SEA-HVO Fellowship Trip Report

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Overview

I spent early January through early February 2026 at the Department of Anesthesiology at Hue University Hospital (HUH) in Hue, Vietnam. I overlapped for three of the four weeks with a resident co-fellow, and an attending volunteer from another US institution. I had an unforgettable experience and hope this report is useful for future fellows.

A Note on Medical Training in Vietnam

I am including this because I had limited knowledge on how medical training works in Vietnam before I arrived, and found this background very useful:

- Students go directly from high school into a six-year medical program.
- To enter residency, graduates must pass another highly competitive exam. Residents told us only ~10–15% of their graduating class passed for their chosen specialty. Everyone else becomes a GP.
- Vietnam has an excellent primary care system as a result. But residents in specialty programs are essentially the top performers in the country, selected twice over — and it shows!
- The anesthesia residency at HUH is three years long.
- A small number of 'specialist' trainees — GPs who return after several years of practice for a focused two-year anesthesia program — train alongside the residents. Two were in the senior group during my fellowship. Fully integrated; I wouldn't have known if no one had told me.

Day-to-Day Schedule and Workflow (M–F)

- **7:00 – 11:00 AM:** Morning OR time — observing and teaching during inductions, discussing anesthetic plans, bedside ultrasound practice during downtime.
- **11:00 AM – 1:00 PM:** Lunch and lecture prep. There's a great coffee spot (Hemen Kafe) right next to HUH and several great spots for lunch nearby (Pho Saigon is terrific).
- **1:00 – 3:30 PM:** Afternoon OR time, more teaching and ultrasound.
- **3:30 – 4:00 PM:** Walk to the lecture hall in the adjacent building and set up.
- **4:00 – 5:00 PM (Mon–Thu):** Fellow lecture (my co-fellow and I alternated).

Fridays were lighter — ORs wrapped up around 3–4 PM, no lecture.

Evenings: lecture prep, gym (Olympic Fitness — highly recommend), dinner. About once a week residents or attendings invited us out — dinner or, once, karaoke. Those nights were some of the best of the trip.

The Clinical Environment

Program Structure

Residents rotate daily across several sites:

- Main HUH building: 6 ORs (where I spent most of my time)

- Secondary HUH building: ~3 ORs
- Hue Central Hospital: cardiac and OB rotations
- ICU rotation within HUH

One of the most surprising features: each OR is staffed by one resident from each training year simultaneously — PGY-1, PGY-2, and PGY-3 — alongside an attending who usually covers one room.

The department also has an active research culture — residents must complete a project to graduate. Projects I heard about included: ultrasound-guided thoracic epidurals, norepinephrine in patients over 60, urinary retention after spinal anesthesia, and videolaryngoscopy.

Case Mix

Diverse in complexity. I observed everything from major oncologic surgery (Whipple procedures, a total laryngectomy) to small cosmetic procedures under local anesthesia only. One OR was dedicated to minor procedures and had two beds to increase throughput. Two rooms had C-arms.

Anesthetic Techniques and Pharmacology

By and large, the techniques were surprisingly similar to what we do in the US. The basic approach and pharmacology were essentially the same. Notable differences:

Anesthetic type:

- Regional anesthesia was used far more than we typically use it. Almost anything below the umbilicus was done under spinal. Patients got no supplemental sedation and stayed fully awake. The stoicism of patients was remarkable.
- Spinals: always lateral, Quincke needles, no introducer. Intrathecal mixture: hyperbaric bupivacaine + fentanyl. Intrathecal morphine not available during my rotation but is used when available. Saw a paramedian spinal technique once — something I'd never seen at home.

Analgesia:

- Thoracic epidurals used in major abdominal cases (Whipples etc.), always midline. Because OB epidurals essentially don't happen here (C-sections under spinal, labor analgesia rarely used), residents get most epidural experience doing thoracic epidurals.
- Fentanyl and morphine for analgesia — no hydromorphone, ketamine, dexmedetomidine, or methadone.

Airway:

- Almost exclusively direct laryngoscopy with Macintosh blades. Videolaryngoscopy used selectively (one resident had a research project on it). One awake fiberoptic intubation during my rotation.

Neuromuscular blockade:

- No succinylcholine.
- Sugammadex is very rarely used — typical reversal with neostigmine/atropine.

Monitoring:

- Invasive monitoring is used very conservatively, even for large cases. No arterial lines observed — even for cases requiring inotropes. No central line placements observed.
- Everyone extubated fully awake, even pediatric patients, in part due to limited PACU monitoring.

Equipment:

- Functional but variable in age and reliability. The team was adaptable — cases continued with broken ventilators (a PGY-1 hand-bagged the whole case), no end-tidal CO2, manual BP checks.

LMAs and bougies were sterilized and reused. IV fluids were once warmed by dunking bags in a jar of heated saline. The ingenuity was genuinely impressive.

Teaching and Lectures

Structure and Format

Residents normally have lectures two afternoons a week. With two of us there, the department expanded to four — Monday through Thursday — each of us doing about two lectures a week. Lectures were in a formal hall with a projector, screen, and microphone. Dr. Thinh or Dr. Long came to almost every session and translated after each slide. Even for residents comfortable in medical English, hearing lectures in both languages reinforced the content significantly.

Curriculum Development

Coming up with a curriculum with limited guidance on what had been recently covered or what level to teach at was one of the harder parts of the fellowship. We tried asking residents what they wanted; they were gracious but deferential. We built a theme-based structure: one big topic per week, four lectures within it.

- Week 1: Obstetric anesthesia
- Week 2: Trauma anesthesia
- Week 3: Neuroanesthesia
- Week 4: Resident vote from a list we provided — highly recommend doing this from the start

Topics that generated the most energy: neuroanesthesia (residents get limited exposure), POCUS, and comparative discussions about US practice — when we use ketamine, norepinephrine, or dexmedetomidine; epidural dosing for OB; pediatric fluid resuscitation. Those comparative conversations were consistently the best discussions of the month.

Advice on Teaching Here

- **Plan for translation time.** With interpretation after every slide, a lecture takes about twice as long as expected. 30–40 image-heavy, text-light slides was the right amount for an hour. I initially prepared way too much.
- **Expect a significant knowledge base.** PGY-2s and 3s have read Morgan & Mikhail cover to cover and everyone comes prepared. Starting too basic was a mistake. Case-based discussion with real clinical complexity is a much better fit.
- **Build in interactivity.** Residents were attentive but generally shy about volunteering questions. Discussion questions built into cases, and an interactive element at the end (short quiz, a game), made a huge difference. The lectures that felt most alive were the ones where we'd engineered a reason to talk.
- **Do skills-based workshops.** We helped run a trauma skills session (manual in-line stabilization, surgical airway, needle decompression, patient transport) and it was the most enthusiastically received thing we did all month. I'd aim for at least one workshop per week.
- **Consider separating by training level.** Lecturing to PGY-1s, 2s, and 3s simultaneously is a real challenge as their experience and interest varies enormously. I didn't incorporate small breakout sessions by year group, but I wish I would have, as I think it would make a meaningful difference.
- **Use interesting cases as warmups.** When something interesting or unusual happened in the OR, having the resident present the case briefly at the start of lecture was always a nice kick-off.

Challenges

During one of the weeks, my co-fellow and I were asked to give lectures on topics we weren't comfortable with. It was a difficult position and, to be honest, felt somewhat uncomfortable for us both. We ultimately handled it by being transparent in our presentations: "I'm not an expert in this topic, but here's what I've learned from reviewing the literature." That felt better. The takeaway: teach to your actual strengths, and be honest when you're at the edge of your knowledge.

Figuring out the right level of complexity for a mixed PGY-1 through 3 audience was the other persistent challenge. I still don't feel like I fully cracked it. I think breakout sessions by year, or perhaps having entire lectures or workshops specific to class year, may have helped.

Point-of-Care Ultrasound Training

Ultrasound training always enthusiastically received. Sessions happened during OR downtime — pulling one or two people out briefly when cases were running smoothly (with three residents per room, this was usually possible).

- Two machines available, both with linear and curvilinear probes. Neither has a phased array probe — cardiac views were done with the curvilinear. Harder but doable; worth practicing before you arrive.
- Topics covered: cardiac POCUS (curvilinear), gastric ultrasound, neuraxial ultrasound (lumbar and thoracic), nerve blocks.
- One gap: ultrasound-guided peripheral IV placement. Residents were very interested but we couldn't demonstrate on patients and found it difficult to describe the technique successfully. A low-fidelity sim would be a good workaround and something I wish I had developed.

Observations and Reflections

- Seeing major cases managed safely with minimal monitoring was thought-provoking. The team was calm and effective in situations that would have made me very uncomfortable. At times I wondered if we sometimes over-monitor patients, at other times I wondered if they under-appreciated certain risks. The truth is probably somewhere in the middle, but I loved that it forced me to reevaluate what I would do.
- Pediatric inductions were universally done without parents in the room (at our hospital we almost always allow parents to come back for induction for younger children). The patients — even small children — almost never cried, and sailed through mask inductions. I wonder if there's something about how expectations are set, for kids and families, that I could be doing better.
- Masking was often done with the two-hand technique, with one person on the mask and another on the bag. It is wonderful to have so many sets of hands for induction, but I think explicit practice on one-handed masking could be beneficial as well.
- With so many hands in the OR, there was often less time to practice independent decision-making and troubleshooting. I think this is a skill worth deliberate practice for any anesthesiologist.
- Some cases (e.g. total laryngectomy) were only done about once or twice per year, and as a consequence many residents never had the opportunity to see them. My institution has a "case reference app" for this purpose; residents contribute information on cases they have done, and anyone in the residency can access it and read their notes about OR setup, monitoring, anesthetic considerations, etc. I think a central case repository such as this could be hugely beneficial for the HUH residents as well.
- A few things I want to bring back to my own practice: doing more spinals (including for cases I'd normally reflexively GA), using the lateral position. I also want to think more carefully about preoperative counseling around sedation. Watching fully awake patients tolerate surgical procedures with minimal distress made me wonder if we're too quick in the US to offer whatever

level of sedation a patient requests, rather than having a real conversation about what makes sense medically.

- Something I didn't expect: spending a month as an observer, without direct clinical responsibility, was actually extremely beneficial for my own clinical development. Watching inductions, deliberate reflection on what I'd do differently, thinking through anesthetic plans without executing them was so useful. There just isn't time or space for that kind of intentional reflection in normal residency. I was worried about coming back feeling rusty, but I actually felt clear, prepared, and confident.

Thoughts on This Site Moving Forward

Vietnam is one of SEA-HVO's oldest and most popular sites, and fellows consistently have meaningful experiences here. But now that the residency has matured considerably and the curriculum is so well developed, I believe the residents would benefit most from the kind of subtle clinical nuance that comes from years of attending-level practice (expertise that residents like me simply don't have yet). At first, my co-fellow and I found ourselves wondering whether we could have made a larger difference at a site earlier in its development. However, upon further reflection, I think this is actually an incredible opportunity for this site and future volunteers to grow away from didactics and toward something more practical, or even structural.

Some ideas my co-fellow and I discussed: a shared case repository, structured workshop or skills-building sessions, case-based discussions, crisis management or leadership courses. The relationship between SEA-HVO and HUH seems ready to evolve from a volunteer model into something more like a true partnership.

Advice for Future Fellows

Before You Go

- **Visa:** Apply for the e-visa at least 3–4 weeks out. Easy online, but stressful to cut close. Rush services exist but are expensive.
- **Travel insurance:** FAYE is an easy, affordable option. Worth doing.
- **Clothing:** Business casual — slacks and a nice shirt. No suit needed. Everyone wears white coats outside the OR. Bring yours if you have room, but it's not necessary.
- **What not to bring:** Scrubs, scrub caps, and OR shoes are all provided. Leave luggage space for things to bring home; the shops are great.
- **Technology:** Bring an HDMI dongle if you have one — the lecture hall is HDMI.
- **Small gift:** A pen or tote bag from your home institution goes a long way.

Money and Getting Around

- **Wise (wise.com):** Debit card with no foreign transaction fees — convert to Vietnamese dong in the app, withdraw from ATMs, pay without fees. Very useful.
- **Moreta app:** QR-code payment used almost everywhere in Vietnam, including street food vendors. Load it up and you barely need cash.
- **Grab:** Uber equivalent, also does food delivery. Cheap, reliable, works for long distances — I grabbed a car to Hoi An (2 hours) without any trouble.
- **Cash:** Still widely accepted, but the apps above cover most things.

Teaching

- The OR whiteboard lists the day's cases in Vietnamese. I found it helpful to photograph it and run it through Google Translate every morning — helped me anticipate teaching opportunities.
- Most residents have solid medical English; Google Translate was useful whenever there was a language barrier.
- Bring your laptop fully charged to lectures

Daily Life

- The city is safe. I ran after dark regularly without any concern.
- Motorbikes everywhere — I never rode one but people who did said it was fun.
- Olympic Fitness gym nearby — affordable, well-equipped.
- If family is visiting, have them come at the end of the fellowship or after. There's basically no time during the week.

Accommodation

Stay in the tourist area just north of HUH along the Perfume River — about 20 minutes' walk from the hospital. Safe, lively, great restaurants, and a beautiful walk every morning. Good range of Airbnbs and hotels at very affordable prices. The SEA stipend covers it comfortably.

Travel Recommendations

- Hue itself: the Imperial Citadel is worth a full day.
- Hoi An: under 2 hours by Grab, incredible food and old town. Don't miss it.
- Phong Nha caves: spectacular.
- Ninh Binh: I ended the fellowship with a week of family travel here. The landscape is extraordinary — a great way to close things out.

Suggested Lecture Topics

Here are some popular topics (by vote) that we didn't get a chance to cover:

- Anesthesia for obesity: pharmacokinetics, airway, positioning, ventilation
- Anesthesia for severe COPD and pulmonary hypertension
- Geriatric anesthesia
- Pediatric anesthesia
- Advanced POCUS: cardiac function, lung ultrasound, IVC for volume status
- Dealing with bad outcomes and how to debrief
- Death in the OR
- Medication errors
- Post op hypotension

This was one of the best experiences of my residency. This fellowship is a real gift. The learning goes both ways, and the residents and faculty at HUH gave me far more than I gave them. I'm grateful to SEA-HVO for making it possible, and to Dr. Thinh, Dr. Long, and everyone else at HUH for their generosity and warmth. I can't wait to return and visit!