The College of Emergency Medicine

A Career in Emergency Medicine

2009
“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 who thrive on challenge, uncertainty and variety. A career in EM will never be dull and offers chances to develop your own interests and areas of expertise within a broad range of patient presentations. This publication gives you the background to the specialty and the role it plays in the modern National Health Service (NHS).

What is Emergency Medicine?
Emergency Medicine (EM) is a young and rapidly evolving specialty in the UK. The Emergency Department (ED) is at 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 or operating theatres. Other patients are assessed, treated and sent home for follow up and ongoing care with their General Practitioner. Most departments now have separate facilities for the care of children, including the presence of Registered Children’s Nurses and play specialists. A particular challenge is the assessment and care of patients with psychiatric illness and liaison with community mental health teams is central to quality care for these patients.

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

What is Emergency Medicine?
“Emergency Medicine is an exciting specialty that gives you the opportunity to keep a good general knowledge of most specialties and opens up the scope of where you can develop a specialist interest. Most EDs are a great place to work, with lots of banter and fun to be had. It’s an up and coming field that encourages people with dynamic personalities and good people skills to join the ‘family’.”
Kasyap Jamalapuram is an ST3 at New Cross Hospital, Wolverhampton

Consultant work patterns and opportunities
The day-to-day work of Consultants is varied and unpredictable. Most Consultants in EM 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. It is anticipated that there will be a considerable expansion in Consultant numbers commensurate with the number of trainees expected to achieve specialist registration in 2011 onwards.

Clinical work
Increasingly, Consultants are providing extended cover to the shop floor, being present from 8am until midnight in many departments as well as working shifts at weekends. The added value of the Consultant presence is seen in improved quality of care, early provision of life saving care, reduced error rates and higher satisfaction levels for trainees and patients.

Teaching
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. EDs have close working relationships with Deaneries and Foundation Schools as they provide excellent training opportunities for a range of doctors in different specialties as well as trainees who intend to become Consultant Emergency Physicians. 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. This management responsibility includes liaising with other specialties, the pre-hospital services, the local community and Strategic Health Authorities (SHAs) or local Regional Health Boards. The development of the major incident plan is also within the EM remit and many ED Consultants are emergency planning leads for the hospital.

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 the wide range of cases that we see. Audit forms a central part of the work of the department – monitoring the quality of the provision of service and ensuring patients are given the correct treatment in an appropriate time frame requires structured systematic audit and review of practice. The ED Consultant is the lead for this work within the multiprofessional team.

There are opportunities to develop a special interest within the field of Emergency Medicine, concentrating on the provision of care and ongoing care to a group of emergency patients. For example, Consultants may sub-specialise in pre-hospital care, Acute Medicine, Intensive Care Medicine, observation medicine or sports medicine. This results in some Consultant Emergency Physicians spending a proportion of their working week within other departments.

Would Emergency Medicine suit me?

Why I chose EM:
“From the moment I walked in St Mary’s ED on my first day as an SHO I knew I was hooked – the noise, the variety, the edge of reason and I was right it was for me.”

Diana Hulbert is a Consultant at Southampton General Hospital

The work is challenging, unpredictable and sometimes stressful. Consultants in EM deal with major trauma, medical emergencies and sudden death (including unexpected death in children and young adults) as well as a large volume of patients with less serious injuries and illness. There will also be exposure to patients with violent behaviour, drug and alcohol abuse, psychiatric illness and social problems. The diversity within this workload can be difficult to balance and a career in EM will never be dull. It offers chances to develop your own interests and areas of expertise. If you enjoy the whole breadth of medicine then EM is the only place within the hospital environment where this can still be realised.

If you specialise in EM you will need to become expert in rapidly establishing the diagnosis, especially in life threatening situations. You will need to develop both the practical and team leadership skills of adult and paediatric resuscitation.

You will learn to effectively differentiate which patients may appropriately be discharged with follow up when needed, or admitted to an ED-based observation unit or hospital ward.

You will need to enjoy working in the sometimes difficult and challenging environment of the ED and be able to prioritise and respond to new and urgent situations. You will work as part of a multi-disciplinary team where good communication and inter-personal skills are essential. You will work closely with a wide variety of in-patient teams and with primary care and pre-hospital clinicians as well.

Why I chose EM:
“The continuous challenge of new patients, with unknown conditions makes the specialty perfect for me. I like the unpredictable nature of the work and I like the characters that you get in the ED - both the patients, and the staff. Most importantly I like that fact that there are multiple types of patients where you have to bring different skills to bear, and the challenges of treating minor injuries alongside patients with critical illness is a joy and means that you can often take refuge and respite in different types of patient and intellectual challenge all in one day”.

Ruth Brown is a Consultant at St Mary’s Hospital, London

Key personal attributes include compassion, flexibility, excellent organisational skills, lateral thinking, a practical approach to problem solving, good psychomotor skills and above all time management skills. 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. The personal satisfaction can be considerable, even if few patients will remember or thank you! 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 (GPs) and in-patient specialists in an environment of mutual cooperation and respect.

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 responsibility is 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.

**What does the future hold for Emergency Medicine?**

There has been a lot of discussion and activity over recent years around the pathway of care for patients with emergency conditions. The four-hour emergency access target has resulted in additional resources being provided to EDs and many departments have developed new ways of working including developing the Emergency Nurse Practitioner (ENP) role, separating the serious and ambulatory cases within the department and developing Clinical Decision Units, or short stay wards under the care of the Emergency Medicine Consultant. More recently discussions with local primary care providers have suggested collaborative working to provide joint facilities for the less seriously ill or injured patients together with urgent primary care services. These discussions are not complete as yet and the future configuration of emergency departments is not confirmed – other than there will continue to be a requirement for resuscitation and assessment of seriously ill and injured patients by specialists in Emergency Medicine.

The English Department of Health has confirmed a commitment to having eight Consultants in each major ED by 2010. This will require considerable expansion of the Consultant grade from the current 736 in England, but will be accompanied by an expectation that Consultants provide on site clinical cover, including weekend and evening work. Consultant expansion is also happening in other nations within the UK and Ireland. You should anticipate that EM Consultants will be working late shifts, weekend shifts and possibly night shifts in the future. This will be to provide senior supervision and expertise to junior doctors and their patients in the 24/7 environment that is EM.

**What does the future hold?**

“We are one of the few specialties embracing a consistent 24/7 level of care whilst others retreat from it. This, coupled with the value that the public continue to place on Emergency Medicine, means that we have nothing to fear. Rather there are enormous opportunities for those who are prepared to continue to change and innovate. The future is bright!”

**Jonathan Benger** is a Professor of Emergency Medicine at Bristol Royal Infirmary

Many departments run Consultant review clinics for patients with soft tissue injuries, burns and minor fractures. The majority of EDs have developed Clinical Decision Units, which are separate areas within the department where patients can have a short period of intensive investigation and active management. These areas are particularly helpful for patients with time dependent investigations (12 hour troponin) head injuries, conditions requiring a short intensive treatment (asthma) or observation (overdose). Observational Medicine is likely to develop as a specialty interest as the provision of these services is recognised as crucially important to the efficient management of large numbers of patients. Another area of growth is likely to be that of the emergency assessment and care of the older patient.

Demand for EM Consultants with sub-specialty training in Paediatric EM currently outstrips supply, particularly since the intention is for every department to have a Consultant with a special interest or subspecialty training in Paediatric Emergency Medicine. Details of guidance for applicants to EM training in 2009 are available to download at: [www.collemergencymed.ac.uk/CEM/Training and Examinations/Training/2009 Person Specifications](http://www.collemergencymed.ac.uk/CEM/Training_and_Examinations/Training/2009_Person_Specifications)

Some EM trainees specialise in pre-hospital care, gaining additional training and qualifications to equip them to practice in this environment. The College of Emergency Medicine is working with other Medical Colleges to determine the skills and competences required for practitioners in this area.

A small number may wish to develop an academic career by applying for an NTN(A) which may involve following either a research or educational track. Details are available at: [www.nccrcd.nhs.uk/intetacatrain](http://www.nccrcd.nhs.uk/intetacatrain)
Who would you be working with?
The majority of departments now have at least two Consultants with many departments having four or more Consultants. Other medical staff include old-style Specialist Registrars and now ST-grade doctors in any of the ST1-6 years. Many departments have Staff Grade and Associate Specialist (SAS) staff include Staff Grades and Associate Specialists and, in some departments, GPs. All departments have specially trained nurses and many employ 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!

What is your Department like?
“I work in a co-located adult and children’s emergency departments seeing 65,000 and 28,000 patients per year respectively. It is within an urban inner-city population with significant social and drug problems. The ED has dedicated adult and paediatric observation units. There is large emergency nurse practitioner service in both departments, and extended scope physiotherapists in the adult ED. Departmental interests cover paediatrics, airway management, ultrasound, pre-hospital care and teaching.” Jonathan Benger is a Professor of Emergency Medicine at Bristol Royal Infirmary

How do I prepare to enter an Emergency Medicine training programme?

As a student
As a student, the key preparation is to make sure you spend as much time as possible in EDs, both talking to and examining patients but also observing the staff and taking part in the team work. This is essential in understanding the breadth of work of an ED and what a career in Emergency Medicine would mean to you.

Taking an elective either abroad or in this country within an ED will give you additional insight and also show a commitment to the specialty. Many medical schools also allow students to choose study modules that can be based in the ED and would help you look at certain aspects of acute care in depth. Some ambulance services allow students to travel with a crew for the day which can give further information and experience. Advanced Trauma Life Support (ATLS) courses often require medical students as “models” for the moulage, such courses are excellent for enhancing your knowledge and skills for finals as well as demonstrating an interest in participating in postgraduate education.

Many medical schools now have student societies for EM and the College is pleased to welcome medical students as Affiliate Members. This membership provides reduced fees to conferences and meetings as well as access to advice, training material and general support.

As a Foundation Doctor
If you can access a Foundation programme with a post in EM we would recommend that you apply for it. This post is excellent experience for all specialties and working in such a post would indicate commitment at an early stage. It is recognised however that such rotations are popular but if you have not completed EM as an FY2 it will not prevent you entering specialty training. We would however expect you to have completed a taster week in the ED as well as completing the full ALS course by the end of your FY2 year. We would also recommend that you visit the College website (www.collemergencymed.ac.uk) for up to date advice of how to show your commitment to a career in EM. In addition, you should complete as many foundation year on line e-learning modules as you can from within the doctors.net website (www.doctors.net).

We would also recommend that you have attended regional training days or conferences in EM relevant to you.

Audit is considered key in EM to allow us to understand the quality of the service we are providing. Completing an audit that is relevant to EM within your foundation years is very important. Such audits might be repeat audits for the Audit Commission or a relevant new audit that is required in your Trust. Being able to demonstrate that you both understand the purpose of audit and the process, but also that you have carried out an audit which effected change demonstrates awareness and a commitment to the specialty.
Many departments have ongoing research programmes. If you are able to participate in a research project or assist in a review of a topic for a BestBET as a foundation doctor – again that demonstrates commitment to specialty.

Entrance into Specialty Training
The run-through training for EM is described in more detail at: www.collemergencymed.ac.uk/CEM/Training and Examinations/Training/General Training Information

The specialty training programme is competence-based, usually of 6 years duration after the completion of Foundation years 1 and 2. Whilst it is possible to enter training at ST2 or above, it is expected that doctors who qualified after 2005 will enter training from year one of core specialty training.

The programme is divided into three years core specialty training and three years higher specialty training. In England, Wales and Northern Ireland entry to higher specialty training is by competitive application. In Scotland the programme runs through from years one to six, though this is likely to change in future years.

Core Specialty Training consists of two years of Acute Care Common Stem (ACCS) training and one year of CT3 specialties. The ACCS consists of a year of training and experience in EM and Acute Medicine and a further year in Anaesthetics and Intensive Care Medicine. CT3 training is tailored to enable trainees to achieve the competences required to care for children in the ED, as well as adults and children suffering acute musculoskeletal conditions including trauma.

The last 3 years (Specialty Training year 4-6) are spent in EDs, gaining additional clinical competences, consolidating prior training and gaining skills in academic emergency medicine, critical appraisal and management topics.

The Membership Examination of the College of Emergency Medicine (MCEM) is required for progression through training. Part A is required for entry to CT3 and Parts B and C are required for entry to ST4. From 2009 entry the College will no longer accept equivalent postgraduate diplomas from other Colleges. Trainees must pass the Fellowship Examination of the College of Emergency Medicine (FCEM) in the last year of training (ST6 or above) in order to be eligible for a CCT.

Satisfactory completion of core training and specialty training and both College exams would allow the trainee to be recommended for their Certificate of Completion of Training.

During the specialty training programme, trainees will be expected to complete workplace based assessments, which will be a combination of observation of clinical practice (Mini CEX and DOPS), case based discussions, multi-source feedback and include other tools which focus on specialist skills.

My path into EM:
“I was a fully committed orthopaedic surgeon before I saw the light – and one day I woke up and realised that I didn’t want to go to work with the whole day planned. I much enjoy the unpredictability and also the full range of conditions. Practical procedures are still something I enjoy and I sometimes look at an X-ray in a patient with a fracture and itch to try to fix it, but the bonuses of EM far outweigh any lingering fondness for the operating theatre.”

Ruth Brown is a Consultant at St Mary’s Hospital, London

Regulations for the MCEM
The candidate must hold a primary medical qualification that is acceptable to the United Kingdom General Medical Council for Full or Limited Registration or to the Irish Medical Council for Full or Temporary Registration.

Part A
Part A cannot be taken earlier than the second foundation year of training or its overseas equivalent. Thus the candidate must have completed at least one year of experience post qualification and be fully registered with the General Medical Council or its equivalent.

Parts B&C
The current regulations for eligibility for the Parts B and C are under review. It is anticipated that candidates will be required to demonstrate that they have completed the equivalent of the Foundation Programme as well as 12 months of post-foundation programme training, of which 6 months must be in Emergency Medicine. The trainee and the trainer will be required to confirm in writing that they
understand the breadth and depth of the curriculum and that they believe that the candidate is ready to take the examination.

Experience in EM or other specialties as a foundation year one doctor will not be counted. Experience gained in EM overseas will be considered if a candidate can show that his/her experience is at least ‘equivalent’ to that of a UK trainee. Documentation of the casemix, work pattern and training and supervision received in such overseas posts will be required.

If you are entering EM training, the ACCS years will provide you with the experience to be both eligible and skilled to be successful in the MCEM by the end of ST3. From 2009 all trainees entering training will be expected to have MCEM by the time of entry into ST4; no other postgraduate examinations will be acceptable. Full MCEM details are available on the College website: www.collemergencymed.ac.uk/CEM/Training and Examinations/Exams/MCEM

What can I expect on the EM Training Programme?
- You will be involved in delivering service by seeing patients, being involved in team resuscitations, reviewing patients in ED clinics and providing care to patients on the Clinical Decision Unit. You will also be expected to take on responsibility for managing the “shop floor”, including supervising more junior staff, supporting the nursing staff, working alongside ENPs, Nurse Consultants and other specialists.
- This supervisory and managerial role will be developed as you progress. In addition you will be given training and opportunities to develop in other aspects including research, audit, management, and clinical governance.
- 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 a few hospitals, at least one of which will be a teaching hospital. You will be told in advance by the programme director, which hospitals you will be going to in order to assist you in your choice of home location, schools, etc.
- The curriculum is updated on a yearly basis and can be viewed at www.collemergencymed.ac.uk/CEM/Training and Examinations/Curriculum. This curriculum indicates the breadth and depth of knowledge and skills expected. A curriculum for the Paediatric Emergency Physician is also available.

What about formal training?
Dedicated protected time will be made available for training, both in the department and for regional training days where you will meet with other EM trainees and cover the curriculum.

Trainees are required to complete life support courses such as ATLS, ALI and APLS. They are also encouraged to attend a major incident management course to equip them to help plan and lead the response to major civil emergencies. Other courses are available for trainees with 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 time out of the scheme to do a full year of research. A small proportion of trainees elect to undertake a research degree.

“I got the trauma research bug back in the 1990’s when I was lucky enough to get funding to do a PhD looking at markers of shock in trauma patients, I quickly understood how many myths our teaching is based on and have wanted to help improve the evidence base ever since.”

Fiona Lecky is a Consultant at Hope Hospital, Salford
Are there opportunities to develop skills in teaching?
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.

“I have a Diploma in Medical Education and am currently studying for an MPhil in workplace based assessment. I am specifically interested in how doctors develop their higher cognitive functions. Training is core to ED work, we need to know how to effectively deliver training within a 24 hour a day seven day a week service delivery based specialty.”

Derek Burke is a Consultant at Sheffield Children’s Hospital

What does the Fellowship Examination (FCEM) involve?
The training programme culminates in an exit examination, the Fellowship of the College of Emergency Medicine (FCEM). Following this and the award of Certificate of Completion of Training (CCT), you will be eligible for a Consultant post.

The FCEM confirms the trainee is adequately trained and is taken during the last year of the training programme.

Candidates must have evidence of satisfactory progress including appropriate workplace based assessments. Non-trainees may also take the examination providing they meet certain criteria including a portfolio of evidence of experience. More information is available on the website: www.collemergencymed.ac.uk/CEM/Training and Examinations/Exams/FCEM

The examination requires candidates to:
• Perform a critical evaluation of a published research paper
• Defend their own pre-prepared review of a clinical topic. This review is prepared three months prior to the exam and is a dissertation which must be no longer than 3,500 words.
• Participate in a discussion of management issues in a viva
• 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 may be an element 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.

How flexible is your job plan?
“I work full time with a 50:50 University / NHS split. I have 3.75 DCC sessions which covers weekends, on call and 2 shop floor per week, plus management and teaching.”

“During the University part of my week I supervise my 4 post grad students doing PhD/Masters on trauma data from TARN and other sources and as TARN research director help clinicians from TARN hospitals use the data for research.”

Fiona Lecky is a Consultant at Hope Hospital, Salford

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 people of interest.
Paediatric Emergency Medicine
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), accident prevention strategies, child protection issues 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.

- Paediatric Emergency Medicine is the only recognised sub-specialty of Emergency Medicine and a limited number of training posts exist around the country for trainees interested in completing this training. Details of sub-specialty training competences are outlined in the curriculum page of the CEM website. Training is 12 months in duration consisting of six months in a paediatric emergency medicine department recognised for sub-specialty training and six months of ward-based paediatrics, including training in the care of unconscious and critically ill children. Training can be started during the six months allowed out of general Emergency Medicine training during ST4-6 but many trainees will need to extend their training by the full 12 months.

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

“Although major trauma does not happen every day it is the biggest killer of children and young adults. Of those reaching hospital alive 50% of deaths occur on the first day – if we get it wrong in the ED the consequences are likely to be disastrous…. If we get it right it makes a huge difference to families and society.” Fiona Lecky is a Consultant at Hope Hospital, Salford

Intensive Care Medicine
Specialty status was granted to Intensive Care Medicine (ICM) in June 1999. It is now possible to obtain a CCT in ICM jointly with a CCT in a parent specialty - Medicine, Surgery, Anaesthetics or EM. Further information is available from the Intercollegiate Board for Training in Intensive Care Medicine www.rcoa.ac.uk/ibticm

In the fullness of time, ICM Training Consultants will only be appointed if they possess a CCT in ICM Medicine. However, for the time being, it is possible to acquire intermediate level training, enabling Consultant appointments 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 EM training programmes with a minimum of additional time. Entrants will now have three months experience of ICM at ST2 level, as well as six months in General Internal Medicine and six months in Anaesthetics. Within the ST4-6 years, 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.
- For the service there is a seamless progression for the patient with one less negotiation during the process of transfer.

Academic Emergency Medicine
EM sees the largest group of patients of any specialty - over 14 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.
**Acute Medicine**

Further training requirements for Consultants who wish to participate in an Acute Medicine service were agreed but are still subject to change. The original understanding was that an additional year of Acute Medicine training (level 2 training) would provide the competences to look after patients for the first 24 hours of admission. Acute Medicine is now redeveloping their specialty and redefining the competency levels so this arrangement may change, though the College has emphasised that it wishes for this route to remain open (though how such additional training is to be recognised is not specified yet). It is unfortunately difficult to provide specific guidance at this time. Updates will be made available on our website.

Additional training will not lead to sub-specialty recognition, as in the case of Paediatric EM training, but to a certificate of competency. This would be completed sometime toward the end of ST4-6 training with approval from the local postgraduate dean. This level of training would be appropriate for EM Consultants who would like to work between EM and medical acute assessment areas.

Trainees who would like to obtain a full CCT in Acute Medicine would have to complete the AM component of medical training, after they have received their CCT in EM. This level of training would allow care of medical admissions beyond the first 24 hours (level 3) and follow up of patients in a clinic. Further details of this sub-specialty training programme are available at: www.jrcptb.org.uk/Specialty/Pages/AcuteMedicine.aspx

**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. Anaesthetic skills are 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 to provide 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.

Pre-hospital care ranges from crowd doctor cover at stadia (football, cricket, rugby), attending road traffic incidents, to major incidents. There are courses such as pre-hospital trauma life support (PHTLS), major incidents medical management (MIMMS), to the Diploma in immediate care.

“Pre Hospital Care had always got my attention as a challenging and exciting area of medicine with the opportunity to “take the emergency department to the roadside”. My initial involvement was covering sports events such as the London Marathon and London Triathlon. I then went on some shifts with local ambulance crews and passed the diploma in immediate medical care. London HEMS is the most challenging job I have ever done. It is a very attractive specialty- both scary and exciting! The multi disciplinary team ‘on scene’ can be both fun and challenging. No two cases are ever the same which is true in the ED but much more acute in the pre hospital environment where every scene throws up new challenges. There is also the opportunity to make a huge difference to the morbidity and mortality of trauma patients- this can be very rewarding”.

**Ali Saunders** is an EM physician with the London Air Ambulance
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. In February 2008, the College merged with the British Association for Emergency Medicine and was granted a Royal Charter.

The College has an annual scientific meeting in the autumn and a spring conference. The College conducts examinations for entrance into the specialty training, and also to assess completion of training. The College has a primary responsibility for education, training and maintenance of academic standards.

The Training Standards Committee 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 TSC will be working with the PMETB to confirm the completion of an individual’s training and suitability for entry onto the Specialist Register.

EMTA is the representative body of all trainees in EM within the UK. The group has elected representatives on the majority of the College committees. The representative’s task is to put forward the views of the trainees. Trainees who are members of the College are automatically members or EMTA. Medical student members of College are also welcomed in EMTA and will be provided with advice and contacts where necessary. An EMTA update appears in every issue of the EMJ supplement and regular news bulletins are sent to trainees. EMTA holds an annual autumn conference and also participate in the bi-annual CEM conferences.
Associate Specialist, Staff Grade and Specialty Posts (SASS)
The majority of hospital EDs have posts at Staff Grade and/or Associate Specialist level; (these posts were previously classed as being Non-Consultant Career Grade (NCCG) appointments). All new posts at this level will be Specialty Doctor rather than Staff Grade.

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

SASS 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. The new SAS contract has transformed what was previously a poorly supported group of doctors by introducing and making mandatory appraisal and protected SPA, as well as an improved payscale.

FASSGEM represent and promote the interest of SASS doctors with representation at most levels in the CEM. An annual conference is held which is educational and also an opportunity to meet SASS doctors from all over the country.

With the changes to specialist registration announced under PMETB (Article 14), it is now possible to achieve a certificate of equivalence of specialist registration (CESR) which allows the holder to apply for inclusion on the Specialist Register, and then to apply for Consultant posts.

The Royal Society of Medicine
Emergency Medicine Section
1 Wimpole Street, London, W1G OAE
Tel: 020 7290 2983 Fax: 020 7290 2989
Email: sections@rsm.ac.uk
Website: www.rsm.ac.uk

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 Emergency Medicine Section was formed in 1986 with a membership of 36 which has grown to the current level of 712 in 2009. 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 forums, 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 and is available on the website: www.collemergencymed.ac.uk/CEM/About the College/Committee structure/College Council
**Certificate of Completion of Training in Emergency Medicine**

**FY2, FY1**

**CT1 & CT2: ACUTE CARE COMMON STEM**

1 year Emergency Medicine & Acute Medicine

1 year Anaesthetics & Intensive Care Medicine

Order of rotation and split of each year may vary according to local programmes that, regardless of their structure, will deliver ACCS competences

**MC EM Part C**

**CT3**

EM + trauma & musculoskeletal or T&O

EM with emphasis on Paediatric EM

**MC EM Part B & C**

**ST4, ST5, ST6 in Emergency Medicine + FC EM**

**ST4 entry:** Entry to ST4 is competitive for all trainees. Eligible trainees will have completed core training or equivalent, the full MCEM exam* and 3 life support courses

**MC EM Part A**

**CT1 & CT2: ACUTE CARE COMMON STEM**

1 year Emergency Medicine & Acute Medicine

1 year Anaesthetics & Intensive Care Medicine

Order of rotation and split of each year may vary according to local programmes that, regardless of their structure, will deliver ACCS competences

**MC EM Part B & C**

**CT3**

EM + trauma & musculoskeletal or T&O

EM with emphasis on Paediatric EM

**MC EM Part B & C**

**ST4, ST5, ST6 in Emergency Medicine + FC EM**

**ST4 entry:** Entry to ST4 is competitive for all trainees. Eligible trainees will have completed core training or equivalent, the full MCEM exam* and 3 life support courses

**MC EM Part B & C**

**CT3**

EM + trauma & musculoskeletal or T&O

EM with emphasis on Paediatric EM

**CT3 entry:** Competitive entry to CT3 available for eligible trainees who have completed the equivalent of two years of core training, part A of the MCEM exam and two life support courses

**CT2 entry:** Competitive entry to CT2 available for eligible trainees who have completed the equivalent of a year of core training and 1 life support course

**CT1 entry:** Competitive entry to CT1 ACCS (EM) with 12 months or less of any specialty that makes up the first 3 years of EM training

**Sub-specialty training in Paediatric EM or dual accreditation in ICM; additional training in Acute Medicine**

**Relevant fixed term posts**

The availability of time-limited posts will vary regionally

Please note that person specifications are issued annually and may vary from year to year. Up to date guidance will be posted on the CEM website at www.collemergencymed.ac.uk

*Trainees who plan to enter training at any level must pass the MCEM exam to progress through to ST4 training. Alternative exams will not be acceptable.