affordable changes into practice.
5. Teaching first aid and bedside care in snake bites and scorpion stings.
6. Fracture and wound management.

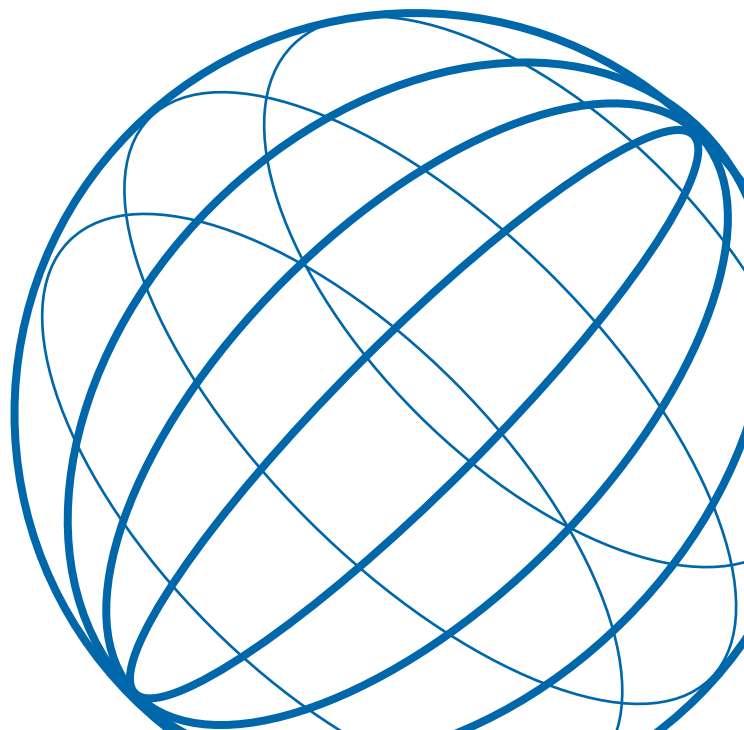
The work was a real joy as it was most satisfying, rewarding and enjoyable. I was impressed by the great enthusiasm of the locals to learn and make a difference despite the limited resources and the world of uncertainty they live in.

However, like any thing else in life there are still some challenges ahead. We realised that there is no quick fix to the situation in Kurdistan. Due to political instability and the circumstances Iraq is enduring at the moment, health as part of the infrastructure will certainly be affected. Despite the desperate need for development of EM in Kurdistan no real efforts have been invested in making it happen as it is not a known field and the need is not recognised. Obviously lack of resources and an underdeveloped health care system are major challenges and if not rectified lives will continue to be lost. It is however important to acknowledge that the expectations for patient outcomes need to be tapered to available resources, whether that relates to medical expertise or supply, or even security and the political situation in the North - if not in all of Iraq.

There is however some future direction should Kurdistan remain relatively peaceful and stable. Possibilities include:

1. Future projects in the form of regular visits by ourselves and volunteer emergency physicians and emergency and critical care trained nurses.
2. Focused local research.
3. Introduction of clinical pathways and protocols.
4. Plans to target further underprivileged areas of Kurdistan especially in remote rural areas and land mine fields.
5. Continuous education of health care workers and the public.

Kavi Haji
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Laos

Beginnings of Emergency Medicine in Laos

Kham Saysana

I am an Emergency Staff Specialist based at the Wollongong Hospital, SESIAHS, NSW. Currently, I am on 6 months long-service leave in Laos, a South-East Asian country. This is my birthplace and through family connections I am an observer at the Mahosot Hospital, Vientiane, Laos. I have a genuine interest in improving emergency services in Laos. Mahosot is the model hospital and I wish to start my work here.

The Mahosot Hospital was the first hospital in Laos, established in 1910 by French doctors, and is the most important public hospital in the country. It has 31 wards with 450 beds, and is administered by one professor, 11 associate professors and more than 600 medical staff, all of whom are Lao nationals. Many have received training internationally such as in France, Cuba, Australia, and Russia.

The Emergency Department (ED) receives up to 150 patients per day, most of whom are of low acuity. It is run by a director who has anaesthetic and intensive care experience. He is the only 'generalist' in the department. There are five junior doctors on a 24 hour shift. Two of these cover internal medicine, two cover surgical and trauma patients, and one covers paediatrics. Forty nurses work around the clock to help the patients and doctors. There are 19 beds in one large treatment area including two resuscitation beds. A defibrillator, an ECG machine, a monitor and resuscitation equipment are of low quality. Radiology is some distance from the department. However, pathology is next to the department.

My **observations and possible solutions** for the ED include:

1. There are no 'generalist' doctors who can attend to all types of patients (except for the director). Thus, the workload is unevenly distributed throughout a 24 hour shift.
Solution – replace the above 5 doctors with 5 doctors who can attend to all types of patients. This should include one senior doctor who can supervise the junior doctors.
2. The doctors have long shifts (24 hours), which can contribute to poor management decisions.
Solution – shorten the shifts to 12 hours.
3. Triage exists for 2 hours each day from 08.00 to 10.00. After 10.00 patients walk into the department and ask the most available staff member for direction to appropriate care. This contributes to significant disorder for the emergency service and to confusion for the patients.
Solution – extend the triage service to 24 hours. The department will definitely run more smoothly.
4. Elective surgical admissions such as TURP, cystoscopies, biopsies, hernia repair, etc, present to the ED to await admission to the ward.
Solution – refer these patients to a separate outpatient department (OPD). ED should only attend to the unstable patients.
5. There is a single monitor for the whole department. This monitors oxygen saturation, cardiac tracing/pulse rate, temperature and blood pressure.
Solution – add an upgraded model which includes a carbon dioxide monitor.
6. The old ECG machine (Cardimax – 2111) is slow to provide a cardiac tracing and breaks down from time to time.
Solution – provide an upgraded model.

7. The old defibrillator (LIFEPAK 300 - from Belgium) does not meet contemporary standards.
Solution – provide an upgraded model which is user friendly.
8. There are two old ventilators (MONNAL S respirateur d'urgence frequence fixe), which are still working.
Solution – provide any spare upgraded model, ie Oxylog 1000.
9. The nursing unit manager is keen to improve the level of knowledge for the nurses.
Solution – provide assistance when required.
10. There is no formal pre-hospital care. This is still being developed by the director. There is a single ambulance (not well equipped) for the hospital. Some tuk-tuk drivers have been designated to assist in transport of sick patients.
Solution – The U.S. Pacific Command (PACOM) military medical community have proposed to provide a First Responder Course. From this, pre-hospital care will be recognised as an essential component of emergency care.
11. There is a significant language barrier. Lao is the spoken and written language. Most medical textbooks are written in French. Some students also use textbooks in English. Textbooks in Thai are also used - these have been translated from the French or English versions.
Solution – lectures are presented in Lao mixed with French and English medical terminology.

My goal is to establish a better emergency service for the Mahosot Hospital and eventually for Laos. The idea of an Emergency Medicine specialist training program has been seeded.

Dr Ponmek, The Minister of Health wishes to improve emergency services in Laos. He is happy for assistance from Australia and has written to the Director of the Hospital to formally accept assistance to improve emergency services.

Dr Bouasone, the director of Emergency at the Mahosot Hospital has requested for junior doctors to work as 'generalists' in the department. This is still pending.

Dr Ounkham, the director of anaesthesiology/critical care medicine wishes to adopt a 3 year Emergency Medicine Training Program in Laos. He has requested training curricula in ICU and Emergency Medicine from the developed countries.

In summary, there is a lot of interest to improve emergency services in Laos. All the important people know that I wish to assist them on this matter. I am highly motivated as Laos is my birthplace.

Phanomkham Saysana FACEM

Can you contribute?

I would be very grateful for any advice in terms of funding/sponsorship and development of a training program for Emergency Medicine.

Contact:

Phanomkham Saysana FACEM
Vansana Hotel, Vientiane, Laos
Email - calm_ss@hotmail.com

Papua New Guinea

First graduates of an Advanced Diploma in Emergency Medicine Divine Word University, Madang

Sandra Rennie

Five proud inaugural graduands of the “Advanced Diploma in Emergency Medicine” joined 700 other students at the March 2008 Graduation Ceremony at Divine Word University (DWU), Madang, Papua New Guinea. They have completed course work relating to emergency medicine over two years and four residential units of a week each.

The Diploma is offered to nurses, health extension officers, and doctors through the faculties of Health Science and Flexible Learning at DWU. (See IEMSIG Newsletter May 2006, Vol2 No3. and the website: www.dwu.ac.pg)

There are currently 20 students enrolled, with a further 20 anticipated in June 2008.

Students have attended from all over PNG, often receiving sponsorship from their employers to cover travel and university costs. As well as teaching and learning, the Diploma has provided a unique opportunity for communion between health care workers from many different walks of life: rural, urban, private, public, government and church run centres. Some of the graduates will be facilitating in future courses.



Can you contribute?

Local and international contributors have generously given their time and energy on a volunteer basis.

Expressions of interest in contributing to the Diploma will be gratefully received. PNG trainers or people with experience working in developing countries are preferred. Any materials, resources or suggestions, please contact me at sandra.rennie@health.wa.gov.au.

The Health Extension School at DWU is currently evolving from a 3-year diploma course to a 4-year degree program. It faces all of the challenges associated with producing appropriate health care providers to a health care system under significant strain. If anyone has a particular interest in this area, I would be happy to provide further information and contacts.



Unit 1: Trauma

June 2006:

Sandra Rennie (emergency trainee), Chris Kruk (FACEM), Fremantle Western Australia
George Kusma (surgeon), DWU and Modilon Hospital, Madang
Sammy Thomas (surgeon), Steve Demock (ophthalmologist), Vincent Atua (emergency trainee), Modilon Hospital, Madang

Description

This unit introduces a systematic, internationally recognised approach to the assessment and treatment of injured patients. It includes the Primary Trauma Care Course with an emphasis on basic life saving trauma care with minimal resources. Morbidity and mortality from trauma due to industrial, road or natural disasters can be reduced with early and effective intervention. Lectures and practical skill stations provide basic knowledge and the opportunity to put the theory into practice via simulated scenarios.

Participants also consider issues of personal safety, injury prevention, domestic violence, workplace organisation, disaster planning and patient transfer.

Teaching and Learning Strategies

Include formal lectures and presentations from appropriate specialists, small group workshops, video presentations, simulated emergency scenarios with role play, surgical procedures conducted on animal parts or mannequins.

Unit 2: Paediatric Emergencies

November 2006:

Sandra Rennie; Paul Hui (emergency), Newcastle Australia
Kurua Nemba (paediatrician) PNG national from Highlands, working in Perth WA

Description

This unit includes the 3-day "Emergency Triage Assessment and Treatment" (ETAT) course published by WHO in 2005. This introduces a systematic "ABCD" approach to recognising and managing severely ill children regardless of the specific diagnosis. The course material is detailed in the WHO Handbook "Hospital care for Children" and is an expansion of the IMCI (Immediate management of childhood illness) that is used widely in PNG. The IMCI 10 and 8 steps are reviewed in the course. Additional material includes management of common conditions such as asthma and snakebite, child and neonatal resuscitation transport issues and child abuse.

Teaching and Learning Strategies

Include formal lectures from appropriate specialists, video case presentations, simulated emergency scenarios with role play, triage drills, and assessment questions based on printed course material.

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Unit 3: Medical Emergencies

June 2007:

Sandra Rennie, Paul Hui, Chris Hall (rural GP)

Description

This unit reinforces a systematic approach to the sick adult based on similar principles to the trauma and paediatric units.

Teaching and Learning Strategies

Include formal lectures, small group workshops, simulated emergency scenarios with role-play, practical activities including use of defibrillators.

Unit 4: Obstetrics and Gynaecological Emergencies

October 2007:

Sandra Rennie, Miriam O'Connor (obstetrician, Safe Motherhood, CBSC Port Moresby), Geoff Clark (nurse, midwife, Public Health, WHO Port Moresby)

Description

Students gain confidence in their ability to anticipate, assess and manage obstetric and gynaecological emergencies, and identify the need to transfer patients to centres of definitive care.

Teaching and learning strategies

Lectures, small group workshops, video presentations, simulated emergency scenarios with role-play, directed practical activities and projects.

Sandra Rennie MBChB BSc FACEM
Clinical Lecturer, University of Western Australia
Email - sandra.rennie@health.wa.gov.au



Sri Lanka

Emergency Life Support International (ELSI) Plans for Sri Lanka – May 2009

Shane Curran

Emergency Life Support International plans to run ELSI courses in Sri Lanka, similar to the successful implementation of a course in Papua New Guinea.

With financial support from the ACEM International Emergency Medicine Fund, two senior doctors from Sri Lanka were brought to Australia to observe a full course and one in fact participated as a candidate.

Professor Chula Goonasekera, then President of the Sri Lankan Society of Critical Care and Emergency Medicine (SSCCEM), and Professor Ariyananda, Head of the Galle Emergency Treatment Unit were brought to Melbourne in 2007, with a view to their becoming leading local faculty in Sri Lanka.

Core equipment for these courses of a rhythm simulator and a venous access training mannequin were presented to the Sri Lankan Society at this time. This equipment is now based at the University of Perediniya and is used for training of local medical staff when not being used by the Society.

Plans for two courses in Sri Lanka for May 2008 were well progressed with a full Australian faculty prepared to pay their own way and further the ELS cause. The first course was to be in Kandy with an added “train the trainer” course for suitable local instructors, followed by a second course in Galle, using the newly trained local instructors.

The intention is that subsequent courses will be run with a core Australian faculty but using increasing numbers of local instructors.

There was significant local interest demonstrated in these courses and it was only after much deep consideration that the courses were postponed due to increasing civil unrest within the country, where the safety of the team could not be guaranteed at that time.

The most likely date for the resumption is May 2009. This seems to be the most suitable time for instructors to be able to devote two weeks.

For further information, contact Shane Curran
Email - shane@unsw.edu.au
Mobile 0429849203.

Anyone wishing to participate in the one day annual meeting of the SSCCEM on 12th November 2008 is also asked to contact Shane Curran

CONFERENCES

PAPUA NEW GUINEA

SOUTH PACIFIC UNDERWATER MEDICINE SOCIETY (SPUMS)

37TH Annual Scientific Meeting
May 25th – May 31st 2008
Liamo Resort and Walindi Plantation, Kimbe, West New Britain

THEMES:

The Treatment Tables; Tropical Medicine Update; Resuscitation Update
The resuscitation update will include AED use and insertion of various airway devices for use in outside hospital resuscitation.

Guest speakers include:

Professor Alf Brubakk
Dr Richard Moon
Dr David Williams (Tropical Medicine)

Convenor:

Dr Chris Acott, President SPUMS
30 Park Ave. Rosslyn Park, South Australia 5072
cacott@optusnet.com.au
Tel. +61 8 8431 2295, Fax. +61 8 8431 8219
Mobile: +61 (0)412 618 417
www.spums.org.au

44TH ANNUAL SYMPOSIUM OF THE MEDICAL SOCIETY OF PAPUA NEW GUINEA

1-5th September 2008
Rabaul, East New Britain

THEME:

Strategic planning for Health in PNG

Convenor

Dr John Maku
Private Bag 3, Kokopo, East New Britain
smong@global.net.pg
Tel. +675 9827 333, Fax. +675 9827 331

The Symposium will be preceded by:

Primary Trauma Care (PTC) course: 26/27th August
Emergency Life Support International (ELSI) course: 29/30th August

Contacts

Chris Curry: chris@chriscurry.com.au
John Kennedy: drjfk@bigpond.com

SRI LANKA

ANNUAL MEETING OF THE SRI LANKA SOCIETY OF CRITICAL CARE AND EMERGENCY MEDICINE (SSCCEM)

12th November 2008
Colombo

Contact:

Shane Curran
shane@unsw.edu.au
Mobile 0429849203

INDIA

EMCON 2008

10th Annual Conference of the Society for Emergency Medicine in India
14-16th November 2008
Salem, Tamil Nadu

THEME:

Spreading wings beyond the Emergency Department
www.emcon2008.com

Convenor:

VP Chandrasekaran
drvpchandrasekaran@yahoo.co.in

THE INAUGURAL CONFERENCE ON GLOBAL ISSUES IN CLINICAL TOXINOLOGY

Melbourne Convention & Exhibition Centre
Sunday 23rd to Friday 28th November 2008

<http://www.mcmconferences.com/toxin2008>

Addressing a therapeutic “black hole”: the worldwide crisis in

antivenom supply and medical training for snake bite treatment

- Snake bite: a neglected disease in the 21st Century
- The essential drugs – antivenoms
- The commercial imperative: unscrupulous distribution of ineffective antivenoms and poor regulatory policies
- Solving the crisis



Professor

David A Warrell

*Nuffield Department of Clinical Medicine,
University of Oxford,
John Radcliffe Hospital, Headington,
Oxford OX3 9DU, UK*

Professor José María Gutiérrez

*Facultad de Microbiología, Instituto Clodomiro Picado,
Universidad de Costa Rica
San José, Costa Rica*

Message from the Organising Committee...

Snakebite affects the lives of around 4.5 million people worldwide every year; seriously injuring 2.7 million men, women and children, and claiming some 125,000 lives.

Globally the greatest burden is experienced in the tropical world; where many nations remain under-developed or suffer from poor governance, political and/or social, conflict, resource scarcity, high disease burdens, or food insecurity.

The Inaugural Conference on Global Issues in Clinical Toxinology will be the first truly global forum in which an eclectic community of health and government professionals will converge to develop an international framework for addressing snakebite problems at National, Regional and Global levels.

GICT '08 aims to invigorate the fight against snakebite, which has long been a neglected tropical illness.



For the very first time we are bringing together a talented and diverse group of experts to lay the foundations for what will be a unique and dynamic multi-disciplinary action model that focuses attention on

- Evidence-based clinical guidance, training and education that is regionally relevant and strategically focused;
- Revolutionary strategies for improving long-term access to safe, affordable and efficacious antivenoms; Community awareness, prevention and first-aid interventions;
- Outcome oriented research projects that address National, Regional and Global priorities;
- Improved burden of illness (BOI) and cost of illness (COI) reporting and surveillance;
- Global coordination, guidance and funding initiatives.

The culmination of the meeting will be the official launch of a Global Snake Bite Initiative to coordinate an international effort to reduce snake bite morbidity and mortality through a programme of sustainable approaches and outcome-oriented strategies.

On behalf of the Organising Committee we invite you to join us in Melbourne, Australia next November, and participate in this important international initiative to address this costly but largely forgotten health problem.

David Williams, Ken Winkel, for the GICT'08 Conference Committee

Conference Secretariat:

GICT'08 Organising Committee
C/-Melbourne Conference Management
MU Student Union Ltd
The University of Melbourne
Parkville VIC 3010 AUSTRALIA
Telephone: +61 3 8344 6389
Facsimile: +61 3 8344 0013
Email: gict08@union.unimelb.edu.au

Scientific Committee

Prof. Graham Brown (AUS), Dr. Jean-Philippe Chippaux (BOL), Ass. Prof. Bart Currie (AUS), Prof. Ponnambalam Gopalakrishnakone (SIN), Dr José Maria Gutiérrez (CRI), Prof. Dietrich Mebs (DEU), Dr Ana Padilla (WHO), Prof. Visith Sitprija (THA), Prof. James Tibballs (AUS), Prof. David Warrell (GBR), Professor Julian White (AUS), Dr. Ken Winkel (AUS)

NEWSCLIP

The Humanitarian Award of the International Federation for Emergency Medicine has been awarded to David Bradt, in recognition of his extensive contributions to international disaster responses.



Letter to the Editor

Recognition of EM in India

19th February 2008

Dear Friends of EM in India - Ladies and Gentlemen,

It is with a sense of satisfaction and pleasure that I wish to announce that the Medical Council of India (MCI) has recognised the specialty of Emergency Medicine.

This evening (19th February 2008) I received a Fax (sent to me by "an insider") instructing the inclusion of the specialty in the Postgraduate Regulations and recommending the Board to start an MD in Emergency Medicine.

The journey that began in 1997 with my first proposal to the MCI has at last reached its destination - a decade later. Exhausted I am, yet jubilant at the outcome. I can now retire and head for the Himalayas, to spend the rest of my life in meditation!

I wish to thank each one of you for your contributions - in thought, advice and letters. I celebrate the culmination of our joint effort and wish to share this rare moment, one which has been expectantly awaited by all of us for many years!

Thank you once again.

Sincerely

*Suresh David
Email - suresh.david@cmcvellore.ac.in*

The College of Emergency Medicine

29th February 2008

Dear Friends

Today has been a historic day for Emergency Medicine in the United Kingdom.

The British Association for Emergency Medicine (BAEM, Founder Member of IFEM) and the College of Emergency Medicine have merged to form one single organisation called The College of Emergency Medicine incorporating functions of both these organisations. According to the British tradition, Her Majesty the Queen granted an order for a Royal Charter which was collected on the 20th February, to form a single organisation. We hope to receive a Royal appellation in due course.

We are all rejoicing the day and feel very confident about the future.

BAEM along with the old college, have been at the forefront of Emergency Medicine for many years nationally and internationally and now The College of Emergency Medicine, which started functioning today, hopes to take over that task.

I thought I better share with you this exciting news.

With best wishes from all of us from The College.

Yours Sincerely,

*Gautam Bodiwala
On Behalf of The College of Emergency Medicine*

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www.emergencymedicine.org.uk*

Delphi Study of Emergency Care in the Developing World Call for Contributors

Peter Hodgkinson and Lee Wallis

Peter Hodgkinson is Senior Lecturer in the Division of Emergency Medicine at the University of Cape Town in South Africa. He is currently contributing to development in Kampala, Uganda.

Lee Wallis is Professor and Head of Division. He was the driving force behind the conference "Emergency Medicine in the Developing World", conducted in Cape Town in November 2007.

Peter and Lee seek assistance with a Delphi study that they would like to conduct to determine the scope, training and staffing for Emergency Care in the Developing World.

They plan to develop a consensus document of the most important factors for the development of effective emergency care systems in developing world settings.

They wish to gather together a panel to take part, especially those with an interest in Emergency Medicine in the developing world. This will involve individuals making statements that they consider important, and then collation and consensus of the panel.

The involvement will be purely on an email (or fax) correspondence basis.

All those with an interest in the development of emergency medicine internationally are invited to contact Peter:

*Peter Hodgkinson
Email - pwhodkinson@gmail.com*

NOTICES

International Journal of Emergency Medicine

Springer.com have launched a new journal. The International Journal of Emergency Medicine (IJEM) is freely available on the internet. The first edition, Vol 1 No 1, was launched in March 2008.

<http://www.springer.com/medicine/critical+care+%26+emergency+medicine/journal/12245>

The Editors-in-Chief are Latha G. Stead and Wyatt W. Decker, both of the Mayo Clinic College of Medicine, Rochester, Minnesota, USA. The Editorial Board includes an Australian, Simon Brown of Fremantle, Western Australia.

Description

The aim of the journal is to bring to light the various clinical advancements and research developments attained over the world and thus help the specialty forge ahead. It is directed towards physicians and medical personnel undergoing training or working within the field of Emergency Medicine. Medical students who are interested in pursuing a career in Emergency Medicine will also benefit from the journal. This is particularly useful for trainees in countries where the specialty is still in its infancy.

Disciplines covered will include interesting clinical cases, the latest evidence-based practice and research developments in emergency medicine including emergency pediatrics.

IJEM will focus on the practice of emergency medicine in a variety of settings, from urban emergency departments to rural clinics in the developing world, to humanitarian and disaster situations. An international representation on the editorial board will help advance the practice globally and shed light on international advances in practice, education and research, with a single common goal: to reduce suffering and promote excellence in patient care worldwide.

Latha Stead: Stead.latha@mayo.edu

Wyatt Decker: Decker.wyatt@mayo.edu

Submit your manuscript online: <http://www.editorialmanager.com/ijem>