IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM

Volume 10 | Issue 2 | December 2014

Contents

EDITORIAL

From the Editor	Chris Curry	2
Message from the IEMSIG Chair	Gerard O'Reilly	2

INTERNATIONAL SCHOLARS' PRESENTATIONS AT THE ACEM ASM

Myanmar: Opening up doors – The first year of the new ED at YGH – challenges and successes.	Rose Skalicky-Klein, Win Kyaw	4
Myanmar: After the Games are over – The development of an ED at Nay Pyi Taw 1000 bedded Hospital	Than Latt Aung	6
Nepal graduates their first emergency medicine specialists	Ramesh Maharjan	7
PNG: Leading emergency medicine in Madang Province	Taita Kila	7
Vietnam: Emergency medicine development at Cho Ray Hospital, Ho Chi Minh City	Tôn Thanh Tra, Pham Thi Ngoc Thao	9

PACIFIC

ELS in the Pacific	Andrew Bezzina	12
Fiji – Perspectives on building an EM training program	Anne Creaton	13
PNG – Update on emergency medicine in Papua New Guinea	Colin Banks	15
Vanuatu – Wins for emergency medicine in Vanuatu	Brady Tassicker	16

SOUTH EAST ASIA

Indonesia – Bali and Lombok: the Methanol Education Program	Di Brown	18
Myanmar – Royal Children's Hospital in Melbourne supports Myanmar	Simon Young	20
Thailand – Emergency Medicine update	Jonathan Knott	21
Timor Leste – An update from Dili	Antony Chenhall	22
Vietnam – The Alfred-Hue Emergency Care Partnership Project	Gerard O'Reilly	23

ASIA and MIDDLE EAST

Mongolia – The Initial Emergency Care Program	Simon Smith	24
Nepal – Australian and New Zealand EPs support the first specialists	Chris Curry	24
India – EM training in India: Public and Private	Pankaj Arora, Anita Bhavnani	25
Sri Lanka – EM in Sri Lanka has progressed	Shane Curran	27
Qatar – Emergency Medicine update	Shinu Varughese	27
Israel – Towards a national training program	George Braitberg	28

EUROPE

Hungary – The study of Oxyology and Central European challenges	Peter Thompson	30
Netherlands – Emergency Medicine update	Naren Gunja	31

AFRICA

Botswana – Opportunities for TESL users and ACEM advanced trainees	Megan Cox	32
Kenya – Can you help a PEM and PCCM program?	Mardi Steere, Jane Cocks	33

Editorial

Chris Curry
chris@chriscurry.com.au

This is the last issue of the chronicles of Australasian involvement in EM developments internationally that will be called the IEMSIG Newsletter. The first issue appeared in September 2004 with 3 authors; this issue carries opportunities and outcomes from 28 authors. So in ten years it would seem we have outgrown the term 'Newsletter'. We have also outgrown 'IEMSIG' and in 2015 we will expand into IEMC and IEMNet (International EM Committee and International EM Network).

Over the past decade Australians and New Zealanders have become increasingly active in our region, making substantial contributions towards the graduation of the first emergency physicians in PNG, Thailand, Myanmar and Nepal. First trainees are nearing graduation in Sri Lanka, Fiji and Botswana. Australasians are spreading further afield, with expanding engagements in the Pacific and Asia and in Europe and Africa.

In this, the second decade of ACEM engagement in EM developments internationally, there will be a need for the consolidation of established training programs and the development of still more new ones. Of the 193 states that sit at the United Nations, fewer than 50 currently recognise emergency medicine as a specialty. There is a great deal to do.

Message from the IEMSIG Chair

Gerard O'Reilly
oreillygerard@hotmail.com

From 2014 into 2015

As you read this message, you will hopefully be fresh from a recent break and re-energised for the year ahead. Following is a summary of the 2014 IEMSIG wrap-up from the Tuesday afternoon IEMSIG session of December's Annual Scientific Meeting in Melbourne.

ACEM fellows and trainees have been helping to improve the delivery of emergency care in developing countries for many years. As each year passes, the support coming from the College has grown considerably to better match and support the efforts of many individuals working in the field on short or long-term programs.

2014 - Some highlights

March and October 2014 saw the graduation of the first emergency physicians in Myanmar and Nepal respectively. Both programs have benefited from major Australasian emergency physician and trainee work. Whilst emergency care remains in its infancy in both settings, the building blocks are clearly there, with opportunities for ACEM fellows and trainees to contribute. In Myanmar, for example, the second Diploma for Emergency Medicine is half-complete, and the first Masters of Emergency Medicine has just commenced.

In early 2014, the Department of Foreign Affairs and Trade (DFAT) directly approached ACEM for assistance in improving the delivery of emergency care to the local population in the Solomon Islands. This led to the creation of a shared (ACEM and DFAT) Terms of Reference and Funding Agreement documents for a Scoping Mission and report which was successfully delivered in May 2015. Notwithstanding the major reduction of Australia's aid budget, it is hoped that the next step will be the planning and delivery of a funded and well-developed program of emergency care capacity development in the Solomon Islands.

The 3rd International Emergency Care symposium was held over two days in September. Many wonderful speakers spoke to topics linked to an overall theme of "Can('t) we do better?" Similarly, this year's Annual Scientific Meeting committed two full sessions on the subject of International Emergency Medicine, where, in addition to the IEMSIG session, we were privileged, with the annual support of the ACEM Foundation, to hear wonderful presentations from EM champions representing Myanmar, Nepal, Papua New Guinea and Vietnam. All of this rich IEM content was followed by a wonderful gathering of more than 50 guests at the annual IEMSIG dinner.

Of course, many unsung contributions and activities to improve the capacity of developing countries to deliver emergency care have continued.

2015 – What's ahead?

In addition to an array of activities, the details of which were presented with country updates at both the International Emergency Care symposium and the Scientific Meeting, and in glorious photographic detail in the pages of the IEMSIG Newsletter, there are some specific activities worth highlighting.

Australasian events with an ongoing commitment to international emergency care in 2015 include the Winter Symposium in Alice Springs, mid-year, the International Emergency Care Symposium and Course in Melbourne in the last week of August, and the Annual Scientific Meeting in Brisbane in November.

And there will be a significant change to ACEM's governance structure for International Emergency Medicine. Since 2004, the International Emergency Medicine Special Interest Group (IEMSIG) has been a broad, organic, informative and flexible network. In 2011 a dedicated committee, the International Development Fund Committee (IDFC), was formed for the very specific task of developing the selection mechanisms and determining the recipients of the annual IDF Grant. As of early 2015, there will be a one stop shop, the International Emergency Medicine Committee (IEMC), which will bring together all the functions of the IEMSIG, the IDFC, and much more, including being an advisory body for the ACEM Foundation's IEM pillar. The IEMSIG will remain the broad network it has been, but will have a name change: the International Emergency Medicine Network (IEMNet).

The broad remit of the IEMC has been captured by its inaugural set of "responsibilities", combining the historical terms of reference of the IEMSIG and the IDFC, and incorporated suggestions from IEMSIG members. The goal and responsibilities are as follows:

The goal of the International Emergency Medicine Committee is to facilitate the capacity of developing countries to deliver safe and effective emergency care. Where international health matters relate to emergency medicine in developing countries, the committee shall:

(a) be a repository of information that includes resources, networking, mentoring and career advice regarding international emergency medicine

(b) be a liaison to ACEM and other relevant institutions regarding international emergency medicine issues drawing on IEMC members' expertise

(c) assist in the establishment of emergency medicine training through facilitating:
- relevant educational activities in developing countries
- support for emergency doctors based in developing countries to enhance their skills in country and abroad, and
- the development of sister hospital relationships with Australasian hospitals

(d) build Australasian emergency physician activities in developing countries by facilitating opportunities for ACEM Fellows and trainees

(e) facilitate and encourage the inclusion of FACEMs who are resident in overseas development posts as members of the IEMC

(f) where appropriate, advise on and facilitate the creation of training posts for ACEM advanced trainees in international emergency medicine

(g) build awareness of international emergency medicine issues across ACEM, other relevant institutions and the wider community through presentations, publications and events on international emergency medicine

(h) establish the criteria by which projects, grants and scholarships will be assessed. These criteria will be aligned to the goals of the ACEM Foundation with regard to building emergency medicine capacity in developing countries

(i) oversee applications for funding and make recommendations to the ACEM Foundation regarding international emergency medicine projects, scholarships and grants

(j) promote and support the fund-raising activities of the ACEM Foundation.

Finally, it is with great pleasure that I welcome Neil Fisher, in his role as the ACEM Foundation Manager, as the lead ACEM manager for the IEMC.

But sadly for ACEM IEM, we will officially be without Sarah Smith as she takes on a senior management role for ACEM. As I mentioned at the recent IEMSIG dinner, Sarah has managed IEMSIG matters and facilitated its many and varied activities for the last 3 years including:

- responding to external and internal requests and queries
- helping edit the IEMSIG Newsletter
- creation of selection criteria , budget and processes for the highly successful and valued International Scholarship Awards
- developing links between Australian Volunteers International and Accredited IEM Training

Posts for Trainees

- generation of the Solomon Islands Emergency Department Improvement Project Scoping Mission, including the Funding Agreement between ACEM and DFAT
- creation of the IEMSIG Executive
- overseeing IEM components of the website update
- bringing structure and professionalism (including agendas, meetings, transparency and minutes!) to a bunch of freelancers, lefties, greenies, do-gooders, backpackers, trekkers, hippies and delinquent volunteers masquerading as global hawkers of the gospel of emergency medicine!
- being a wonderful advocate for IEM in the corridors of ACEM and elsewhere
- dealing with three passionate, quirky, and pesky IEMSIG Executive members.

Sarah has looked after many other aspects of ACEM's engagement with IEM not listed here - and she has achieved all of this with a constant, calm, gentle, and always positive and passionate spirit and temperament, perfect for the many cultures embraced by ACEM's IEM work.

So on behalf of all IEM groupies and beneficiaries, I say thank you to you, Sarah Smith.

And I say thank you all for your hard work in 2014 for International Emergency Care; we all look forward to our continued efforts in 2015. Best wishes.

INTERNATIONAL SCHOLARS' PRESENTATIONS AT THE ACEM ASM

Myanmar: Opening up doors – The first year of the new ED at YGH - challenges and successes

Rose Skalicky-Klein and Win Kyaw,
drrosanne.skalicky@gmail.com
winkyaw1967@gmail.com
presented at ACEM ASM 2014 by Win Kyaw

With the successful conclusion of the first Diploma of Emergency Medicine (EM) program in October 2013, the 18 graduating specialists were used in preparing and managing the emergency systems for the 2013 South East Asia (SEA) Games. After the conclusion of the SEA Games 10 of those graduands remained full-time in EM and have been distributed throughout the country, with 4 specialists continuing at the Yangon General Hospital (YGH).

The YGH was established in 1899 and had the only recognised 'Accident & Emergency' service in the country in 2009. At present it sees more than 70,000 patients per year. Integrating a modern EM system and department has been challenging. In 2014 the 'Accident & Emergency' area was renamed the 'Emergency Department' and the EM specialists were given responsibility over the department. However, functionally the ED is still run by the orthopaedic trauma service, medical unit and surgical unit.

The EM specialists' role was to develop, equip and staff the resuscitation room to cater for the triage category 1 patients. In parallel this has meant setting up a triage system to sort by acuity rather than specialty. This is a long term process and not yet consistent, but despite this we are seeing dividends from having a triage system.

Two EM specialists, along with new Diploma of EM candidates, were present at YGH for much of the first half of 2014, while others were on an observational trip in Japan. With limited staff, the ED ran an office-hours resuscitation service. Over this time 422 patients were seen in the resuscitation room, 70/month. Over half of the triage category 1 patients presented with head injuries from road trauma or falls. In August 2014 the resuscitation service became 24/7, and still over half of the patients have severe head injury.

A recent success story was a lady who arrived with a 2-week history of increasing neck swelling. On arrival at 2am she had a reduced conscious level, cyanosis, oxygen saturations 40% with signs of an obstructed airway. In the past she may have died. It was a difficult intubation but the EM specialist was successful. She then went to ICU, with the surgeons planning to operate on the neck mass.

Our 3-category triage scale, although inconsistently implemented at present, is still an improvement in process and is leading to many more success stories.

Our floor space is once again undergoing renovations and we are hopeful that these improvements will help with the implementation of better working functions and a more integrated approach between the various units currently in the ED.

In treating patients one of the challenges has been the lack of supporting staff – initially maybe only an intern or resident to assist. Other staff would refuse to help. We have been able to teach and up-skill the interns and residents and slowly assistance is improving, but it is variable.

We have been able to increase the level of care in the ED, but this is now highlighting some deficiencies in the receiving areas for our patients.

Despite the successes we are mindful of many challenges still facing the ED.

- With increasing patient load and casemix we need more trained doctors and nurses who are able to work competently. With the upcoming Masters of EM and Diploma of Emergency Nursing this will happen, but it will be a slow build. We are trying to increase training of our junior medical and nursing staff but this teaching role is difficult to balance with our clinical workload.
- Our workload is increasing and the national introduction of the 'Free of Charge' care for ED patients has increased it further.
- Many system processes have been used for many years, such as for patient registration and sorting. It will take time, perseverance and patience to negotiate the changes required for the system to be more patient centred and effective.
- Building relationships that are helpful not only to the ED but also, more importantly, for patient care is important and does not always go smoothly.
- We are aware that the training of the Masters of EM candidates will be important, but our resources will be stretched.

Emergency physicians at the newly named Emergency Department, YGH (Win Kyaw second from right).

Emergency physician Aung Myo Naing teaches nurses in the ED, YGH.

- Because of low pay levels it is necessary for YGH doctors to have additional work outside the government hospital, to earn a living.

There are opportunities for the EM specialists to play a role in international gatherings, like ASEAN. We are hopeful that we can also play a meaningful role in road trauma prevention policies, education and strategies, and in developing an ambulance service. We see a role in developing good hospital care guidelines.

We are very thankful for ongoing international support, in particular via the Australian Volunteers International (AVI) programme. We see ongoing opportunities for people to help us:

- teaching for the Masters of EM
- training in specialist skill areas like ultrasound,

management and QI, for Masters of EM and for specialist CME

- facilitating clinical attachments outside Myanmar to help broaden experience

The challenges faced in establishing a functioning ED in a hospital steeped in medical tradition and culture such as the YGH have been many and at times have appeared insurmountable. With persistence and patience these challenges are being managed, systems are changing and new doors are opening. A patient once thought to have little hope of survival, now living because of good ED care, is reason enough to continue.

New programs

Master of Medical Science (Emergency Medicine)

University of Medicine 1, Yangon.

This program, led by Professor Zaw Wai Soe and Rose Skalicky-Klein (left of picture), commenced on 1st January 2015 with 25 candidates.

Diploma of Emergency Nursing

University of Nursing, Yangon.

This program, led by Nigel Klein (centre), commenced on 1st January 2015 with five candidates.

Myanmar: After the Games are over – The development of an Emergency Department at Nay Pyi Taw 1000 bedded Hospital.

Than Latt Aung

Terrymichael999@gmail.com

ABSTRACT

Aim & Background: Nay Pyi Taw (NPT), the capital city of Myanmar was the key location for the 2013 South East Asia Games and continues to be an important international city as Myanmar is the chair of ASEAN, 2014. Development of a functional Emergency Department (ED) was given high priority by the Ministry of Health and a new Emergency Department was custom built in the Nay Pyi Taw 1000-bedded Hospital. Newly graduating Emergency Medicine (EM) specialists were given the role of managing the ED and a pre-hospital ambulance service during the SEA games. Since the Games the 2 EM specialists have continued to manage the ED. NPT Hospital is a non-training, consultant-run hospital with junior staff at the level of a second/third year postgraduate. As the major hospital in the city where the Government sits, the challenges faced are quite different to other EDs in Myanmar. This talk aims to highlight what development has taken place, the challenges and successes as well as future direction.

Method: The experiences of the Emergency Specialists working in NPT 1000-bedded Hospital will be shared showing the progressive development of the ED and the challenges faced and successes experienced.

Conclusion: The challenges faced in developing a modern Emergency Department in the capital city of Myanmar have been different from those experienced elsewhere. However, the international focus on NPT has meant that EM services remain in focus and development is able to continue despite these challenges. The SEA Games may be over but Emergency Medicine is just getting started.

Nepal graduates their first emergency medicine specialists

Ramesh Maharjan

drmfamily@yahoo.com

ABSTRACT

Background: The first program of emergency medicine training in Nepal was launched by the Institute of Medicine (IOM) at Tribhuvan University Teaching Hospital (TUTH) in October 2011.

Objective: to describe the three year Doctorate of Medicine in Emergency Medicine (DMEM) program.

Method: the period described is from October 2011 to October 2014.

Results: The first Nepali emergency medicine training program was launched after a delegation of Dean, Campus Chief, Hospital Director and Professor of GP&EM visited the ACEM office and several EDs in Melbourne in February 2011 and received offers of support from FACEMs.

The Doctorate of Medicine in EM (DMEM) was opened to Nepali doctors with a specialty qualification, i.e. with 3 years of postgraduate (MD/MS) training after MBBS and internship.

Selection was on the basis of an entrance examination. Two candidates were selected, both with the MDGP qualification and a background in GP&EM

The DMEM program included 2 years in the ED at TUTH, with 3 month rotations to Anaesthesia, Critical Care Medicine, Cardiology, and to the ED at CMC Vellore in India.

The ED training was under the supervision and mentoring of emergency physicians from Australia and New Zealand. The rotations were conducted with coordination between the relevant faculties at TUTH.

The program included the undertaking of substantial research, and the submission of a research thesis.

Final examinations were conducted in September and October 2014, with the two candidates meeting the requirements to be awarded DMEM.

Conclusion: The beginning of academic emergency medicine training in Nepal has been possible through cooperation with Australian and New Zealand emergency physicians. A challenge for the future will be to develop this specialty for different levels of healthcare provision throughout the country.

Papua New Guinea: Leading emergency medicine in Madang Province

Taita Kila

taita.kila@gmail.com

Papua New Guinea (PNG) graduated its first locally trained emergency physician (EP) seven years ago. Today there is a total of 10 locally trained EPs, 7 of whom are in public practice. Two more have passed their final exams in October this year, making a total of 12 EPs in 2015.

An emergency physician in Madang Province is essential for the support and continuation of already existing programs for nurses and health extension officers (HEOs) at the Nursing College and at Divine Word University. These students do their clinical practice at Modilon General Hospital. The EP is also the local supervisor for the ACEM advanced trainees who do a rotation at Modilon General Hospital.

I transferred to Modilon General Hospital 9 months ago to support the above programs.

Distribution of Emergency Physicians in PNG in 2014.

Key ★ – Emergency physician in public practice.
★ – Emergency physician in private practice.

Madang Province (yellow arrow) is located on the north coast of mainland of Papua New Guinea and has a population of 530,146. There is one provincial hospital and two district hospitals. The provincial hospital in Modilon General Hospital. It is the referral and teaching hospital and is run by the government. The two district hospitals are run by church organisations. There are 45 health centres, of which 2

are closed, and 238 aid posts, of which 65 are closed. Church organisations run 42% of the facilities.

Modilon General Hospital (MGH)

Modilon General Hospital has a bed capacity of 258 and a total of 29 doctors. All the doctors and most HEOs in the province work at this hospital. HEOs have responsibilities like doctors but are not doctors.

MGH supports two programs run by Divine Word University:

1) Advanced Diploma in Emergency Medicine (ADEM), which is a postgraduate program for nurses and HEOs. The program has been running successfully since it started in 2008. About 40 students have graduated and we expect another 10 more graduates next year.

2) Undergraduate HEO program. The ACEM advanced trainees are involved as clinical lecturers.

Some challenges in the Adults Outpatient, Accident and Emergency Department.

The building design-

There are three main areas.

- Triage Area, which is outside the building
- Acute Area, with a total of 3 beds where resuscitation is done. It also has the minor theatre and a staff room.
- The Non-Acute Area, which has a total of 9 beds. There is a plaster room, an examination room and a consultation room in this area.

The design is a barrier to ED function and affects the flow of patients. There is a narrow door that connects the Acute Area to the Non-Acute Area. It is difficult to know what is happening in the Acute Area if one is in the Non-Acute Area.

The hospital has a few projects that are under way and a redesign of the Emergency Department is in the plans.

Triage Area

Acute Area – with the door that connects it to the Non-Acute Area

Dr Rob Mitchell, ACEM advanced trainee, teaching FAST scanning

Staff Numbers

In February 2014 the medical team consisted of a consultant, a registrar and an HEO. We worked 8am to 4pm shifts Monday to Friday. After hours and weekends were on call. Nine months later our numbers have increased to eight. We now do three shifts per day resulting in improved patient care and outcomes.

The ACEM advanced trainees who do their attachments are a great help to the department. They add to our numbers but most importantly they help to improve patient care and they teach staff and students. None of our doctors have had any formal training in emergency medicine.

The nursing team consists of 8 nursing officers and 7 community health workers (nurse aids). There are only two trained acute care nurses. Nurses do 3 shifts per day.

Staff Teaching and Training

We started a weekly department continuing medical education (CME) program. The nurses are included as they do not have any such program. We also do on the job teaching when the opportunity arises.

There are few emergency trained staff so staff training is encouraged. There were short training courses throughout the year attended by our officers. One nurse will graduate in Acute Care Nursing and one will go on to do the Advanced Diploma in Emergency Medicine in 2015. Two of our doctors will go on to do the Emergency Medicine specialist program in 2015.

Resources

Vital tools that the department does not have include a defibrillator, cardiac monitor and ultrasound scan machine. The hospital has a cardiac monitor, a defibrillator and two ultrasound scan machines that we borrow. We are working towards having our own in the near future. The only lab tests that the hospital can do are haemoglobin, white cell count, malaria parasites, Widals test and cross match.

Conclusion

There are many challenges, above are a few. We have huge support from Australia in Emergency Medicine Development in Papua New Guinea. Our progress is slow but encouraging as the rewards outweigh the challenges.

Vietnam: Emergency medicine development at Cho Ray Hospital, Ho Chi Minh City

Tôn Thanh Tra*, Pham Thi Ngoc Thao**

(*) Emergency Consultant - Emergency Department, Cho Ray hospital, Ho Chi Minh City, Vietnam. Lecturer - Faculty of critical care medicine, emergency medicine, toxicology, University of Medicine and Pharmacy at Ho Chi Minh City.

tonthanhtra@yahoo.com

(**) Vice Director - Cho Ray Hospital. Chief - Faculty of critical care medicine, emergency medicine, toxicology, University of Medicine and Pharmacy at Ho Chi Minh City.

thaocrh10@yahoo.com.

Located in Ho Chi Minh City, Cho Ray Hospital is a tertiary teaching hospital in the south of Vietnam. Established in 1900, Cho Ray has 2,400 beds but has 2,600 inpatients and about 4,000 outpatients per day with trauma and non- trauma patients. It is a leading hospital in emergency medicine development in Vietnam and also the place for international medical students to study their elective courses. Emergency Medicine in Cho Ray Hospital was created over 20 years ago with an Emergency Room in the Outpatient Department, emergency staff and clinical pathways. EM was recognized by law in 2010. Since then, Vietnam health care law was approved and the Faculty of critical care medicine, emergency medicine, toxicology was established at University of Medicine and Pharmacy in Ho Chi Minh City.

The Emergency Department sees about 100,000 patients per year, of which 70-75% need hospitalization and 10% need an emergency operation. 55% have a surgical problem, 45% have an internal medicine problem. About 10-15% of patients need urgent resuscitation on arrival. The number of trauma patients is about 20,000 to 25,000 per year. The ED has the following areas: triage, general admission area, resuscitation area, cast area, isolation area and operating room. There are some medical tools like ventilators, defibrillator, ultrasound machine, Xray machine, monitoring.

The ED at Cho Ray Hospital has the following duties:

- 24/24 hours emergency services
- pre-hospital care if needed

- training for Vietnamese and international medical students, postgraduates.
- direction of healthcare activities
- international cooperation

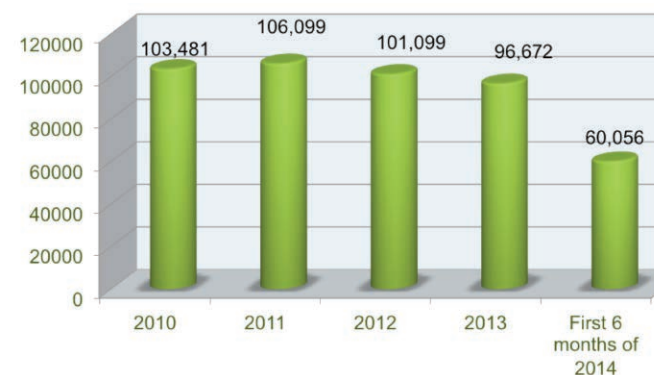
As a leading hospital in Vietnam, the ED receives many severely ill patients from many hospitals and is a place of training for emergency staff and medical students. To have a professional team is very important in our activities. To achieve this purpose, the ED and the Faculty cooperate in activities and training. We have a lot of training courses:

- continuing medical education training for lower levels of emergency staff
- continuing medical education training for staff of Cho Ray Hospital
- postgraduate education for level 1 specialty in critical care medicine, emergency medicine, toxicology
- organizing of emergency medicine conferences
- writing emergency medicine books
- researching in emergency medicine
- supporting training in emergency medicine for remote areas
- developing an emergency medicine network
- training in disaster medicine for Cho Ray staff and other hospitals in Vietnam
- contributing to the Vietnam Society for EM (VSEM).

We have published 7 articles, including ultrasound diagnosis of acute appendicitis by ED, FAST exam, ultrasound to estimate intravascular volume, mass casualty incidents, and the compliance of surviving sepsis campaign 2012 in the ED.

In 2010 Dr Tra received a scholarship from Queensland University to study for 3 months as a clinical visitor at the Royal Brisbane and Womens Hospital. In 2014 Dr Tra received an ACEM award to attend and present at the ACEM Annual Scientific Meeting in Melbourne Victoria, Australia. This opportunity generated linkages with ANZ EPs and offers of support for the development of EM at Cho Ray Hospital and more widely in Vietnam.

Numbers of patients to ED from 2010 to June 2014



The development of emergency medicine in Vietnam has some advantages and challenges:

Advantages include:

- Emergency medicine as a specialty is receiving attention from government and community.
- Emergency medicine regulations of 2009 and Vietnam healthcare law have emphasized the role of emergency staff.
- Most hospitals in Vietnam have an emergency department or emergency room.
- The Vietnam Society of Emergency Medicine (VSEM) was established 2011 and provincial associations will be established in the near future.
- Some provinces have 115 emergency centers by themselves.
- The code of training for postgraduate emergency medicine is ready.
- There is support from international organizations such as ACEM, Utah University, Good Samaritan Group, and others.

Challenges include:

- There is an overload of patients in the EDs of central hospitals.
- The overload and the limitation of personal income mean that emergency staff cannot maintain a long career in ED.
- Emergency medicine is increasingly complex and patients increasingly expect emergency staff to perform at a professional level.
- The emergency medicine system in Vietnam is not comprehensive and not uniform at all levels.
- There are no paramedic staffs in Vietnam.
- We do not have enough family doctors so that patients may come to the ED without any emergency problems. Emergency staff cannot refuse care.
- The specialty of emergency medicine is not really recognized by medical leaders and colleagues.
- Lastly, health care insurance does not cover all the population and access to the medical system is not uniform.

Future plans

To practice emergency medicine well at Cho Ray Hospital and in Vietnam, we should develop professional emergency staffs with postgraduate education. Training programs could include Specialty, Master degree, Philosophy degree in Emergency Medicine and continuing medical educations (CME), with hands-on training courses. We should have some short training courses for doctors and nurses who are working in EDs. We will try to make a training curriculum for paramedics in Vietnam to supply the human resources for pre-hospital care and medical evacuation. We must develop an emergency medicine system that is suitable for Vietnam's economic, cultural and medical circumstances. We need to develop training curricula for disaster management and we need to develop specific emergency centres for trauma, surgery, internal medicine and toxicology. To do that, we need support from internal and international organizations.

Conclusion

The emergency medicine system in Vietnam is still in its infancy and is not comprehensive. This specialty is very hard work and has many challenges. Special policies and regulations for professional development are necessary to meet community needs. The development and implementation of modern emergency medicine is very urgent in Vietnam.

An Emergency Department team – Cho Ray Hospital

PACIFIC

ELS in the Pacific

Andrew Bezzina
andybez@ozemail.com.au

2014 saw the voluntary development arm of the Emergency Life Support Course spreading into new territories and visiting old with ELSi/ SIREn and ELSn courses being held in the Solomon Islands, East Timor, Myanmar and Vanuatu. (ELSi – Emergency Life Support-international; SIREn – Serious Illness in Remote Environments; ELSn – Emergency Life Support-nurses)

The Pacific experience (the Solomon Islands and Vanuatu) was a "Tale of Two Islands" with very different circumstances in the two countries.

Solomon Islands

ELS visited the Solomon Islands in May 2014 at the request of the local clinicians after their experience with the inaugural courses in 2012. Our arrival was just as the Health System was winding down from disaster responses firstly to severe flooding which claimed many lives and left many thousands homeless and then to an outbreak of diarrhoeal illness as a direct result of the impact of the previous floods on the water supply around Honiara.

It also coincided with an AusAID sponsored review of the Emergency Department in Honiara.

Despite (or possibly because of) the obvious strain that had been placed on the clinical staff their enthusiasm and organisational support for the courses was exceptional and a real reflection of local hospitality. Solomon Islanders continue to provide an emergency medicine service in the absence of any fully trained or qualified emergency physicians. The Islanders struggle politically and from a resources perspective. In that context they demonstrated an incredible thirst for education and support.

Two courses were run in the time frame with an ELSi course provided for doctors on the Thursday and Friday followed by a SIREn course for nursing staff on the Monday and Tuesday.

The faculty for these courses were:

Solomon Islanders - Kenton Ratu Sade, Trina Sale, Patrick Toito Ona, Fletcher Kakai;

FACEMs - Phil Hungerford, John McKenzie, Greg McDonald, Andrew Bezzina (convener).

This proved a successful mix especially in the delivery of parts of the course in the local Pidgin. There is great local enthusiasm for education generally, and more specifically for the ELSi courses to continue.

Vanuatu

Vanuatu courses were delivered in December 2014 under a very different model of introduction and support. The prime driver for their delivery was from the Australian end with support from health authorities in Port Vila. This was partly funded by a grant from the International Development Fund (IDF) of ACEM and allowed for an ELSi course and SIREn course in Port Vila and a SIREn course in Luganville on Santo.

Vanuatu has only one doctor formally training in emergency medicine and he is on rotation in Port Moresby. This meant that "in country" and invested organisational support was in limited supply until very close to course delivery time. Emergency medicine in Vanuatu is even more of an orphan than is the case in the Solomon Islands.

In support of the course delivery and courtesy of the IDF grant we were able to bring the Ni Vanuatu doctor training in EM, Trelly Samuel Patunvanu, and a doctor from the Solomon Islands, Trina Sale, as faculty members to team with an Australian contingent. This concept has proven time and again to be beneficial in course delivery due to the advantages of language and cultural background.

The faculty for these courses included:

Emergency Life Support international (ELSi) course in Port Vila, Vanuatu

Serious Illness in Remote Environments (SIREn) course in Port Vila, Vanuatu

Brady Tassicker-Tasmanian; Nick Ryan - somewhere in there is a mad Irishman; Craig Wallace - Kiwi Scot; Alan Tankel - Glaswegian Scot; Vincent Russell - true Aussie; Andrew Bezzina (convener) - a mongrel. Trina Sale from Honiara was the 7th member.

The SIREn courses were delivered by the above faculty minus Drs. Tankel and Russell, who had other commitments. Trelly Samuel Patunvanu (Ni-Vanuatu) was an addition.

Whilst the courses were not fully subscribed, they were very well received by the locals, with some staff attending the courses despite working night shifts throughout. If proof was needed, these courses demonstrated how important having 'on the ground' organisational and political support is in maximising access and benefits for the participants.

As is always the case in these circumstances, the Australasian faculty continued to be impressed by the capacity of the local clinicians in these environments to deliver a service to their communities.

Fiji: Perspectives on building an EM Training program

Anne Creaton
acreaton@hotmail.com

Constructing an emergency medicine (EM) training program in another country presents challenges.

Questions that arise include:

- content: relevance to global and local disease patterns, diagnostics and treatment
- delivery: what is desirable, what is possible?
- feedback and evaluation: are you meeting the learners' needs?
- translation into practice: can they practice what they learn?

It is important to consider the risks. The emergency department is not an island and is highly dependent on a complex web of support and inpatient services. For changes to practice in the emergency space to be effective, they must gain acceptance from other stakeholders. This may take considerable time and effort but is necessary to limit conflict and improve care during the whole patient journey. Collaborating with other departments in education and quality improvement projects helps to build relationships, mutual understanding and respect. For impatient emergency clinicians the pace of change can seem painfully slow. One must persist to effect sustainable change. Patience, acceptance, tolerance and understanding of local processes and power structures are essential. Trust is key and local skepticism is understandable in places where many visit and look but few stay and help.

Structures and Fluidity

Universities and hospitals provide structures for training. These structures may not be as straightforward or as robust as they appear. Navigating foreign structures and discovering how things work requires a degree of cultural assimilation that cannot be rushed

L to R: **MIMMS course - with representatives from fire, ambulance and police | MIMMS course – communications practice.**

and should not be underestimated.

A training program requires structure to ensure essential material is covered, yet must be flexible and adaptable. Be prepared to take on a sea of interrupting forces that will challenge your program structure such as:

- conflict with service provision (minimal staffing with no cover for annual leave or sick leave)
- visiting clinicians who wish to teach their pet topics
- the need to provide outreach education to other clinicians providing emergency care in the region
- addressing sentinel events, complaints and quality issues as they arise

Teaching on the run during ward rounds is extremely effective in an environment where there is a wealth of interesting clinical material. It addresses translating knowledge into clinical practice and allows insight into the thought processes and behaviours of an experienced emergency medicine practitioner. However, relying on this alone is likely to leave significant gaps, particularly with the less common but significant emergency presentations.

Asynchronous e-learning materials are good for motivated students doing shift work. Opportunities to reinforce case based learning using web based resources such as podcasts and blogs provide summaries of the evidence base for your teaching points. The FOAMEd (Free Open Access Medical Education) movement has provided numerous opportunities to interact with experts around the world and facilitated teaching visits from respected educators. It also provides a sense of community and support, which can help in times of uncertainty and isolation.

SMART Goals

Developing emergency care can feel like an overwhelming task. It helps to pick key areas for improvement. In Fiji trainees are allocated an area to manage as a portfolio, which teaches leadership, organizational and change management skills. It combines the academic and departmental development agendas by encouraging the review of existing evidence, writing guidelines and conducting research. Portfolios require clinicians to meet with those from other departments, hence developing important collaborative relationships for quality improvement.

Examples include asthma, trauma, cardiology, paediatric emergency medicine.

Goals should be

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**ime limited.

Emergency Medicine in Fiji has started. So where to now?

Commencing a training program is just the beginning. Embedding sustainable systems is the next challenge.

“Making systems work is the great task of our generation.” (Atul Gawande)

It is time to make the shift from being the go-to person to creating a team of go to people.

PNG: Update on Emergency Medicine in Papua New Guinea

Colin Banks
colinbanks@yahoo.com

The year 2014 has been significant for emergency medicine (EM) in Papua New Guinea (PNG). Changes to the training program are afoot, there are two newly graduated emergency physicians and there is now EM being practiced at specialist level in four provinces.

In PNG all specialty training is administered by the University of PNG towards Masters of Medicine (MMed) degrees. The first year of MMed (EM) has been spent as a surgical trainee, working as a surgical registrar and sitting surgical first part exams. This has been necessary until now, but as of 2015, the first year will be spent as an emergency registrar working in Port Moresby General Hospital and there will be an emergency medicine specific first part exam. This will mean more accredited trainees present in the emergency department (ED), which should improve morale, develop a more academic culture and ultimately increase the standard of care. An emergency medicine first part will be more relevant to the future emergency physicians of PNG.

Dr Bobby Wellsh being assessed by a multitude of examiners

Locations of PNG’s emergency physicians (6 in Port Moresby)

Congratulations to Bobby Wellsh and Dennis Lee who were successful in completing their final exams in November. They are both excellent practitioners who are highly motivated to continue the development of EM. With them both remaining in Port Moresby, they will be able to contribute greatly to the expanding teaching programs within the ED.

With only one or two emergency physicians graduating each year, the spread to the provinces has been slow and steady. Taita Kila went to Madang to provide relief for Vincent Atua who has been studying in Brisbane. In addition to running the ED there, she has also been able to provide supervision for the Visiting Clinical Lecturer program, filled by ACEM advanced trainees. Alex Peawi has moved to Lae, PNG’s second largest city, and has even managed to become quite prominent in the national media. Julius Plinduo is based at Kiunga in Western Province.

The Visiting Clinical Lecture program is an opportunity for ACEM advanced trainees to spend six months doing an accredited term in Madang. It is an innovative role with time spent teaching Health Extension Officers through Divine Word University as well as time spent in Modilon General Hospital in Madang. It has been found to be an extremely rewarding experience by all ACEM trainees who have done it thus far, most recently Dr Rob Mitchell. It is now linked with Australian Volunteers International who provide additional in-country support. If any trainees are interested, the contact is Georgina Philips at drgeorgina@gmail.com.

Other developments this year include the launch of a website by the South Pacific Society for Emergency Medicine at www.spsem.net. While some parts of it are under construction, it is an interesting insight nonetheless. This is complemented by Zafar Smith’s site www.emergencymedicinepng.com. (Zafar is a Brisbane-based ACEM trainee.)

Taita Kila was fortunate enough to be sponsored by

ACEM to come to the Annual Scientific Meeting in Melbourne just recently. She made an excellent presentation, met some great people and then went on to do an ultrasound course courtesy of St Vincent's Hospital in Melbourne. Thanks to everyone at ACEM and St Vincent's who facilitated this.

No-one quite knows what 2015 will hold in store in the 'land of the unexpected'. There are the new changes to the MMed(EM), some excellent trainees sitting the part two exam, and the EM community is involved with the South Pacific Games to be held in Port Moresby in July. There are some opportunities to get involved, particularly with teaching in Port Moresby, although the logistics can be challenging.

If you are interested then contact either myself at colinbanks@yahoo.com or the Chief Emergency Physician, Sam Yockopua at nungasyockus@yahoo.com.

Vanuatu: Wins for emergency medicine in Vanuatu

Brady Tassicker
brady.tassicker@ambulance.tas.gov.au

The past year has seen some significant wins for emergency medicine in Vanuatu. The long-awaited new emergency department (ED) in Vila Central Hospital, the tertiary referral hospital, has been completed (more on this later). The first ever Ni-Vanuatu emergency medicine registrar, Trelly Samuel Patunvanu, is progressing well through his training, and is due to commence employment in Canberra in 2015, after which the final barrier to completion of his specialist EM training will be the examinations for MMedEM of UPNG. And an IDF grant from ACEM was used to run the inaugural ELSi and SIREn courses (see report by Andrew Bezzina in this newsletter). All of this has undoubtedly helped raise the profile of emergency medicine within Vanuatu.

The Japanese government donated a new hospital wing, with construction finished earlier this year, and the Outpatients and ED have only recently moved into this new facility. The comparison with the old one is fantastic. Emergency care in Vanuatu, as in much of the world, continues to function as though outpatients and emergency medicine were separate entities, assuming that patients have enough health literacy to know how urgent their clinical presentation is. The blurring of these boundaries was compounded in the old department by the mingling of patients in a dark and poorly ventilated corridor, which confused patient flow.

The new layout continues this separation of outpatients and emergency, but in a way which is much more functional. There is a large open-air waiting area for outpatients, and flow of patients is well controlled by the layout of doors and rooms. Outpatients backs directly onto the ED, facilitating ease of transfer of patients between the two.

The ED itself is spacious, well ventilated and well lit. The department is well resourced, with dedicated barouches, monitors, and portable X-ray machine.

The model of care across both departments is unchanged: nurses and nurse practitioners with no dedicated medical staff. This reflects a shortage of medical staff generally, across the nation.

Even this shortage is likely to change in the near future. There are a large number of Cuban-trained Ni-Vanuatu medical students due to start their internships in Port Vila over the next couple of years. This influx of medical staff will inevitably improve the staffing model for the ED, and hopefully include some emergency physicians of the future.

The next project being tackled involves trying to bring the inaugural Emergency Management of Severe Burns course to Vanuatu. As with any project in this environment, there will undoubtedly be challenges in realizing this. The lessons learnt from preparing the ELSi and SIREn courses will prove invaluable in this.

Current development needs are broad. Any visiting delegation is most likely to be successful if it includes both medical and nursing representation. If anyone is interested, please contact me on the email address above.

New Outpatients and ED waiting area – Vila Central Hospital

New Emergency Department entrance

Resuscitation facilities

SOUTH EAST ASIA

INDONESIA
Bali and Lombok: the Methanol Education Program

Di Brown
dibrown456@gmail.com

Building on the work done in 2013, in 2014 two streams of educational programs about methanol poisoning were developed: one focused on community education (for the general community and primary health centre staff) and the second for clinical staff within hospital settings. The programs are managed by the Lifesaving Initiatives About Methanol – LIAM - Charity, based in Western Australia, which works collaboratively with selected staff from both Sanglah Hospital and the Public Health School at Udayana University in Bali. The clinicians from Australia are Di Brown RN (coordinator of the Sister Hospital Program between Royal Darwin Hospital and Sanglah Hospital) and Malcolm Johnstone-Leek FACEM from the National Critical Care and Trauma Response Centre (NCCTRC). Mark Monaghan, FACEM toxicologist, provides long distance advice and mentoring from Perth. Funding has come from NZAid, the LIAM Charity, the Methanol Institute and the NCCTRC.

https://www.facebook.com/pages/Lifesaving-Initiatives-About-Methanol-LIAM/389335401165731

http://indonesiaexpat.biz/other/lifesaving-initiatives-against-methanol/

http://methanol.org/blog/?p=407

http://www.methanol.org/

The community education program has initially focused on 14 villages and 12 community health centres in the regions in Bali where the most arak-poisoning deaths have occurred. Initially the communities were suspicious about the motives for the program as they suspected the aim was to close the arak production down. To engage the local communities, Bondres - traditional Balinese folk dance - is used to convey the messages about methanol poisoning. This has been well received and the attendance at the workshops has been good.

Information is also provided by social media and local and national TV and newspapers, etc.
The clinical education program has targeted the major public hospitals and the main private hospitals in both Bali and Lombok.

To date over 1000 people have received education about recognition and treatment for people who present with methanol poisoning. The program is very relevant and topical as 117 people were poisoned in western Java before Christmas 2014 and more than 25 of them died.

Bondres – telling the story with folk dance

Di Brown is interviewed by Bali TV during a workshop in Badung.

In December 2014 a workshop of key stakeholders - from public health, food and liquor, tourism and police - was held at Udayana University to discuss the issues surrounding methanol poisoning. While all participants were willing to support the treatment options that are available they are not able to do so until there is written approval and a standard operating procedure received from the Ministry of Health in Jakarta.

In 2015 the following is planned:

1. continue both streams of the education program in Bali and Lombok;
2. provide a national seminar in Jakarta to key policy and educational stakeholders with a view to getting changes in standard operating procedures for patients with methanol poisoning;
3. Malcolm Johnston-Leek and an emergency nurse from the NCCTC will come to Lombok for 2 months to work in the main Provincial Hospital to train emergency staff and first responders there;
4. develop a position and training program in Java;
5. send suitable staff to Australia for training in triage and assessment of patients presenting to EDs (this will require funding).

There is no emergency medicine specialty in Indonesia and patients suffer because there is no systematic triage and assessment process and because EDs are staffed by the most junior doctors. Opportunities for emergency physician involvement exist in EDs across the archipelago, but the development of any program will require careful negotiation and the systematic building of relationships. Di Brown is happy to be of assistance.

The methanol team at a workshop in Lombok.

Montage from a workshop. Malcolm Johnston-Leek responds to questions from army medical personnel

Myanmar: Royal Children's Hospital in Melbourne supports Myanmar

Simon Young
simon.young@rch.org.au

The opportunity to host an overseas colleague in your ED is both a privilege and a pleasure, with the potential for both parties to gain significantly from the experience.

Last year I and the ED team at the Royal Children's Hospital (RCH) hosted Dr Aye Thiri Naing, a consultant paediatrician from the Yangon Children's Hospital (YCH) who had just finished the training program for DipEM supported by ACEM. We were lucky in that we already knew Aye Thiri Naing, having been to Yangon and taught with her the previous year. We had also been to her hospital and department and had a good understanding of the challenges she faced in developing paediatric EM in Myanmar. We were pretty certain that we could provide a professionally and socially successful attachment for her. Achieving a successful attachment, though, takes a bit of planning, and having done this a few times now, I would like to share a few thoughts:

"The right person to the right place at the right time" principle is key. Aye Thiri Naing was indeed the right person: highly motivated, smart, committed to EM and in a senior position in the ED of the YCH. Knowing whether the proposed visitor is the right person can be difficult, especially if you have not met them. Personal references and recommendations are helpful but my advice is always meet them first if possible.

Were we the right place? Well of course my totally unbiased and objective opinion is "Yes"!!

Realistically though, many institutions around the world could have hosted Aye Thiri Naing successfully in a professional sense. What made Melbourne different was the social links that she already had here, specifically with people like Shona McIntyre and Michael Augello who had spent an extended time in Yangon. Clearly a comfortable, relaxed, interactive guest who feels welcome will absorb far more than the alternative.

Professionally at the RCH we could offer Aye Thir Naing the chance to see a lot of what she had asked for. There were examples of clinical medicine, triage, trauma team function, critical incident management, debriefing, registrar teaching, clinically based research, and a whole range of other ED functions. Not all of these would be immediately relevant to her department in Yangon but maybe some would be, maybe some would be aspirational and maybe she would see some things best avoided!! We were certainly aware the RCH could be seen as being too tertiary, too high tech, too well resourced to be of use, so visits to other hospitals in Sunshine and Geelong were organised to give balance.

And finally it was the right time. Emergency medicine in Myanmar, although still embryonic, was developing quickly with backing from the Government, ACEM and other professional bodies. People of influence and leadership were realising the benefits of an effective ED with well trained staff and strong leadership. Paediatric EM needed early support and strong leadership so as to not lag behind, as it has in a number of countries. Aye Thiri Naing and her department were ripe with opportunity!!

Having got the right person to the right place at the right time, the rest is forms, funding, logistics, forms, committees, visas, and of course more forms. Each institution and State has different rules and regulations, none of which are insurmountable, but to carry it off does take a bit of knowledge, time and persistence – which of course an emeritus director like me has aplenty.

Thailand: Emergency Medicine update

Jonathan Knott
jonathan.knott@mh.org.au

Thailand has a well established medical system befitting its relatively strong economic position. There is a mix of private and public practice and most medical specialities are represented. Universal health care is provided and the Ministry of Public Health oversees more than 1000 hospitals. Training is typically conducted along a mix of models consistent with Western Europe and North America.

Whilst there were casualty departments and a nascent pre-hospital service, there was no speciality of emergency medicine until the mid-2000s. This changed as a result of the 2004 Boxing Day South Asian tsunami that devastated the local Indonesian province of Aceh but also gravely affected many nations on the Indian Ocean boundaries. The Thai government, recognising the gap in their medical services, tasked the Thai Association for Emergency Medicine (TAEM) to fast-track the development of emergency medicine (EM) as a speciality.

Following contact with ACEM, Dr Somchai Kanchanasut and Dr Pairoj Khruekarnchana teamed up with Associate Professor Marcus Kennedy and Dr Don Liew at Royal Melbourne Hospital (RMH) to win the first of several AusAid grants to help fund the development of Thai EM.

The program included:

- A 12 month project (2005) to bring the current Thai leaders in the nascent specialty of EM to RMH to be taught about the specialty, its governance, administration, research and teaching.
- A follow-up project (2007) for the current cohort of advanced trainees, those doctors destined to become the first graduates in EM in Thailand.
- Establishment of a Thai Emergency Medicine residency program. This has been supported with teaching and research forums by Australian faculty.
- The first Thai / International Emergency Medicine conference, held in Bangkok.

The initial program culminated with the 1st Thai / International EM conference. The local response was overwhelming with attendees far out stripping expectations. Less surprising was the willingness of key speakers to come from around the globe to support the development of their specialty in a new country.

2010 CRM course faculty and students

Relationships have been maintained with on-going support for the resident research conferences, workshops in crisis resource management and direct teaching when in country. Many of the original expatriate supporters have continued to stay closely involved and many FACEMs have devoted time to assisting the Thai association fully develop their specialty. As well as alumni from RMH, contributors include Glenn Harrison, Sol Zalstein and Alastair Meyer; fellows very familiar to IEMSIG include Anne Creaton, Marian Lee and Shane Curran.

Given a strong foundation, support from government in both Australia and Thailand and the enormous enthusiasm of the Thai doctors, it is unsurprising that a fully fledged speciality has been established so quickly. The future of EM in Thailand involves the consolidation of specialist numbers as there is currently only a handful in the country. With many active residential programs this will soon be rectified but current demand is high. Thailand is also well placed to be a regional leader in EM. Thai consultants have been active in support for the speciality in neighbouring countries. Several of these are likely to have a slower rate of development but should be greatly encouraged by what has been achieved in Thailand.

Dr Pairoj in the Sim Centre

Rajavithi Hospital ED, Bangkok

Timor Leste: An update from Dili

Antony Chenhall
chenhall.aj@gmail.com

I am now into my 4th year living and working in Dili, Timor Leste (in two stints since 2009), long enough to see a number of changes.

The Timor Leste health system now is very different to 5 years ago and one of the more obvious changes is the number of Timorese doctors. There are currently approximately 850 Timorese doctors which is almost a 20 fold increase since 2009 and this great opportunity (and great challenge) has driven changes to the program I work for. The program goals are still around postgraduate medical education, strengthening in-country medical education capacity and hospital Quality Improvement but the program (at the request of the MoH) now has much more of a focus on Post Graduate Year 1 – 2 junior doctor education. QI (the systems change stuff) is still happening in the ED and elsewhere and it is still hard and still limited by systemic factors including accountability that need a hospital wide (or wider) approach. Maybe 2015 will be the year the ducks line up for some of that. Working towards those ducks line up is probably the most important and effective thing to do from a QI point of view, even if technically some would not see it as QI.

In the ED there are more medical staff and some show an interest in staying in ED. Dr Todi will go to PNG for MMedEM next year, so there is a long term plan for department leaders. So a big shout out to Colin Banks!

The major collaboration with Australasian FACEMs this year has been in starting ELS courses, with the ELS course forming a component of the junior doctor training program. We had 2 visits from ELS trainers this year. The plan is for two more next year. And a big shout out to Phil Hungerford and the ELS team!

Also a big thank you to the SMACC Gold team for live streaming the conference into Timor Leste.

My role in the team has changed. I am now team leader for a team of five specialist expatriate clinicians covering ED (me), anaesthesia, surgery, obstetrics and paediatrics. The much greater program planning, implementing and managing responsibilities do take some time away from ED work but I still manage to get time in the ED every day. Personally, the program redesign and team leader position has led to a big learning curve on program design, monitoring and evaluation (M&E), etc, also the ways of Department of Foreign Affairs and Trade, so I feel professionally enriched - and a bit tired.

Socially, Dili is a great place for family life with good beaches in town and fantastic beaches nearby. The cycling in the nearby hills is great. And every year as Dili changes and builds the hassles of domestic life are reducing.

Antony Chenhall is Team Leader, Australia Timor-Leste Program of Assistance in Secondary Services (ATLASS II). This is an Australian Government funded program, delivered by the Royal Australasian College of Surgeons (RACS) at Hospital Nacional Guido Valadares, Dili, Timor Leste.

Phone: +670 7756 2340. Skype: chenhall.aj

Vietnam: The Alfred-Hue Emergency Care Partnership Project

Gerard O'Reilly
oreillygerard@hotmail.com

The Alfred-Hue Emergency Care Project was delivered by the Emergency and Trauma Centre staff of the Alfred Hospital in Melbourne, in Hue, Vietnam in 2013 and 2014. The completion of this project was made possible through the generous support of the ACEM International Development Grant (2013).

Emergency medicine is only just beginning to develop in Vietnam. In March 2010 the first annual Vietnam Symposium in Emergency Medicine was held in Hue, Vietnam. In April 2012 two Alfred Hospital Critical Care Nurses visited Hue University Hospital emergency department to provide training. Hue University Hospital has 300 beds and is usually overcrowded.

Important gaps identified within the emergency department during a 2012 visit by Alfred emergency staff, included: no triage system; no systematic assessment of patients; a lack of emergency medicine and emergency nursing knowledge; the under-utilisation and maintenance of equipment; and limited education programs.

The primary aim of the Alfred-Hue Emergency Care Partnership Project was to develop the capacity to improve emergency care in Hue. In September 2013 and again in February 2014, Alfred teams of two emergency physicians and two emergency, critical care trained nurses delivered two week programs in Hue University Hospital and Hue Central Hospital. For each visit, there were more than twenty emergency medical and nursing participants. Following the delivery of the Alfred Emergency and Trauma Team Training Manual, translated into Vietnamese, the program consisted of predominantly emergency department bed-side training with a two day formal training component. The focus of the program was on emergency triage and the systematic and team-based approach to managing the seriously ill or injured patient. There was large emphasis on scenario-based and real patient-based learning. Evaluation was conducted via written examinations, with formal and informal observation of emergency scenarios. Self-rating questionnaires demonstrated that the all participants believed they had improved across the key skills in managing the critically ill or injured patient.

In addition to the delivery of the Project in Hue, one emergency physician and two emergency nurses also attended the annual emergency medicine conference for 2014, this time at Cho Ray Hospital in Ho Chi Minh City in early March, where the Alfred team joined with a large, predominantly U.S.A. faculty and delivered skill stations focused on the team-based approach to the assessment and management of the severely injured patient.

The Project was also an excellent opportunity for collaboration between the key emergency care stakeholders in Vietnam and emergency physicians and emergency nurses from Australia. It is intended that there will be further engagement in the near future in an effort to further develop emergency care capacity in Vietnam.

ASIA and MIDDLE EAST

Mongolia: The Initial Emergency Care Program

Simon Smith
simonmartinsmith@gmail.com

Following the success of recent programs delivered in Mongolia, the IEC (Initial Emergency Care) Program is planned to be delivered in Mongolia again in 2015. As previously described, the program is a 3 day course given to soum (rural) doctors to introduce the concept of emergency medicine as a discipline as part of a developing Mongolian Health Network. The program is structured similar to other courses in that there are a combination of lectures and workshops delivered on core emergency medicine topics relevant to Mongolian Healthcare. This program has backing from the Mongolian Health Ministry and is hopefully going to expand into something more detailed and permanent in the future. IEC is run in conjunction with other similar projects in the fields of anaesthesia, obstetrics and gynaecology.

We are looking for interested FACEMs to help develop and expand the program. In 2015 it is planned that two teams will travel to Mongolia in mid June to deliver the course in two separate Aimags (regional centres) concurrently. Previously the courses have been challenging to deliver due to language difficulties, however they are incredibly well received and fun to be part of. The Mongolians are incredibly appreciative of the efforts that have been made thus far, and ensure that in any spare time the true Mongolia is experienced.

It is an exciting time to be involved in a program that will hopefully evolve into much more in the coming years. I look forward to hearing from anyone interested, and am happy to be contacted if you have any questions.

Nepal: Australian and New Zealand EPs support the first specialists

Chris Curry
chris@chriscurry.com.au

The ACEM Annual Scientific Meeting in December 2014 saw Ramesh Maharjan, one of the first two EPs in Nepal, present on “Nepal graduates their first emergency medicine specialists”. (See his abstract in this issue.)

This is the outcome of many years’ work, some of which has been chronicled in IEMSIG Newsletters since 2007 (see below).

The three years of the Doctorate of Medicine in Emergency Medicine program of the Institute of Medicine at Tribhuvan University have been supported by a large group of Australian and New Zealand emergency doctors. Contributions varied from days to months, all making a difference.

Ramesh Maharjan and Ajay Thapa, the first two emergency physicians in Nepal

Thanks are extended to Sanj Fernando, Peter Freeman, Adrian Goudie, Jamie Hendrie, Joanna Koryzna, Tony Mattick, Mark Monaghan, Tom Morton, Guru Nagaraj, Mike Nichols, Brian O’Connell, Jennifer Rush, Athol Steward, Ryan Tan, Ros Taylor, Kavita Varshney, Gina Watkins, Merle Weber.

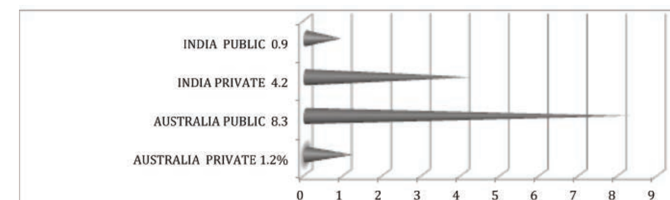
Articles relating to EM in Nepal can be found in the following issues of the IEMSIG Newsletter:

- Volume 3 / Issue 2 / April 2007
- Volume 5 / Issue 1 / May 2009
- Volume 7 / Issue 1 / April 2011
- Volume 7 / Issue 2 / December 2011
- Volume 8 / Issue 2 / December 2012
- Volume 9 / Issue 1 / July 2013
- Volume 9 / Issue 2 / December 2013
- Volume 10 / Issue 1 / July 2014

India. Emergency Medicine training in India: Public and Private

Pankaj Arora and Anita Bhavnani
panaashray@me.com bhavnani.gaem@gmail.com
Global Academy of Emergency Medicine

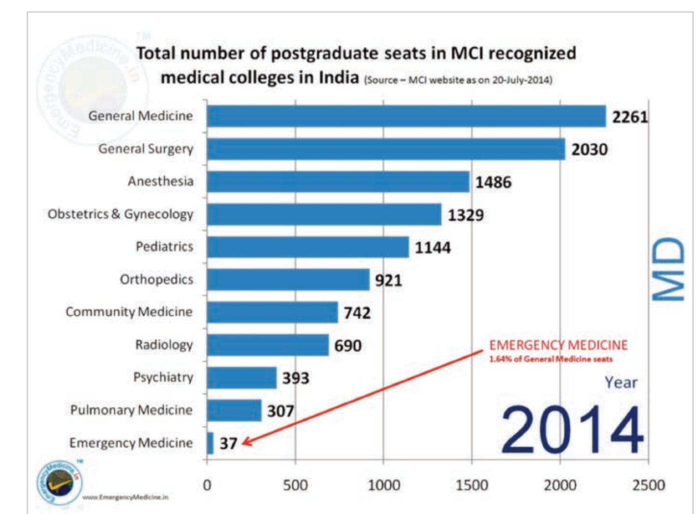
The majority of the health dollars spent in India goes to the private sector and helps the disproportionately small wealthy population. The World Health Organization estimates that only 0.9 % of GDP is spent by India’s government on health in the public sector whereas another 4.2% of GDP is spent on private health care. In comparison, 8.3 % of Australia’s GDP is spent in the public health sector while 1.2 % of GDP is spent in the private health sector. In other words, if an Australian spends a dollar for health, the government spends 8 dollars; if an Indian spends a dollar on health, the government spends 23 cents.



Medical training in India occurs both in the public and the private sector; and hence there are government and private hospital training programs.

There are approximately 43,000 graduates from medical school annually however there are only 17,000 openings for residency training. Of all the residency seats only a fraction of them are recognized by the national certifying bodies in India, the Medical Council of India (MCI) and the National Board of Examinations (NBE).

Emergency Medicine has now been recognized as a specialty by both medical certifying bodies. There are MCI- and NBE-recognized seats in several residency programs that are conferring a recognized qualification on these graduating residents, although the numbers are paltry. The rest of the residents pass through the residency programs with the same training but with no qualification.



The private sector, motivated by international standards, prestige and financial gain, leans towards offering cutting edge medicine and the concept of acute care medicine, both in Intensive Care Medicine and Emergency Medicine, has become quite popular.

With regards to EM, the private sector has involved international interest groups and foreign universities to create quality EM training. These programs are graduating well-trained physicians many of whom have become the leaders of EM in India and are instrumental in maturing the specialty, however these doctors have no national recognition or qualification. The debate in the EM academic community centres around the value of having the private system of training which is putting out increasing numbers of well-trained but unrecognized EPs, while the nationally-recognized tracks are producing such small numbers of EPs that it may very well take more than a century to have half the number that India requires.

Public training boasts large numbers of patients conferring vast experience. The environment however is often chaotic and overwhelming because of sheer volume and dearth of resources. Due to the lack of primary care medicine in this population, many patients present to the ED with primary care issues and the admission rates are as low as 25% in many institutes. The supervisor to trainee ratio is mandated at 1:2 by the certifying bodies, but there are few EM-trained supervisors. Residents have the opportunity to do many procedures, however the training is under-resourced, often leading to lack of equipment available for procedures. Since the graduates of these programs will hold recognized qualifications, they will get prestigious postings and will have the opportunity to continue in academic emergency medicine.

In the private system, the numbers of patients seen in the ED are much lower (per hospital) than in the public system, as low as one tenth of the numbers seen at a government hospital, with most of the patients being referred or transferred patients. Admission rates are higher, in concurrence with the acuity, however there is significant attrition of admitted patients because of high cost. These EDs usually have state of the art equipment and other specialists that are eager to see patients and take admissions. There are many private training programs that have international faculty and training in international practices. These graduates most often do not get national recognition or qualifications by the MCI or the NBE, but are finding well paying jobs nationally and internationally.

Distribution of training positions

Programs in Private System

DNB Emergency Medicine
MD Emergency Medicine
International MEM
Training initiated by local organisations
FEM

Programs in Public system

MD Emergency Medicine in
JIPMER Pondicherry
AIIMS Delhi
7 other government medical colleges

Major organisations involved

National Board of Examinations
Vinayaka Missions University
Sri Ramachandra Medical College
CMC Vellore
George Washington University
SUNY Upstate Medical University
University of Maryland
North Shore LIJ
SEMI
American Academy of EM India
Global Academy of Emergency Medicine

The question remains: Do we need both types of programs? And which is better? The follow up question is: what does better mean? Does better mean better quality training? Better in the number of graduates trained? Better income opportunity and status for the graduates?

The Global Academy of Emergency Medicine (GAEM) is an academic endeavour of the American Academy of EM in India (AAEMI) and has been able to collaborate with more than 40 EPs from ACEP, ACEM and CEM (UK), as well as several US University-based programs, to commit to capacity building in India. The training programs supported by GAEM are Mission Hospital Durgapur, Apollo Hospital Calcutta, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER) in Pondicherry. GAEM is also working with PGI in Chandigarh and Dayanand Medical College to promote EM and to build capacity.

There are several ways FACEMs can get involved:

1) participate in conferences
2) participate in short courses
3) approach individual organisations involved
4) become a GAEM Faculty Scholar: www.globalacademyem.org/faculty-interest.html

Sri Lanka: Emergency Medicine in Sri Lanka has progressed since my last report

Shane Curran
Shane.Curran@gsahs.health.nsw.gov.au

The second intake of trainees has occurred to the MD in EM program, with the first intake now in their third year of training.

There is a nationwide EM strategy by the government, with an extensive building program across the country of new EDs financed by The World Bank.

Ongoing education from international faculty is now established. There are monthly video tutorials facilitated by Nilantha Lenora, an American EP. He is also organizing a mentor program for EM trainees.

Emergency Life Care courses

There have now been 6 sessions of the Emergency Life Care course run, with the 200th candidate passing in November 2014, including a doctor from the Maldives. November saw the first course to be run in Jaffna, with local medical staff indicating a firm desire for the course to be run there again. Apart from the mannequins we now have a full set of equipment based in Sri Lanka owned by the SSCCEM, allowing portability of the course. Plans for 2015 include taking the ELC course to Galle, and in the second sessions in October taking it to the East Coast.

SSCCEM

Activities by the Sri Lankan Society of Critical Care and Emergency Medicine (SSCCEM) continue. In November 2014 there was a very successful Annual Scientific Meeting, with Professor Tony Brown delivering a keynote lecture via Skype from his living room! The SSCCEM ASM in 2015 will coincide with the October sessions of the ELC course and again involve overseas faculty. Preliminary discussions are being held regarding running an ATLS course in conjunction with that ASM.

The SSCCEM has been invited to participate in the Sri Lankan Medical Association annual meeting in July 2015 and Sally McCarthy has agreed to talk on behalf of the Society as the international speaker.

I have recently had contact with the EPs in the Maldives about supporting their education efforts.

As always, I am keen to involve anyone who wishes to help. Opportunities include coming to Sri Lanka and teaching and/or talking at the SSCCEM ASM, or from home contributing to video tutorials and to the mentoring program. At the moment we are short of mentors.

Qatar: Emergency Medicine update

Shinu Varughese
drshinuvarughese@gmail.com

Emergency medicine in Qatar has evolved rapidly in the last decade. The primary focus of EM in Qatar is the EDs of Hamad Medical Corporation. The ED at Hamad General Hospital is the largest in Qatar, in the largest tertiary care facility. The daily attendance stands at around 1500 patients, with around 200 highly qualified emergency physicians from around the world currently headed by Professor Peter Cameron FACEM. Besides patient care, health care education and research is of paramount importance. A residency training program accredited by ACGME (Accreditation Council of Graduate Medical Education, USA) and a postgraduate fellowship training program both play a significant role in developing highly qualified emergency physicians to guide and support emergency health care in Qatar into the future. Emphasis is on the delivery of care that is on a par with that in other developed countries of the world. The ED aspires to be a centre of excellence in the region for healthcare delivery and medical education.

Shinu Varughese is an Acting Consultant, ED, Hamad Medical Corp, Doha-Qatar

Israel: Towards a national training program

George Braitberg
George.Braitberg@mh.org.au

Israeli physicians have considerable expertise in blast and penetrating trauma, burns and other injuries of war and terror. Israeli traumatologists such as Katz et al have even published on the likelihood and prevalence of injury after a bomb explosion on a civilian bus. In the past, Israelis have interpreted trauma medicine as the equivalent of emergency medicine thus hampering the development of the specialty. However, for every person injured in a peguah or war there are many thousands that present to emergency departments all over Israel with the same conditions that are treated in our departments in Australia; infarcts, strokes, respiratory diseases, UTIs etc. The Israeli Emergency System must provide for the day to day needs of its population as well as maintain a readiness to deal with the sad reality of terrorism and war.

Halperin et al reported in the British Medical Journal (2004) that there were 27 EDs in Israel providing care for 2.3 million annual ED visits. At that time most EDs were staffed by a small number of physicians who called themselves emergency doctors, with most of the staffing provided by doctors rotating from other specialists with diverse training backgrounds. On-call residents from medical and surgical departments, often without direct supervision, were responsible for all patient care related decision-making after hours and on weekends. In 2014, little has changed; EDs remain compartmentalised with specialties such as internal medicine, paediatrics, obstetrics and gynaecology, general and orthopaedic surgery running independent and autonomous emergency rooms. The patient with an inferior infarct presenting with epigastric pain might find himself or herself being cared for in the surgical ER by a surgical resident.

In the background, however, there has been significant change, culminating in the adoption of a national training curriculum by the Ministry of Health in late 2014. This has been driven by the Israeli Association for Emergency Medicine (IAEM) formed in 1992. Emergency Medicine (EM) was recognised as a "super-specialty" in 1999. To become an emergency physician in Israel, a board certified physician in internal medicine, general surgery, anaesthesiology, paediatrics, orthopaedic surgery, or family medicine is required to undergo further training in EM. Thus, the EM resident is a specialist being "retrained" in the discipline of EM. Until now the EM training provided was by an academic institution or health service with no consensus on what to teach and what level of knowledge should be sought from the trainee. The delivery of care to patients was potentially as fragmented as the courses offered to doctors interested in pursuing a career in EM.

With the adoption of a National Curriculum, all Israeli EM trainees must complete the recognised two year modular Fellowship in Emergency Medicine. It is now possible for physicians who choose EM to enter directly into the speciality without being boarded in another. There are currently nearly 50 trainees across Israel enrolled in the "direct" pathway.

I have been fortunate to work with a number of talented and passionate Israeli EPs in writing the National Curriculum for Emergency Medicine. It is built upon the Australasian curriculum and is competency based. The aim of the curriculum is to ensure that all EPs trained in Israel achieve competency in each of the core skills listed below:

1. specialty specific skills
2. personal and interpersonal skills
3. systems based practices
4. research and academic skills
5. managing emergency scenarios
6. core emergency medicine knowledge

Over the 2 years, the course is delivered in 40 sessions with 240 contact hours via a combination of half day and full day seminars and workshops. The course director is Debra West (from Ichilov Hospital) assisted by content coordinators and theme leaders from across Israel. Three of the 12 theme leaders spent up to 18 months training with our own trainees at Monash Health and have returned to Israel in leadership positions; Moshe Sharist as Director or Woolfson ED, Ariel Bentacur, senior leader at Tel Hashomer ED, and Merav Slotky, soon to take up the position of ED Director at Kfar Saba Hospital.

The IAEM have an annual conference before Pesach each year and I would encourage anyone interested to attend. For further information I would be happy to be contacted. The current President of the IAEM is Aziz Darwashe, Director of Hadassah Hospital ED.

I must acknowledge the considerable assistance of Danny Beneli, EP at Monash Health, who has been instrumental in developing the links to EM specialists in Israel and mentoring the Israeli EPs who have come to work in Australia.

Katz E, Ofek B, Adler J et al. Primary Blast Injury After a Bomb Explosion in a Civilian Bus. Ann Surg. Apr 1989; 209(4): 484–488

Halperin P, Waisman Y and Steiner IP. Development of the specialty of emergency medicine in Israel: comparison with the UK and US models Emerg Med J 2004;21:533-536

George Braitberg and Moshe Sharist, Director of Woolfson ED (South Tel Aviv)

George Braitberg, Aziz Darwashe, Director of Hadassah Hospital ED (Jerusalem), and Danny Beneli

EUROPE

Hungary: The study of Oxyology and Central European challenges

Peter Thompson
pkthompson@mac.com

Hungary is a landlocked central European country that is full of the charm of old Europe together with the challenges of developing a functional democracy. The population of the country is about ten million with approximately a fifth being based in Budapest- the capital. The current political environment is challenging with a growth in the right wing, nationalist sector. From a political historical perspective Hungary, along with several of the Central European countries, is currently struggling with its transition between the European Union and a growing Nationalist movement. The current concern is that aspects of Nationalist intolerance will rise again. Several Health and Community groups are emphasising the importance of strong advocacy across healthcare for equality, and access to care has been seen as important.

Across Europe there are several differences in systems provided but there is an overarching organisation, EUsEM (European Society of Emergency Medicine), that works to ensure suitable collaboration and sharing of focus/ vision across the different systems. There is now a European Fellowship exam for Emergency Medicine and trainees within Hungary are able to work towards this. Currently EM is not regarded as a specialist practice in its own right and most departments are linked to Anaesthetics and ICU as part of a Critical Care hub. The ability to develop doctors interested in acute and emergency care is difficult owing to the lack of structure in training and the limited number of specialists available. I have had the opportunity to spend two separate weeks last year in Budapest to assist with some of the prehospital education provided for the first response paramedic teams as well as to develop some links with the University Emergency Department based in Budapest.

All of my communication is in English and most of the doctors are able to understand English adequately. Certainly an understanding and enthusiasm to use Hungarian is an advantage but it remains a tricky language to master- so English is fine.

The pre-hospital EMS is strong in some places and the opportunity for emergency physicians to be tasked to a prehospital setting is common. Final year medical students often work as paramedics within EMS and hospital doctors will continue to provide additional shifts to cover this work. Budgets are struggling and the need for innovation and change in how the healthcare system is coordinated, structured and delivered has been identified but not funded.

During the years of Soviet domination in Hungary (1947-89) Oxyology was developed and this specialty represents emergency medicine. It was described by one of the early pioneers of acute medicine within the country- Dr Aurel Gabor. He outlined the need for urgent clinical care to be based upon sound science and evidence and formulated Oxyology from the Greek oxys (quick) and logos (science).

The main Medical School in Budapest is Simmelweis. This academic institution is enthusiastic about a growth in collaboration for developing the structures of EM within the city and country. It is very early days in developing this supportive link so assistance from enthusiastic clinicians across the emergency spectrum would be great. Paramedic and nursing educators related to emergency care are similarly helpful.

The opportunities for FACEMs who wish to help support Hungarian emergency healthcare include:

1) mentoring the local emergency specialists and helping in their strategic planning for service delivery
2) assisting in educational projects for skills training and critical problem solving as part of the ongoing professional development for specialists as well as for the assistance in training the junior doctors
3) collaborating in research projects through Simmelweis University
4) offering secondments for trainees or specialists from Hungary to be able to observe or do research work in Australasia.

Similar to many international areas of interest there is no specific funding for our involvement in Hungarian emergency medicine. The opportunity exists to seek funding through the European Union to help in the development of improved access to emergency care.

In March of 2015 there is the main Critical Care Conference (SIASTOK) that is run through Simmelweis University Hospital. This is on the outskirts of Budapest from March 26-28th. Any FACEM interested in attending and/ or providing input can let me know and I can forward on or connect you to the organising committee.

Netherlands: Emergency Medicine update

Naren Gunja
naren.gunja@sydney.edu.au

Emergency Medicine in the Netherlands has come a long way from its inception in the 1990s. In 1999, the Netherlands Society of Emergency Physicians (http://www.nvsha.nl/) was formed, which has been instrumental in establishing a national curriculum and assessment framework. This has resulted in a robust three year training program, with partial recognition as a specialty since 2008. Currently, an expansion to five years is being considered.

A significant number of Dutch emergency physicians have spent training time in various hospitals around Australia and the UK. Several have even become FACEMs, and are expected to return to the Netherlands in the next few years.

In 2012, a group of Dutch and Australian EPs established a web-based CPD program, intended to help expand knowledge and skills for EPs after completion of the Dutch EP training program. It is called 'MNSHA Masterclass' (Modulaire Nascholing SEH-artsen) - http://www.mnsha.nl/en/. It consists of 15 week, themed modules. Case-based self-study is complemented by web-based mentoring by FACEMs/FCEMs. There are several intense face-to-face days in which participants' knowledge is discussed, consolidated and challenged.

Opportunities for FACEMs include site visits and lecture schedules, as well as internet-based mentoring of local EPs. FACEM contacts include Femke Geijsel, Sander Manders, Kevin Lai, and Naren Gunja.

AFRICA

Botswana: Opportunities for TESL users and ACEM advanced trainees

Megan Cox
mcox2050@gmail.com

'Dumela' (Hello) from Gaborone.

Thanks for your interest in EM in Botswana. As of January 2015 there are 8 local emergency medicine trainees and still only one emergency physician (me) in the country. Four of these are advanced trainees, moving temporarily to South Africa, as part of the Botswana program, to attempt the SA FCEM (South African Fellowship of the College of Emergency Medicine) in the next 18 months. The other 4 have just excitedly started the program. I am hopeful that Botswana will have its first local emergency physician by 2016.

I work full time here for the University of Botswana heading a team of two Cuban ICU specialists, a nurse anaesthetist running BLS and ACLS courses at the University of Botswana, and many interested local health professionals in EMS, ICU and A&E. In August 2014 the University of Botswana held the first graduation of locally taught medical students graduating to doctors. They are now working with us as interns. There is also a formal rotation for EM in the A&E for the local University of Botswana 5th year medical students. There is increasing interest from International (especially Australian) medical students applying for medical electives in EM and ICU here.

There will be two ACEM advanced trainees in Botswana in 2015, doing approved terms here. The minimum time frame to consider for this is 3 months. I am very grateful for past and present ACEM colleagues coming to assist me. Senior EM registrars or FACEMs reading this who are considering using their LSL, annual or study leave and would like to teach any of the following - basic sciences, ultrasound, EMS, retrieval skills, paediatric EM or critical care, team work and leadership, clinical EM, simulation, or any type of research - would be much appreciated. A minimum of 6 weeks is required, to allow for registration, orientation and familiarization.

If you or anyone you know would like to come and assist in the next 2 years, it would be a perfect time frame. If you would like an African medical experience with little malaria, relatively peaceful surroundings (especially compared to its neighbours), no ebola, lots of trauma, teaching and procedures ... please let me know!

If you enjoy child-friendly safaris, fabulous sunsets, great BBQs, SA wine and Namibian beer, good imported food, 4W driving or visiting world heritage sites close by (Okavango Delta and Victoria Falls) this would help too...

For more insight, please visit this video http://vimeo.com/76859965

Megan Cox is Assistant Program Director and Acting Head of Department, Department of Emergency Medicine, Faculty of Medicine, University of Botswana
+267 76574766

Kenya: Can you help a Paediatric Emergency and Critical Care program?

Mardi Steere and Jane Cocks
meddir.kh@gmail.com jane.cocks@health.sa.gov.au

For the last 4 years Mardi has been living and working in rural Kenya as the country's only PEM physician. Kijabe Hospital is recognised as a national training site for the University of Nairobi in general surgery, pediatric surgery, orthopedics, nurse anesthesia, pediatric anesthesia and pediatric neurosurgery.

In Kenya, with 40 million people, there are 4 ICUs - a perpetually full public one and a private expensive one in Nairobi, one in Eldoret 8 hours away, and one at our hospital. Currently the only place to train in emergency and critical care is internationally. So we are keen to train pediatricians who will be working rurally in emergency and critical care, and in how to set up a rural hospital to be able to provide critical care.

For the last 2 years Mardi has been liaising with the University of Washington and with the paediatric intensivists and chair of pediatrics at the University of Nairobi to work on developing sub-Saharan Africa's first 2 year fellowship in Pediatric Emergency and Critical Care.

Kenya has 3 pediatric intensivists, trained in Europe or South Africa, and now 2 PEM physicians, Mardi and Arianna Shirk who has just finished fellowship in the USA. So we are looking for doctors to assist us as visiting faculty in PEM and PCCM. Can you help?

Mardi Steere FRACP FACEP is Medical Director at AIC Kijabe Hospital. She was previously an EP at Women's and Children's Hospital and with MedSTAR retrieval service in Adelaide. www.kijabehospital.org

Jane Cocks FRACP FACEM FCICM works at Women's and Children's Hospital and at MedSTAR retrieval service in Adelaide.