

IEMSIG

Newsletter of the International Emergency Medicine Special Interest Group of ACEM



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In this Edition

As this Newsletter enters its sixth year we see major advances in Africa and Europe, and new territory being explored in South East Asia.

In Africa, Cape Town has hosted the second conference for EM in the Developing World. An important outcome was the establishment of an African Federation for EM. Neighboring Botswana is establishing a medical school, with both undergraduate and postgraduate EM. FACEMs with South African connections are returning to support their country of origin. And Africa offers opportunities for those looking for something different.

In Europe, movement in the 'old world' is starting to accelerate. Endorsement of EM by the Union Européenne des Médecins Spécialistes (UEMS) will be a major catalyst for the development of training programmes.

Meanwhile, nearer to home, Australian emergency doctors widen their explorations into new territory in South East Asia.

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Contents

Articles

AFRICA

Emergency Medicine in the Developing World – 2nd Conference	Ngaire Caruso	2
The African Federation for Emergency Medicine	Lee Wallis	3
Emergency Medicine in Botswana	Andrew Kestler	4
A night on call - Manguzi District Hospital, South Africa	Stephen Hartwig	5
Extracts from a Diary - Mseleni Hospital, Zululand	Sandy Inglis	7
Looking for something different – a visit to Tanzania	Robyn Parker	10
Letter to the Editor	AFEM	11

EUROPE

Europe Report	Gordian Fulde	12
Policy Statement on Emergency Medicine in Europe	UEMS and EuSEM	13

SE ASIA

Beginnings of emergency medicine in Sulawesi, Indonesia	Ameera Khan	14
Time on the Fly – Kiunga Hospital, Papua New Guinea	Farida Khawaja	16

NEWSCLIPS FROM SOUTH ASIA

India, Sri Lanka, Nepal, Myanmar		18
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CONFERENCES

The 2nd EurAsian Congress on Emergency Medicine. Turkey, October 2010		19
---	--	----

OPPORTUNITIES

FACEMs wanted in Shanghai		20
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COURSES

Short Courses in International Health		20
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Emergency Medicine in the Developing World 2nd Conference - Cape Town, November 2009

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The second Emergency Medicine in the Developing World Conference was held in Cape Town over four days from the 23rd to the 26th of November, 2009. Over 650 delegates from 45 countries enjoyed an informative and interactive meeting. Special mention should also be made of the 13 delegates who attended as part of the Adopt-a-Delegate project. Through this project, 13 delegates from developing countries were sponsored by peers from high-income countries. All registrants had the opportunity to act as sponsors. Hopefully the number of sponsors will increase at the next conference in 2011, to enable the participation of more delegates from developing countries.

Given the upcoming 2010 World Cup, there was a timely focus on mass gathering and disaster medicine. Other themes included teaching in emergency medicine, trauma, and emergency nursing. The conference also saw the establishment of the African Federation of Emergency Medicine.

Pre-conference workshops included emergency ultrasound, an ECG master class, an airway management course, emergency radiology and hospital disaster planning. The workshops were well attended and received much positive feedback.

The formal sessions were busy, with four or five concurrent sessions running over three days, addressing a plethora of topics. Obviously I can only comment on the sessions I personally attended, therefore my perspective may not be representative. The overall quality of speakers was very good.

The sessions on disaster medicine focused on real life preparation for the upcoming World Cup, with insights from speakers who have played key roles in the planning for this event. The sessions on teaching in emergency medicine were of great value, with an emphasis on practical advice for teaching in a developing world context.

Personally, the most inspiring speaker was Dr Sooliman, founder of the South African non-government organisation "Gift of the Givers." Since their establishment in 1992 they have developed into the largest disaster response NGO of African origin and have delivered aid to millions of recipients in 25 countries. Dr Sooliman spoke with

incredible passion and eloquence and I was not the only member of the audience literally moved to tears (twice!). For further information, see their website www.giftofthegivers.org

The conference also provided a forum for several meetings focusing on the African development of emergency medicine. EM was recognised as a specialty in South Africa in 2003. In other African countries it is developing rapidly, although still in the early stages. Important outcomes included the establishment of the African Federation for Emergency Medicine and the recognition of the need for an African Emergency Medicine Journal. Country specific meetings also addressed EM development in Botswana and Tanzania.

The African Federation for Emergency Medicine (AFEM) was established on November 26th, with the stated objective of "supporting Emergency Care across Africa". The AFEM will act as an umbrella organisation for African national EM Societies. At the time South Africa was one of only five African nations with an established EM society. However several others are in the formative stages of developing societies, including Botswana, Ghana, Kenya and Ethiopia. Ghana formed a Faculty of Emergency Medicine (within the College of Physicians and Surgeons) in December 2009 and currently has 7 registrars training in a 3 year Master of Emergency Medicine programme. Postgraduate EM training in Botswana is scheduled to begin in January 2011. The AFEM will provide a vehicle for collaboration and support for development in these and other African countries. In recognition of the multidisciplinary nature of emergency care, AFEM membership will be open to other health professional societies, including nursing and paramedic organisations.

Another important outcome of the discussions was recognition of the need for an African Journal of Emergency Medicine. There has been little research on emergency medicine in Africa, and researchers have historically had limited opportunity to publish their work. General consensus was that the main aim of an AEMJ would be to encourage research in Africa and to facilitate its publication. The journal would be peer-reviewed, indexed, and Africa centric. The value of support from emergency physicians

in developed countries, in an editorial capacity or peer and mentor system, possibly with co-authorship, was discussed. Under the auspices of the newly formed AFEM, a task force was established to look into the establishment of a journal. This process is still at a very early stage, however Australian and other IEM physicians who would be interested to contributing can contact Dr Lee Wallis at leewallis@bvr.co.za.

A meeting focusing on EM development in Botswana was held with enthusiastic participation of international delegates. The University of Botswana has recently established an undergraduate medical school and the first students began their studies in August 2009. Post graduate Master of Medicine programmes in paediatrics and internal medicine commenced in January 2010. A four year Master of Medicine in Emergency Medicine is scheduled to begin in January 2011.

Botswana is a stable, relatively well resourced, democratic country, with political support for the development of

EM. HIV/AIDS is the greatest cause of mortality, with trauma being the "second epidemic". At present there are only two emergency physicians working on establishing the programme – Dr Andrew Kestler and myself! We are recruiting emergency physicians at present, so anyone interested in working in Botswana can email myself (ngaire.caruso@gmail.com) or Andrew (andrew.kestler@mopipi.ub.bw) for further information.

The 2009 Emergency Medicine in the Developing World Conference was successful in providing informative, interesting sessions on EM in a developing world context. Most importantly, it acted as a forum to facilitate international cooperation in developing countries.

The next conference will be held in Cape Town on the 15th to 17th November 2011 and the central theme will be education and training in a developing world setting. For further information see www.emssa2011.co.za or email belinda.chapman@uct.ac.za I hope to see you there!

The African Federation for Emergency Medicine 'supporting Emergency Care across Africa'

Email: admin@afem.info

Web: www.afem.info

We are proud to announce the formation of the African Federation for Emergency Medicine (AFEM), dedicated to 'supporting Emergency Care across Africa'. Lee Wallis, President of the Emergency Medicine Society for South Africa (EMSSA), organized several meetings on this and other topics during the 2nd EMSSA 'EM in the Developing World' Conference, held from 24-26 November, 2009, at the Cape Town International Conference Centre. The AFEM will act as a formative, 'umbrella' organization for all the existing and future African National EM Societies. EMSSA is the largest national EM Society in Africa, but many more are in the early stages or are on the brink of formation, including Botswana, Ghana, Kenya, Ethiopia and others. AFEM is also proud to announce that they will accept as full members and / or member societies other health professionals and health professional societies, including EM nursing, EMTs and paramedics, in recognition of the multi-lateral, multi-disciplinary, multi-professional nature of emergency medicine and acute care. The conference also saw the official formation of the Emergency Nursing Society of South Africa (ENSSA), as an equal-member sub-group of EMSSA, as a further reflection of our natural partnership with the specialty of emergency nursing. The current AFEM interim Executive Committee of 9 elected persons will determine over the oncoming months the ultimate structure of AFEM; 5 initial committees (Identity; Governance, Membership, Terms of Reference and Services) were formed to assist in this most crucial phase.

The Interim Executive Committee is:

Chair	Lee Wallis
Vice Chair	Conrad Buckle
Secretary	Charles Otieno
Officers	Petra Brysiewicz, Bob Corder, Heike Geduld, Steve Justus, Valerie Krym, Hein Lamprecht, Terry Mulligan, Sebastian Spencer

Also announced at the EMSSA conference during these same talks was the formation of the African Journal of Emergency Medicine, a peer-reviewed, indexed journal to be dedicated to clinical, academic and developmental aspects of emergency medicine in the many and varied nations of Africa and elsewhere in the developing world. While the exact details of this journal and the plans for its ultimate structure remain in the planning stages, we are proud to announce this new addition to the growing family of academic and scientific emergency medicine journals.

We welcome the advice and participation of our colleagues in emergency medicine, emergency nursing, pre-hospital emergency care and in all areas of acute care and emergency medicine to join with us and to assist us in the formation of this monumental organization, and we look forward to your active membership in the months and years to come.

For more information or if you have questions/comments, please contact: admin@afem.info or visit www.afem.info.

Emergency Medicine in Botswana

Andrew Kestler

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In the last month Accident & Emergency at Princess Marina Hospital, or A&E as the Emergency Department is called, has run out of soap, clean suture kits and betadine, though fortunately not all at the same time. The phones were down for over a week, and the pager system is still out of action. Some staff members arrive late for shifts, some disappear after lunch, while others work very hard. And yes, critical septic patients occasionally get forgotten in the hallway for hours. On the street outside the hospital no less than four ambulances (perhaps three private, one government) could report to the scene of a crash. Botswana has plenty of cell phones, but no centralized dispatch of pre-hospital services.

Less than a year now remains until the launch of a new emergency medicine training programme in Gaborone, Botswana. Sound challenging? Of course, starting a new training programme can be difficult under the most routine of circumstances.

Now also factor in the following:

- The main government hospital is now the de facto teaching hospital. Most employees will rightfully claim that teaching is not explicitly included in their job descriptions.
- The government rotates most nurses every year to different units, hampering the development of nursing expertise and team spirit.
- The prevailing mindset dictates that the emergency department is a triage station rather than a site of care.
- Human resources move very slowly in the government, deterring qualified staff.

On the bright side:

- The Department of Emergency Medicine just doubled in size. With a new appointment, Dr. Ngaire Caruso from Australia, we are now two.
- The head nurse in A&E is stellar, and she 'gets' emergency medicine.
- A few shining stars among the medical officers are planning to apply for the emergency medicine training programme.
- The Permanent Secretary in the Ministry of Health is an emergency physician!
- No shortage of patients: HIV and trauma are the first and second causes of morbidity and mortality.
- The brand new University of Botswana School of Medicine is off the ground and running: 36 first year students, and more due to start in August.
- A brand new African Federation of Emergency Medicine provides an exciting avenue for collaboration with South Africa, Ghana, Tanzania and other African countries developing emergency medicine.

'Contrasts in a developing environment: there is PACS for imaging, while there is only one suction machine in the ED'



- A country that has had the resources to provide anti-retrovirals to over 80% of its HIV+ people in need of therapy, also has the resources to make great strides in emergency care.

The frustrations are many and it is fun to complain. On the other hand, I am never ever bored. The potential rewards are great. The relative lack of qualified emergency care provides a blank slate for improvement. For the moment it is hard to imagine returning to a 'regular job' in emergency medicine.

Outside work Botswana is a great place to raise a family: a child-friendly country with decent schools, modern conveniences, and a stable, democratic government. Strong cultural traditions and big game, among other things, will remind you that you are indeed in Africa.

We are still recruiting in emergency medicine, so if any of the above craziness sounds appealing to you please contact andrew.kestler@mopipi.ub.bw

- A night on call - Manguzi District Hospital, South Africa

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It was 2am in mid December and I was three quarters through my very last 24hour on call duty at the Manguzi District Hospital in Far Northern kwaZulu Natal, South Africa. I had been undisturbed since about 10pm after a busy public holiday and during my fitful awakenings I was beginning to think that I might just be left alone until my duty ended (well, the on-call bit) at 8am. It wasn't to be. I got the last thing I wanted – a call from the little RU (optimistically named Resuscitation Unit) in the hospital saying a man had been brought in with a head injury following an MVA and he was having trouble breathing.

My young family and I had returned to our native South Africa in February 2009 for a bit of bush life, seeing family and, for me, 'real medicine'. I had been given a post as Chief Medical Officer at the Manguzi Hospital, which lies just a few kilometres south of the Mozambique border. There are about 15 doctors serving a population of 100,000 people, some of whom are across the border in Mozambique, treating all sorts of severe illnesses, trauma and vast numbers of children and pregnant women. Malaria is occasional, HIV and TB ubiquitous (multi drug resistance is a problem) and gun trauma unusual! In fact in 9 months I didn't see a single gun shot wound – remarkable for modern South Africa.

The work was endlessly interesting – the range of pathology (ie human suffering) amazing. Higher levels of care for medical problems is almost non-existent except for a few "lucky" patients with interesting conditions who get into Inkosi Albert Luthuli hospital in Durban, 500km to the south.

Sick HIV negative children have some chance of higher care in the regional Ngwelezane Hospital 200km to the south. Occasionally we would get a Squirrel helicopter up from Richards Bay to collect sick patients - especially low birth weight neonates, who took their chances getting ventilated by a competent paramedic after I had intubated them (orally) on the rather questionable advice of the receiving paediatrician. Needless to say, intubating and securing tubes in 1-1.2kg babies caused some angst... but no tube, no acceptance for transfer – non-negotiable.

The orthopaedic and general surgical services at Ngwelezane struggle manfully to provide a good service. The sole emergency physician there runs a good service with a functioning HDU (with a few ventilators) within his department.

In between sick patients were the 'challenges' – what you call a problem caused by those senior to you. Lack of budget. Lack of staff. Frozen posts. No ambulance transport... Fortunately, the nurses and hospital staff genuinely care for their patients – and are grateful for people from far away who come to help out.

The junior medical staff asked questions and for help all day long, often about things I only remembered from medical school, but I had to have an answer! Fortunately, there were hands with more surgical experience than mine to help out.

There was plenty of opportunity for getting into the bush (biggest elephants in Africa, ie world, just 30km down the road), wild beaches, diving (whale sharks) and similar.

Back to my last on call...

I got to RU and there was this young man who had wandered in front of a car, with closed head injury, gasping... looking like death was minutes away.

Even after nine months in a small hospital, working with a team of doctors is still what is most comfortable. How to manage this guy all by myself? So I fell back on ABC.



Getting on with it

Cont'd from p5



Dusting off after a long day

An enthusiastic junior RN and EN helped out, while the night matron did paperwork in the office!

Fortunately, he picked up with oxygen. It turned out that his biggest problem was ventilation (lung contusion/haemothorax) and his GCS went from 4 to 13 once his sats improved to 90%! No evident abdominal blood (ultrasound machine with Y2K compliant label still displayed) and clinical fractured femur pulled out and splinted. So I intubated him (Oxylog 1000 but no peep valve), put in a chest drain and then took him round to X-ray to confirm the femur fracture and lung contusion. Then I started the difficult task of arranging a transfer to Ngwelezane by air for when daylight came.

Then labour ward rang and it was time for an emergency Caesar. I did have a second on call doctor, to help out with the spinal. While the pregnant patient was getting prepped for theatre I sorted out a sedation infusion for my trauma man, filled him up with vecuronium and gave the nurse 4mg vials to give him every 30-45minutes prn. And don't touch the patient, for fear of extubation!

All three patients (trauma, mother and newborn) survived, as did I. Last time I saw the trauma victim he was heading off in a helicopter 10 hours after arrival in RU, stable and with very promising neurological signs.

I eventually got home, satisfied in the knowledge that often one's best IS good enough, even if it is not quite what you would do in a modern ED.

Life back in Australia now has different pressures... generally less, with fewer frustrations. But I know there are many other people who could do my job here. Somehow, I miss the knowledge that I was **really** needed...



- Extracts from a Diary - Mseleni Hospital, Zululand

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Getting there

Today I started my new job in Africa. Only 28 degrees from the equator and a mere 40km from the Mozambique border, and perched on a little hill near Lake Sibaya, Mseleni Hospital has jolted me out of my cool comfortable Christchurch consultant life. My job description is Chief Medical Officer but so far there has been nothing 'chief' about it as it is all hands to the grindstone and time served here seems to determine who calls the shots! I feel naïve and out of my depth and crave for anything trauma related or vaguely emergency where I can perhaps flex a bit of muscle. The hospital has 190 beds and is generally well equipped and staffed (we are flush with about 10 doctors) and has clean ORs where many C-sections are carried out, and even the occasional hip replacement for the local 'Mseleni Hip Disease'.

Following a whirlwind tour of the hospital by CMO Johan, a burly South African, I have my first shift in 'OPD' which is ED, GP, and sort of OPD all wrapped up in one. The waiting room heaves with sweat and murmurings and babies crying and 3 doctors jostle for small bays and the all essential interpreter. It horrifies me to see the three 'resusc' bays being used to prepare patients for the OR next door and I feel somewhat guilty as I incise a large abscess on the chest of a one year old (nicely sedated under ketamine) in the bed next to a woman waiting for her tubal ligation. We are allocated three hour blocks in OPD, which is wise and ensures survival I think.

Then it is up to my allocated ward, Ward 4 (men's surgical and medical) and I am hugely grateful to Martin, a young British doctor who has had a few months here to come to grips with the complexities of African medicine. The first chap has recovered from tonsillitis and I discharge him, lulled into a false sense of security. Then I see an (ex) taxi driver who rolled his bus. He is five weeks post his traumatic brain injury and type one peg fracture, he has a filthy Phili collar on, is wallowing in his own shit and his Pauls tubing lies dribbling on the floor. I wretch and plead with nurses to clean him up.

Then the fun starts. This patient has RVD (retroviral disease...we are not allowed to say HIV!) and his CD4 count is 50. He is on RHZE treatment for pulmonary TB, LFTs are through the roof, he is jaundiced and has a huge palpable liver. Is it ok to get going with the 1a anti-retroviral protocol, not wanting to cause an IRIS if we do not have his TB under control? We need help and call one of the long-termers. Yes get going. Whew!

And on it goes. A chap with cuffs on his ankles, and with his legs, buttocks and back bruised black from 'the community justice'. His urine looks ok and we encourage fluids and will watch his creatinine. An old boy off his legs, demented and, we think, Parkinsonian...he needs sedation and we hope a urine test will confirm UTI. Another RVD with a high lactate (usually due to Stavudine or D4T) who also seems to have a peripheral neuropathy and marked renal impairment and we are forced to stop his antivirals. Then this elderly man who has had his acute CCF treated (no CPAP or GTN but Lasix, spironolactone and enalapril) whose ALT is 2113 which may be due to the Zulu medicine he tried before coming to see us...but we are not sure.

We crawl into the next ward and review a fractured mandible; and next to him a chap on antiretroviral, pulmonary TB and STD treatment. Then a patient with advanced alcoholic liver disease who has had 17 litres of ascites drained. And yet



Sandy Inglis and the trusty US

another peripheral neuropathy, this time maybe from his TB meds. More RVD and pleural effusion drained of 1200mls but still looking very sick; and next to him an acute psychosis whose organic work up including LP are normal, so we can discharge. The next psychotic patient has an abnormal LP with 200 lymphs so he gets the full treatment and we have a CT booked for about two weeks time in the nearest big town two hours away.

My ED in Christchurch seems a long way away but I am here on a fabulous adventure with my wife Ilda and two daughters, Margot 9 and Zara 6. Ilda has charged into this grueling African experience with vigor, equipping our rectangular 'park-home' box with all the essentials and home schooling the girls. They too have embraced this new life and now revel in collecting insects, climbing trees and identifying antelope in the many game parks around here. The decision to leave was a big one but we are here to explore this beautiful country and I was keen to see more of my immediate family as well as expose my family to the richness of Africa. I had always hoped to work in a remote location in a developing country and now it has happened. After day one I now realize how little I really know.

My first 2 weeks were spent at the tertiary hospital in Pietermaritzburg where I did my internship 20 years ago. The hospital is almost exactly as I remember it - infinite queues of patient patients, the same muddy floors, scant facilities and massive wards full to bursting - but the mood is buoyant and the tolerance fabulous. I am hosted by an old fellow intern who is now HOD of surgery. He guides me around the campus - this is where the bullet holes were in the locker in ICU, this is where we watched live gun battles from the OT tea room (we were there in 1990 at the height of ANC / Inkhata political war), and this is where our old pub and heart of our youthful social life used to be. The hospital bar and pool ('Easy Riders') is sadly now the occupational therapy department and the pool and squash court are gone.

I am assigned to the OR and start the morning assisting with a complex peritonitic appendicitis, glad that I had not accepted the offer to perform the operation. I am delighted to hear that, to confirm pathology here, myriads of investigations are not the norm, but then diagnoses are mostly fairly obvious. A long ward round is fascinating for the number of stab and gunshot wounds and a mass of road trauma from the week-end, but sadly not for a young woman with a fractured pelvis, ruptured spleen and liver lacerations who died on the table.

Then back to OR for a fasciotomy of lower leg on a lad who was bitten by a snake and has severe local toxicity as well as a coagulopathy. The constricted muscles flop out of the wound relieved to be freed but some of the muscle looks a bit like biltong (dried meat). We decide to give it a chance and see if it will survive.

I am surprised to be called into a hospital management meeting and introduced as an 'A&E expert from NZ', but enjoy sharing some ideas on ED design for their new hospital.

The next day is spent entirely on doing massive skin grafts on desperate burn victims. The dermatome neatly peels off layers of fresh skin which we mesh and then reapply on the burnt bare areas. I remember doing this 20 years ago too!

I join the O&G team for the second week. Wow! Trying to remember how to analyze a Partogram, assess the cervix and manage GPH and eclampsia! I angle for the OR as much as possible and enjoy the buzz and action there - I assist with a messy ruptured ectopic and a belly full of blood but she does well, and I assist many C-sections but I am competing with interns who need 10 sections each. I at last get to cut and revel in the experience of extracting the baby. The first one goes well but the second one bleeds quite a bit and has me worried (my supervisor, 3rd year out, is happy though!).

And so our life in Africa has started. We have learnt so much already, but know that we haven't even scratched the surface.

Baptism by Fire

I promise that I will never, never, winge about being on call in Christchurch again! It started with a prayer, which is the custom here before any procedure in the OR. This teenager had an acute abdomen and we were after his appendix. I was performing my first GA in a long time and did quietly wonder if the Zulu prayer reflected this. Anaesthetics are a simple affair here with ketamine the backbone, and as he dozed off I felt grateful that I was at least familiar with this drug. Sux, ETT down and then crank up the halothane and nitrous and keep him still with a vial of vec. It all went smoothly and I felt a sense of smug satisfaction as I gazed over the green drapes at Johan digging around McBurney's. He wasn't having as much fun. His Babcocks anxiously suspended an open section of bowel which he sadly had plunged into, it being adherent to the fascia above. The appendix mass was an impossible proposition and he repaired the bowel and closed up. I was relieved to wind down the gases, reverse his paralysis and whip out the tube, but this was by no means a slick affair and Johan was long gone by the time I left theatre.

Then I made a quick stop on the ward to review my pale yellow patient, who had HIV with a CD4 count of about 100 and both renal and liver failure. I wasn't surprised to find his Hb was 2.4 and managed to secure the last 2 units of blood in



...while OPD waits

the hospital, to at least give him some symptomatic relief.

At about 01.00 the fun started. 'Hello Doctor, this is sister on Labour Ward, can you come? The baby is not coming.....'. I ran up past the mango trees in the dark hoping like mad that a mamba wasn't out for an evening slither and sprinted around the hospital trying to remember where Labour Ward was. What greeted me would have been comical had I not been so terrified - an elderly multip. suspended in stirrups, fetal head on view, tired and annoyed midwives looking at me expectantly. I gazed hopefully at the ragged CTG, fetal decelerations obvious and remembered something about vacuums. A quick call to the faithful Johan confirmed my attack - 'you're allowed 3 pulls and if it doesn't come then go for Caesar'. I found some gloves, a scruffy mask and visor (yes, HIV+) and set about connecting the vacuum. Suction was variable but somehow we got it going and with a bit of prompting from the midwives about 'rocking' the head, out it popped. The cord was wrapped tightly around the neck and we divided it and then with a bit of a wriggle delivered the body, limp and quiet. Thankfully with a bit of bagging, some oxygen and a bit of rubbing the little critter gave a howl and never looked back.

The drama in Labour Ward continued with the birth of a macerated still birth and then a mother who came in with her tiny dead baby covered in sand and the cord tied with a pathetic little bit of blue wool. A hypertensive mother reportedly without a fetal heart turned out to have one and her BP responded nicely to some nifedipine. Her labour was augmented with some Pitocin, but not before I combed the handbook reminding myself of all the perils of cephalo-pelvic disproportion and eclampsia. We ruptured her membranes (ok if she has had her anti-retrovirals at least 4 hours before) and she delivered a healthy boy.

It was now getting light and it was time to tidy up in 'OPD'. A policeman with a gunshot to thigh was interesting for the lack of an exit wound, 'a ricochet' he thought, but was lucky to have normal neurology and sensation and the femur appeared ok. But I was unable to confirm this because the radiographer was away for the week-end. The next chap, with a stab wound to the left costal margin in the midline, also seemed in pretty good shape but again a lack of X-rays frustrated me. I was keen to observe him on my ward but was advised to send him two hours down to our referral hospital. The rest was a blur of fevers, HIV, TB and abscesses, but one did stand out - an 8 year old boy with a neck like a Springbok rugby player. It may have been an abscess but lymphoma was also a possibility, so we elected to put him on the ward for a biopsy the next morning. I wouldn't like to have to manage his airway.

So as the day dawned I reflected on my first night on call and smiled as I thought about my consultant call in Christchurch. Hopefully I had made a difference but perhaps a ripple in a pond. I wandered off to do my ward rounds.

- Looking for something different? - A Visit to Tanzania

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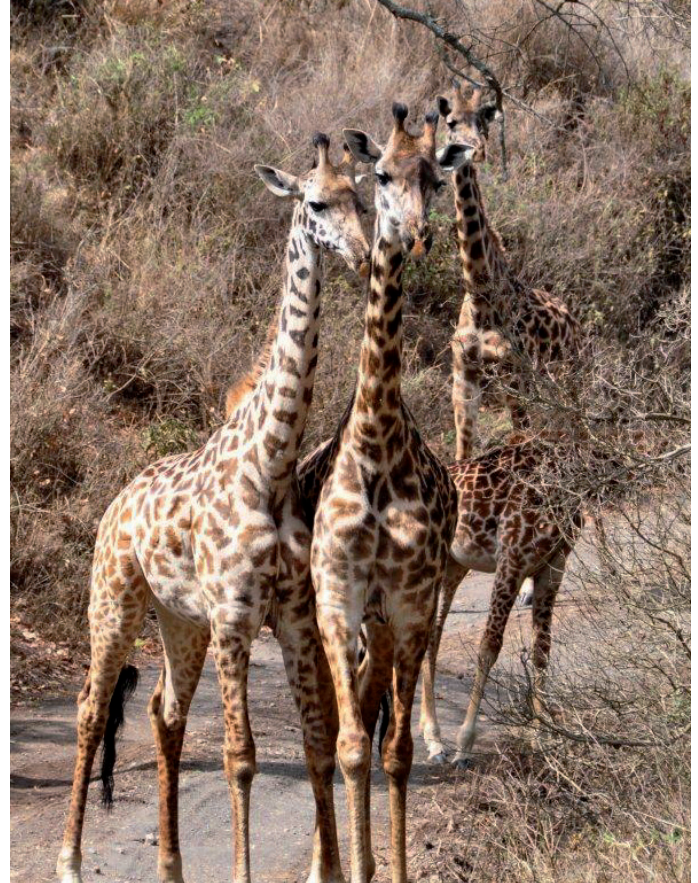
My husband and I visited Tanzania in October 2009 to attend a wilderness medicine course run concurrently with a safari tour. It seemed a great way to combine travelling safely in the developing world with an interesting CME course, especially since the hospital I work at has no formal ties with or programmes in a developing country.

The "Wilderness Medicine Safari", run by BioBio Expeditions, was even better than I had expected, visiting Ngorongoro Crater, the Serengeti National Park and some smaller but no less amazing nature reserves. Local guides were joined by an American physician with thirty years experience working in the developing world, as well as a major in large mammal biology during his pre-medicine college years. Lectures were delivered at the end of the day with a Tusker beer in hand and covered the basics of developing world issues as well as environmental medical emergencies. I quickly learned that while as tourists we were there for the "Big Five" animal sightings, the locals were far more concerned with the "big five" causes of childhood mortality: pneumonia, diarrhoeal disease, malaria, HIV and an associated resurgence of TB.

Whilst in the safari parks the living was entirely at Western standards and the views were of towering giraffes, families of elephants stripping the bark from baobabs, flamingoes turning an entire lake pink, lions sprawled and gorged on wildebeest. In contrast, the view from Africa's longest central highway told an entirely different story – lack of electricity and running water, drought, dead livestock, orphanages every couple of kilometres.

The antecedents to sustainable health are very simple: safe drinking water, basic sanitation, adequate nutrition, stable economic status and the basic education of women. Interventions that have accordingly made a significant difference to child mortality are therefore predictable: child vaccination, availability of antibiotics, growth chart monitoring, protein supplementation and oral rehydration for diarrhoeal illness, treated bed nets, and the education of women to the equivalent of high school entry.

We tried to tee up a visit to the main regional hospital in the months prior to departing, but emails went unanswered and I felt a bit awkward about just turning up to a large hospital already well-staffed by American ex-pats to offer my two cents worth about the local health system. In the end the tour operator was able to arrange some visits to local clinics, the equivalent of which would be a community health centre in Australia. In a continent proud to have an African in the White House (we saw Barack Obama merchandise being sold wherever we went), the



...looking for something different?...

doctors were pleasantly surprised that the concept of free health care for the needy is not necessarily something citizens of the United States can enjoy. Health care at government clinics in Tanzania is free for those under five or over sixty and for people who are HIV positive. The official HIV positive rate is running at around 11%. Consultations for everybody else are the equivalent to thirty cents, and treatments each have a separate charge, except for HIV and TB treatments, which are provided free of charge.

A couple of patients stand out as illustrations of the differences in patient presentations in our respective countries. One, a clearly disturbed woman brought in by relatives, was lying shrieking and thrashing around on the floor. The treating doctor's approach was to screen for cerebral malaria. "It is either malaria or a mental problem. If the test is negative, she will go home with Largactil." A second, a man in his thirties smiling broadly and happy to be photographed, had just learned by point-of-care testing that he was not infected with HIV. I wondered whether my versatility with the diagnostic challenge of chest pain would ever be needed in this setting. Even our infectious disease physicians may have to take a refresher before working in Africa.



...looking for something different

Letter to the Editor

Seeking contacts in Africa

Dear Colleague

As you may be aware, at the 2009 Emergency Medicine Society of South Africa Conference in Cape Town, the African Federation of Emergency Medicine was formed. This is an exciting development and opportunity to co-ordinate and rationally develop the speciality all over the continent. An executive was formed and has been tasked with developing the AFEM, along with a peer reviewed journal.

As one of the first endeavours of the AFEM, we will develop a database of emergency medicine activities around the continent.

To effect this we will start with a quick and simple survey. There are 10 questions only...

Please can you assist by completing the survey if you are a key player in any project, organization or institution active in emergency medicine in Africa.

http://www.kwiksurveys.com/online-survey.php?surveyID=KKMJKO_1ae3706d&ooo=MCKNML_11fbd98d

We will be sending the survey out to a large number of potential contributors. Please forgive us if you receive multiple invitations. We would ask you to send it on to anyone else who may be able to contribute.

Many thanks

AFEM Interim Executive
 admin@afem.info
 Chair – Lee Wallis
 Vice-Chair – Conrad Buckle
 Secretary – Charles Otieno

Europe

Europe Report

Gordian Fulde

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As one of the founding grandfathers of the Australasian College for Emergency Medicine in the early 1980s I believe I have some insight into the hard cross-country marathon of setting up a new specialty. It has always been interesting, a challenge, and rewarding to observe and at times to aid such journeys in other countries. Even superficial reflection underscores the absolute necessity for local conditions, obstacles, and politics to be individually recognised and worked through.

Surprisingly, at first glimpse it seems the “old world”, Europe, has generally taken longer to embrace emergency medicine as a separate specialty. The adages “professions are their own worst enemies” and “the bitterest enemies come from within” unfortunately apply to the medical profession when a new interest group forms.

European countries, as a generalization and some more than others, have long established conservative medical disciplines which often hold all the power and influence. This is at all levels – universities, hospitals and government. These colleagues have often actively blocked the emergence of emergency medicine.

However, this has now changed with the majority of Europe recognising emergency medicine (see Table 1).

In the hospitals, for a long time, a lot of European medicine and surgery disciplines occupied space – “reception areas” – on the ground level. This reception area often was separated physically into medical and surgical sections. These also have separate staffing, systems and their own diagnostic equipment. Organisational lines go up to the professors who at times have feudal powers and total financial control. This was a classical silo set-up for the main specialties.

This set-up, for reasons that are “mother’s milk” to modern emergency physicians and administrators, is not cost or patient outcome efficient. Problems include expense, inefficiency, poor outcomes with multiple diagnoses and diseases (eg medical and surgical), and delays to definitive care (often a junior person was sent down to assess the patient, etc.)

The old system started to crumble and re-organisation commenced. Often then a group of colleagues would

Table 1. EM specialty status of European Countries

EM is recognised as a specialty	Belgium Bulgaria Czech Republic Estonia Hungary Iceland Ireland Italy Latvia	Malta Netherlands Poland Romania Slovakia Slovenia Spain United Kingdom (Turkey = non EU member)
EM is a supraspecialty: - it has been added to an existing specialty. * to change to independent recognition in 2012	Denmark Finland Sweden (Switzerland = non EU member) France*	
EM is not recognised * applied in 2009, currently still under process, no outcome as yet	Austria Greece Lithuania Norway Portugal Germany *	

become difficult. This was at times our critical care siblings the anaesthesiologists. The thought that anybody else could care for an airway, sedate or intubate a patient was an anathema to them, thus to be violently resisted. This still occurs. Outsiders would just see it as a turf war or a potential loss of income issue. They would not realise the significance of timely expert resuscitation at a front door of a hospital.

Especially over the last few years there has been great progress made in recognising emergency medicine. This can be seen from the European Society of Emergency Medicine (EuSEM) Policy Document, October 2009 (see below). Europe is well on its way to standardising emergency training and care.

Personally I hope Europe, being a later developer of emergency medicine, can benefit from relevant innovations and experience as well as avoiding mistakes we have made in developing emergency medicine in our regions.

Acknowledgement

For his advice and information, I would like to pass on my gratitude to Thomas Fleischmann, director, Emergency Department, Northwest Hospital, Sanderbusch; past vice-president, German Society of Interdisciplinary Emergency Departments (DGINA); past representative for Germany at EuSEM.

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Policy Statement on Emergency Medicine in Europe

Approved and endorsed by the Council of the Union Européenne des Médecins Spécialistes (UEMS) in October 2009

Prepared by the UEMS Multidisciplinary Joint Committee on Emergency Medicine (MJC-EM) and the European Society for Emergency Medicine (EuSEM).

The UEMS MJC-EM includes representatives from nine specialist groups. The EuSEM includes 24 national societies and represents more than 16,000 members.

The EuSEM considers that the provision of high quality emergency care requires physicians with specialized training in EM because this is the most effective way to provide high quality care during the critical stages of emergency treatment.

In 2009 EM was recognized as an independent specialty in 15 member states, and in 5 it existed as a supraspecialty.

The main objective of the EuSEM and the MJC-EM is that the specialty of EM should continue to develop to the standards endorsed by the Council of UEMS to seek to ensure the highest quality of emergency care for patients. This care should be delivered by physicians trained in EM.

In order to achieve these objectives the EuSEM and the MJC-EM have the following aims:

- A European competency-based core curriculum to include: Patient care; medical knowledge; communication, collaboration and interpersonal skills; professionalism, ethical and legal issues; organizational planning and service management skills; academic activities – education and research.
- Education and training programmes to deliver this core curriculum
- Assessment and examination structures to confirm that the necessary competencies have been acquired
- Clinical standards and a robust audit programme to ensure that these standards are being achieved
- Research projects to contribute to the development of an international evidence base for the specialty
- Inclusion of EM as a core part of the medical undergraduate curriculum.

The full document can be viewed at:

http://www.eusem.org/downloads/pdfs/eusem_policy_english.pdf

Beginnings of Emergency Medicine in Sulawesi, Indonesia

Ameera Khan

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Sulawesi is a large K shaped island located to the east of Borneo in Indonesia. It is a relatively remote island with approximately 14 million people, 7.25% of Indonesia's total population. Sulawesi is a diverse island with varied natural attractions and cultures.

The island is divided into 6 provinces – North, South, Central, Gorontalo, West and South East Sulawesi. Bunaken Island to the north is an internationally renowned diving centre, Tana Toraja to the south have elaborate funeral ceremonies and burial cultures.

There are two medical schools in Sulawesi – the Hasanuddin University in Makassar and the Sam Ratulangi University in Manado. The medical degree is a 6 year undergraduate course which only those who can afford the university fees can attend. There is currently no emergency medicine training programme in Sulawesi. The hospital emergency departments are staffed 24 hours a day, 7 days a week by both medical and nursing staff. The experience level of medical staff is variable. These staff members have no postgraduate training and are referred to as “Dr. Umum”, or general doctor.

I spent most of my time based at Luwuk General Hospital, a 125 bed hospital in Central Sulawesi. The surrounding region is developing rapidly, leading to an increased population and increased emergency presentations. The Emergency Department is staffed by a medical practitioner 24/7, but this doctor may be quite junior with no senior supervision. Luwuk Emergency Department has extremely limited access to drugs and equipment. Sterilization techniques are limited. Pathology and radiology are only available during office hours. There is no CT or MRI access. It has a three bed emergency room with one portable oxygen cylinder, one suction machine, a pulse oximeter, an ECG machine, one bag valve mask and one Laerdal bag. It had no continuous cardiac monitoring equipment, ventilator or defibrillator.

The main emergency presentations are for trauma, sepsis and TB. There were 408 motor vehicle related presentations to the Luwuk General Hospital in 2006. Other trauma related events include falls from trees. Obesity related diseases including diabetes mellitus and cardiovascular disease are increasing. This has been attributed to a rise in sedentary lifestyle, most likely

secondary to an increase in affluence leading to a change in diet and increased use of transport for travel. Public awareness of health is lacking and health infrastructure has not improved to meet the increasing demands on the emergency departments. Preventative health measures including compulsory helmet use while riding a motorbike have been recently introduced. Enforcement of this has not been universal but with the institution of fines helmet use will increase.

There are a number of factors which inhibit the local population from presenting to emergency departments. These include financial restraints. Patients are expected to pay for all their medications, pathology and radiological investigations, food, accommodation and medical consultations while an inpatient. Patients are often asked to remain in hospital for a prolonged period of time with no clear diagnosis. If the main income earner is the patient this can lead to prolonged loss of income which impacts on the entire family. There is also a lack of awareness by the public as to which medical conditions require emergency presentation, with a continuing reliance on non-medical treatment or alternative medicine techniques. For example, a patient summoned a local massage therapist for chest pain after a 2metre fall from a coconut tree, rather than attend an emergency department. The patient subsequently died at home, presumably from chest injuries.

Universities in Sulawesi do conduct postgraduate training for other specialties including obstetrics and gynaecology, ophthalmology, paediatrics, general surgery, orthopaedics and anaesthetics. There is no postgraduate training for general practitioners, who can work independently after completing their undergraduate training in either emergency departments or their own clinic. Specialties are expected to be involved in CME activities but this is not regulated or enforced. Specialty doctors have been encouraged to attend national and international conferences (especially South Pacific conferences), however language barriers usually preclude this. Medicine is taught in Bahasa Indonesian in Sulawesi. Language issues also limit access to international journals.

Pre-hospital care is virtually non-existent in Sulawesi. Ambulances are primarily used to transport deceased patients back home or to the mortuary. Local transport (ie bemos, motorbikes) are relied on to transport acutely

unwell patients to the hospital as ambulances are believed to be expensive, unreliable, and time consuming. Ambulances in Luwuk are staffed by a driver only, and have no paramedic staff. In Luwuk there has been recent controversy over the inter-hospital transfer of patients which was publicised in the local newspaper, The Luwuk Post. A patient transferred by boat from a nearby island for further care by Luwuk Hospital was left to organize their own transport as the only ambulance available had been un-roadworthy for months. All other Luwuk Hospital ambulances were in private use by the attending physicians.

Inter-hospital transport is reliant on public transport – usually via boat or plane. Often there is no medical escort, sometimes a nurse will accompany the patient but in most cases it will be family members. Family members are expected to pay for the transfer.

The development of emergency medicine in Sulawesi is in its infancy. A Masters programme for emergency management under the supervision of the World Health Organization is planned to begin in 2010 at Hasanuddin University in Makassar. Potentially this programme will be adopted in other areas of Sulawesi. I hope to be involved in some capacity, but I am still establishing medical contacts.

Sulawesi is an amazing place with spectacular natural beauty and diverse cultures. Anyone interested in any further details can contact me at: ameerakhan@hotmail.com.



The broken down ambulance at Luwuk Hospital



The entrance to Luwuk Hospital



The emergency room at Luwuk Hospital

- Time on the Fly - Kiunga Hospital, Western Province, Papua New Guinea

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Background

Kiunga Hospital is a 39 acute care bed hospital located in the Western Province of Papua New Guinea. It is in the process of being established as the District Hospital serving the remote population of the North Fly District and possibly Middle and South Fly as well. Eight months ago Sister Joseph, a renowned surgeon experienced in working in resource-poor situations and in responding to clinical situations creatively, was requested to help develop Kiunga Hospital as a main referral centre.

The hospital has a 24 bed general ward that cares for medical, surgical and paediatric patients. The 15 bed obstetrics and gynecology unit cares primarily for antenatal and postal natal mothers and neonates. The out-patients department sees all the emergencies, where community health workers, nurses and health extension officers (HEOs) address patients needs and as required request the two doctors on call for assistance with more complicated cases. The maternal and child health unit has regular clinics at the hospital and outstations providing antenatal services, vaccinations and health education. There is a tuberculosis ward, run by an HEO following the World Health Organization guidelines to provide directly observed therapy (DOT) for up to 6 months. The sexually transmitted infections clinic is run by staff that provides pre-test and post-test counselling for HIV/AIDS and does health education outreach programs.

Response

In September 2009 Siah Kim, a paediatrics trainee, and Farida Khawaja, an emergency medicine trainee, had the opportunity to work at Kiunga Hospital on a volunteer basis to attempt to help. Coming from well equipped and resourced hospitals, it was an adjustment to make. In preparation for the journey we inquired from Sr. Joseph about equipment needs of Kiunga Hospital. To help cover some of the costs of the equipment a fundraising raffle was held in Alice Springs, where the business community donated generously. Funds assisted in the purchase of glucose strips, liquid paraffin, a polycarbonate skin grafting board, surgical drain sets and a surgical tourniquet. We contacted the Alice Springs Hospital surgical, anaesthetic, wound care and remote health departments who also very generously donated useful expired goods, which are not used in Australia but were very useful at Kiunga Hospital.

Clinical experience

During our four weeks we helped with the ward rounds and response to emergencies. As most people live in very

remote regions and need to travel long distances to access health care, many presentations of illnesses occurred late. The majority of the cases are seen on an outpatient basis by the community health workers, nurses and HEOs. The team follows national treatment guidelines to assist with management of common illnesses and provide health education. The doctors were called to assist with cases that were serious and were not responding to treatment. We assisted in cases of severely unwell children suffering from meningitis, cerebral malaria, tuberculosis, severe dehydration, pneumonia, and neonatal sepsis. We also assisted in the care of adults with snake bites, heart failure, tuberculosis, respiratory failure, and renal failure.

Sadly several young people with end stage cancers also presented. These included breast, prostate, stomach, parotid and bladder. Most of the cases presented late and were assisted with palliative pain management. Some of the patients were assisted with palliative surgical intervention to prolong life and improve quality of life.

Unfortunately due to the nature of our training we are not equipped with skills to address surgical or obstetric emergencies such as retained placentas and Caesarean sections. The surgical emergencies were addressed by Sr. Joseph, together with elective cases that were identified during the weekly surgical out-patients clinics.

Weekly 'tok save' (discussion sessions) were held on clinical cases and learning issues identified during the week. Sr. Joseph conducted weekly teaching ward rounds and supervised the care of patients. Her breadth and depth of knowledge plus attention to detail helped us to refine the care of patients.

The future

Working at Kiunga Hospital has been an invaluable experience for us both professionally and personally. We hope we were of some assistance to the hospital, but feel that a longer time is required to become familiar with the local circumstances, and thus respond more appropriately. Working in a resource-poor situation together with very experienced clinicians working with few diagnostic tools, we have gained a lot and been inspired to consider broader training experiences to develop appropriate skills.

We would like to consider fostering a continued personal and broader relationship with Kiunga Hospital and its staff to hopefully benefit both Papua New Guinea and medical staff from Australia interested in gaining experience for working in resource-poor, remote locations.



An unwell child receiving physiotherapy



Kiunga Hospital



Surgical tourniquet in use



Siah Kim and Farida Khawaja



An extensive parotid tumor



General ward

Newsclips from South Asia



A call for emergency care in Nepal

In *India* - the Medical Council of India (MCI) recognized emergency medicine as a specialty in 2009. There is now activity to have emergency medicine training programmes approved by the MCI so that the training of specialists can get under way.

In *Sri Lanka* - application has been made to the Postgraduate Institute of Medicine for recognition of emergency medicine as a specialty.

In *Nepal* – four major teaching institutions are considering the development of emergency medicine training programmes. Proposals will be put to the Nepal Medical Council for approval.

In *Myanmar* – a team mainly from Hong Kong and including Georgina Phillips from Melbourne has presented a second round of Primary Trauma Care (PTC) instructor and provider courses.

The emergency medicine road can be challenging



Conferences

2nd EurAsian Congress on Emergency Medicine presented by Emergency Medicine Association of Turkey



<http://www.eacem.org>

Welcome Message

‘Emergency Medicine: The specialty that bridges continents’

Dear Emergency Medicine Professionals, Colleagues, Supporters, and Friends

We are pleased to invite you to the 2nd EurAsian Congress on Emergency Medicine (EACEM) to be held in Gloria Golf Resort Hotel, Antalya – Turkey during October 28 – 31, 2010.

EACEM is the biennial International congress of the Emergency Medicine Association of Turkey (EMAT) in collaboration with SUNY Downstate and the Singapore Society of Emergency Medicine (SSEM) with endorsement by the International Federation for Emergency Medicine (IFEM) and The Ministry of Health of Turkey.

The scientific program will cover multiple aspects of Emergency Medicine. The congress will feature state of the art lectures, workshops, panel discussions, as well as scientific oral, poster and video presentations. Most importantly it will foster exchange with leaders of Emergency Medicine in the world. The congress will also include a trade exhibition on the latest technologies, pharmaceuticals and systems relevant to Emergency Medicine.

As evidenced by the success of the last congress we believe that EACEM 2010 will again create an atmosphere of superb networking opportunities for Emergency Medicine professionals and leaders of various continents and countries as well as exposure to the newest in Emergency Medicine technology.

Antalya is one of the major touristic cities of Turkey. The city is well connected to major airports and other places of interest. The meeting is being held in an exclusive golf resort in the beautiful city of Antalya. The climate is wonderful during that time of the year and there will ample opportunity to explore the rich history and culture of its surroundings.

We look forward to welcoming you to Antalya.

Levent Avsarogullari
Congress Chairman

Opportunities

FACEMs wanted in Shanghai

Shanghai United Family Hospitals is recruiting for two emergency medicine physicians, one of whom would serve as Chair of the Emergency Department.

Currently physicians work seven 24-hour shifts per month in a relatively low acuity emergency department, seeing about 20-30 patients per shift with a 5% admission rate. Physicians regularly sleep 4-6 hours per shift. The patients are predominantly English-speaking expats, and the language of function in the hospital is English. A full spectrum of English-speaking specialty back-up is available. CT, MRI, and US are available 24 hours to the emergency department.

You will never find a job with a better lifestyle. Working seven shifts a month allows for ample time to travel or further develop your personal interests. Shanghai is an excellent base to explore China, Southeast Asia, and Oceania, and doctors routinely have 7-10 days off in a row each month to do so. Shanghai is a cosmopolitan city with excellent international restaurants and nightlife, and expats in Shanghai live an extremely comfortable lifestyle. If you have children, the international schools here are excellent.

We are looking for a physician who is able to commit at least a year or two, and a Chair who is able to commit for several years. Given the relatively slow pace and low acuity, this job is not good for recent graduates who are looking to hone their skills, and we are looking for physicians several years to decades out of training. If you're interested, please send your CV in confidence to gregg.miller@ufh.com.cn.

Thanks
Gregg Miller
Chairman, Emergency Department
Shanghai United Family Hospital and Clinics

Short Courses in International Health

Macfarlane Burnet Institute for Medical Research and Public Health (the Burnet Institute), Melbourne

The Burnet Institute, established in 1986, has a Centre for International Health (CIH). The CIH collaborates with other Australian, overseas government and international agencies to promote the health of populations in less developed countries. It conducts short courses, accredited by Monash University, that can be credited towards a Master of Public Health or of International Health, a graduate diploma in International Health, or may be attended by persons not seeking academic accreditation.

Courses of five to six days include:

- public health in refugee settings
- field methods for international health planning evaluation
- health communication and training

and specifically for developing countries:

- health of women and children
- managing community based HIV programmes
- health economics
- primary health care
- communicable disease control
- nutritional issues

For more information go to:
<http://www.burnet.edu.au/home/cih/education>

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