

EDUCATION AND TRAINING IN EMERGENCY AND DISASTER MEDICINE

275

Training of Members of Japan Medical Team for Disaster Relief (JMTDR)

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The law concerning dispatch of Japan Disaster Relief Team was promulgated and enforced on 16 September 1987. The training committee of the Japan Medical Team for Disaster Relief (JMTDR) offers two training courses to JMTDR members. The first course is the introduction of JMTDR for new members and the evaluation of their aptitude for JMTDR missions. The second course is an upgraded course for leaders of JMTDR. Both courses offer curriculum over a three-day period. Thirteen introduction courses and three leader courses have been conducted. Training has been provided for 175 doctors, 179 nurses, and 123 medical assistants. A total of 477 members have registered with JMTDR. The Japanese government sent JMTDR to disaster-affected countries on 19 occasions between 1987 and 1992.

The presentation will introduce the training system of the Japan Medical Team for Disaster Relief and its future prospects.

278

Post-Graduate Emergency Medicine Training for Physicians in Brooklyn, New York

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Objective: To describe the structure of an Emergency Medicine Residency Program.

Method: The inter-relationships among the institutional mission statement, the mandated curriculum of the Residency Review Committee, and the curriculum of the individual program will be demonstrated. Clinical rotations, lectures, and learning experiences, each with its objectives and evaluation procedures, will be presented.

Conclusion: Emergency Medicine is a field which is advancing in many countries. Through an understanding of the training programs of other countries, each country can choose those elements most suited for training of its own specialists. International cooperation and a better understanding of the orientation of emergency physicians in all countries may result.

279

Documentation of the Need for Attending Supervision of Residents in the Emergency Department

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Objective: To determine the changes in patient care by attending emergency physicians (AEP) supervising non-emergency medicine house staff (HS), and compare these changes to a prior study of emergency medicine (EM) housestaff elsewhere (*Ann Emerg Med* 1992;21:749-752).

Design: Prospective study of 1,000 consecutive housestaff patient care plans.

Setting: University Hospital Emergency Department (annual census 26,000).

Participants: Thirty-two second- and third-year housestaff and eight attending emergency physicians participated from October-December 1992.

Interventions: Housestaff presented cases with their diagnoses and treatment plans to the attending emergency physicians, who then classed any housestaff errors or attending emergency physicians' change of care as major, minor, or none, according to a predetermined 40-item data sheet list.

Results: There were 15% major and 35% minor changes in patient care by the attending emergency physicians. The most common major changes by the attending emergency physicians were: 1) ordering lab tests (2.1%) or x-rays (1.7%) which showed a significant abnormality; 2) finding additional pathology on physical exam (1.6%); and 3) correction of intravenous medication orders (1.1%). The attending emergency physicians provided direct patient care in an additional 650 cases during the study period.

Conclusions: Attending emergency physicians prevented frequent patient care errors and deficiencies by housestaff, while also providing direct patient care and supervision of students and interns. The major error rate for non-emergency medicine second- and third-year housestaff was three to four times greater than that of emergency medicine housestaff reported in the prior study, showing that attending emergency physicians' supervision is even more important in an emergency department staffed by non-emergency housestaff.