

IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM



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Editorial

Accreditation

Australasian engagement with International Emergency Medicine has gained a new level of momentum through the ACEM accreditation of experience by trainees. This is an enlightened development by the Accreditation Committee of the Board of Education, chaired by James Collier, in which IEM can be considered within the Special Skills, Category C, criteria.

The process requires that a trainee makes application for individual consideration in advance. Key components include level of supervision, the nature of the experience and the duration. Where supervision in the international position may be limited it is possible for a suitably qualified FACEM to supervise from a distance. Learning objectives and a log of experience are required. The minimum term that can be accredited is 3 months, of which 1 month can be leave.

FACEM involvement in IEM has now reached a level of maturity that can support trainees. There are currently more than 250 members of IEMSIG and the group is expanding steadily, while the scope and span of activities is increasing. FACEMs who could offer distance supervision for a trainee are invited to contact Hydie Pallier at ACEM or this editor.

The ACEM office is growing its involvement with IEM. Hydie Pallier and Dee Reynolds are the college officers. They have visited the well developed International Office of the RACS, and Dee attended the IEMSIG meeting and IEM track at the ACEM ASM in Canberra. On the agenda are plans for support from an ACEM International Development Fund.

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Editorial *Cont'd*

IEMSIG Meetings at the ACEM ASM in Canberra

Deliberations on International EM at the Annual Scientific Meeting of the Australasian College for Emergency Medicine in Canberra fell into three parts – a lunch-time meeting, a formal track, and a dinner.

The informal lunchtime meeting included some thirty delegates. Discussion focused on how ACEM trainees might gain accreditation for international experience. John Kennedy, Georgina Phillips, Marian Lee, Michael Augello and Sheila Bryan have recently assisted trainees in successful applications to the Accreditation Committee of the Board of Education using the Special Skills, Category C, criteria.

Other matters discussed included the increasing engagement of ACEM with IEM, and the processes of training for and accessing IEM projects.

The formal track included:

- 'Quality care in resource poor situations: Kiunga in PNG', by Farida Khawaja, who is preparing an application to have time at Kiunga Hospital accredited. See article in this issue.
- 'IEM – how to train for the job', by Vera Sistenich. See article in this issue.
- 'EM in the South Pacific', by Jules Willcocks, who is building connections with several Pacific Island nations. A two week scoping project was under way in Vanuatu at the time.
- 'Taking Primary Trauma Care to Myanmar', by Georgina Phillips, who emphasised how introducing specific courses can open doors towards further development of EM.
- 'EM in Europe', by Gordian Fulde, who gave an account of the expanding uptake of EM as a specialty in the 'Old World'.

The dinner organised by Jules Willcocks was attended by more than thirty IEM enthusiasts and was a great opportunity for informal sharing and networking.

It was clear from the extent and enthusiasm of discussions that IEM has outgrown a single 1.5 hour track at the ASM. It is time to be considering a full day meeting.

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The Editor at large in Ladakh, Indian Tibet

Papua New Guinea

An Advanced Trainee's Adventure! Emergency Medicine in Madang, Papua New Guinea

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A PNG training position

In August, September and October 2010 I was fortunate enough to go to Madang, PNG on an ACEM approved Special Skills, Category C, (rural and remote) posting. I worked in Modilon Hospital, in Madang as an Emergency Registrar under the supervision of Dr Vincent Atua, and also taught at Divine Word University. I was responsible for teaching the 3rd year Health Extension Officers (Medical Assistants) the Accident and Emergency curriculum of their rural health degree and also providing clinical supervision and tutorials when they were rotating through Modilon Hospital Emergency Department.

Modilon Hospital is the main referral hospital for the Madang Province (population 300,000) and it also serves as the teaching hospital for the The Lutheran School of Nursing and The Divine Word University which offers the Bachelor of Rural Health for Health Extension Officers. Modilon is a 300 bed hospital and has medical, surgical, obstetric and paediatric wards, as well as dedicated tuberculosis and HIV outpatient clinics and a leprosy ward. It also has a busy Fred Hollows Ophthalmology department and a dental clinic. The 4 bed Intensive Care Unit was closed due to staff shortages.

My time working in Madang can only be described as amazing!

Learning Objectives

My Learning Objectives for the term had been to

- 1) practise medicine in a resource and staff constrained environment,
- 2) get hands on experience in diagnosing and treating tropical diseases,
- 3) practise emergency medicine in a different cultural and socioeconomic environment and
- 4) teach the HEOs, students and RMOs within the Emergency environment.

Experience

My week was split between teaching (30%) and working (70%). The Emergency Department ward rounds were at 8am, and then the days were spent reviewing the overnight patients and assessing new patients as they arrived. During the quiet periods I would give tutorials and clinical sessions to the HEO students (how to read XRays, basic airway management, clinical examinations etc). On Monday, Tuesday and Friday afternoon I lectured for 1 hour at the Divine Word University.

In the first week I saw cholera, typhoid, tuberculosis, HIV, meningitis, fungal skin infections, more malaria than I can count - ranging from uncomplicated malaria, to blackwater fever and lots of cerebral malaria in children, who have often travelled from distant villages to attend hospital usually having 1-2 seizures along the way. There was an enormous assortment of fractures and infected wounds from falling out of coconut trees and other village accidents, and lacerations commonly from machetes or knives to stitch up.

As expected I found the biggest challenge was adapting to medicine without tests and investigations. There was a pathology service in the hospital but the delivery of results was haphazard and slow. Hb and malaria slide/parasite counts were prompt as these made up the majority of requests, but EUC often took 2 days. Using gentamicin without creatinine levels took some getting used to, as did using chloramphenicol as my broad spectrum antibiotic. Diagnosing a ruptured ectopic pregnancy by doing a culdocentesis as there was no ultrasound was something to write home about (literally). Treatment was always based on clinical judgement, and often I did not know what actually was wrong with the patient - infection versus malaria - before they got better and went home!

In the middle of my stay the hospital staff went on strike in relation to administrative concerns. This stretched an already under resourced hospital as supplies were not stocked (interesting how quickly your rules about fluid use go out the

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window when all you have left is 4% Dextrose and 1/5 Saline or Darrows). Only emergency labs requests were processed and the XRay department shut (no CT or US at Modilon). The few that stayed at work in the Emergency Department were dedicated to providing medical care as best able, as the wards became unable to take patients. It was during this period that I saw 3 tiny 1.4kg babies with respiratory distress and sepsis, and could offer nothing more than fluid and antibiotics, no oxygen and no NICU. Surprisingly, 2 survived.

Chronic diseases (asthma, TB, COPD, GORD) were difficult to manage due to the patients' inability to afford or source appropriate medications in the villages. There were frequent presentations, often weekly, with the same symptoms. For 2 kina (~\$1) a patient could see a doctor and for another kina get a week's supply of medicine, so it was a lot cheaper to come to ED.

A very rewarding aspect of my time in Madang was definitely teaching the Health Extension Officers. They ultimately play an important role in health care in PNG, where most people live in villages and may never see a doctor. The HEOs provide the first and often only medical aid received. The third year students were my responsibility right up to the exam I set for them! By being the lecturer and clinical supervisor I was able to merge lectures with practical examples, and in exchange they taught me Tok Pisin, the local language, my attempts being a source of great amusement.

Making it happen

So how did I make it happen? With lots of help from some amazing people. Dr John Kennedy, my DEMENT at RNSH, made first contact as he has taught Emergency Life Support courses in PNG and knew Dr Vincent Atua from Modilon Hospital. He also put me in contact with Dr Georgina Phillips from St Vincents Hospital in Melbourne who has spent an extensive period of time in Madang working with Dr Atua in Emergency and also with the University regarding the HEOs teaching. Together we arranged for my accommodation at the University; essential as housing in Madang is expensive and the University is gated and therefore secure. The Special Skills, Category C, paperwork went through the College and I was off. I wrote an email update to Dr Kennedy every week, going over some interesting cases, and we spoke twice during my time there. The log book (a requirement of a special skills post) was easy to fill, I actually needed more space.

For any trainees interested in overseas work, I cannot recommend PNG and Madang more highly. The people are wonderfully warm and friendly, and very tolerant of my attempts at Tok Pisin, the tropical medicine is fascinating and Madang is a tropical paradise -palm trees, blue seas, tropical fish 1 metre off shore on coral reefs! I hope to get back there soon.

Many thanks to John Kennedy, Georgina Phillips, Jamie Hendrie, Vincent Atua, and Clement Mannering.



Katryna and ED nurses



Katryna and Vincent Atua with Modilon and DWU staff

A Trainee Term at Kiunga, Western Province, PNG

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Farida worked as a volunteer at Kiunga Hospital in 2009. See IEMSIG Newsletter March 2010, Vol 6 No 1. Out of this experience she is developing a Proposal for accreditation for a trainee spending time at Kiunga. If you are interested, contact Farida directly. Ed

The Objectives of an accredited term would include learning related to:

- Delivery of quality medical care in a resource scarce environment.
- Leadership skills in the clinical context - through conducting ward rounds in general medicine, paediatrics, O&G, which build skills in clinical assessment, prioritisation, decision making and implementation of management.
- Accountability and professionalism - through being on call for critically unwell patients, and providing timely and appropriate advice for the local context.
- Teaching - based on locally relevant cases and topics with a multidisciplinary audience.
- Health system knowledge - through building an understanding of the PNG health care system, the role of health promotion and prevention of illness, and public health.
- Cultural awareness - through learning some of the local language and through understanding the role of culture and language in health.

A Proposal needs to give consideration to:

1. Supervisors

On site supervision can be provided by Sister Joseph, an English woman and UK trained general and vascular surgeon who is CEO of the hospital. Remote supervision can be arranged with a willing and suitably experienced FACEM.

FACEMs who have contributed to the development of EM in PNG include: Peter Aitken, Michael Augello, Colin Banks, Peter Barnett, Michael Bastick, Andrew Bezzina, Antony Chenhall, Chris Curry, Steve Dunjey, David Eddey, Jeremy Furyk, Steve Grainger, Naren Gunja, Jamie Hendrie, Jack Hodge, Rachel Hoyle, Phil Hungerford, Sandy Inglis, Simon Jensen, Pip Keir, John Kennedy, Chris Kruk, Marian Lee, Sally McCarthy, Mark Millar, Gerard O'Reilly, Georgina Phillips, Kate Porges, Luke Pritchard, Sandra Rennie, Nick Ryan, Niall Small, Guy Sansom, Paul Spillane, David Symmons, Brady Tassicker, Peter Thompson, Ric Todhunter, Greg Treston, Chris Trethewy, Simon Young, Bryan Walpole, James Wheeler. Ed.

2. Communications

Remote supervision will require at least email contact. In Kiunga there are internet cafes. It is intended to improve access to electronic media at the hospital.

3. Relevance of the planned experience

An application will include a submission on the perceived relevance of the planned experience towards emergency medicine training



A PNG medical ward.

Médecins Sans Frontières

A Médecins Sans Frontières (MSF) mission in Nigeria

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I undertook a mission with MSF in Nigeria for five months in 2009.

I started in a trauma hospital in Port Harcourt in the oil-producing Niger Delta region, which has a very high level of violence. The 70 bed hospital is for trauma patients only, with ED, orthopaedic and general surgery facilities, inpatient care and outpatient clinics. The hospital treats patients from all sides of the many conflicts that are ongoing in the city.

I worked in the ED, seeing a busy caseload of shootings, stabbings, machete injuries and road accidents! There were lots of open fractures, delayed presentations, complex suturing and multi-trauma. Practise was based on good ED principles - triage, EMST/ATLS management etc, and was very effective in a challenging environment. I also assisted in theatre and on the wards.

There were strict security protocols for the MSF staff due to the kidnapping and instability in the city, and essentially we were limited to our house and the hospital.

While in Port Harcourt reports came through of a developing meningitis outbreak in the northern states. Meningitis cases occur yearly in this region, and approximately every 10 years there is a huge outbreak at the end of the hot and dry season. I was keen to be involved with an acute project, and to try out some of the things I had learned in my tropical medicine diploma. I asked for a transfer and was one of the first team members assigned to Jigawa state. This is the poorest state, bordering Niger, and has 5 million people.

This was a really interesting project and it was great being involved from the start of the emergency response. I co-ordinated a team of 7 doctors, and we made contact with and supported 50 hospitals and health clinics. Day-to-day work consisted of travelling round the state, collecting data on cases, performing LPs to analyse, distributing treatment kits, assisting with ward rounds and clinics, and many meetings with officials. I collated the data on cases, and helped plan the vaccination campaign for the state. We had 13,000 cases of Neisseria meningitis C over 3 months, and the total for Nigeria was 300,000. Due to many factors, the case fatality remained low at an estimated 2-3%. MSF vaccinated 3.3 million people, which is a huge feat especially in Nigeria!

There were lots of challenges, including lack of maps and population data, variable 'roads', an extremely hot and dry climate, and many cultural and political issues. Luckily we had good co-operation from the Ministry of Health.

So lots of different skills here - emergency medicine, paediatrics, epidemiology, public health and diplomacy!

I certainly had a very positive experience overall. The difficulty with MSF projects is the short notice and variable nature of the work, and combining this with ongoing training.

I am keen to continue overseas work and find a way to combine this with an emergency medicine career. Emergency medicine definitely provides you with the right skills for this kind of work, and also there is huge scope for building EM in developing countries.

Getting a Médecins Sans Frontières (MSF) mission accredited for training

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Allison undertook an MSF mission in Zalingei, the provincial capital of West Darfur state in Sudan. The process of gaining accreditation included:

- A proposal to the Accreditation Committee, ACEM
- A letter of support from a FACEM supervisor ('remote supervisor')
- Identification of an on-site supervisor ('training supervisor')
- Submission of an 'In-Training Assessment' (ITA) form to ACEM on completion

A five page proposal submitted prior to embarking on the mission included:

- Descriptions of the location, work situation and work role
- Proposals for remote and training supervision
- An explanation of the relevance of the mission to EM training

Description

Zalingei District Hospital is a secondary referral hospital with paediatric, O&G, and male and female wards with both medical and surgical inpatients, as well as a therapeutic feeding centre (TFC), an outpatients department and an outreach service. MSF has been involved in this project since 2003. Currently MSF supports the emergency department, paediatrics/therapeutic feeding centre (TFC) and operating theatres, as well as logistics support for water, electricity and waste management.

The work role was under the supervision of the national referent doctor. It required collaboration with all national staff, following MSF protocols and guidelines in treating all patients. Main fields of practice were paediatrics/therapeutic feeding and women's health. The proposal included the detailed MSF job description

Supervision

Remote supervision was undertaken by Marian Lee, Allison's DENT at the Prince of Wales Hospital (POW) in Sydney. It was proposed that Allison would submit case reports to the DENT, provide monthly reports to the registrar teaching sessions at POW and prepare a journal article. A training supervisor was identified on-site. There was a fully qualified UK paediatrician who undertook this role.

Expectations

Allison proposed that the mission would expand her knowledge and skills in paediatrics, women's health, tropical and infectious diseases, triage and allocation of resources, collection and analysis of data, and training of other health care workers.



Allison and young friend

"I expect to find this a very challenging six months. Much of what I do will be similar to Australia: working in a team, providing equitable access to health care, working in an ethical fashion. However the context will be completely different. Will I be able to work effectively within a team where communication may be difficult and other team members' (including patients!) expectations of care may be very different? How will I provide the best standards of care when the resources I am used to at home (laboratory, radiology, resuscitation equipment, drugs...) just aren't there? Will I find local/MSF protocols deliver a satisfactory standard of care, and if not, what can I do about it? What sort of ethical dilemmas might I face if forced to allocate resources where they will do good for the most patients, as opposed to the patients who most urgently need them?"

I hope to leave behind in Darfur at least the enthusiasm, work ethics and clinical skills that I have practiced there. Ideally, my contribution will be long lasting in terms of furthering education of colleagues and developing/furthering useful structures for delivery of care including administration, documentation, clinical protocols, standards of care and staffing, and appropriate use of resources. As an emergency trainee, specific areas to which I expect to be able to contribute are triage, resuscitation, differential diagnosis, initiation of appropriate investigation and management, and appropriate disposition of patients.

On return to Australia, I believe I will have gained a wealth of useful experience, as well as a new perspective on health care. I hope to be able to use this to improve both my clinical and non-clinical practise. I also hope to be able to share my experiences with Australian doctors and encourage more to take up the challenge of working in the developing world to share their own skills and experience, and thus contribute to the development of Emergency Medicine as a specialty throughout the world."

Allison kept a log book of all her medical activities, clinical and non-clinical, which more than bears out her expectations.

A Mission with Médecins Sans Frontières (MSF) that earned accreditation

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After years of ruminating, discussing and attending information sessions, I decided that the time was right for me to apply for my first mission with MSF. After working in a remote area in Northern Territory and finishing a course in Tropical Medicine, I was more confident of my clinical skills and I had no financial or personal obligations to keep me in Australia. Perfect timing, except for the fact that I had not yet finished my emergency medicine training. After several unsuccessful inquiries into the possibility of having an MSF mission accredited, I decided to request an interruption of training instead, which was granted.

An application for accreditation

Luckily, a few events occurred in my favour. First of all, I came in touch with an EM trainee who had successfully had her MSF mission accredited, which gave me some hope. Secondly, I was offered a mission several months before departure, which is rare in MSF. Most missions are offered on a much shorter notice. I was to work in an MSF hospital in Agok, South Sudan and was now able to gather information regarding the mission and my responsibilities. I requested Dr. Sheila Bryan, DENT of Dandenong Hospital, Victoria, to act as a remote supervisor. Guided by Dr. Bryan, and using documentation from MSF, discussions with MSF staff and returned volunteers, I then submitted a 16 page proposal containing the following elements:

- Relevance of an MSF mission to emergency medicine training.
- Proposal for communication and requirement for remote supervision
 - monthly email communication providing a logbook of patient numbers, diagnoses, acuity, mortality rates, procedures and case reports
 - non-clinical activities: supervision, training and teaching, development of guidelines/protocols, systems management, clinical risk management
 - After completion of my mission: preparation of a paper of publishable standard, as well as a presentation on the mission during ED registrar teaching sessions
- Job description (as provided by MSF)
- Overview of the activities of the project
- Brief historical and political background on South Sudan

I submitted my proposal to the College with the request to have my mission accredited under the Special Skills, Category C Rural and Remote Medicine criteria - and left for the field.

The field

After a long trip via Sydney, Geneva, Nairobi and Juba, I arrived in Agok, South Sudan at the end of the dry season. The handover was brief and intense, and soon I found myself responsible for a hospital with around 80 inpatients, an outpatient department with 150 presentations per day and three mobile clinics per week. The first few weeks were hard: being the only doctor I did most of the clinical work in the inpatient department myself, and supervised a team of "Medical Assistants". A Medical Assistant has completed three years of training after secondary school, but most have learnt their skills during MSF missions. They are able to perform outpatient consultations, but have very limited procedural skills. It was the middle of the hunger gap, the seasonal pre-harvest period during which food is scarce, and mortality from malnutrition high. Radiology was non-existent, and only a limited number of laboratory investigations were possible. Essentially, I was on call 24/7 and with the living compound next to the hospital, there was very little downtime. The learning curve in the first few weeks was steep, and I was lucky to have a very supportive team of expat and local staff. After a few months, though, things changed.

The rainy season started, and with that, the landscape turned from dusty and dry to lush and green. Malnutrition rates dropped, as did mortality. I had become used to my environment and my environment had become used to me. Staffing had improved and I had gained a much better idea of the nuts and bolts of the project. Well rested after a much needed holiday I changed strategy, and shifted emphasis from clinical work to capacity building. I introduced twice weekly Grand Rounds, commenced weekly Mortality Meetings on top of the regular teaching sessions, and reviewed and revised the protocols. It was also during this time that I became involved in the Emergency Preparedness planning. The political situation is expected to become volatile as the referendum in January on the independence of South Sudan is coming near. Together with the rest of the team both in the field and in the capital Juba, we prepared for different scenarios of increased numbers of war wounded and increased insecurity.

Reflections

Before any of those scenarios became a reality, it was time for me to go home. Six months is at once a very short and a very long time. Just as I had developed a comfortable routine and gained a little momentum in capacity building, my end of mission had arrived.

I had communicated regularly with my remote supervisor, and I was pleasantly surprised when the College informed me after five months that my term was accredited.

Looking back, I feel that emergency physicians are ideally suited for emergency humanitarian aid missions, and vice versa. In the field, I had the opportunity to grow from a predominantly clinical role into a more teaching and leadership role. While some aspects of working for MSF in Sudan are different from working in an Australian urban ED – limited diagnostic capacity, limited pharmacy, no backup – other aspects are surprisingly similar: dealing with whatever situation arrives, improvising with limited resources and the ability to work in a team as a learner, a teacher and a leader.



Wanda at work

Wanda and team



Under the tree MSF clinic



Other News

Supporting EM trainees interested in training in the Developing World

Andrew Perry
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Andrew is the newly elected chair of the ACEM Trainee Committee and he sits on the Accreditation Committee of the Board of Education. He is the immediate past chair of the AMA Council of Doctors in Training. Ed.

A strong interest

There is strong interest in undertaking work and education in developing countries amongst Emergency Medicine (EM) doctors, as evidenced by the establishment of the ACEM International Emergency Medicine Special Interest Group (IEMSIG) in 2004 and its steady growth.

What is becoming increasingly apparent is that this interest is shared by EM trainees who are often willing to set aside some time from completing the steps to fellowship to supplement their training with a period spent working in a developing country.

Until recently EM trainees have sacrificed both training time and money to take up such opportunities because of limitations on getting overseas posts accredited and because of limited access to funds to help meet the costs. They have viewed this as worthwhile for various reasons, including altruism and the unquantifiable value of the placement to their futures. Other trainees are keen to undertake these placements but view the costs as too high.

It is my view that wherever possible we should encourage and support EM trainees to train in developing countries to extend themselves clinically and to better appreciate the inequities that exist in the health care offered to citizens in first compared to third world countries. Ideally these trainees will not only be making a clinical contribution to the site but will also be contributing educationally in some way.

A number of promising developments are now under way:

Accreditation

Firstly, the matter of accreditation of posts in developing countries has benefited from a number of trailblazing EM trainees who have prospectively secured accreditation under ACEM's Special Skills, Category C criteria for placements in areas such as Sudan and PNG. Each of these trainees convinced the Accreditation Committee and ultimately

the Board of Education, that their post would meet the comprehensive but fair requirements to ensure that it would be a quality placement. Some innovative methods have been developed to address the issue of supervision from a distance. IEMSIG could bring these together to provide a model of remote supervision that other trainees and their supervisors could consider using.

Funding

Secondly, on the funding front there have been some embryonic discussions about the role of the Australian Federal Government in supporting trainees of all specialties, including EM, to train in developing countries in the Asia Pacific. There is already precedent for the Government supporting specialty training through such measures as the Specialty Training Program, which will subsidise the cost of a trainee's salary by providing \$100,000 FTE to providers of specialty training in expanded settings that have been accredited by the relevant college.

In addition AusAID (the Australian Agency for International Development), through the Australian Youth Ambassadors for Development program, offers a reputable and well supported pathway for young Australians to make a contribution to the development of nearby countries.

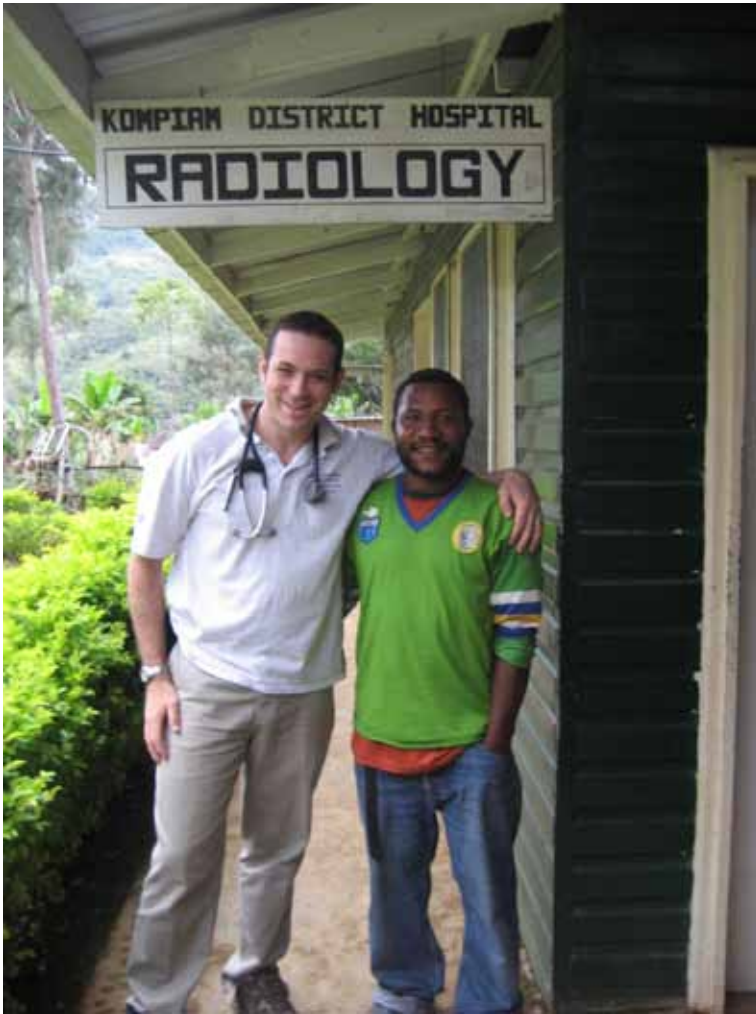
A number of bodies, spearheaded by the AMA, are currently trying to establish a funding and governance proposal that may be put to either of these two federal government sources, or at the least be used as a precedent and model.

Trainee involvement

A third positive development was the recent resolution by ACEM Council to formally allow trainees to be members of all the Special Interest Groups. Whilst IEMSIG has included trainees from the outset, this move will further encourage their participation.

As the newly elected chair of the ACEM Trainee Committee it is my hope that the issues of accreditation and training can be addressed so that a significant proportion of EM trainees can take the immeasurably positive step of training in a developing country.

If you have any advice or suggestions on how you think we can achieve this please contact me at the email address andrewwalterperry@gmail.com



Andrew at Kompiam District Hospital, Enga Province, PNG in 2008



Improvised splinting: pedestrian hit by car



Highlanders going to market

International Emergency Medicine: How to Train for the Job

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This article reviews the knowledge and skills areas that are components of IEM and provides a resource of how relevant training can be obtained in Australia.

Introduction

International Emergency Medicine (IEM) currently has no precise definition but has been described as “the area of emergency medicine concerned with the development of emergency medicine in other countries”. It is recognised to encompass two main areas: humanitarian assistance (HA), and EM specialty building (EMSB). HA falls within the larger discipline of Global Health which is multidisciplinary and includes fields such as law and engineering. The need for HA globally is likely to increase in the future and remain with us indefinitely. EMSB, by contrast, falls wholly within the realm of EM. While EPs have many qualities which make them particularly suited to the practice of IEM such as broad-based medical knowledge and tolerance for working in unpredictable and stressful environments, most have little or no training in public health, tropical medicine, strategic planning or health administration.

In the USA there are now more than twenty private institutions with strong EM training programs that offer ‘fellowships’ in IEM. In 2010 Bayram et al reviewed all available curricula and descriptive online materials for these fellowships to describe and categorise their common education goals and elements¹. They all contained seven discrete knowledge and skills areas:

- EM Systems Development
- Humanitarian Relief
- Disaster Management
- Public Health
- Travel & Field Medicine
- Program Administration
- Academic Skills

These are areas in which particular competencies are important and their acquisition can be enhanced through formal training.

Training for IEM in Australasia

It is desirable that doctors seeking to engage in international EM projects have skills that equip them for the area of IEM that they are going to be involved in. For those with a primary interest in disaster response or humanitarian relief, these circumstances call upon particular skill sets and competencies, and specific training is valuable. Closer to the experience of most FACEMs is the building of EM training and EM systems. These competencies too can

be enhanced by training focused on the business of building these capacities within very different economic and cultural environments from those in Australia and New Zealand (ANZ).

In the USA fellowships are undertaken by new specialists (‘attendings’) who have completed their EM training (are board certified). Within the US billing system they are then able to contribute financially to the institution, which justifies the institution supporting their fellowship. Most of these teaching hospitals are part of private universities which can offer a Masters in Public Health (MPH) as a component of a fellowship. In general, fellows fund their own travel and expenses for international EM missions and the institution covers their unpaid time away from their ED work.

The Australian and New Zealand situation is different from this. It is less likely that ANZ public hospitals will financially support FACEMs to undertake training for roles outside the country. However, it is within the capacity (though perhaps not yet the inclination) of public hospitals to support leave without pay, where staffing levels allow.

Of considerable and increasing interest in ANZ is the development of IEM skills while still in training. Recently several ACEM trainees have been awarded accredited training time for IEM experience. There is the potential for ACEM training EDs to support the aspirations of trainees towards engagement in IEM training and activities.

Resources available to FACEMs and ACEM trainees for the acquisition of knowledge and skills are presented below:

Resources for Training

1. EM Systems Development

The ACEM fellowship curriculum covers much of this and the ACEM website carries a collection of policies and guidelines for ED design, administration and quality management.

Many courses, such as EMST (ATLS), APLS, ELS, PTC, ALS, ILS and ALSO contribute to understanding the principles of algorithms, so gaining instructor status is valuable.

Simple translocation of Australasian EM practices to lower income systems can be problematic. Care must be taken that principles and resources proposed overseas are made practically and culturally applicable and acceptable to their location of use.

Knowledge of the challenges and pitfalls of EM systems development internationally can be gained from more

experienced practitioners, from field trips and by reading the available literature on individual countries.

In Australia the Remote Area Trauma Education (RATE) course offered to health workers, primarily Aboriginal, in isolated areas of the Northern Territory is a good example of systems adaptation for resource-limited environments²⁻⁶.

2. Humanitarian Relief

Field experience on missions with NGOs such as Médecins Sans Frontières (MSF), Oxfam, Save the Children and International Committee of the Red Cross (ICRC) are valuable. Although much is learnt on the job these organisations offer training, to differing levels. In Australia the organisation RedR trains both medical and non-medical personnel for relief work through a range of courses such as Essentials of Humanitarian Practice, Personal Security & Communications and Humanitarian Logistics in Emergencies.⁷ Individuals can conduct personal study on refugee health or complete modules in this and associated fields as part of wider public health studies. The James Cook University offers a Postgraduate Diploma of Disaster and Refugee Health.

Internationally recognised courses covering core topics include the Health Emergencies in Large Populations (HELP) course offered by the ICRC⁸ and the Public Health in Complex Emergencies course organised by the International Rescue Committee (IRC).⁹ Individual institutions also run courses such as the Global Emergency Medicine Program at the Weill Cornell Medical College in New York and the Humanitarian Studies Course conducted by the Harvard Humanitarian Initiative in Boston.¹⁰ The website for the Center for International Humanitarian Cooperation is useful for further HR training resources included the more extensive International Diploma in Humanitarian Assistance.¹¹

3. Disaster Management

The Major Incident Medical Management and Support (MIMMS) course is widely recognised and available in Australia. Its approach is reflected in the disaster management section of the ACEM curriculum and the College also offers policies and guidelines in this area. The Department of Health in each Australian state or territory has its own disaster preparedness and management plans, the familiarisation with which is a good way to learn about the logistics of a domestic emergency response. Getting registered with a local Australian Medical Assistance Team (AUSMAT) or Disaster Medical Assistance Team (DMAT) can provide exposure to training resources and activities. States and territories also organise extensive field disaster simulation operations involving the police, fire and medical services in which interested physicians can volunteer to participate. Less elaborate but similarly informative Emergo Train System (ETS) exercises are conducted across the country; this is a pedagogic educational simulation system developed in Sweden which uses appealing magnetic representations on whiteboards of the personnel and equipment involved in a disaster response.¹²

A difference in resources means that the assessment and response to disasters in developing countries will be significantly different from domestically. The National Critical Care & Trauma Response Centre (NCCTRC) at the Royal Darwin Hospital runs a Needs Assessment Team Training (NATT) course to address this topic, although participation is currently by invitation only. However, many of the humanitarian relief courses and resources mentioned above include disaster needs assessment training. The NCCTRC also offers many other disaster response and management courses throughout the year open to public application.

4. Public Health

Fundamental public health concepts including biostatistics, epidemiology and research methodology form the core of all Master of Public Health (MPH) degrees. Most also offer modules in topics which cover or complement many key areas in IEM such as Health Policy & Administration, Theory of International Health and Health in Immigrant Populations.¹³ While a MPH qualification is not mandatory in those wishing to pursue IEM, and indeed is not stipulated by all of the US IEM fellowship programs, it is often the only non-clinical academic qualification sought and recognised by international agencies such as WHO and UNICEF. It is therefore highly encouraged in EPs intending on pursuing leadership and policy-making roles in IEM.

Public health knowledge and skills can also be obtained, however, through relevant courses outside of a MPH program. There are a host of courses offered by schools of public health throughout Australia as well as in the United Kingdom (UK) and summer school programs in the USA. There are also extensive distance-learning online resources available such as the website of the University of Pittsburgh's Supercourse in Epidemiology and Global Health.¹³

5. Program Administration

Development and implementation of international projects calls on skills in writing grant proposals, securing sustainable funding and managing projects.

If a MPH is being undertaken, relevant modules should be considered. During their training, ACEM members may also undertake a College accredited rotation in ED Administration and seek out experience in funding proposals and systems management issues. Opportunities for involvement in all aspects of grant writing, in particular on international projects, should be sought. EPs could also become familiar with and learn to search for potential sources of research and project funding, such as the websites of the National Health and Medical Research Council (NHMRC) and AusAID. The annual International Emergency Department Leadership Institute (IEDLI) course in the USA provides leadership education for current and future healthcare leaders in EDs worldwide and would be particularly valuable for EM specialty building activities.

6. Travel and Field Medicine

Knowledge can be acquired through involvement in field work, participation in travel clinics and more formally

through certificate programs or diplomas. In Australia, James Cook University offers a Postgraduate Diploma of Tropical Medicine and Hygiene. Importantly, Australia also has an indigenous population with one of the worst life expectancies of all indigenous populations and the highest incidence of rheumatic fever, a disease of poverty, in the world. EM trainees could be encouraged to undertake part of their training in areas with a large indigenous population such as in the Northern Territory and far north Queensland. These areas are not only interesting and beautiful but offer domestic opportunities to experience a range and acuity of pathologies analogous to those seen in developing countries and induce a sobering appreciation of the impact of poverty on health.

Internationally, a variety of qualifications in tropical medicine are available. Renowned and widely recognised courses are offered by the Liverpool School of Tropical Medicine (UK), the London School of Hygiene and Tropical Medicine (UK) and the Gorgas Course in Clinical Tropical Medicine (Peru). Other institutions running programs include Johns Hopkins and Tulane Universities (USA), the Royal Tropical Institute in Amsterdam (the Netherlands), University of the Witwatersrand (South Africa) and the Bangkok School of Tropical Medicine (Thailand).

7. Academic Skills and Teaching

The ACEM's mandatory Regulation 4.10 training component stipulating completion of a research project or the more recently approved alternative pathway subjects provides an excellent opportunity to develop academic skills. Particular attention should be given to learning about study design, data gathering and analysis, literature search and review methodologies and effective scientific writing. The academic faculties associated with many training EDs can be valuable in providing resources and guidance in the acquisition of academic skills.

A critical skill is that of teaching. Instructing on standardised emergency courses (EMST, APLS, ELS, etc) is a good way to learn about and practice clinical teaching. The Teaching On The Run (TOTR) program teaches principles of adult learning and aims to improve the quality of teaching and supervision of trainee doctors and students.¹⁷ It is run nationally and also has an accredited facilitator training program. Trainees in EM may also consider undertaking one of the College's accredited rotations in Medical Education or Simulation which include training on how to teach adults. Participation at the annual National Prevocational Medical Education Forum is a further useful way to familiarise with current issues concerning postgraduate medical education in Australia.

Conclusion

IEM is an important and rapidly growing discipline. Many EPs and EM trainees in Australia are already involved in IEM activities and interested ACEM members number in the hundreds. Formal guidance to IEM training and a coherent approach to project involvement would be useful.

Funding and employer flexibility are significant issues to be addressed towards developing an IEM fellowship program in Australia, the establishment of which would be welcomed not only to provide training structure but also because it would endorse IEM as a discreet discipline. Nevertheless, the knowledge and skills areas core to IEM have been well characterised through study of existing fellowship programs in the US. Domestic and international resources for knowledge acquisition in each key area have been provided here and will continue to expand and evolve. Using these resources, it is possible to train effectively for the job today.

Thoughts and suggestions would be highly appreciated and are invited by email to vsistenich@hotmail.com.

References

1. Bayram J, Rosborough S, Bartels S et al. Core curricular elements for fellowship training in international emergency medicine. *Acad Emerg Med* 2010; 17(7):748-57.
2. Australasian College for Emergency Medicine, Special Interest Group, *International Emergency Medicine*. Available at: <https://www.acem.org.au/members.aspx?docId=29>. Accessed November 18, 2010.
3. Alagappan K, Schafermeyer R, Holliman CJ et al. International emergency medicine and the role for academic emergency medicine. *Acad Emerg Med* 2007; 14(5): 451-6.
4. Australasian College for Emergency Medicine, *Training & Examination Handbook*. Available at: http://www.acem.org.au/media/training/T__E_Handbook_151110.pdf. Accessed November 18, 2010.
5. Australasian College for Emergency Medicine, *Policies & Guidelines*. Available at: <http://www.acem.org.au/infocentre.aspx?docId=59>. Accessed November 18, 2010.
6. National Association of Emergency Medical Services Physicians. Available at: <http://www.naemsp.org/index.html>. Accessed November 18, 2010.
7. RedR Australia, *Training Service*. Available at: <http://www.redr.org.au/training-service/training-courses.html>. Accessed November 18, 2010.
8. International Committee of the Red Cross, *Resource Centre*. Available at: http://www.icrc.org/eng/resources/documents/misc/help_course.htm. Accessed November 18, 2010.
9. International Rescue Committee, *Public Health in Complex Emergencies*. Available at: <http://www.theirc.org/public-health-complex-emergencies>. Accessed November 18, 2010.
10. The Humanitarian Studies Course. Available at: <http://humanitarianstudiescourse.org/>. Accessed November 18, 2010.
11. The Center for International Humanitarian Cooperation, *International Diploma in Humanitarian Assistance*. Available at: <http://www.cihc.org/idha>. Accessed November 18, 2010.
12. Emergo Train System. Available at: <http://www.emergotrain.com/>. Accessed November 18, 2010.
13. Supercourse: *Epidemiology, the Internet and Global Health*, University of Pittsburgh. Available at: <http://www.pitt.edu/~super1/>. Accessed November 18, 2010.
14. Australasian College for Emergency Medicine, *Special Skills Posts approved for Advanced Training in Emergency Medicine*. Available at: https://www.acem.org.au/media/docs/SS_List_16_Sept_2010.pdf. Accessed November 18, 2010.
15. Carapetis JF, Wolff DR, Currie BJ. Acute rheumatic fever and rheumatic heart disease in the top end of Australia's Northern Territory. *Med J Aust* 1996; 164(3):146-9.
16. Australasian College for Emergency Medicine, *Alternative Pathway Subjects*. Available at: https://www.acem.org.au/media/Approved_Subjects_1010.pdf. Accessed November 18, 2010.
17. *Teaching On The Run*. Available at: <http://www.meddent.uwa.edu.au/teaching/on-the-run>. Accessed November 18, 2010.

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In January 2010 we conducted the Basic Assessment and Support in Intensive Care (BASIC) course in Duhok, Kurdistan, North Iraq. The course was deemed successful thanks to the enthusiasm and the relentless efforts of all the contributors, being the faculty, the local organizers and the students.

BASIC was established by the University of Hong Kong and is currently conducted in several countries including in the Middle East. It is a 2-3 day course made up of lectures and clinical skill stations. It is taught by intensive care specialists. The course emphasizes a practical approach to the management of critically ill patients. I have been running the course on a regular basis at Peninsula Health in Melbourne over the last two years.

A well structured and rounded course like BASIC is a great teaching model that can provide the basics of critical care medicine to the region. Over the last few years changes have been occurring at a fast pace in peaceful Kurdistan, however Health is still struggling, mainly due to lack of training and resources.

Preparations for the course started 18 months earlier with a lot of uncertainty, mainly because of our limited resources. I was able to obtain an old intubating manikin from Laerdal Medical. The Chinese University of Hong Kong kindly gave us permission to access the course material. I started promoting the course electronically through the Department of Health of Duhok City. We had 26 registrants, doctors from all around Kurdistan. They were mainly specialists with an interest in critical care and trainees in anaesthesia and general medicine.

The faculty consisted of: Associate Professor Gavin Joynt, intensivist, Chinese University of Hong Kong; Associate Professor Ross Freebairn, intensivist, Hastings, New Zealand; Dr. John Copland, director of anaesthesia at Peninsula Health, my husband Darsim Haji, ED physician, and myself.

The help from the Department of Health in Duhok was instrumental, with great thanks to Dr Abdulla Rajab who had a fundamental role as a facilitator and a liaison between the faculty, the local organizers and the registrants. Despite multiple stop-overs, travelling to Kurdistan was smooth and uneventful. The airlines flew directly to Erbil, the capital city of Kurdistan, bypassing Baghdad, which was a great relief. The course was run over 3 days. In the last day the candidates underwent a post-course case based MCQ test.

BASIC was well received and we hope it helped to bring new concepts in the management of critically ill patients to the region. The feedback since has been very good, with a request to conduct BASIC again, next time in Erbil.



Left: Assessment of critically ill station given by Gavin Joynt

Below: Faculty and participants



Newsclips

PNG

Sonny Kibob has completed MMed EM. He will now become senior emergency physician for the Highlands.

Sri Lanka

EM as a specialty: Specialty recognition is under the control of the Postgraduate Institute of Medicine (PGIM). A proposal had been put for a combined critical care and emergency medicine recognition. However, the PGIM has decided to proceed with the development of Critical Care Medicine as a separate specialty and a Board of Study has been appointed. The way is now open for a proposal for Emergency Medicine to be established as a separate specialty.

ELS courses: Now that the Tamil difficulties have subsided, Shane Curran is planning to take ELS courses to Sri Lanka in 2011. If you are interested in participating, contact Shane at shane.curran@bigpond.com

India

Medical Council of India (MCI) recognition of EM as a specialty is generating applications from numbers of institutions to have their EM programmes recognised for specialty training. The MCI has established how it will recognise suitable trainers for new EM programmes.

Nepal

Internal difficulties at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu have delayed a planned visit by a senior delegation to learn how EM is done in Australia. This is likely to proceed in 2011. Meanwhile, opportunities exist for FACEMs and trainees to contribute to EM training and development at the BP Koirala Institute of Health Sciences (BPKIHS) in Dharan, Eastern Nepal.

See IEMSIG Newsletters April 2007, Vol 3 No 2; and May 2009, Vol 5 No 1.



Above: Nepal wall paintings



Right: Nepal pilgrims