LOW-FIDELITY SIMULATION IN GLOBAL AND DISTRIBUTED SETTINGS

To the editor:

I enjoyed the C7EM June 2015 article about the International Federation of Emergency Medicine (IFEM) and continuing professional development. Hobgood et al. note that there is "at least modest evidence for the use of high-fidelity medical simulation, particularly for use in teamwork training and critical incident communication, two essential EM competencies." They also note that "there are core principles that IFEM endorses: every EP should evolve in the multiple domains that are required for practice advancement; patient care should evolve according to the best available evidence; and there is a set of basic core EM knowledge, skills, and attitudes that define the discipline regardless of the location of practice."1

Low-fidelity simulation, used with sound pedagogy, also has a positive effect on learning²⁻⁶ and may be a more effective tool than high-fidelity simulation in global low-resource

settings. Simulation feasibility, or required cost and value attained, relates to affordability and logistic implementation.⁵ High-fidelity simulation is expensive, challenging to maintain and operate, and may lack contextual validity in low-resource or distributed settings. High-fidelity simulation is not always superior to lower-fidelity; it depends on the type of task involved and the learner's level.

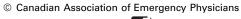
IFEM represents emergency medicine (EM) learning in global contexts. These contexts exist on a spectrum with rural and remote EM in distributed settings closer to home, where low-fidelity simulation sustainable and contextually relevant. Moreover, the use of local materials to make low-fidelity trainers can provide insight for learners into the social determinants of health when, for example, local and visiting learners attend village markets together to buy simulation materials. Low-fidelity simulation should be included as a learning tool for core EM knowledge, skills, and attitudes.

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77

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