

Visiting Faculty FAQ

What will my schedule of activities be as a visiting faculty member?

Your day will start at 8 AM with morning report. The resident on duty from the previous night reports on patients seen and presents the most critical or interesting cases for discussion. All residents, the program director, and pediatricians are present, and are often joined by other hospital staff including the matron (head nurse), and pediatric nurse practitioners.

Morning report is followed by resident work rounds which are joined by the attending on service at some point in the morning most days. As a visiting faculty member, you will spend your mornings rounding with one of the inpatient teams or in the ER or OPD. You can work on whichever service you feel most comfortable and most useful. Orotta Hospital for Children has 6 clinical services: OPD, ER, and Wards A – D, divided by age. A 4-bed PICU is scheduled to open in 2009. In general, we will suggest that you choose to focus on one service for morning rounds or patient care per week.

There is a lunch break from noon or 12:30 to 2 PM.

Your afternoons can be spent consulting on inpatients that need your expertise, or depending on your area of specialty/interest, you may also choose to join a subspecialty clinic for ½ days (see table below). If there is not a subspecialty clinic that already exists in your area of expertise, we may try to arrange to have patients called in for an ad-hoc clinic for your consultation. You could also choose precept the resident in the OPD or ER.

Afternoon conferences take place from 4-5 on Tuesday, Wednesday, and Friday. We will ask you to give conferences on Tuesdays and Fridays. Occasionally, we add conferences on Mondays and Thursdays as well to accommodate material that visiting faculty would like to present. Our conferences are attended by the program director, all of the residents, and most of the faculty, as well as others. We ask that you make your presentations interactive and case-based. Wednesdays are resident-led case presentations. Your input and participation in those discussions can be very helpful.

	MON	TUES	WED	THURS	FRI	SAT
8 – 9	Morning Report*	Morning Report	Morning Report	Morning Report	Morning Report	
9	Resident work rounds	Resident work rounds	Resident work rounds	Resident work rounds	Resident work rounds	Resident work rounds
Morning Subspecialty Clinics		RVI**/High Risk Clinic	Neurology Clinic	Chest Clinic	RVI**/Misc Clinic	
12 - 2	Lunch***					

4-5		Pediatric Conference	Grand Rounds (Case Conference)		Pediatric Conference	
Afternoon Subspecialty Clinics	Chest/Nutrition Clinic	Seizure Clinic		Cardiac Clinic		

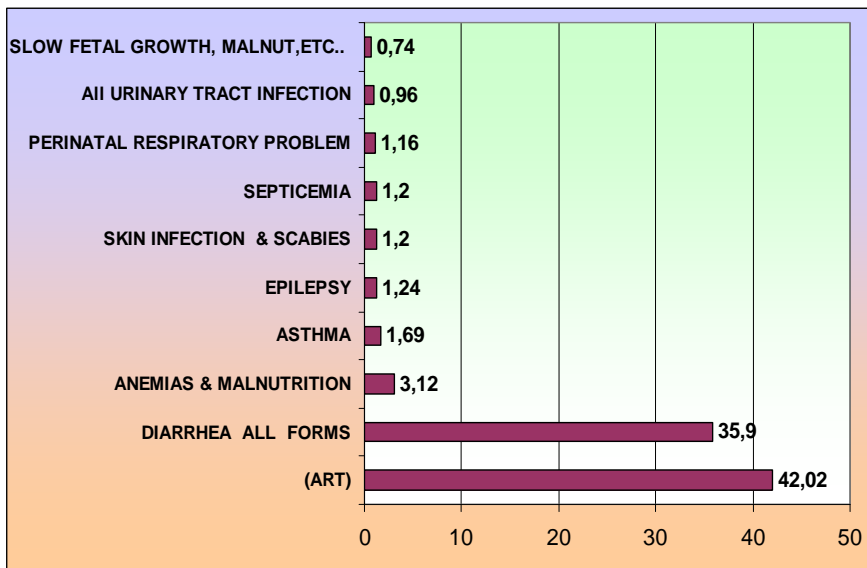
What kinds of patients are seen at Orotta Children’s Hospital?

The hospital is a 200-bed facility that includes 4 inpatient units, divided by age, a referral out-patient department, and an Emergency Room. The inpatient units include: Ward A , NICU; Ward B , Infants; Ward C , Toddlers; Ward D , Children 5-14 y.o.

The nursery, Ward A, receives admissions from the busy obstetrics ward next door, as well as admissions from home who were discharged and returning or who were born at home. Babies who are born healthy are discharged directly home from OB. The nursery can provide phototherapy, CPAP and oxygen, and has an ultrasound machine.

Ward B and C admissions are primarily infants and toddlers with malnutrition complicating diarrheal illness and acute respiratory tract disease. Both of the charts below provide a somewhat false impression, as data collection allowed one diagnosis only. Many cases are complicated by malnutrition, for example.

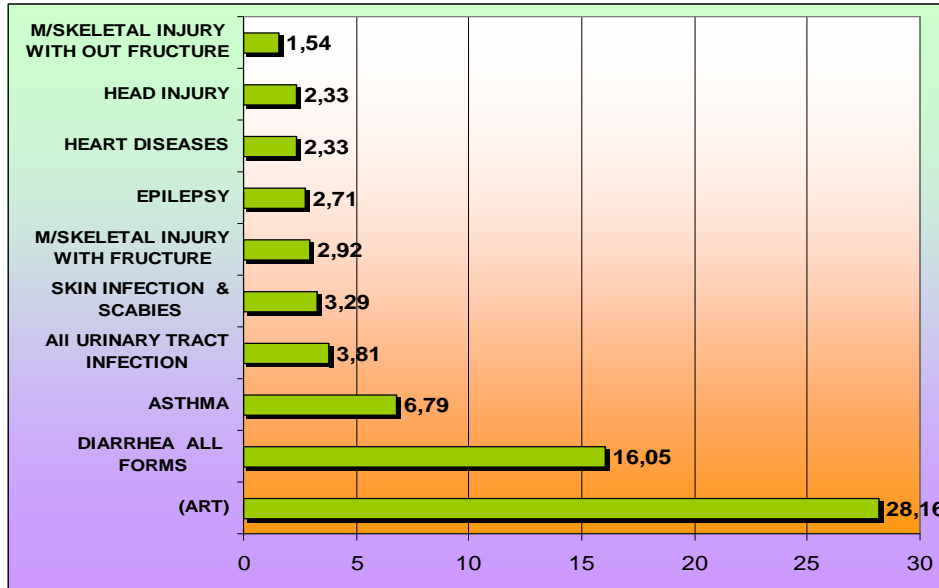
Top leading causes of hospitalization in OPH in 2007 < 5 years



The older children in Ward D can be our most challenging patients. They have a range of illness, including tuberculosis, cancer, rheumatic heart disease, renal disease. As many

oncologic are never definitively diagnosed, they are likely under-represented in the chart below.

Top leading causes of hospitalization in OPH in 2007 5 & above years



The OPD is a referral clinic, not a well-baby clinic. Clinicians there see 23,000 visits/year. Patients come mostly from Asmara neighborhoods sometimes referred by local health clinics; most are self-referred. In a recent analysis, we found that ___% of patients seen in OPD were referred on to the Emergency Room and/or inpatient for admission.

The ER has 30 beds and includes a room for patients with acute diarrheal illness in need of rehydration and a resuscitation room equipped with oxygen and all the equipment necessary for fluid resuscitation.

A 4-bed PICU is planned for early 2009.

Who will I be teaching?

Our first class of residents who started the program in January 2008 are general practitioners who have been practicing from 7 to 14 years in Eritrea. They completed their undergraduate training in Hungary, Sudan, and Ethiopia. They will be joined by a second class of GP's in 2009. In addition, the first class of medical students from Orotta School of Medicine (founded in 2003) will be joining the teaching teams in their 9-week rotating internships in pediatrics. See Resident Profiles.

While your primary teaching is for our residents, the medical school is always eager to have special guest faculty teach students there as well. Often, these opportunities open up in the evening hours.

What will I teach?

In addition to your didactic presentations during afternoon conference, you will be providing clinical supervision on inpatient and outpatient units along with the Eritrean pediatricians. While you will likely learn a lot from the Eritrean trainees about malnutrition and management of common conditions in Eritrea, you will have quite a bit to contribute. Our trainees are eager for guidance in synthesizing information gathered in their histories and physicals to develop a differential diagnosis and management plan for their patients. They are still working on critical thinking, presentation skills, and judicious diagnostic work-up and therapeutic plans.

If you are in the OPD or ER, you will precept the resident seeing patients. Offering suggestions for better history-taking, note-writing, use of lab tests, consultation on diagnostic dilemmas and encouraging use of textbook/on-line resources can be useful. Trainees also value feedback on their presentation skills and critical thinking. The heavy clinical demand often requires making notes and providing teaching points when time allows. By precepting the residents, you can also learn what kinds of patients are seen in OPD and ER and how they are treated.

If you are a hospitalist or are more comfortable in the inpatient setting, you can work with an inpatient team. There again, our trainees will value your input regarding their clinical skills in history taking, physical examination, critical thinking, and presentation skills.

For both outpatient and inpatient work, we may ask you to schedule a session with each trainee to provide feedback on their presentation skills.

Finally, the 5 Eritrean pediatricians who are serving as clinical faculty for the program are expert busy clinicians whose responsibilities now include teaching as well. To the extent that you are comfortable with doing so, they may call upon you for feedback on their teaching and pointers on teaching in a busy clinical setting or effective methods to present interactive teaching conferences.