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SUPPLEMENT

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Training in paediatric accident and emergency medicine

Altogether 25%–30% of all A&E attenders in the UK are children under 16 years of age. This adds up to approximately 3.5 million attendances per year, 8% of which are to specialised paediatric A&E departments and 92% to general departments.[1–3] Children are not just little adults. They differ physically, physiologically, and psychologically and present with a different pattern of disease. Their needs are being increasingly recognised. In 1999, a multidisciplinary working party convened by the Royal College of Paediatrics and Child Health (RCPCH) produced a report on accident and emergency services for children. This made many recommendations about the service, the facilities, and staffing and staff training. In particular it recommended that paediatric A&E consultants should be in post in departments treating upwards of 18 000 children by 2004 and in all departments treating children by 2010.[1] If this were carried out, it would give an estimated need for 50 new consultants with a special interest in paediatrics by 2004 and over 150 by 2010.

There is no certificate of completion of specialist training (CCST) in the European Specialist Register, but there is the possibility that consultants with a CCST in either paediatrics or A&E medicine who have the proper training will be able to register a special interest in paediatric A&E medicine. The Faculty of Accident and Emergency Medicine (FAEM) and the RCPCH have agreed guidelines for the duration and content of this training. These are awaiting ratification by the Specialist Training Authority (STA). The extra training varies depending on whether the trainee comes from a background of paediatrics or A&E medicine. With proper forward planning, both types of trainees can achieve this within their five year higher specialist training. However, doctors who develop the interest late may need to apply to their postgraduate dean for an extension to their period of training.

CCST in general A&E medicine with a special experience in paediatric A&E medicine

A doctor with a CCST in general A&E medicine with special experience in paediatric A&E medicine will be eligible to undertake full duties, including on-call in a general A&E department or in a specialised paediatric A&E department.

The training will involve the core three year specialist registrar A&E training together with the five essential secondments which may be taken at senior house officer or specialist registrar level. In addition, there will be one extra year of training in the care of children over and above the essential three months paediatric secondment, comprising:

- Six months of paediatric A&E medicine in an approved department.
- Six months of ward based paediatrics in addition to the essential paediatric secondment. This will comprise at least three months of ward based paediatrics, including the care of emergencies, at a level appropriate to the registrar grade. Paediatric anaesthesia and paediatric intensive care should also be included if not covered previously.

CCST in general paediatrics with a special experience in paediatric A&E medicine

A doctor with a CCST in general paediatrics with registered subspecialty experience in paediatric A&Emedicine will be eligible to undertake full duties including on-call in a paediatric A&E department and would be able to undertake duties for the paediatric workload of a general department. He/she would not be able to cover on-call duties for adult patients in A&E but could be on-call for paediatrics.

The five year higher specialist training for this doctor would include the core paediatric training and in addition:

- One year of A&E medicine, most of which will be undertaken in a specialist children's A&E department, but up to three months of which may be in a general department to give training in the care of older children and adolescents
- A further nine months of paediatric subspecialties if there has been no previous experience at senior house officer or specialist registrar level, comprising:
- Three months of paediatric anaesthesia with intensive care
- Three months of paediatric orthopaedics
- Three months of paediatric surgery including the care of head injuries

Currently some paediatric specialist registrars are having difficulty in obtaining the paediatric orthopaedic and paediatric surgery training. Work is ongoing to try to resolve this.

The full draft guidelines for the training are available from the FAEM or the RCPCH. Once the guidelines have been ratified by the STA, the Joint Committee on Higher Training (A&E), will initiate a process whereby A&E departments can be formally recognised for training in paediatric A&E medicine. The draft guidelines include the interim arrangements until the formal process is set up.

Accident and Emergency Services for Children recommends that postgraduate deans should encourage the setting up of paediatric A&E medicine training programmes in their deanery.[1] Some training posts are available, most based in specialist paediatric A&E departments. Currently some trainees have to patch together an individual training programme but over the next few years more programmes will be established.

Doctors at various stages of their training are increasingly expressing an interest in paediatric A&E medicine. Until more training programmes are set up, some doctors may need individual advice on the way forward. This can be obtained from the RCPCH representative on the Joint Committee on Higher Training (A&E). There are expanding opportunities in paediatric A&E medicine and we should train young doctors to continue to improve the quality of care to children and their families in the A&E department.

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1 Royal College of Paediatrics and Child Health. *Accident and emergency services for children*. Report of a multidisciplinary working party. London: RCPCH, 1999.
2 Phillips BM, Robson WJ. Paediatrics in the accident and emergency department. *Arch Dis Child* 1992;**67**:560–4.
3 Davies F. The future of paediatric accident and emergency medicine. *J R Soc Med* 2000;**93**:484–6.

Highlights of the BAEM Council meeting in January 2001

- There was concern and disappointment that the report from the A&E Modernisation Group had still not been published.
- The Association and Faculty are to meet to clarify what is to be regarded as the core activity of the specialty.
- The Association and Faculty are to begin formal discussions concerning a possible merger and eventual evolution into a College or Royal College.
- The newly established Society of Acute Medicine is to hold a meeting in Southampton on 20 April. This is an informal group of consultant physicians with an interest in the management of medical emergencies; there are many areas of common ground between us and a good attendance from A&E is encouraged. Details of this meeting will be circulated to the membership and posted on the web site.
- The clinical services committee and the academic committee are to be merged to form a new group, the clinical effectiveness committee.
- There was much discussion concerning non-consultant career grades. The association recognises the importance of this increasingly large body of doctors and hopes to increase their involvement in BAEM. We need to consider how it can contribute to the development of their training, personal and professional advancement, and work practice.

Assessment—a personal view

Once upon a time, the medical profession was virtually above criticism. The word of the doctor went unchallenged. But there have been a number of events over the past few years which have caused the public to realise that the medical profession is not infallible, as was perhaps once supposed. There can be no doubt that these situations have received enormous publicity from politicians and the press. It is now becoming increasingly recognised that untoward incidences are very often the result of a combination of circumstances, rather than being due to the incompetence of an individual.

When considering these situations, I believe there are four facts which must always be borne in mind:

(1) We can all make mistakes. The only way to avoid making any clinical mistakes is to avoid seeing any patients.

(2) Mistakes are mistakes! They are not intentional. No one goes into work with the intention of making a mistake.

(3) Mistakes should be identified, admitted, and regarded as learning opportunities.

(4) Medicine is not an exact science. There is always room for opinion.

That said, it is obviously desirable to avoid mistakes. It follows that doctors at all levels of seniority should be competent for the job which they do. Regular assessments should ensure that doctors are progressing satisfactorily and safely in their careers.

The Calman reforms and the introduction of the single specialist registrar grade included the requirement of annual assessments. The RITA (record of in-training assessment) process for specialist registrars is now well established throughout the country. Different deaneries and different specialties organise the process in various ways. The usual process in the Mersey Deanery has been described elsewhere.[1]

The various types of RITA forms issued are as follows:

- RITA A: core information on the trainee
- RITA B: changes to core information
- RITA C: record of satisfactory progress within the specialist registrar grade
- RITA D: recommendation for targeted training—stage 1 of "required additional training"
- RITA E: recommendation for intensified supervision or repeated experience—stage 2 of "required additional training"
- RITA F: record of out-of-programme experience
- RITA G: final record of satisfactory progress

The RITA process was initially regarded by some as a tick-a-box exercise, pure bureaucracy of very dubious worth. As experience increases and the process becomes more robust, I believe that more RITA Ds will be issued but this should certainly not be seen as punitive. In contradistinction to a RITA E, a RITA D does not delay the date of CCST (certificate of completion of specialist training), but it recognises that there are some aspects of training which require particular effort.

The essential purpose of the RITA process is to ensure that specialist registrars develop into safe consultants. The vast majority of trainees will progress without problems. A few will develop difficulties of one sort or another. It could be considered that failing the FAEM examination indicates that the RITA process has been unsuccessful for that particular registrar. It is essential that problems are identified and addressed as early as possible. To do this, it is mandatory that trainers and trainees are prepared to identify

problems with honesty. It is no longer acceptable to ignore problems on the basis that the trainee will soon rotate elsewhere, taking his or her difficulties with them.

Areas for improvement will be identified on occasions and it is obviously essential that these are pointed out to the trainee. In all cases, however, the process should be regarded as a positive method of ensuring that training is progressing satisfactorily, and identifying any deficits, to the benefit of the trainee, the trainers, and future patients.

Specialist registrar assessment is certainly a success but assessment must be extended to all medical practitioners, at all stages of their careers. Work is already underway to extend the RITA process to the pre-registration house officer and senior house officer grades. Consultants and general practitioners will certainly have to undergo regular assessments within the next few years, and I suggest that a system based upon the principles of RITA would be very appropriate. Some thought needs to go into deciding who should conduct this assessment, and we need to recognise that all consultants in time develop in different ways and are to some extent moulded by the local demands of their posts. We need to be clear about what core competancies are expected of an active A&E consultant. Mechanisms will need to be established to ensure that other doctors are identified, including locums, clinical assistants, staff grades etc, and that they are all included in the process. This is in many ways a greater challenge, but as more "non-career grades" are appointed it is important that an effective way of assessing them is established. Medical students will be involved, so that they become familiar with regular assessments at the beginning of their careers. One obvious problem is a mushrooming of bureaucracy, and this must be avoided. We need to identify a process which is simple but effective.

I anticipate that assessments will include input from other professionals and from lay members, representing patients. Complaints are frequently due to attitude rather than knowledge. Excellence at relevant practical procedures is clearly essential. No less important, however, is the ability to communicate effectively and appropriately with patients and their relatives. Many professionals have poor insight into their abilities of communication but they cannot be expected to improve unless the problem is identified with honesty and addressed with vigour. In A&E of course complaints are rarely directed personally at a consultant, but many reflect shortcomings in the ethos of the department, for which the consultants are, at least in some measure, responsible.

The best trainee cannot be expected to progress satisfactorily without suitable opportunities. There can be no doubt that training posts will be assessed and continually improved. As the numbers of trainees in various specialties change from time to time, in accordance with predictions of consultant numbers, so posts will have to be added to or taken from the various hospitals. The only fair way of doing this is to ensure that trainees are placed in posts from which they will derive maximum benefit. Consequently, a method of assessing training posts is required, and this too could be incorporated into the annual RITA assessments. We need to develop methods of evaluating the training and educational opportunities of each post.

The robust assessment processes which are being developed at present will identify problems at an early stage. With goodwill on both sides, and from the employing trust, the vast majority of difficulties will be correctable. If they are not, the practitioner (medical student, junior or senior house officer, specialist registrar, or consultant) may, on rare occasions, need to be sympathetically supported in developing new career opportunities which are more appropriate to his or her specific talents. This is relatively simple with junior trainees. To tackle the problem of poorly performing consultants in an effective but sympathetic fashion will test the maturity and wisdom of our specialty.

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1 Bache J. Making friends with RITA. *BMJ* 1999;**318**(classified section 13 Feb):2–3.

News from BAETA

As Elspeth Worthington mentioned in the last BAETA update, I have recently taken over from her as President, although for the first few months, she will hopefully help to keep me on the straight and narrow. I'm sure I can speak for all in wishing her well during her maternity leave. I look forward to working with the new-look committee to push forward the invaluable work that Elspeth and the rest of the committee have begun, and I am sure the next couple of years will be an exciting time for everyone involved in emergency medicine.

Communication

One of the most important things that we can do is to improve communication between trainees. By far the easiest way to do this will be by email contact, and I would urge anybody without access to email to get an address either at work or via an internet service provider such as doctors.net. Moves to try to put together a database of contact email addresses have already begun, and between Jonathan Benger, Chris Biggin and myself, we have obtained almost 100 addresses so far. This database will be used according to the following rules:

- It will only be used by a few elected trainees
- It will only be used for business and to disseminate information of interest to all
- Details will be removed from the database at a trainee's request or on taking up a consultant post

It would be a great help if regional BAETA representatives could put together a list of all trainees' email addresses in their region, and forward it to Jonathan Benger at the address below. If this is not possible, individuals should contact Jonathan directly.

The other portal of information that we will endeavour to improve and update is the BAETA web site (available as a link through BAEM), which has the potential to be an invaluable point of contact and source of information for all trainees.

Training

It is a fact accepted by all of us that training for registrars in emergency medicine in different hospitals and regions varies almost as much as the treatment that their patients receive. A good illustration of this is the difference between regions of supervised preparation towards the FFAEM examination. It has been suggested that a degree of uniformity of training must be established if we are to move forward as a specialty. Hopefully in the near

future BAETA can work together with the faculty to establish a job profile for a specialist registrar in A&E, within which there will be a minimum acceptable standard of training and clinical supervision, and time set aside for non-clinical aspects of the job such as teaching, management, and audit. Updates on any progress made will follow.

Examination course—For those of you taking the FFAEM examination in April, there is a preparation course being run by Ahmed Kamal in Cardiff from 9–10 April (contact akamal1601@hotmail.com).

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A&E section of the Royal Society of Medicine

The Royal Society of Medicine (RSM) was formed in 1805 "for the cultivation and promotion of physic and surgery and other branches of science connected with medicine". The A&E section began in 1986 with a membership of 36 and now has 464 members. There are, however, many more consultants and registrars who are not formally signed up as members, but nevertheless regularly attend the scientific meetings. The A&E section has been designated a "beacon section" as it fulfils the highest criteria for quality of meetings and financial stability.

Recent events have included a day examining all aspects of infectious disease, a joint meeting with the section of cardiology and cardiothoracic surgery, and a meeting focusing on ear, nose and throat, ophthalmology, and maxillofacial topics. The January meeting included lively discussion on the future of emergency medicine, workforce planning, and the interface between A&E and emergency medicine. There is a joint meeting with the section of clinical neurosciences on 29 June, and there is a paediatric theme "Child's play" on 28 September.

In addition to the well attended and informative meetings the RSM has much else to offer. The medical library is justifiably famous, the domus medica provides comfortable accommodation at a reasonable price in the heart of the West End, and there are excellent dining and gym facilities.

The RSM is not a stuffy London club for retired Harley Street doctors; it is an excellent forum for medical education in comfortable surroundings. Come and earn a few CME points in a civilised atmosphere, and catch up with old friends who you haven't seen since registrar days. Email us on a&e@rsm.ac.uk for more details.

JEREMY BOOTH
President of the A&E section