BRITISH ASSOCIATION FOR EMERGENCY MEDICINE

THE COLLEGE OF EMERGENCY MEDICINE

A CAREER IN EMERGENCY MEDICINE 2006

Emergency Medicine (EM) is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development. *International Federation for Emergency Medicine 1991.*

EM has developed into an exciting and rewarding career, which attracts individuals from many different backgrounds. A career in EM will never be dull and offers chances to develop your own interests and areas of expertise. This publication gives you the background to the specialty and the role it plays in the modern National Health Service (NHS).

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THE JOB

The Emergency Department (ED) is the centre of the acute work of all Trusts. EM specialists are responsible for assessing and resuscitating patients with serious illness and injuries before their transfer to hospital wards. Patients with more minor conditions are treated and sent home. There are frequently special facilities for the care of children including Registered Children's Nurses, while patients with psychiatric illness present particular challenges and liaison with the community mental health teams is crucial.

Recent focus on the emergency patient pathway has provided additional resources into EDs and has resulted in improved ways of working for Consultants and other staff.

Consultant Work Patterns and Opportunities

The day-to-day work of Consultants is varied and unpredictable. Most Emergency Consultants have five main areas of activity that they keep in balance - clinical work, teaching, management, research and audit. The Department of Health (DH) has confirmed a commitment to having eight Consultants in each major ED by 2010. This will require considerable expansion of the Consultant grade, but will be accompanied by an expectation that Consultants provide on site clinical cover, including weekend and evening work.

Consultants work alongside more junior staff on the shop floor bringing expertise and experience particularly in the most serious cases. Many departments have Consultant staffed review clinics for soft tissue injuries. Since the introduction of the four hour target, many departments have also developed Clinical Decision Units, which are separate areas within the department where patients can remain for longer whilst having further investigations or a short period of observation. These have mostly replaced the traditional observation ward and are now a focus for more intensive ongoing investigation and active management. Observation medicine is likely to develop as a specialty interest together with the development of an interest in acute medicine.

Within the department there is a requirement to provide training for the junior staff, both doctors and nurses, and to support the professional development of individuals. Many departments have medical students attached for certain periods, requiring supervision and teaching.

Consultants are also responsible for the management of the service and the provision of adequate staffing and facilities within the allotted budget. Within this management responsibility is also liaison with other specialties, the pre-hospital services, community and Health Authorities. The development of the major incident plan is also within the EM remit as is clinical audit.

There is considerable scope for research and development within the specialty; much of the day-to-day clinical workload is based on tradition and the evidence base is, as yet, small for our workload.

There are opportunities to develop a special interest, for example, in pre-hospital care, acute medicine, observation medicine and spend some of the working week engaged in that work in some way.

What attributes are needed?

EM Medicine is a young and rapidly evolving specialty in the UK. The work is challenging, unpredictable and sometimes stressful. Consultants in EM deal with sudden death (including unexpected death in children and young adults), major trauma, medical emergencies and a large volume of minor injuries and illness. The diversity within this workload can be difficult to balance and there may also be exposure to patients with violent behaviour, drug and alcohol abuse, psychiatric illness and social problems that cannot be resolved in the ED. Therefore the e Emergency Physician must possess certain attributes:

- Communication skill – the Emergency Physician must be able to communicate with patients and professionals from all backgrounds
- Compassion – may patients have significant personal difficulties and the Emergency Physician must be able to be compassionate as well as professional
- Flexibility- adapting to the unpredictable workload and case mix is essential, and many plans are disrupted because of unforeseen events
- Organisational skills – the number of staff, patients and conditions requires an organised mind and an ability to structure and plan for consistent service
- Analytical skills – above all else EM requires the physician to be able to analyse a patient history and signs and to respond in a timely and safe way. Because of the wide range of presentations the Emergency Physician needs to be able to apply basic principles and think laterally
- Practical ability – there are many practical procedures in EM and the physician must be adept at psychomotor skills
- Time management skills – juggling the many calls on your time calls for excellent time management

The career is often extremely rewarding in that it is constantly challenging and provides a genuine opportunity to make a real difference in the management of illness and injury. Few patients will remember or thank you for it, but the personal satisfaction can be considerable. If you have an interest in the whole breadth of medicine then EM is the only place within the hospital environment where this can still be realised. EDs are also a place for strong multi-disciplinary team working and it is important that you feel comfortable working alongside nursing staff, paramedics, general practitioners and in-patient specialists in an environment of mutual co-operation and respect.

There is an increasing movement towards shift work in EM, as in other specialties, and you should anticipate that EM consultants will be working late shift and possibly night shifts in the future. This will be to provide senior supervision and expertise to junior doctors and patients in the 24/7 environment that is EM.

Who would you be working with?

The majority of departments now have at least two Consultants with many having four or more. Other medical staff include Specialist Registrars (SpRs), Senior House Officers (SHOs), Non-Consultant Career Grade (NCCG) staff including Staff Grades and Associate Specialists and, in some departments, General Practitioners. All departments have specially trained nurses and Emergency Nurse Practitioners (ENPs) who have varying levels of clinical autonomy. Nurse Consultants are also increasingly common, working as part of the team of Consultants, often with specific responsibility for minors' patients and the ENP service.

Other essential staff include administrative, clerical and portering staff, not to mention therapists, social workers and technical support staff – it's a big team!

Being able to work effectively in a multidisciplinary team is a vital skill that all doctors in the ED need.

How do I know if it is for me?

To help you decide whether EM is the right career, you should take the opportunity to work in at least two different departments and talk to SpRs and Consultants in the specialty.

Entrance into specialist registrar training

Current situation

The development of the training scheme coincided with the Calman reforms and culminates in an Exit Examination for the Fellowship of the College of Emergency Medicine (FCEM). The specialty has recently (2003) developed their own Entrance Examination for entrance into specialty training and this is becoming increasingly popular with applicants for specialist training.

Candidates for SpR posts who qualified before 2005 and therefore are not part of the Foundation programme should continue to develop their experience by completing at least a year in EM (post registration). These jobs should be in busy departments, where there is a good teaching programme and lots of support from middle grade and senior staff.

In addition you will be expected to have at least a year in posts in related subjects:

- Acute Medicine (General Medicine with on take duties)
- Anaesthetics/Critical Care
- Paediatrics
- Trauma and Orthopaedics
- General Surgery

You will be expected to have a postgraduate diploma (preferably Membership of the College of Emergency Medicine – MCEM) and have completed one or more of the life support courses.

Future situation after Foundation programmes are established

As the Foundation programme progresses there will be clarity about the future selection processes. Many Foundation programmes have EM slots for F2 doctors, mostly for 4 months, but some for 3 or the more traditional 6 month slots. After completing the Foundation programme you will be expected to apply for a common stem training (see appendix Modernising Medical Careers).

This proposed programme has been approved in principle by the Postgraduate Medical Training and Education Board. The specialty is currently determining the number of such posts that will be required nationally, as well as the number of run through training posts that will be required to replace the traditional SpR posts. There will be a transition period of a few years during which old style training programmes will co-exist with new MMC training programmes.

Currently, every SpR post advertised attracts strong applications from doctors who have trained specifically for the job. You can be one of these!

Regulations for the MCEM

"Part A (MCQ) at least six months post-full registration experience in an ED
Part B (short answer) and Part C (clinical OSCE) at least 20 months of experience in post relevant to the practice of EM"

Therefore, experience in the specialties above can be seen to be important for eligibility to the examination, as well as contributing to your development.

Alternative examinations to MCEM that are **currently** accepted for entrance into specialty training are: MRCS, MRCS(A&E), FRCA and MRCP.

It is possible, however, that these exams will not be accepted after the establishment of common stem and run through training under modernising medical careers and that trainees will be required to possess the MCEM.

What can I expect on the EM training programme?

- The training programme is currently five years (anticipated to reduce to 3 years after a three year common stem) and currently includes opportunities to work outside of the department in core specialties. These secondments are usually 3-months long and allow you to spend time, usually as a supernumerary Registrar, learning clinical skills and also understanding the needs of that specialty. The core specialties are Medicine with Cardiology, Surgery, Orthopaedics, Paediatrics and Anaesthesia with Intensive Care. In the future, it is likely that trainees will gain these specialised skills by focussing on individual patients and their pathway within the department and into the hospital rather than spending specific secondment time out of the department

- During your training you will be encouraged to develop a special clinical interest, for example, children's EM. You may spend extra time in secondments in this area, or you may take an "out of programme" break to gain extra experience, sometimes in an overseas environment as appropriate.

- The training programme will normally be spent between three hospitals, at least one of which will be a teaching hospital. You will be told in advance which hospitals you will be going to in order to assist you in your choice of home location, schools, etc.

- The curriculum has recently been updated and can be seen at http://www.emergencymed.org.uk/CEM/curriculum. This curriculum indicates the breadth and depth of knowledge and skills expected. A curriculum for the Paediatric Emergency Physician is also being developed at present.

What will I do all day?

The training programme is structured so that you will spend the majority of the first year acquiring clinical knowledge and then increasingly be exposed to management training and developing your special interest. Most of the time you will be working shifts where you will do a pre-determined number of hours (including night shifts) and then go home.

During your shift you will be working continuously, seeing patients and supervising the SHOs. You will also be expected to carry out audit and perform management duties within the department, involving risk management and manpower issues, for example, review pathology and X-ray results and manage rotas. There are relatively few posts which are on-call from home - most are now residential or full shift at night.

What about formal training?

Dedicated protected time will be made available for training, both in the department and for regional training days.

Trainees are required to go on life support courses such as Advanced Trauma Life Support, Advanced Life Support and Advanced Paediatric Life Support. They are also encouraged to attend a major incident management course to equip them for major civil disruptions. Other courses are available for special interests.

What about research?

All trainees are encouraged to participate in research during their time in EM. Some trainees take a secondment of six months to do some research, others may take a year out of the scheme to do a full year of research. A small proportion elect to undertake a research degree.

Are there opportunities to teach?

All trainees will be involved in teaching. If they wish, they may take a special interest in this and many become recognised instructors in the life support courses, as well as lecturers in medical schools.

The programme culminates in the Exit Examination Fellowship of the College of Emergency Medicine (FCEM), currently taken after the end of your fourth year. Following this and the award of Certificate of Completion of Training (CCT), you will be eligible for a Consultant post.

What does the Fellowship Examination (FCEM) involve?

The FCEM confirms the trainee is adequately trained and is taken after the end of the fourth year. Candidates must have had a satisfactory fourth year RITA assessment.

The examination requires them to:

- Perform a critical evaluation of a paper and defend their own pre-prepared review of a clinical topic. This review is prepared three months prior to the exam and is a dissertation of around 3-5,000 words long.
- Participate in a discussion of management issues in a viva situation
- Be assessed in a short answer paper using clinical data
- Undergo an OSCE examination

The examination is currently undergoing development and will probably evolve into a predominately clinical examination, with the management and critical appraisal assessed during the training time, rather than at the end of training.

The success rate for this examination is around 85% and reflects the excellent training opportunities offered.

Is an EM career flexible?

EM as a specialty lends itself to flexible training and working. The nature of the work is intense, but each patient contact is relatively short and follow-up responsibilities limited.

As a trainee there is a moderate amount of on-call, but the majority of training schemes run as a full or partial shift system. Around 18% of all Consultants are female, and an increasing number are employed on a part-time basis. There is a job-share register maintained by the Editors of the Emergency Medicine Journal (EMJ) supplement.

The Emergency Medicine Journal

The EMJ is published monthly and includes original research, review articles and evidence-based topic reviews. The EMJ is peer reviewed and attracts international contributors and readership. A supplement to the EMJ is also published which contains news of Consultant appointments, articles of current relevance and interviews with figures of interest.

SPECIALISATION WITHIN THE EMERGENCY DEPARTMENT

The specialty of EM is broad, covering a wide range of conditions and needing many different skills. However, there are opportunities for some sub-specialisation within the job, commonly in Paediatrics or Intensive Care.

Paediatrics

Children make up about 25% of attendances at EDs and there is increased interest in improving their care. Improvements are being made with life support courses targeted at children (APLS and PALS) and accident prevention strategies and vaccinations to decrease infectious disease. The specialties of Paediatrics and EM have much to offer each other and Paediatric EM is growing in popularity as an individual specialty in its own right.

Trainees from both EM and Paediatrics can train with a special interest in Paediatric EM.

- At present, the recommendations are that emergency SpRs have an additional one year of varied Paediatric experience over and above the 3-month essential Paediatric secondment. This is in addition to a minimum of three years spent in emergency training. Six months of this extra time should be spent in Paediatric EM and six months spent in ward-based Paediatrics dealing with emergencies, of which half must be in general Paediatrics. In addition, the trainee should gain experience in Paediatric Intensive Care and Anaesthetics.

- For Paediatric SpRs the recommendations are that, in addition to their core Paediatric training, they should experience one year of EM (with 3 months in Adult EM, and 9 months in Paediatric EM). In addition, the trainee should have 3 months in Paediatric Surgery (including the care of the head-injured patient), Paediatric Orthopaedics and Paediatric Intensive Care and Anaesthetics. There should be a minimum of three years in an EM orientated programme.

Paediatric EM training will take place in recognised departments with recognised trainers.

Intensive Care Medicine

Specialty status was granted to Intensive Care Medicine (ICM) in June 1999. It is now possible to obtain a CCT in ITU Medicine jointly with a CCT in a parent specialty - Medicine, Surgery, Anaesthetics or EM. The training requirements are set out in an ICBT ICM document (January 2000).

In the fullness of time, ICM Training Consultants will only be appointed if they possess a CCS in ICM Medicine. However, for the time being, it is possible to acquire intermediate level training, enabling Consultant appointment with additional commitment to ITU Medicine, if not a whole-time appointment or Clinical Directorship. This describes the job plan of most Emergency Physicians who work in ICM in the UK.

Intermediate level training can be incorporated into most SpR EM programmes with a minimum of additional time. Entrants must have three months experience of ICM at SHO level, as well as six months in General Internal Medicine and six months in Anaesthetics. Within the SpR programme a further six months training in ITU is required.

There are advantages to integrating a job in EM and ITU.

- For a Consultant there is job satisfaction and intellectual challenge.
- For the patient there is the extension of critical care skills from the resuscitation room to the ITU and vice versa.
- For the service there is a seamless progression for the patient with one less negotiation during the process of transfer.

Academic EM

EM sees the largest group of patients of any specialty - 12 million per annum. All disease processes are represented across the spectrum. These patients represent a golden opportunity for research into all aspects of their care.

Currently Academic EM is a very young branch of the specialty. There are a number of Chairs and Senior Lecturer posts around the country.

Academic training posts and research posts are available in many major departments. The Modernising Medical Careers programme has specific guidelines for academic training in the future and these are to be found on the MMC website.

LINKS WITH OTHER SPECIALTIES

Acute Medicine

The majority of patients that are admitted to hospital have medical problems and thus the interface between EM and Acute Medicine is of huge significance.

The line of demarcation between the two specialties is blurring as more and more of the initial patient management is taken over by the ED. In years to come we may see a move to the Australasian system where emergency admissions are looked after in the ED for several hours.

There is creeping sub-specialisation in all hospital specialties and the undifferentiated patient will ultimately become the preserve of the Emergency Physician, with all the diagnostic and practical challenges that such patients can present.

Pre-hospital Care

Pre-hospital care has a history that lies in military medicine and many field treatments were developed in situations such as Vietnam. In the early 1960s roadside care started to be provided by GPs in rural areas in the UK.

Doctors who have an interest in pre-hospital care need to be trained, not only in EM, but also in other aspects of acute care. Anaesthetics is a key component to modern pre-hospital care, particularly being able to undertake difficult intubations in unfamiliar environments with administration of drugs if required. The extra hazards of the pre-hospital environment mean that doctors also need to undertake specific training with regard to safety of themselves, the scene and their patients. There are also extra clinical skills that need to be acquired, such as treatment of the physically trapped patient.

The decision of how much treatment at the scene before transfer to the local ED is often complex. The British Association for Immediate Care (BASICS) has developed courses in pre-hospital care and co-ordinates Immediate Care Schemes around the country. At present, the service is scattered and highly variable, as is the training, although the recent creation of the Faculty of Pre-hospital Care is bringing some consistency.

The introduction of the concept of clinical governance into Ambulance Service Trusts has brought increasing numbers of doctors into managerial roles within them. Paramedic training is rapidly changing and there is an important role for the emergency specialist in this field.

PROFESSIONAL ASSOCIATIONS

There are now two bodies involved in promoting and regulating the specialty.

British Association for Emergency Medicine

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The BAEM was founded in 1967 as the Casualty Surgeons Association by senior casualty officers who negotiated with the then Department of Health and Social Security for the establishment of separate Consultant posts in EDs.

The Association holds an annual clinical meeting in March or April in different parts of the country. These clinical meetings serve to illustrate the diversity of EM and give the opportunity to members of the Association to present original work.

The Association has formal links with the American College of Emergency Physicians (ACEP), the Canadian Association of Emergency Physicians (CAEP) and the Australasian College of Emergency Medicine (ACEM). In 1990 these four groups founded the International Federation of Emergency Medicine (IFEM). International meetings are held on a biannual basis; the first in 1986 was held in London. Subsequent meetings have been held in Brisbane, Toronto, Washington, London, Sydney, Vancouver, Boston and Cairns. The next one will be held in Halifax, Nova Scotia, Canada in 2006.

Membership of the Association is open to any registered medical practitioner who has an interest in the specialty.

This professional Association sets standards for facilities and staffing, as well as working with the College of Emergency Medicine to promote education, training and research.

The Association provides and maintains links to other bodies including the Government. The Association also protects the interests of members. The Association also continues to monitor the provision of care provided to all patients attending EDs.

The College of Emergency Medicine

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In 1993 the specialty founded an Intercollegiate Faculty of the Royal Colleges of Surgeons and Physicians and Royal College of Anaesthetists to manage the holding of higher examinations and the award of diplomas and to serve as a focus for academic development and research within the specialty. In 2005 the Annual General Meeting voted to change the name of the Faculty to College following permission from the parent Royal Colleges to pursue independent status. The newly named College of Emergency Medicine is now an independent organisation although still collaborating with the parent colleges over the business of the College.

The College has an annual meeting in the autumn and conducts examinations for entrance into the specialty training, and also to assess completion of training.

The College has primary responsibility for education, training and maintaining academic standards.

The Higher Training Committee (HTC) is a Sub-Committee of the Council of the CEM that manages the inspection and accreditation of training programmes for the CEM. The relationship with the PMETB is still being established but the HTC will be working with the PMETB to confirm the completion of an individual's training and suitability for entry onto the Specialist Register.

The specialty has begun work to merge the two organisations together and to make application for a Royal Charter to become a College by Charter.

Emergency Medicine Trainees Association (EMTA)

Website: www.emergencymed.org.uk

EMTA is the representative body of all trainees in EM within the UK. It is our aim to provide representation for the views and interests of our trainees and to aid in the process of communication between trainees, BAEM and CEM. We have elected representatives of all of the BAEM and CEM committees whose task it is to put forward the views of the trainees.

An EMTA update appears in every issue of the EMJ supplement and regular news bulletins are sent to trainees via EMTEL (see below). As well as holding our own conference each year, we also run a social and business programme during the BAEM Annual Conference and the CEM Annual Scientific Meeting.

Emergency Medicine Trainees' E-Mail List (EMTEL)

EMTEL is an e-mail list database of contact details held by EMTA. It is our aim to use this, along with the regular update in the EMJ supplement, to keep trainees informed of issues that are of interest and relevance. If anyone is interested in receiving the EMTEL updates, they should e-mail the EMTEL administrator at EMTEL.admin@gmail.com.

Forum for Associate Specialists and Staff Grades in Emergency Trainees Medicine (FASSGEM)

Website: www.emergencymed.org.uk

Associate Specialist and Staff Grade Posts

The majority of hospital EDs have posts at Staff Grade and/or Associate Specialist level; (these posts are classed as being Non-Consultant Career Grade (NCCG) appointments).

These posts can offer a great opportunity for experienced doctors to work in EM outside of the more traditional framework of specialist training and Consultant appointments.

Staff Grade posts are often suitable for those who wish to work part-time or for those who wish to practice EM, as part of a broader based portfolio career (with sessions in other fields of medicine such as general practice, medico-legal work, sports medicine etc). They are also often suitable for doctors who are in the process of changing their career from another specialty into EM.

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The Royal Society of Medicine was founded in 1805. It was instituted in the words of its first charter *"for the cultivation and promotion of physic and surgery and other branches of science connected with medicine"*

The Accident and Emergency Medicine section was formed in 1986 with a membership of 36 and this had grown to 550 by the year 2002.

The Section holds meetings at least three times a year where EM specialists of all grades can meet to share examples of best innovative practice.

We have been leaders in meetings with other sections and fora, Cardiology and Cardiothoracic Surgery, Geriatrics and Gerontology and the United Services to name but three.

We regularly hold multi-disciplinary meetings as we feel that we are one of the major exponents of the team approach.

Who can I talk to now?

If you would like to have an informal chat about your career, please do not hesitate to contact your local EM Consultant, Regional Adviser or a trainee in the specialty. The list of Regional Advisers is maintained at the CEM office.

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Modernising Medical Careers
Emergency Medicine
Specialist Training - 2006

FY1
FY2

Career guidance
Interview and structured references

ST 1+2
EMERGENCY CARE COMMON STEM
Emergency Medicine
Anaesthetics
Acute Medicine
Critical Care Medicine

Learning: from practice, from trainers, group teaching, study, life support courses, skills lab
Assessment: 360 appraisal, Min-CEX, DOPS, Case based discussion

MCEM Part A ⇐ Other specialities + overseas

Career guidance

⇔ **EM SERVICE POSTS**

⇒ Anaesthetics, ICM, Acute Medicine

ST3
Orthopaedics
Paediatric EM

Learning and assessment as above

MCEM Part B ⇐ Other specialities + overseas

⇔ **SERVICE POSTS**

Interview and structured references

ST 4,5,6
Emergency Medicine
(up to 6/12 "optional" training)

Learning and assessment as above + practice FCEM ST4

FCEM
CCT or ⇒ Sub-speciality training Paediatric EM/ICM/Acute medicine then CCT