

# IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM



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## Editorial

### The IEMSIG website Noticeboard

The College continues to develop capacity to support those interested in exploring international emergency medicine developments and opportunities. A new step is the inclusion of a Noticeboard on the IEMSIG website, to carry information on upcoming conferences, courses and jobs.

This can be accessed by going [www.acem.org.au](http://www.acem.org.au) go Infocentre, go International Emergency Medicine, go Noticeboard or by going directly <http://www.acem.org.au/infocentre.aspx?docId=1193>

Anyone with items that might be useful on the Noticeboard is invited to email the editor: [chris@chriscurry.com.au](mailto:chris@chriscurry.com.au)

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## Working with Médecins Sans Frontières - with ACEM accreditation

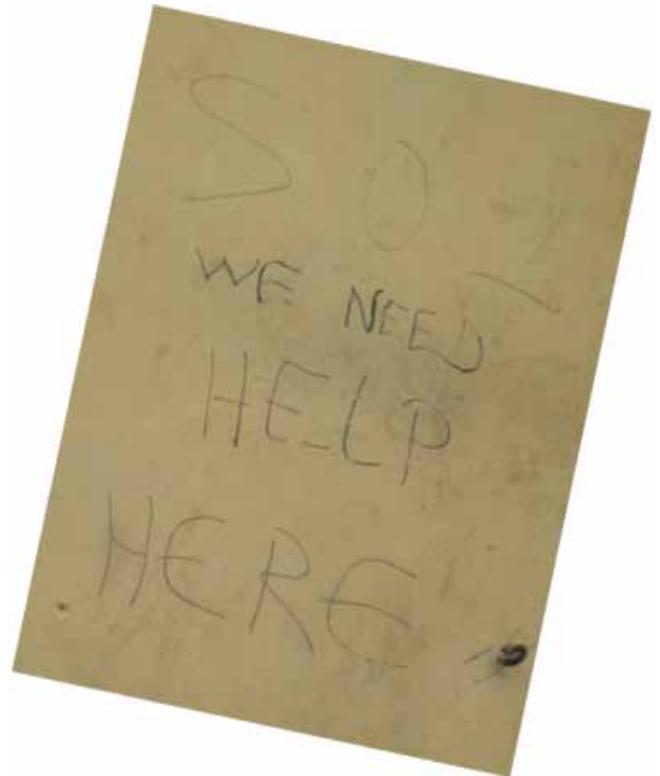
Melissa McRae  
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### “SOS - WE NEED HELP HERE”: Special Skills Training: Research and Epidemiology

In the last IEMSIG Newsletter issue (Dec 2010, Vol 6 No 2) there were several inspiring articles giving personal accounts of experiences gained whilst working with Médecins Sans Frontières (MSF) in Africa, as well as with other organisations in Papua New Guinea, with the common theme being that trainees are now able to prospectively apply for ACEM special skills, category C, accreditation towards such work.

Like the last issue's contributors, I was also fortunate enough to receive 6 months accreditation during my time with MSF over the past 2 years. My previous MSF missions had shown me the huge yield achievable through utilising smart and practical public health strategies when working in remote and non-industrialised settings. I also grasped the importance of ongoing field research, research that is applicable when trying to deliver the best possible care in these settings under an insurmountable pile of constraints. Such challenges include insufficient trained health care providers, cold-chain facilities and most importantly finances, equates to reduced access to the research driven pharmaceuticals and medical practices that continue to save lives in the resource rich areas of the world. When a viable HIV vaccine reaches the market, as seems achievable in the near future, despite the best efforts of global agencies, it will be some time before that research directly benefits the polygamous tribes in Homa Bay, Western Kenya, where HIV prevalence approaches 30 percent.

So, I completed a Masters of Public Health (MPH) whilst working as an emergency registrar and then applied for one year off training and was lucky enough to get a job with Epicentre, one of the research arms of MSF. My first post was as a clinical research assistant working in an MSF HIV mission in Homa Bay. I co-ordinated the research at the field level with continuous input from the principal investigator based in Paris. Our research focused on the acceptability, feasibility and effectiveness of offering chemotherapy treatment for AIDS-Kaposi's sarcoma (AIDS-KS) in rural areas, previously only available, at cost, at the tertiary referral hospital in Nairobi. The chemotherapy under review has long been surpassed in resource rich nations due to its high side-effect toxicity profile but remains the first line treatment in African nations who carry the highest incidence burden of AIDS-KS worldwide. Through MSF, lobbying of pharmaceutical companies continues in an effort to lower the prices of the gold standard medications (~A\$1,400 per dose) but we



proceeded with research of 'old school' chemotherapy that is readily available and affordable to our target population and thus a sustainable treatment option.

Given my knowledge of oncology and dermatology is below cutting edge to say the least, luckily I had a few weeks preparation pre-departure to learn about the drugs, the disease, review protocols and write standard operating procedures, and then a steep learning curve in the field. It was really a dream job, a mixture of clinical and research work and gave me the opportunity to put into practice valuable skills learnt during my MPH. Anyone who has done similar works knows that you expect daily challenges when delivering healthcare in such settings and running to a strict research protocol added another layer of complexity. Some days I couldn't even put a positive spin on an issue to make it a "challenge"; from every angle it was a problem! The laboratory equipment failed, a local doctor was refusing to refer patients without receiving personal financial kickback, patients missed treatment due to transport failure, bloods were taken on the wrong day etc. Despite everything many patients got better and regained their ability to function within their family unit, the hallmark of wellness in this culture. This research is still continuing today via a Kenyan trained team and support from Epicentre with promising interim results.

After my time in Kenya I moved into a position where I was based out of Europe and moving constantly to different field missions to help on various projects. My AIDS-KS work stayed with me a while longer as I sought out additional potential sites for research, liaising with government officials and designing appropriate protocols

for each setting. I also had the opportunity to work on other projects, helping MSF missions with routine data collection and analysis, investigation and monitoring of infectious disease epidemics in Haiti and Burundi as well as community morbidity and malnutrition surveillance following the Haiti earthquake. Reviewing childhood vaccination practice and research in sub-Saharan Africa and helping to change MSF vaccine practice became a pet project.

My first year was taken as approved leave from training and then I prospectively arranged a second year of which 6 months was accredited as special skills. My accreditation process was identical to those clearly outlined by others in the last IEMSIG issue. I had an on-site supervisor at Epicentre and, very importantly, a supportive DENT in Australia. Clear objectives were established in my initial proposal for accreditation and I completed ITA assessments and a work portfolio as required.

Emergency Medicine is a great specialty for fieldwork; more often than not we are easy going folk with a wide range of interests and skills who are used to working in teams, have coping skills for when the mercury boils and can laterally problem-shoot when needed (medically and non-medically). If you have made it to this point of my article, I am guessing you may have enjoyed similar experiences, or find yourself in the 'hoping to do that someday' group. The latter often brings up issues of when and how to fit these experiences into ACEM training and 'life as you know it'. Whilst I've had a good deal of luck come my way some planning helped that luck fall where I needed it most. The possibility of special skills accreditation makes exploring international medicine during training all the more feasible. The required 'flexibility' often daunts people who are contemplating working with MSF as it can be hard to get exact dates ahead of time. I would recommend having 2-3 months either side of your mission dates; initially time to apply and obtain prospective ACEM approval and afterwards to clear your head and recuperate, as the work is as demanding as it is rewarding. This lag period also allows for unexpected events that happen so often we should rethink if they really are unexpected: It is life in the field!

Whilst I have had only a small taste of the wide world of international medicine the scope and possibilities are inexhaustible but having a realistic personal perspective helps in getting you well matched for the job ahead. Before taking a position I think through what is important to me and why I am doing it, which helps me think what I can realistically achieve, where my personal boundaries lie and what is not negotiable for me. I respect my own safety limits and limits that my loved ones back home would like me to have whilst I am away. Travelling, learning and living in different cultures is definitely one of the attractions but unlike adventure holidays we need to learn to work and function within different cultures and even with the best cultural acceptance on board it is confronting when patients are dying in front of you from reversible causes due to cultural practices. If you are keen to do it then organise it, this type of work passes you by if you sit still.



Mobile Street Pharmacy in Port-au-Prince, Haiti, 2010



Clean up efforts during community surveillance in Port-au-Prince, Haiti, 2010



Temporary malaria outpatient clinic in Karusi, Burundi during malaria epidemic, 2010

# Southern Africa

## Emergency Medicine Development in Botswana - an Update

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Botswana faces a high burden of illness requiring emergency care, including infective complications of HIV/AIDS, road traffic trauma, and an increasing prevalence of cardiovascular disease. Emergency care is largely provided by medical officers and nurses who lack specific training. Botswana is also heavily reliant upon expatriate doctors - over 90% of doctors practicing in Botswana are expatriates.

In order to address the need for locally trained doctors the University of Botswana (UB) opened the first medical school in the country in 2009, with the commencement of an undergraduate Bachelor of Medicine and Bachelor of Surgery program. Post graduate Master of Medicine (MMed) programs in internal medicine and paediatrics were introduced in 2010, and in 2011 four more MMed programs were commenced, including emergency medicine.

The four year Master of Medicine in Emergency Medicine [MMed(EM)] is largely based upon the South African Master of Medicine model. South Africa faces similar burdens of disease and resource constraints, and the College of Emergency Medicine of South Africa [CEM(SA)] is supportive of the development of emergency medicine training programs in the southern African region.

Residents must have completed a minimum of two years of clinical practice before entering the program. The four year program includes clinical rotations in emergency medicine (approximately two and a half years) and 18 months in other specialty areas, including intensive care, anaesthesia, paediatrics and other specialty areas. Residents must successfully complete the South African CEM(SA) Part 1 and Part 2 Exams, and a dissertation based upon original research, in order to complete the MMed program.

The main teaching site for the program is Princess Marina Hospital (PMH), one of only two public referral hospitals in Botswana. PMH Accident and Emergency Department sees around 35,000 patients each year, 20% paediatrics, with a 30-50% admission rate. PMH is a challenging environment to work and teach in: patients are high acuity, and there is a lack of highly trained staff. Equipment is inadequate and poorly maintained, and supply of drugs and non-drug items is unreliable. Laboratory and radiology services are not always readily available, and communication is difficult as

there is no functioning pager system.

Despite these challenges, considerable progress has been made. The University of Botswana now has three emergency physicians on the faculty (two Americans and one Australian) who provide clinical supervision and formal teaching at PMH A&E and at the University. Funding is currently available for an additional three emergency physicians to join the faculty.

Significant quality improvements at PMH over the past two years include emergency physician presence in the A&E Department five days a week, introduction of an objective triage system, a patient tracking system, formal handovers at shift change, introduction of clinical guidelines, and regular morbidity and mortality meetings. The first cohort of four EM 'residents' (registrars) commenced the MMed program in January 2011, and are on track to sit the CEM(SA) Part 1 exam in September 2011.

The estimated projected need for emergency physicians in Botswana is 60 physicians by 2035. This figure is based upon a model where emergency physicians direct patient care at referral hospitals, act as Emergency Department directors at district level hospitals and play a role in the development of the Emergency Medicine System, including pre-hospital care. The UB MMed(EM) program is planning an annual intake of 4-6 registrars which, provided adequate retention, would generate 60 specialists ahead of the target. Excess training capacity could then allow Botswana to become a regional EM training centre for southern African countries without specialty training.

This is an exciting time in the development of EM in Botswana. Despite considerable challenges significant progress is being made and the first group of future emergency physicians has commenced training.

There are opportunities for employment for emergency physicians, and short term volunteer placements for emergency physicians and senior registrars. ACEM trainees could have time accredited towards advanced training under the Special Skills Category C criteria.

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## Missionvale: confronting the realities of a shantytown

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The name Missionvale has rather an uplifting ring to it. Sadly, the reality is rather different: grinding poverty, endemic TB and HIV, and early death. Our 6½ weeks working there forced us to confront the realities of living in a shantytown.

Located on the outskirts of Port Elizabeth, South Africa, the township is the direct result of the horrific policies of the apartheid era. There was a functioning cosmopolitan township called South End near the affluent suburb of Walmer, to which it provided domestic and other labour. The land was deemed desirable for white settlement. So from May 1965 onward 8000 mainly coloured people were forcefully uprooted, their shacks bulldozed, and dumped by the salt pans of Missionvale, some 20 kms away, dislocated from their main means of employment. The addition of 16 water pumps has seen the influx of numerous Xhosa, swelling the township to around 100,000.

Sister Ethel Normoyle, Irish nun, nursing sister, and Port Elizabeth Citizen of the Year, found these political refugees living in impoverished circumstances and helping them has become her life mission. She founded the Missionvale Care Centre, where we worked.

As Penny my wife, Douglas my son and I drove into the township we passed people picking over the rubbish beside a cemetery. Black plastic bags of rubbish lie in heaps, broken open, spilling their contents on the ground. Houses are made of tin, bits of wood, anything that they can find that might help to keep the rain, dust and heat or cold out. Tears still come to my eyes as I recall our first walk through the shantytown. It was not a pretty place.

Penny worked first in the food distribution centre that feeds the most impoverished in Missionvale. A day parcel comprised ½ a loaf of wholemeal bread and a cup of dry soup powder for one person. Those with HIV or severe health issues had supplemental milk powder. The weekly parcel was 500gm maize meal, 500gm sugar, 1 can of soup, 1 can of pilchards, 5 tea bags, 1 bar of soap and 1 of laundry soap – in exchange for one piece of recyclable rubbish. Up to 500 people a day would queue 3 hours for these modest offerings. Later Penny worked in the clothing distribution centre, and then did cut-outs in the sewing room.

Doug, a writer-journalist, sought out stories of hardship and love, of which there was no shortage, and befriended the AIDS orphans at the centre.

I worked as a volunteer doctor in the community clinic attached to the centre. Four nurses usually run the clinic, with a retired doctor attending 2 hours per week. Chest and upper respiratory tract infections were the commonest presentations. Mixed in with the more usual bronchitis and pneumonia were open cases of tuberculosis – still South Africa's number one killer. This I found a bit scary – none of them came in saying they had TB so avoiding exposure was hard. Probably my only lasting achievement was to separate

the HIV testing room from the TB room – located next to each other when I arrived, with obvious risk of cross infection.

The anti-natal nurse estimated the prevalence of HIV in the antenatal clinic was 50%, which is higher than the 29% quoted by a South African Department of Health Study in 2009, but may be indicative of rates in a shantytown. Access to antiretroviral treatment was very limited – a single agent for pregnant mothers. Others had to wait till their CD 4+ count was less than 200 and many of these failed to access treatment through ignorance or poverty: they cannot afford the taxi van fare to the HIV treatment centre; treatment is not available at the clinic. An HIV positive Xhosa man who attended the clinic one day brought their poverty home to me. Clinically he had RUL consolidation, confirmed by the weekly X-ray van. TB was most likely, for which we started treatment, but he was a smoker, so cancer was in the differential. One of the few CT scanners was in a hospital some suburbs away, so referral was made there. I saw him some days later – he had not been able to afford the A\$1 to get there.

Confronting the HIV epidemic first hand made me consider what it would take to stop the epidemic. Adopting monogamous sexual relationships, while unfashionable, would have a major impact. While Christianity is fairly strong in South Africa, including, ironically, the Dutch Reform Church that was implicated in justifying apartheid, the predominant philosophy in the Eastern Cape was Xhosa tribalism, in which the men are highly promiscuous. Thus condoms seem more practical, but are expensive relative to their income and have variable acceptance. Secondly, an honour code in which HIV+ people only have relationships with HIV+ people would stop the spread of HIV. Thirdly, there would need to be ready access of antiretroviral therapy and the commitment to taking it. As emergency physicians are no doubt aware, the regime is extremely onerous, even for highly educated patients who understand and believe in Western-type medicine. There would also need to be concurrent treatment of TB – this they did quite well at the clinic. There is little cause for optimism. The general populace is unlikely to abandon highly promiscuous behaviour, and the South African government will have difficulty affording the vast expense of life-long antiretroviral treatment for 5.6 million people. President Zuma in hardly a good role model, having a relationship with an HIV+ woman and recommending a shower afterwards as a means of prevention.

Sister Ethel had hoped to provide antiretroviral treatment through a research program funded by the United States to the tune of \$150 million. Discussion occurred while we were at Missionvale. The Mayor of Port Elizabeth made a grab for the money, saying that the medications should be distributed through HIV 'centres of excellence'. The ANC wished to be seen to be handing out the anti-retrovirals.

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I must commend the nurses who ran the clinic. Working in difficult circumstances year in year out, they provided primary care for a vast population who would otherwise have difficulty accessing health care. After 7 years the charge nurse was 'burnt out'. Fortunately, she obtained a posting while I was there.

Thanks and fond farewells by Sister Ethel led to the inevitable question: when will we return?

Stopping the HIV epidemic: what would it take?

- Monogamous sexual relationships
- Ready access and willingness to use condoms
- An honour code – HIV positive people only having relationships with HIV positive partners
- Ready access to antiretroviral treatment
- Understanding and lifelong commitment to an antiretroviral regime
- Concurrent treatment of tuberculosis



Tuberculosis, - and HIV?

Jamie Hendrie with the team



## As a reward to ourselves.....

As a reward to ourselves, we spent 6 days in Kruger National Park at the end. It was absolutely magic - like walking through the Garden of Eden. Tiring of being in the car, we took 4 walks in the park, accompanied by 2 rangers armed with elephant guns. We surprised a male lion stalking an impala – fortunately he was surprised as us, passing within 20 metres as he ran off. On our last walk we stalked a rhino coming up on the other side of a water hole on a dried up riverbed. After some photos we hurriedly departed – dark was falling and the hippos would emerge soon. After walking 100 metres back along the opposite riverbed our ranger-in-command elected to cross over the dry riverbed onto the side of the rhino. The rhino stopped browsing, lifted his head and started trotting purposefully toward us. We crouched down beneath the level of the bushes and scuttled along. I glanced back. The rhino towered 8 foot at the tip of his horn. The second ranger dropped back to protect us. Fortunately the bush hid us and we made our getaway. Lightning ignited a bush fire some kilometres away. Then a tropical storm engulfed us, torrential rain drenching us. The rangers seemed as glad to see the Landrover as we. We passed a browsing bull elephant at 50 metres driving out. It had been a memorable walk.



Kruger National Park

# Pacific Islands

## Growing Emergency Medicine in Vanuatu

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In late November I was in Vila Central Hospital (VCH) in beautiful Port Vila, Vanuatu, at the invitation of the Ministry of Health (MoH). My purpose was to help review the function of their emergency department. It was therefore somewhat disconcerting to be met with an elegant sign reading "Closed". The Emergency Department was clearly not open - a state of affairs for which I was not prepared.



*The sign. There are some days I'd quite like that sign in my department here in Burnie.*

Throughout the Pacific there is a growing awareness of the importance of emergency medicine to the function of a health service. Certainly its development in Papua New Guinea has been well received and steady progress is being made. With the importance of the University of Papua New Guinea for training medical staff throughout Melanesia, and with the relatively mobile Melanesian workforce, it was only a matter of time until these ideas began percolating through to other countries in the region.

The MoH in Vanuatu was aware of problems in the function of their department, and had requested advice on how to improve their service delivery.

I spent two weeks there as part of a four person delegation:

- Me - a FACEM based in Burnie, Tasmania
- Mrs Carol Scott - clinical nurse educator for the emergency department in Burnie

- Dr Kenton Sade - emergency department director, National Referral Hospital, Honiara, and trainee in the UPNG Masters in Emergency Medicine
- Mrs Krystalee Horoto - emergency nurse specialist, National Referral Hospital, Honiara

Before going into the details of our findings, I think a comment about the team composition is warranted. A combination Solomon Islander-Australian team worked wonderfully well. The Islander experience brought a grounding in reality to the more ambitious flights of fancy in which I tended to indulge. And hearing first-hand how the Emergency Department in Honiara had developed with a bottom-up approach proved really inspiring. At the same time the organisational skills which the Australians brought were not to be underestimated. This is a model which I whole-heartedly recommend for the future.

The problems identified were many, but all potentially soluble.

In common with many other hospitals in the Pacific, the Emergency Department was co-located with general practice-style outpatients, specialist outpatient clinics, acupuncture, and chronic diseases clinics. This has the inevitable consequences of disordered patient flows and diluted emergency care.

The model of medical staffing was also challenging. There were no full-time ED doctors. Rather, interns rotated through from their ward jobs for individual 24 hour shifts. As a consequence interns were highly stressed and not inclined towards working in EM again.

Nursing care was enthusiastic, but hampered by a generally low level of nurse education and a virtual absence of higher level qualifications. There is also an entrenched practice of rotating nursing staff to other departments, further diluting experience. The impending retirement of a number of key staff is likely to weaken further an environment with under-developed attention to quality and to safety procedures.

Perhaps unsurprisingly there was a paucity of clinical leadership at both medical and nursing levels, and a paucity of long-term planning.

The physical layout of the department, made up of individual rooms with narrow doorways along a long, narrow, dimly-lit corridor, also limited patient care.





*The waiting room, and narrow corridor off which the treatment rooms are aligned*

Shortages of key equipment and medications added to the challenges.

It was a daunting situation. How does one start? Particularly as there is no foreseeable source of funding to support a permanent in-country presence to drive the changes needed.

We saw the only realistic approach as being aimed at training up local medical and nursing staff to take on the leadership roles. There are several registrar level doctors, and one intern, who have expressed both interest and aptitude in emergency medicine. All potential candidates are relatively junior, so senior administrative support was recommended; a surgical consultant expressed some enthusiasm for the role.

A long-range mentoring/support model for the staff was envisaged, and medical staff could seek to enrol in the Master of Medicine, Emergency Medicine, through the University of Papua New Guinea.

How have things progressed since our departure? Surprisingly well. A registrar and an intern have just been appointed to permanently staff the ED. There is a potential solution to the design problems of the ED. The Japanese government has generously offered to build a new hospital on the existing site. I have recently received word that the design team will be in country shortly, and as I write I am preparing to return to Vanuatu for a lightning visit, having frantically sought to arrange funding, leave and appropriate documentation at very short notice. I'm hopeful that a suitable floor plan for the new department will appear in the designs. It remains to be seen what effect the tragic earthquake and tsunami in Japan will have on the project.

One of the advantages of working in a small institution is it can be relatively easy to gain institution wide interest in



*Resuscitation bay*

programs you are developing. This is certainly the case here in Burnie. There is widespread enthusiasm to cultivate an ongoing relationship with Vanuatu. This extends to the clinical school of the University of Tasmania on site: they wish to cultivate a student exchange programme and fund their students to have their electives there. And, quite by coincidence, the newly-appointed AusAID-funded anaesthetist in Vila Central Hospital is from the sister institution just down the road in Devonport. Maintaining links is likely to be readily achievable.

No doubt the challenges ahead are many and varied. I am quite optimistic though. There is an old joke: 'How many social workers does it take to change a light bulb? Only one, but it has to really want to change'. Well, there is no doubt this Emergency Department needs changing, and it is ready to do so.

## A Visit to ACEM by a Nepali Delegation

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In February 2011 ACEM hosted a visit by a senior delegation from the Institute of Medicine of Tribhuvan University in Maharajgunj, Kathmandu.

The delegates were:

Professor Arun Sayami, Dean, Institute of Medicine (IOM)  
Professor Keshav Singh, Executive Director of Tribhuvan University Teaching Hospital (TUTH)  
Professor Ram Upreti, Campus Chief, Maharajgunj campus of the IOM  
Professor Pratap Prasad, Chief of Emergency Medicine at TUTH

Their purpose was to learn about the practice of EM in Australia and how EM training is delivered, and to establish links with ACEM and with IFEM. Their intention is to launch emergency medicine training in Nepal through a specialist program at the Institute of Medicine.

Their formal program in Melbourne included meetings with:

- IFEM: Peter Cameron, President; Carol Reardon, Executive Officer
- ACEM: Jenny Freeman, CEO; Alana Killen, Director of Education and CEO-elect; Andrew Maclean, Hon. Treasurer; Anthony Cross, Hon. Secretary; Ruth Hew, Deputy CIC.
- The Alfred Hospital: Gerard O'Reilly, Chair IEMSIG; De Villiers Smit, Director of ED; Mark Fitzgerald, Director of Trauma Services

- St Vincents Hospital: Georgina Phillips, IEMSIG; Michael Augello, DENT; Stuart Dilley, Simulation Centre; Guy Sansom; Alex Swain
- Box Hill Hospital: Antony Cross, Andrew Maclean
- Royal Melbourne Hospital: Jonathan Knott, Deputy Director; Glenn Harrison, DENT

The visit exceeded expectations. The delegation developed an understanding of modern emergency medicine, of IFEM and of ACEM. They established linkages with FACEMs and with Melbourne EDs. They return to Nepal with Letters of Understanding from the President of IFEM and from the President of ACEM that will enhance their promotion of emergency medicine, initially within the Institute of Medicine and ultimately more widely in Nepal.

ACEM supported the inclusion of Chris Curry from Fremantle Hospital as convener of this visit, and provided accommodation, meals and transport for the delegation while in Melbourne.

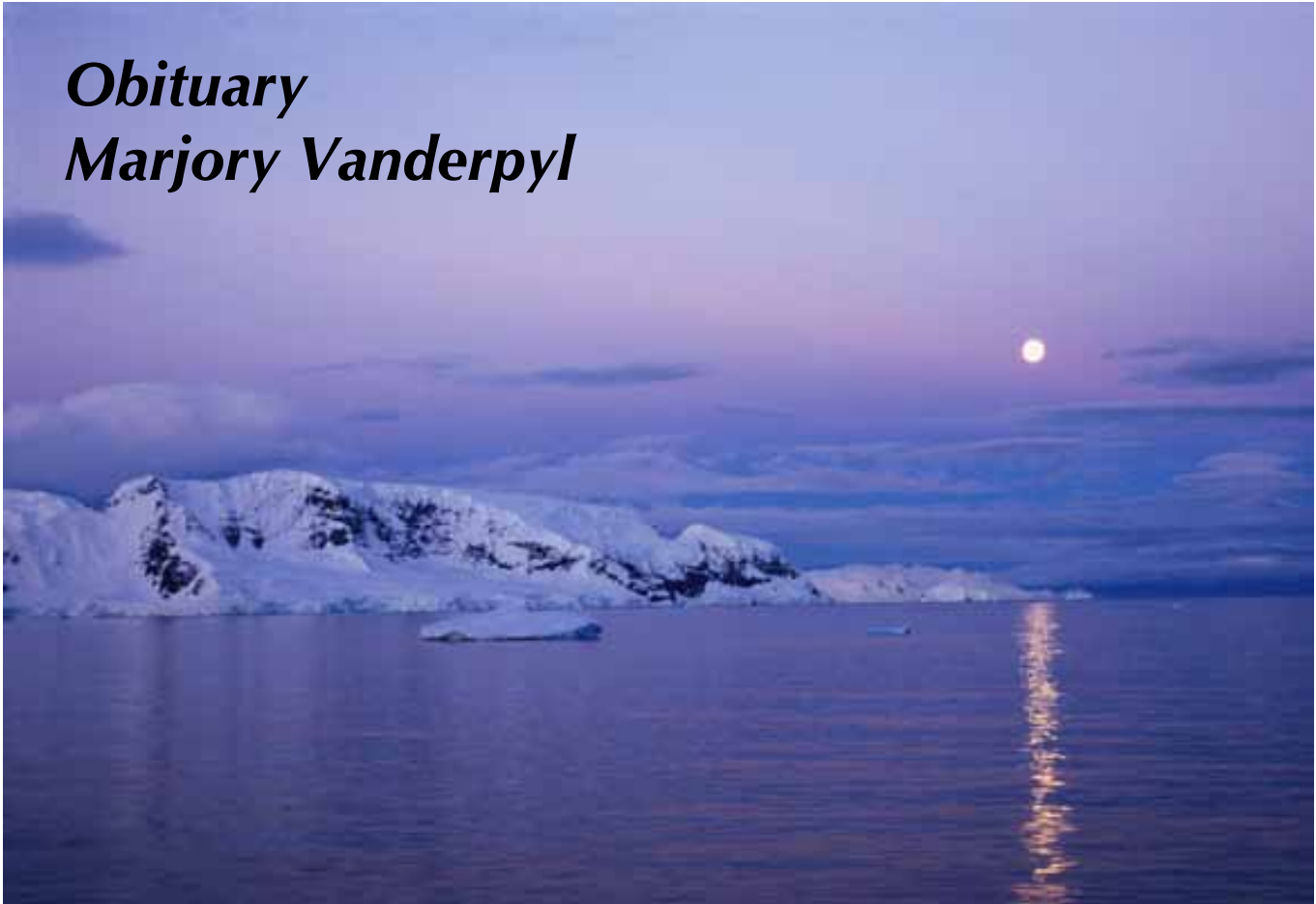
It is hoped that IOM will establish a specialist training program in the near future. They will seek the support of ACEM and there will be opportunities for fellows and trainees to contribute to the building of EM in Nepal. Anyone interested in contributing is invited to contact Chris Curry at [chris@chriscurry.com.au](mailto:chris@chriscurry.com.au)



The Nepali delegation with Michael Augello, Chris Curry and Georgina Phillips at St Vincents Hospital

## *Obituary*

### *Marjory Vanderpyl*



Marjory died peacefully with her family on 1st April in Christchurch following a bone marrow transplant for acute myeloid leukemia. She was 52 years old.

Marjory embarked on emergency medicine training in New Zealand in the uncertain and difficult days of 1990 with a resilient enthusiasm and commitment. Completing Fellowship in 1997, she made substantial development contributions to the Waikato and Wellington EDs, and her wandering spirit took her to EDs in the UK and Australia.

She was an inveterate traveller, on land and, particularly, at sea. Working as a ship's doctor in polar regions on Russian icebreakers and throughout the Pacific on small adventure ships, she enjoyed remote and wild places where she could indulge her interest in photography.

Her safe harbour was with family, where she was a much loved auntie to nieces and nephews, a holiday-maker and an enthusiastic (if messy) cook.

She found strength and sanctuary in her faith and church, inspiring those with whom she shared her diary when suddenly confronted by life threatening illness.

Such was her spirit that while recovering from the marrow transplant she presented herself to work in the ED in the immediate aftermath of the recent Christchurch earthquake.

She was a bright light to many, and will be missed.

Chris Curry

## Noticeboard

See the Noticeboard on the IEMSIG website for more information:

<http://www.acem.org.au/infocentre.aspx?docId=1193>

### Calendar of Events

IFEM Symposium on Resuscitation  
San Miguel de Allende, Mexico  
21-24 June 2011  
[www.ifem.cc/IFEM\\_Conferences\\_and\\_Symposia/Symposia.aspx](http://www.ifem.cc/IFEM_Conferences_and_Symposia/Symposia.aspx)

Asian Conference on Emergency Medicine  
Bangkok  
4-6 July 2011  
[www.acem2011.org/](http://www.acem2011.org/)

Brazilian Congress of Emergency Medicine  
São Paulo, Brazil  
14-17 September 2011  
[www.abramede.com.br](http://www.abramede.com.br)

7th INDO-US Emergency Medicine Summit  
New Delhi  
28th Sept - 2nd October 2011  
[www.indusem.com](http://www.indusem.com)

The Third Biennial Emergency Medicine in the Developing World Conference  
Cape Town  
15 - 17 November 2011  
[www.emssa2011.co.za/](http://www.emssa2011.co.za/)

### Courses

Short Courses in International Health 2011  
Macfarlane Burnet Institute for Medical Research and Public Health  
Melbourne  
[www.burnet.edu.au](http://www.burnet.edu.au)

### Job opportunities

Emergency Physician in Timor Leste with ATCLASS (Australia Timor Leste Assistance for Specialist Services)

EM teaching in Iraq and Afghanistan

Emergency Care Advisor with MSF in Brussels

Emergency Physician in Botswana  
(see update in this issue)

## Announcement

### Launch of the African Emergency Medicine Journal

The editors and section editors are currently working day and night to ensure that the first edition of the African Journal of Emergency Medicine be published within the next few weeks! This issue will feature reviews on drowning and toxicology, and original articles on inter-hospital transfers, crush syndrome (rhabdomyolysis) and pre-hospital intubation. Prof. Brysiewicz shares her views on emergency nursing in an editorial and much, much more. If you would like to know how you could get hold of a copy email us on [enquiries@afjem.com](mailto:enquiries@afjem.com).

Each issue will feature editorials discussing key issues as it relates to emergency care in Africa, original articles and reviews, case studies, letters and our regular features: African Diary, Practical Pearls and Journal Watch. Each original article, review or case study will feature an abstract in French as well as English. We'll even summarise the main findings and describe the African relevance of the paper. You can let us know about events with an African emergency care flavour happening in your area by emailing us on [africandiary@afjem.com](mailto:africandiary@afjem.com) and your practical ideas to [practicalpearl@afjem.com](mailto:practicalpearl@afjem.com).

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