

IEMSIG

Newsletter of the International Emergency Medicine Specialist Interest Group of ACEM



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In this Edition

This Newsletter contains news of diverse activities that point towards areas for expanding emergency physician involvement. It could be a busy and challenging 2006 for those who are keen to participate:

Antarctica

Eve Merfield has just returned from a year of the most remote medical practice on the planet. The Australian Antarctic Division wants FACEMs.

India

Tony Joseph reports on the first Indian EM conference to involve a significant FACEM faculty. Suresh David extends an invitation to FACEMs to expand our involvement.

PNG

The Annual Symposium in September is featuring EM. FACEMs with an interest in tropical medicine and EM training are encouraged to visit Madang, a Pacific paradise.

Sri Lanka

Varna Amarasinghe is cultivating a willing interest in EM. FACEMs will have opportunities to visit and to contribute to the annual conference of the Ceylon College of Physicians.

Uganda

Ngaire Caruso confronts us with the realities of conflict on the African continent. MSF is always looking for humanitarians with generalist skills and courage.

Vietnam

Simon Young reports on the expansion of APLS in Vietnam and beyond, George Braitberg describes establishing a toxicology service, and Chris Curry responds to the question 'how do we get EM started here?'

If you or someone you know have been overseas doing interesting things with emergency medicine, we would be very interested to hear from you.

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Editor Chris Curry chris.curry1@compuserve.com

Teaching paediatric resuscitation skills in a developing country: APLS in Vietnam and beyond.

Simon Young

Introduction

It was easy to be frightened by the sight of hundreds of families camped outside the emergency department of the National Hospital for Paediatrics clutching sick children. It was even easier to be overwhelmed when inside the department by the meagre resources, few monitors, unreliable oxygen and two children to a bed. How could one meaningfully help? Where does one start? My first thoughts were that this will take some time and a lot of help.

These first impressions happened during my first visit to Hanoi in 2000 where I was presenting on paediatric emergencies at a symposium organised by the National Hospital for Paediatrics (NHP) in Hanoi and the Royal Children's Hospital International (RCHI). Five years later the sights at the National Hospital are dramatically different. Many people have contributed to this change: many visionary and dedicated doctors from NHP, the staff of the RCHI, and, through the Advanced Paediatric Life Support (APLS) teaching, many fellows from the Australasian College for Emergency Medicine.

Soon after this first visit the Vietnamese Government Ministry of Health commissioned a study examining the existing system of paediatric emergency care in Vietnam. I was asked to act as a consultant. In a developing country with 80 million people and a vast number of children this was a daunting task. The aims of the study were to document and understand the current system of care, and to suggest interventions that may improve the standard of emergency care for acutely ill and injured children. Over a gruelling three years period the study group surveyed over 600 hospitals, conducted site visits at over 20 hospitals and constructed and implemented a pilot model of care in a provincial setting.

As part of the project it was necessary to consider staff education and training and to propose and test a method of improving this. The APLS course was chosen as it is an internationally recognised training course for doctors and nurses in paediatric resuscitation. It has simple objectives: that is to teach the knowledge and practical skills necessary for the recognition and initial treatment of seriously ill and

injured children. It emphasises the basic principles of resuscitation, uses simple equipment and is conducted in a manner mindful of the principles of adult learning methods.

Although this course has been conducted in many countries around the world this was to be the first time that an attempt has been made to introduce the APLS course to a developing country in a sustainable way.

The plans to introduce the course were discussed with the Direction Board of NHP and RCHI. Key clinical personnel were identified and recruited from NHP and RCHI to develop the project and plan its implementation. Dr Nguyen Van Tu and Dr Le Thanh Hai travelled to Australia to complete the APLS course, enabling them to get a participant's view and to advise on necessary modifications. They were to become strong clinical champions for the acceptance and spread of the course within NHP and the rest of the country.

A project plan was developed, the project was costed and funding was obtained from a philanthropic non government source.

Preparation for the courses included:

- 1) Discussing and gaining agreement on curriculum changes
- 2) Translation of the APLS teaching manual, slides and other teaching materials.
- 3) Selection and provision of manikins and other clinical equipment for teaching.
- 4) Training of a local course coordinator
- 5) Conducting pilot courses

The curriculum was developed with specific attention to the types of presentations at various levels of hospital based health care, local medical practices and available resources. Scenarios were re-written for common presentations and local conditions. Each deviation from the "standard" APLS course was carefully considered and evaluated. The reasons for deviation varied. Some were agreed because the infrastructure was different, such as deleting defibrillation because of limited access to defibrillators. Others took into



APLS principles being applied to the resuscitation of a septic child

account local drug availability and Ministry of Health guidelines. Senior Vietnamese clinicians made the final curriculum decisions.

The first APLS course was conducted in Hanoi over three days in March 2004. Twenty four candidates (16 doctors and 8 nurses) from Hanoi, Ho Chi Minh City, Hue, Da Nang, Haiphong and Thai Binh attended the course. The candidates had a variety of clinical backgrounds including emergency, intensive care, general paediatrics and infectious diseases. The instructor faculty consisted of 6 experienced APLS instructors from Australia and 3 newly trained instructors from Vietnam. Australian instructors taught in English and used a translator. Vietnamese instructors taught in Vietnamese.

Over the next 18 months a further 9 courses were conducted with a total of 240 nursing and medical staff trained. The courses were conducted in Hanoi, Ho Chi Minh City and Hue. All have run according to plan with no major problems or disruptions. An important early priority was to identify and train new local instructors.

Potential instructors were selected by a similar method to that used on the standard APLS course. This consisted of examining the candidate's performance during the course and their marks obtained in the course tests. Each candidate was assessed during every skill station, discussion group and scenario. A consensus view on the appropriateness of an instructor recommendation was reached on the provider course by the instructor faculty.

Instructors were trained using the generic APLS instructor course and underwent an instructor candidacy on their first teaching course.

As the number and experience of locally trained faculty has increased the number of Australian instructors present on any course has decreased and consequently their role has changed substantially. It is current practice to have 2 Australian instructors per course, largely to supervise and give feedback to local instructors and to assist with problems as they arise.

The officially funded project has now come to an end. It is currently being audited and evaluated by an external body. Recently after a presentation of our project the Vietnamese Government officially sanctioned the course and is currently looking for funding partnerships to keep it going.

Other countries in the region have been watching these developments closely. I recently directed the first APLS course in Cambodia at the Angkor Hospital for Children and next year we are planning a course in Laos.

The success of any project such as this relies heavily upon the generous donation of time by many people. Many College members have contributed to the courses in Vietnam and Cambodia. Their skill in teaching (as well as their contributions to the singing at the course dinners) has been appreciated enormously by the course candidates and all the project team.



A scenario teaching session on an APLS course in Hanoi

Establishing a National Poison Centre in Vietnam

George Braitberg

I spent 7 weeks in Vietnam, from February 16th, 2004. I worked at Bach Mai hospital in Hanoi assisting in the establishment of the Vietnamese National Poison Centre. The aim of the Vietnamese Government was to establish a single Centre of Excellence in the Capital and assigned this task to the Intensive Care Department at Bach Mai, headed by The Director of the ICU, Professor Dinh and his assistant, Professor Du.

Professor Du was appointed head of the Toxicology Service and recruited bright young intensivists to look after patients in a 20 bed ward. The patients, when needed, were ventilated in the ward and only overflow intubated patients were sent to the ICU.

The major issues in setting up the Toxicology Service and the Poison Centre were resources, education and a fundamental understanding of the role of both services.

The doctors were unable to get access to many textbooks (money and language), internet access was mostly dial up, and the subscriptions to journals too costly to maintain.

The technological resources in the ward were limited and some patients were being ventilated on old bellows ventilators.

However, despite these limitations the interest and enthusiasm to which the young physicians took to their work was incredible.

Where did I fit in? Eventually we established a schedule where I was “clinical” in the morning and academic in the afternoons. In the mornings I would round on the patients and with my doctor interpreters make comments and suggestions on management. The spectrum of toxins was wide ranging and fascinating. Pesticide and herbicide poisonings were commonplace. Organophosphate, strychnine, aconite, paraquat, organochlorine poisonings mixed with the “regular” benzodiazepine, paracetamol and opiate/recreational drug intoxications seen in the “West”.

I was particularly interested in snake bite and my sponsor, Dr Kiem Xuan Trinh, MD., Ph.D, whom I met at the South Australian Toxinology Course some years ago “schooled me” in South East Asian snakebite, culminating in a visit to a Vietnamese snake village and drinking traditional snake wine. The management of snake bite in Vietnam is problematic in itself with limited antivenom supplies, lack of public knowledge of snakebite first aid and the intervention of traditional healers, often the first “port of call” for a snake bite victim, who often delayed access to definitive care. There are 30,000 cases of snake bite in Vietnam per annum with a fatality rate from a number of sources (unpublished to date) of between 60 and 90%.

In the afternoons I provided lectures with the aid of my interpreter doctors. By the end of my stay I had given over 40 lectures on all aspects of toxicology.

Another key activity was meeting Health officials to promote the idea of a national Poison Centre Information Line staffed by pharmacists or specially trained nurses to overcome some of the problems associated with a largely rural based society, in terms of provision of high quality reliable and appropriate advice. Soon after my return I hosted some of my Vietnamese colleagues on a visit to the Victorian Poison Information Service and the Deputy Minister of Health.



While the message was heard at this level, unfortunately there has been little progress in this area to date.

At the present time I am finalizing an epidemiological review of snake bite in Vietnam and hoping to get some ongoing support for more resources to the Toxicology Service.

There is a need to share the knowledge of the Vietnamese Toxicologists who have difficulty publishing in peer reviewed English language journals.

In conclusion, I am grateful for the opportunity I had in being able to spend time in Vietnam, extremely grateful to my hosts for their hospitality and would recommend the experience to any physician interested in working in Asia, a little outside their "comfort zone".

Can we assist EM development in Vietnam?

A visit to Hospital C, Da Nang

Chris Curry

Vietnam has a land area slightly bigger than Italy and slightly smaller than Japan, with a population of 83 million. The 3450km of coastline is the distance from Sydney to Perth. After growth at 8.6% per annum over 1990-1997, the GDP in 1997 was US\$310 per person. In Australia it was US\$20,650 per person. So you could say on that scale that Australians are seventy times richer.

Vietnam is the fourth biggest recipient of funding from the Australian Agency for International Development (AusAID), after Papua New Guinea, Indonesia and the Solomon Islands. The AusAID budget for 2005/2006 has allocated A\$492 million to Papua New Guinea, A\$77 million to Vietnam. The Australian contribution to international development is being increased, up to 0.3% of GDP.

Da Nang City is the third city of Vietnam, on the coast mid way between Ho Chi Minh City in the south and Hanoi in the north. On latitude 16 degrees north, it is as close to the equator as the Daintree, north of Cairns. But while I was there in December it rained continuously and the temperature didn't exceed 21degrees C. There is no malaria in Da Nang, but there is dengue fever.

I visited in response to a contact made by an AusAID agency, to assist with the question "how can we develop emergency medicine here?" Hospitals are funded either by the Ministry of Health or by Provincial Governments. Of the seven MOH hospitals, six are in Ho Chi Minh and Hanoi. The seventh is in Da Nang, called Hospital C. C stands for Common, as in Public. There is not an A or B. There are five other hospitals in Da Nang, including the General Hospital, Military Hospital, TB Hospital and HIV Hospital.

The casemix at Hospital C is heavily weighted to the non-communicable diseases of development. Motorbikes now number close to 10 million in Vietnam and are displacing pedestrians and bicycles. In spite of law requiring it, riders do not wear helmets. The rates of road trauma are high. Medical problems are dominated by coronary artery disease,

cerebrovascular disease, COAD, hypertension, hyperlipidemia, diabetes type 2 and renal failure.

Emergency Medicine is at its beginnings at Hospital C. A new building designed and built by Vietnamese and opened in 2004 has a two room Emergency Department with four outpatient-style plinths in one and two hospital beds in the other. The staff amenities, office and night shift rooms exceed the space available for patients. There is a very small procedure room but no equipment. The ED had no oximeter, no ECG machine, no defibrillator. The entire list of available drugs numbered 23 items.

The Hospital Director (CEO) was formerly Director of ICU and is deeply disturbed by the inadequacy of the hospital's capacity to receive the acutely ill and injured, to the point where he has publicly advised people to go elsewhere. He has appointed the Deputy Director of ICU to do something about it.

So what kind of assistance can we offer? I include the following from my Report to the Director in case it may be of use to other visitors to developing EDs:

"

A process for development

It is possible to make improvements in the delivery of care to the acutely ill and injured within the facility available at present, but only to a limited extent. Improvements can be made in leadership, equipment and supplies, training and education, and in processes and practices.

Essential to further development is a rebuild of the ED to provide more space and specific capacities, such as resuscitation room, monitoring, procedures and short stay. Then staff can be trained to provide a service achievable with the resources.

Much development can be undertaken with the human resources available at Hospital C. Support from an emergency physician with experience in the development of emergency medicine will be useful from time to time.

1. Acquire information resources for Emergency Medicine

Provided to Dr Tri:-

- Websites
- Books: A Brown, P Cameron et al.
- ACEM guidelines
- Diploma in Emergency Medicine information
- Fremantle Hospital Emergency Nursing Course program

2. Introduce equipment and supplies to the Emergency Department

Essential components of provision of service are equipment and supplies. These need to be available on site.

- Provided:- 'Minimum Inventory'
- Accessible:- Guidelines for ED Planning on the ACEM website: www.acem.org.au

3. Develop plans to remodel the Emergency Department

There is a critical need for more space and for specific purpose facilities.

- Guidelines for ED planning are available on the ACEM website.

4. Director of Emergency Medicine Dr Tri to:

4.1 establish education in emergency medicine for doctors and nurses.

This can be started within the twice weekly program that exists. Involvement of specialists in teaching the early management of emergencies in their disciplines will be useful. The index to a standard EM text is a good starting place from which to develop a locally appropriate curriculum.

4.2 visit a site with established emergency medicine, eg Singapore, Hong Kong, Perth in Western Australia.

Emergency Medicine is well established in Singapore, Hong Kong and Australasia.

- The Asian Society for Emergency Medicine: www.asem.org.sg
- Society for Emergency Medicine, Singapore: www.semsonline.org
- Hong Kong College of Emergency Medicine: www.hkam.org.hk
- Australasian College for Emergency Medicine: www.acem.org.au

4.3 undertake the Diploma in Emergency Medicine, Melbourne Australia.

This is a one year program requiring employment in an Emergency Department in Melbourne. A requisite is English fluency (no less than IELTS 7 overall).

- University of Melbourne, School of Enterprise: www.muprivate.edu.au/index.php?id=1452
- [www.soe.unimelb.edu.au/emergency medicine](http://www.soe.unimelb.edu.au/emergency%20medicine)
- Email: d.samuel@soe.unimelb.edu.au

5. Facilitate nurses to undertake the Fremantle Hospital Emergency Nursing Course

This is a four week intensive course conducted in May each year. It is specifically oriented towards nurses in environments with limited resources. English fluency will be important.

6. Identify a senior emergency nurse to undertake training in a developed ED

The ongoing development of an emergency service requires a committed senior nurse to provide leadership in management, in training and in nurse practice.

7. Rebuild the Emergency Department

The rebuild of the ED will allow the development of practices and processes of a modern Emergency Department. This will include such features as record keeping, triage, initial assessment, stabilisation and management.

8. Further develop the capacity of ED doctors and nurses

In conjunction with an improved environment there can be the development of capacity to undertake the practices and processes of emergency medicine. This is achieved through 'in-service' training.

9. Facilitate additional doctors and nurses to undertake foreign EM training, eg Singapore, Hong Kong, Perth, Diploma in EM Melbourne Australia

As the capacity and workload increases there will be a need for further foreign experience for leading emergency department staff.

“

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December 2005.
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Report on the Emergency Medicine Conference, 'EMCON 2005', Vellore, India "Critical Decisions in Emergency Medicine" 26-28th October, 2005

Tony Joseph

This was the 7th National Conference of Emergency Medicine held at the Christian Medical College in Vellore, India. Dr Suresh David was the Organising Secretary and he was ably assisted by his team in providing an excellent program which covered the breadth of current Emergency Medicine practice.

There was a significant contribution from an International faculty (Australia, USA, United Kingdom, Singapore) as well as a strong local speaker contingent.

Significant issues facing Indian Emergency Medicine include trauma, infectious diseases and drug overdoses which were all well covered at the meeting. There were also many excellent clinical update sessions such as in acute cardiac, neurological, paediatric and other conditions.

The Australian Faculty (Frank Daly, Tony Joseph, Ann-Maree Kelly, Sally McCarthy and Lindsay Murray) were the largest of the international faculty indicating the close links developing between the Indian and Australian Emergency Medicine Community. There is immense interest in further developing Emergency Medicine in India. Resources are limited as in any developing county but many of the impediments are political and there is much interest amongst young Indian doctors.

There is also an opportunity for visiting international faculty at well respected institutions such as the Christian Medical College in Vellore and the JIPMER hospital in Pondicherry.

Dr Suresh David is also developing an Indian Emergency Medicine website which any Emergency Physicians are welcome to join in order to exchange ideas and practices.

The next meeting is planned for October 2006 in New Delhi.

For those interested as a visiting Faculty in India, please contact
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Tony Joseph; 12-12-2005



Network for Emergency Physicians in India (NEPI)

**An invitation from Suresh David, Vellore, India
December 2005.**

Dear Friends

Greetings from CMC Vellore. It was indeed a pleasure interacting with you all during EMCON 2005. I presume that the General Body Meeting of the Society of Emergency Medicine India (SEMI) has left us fired up with enthusiasm to take our organisation forward. Before our spirits sag and the malady of complacency sets in, I have an idea for which I need your opinion and co-operation.

Thanks to Anantharaman's encouragement (Singapore), I am contemplating about a website called "NETWORK OF EMERGENCY PHYSICIANS IN INDIA - NEPI". The purpose of this website is to carry on the fellowship that we have developed thus far and not have to wait until the next Conference, before we talk to each other. This virtual wing of the SEMI would also serve as a platform for all of us and others who wish to raise and to seek answers for academic and professional interest. Hence, I have invited a few of our overseas friends who had demonstrated keen interest for the cause of Emergency Medicine in India to join hands with us in this endeavour. I hope that more would join us as we move along.

I wish to have your input for the designing of this website. Presently, I have been considering to have separate sections on

- * Ask the expert
- * Members podium – to air your views on specific issues
- * Medico-legal Section
- * Interesting articles
- * Forthcoming Events, etc.

Please send in your comments and additions if any. I want NEPI to be like a newspaper – to be read every day by all those who work in emergency departments throughout our country and in similar surroundings.

There is no membership fee for NEPI nor is it restricted to the members of SEMI. There is no Committee; no Secretary. The webpage shall be hosted from Vellore and to begin with, I shall coordinate the input, ensuring that there are no bugs, viruses or mischief-makers!

I envisage that this launching pad would invoke the interest of youngsters all over our country and enlighten them about the existence of our Society. Moreover, the existence of an active website would catch the eye of the 'movers and shakers' of the Medical Council and would facilitate our crusade for national recognition as a distinctive specialty.

One of my favourite quotations is 'the best way to predict our future....is to invent it.'
Let us strive towards new beginnings.

I await your response.

Yours sincerely,
Suresh David
Email: suresh.david@cmcvellore.ac.in

Update on EM developments in Sri Lanka

Varna Amarasinghe
December 2005

Dr Ragnathan is Chairman of the Ceylon College of Physicians in Colombo, Sri Lanka. He is interested in establishing EM as a specialty in Sri Lanka. He suggested increasing awareness initially by way of a symposium dedicated to EM before the annual conference of the Ceylon College of Physicians, to be held in Colombo in September. He will also take steps to arrange a keynote address dedicated to EM to be given by an emergency physician at their annual conference. Dr Ragnathan also expressed an interest in having a satellite conference/symposium in Galle, where he is working as a physician.

In Galle I met three doctors who had completed their MD and were undertaking postings abroad for board certification. Two of these are currently working in the Emergency Department at Frankston Hospital in Melbourne. I hope that they will form the nucleus of the initial group of physicians who would help to establish EM in SL. If we could attract more physicians at pre-board certification level to be trained in Australian Emergency Departments, that will further increase the awareness and the benefits of EM.

At Durdans Private Hospital in Colombo I had the opportunity to meet with Chairman of Board of Directors Mr. Ajith Tudawe and Medical Director Dr Rabel. It was very pleasing to note that they support EM as a specialty in their hospital. Durdans Hospital is one of the oldest private hospitals in Colombo, established in late 1940s on the site of a World War 11 army hospital. Currently they have almost all specialties with the exception of Paediatrics, and lead in Cardiology and Coronary Care. The hospital has a small 'Emergency Treatment Unit' staffed by a doctor 24/7 trained in airway management and patient stabilization. They are embarking on their Stage 3 development very soon and I was able to interest Dr Rabel and Mr. Tudawe in considering a better located and spacious ED with radiology and laboratory facilities.

Within the last year Colombo City Council has established an ambulance service. It is in its early stages of functioning. This may be another aspect of emergency care that emergency physicians could contribute to.

The MSF in Lira District, Uganda – An update

Ngaire Caruso
December 2005

Ngaire Caruso is an ACEM advanced trainee working for Medecins Sans Frontieres (MSF) in Lira District, Northern Uganda. In September 2005 she wrote an article which was published in this newsletter describing the work undertaken by MSF in Lira. In Northern Uganda 1.2 million people live in Internally Displaced Peoples (IDP) camps, as a result of the 20 year old conflict between the Ugandan Government and the Lord Resistance Army. MSF runs a therapeutic feeding centre for severely malnourished children in Lira town, six clinics in IDP camps in Lira District, and also runs a water and sanitation programme in the same six camps. Through this programme MSF provides medical care to a population of over 170 000 people. Other MSF programmes in Northern Uganda run clinics in 14 IDP camps as well as targeted programmes addressing specific diseases such as HIV/Aids, malaria and kala-azar (leishmaniasis).

“Unfortunately the situation in Northern Uganda has deteriorated further since I wrote the previous article in September 2005.

There has been a recent spate of attacks on Non Government Organisations (NGO) within the region. The first such attack occurred on October 25th here in Lira District - a Christian Childrens Fund (CCF) vehicle was ambushed on the road. Two CCF staff members were shot – they were evacuated to Kampala by helicopter and both fortunately survived. Four more attacks on NGO vehicles occurred over the next two weeks – two more in Northern Uganda and two incidents in Southern Sudan. Five aid workers were killed in those ambushes. A British tourist was also killed in Murchison Falls National park, Northern Uganda on the 8th of November. Then a handwritten letter surfaced, allegedly signed by a known LRA Commander, stating that the LRA would kill any white person moving in the region.

It is not completely clear whether these attacks were all perpetrated by the LRA, whether the letter was genuine, or why NGOs are being targeted. Some theorise that it is a response to the recent issue of arrest warrants for five LRA Commanders by the

International Criminal Court. However it is clear that the risk to NGOs working in the region has increased significantly. As a result of these attacks, most NGOs stopped or restricted their movements to the Internally Displaced Peoples (IDP) Camps where they are working. Of course, this situation has made life even more difficult for the 1.2 million people living in camps in Northern Uganda, who are forced to rely upon NGOs to meet basic needs such as adequate water supply and health care.

In our case here in Lira, we immediately stopped all movements of MSF vehicles and expats to the camps, and our expat team was reduced from 14 people to 7 people. There was a lot of fear in the camps that MSF would leave. – as one local said to me “If MSF leave it will be like before – our children will just die.” Fortunately we have been able to continue our work in the camps, running our clinics by “remote control” from Lira town. This is largely due to the dedication and hard work of our Ugandan staff who have continued to work in the clinics, travelling to the camps on public transport. The reduced expat team has remained in Lira town, and has worked hard to support our Ugandan staff in the field.

By mid December things were looking up – there had been no attacks on NGO vehicles for several weeks, our clinics were running well on remote control, and we were starting to consider travelling back to the camps in MSF vehicles. While districts further north were still suffering from ambushes, killings and abductions of civilians, at least Lira District seemed quiet. Then on December 13th, a public transport vehicle was ambushed on the road between two of our camps. A few people burnt to death inside the vehicle, after it was set alight by the gunmen. The other people were made to hand over their belongings, and then to strip naked. Then the gunmen began to shoot. At least six people managed to escape, including a man and a young boy who made it to our Clinic in Omoro. At least eight people were killed. Those killed included the driver of the vehicle, who had transported some of our staff and medicines in the same vehicle, on the same road, the previous day.

Over the next week more incidents occurred in Lira. Four people were abducted from the outskirts of Aloi Camp – the gun shots and cries of the people could be heard by our staff from their compound in the camp. Two people were abducted very close to Apala, another camp where we work. There were several other abductions within Lira District, and ongoing looting, ambushes, murders and abductions in the surrounding districts. Fortunately in the last week of December, things quietened down again, at least in Lira. However the situation is very unpredictable and could flare up again.

So where do we go from here? For me personally it has been a difficult time, with several ethical dilemmas. On one hand there is the massive need for the medical care provided by MSF in the camps. On the other hand, how can we ask our Ugandan staff to travel on public transport to the camps, given the recent escalation in incidents within Lira? Particularly when the expats are relatively safe within Lira town. Of course, we only ask our staff to travel after security checks have been made, and all staff have the right not to travel if they feel unsafe – but the situation is very difficult to predict and no road can be guaranteed safe.

Some other NGOs have started to travel with a military escort. MSF does not do this as it would compromise our neutrality and impartiality, which MSF believes is essential in allowing us access to people in need. But if the choice comes down to travelling with the military versus closing the clinics, what is the right thing to do?

The situation is further complicated by recent political upheaval in Uganda. Kizza Besigye, leader of the

main opposition party the Forum for Democratic Change (FDC) returned to Uganda in October after 4 years of self-imposed exile. After touring the north of the country and being greeted by large crowds, he was arrested on the 14th of November. Besigye was charged with treason and rape by the High Court, and on terrorism and unlawful possession of firearms by the General Court Martial. He is still in prison despite being granted bail by the High Court, and is challenging the legality of the trial in the General Court Martial. His arrest was followed by two days of riots in Kampala and other towns in Uganda.

Several European countries have suspended aid to Uganda in response to these recent political developments. As stated by the United Nations Integrated Regional Information Network “Britain questioned Uganda’s commitment to the independence of the judiciary, freedom of the press and freedom of association following Besigye’s arrest and trial.” With the National Elections scheduled for February 23rd there is significant potential for violent unrest in the next few months.

I am leaving Lira next week. After a holiday in Europe I will return to my comfortable life back in Australia and escape the dilemmas and difficulties of life here. But for the Ugandan people there is no escape – for the 26 million Ugandans facing an uncertain political future and the potential for violence and civil unrest; for the 1.2 million people living in the camps in appalling conditions, lacking basic services such as clean water, education and health facilities. The war with the LRA has been going on for twenty years, and at the moment there is no reason to predict it will not continue for twenty more.”



Antarctica, Casey Station

Eve Merfield

The Australian Antarctic Division maintains three wintering stations on the Antarctic Continent and one on Macquarie Island in the Subantarctic. Each base has a medical officer who spends a year looking after the health of the expeditioners. The number of expeditioners on each station varies between as few as 14 for the long winter months and up to 120 in summer. All expeditioners have a thorough medical examination before acceptance on the program. Any conditions needing regular medication are reason for rejection. Attention is also given to risk factors, for example the BMI must be less than 35.

Requirements for the medical officer include a wide range of experience, some surgical and anaesthetic experience, and a willingness to be away from home and usual workplace for over a year. An elective appendicectomy is also obligatory for doctors. Emergency Physicians and rural GPs make up the majority of the doctors heading south.

Before leaving there is a 2-3 month training period in Hobart which includes a 2 week course in dentistry as well as courses in diving medicine, physiotherapy, radiography, laboratory techniques and specific cold related problems. In addition there are courses on fire fighting, manual handling and workplace diversity issues, as well as optional courses in hydroponics, hairdressing, boating and so on.

The medical facilities at the stations are excellent, each having a consulting room with well stocked pharmacy, examination room, basic resuscitation area, theatre and scrub room, 2 bed ward, dental area, store room and laboratory. There is equipment for a wide range of investigations including haematology, biochemistry, microbiology and cytology. The recent addition of Istats, handheld chemistry analysers, has simplified some of these procedures. The theatres are well equipped with a wide range of instruments. A team of 4 assistants goes through 2 weeks training as theatre assistants at the Royal Hobart Hospital. In my case these were the chef, carpenter, communications officer and plumber. The training provided was excellent and all were competent at scrubbing, setting up and handling sterile instruments as well as monitoring patients. Training of the team continued throughout the year with scenario based sessions devised and run by me. The team learnt to develop

X-rays, do basic wound closure, set up the theatre for various operative procedures, prepare for anaesthesia, draw up drugs and so forth.

Work on station consists of dealing with any medical emergencies that arise, 24/7 on call. This means carrying a radio at all times when off station, and not going further from station than it is possible to return within 24 hours. There are regular medicals for all wintering expeditioners throughout the year, maintenance of all the equipment, sewage testing and water testing. A seemingly minor problem that may take 10 minutes to deal with in Australia can take a whole day in Antarctica. After assessing the patient any investigations need to be done by the MO: taking and developing X-rays, taking and processing blood samples, making agar and plating out microbiology samples, then making and staining slides of growth. Instruments have to be cleaned and resterilised, the surgery cleaned and tidied, and rubbish disposed of.

Thankfully there is excellent back up, with a range of specialists available though the Polar Medicine Unit - photos of pathology slides can be sent for review, X-rays scanned and sent to radiologists, and every speciality can be contacted for advice. Once the air link is established in a couple of years, it should be possible to evacuate patients by air over the summer, subject to weather constraints.

Most consultations are minor General Practice type problems, sprains, skin disorders and suchlike. Dentistry is an interesting diversion enjoyed by most Antarctic Practitioners. The equipment is simple and easy to use, with excellent back up and advice provided by the Royal Dental Hospital in Melbourne. I carried out a few restorations and offered scaling and polishing at Midwinter.

I had one case of Guillain Barre like syndrome during summer and I was able to return the patient to Australia by ship, fortunately without the need for ventilation. There was also a case of recurrent frank haematuria, which occurred in the middle of winter. It required some challenging investigations including multiple blood tests, urine sediment cytology and microbiology, and an intravenous pyelogram. With limited X-ray equipment this was given a 'dummy run' on the Resuci Annie to see if it was feasible. Specialist input was invaluable in this case, with



review of X-rays and cytology and a Urologist opinion.

I also dealt with renal colic, ophthalmic herpes zoster and severe tonsillitis, and did a few minor surgical procedures under local anaesthetic.

Psychological and psychiatric problems may also occur and can be difficult to manage in the isolation of winter.

Search and Rescue involves training of both the doctor and a team of volunteers, and was enjoyed by all. Abseiling down ice cliffs, retrieving stretchers on rope systems and the other various exercises were a welcome diversion.

Living conditions at Casey station are very pleasant, with a “ski lodge” feel to the buildings. Expeditioners have their own room in winter, while some share in summer, with shared bathrooms. Doctors always have their own room. The chef provides 3 meals a day. Everyone on station helps out with cleaning up. There are field huts in the vicinity of the station provided for recreational visits, a great escape from the confines of the station over the course of the year. These can be reached variously by walking,

skiing, quad bikes, skidoos and Hagglands oversnow vehicles. The Australian Antarctic Division has a fairly liberal policy on recreation compared with other countries. Expeditioners have access to all vehicles for recreation and travel off station if approved by the station leader after completing comprehensive field training. I enjoyed skiing all year and regularly went on recreational trips off station, even in the depths of winter. This was really the highlight of the year. It was fantastic to watch the changes over the year, to see the wildlife leave at the end of summer and the sea ice form, and to see the fabulous landscapes over winter as the days shorten to just a couple of hours of dim light. Then the days lengthen, eventually the sea ice breaks up and wildlife returns. Seal pups are born and penguins and birds return to their nests to lay eggs and bring up young, as the cycle completes. Photography is understandably a popular hobby, and I took over 10,000 photos over the year.

All in all I had a fantastic 14 months watching the entire cycle of a year in Antarctica. Medically there were few real challenges but always the possibility of major problems with limited resources and so the need for a constant state of preparedness.

Postgraduate Diploma in Emergency Medicine

Anne-Maree Kelly

The University of Melbourne/ Western Health

This 1 year full time course is aimed at people seeking additional experience and qualifications in the field of Emergency Medicine including general practitioners practising in rural/ remote areas and overseas-qualified doctors seeking occupational training in the field.

Note: This qualification **does not** qualify a successful candidate as a specialist Emergency Physician in Australia and is not specifically recognised towards the specialist training course of the Australasian College for Emergency Medicine [ACEM].

Entry requirements

To be eligible for selection for this course, applicants must:

1. Have a degree in Medicine from a university acceptable to the Faculty of Medicine, Dentistry and Health Science, AND
2. Have a minimum of two years relevant experience in a health service setting in Australia or overseas, AND
3. Be eligible for registration as a medical practitioner in the State of Victoria [temporary/ provisional registration is acceptable], AND
4. Be fluent in English equivalent to a level of no less than IELTS 7 overall and with a score of no less than 7 in speaking and listening. AND
5. Be nominated by a hospital participating in the course.
6. Participation is conditional upon employment at the nominated hospital. Note: Candidates are paid a salary for their work-component at the appropriate rate.

Course intake

There will be up to two intakes/year –in February and August. Details of applications are on the website [see below].

Course structure

The course is based on a points structure with students required to accumulate a certain number of points in order to receive the award.

To satisfy the requirements of the Postgraduate Diploma students will pass subjects accumulating a total of 100 points. All subjects are compulsory.

Principles of Emergency and Critical Care	12.5 points
Emergency Medicine: Clinical Placement 1	37.5 points
Clinical Emergency Medicine	12.5 points
Emergency Medicine: Clinical Placement 2	37.5 points
Total	100 points

Principles of Emergency Care and Clinical Emergency Medicine are tutorial/ seminar-based subjects comprising 3 hours/ week.

Emergency Medicine: Clinical Placement 1 and Emergency Medicine: Clinical Placement 2 are experience-based subjects involving working under supervision in the emergency departments of Western Health.

Further details can be obtained from the website: <http://www.muprivate.edu.au/index.php?id=1452>

Also: Dr Delyth Samuel, Tel 61 3 9810 3212, Mobile 0418 392 194

Email d.samuel@soe.unimelb.edu.au

[www.soe.unimelb.edu.au/emergency medicine](http://www.soe.unimelb.edu.au/emergency%20medicine)

IEMSIG Places and Connections

This is a compilation of places and people who have been there and know something about EM there. If you can add to this, either yourself or someone you know, please let me know. Editor Chris Curry. chriscurry1@compuserve.com

Update December 2005

Afghanistan

Gerard O'Reilly, Aled Williams

Antarctica

Australian Antarctic Division (AAD): Glen Browning, Andrew Climie, Eve Merfield, Ogilvy Thom, David Taylor, Bryan Walpole, Michael Woosey
British Antarctic Survey (BAS): David Rigg
Ship expeditions: Chris Curry, et al

Cambodia

Steve Priestley, Simon Young

Canada

Gary Browne, Chris Baggoley, Barry Gunn, et al

China

Lisa Bell, Gary Browne, Tony Joseph, Ross McAlpine, Paul Preisz

Croatia

Anne-Maree Kelly

East Timor

Norman Gray, Bryan Walpole, Aled Williams

Fiji

Joe Epstein, James Taylor

Hong Kong

Peter Cameron

India

Frank Daly, Mark Fitzgerald, Tony Joseph, Anne-Maree Kelly, Mark Little, Gerard O'Reilly, Sally McCarthy, Lindsay Murray, Bhavani Peddinti

Indonesia

Chris Curry, Michael Davey, Gordian Fulde, Bryan Walpole
Aceh: Rick Brennan, Jon Field, Alan Garner, Norman Gray, Gerard O'Reilly, Andrew Pearce, Kate Porges, David Symmons, John Vassiliados
Nias: David Bradt, Mark Little, Herbert Sadlier

Iraq

Norman Gray, Darsim Haji

Iran

Andrew Dent, Gerard O'Reilly

Ireland

Justin Bowra, Michael Davey, David Eddey, Tony Mattick, Andrew Waring, et al

Japan

Paul Preisz

Kenya

Megan Cox, Aled Williams

Kiribati

Georgina Phillips, Brady Tassicker

Kurdistan

Darsim Haji

Laos

Bryan Walpole, Simon Young

Malaysia

Paul Gaudry
Phuket: Greg Hollis, Drew Richardson

Maldives

Michael Novy, Peter Roberts

Netherlands

Gary Browne, Marjory van der Pyl

PNG

Peter Aitken, Antony Chenhall, Chris Curry, Andrew Dent, Peter Barnett, Steve Dunjey, David Eddey, Mike Galvin, Naren Gunja, Chris Hall, Jack Hodge, Rachel Hoyle, Sandy Inglis, Simon Jensen, Marian Lee, Bill Nimo, Gerard O'Reilly, Kate Porges, Sandra Rennie, Niall Small, Paul Spillane, David Symmons, Ric Todhunter, Greg Treston, Simon Young, Bryan Walpole

Solomon Is.

Simon Jensen, Gerard O'Reilly, Andrew Pearce, Georgina Phillips, Guy Sansom, Bryan Walpole

Somalia

Mark Salib

Conferences

Sri Lanka

Varna Amarasinghe, Aled Williams

South Africa

Sandy Inglis, Cambell Macfarlane, Andrew Parkin, Jane Terris, et al

Sudan

Megan Cox, Gerard O'Reilly

Tanzania

Megan Cox, Martin Duffy, Gordian Fulde

Thailand

George Braitberg, Anne-Maree Kelly

Tonga

Bhavani Peddinti

Uganda

Ngairé Caruso

UK

Justin Bowra, Gary Browne, David Eddey, Scott Pearson, Marjory van der Pyl, et al

USA

Justin Bowra, Rick Brennan, Gary Browne, Frank Daley, Peter Sprivulis, Janet Talbot-Stern, John Vinen, et al

Vietnam

George Braitberg, Marianne Cannon, Chris Curry, Tony Joseph, Simon Young, Aled Williams

(35)

Agencies

International Red Cross

Aled Williams

International Rescue Committee

Rick Brennan

Medecins sans Frontiers

Ngairé Caruso, Darsim Haji, Gerard O'Reilly

UNICEF

Darsim Haji

World Health Organisation

David Bradt

Annual Symposium, Medical Society of Papua New Guinea.

September 4-8, 2006

Themes: Emergency Medicine, Disaster Management, Rehabilitation and Occupational Health.

At Divine Word University, Madang.

General enquiries and abstracts to:

Dr Billy Selve, Dean Faculty of Health Sciences, Divine Word University

Secretary of 2006 Annual Medical Symposium

Organizing Committee in Madang

Email bselve@dwu.ac.pg

Prof. Mathias Sapuri, President Medical Society of PNG

Executive Dean, School of Medicine and Health Sciences

Email: sapuri@daltron.com.pg

Prof Sapuri writes: The Organising Committee wishes to encourage Emergency Physicians with PNG or developing country experience to attend. An invitation could be extended to them to attend as Guest Speakers. We would greatly appreciate it if their respective societies/hospitals/DOH could sponsor them to the symposium. The Organizing Committee will accommodate them during the week. Abstracts could be forwarded to Dr. Billy Selve

See Madang Resort for accommodation, excellent diving opportunities and ancillary travel and activities while in this fascinating "Land of the Unexpected". <http://www.meltours.com/>

News

International Federation for Emergency Medicine

(IFEM) Humanitarian Award 2005

Awarded to Rick Brennan FACEM, International Rescue Committee

ACEM Website

This is newly updated and provides access to a mass of information that will be useful to those involved in developing EM elsewhere.