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SUPPLEMENT

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Research in emergency medicine—a cause for concern?

An interview with Mike Clancy

It is natural to be frustrated by the slow pace of medical advances, but research in emergency medicine in the UK seems to be less productive than it should be.

Mike Clancy is a consultant in Southampton and a recent past chairman of the Faculty research committee. His interest in research dates back from a research fellowship at Yale in 1991. He has a close interest in the research activity of trainees and is a member of the Acute Panel of the Health Technology Assessment programme (NHS R&D).

What do you think of the state of research in A&E at present?

If we use the number of publications appearing in the journal and abstracts submitted to the annual scientific meeting I would say the volume of research is increasing. Importantly in my view the quality of that research is improving, and there is an increasing proportion of high quality reviews and reports of randomised controlled trials. However our specialty is not properly reflected in the mainstream journals where topics clearly related to this specialty often do not include emergency physicians among their authorship. The quality of some of the research projects can no doubt be improved and reflects the fact that many are typically short term and not thoroughly thought out, and there may be a lack of expertise and research infrastructure that is needed for successful research. Nevertheless there is high quality work being carried out in the UK, but this is typically in well supported departments familiar with the grant application process where the expertise needed from many different fields to undertake research has been assembled. This takes time to set up but has been achieved at some centres such as Manchester. Although there is less "responsive" funding available than in previous years, it is encouraging to see that more of the commissioned research by the NHS reflects topics directly relevant to this specialty.

How do you think research should fit into emergency medicine training?

First of all I think that all trainees should develop critical appraisal skills to assess the literature and this should be acquired in the first two years of training. For those trainees who wish to experience research I think they should be given the opportunity to have a three month attachment working with someone with a proven research track record. During this time the trainee can participate in a project and begin to understand what is involved in terms of skills and acquiring grants. After this period if the trainee and their supervisor are agreed that research is for them then they have to join the mainstream grant application process. This is extremely competitive as it is open to all specialties but the rigour of that process is a good thing. If the grant application is successful then the trainee is ready to study for a higher degree. The majority of trainees who are less interested in research should nevertheless be encouraged to participate in some way in a research project.

Much of the literature reviewing activity that is undertaken for clinical topic reviews identifies important research areas that should be shared with those with an interest in research. Those trainees who do not wish to undertake research must demonstrate increased scholarly activity in other areas such as audit, education, and accident prevention.

Many years ago when anaesthetics was a Cinderella specialty, Lord Nuffield set out to improve it. He didn't give out a few low value prizes for registrars; he set up chairs of anaesthesia in major academic centres. Is this something we should be looking at?

The Faculty is between a rock and a hard place in terms of providing funding itself and we do not have a Lord Nuffield. The limited funds have acted in the past to provide "seed corn" funding to try and get projects off the ground. We have had more money in recent years and the value of the prizes has increased substantially. The Laerdal prize is worth £4000 and the Boehringer prize is £5000. The faculty recently commissioned work and made £5000 available for that work. We have tried to fund as much research as we can. Nevertheless your point is well made—these figures fall short of the typical funding needed to undertake projects (£30 000 or more).

If academic emergency medicine is to survive in this country it needs more professors and senior lecturers. There are some notable centres that have succeeded in setting up chairs and it is a tribute to their tenacity and enthusiasm that they have achieved that. If we are to make the research impact this

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specialty deserves we need an expansion of our academic workforce. Importantly we need to create posts for those who have completed higher degrees and who wish to continue research. At present we are not capitalising on the expertise of these individuals.

As I see it the way forward is increased collaboration both within the specialty and outside, linking to successful research groups. Our best chance is to be more symbiotic!

The Faculty has tried to help by appointing Faculty professors. Our intention was to try to extract the benefit from using such a title and also it was an opportunity to recognise individuals who have made an important contribution. Other specialties such as cardiology have appointed more chairs as you suggest. The British Heart Foundation professors were a very successful initiative. Substantial funds are needed for this, however, which the Faculty does not have.

A good shopfloor consultant may not be a good researcher and vice versa. Do you think there is a role for a researcher in a multiconsultant department?

I think research is given too much weight in the appointments process at present. The focus of the specialty should be on clinical performance. For those with an interest in research I think they are most likely to be successful if they are working in multiconsultant departments in which they have protected time for this activity. Too often research is done in people's own time and is unfunded. We need to ring fence time for people with a defined academic role. The academic aspirations of the specialty cannot develop without a proper allocation of protected time.

How would you counsel someone who would like to be involved in research, but does not work in a major centre and has little time to spare?

We have to recognise that none of us possesses all the skills needed to undertake research in the modern NHS. The answer is to join a network or offer to collaborate with a researcher of good reputation. We all have different contributions we can make and by working as groups we have a greater chance of assembling the necessary skills and this has the added advantage of dividing the workload. I am concerned that some people are afraid to share research ideas for fear they will "be stolen". The truth is that the good ideas that are not shared never get to see the light of day.

One of the most popular parts of the *EMJ* is the BETS. What do you think of those?

I think they are a pragmatic response to the need to find answers to the everyday questions we all face in A&E and in that sense are to be welcomed. I have some concerns about the methodology. It is not always evident how some papers are discarded and on occasion it seems that the evidence is difficult to translate into the clinical bottom line. They do not have the rigour one would ideally like but that is the price paid for their quick nature. In fairness, several of them have been repeated by trainees who by and large have come up with the same papers and the same conclusions. The BETS may also be a good way of capturing all the hard work that goes into the clinical topic reviews. I would encourage all trainees who are coming up to the exam to make their topic reviews count by submitting them for publication either as a review article or to the BETS programme.

How do you see the future?

I think now is an excellent time to become involved in research in our specialty. Emergencies in general are high on the politic agenda. Each target, guideline, new method of working, or delivering care is a research opportunity. However, we need to balance the focus on service delivery research with clinical research. This specialty has the broadest range of pathology of any and we should take advantage of that.

Consultant appointments November 2002 to January 2003. The information for the consultant appointments is provided by the Faculty and any errors should be notified to them and not the journal

Name	Hospital	Previous post
Saad Abdulla	Basildon Hospital	SpR, South Wales
Nicola Batrick	St Mary's Hospital, London	SpR, South West Thames
Steven Crane	York District Hospital	Locum consultant, Leeds General Infirmary
Peter Adrian Evans	Morriston Hospital	Consultant, Leicester
Geraint W L Evans	Prince Charles Hospital	Consultant, South Wales
Neil Halford	Queen Elizabeth Hospital, Gateshead	Consultant, Auckland, New Zealand
Robert Halstead	Bradford Royal Infirmary	SpR, Bradford
M Hayder Hassan	Queen Mary's Hospital	SpR, South Thames
Robin Jones	Aintree Hospital	SpR, Mersey
Paul Knowles	Leighton Hospital	SpR, Mersey
Chieh-Min Lin	New Cross Hospital	SpR, West Midlands
Andrew MacNab	Morriston Hospital	SpR, South Wales
Ruth Marshall	Cumberland Infirmary	Consultant, Paisley
R Stephen Moore	The Countess of Chester	Consultant, Northampton General Hospital
Michael A Obiako	Prince Charles Hospital	Locum consultant
Delia Parnham-Cope	Gloucestershire Royal Hospital	SpR, South Thames
David Roe	Whiston Hospital	Consultant, Preston and Chorley
Arvinder Sadana	St George's Hospital	Consultant, Whipps Cross Hospital
N Sivayoham	St George's Hospital	Locum consultant, St George's
James Stuart	Manchester Royal Infirmary	Consultant, North Manchester and Booth Hall Children's Hospital

News from BAETA

Springtime means different things to different people, and emergency medicine trainees are no different in this respect. For some trainees it is the first conference of the year—BAEM2003. This year's conference is being held in Derby from 1–4 April. The BAETA meeting will take place at the end of the first day and the agenda for this will be posted on our website but will definitely involve elections to various posts on your committee. Following this we have traditionally "hit the town" for what, in the past, has been euphemistically called networking. The conference organisers have also arranged a dinner for the second night that I am sure will be enjoyable too.

For some senior trainees springtime may mean blood, sweat, and tears as the FFAEM approaches. If the exam does make you nervous, then take heart in that there are some courses out there to help you through.

There is a one day exam preparation course in Glamorgan on 11 March. For more details contact Mr Ahmed Kamal, A&E Consultant at Royal Glamorgan Hospital on 01443 443550 or email ahmed.kamal@pr-tr.wales.nhs.uk. If one day doesn't seem enough there is a two day course at the Chelsea and Westminster Hospital in London. For more details contact Dr Julia Harris via email julia.harris@chelwest.nhs.uk.

There are also a couple of critical appraisal courses. Health R&D North West is hosting a one day course in Warrington on 27 March. Contact Vicki Bell on 01524 593209 or via email hrdn@lancaster.ac.uk. Another Leeds critical appraisal course is taking place. More details and confirmed dates can be obtained from Richard.Hardern@ndhcnt.northy.nhs.uk.

If springtime for you means the budding of research ideas then don't forget the funding. There are Faculty funds available for trainees with closing dates in springtime. Contact your regional research lead and have a look at the faculty research website www.faem.org.uk/index.htm for more help.

If you aren't taking the exam and your study leave budget will not stretch to the BAEM conference then what about the anaesthetic trauma and critical care course (ATACC) which is targeted at those with anaesthetic and airway skills who may be involved in the management of trauma patients. It is a three day course designed to take the principles of ATLS a few stages further into the critical care phase of management. The next course is from 20–22 March. Visit the website at www.anaesthetic-trauma.org or contact the course director, Dr Mark Forrest, on 01925 635911 extension 2232.

Something else slightly different is the hospital incident team support (HITS) course. It is aimed at hospital based practitioners who may form part of a pre-hospital care team and covers communications, scene safety, extrication, clinical management, and major incident medical support. The next course is from 5–7 April, at Essex Police Training Centre. Contact Aaron Pennell at arpennell@doctors.org.uk, or by phone on 01279 444455.

Finally, the administration of EMTEL, the emergency medicine trainees' email list, has changed hands. Jonathan Benger, after a marvellous job, has handed over the reins and if you want to receive the messages email me at the address below. It contains no advertising, and is used only by your elected committee to disseminate information of interest to all.

STEVE JONES
President of BAETA;
steve.r.jones@bigfoot.com

Round up of forum news from FASSGEM

As I write this in early January we are still awaiting the (delayed) publication of the "Pay Review" by the DDPRB. Undoubtedly this delay is a knock on effect of the rejection of the "New Contract" by the consultant body last year. Time may hopefully have proved me wrong, however at the current time my understanding (from reliable sources) is that the pay increase for 2003–4 will be a percentage uplift only and will not include any significant redress to the NCCG pay scale as alluded to in the last DDPRB report (December 2001). In effect (if my understanding is correct) this will mean that the findings of the PricewaterhouseCoopers survey will have been "filed for future reference" rather than having been acted upon. This is obviously deeply frustrating for all NCCG doctors, especially those of us who are working a significant percentage of our contract as "antisocial hours" for which, at present, there is no form of "intensity" related payback.

THE GOOD NEWS . . . Is that the Department of Health have given me strong assurances that the full spectrum of problems affecting NCCG staff in emergency medicine will be discussed and as a result of this change can be expected. At a recent meeting in the Department of Health indications were given that this process could be expected to begin in mid-February 2003.

I have had reassurances that FASSGEM will be represented at any meetings/discussions that do take place. Indications were also given that reform to the NCCG structure would be considered and implemented either in advance of (or at the same time as) any changes to the SHO structure. Updates on the progress will be circulated regularly by email cascade through regional FASSGEM representatives (see the list below)—so make sure your rep knows how to contact you so you can be kept up to date!

At a recent meeting with the Minister for Health (David Lammy), I received reassurances that the problems facing NCCGs within emergency departments are both appreciated and understood at a governmental level. Moreover the Department of Health has acknowledged the key part that our membership has to play in the implementation of the changes to emergency care outlined in *Reforming Emergency Care*.

Star rating survey

A star rating survey questionnaire has been circulated with the *FASSGEM Newsletter*, if you have not already done so please complete and return this through your regional representative as soon as possible (it is intended that we will use the results of this to help inform discussions with the Department of Health).

Chichester meeting

A one day CME meeting for FASSGEM members will be held in Chichester on 9 May 2003. The spring regional representatives meeting will take place after the close of the academic portion of the meeting. Further details are available from Vimal Desai in Chichester.

FASSGEM conference 2003

The annual conference will be held in Wakefield from 18–21 November; full details will be in the next *FASSGEM Newsletter*.

Representatives' list

The current list of FASSGEM regional representatives is as follows:

South West—Dr A Newton (Chair); apnewton@fairviewshipham.fsnet.co.uk

Wessex—Dr C Hargreaves (Secretary); chargreaves@doctors.org.uk

South West Peninsula—Dr S Barton (Treasurer); sue.barton@rcht.swest.nhs.uk

Trent—Dr N Howarth (FAEM representative); Nick.Howarth@doctors.org.uk *and* Dr R Shahid; Riazshahid@doctors.org.uk

North Thames West—Dr M Aw-Yong (BMA representative); drmeng@btinternet.com

North Thames East—Dr P Schymanski; schymp@apiyo.freeserve.co.uk

South Thames West—Dr S Nallanathar; tsirissia@hotmail.com

Oxford—Mr V Rao (pending election)

West Midlands—Mr D Gupta

East Anglia—Dr U Ikidde; usikidde@cwctv.net

North West—Dr T Jaiganesh; jaisri@aol.com

Mersey—Dr L Teebay (pending election); teebay@btinternet.com

Yorkshire—Dr J Ballesteros; DTS@juanb.freeserve.co.uk

Scotland—Dr J Burns; burns.five@ ntlworld.com

Wales—Dr A Dexter; andy@tallcanuck.freeserve.co.uk

Northern Ireland—Dr L Abernethy (pending election); liz.abernethy@tinyworld.co.uk

South Thames East/Northern—vacant.

ANDREW NEWTON
Chair of FASSGEM (Forum for Associate Specialists and Staff Grades in Emergency Medicine)

Views and news from the "Trolley Csar"

So one frenetic year is over and the new one just begun. Will life be calmer—or will our search for perpetual motion continue? But was it a bad year might be the first question.

Overall I feel that 2002 was the best year for many a decade for emergency medicine and emergency services. This was primarily because finally it was accepted unequivocally that emergency services were important and were the government's top priority. No longer were we considered the carbuncle on the side of the hospital, the reason why waiting lists could not be met—because we filled up beds with all those unnecessary emergencies—the poor relation of elective surgery. We became the number one priority. This is easy to say but after 30 years of underinvestment and lone voices crying in the NHS wilderness, there were no instant solutions. Everywhere you looked there was a need for investment: in people, in equipment, in space, in beds, and in resources.

It is unfair to state that nothing had happened before last year. There had already been considerable publicity for trolley waits and help was being delivered through WEST and NPAT, but mostly from the standpoint of bed-blocking. The setting of the target of 90% of patients coming to A&E being admitted or discharged by March 2003 (and 100% by December 2004—but more of that another time!) focused minds as nothing had done before. A series of strategies were introduced to try to move quickly and effectively to the first of these deadlines. The second half of the year saw a series of initiatives: the setting up of the emergency care collaboratives, appointment of emergency care leads, the encouragement to establish local networks, See and Treat, the rapid appointment of emergency nurse practitioners, etc. Perhaps most important was the encouragement of local initiatives—something which had disappeared over the years.

None of this means, however, that all the problems were solved. It was immediately apparent that although quite a lot could be done quickly, much would take months and indeed years. There is a political drive to meet the preset targets—and indeed for the sake of patients this emphasis can do little but good. On the other hand until some of the longstanding deficiencies are made good it will be difficult to produce the sort of service that we all want.

So what of 2003 and where do I fit in (window dressing or a real function)? This will be a tough year—again, but with much encouragement and a steady increase in resources, albeit less than we would like. There is a clear target to be met by 31 March, and much effort is going in to meet this. More exciting perhaps are the bringing into play nationally many of the innovations that have been introduced by a few places so far. We have a real problem with shortage of consultants, poor terms and conditions for staff grades, and disappearing trainees. This has been exacerbated by the service being more consultant delivered than previously—for example, See and Treat. This has led to expanded roles for other staff to very good effect. There is in the medium and longer term signs of real consultant expansion with a substantial in crease in NTNs likely from 1 April, albeit with a tranche of local money needed for implementation.

Other interesting areas include walk-in centres where I see the real advance being in those sited away from acute hospitals. Another area ripe for improvement is the interface between emergency departments and the rest of the hospital. A much clearer relation between emergency medicine and acute medicine is required—and is likely.

One downside of the four hour target has been that much of the focus has been on the emergency department. It is, however, obvious that the problem is not theirs alone. It is very much a whole system problem encompassing primary and community care, the ambulance service, the voluntary sector and social services, among others. One focus for us now for the intermediate term is to try to stitch all the pieces together. The emphasis will be very much on providing appropriate care wherever it is needed, with much outside the acute hospital.

So there are many challenges—but much encouragement to tackle them. And how do I fit in (a question I have asked myself on several occasions!)? I act as an interface with the professions. I meet, for example, on a regular basis with John Heyworth and the President of the Faculty, now Alistair McGowan. This provides me with a reality check for the ideas that are emerging from all quarters. I am also involved in the interface issues between emergency medicine and surgery and acute medicine on the one hand and primary care on the other. Together with Matthew Cooke (for A&E) and David Carson (for primary care) we give clinical input at many levels. We dovetail with the senior NHS managers—all of whom have had wide experience of hands-on management in trusts—and senior civil servants. Together I feel we make a powerful team, which will help people almost literally "busting their guts" to improve the lot of patients.

I am also a point of contact for individual members of the health professions. Frequent contact is indeed vital if I am to represent you centrally. I have visited and will continue to visit many hospitals and departments when there are specific problems or new initiatives. I really do welcome ideas, thoughts, and even criticisms from all of you. Keep the letters and emails flowing.

In future I shall report on specific issues or new initiatives but felt that a new year's brief overview was a good place to start.

K G M M ALBERTI
National Director for Emergency Access