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SUPPLEMENT

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THE COLLEGE OF EMERGENCY MEDICINE

There have been many milestones along the evolutionary pathway to emergency medicine. The Casualty Surgeons Association was inaugurated in 1967, the name was changed to BAEM in 1990 and the Faculty began in 1993. However, there are now some new dates, which must be burnt into our collective cortex and they are Winter 2005 and Spring 2007.

During meetings on 25 November 2005 the AGM AND THE board agreed to become the College of Emergency Medicine.

What does this mean?

This means that we are one step up a three step ladder to becoming a Royal College of Emergency Medicine.

Step 1

Thanks in large part to the machinations of many from BAEM and FAEM including John Heyworth and Alistair McGowan over a number of years we found ourselves in a position two years ago where becoming a college as a ''good idea''. We needed to seek the support of our 6 parent colleges. This required the diplomatic skills of a UN negotiator and the tenacity of a focused lurcher. The man with this enviable set of skills was Alistair McGowan. Thanks to his perseverance our parent colleges eventually gave their benediction to our future independence and we also achieved the support of the DOH. This allowed the Faculty to become a College.

Step 2

Over the next 18 months the functions of BAEM and FAEM (now the college) will be merged in order for these two bodies to be dissolved. At an EGM of BAEM on 24 November there was a unanimous vote to allow constitutional change to facilitate this change. This will lead to a chartered College, which will incorporate the function of both bodies. This includes clinical standards and professional standards from BAEM education, training, examinations, and curriculum from FAEM. A merger group already exists to oversee this radical step, which incorporates officers from FAEM and BAEM. A merger board will oversee the new constitution and lead on joint ventures.

If the merged body is to become a chartered college it needs the support of the Privy Council and they will feel positive towards us if we are viewed as ''a body of substance''.

If the chartered college could be announced in the spring of 2007 this would neatly salute the CSA formed 40 years before.

Step 3

In the long term the college can apply to become a Royal College with a royal warrant via the Privy Council.

Questions

1. Why bother?

It is time for us to stand up and be counted with the other colleges, speak with the authority of one governing body and have national and international status.

2. How much?

It is hoped that the College subscription will be slightly less than the combined FAEM and BAEM subscriptions.

3. Where does Churchill House fit in?

We can become a college without moving but we have outgrown our lodgings at the RCS. The case for moving has been put in a previous supplement, details of fundraising will appear in future communications.

JIM WARDROPE
MARTIN SHALLEY

Consultant appointments May to December 2005.
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
Ashis Banerjee	Barnet & Chase Farm Hospital	Counsultant, University Hospital of Lewisham
David F Bowden	Good Hope Hospital	Consultant, Wallsall
Kathryn L Coleman	Mayday University Hospital	SpR, S W Thames
Naomi D Cuthbert	Derbyshire Royal Infirmary	Locum Consultant
Julie A Davies	North Tyneside General Hosptial	SpR, Northern
Thomas M Davies	Pinderfields General Hospital	SpR, Yorkshire
Hugo Dowd	University Hospital, Cardiff	Consultant, N East
Margaret S Fitzpatrick	Antrim Hospital	Locum Consultant, Antrim Area Hospital
Anne Frampton	Bristol Royal Infirmary, A&E Consultant with interest in Paediatric Medicine	SpR, unknown
David F Graham	Whipps Cross Hospital	Locum Consultant, S W Thames
Anne E Hicks	Derriford Hospital	SpR, S Western
Arshid A Khan	St Luke's Hospital Bradford	SpR, Yorkshire
Elizabeth M Kidney	Barnsley District Hospital	SpR, Yorkshire
Yong Hwa Lim	Weston General Hospital	Consultant, Singapore General Hospital
Kevin Maguire	Mater Hospital	SpR, Royal Victoria Hospital
Johanna Mower	University Hospital, Cardiff	Consultant, Nevill Hall Hospital
Lisa E Munro-Davies	Bristol Royal Infirmary	Locum Consultant, Bristol Royal Infirmary
Sugata Nag	Great Western Hospital, Swindon	Consultant, University Hospital of North Tees
Mark J Pontin	The Royal Surrey County Hospital	SpR, S W Thames
Sanjay Ramamoorthy	Portsmouth Hospital	SpR, Wessex
Junaid S Rathore	Royal Liverpool University Hosptial	SpR, Royal Liverpool University Hospital
S L Tan	Barts and the London	Locum Consultant, Royal London Hospital
Hiu Nam Tong	Queen Elizabeth Hosptial	Locum Consultant, East Anglia
Sian L Veysey	Bristol Royal Infirmary	SpR, S Western
Andrew P Webster	The Royal Lancaster Hospital	SpR, South Yorkshire
Andrew Wright	Scarborough Hospital	Consultant, Doncaster Royal Infirmary
Kelvin D Wright	Frimley Park Hospital	Counsultant, Royal Surrey County Hospital
Mohammad I Zia	Whipps Cross Hospital	Consultant, University College Hospital

THE EARTHQUAKE IN PAKISTAN

Dr Abid Farooqi, a consultant physician in the Pakistan Institute of Medical Sciences, Islamabad was doing a locum in the UK at the time of the earthquake. These are his impressions on his return home.

I landed back at Islamabad airport (from the UK) on Monday 17th October and the ramifications and effects of this massive earthquake, that had occurred nine days previously, were to be seen straightaway. There were lots of piles of foreign aid on the tarmac itself — probably because a lot had come in and there was not enough space for it to be put under a roof somewhere. Our baggage did not start to appear on the conveyor belt till an hour after landing since all the porters were engaged in unloading the foreign aid from another plane first. That first day back was spent at home with the family only since I was rather jet-lagged and the body just needed a rest.

I had originally planned to take two days off work before rejoining the hospital, but on the first day back I got a phone call from my colleague who mentioned the huge amount of work needed to look after the quake victims and that meant I jut could not have the luxury of staying at home on Tuesday whilst everybody else worked their butts off; duty called!

As I drove into the hospital on Tuesday morning, one could see that this was not a normal hospital scene. There were tents erected in several of our lawns and these had banners proclaiming they were camp offices for one relief organisation or another. At one site, the Islamabad Chamber of Commerce had erected three large tents, which were serving as additional wards for patients who could not be accommodated inside the hospital building. As I walked in through the outpatient entrance, I could see that both floors were full of beds occupied by the wounded victims. There was no regular outpatient service under these conditions. Everywhere I went, the hospital looked like a huge surgical ward only. Men and women were lying with either broken bones or infected wounds and there was a sense of purpose palpable in almost everybody who was there to help out. I saw a large number of volunteers, young and old who were chipping in. The young school boys were acting as porters, transporting patients from one place to another as needed and ensuring that all investigations like x rays and blood tests arrived back in the appropriate patient folder. The Blood Bank for once had no dearth of supplies; the volunteers had given more than was needed and more were waiting for donating blood as the need arose. The large Administration entrance was filled with boxes containing medical supplies and there seemed no shortage of these either.

At 10 am every day, all consultants (except those busy in the theatres) gathered in the Hospital's conference room for a daily briefing by the Executive Director. This meeting gave us an update on the overall statistics of patients having arrived at our hospital and for us to discuss any problems that we may be facing in looking after the patients. I joined in and learnt that the hospital was looking after nearly 50% more patients than it was designed for and resources were stretched. The surgeons had started showing signs of fatigue but the inflow of wounded was not letting up. As many patients as possible were being transferred daily to field or camp hospitals around the city to make way for fresh arrivals. These fresh arrivals were averaging 150–200 a day! The hospital had sent 14 teams (a total of 600 staff) to various field hospitals in the affected areas and there was a daily feed back from them as well. A duty roster was in place to have these people replaced by other staff members every three to four days.

I was made in charge of one of the wards, along with a team of trainee doctors. As I went round the patients, the stories were heart rending indeed. The number of people left paraplegic because of spinal injuries was astounding. They had had their spinal fixation done or were waiting for that, but how were they ever going to walk again? These included young and old, mothers with small children, and men who were the only earning members of their families. Some had medical problems along side, like severe lung problems or infections like tetanus. For once, there was no shortage of medicines; I could get any drug that I asked for. However, the hospital did not have enough ventilators. Those requiring assisted ventilation had to wait for their turn — and some would not survive! I had seen only the occasional case of tetanus earlier in my career, but now I have seen fresh cases every day; not at all a pleasant experience.

It has now been five days since I have been back. I have barely had time to rest. Every night I come back late because of having to go around all ward patients twice daily. Sleep deprivation has been a problem. But yesterday for the first time, the inflow of patients seemed to have reduced. We were told that the several field hospitals in the affected areas have now become operational and are catering to a lot of wounded without the need for them to be flown to Islamabad. The official death toll has crossed the 50,000 mark, but the unofficial estimates far exceed that figure. What is unimaginable is the plight of the survivors — left homeless and penniless and with a large number of them being physically handicapped for life.

This is the month of Ramadan, during which all Muslims fast and at the end of this month celebrate Eid — an occasion meant to be as festive as Christmas. This year there is no joy in the air over here. Eid is going to be a muted affair. The whole nation has been saddened and it is going to be a long, long time before people here return to a normal life.

ABID FAROOQI

CONTINUING PROFESSIONAL DEVELOPMENT

I took over as Director of CPD in June 2004 at a time of increased pressure from outside agencies to document what we as individuals are doing to maintain good medical practice and professional conduct. These aspects of our professional lives are interlinked throughout our career pathways. In view of these changes, the Directors of CPD or the CPD Committees within each College or Faculty have taken on an expanding role including advising for a parent College or Faculty on appraisal and attempting to define standards and evidence for revalidation.

As part of my role as director of CPD, I attend the directors of CPD meeting, which are chaired by the Academy of Medical Royal Colleges. These meetings occur four times a year and this keeps me abreast of developments in CPD, appraisal and revalidation in the other Colleges and faculties as well as keeping me appraised of current developments in the GMC. I feedback to the Faculty board and the Education and Examination committee.

I ensure that annual CPD returns are completed by colleagues who have registered for CPD and audit 5% of these annually to quality assure the CPD performed by individuals.

CPD guidelines

Continuing Professional Development is a continuing learning process that complements formal undergraduate and postgraduate education and training. CPD requires doctors to maintain and improve their standards across all areas of their practice. CPD should also encourage and support specific changes in practice and career development. (CPD Guidance GMC April 2004). CPD is an obligatory requirement for all practising emergency medical physicians and it is the responsibility of the individual to keep up to date.

CPD has undergone dramatic evolution and was initially formalised by an agreement in 1993 by the Conference of the Medical Royal Colleges and Faculties. First guidance for continuing medical education for the Faculty of Accident and Emergency Medicine was drawn up in November 1995. Since then there have been many changes due to the introduction of appraisal and recommendations by the GMC, and the guidelines were amended in 1999 and January 2000. The most recent guidelines were written in September 2003. The GMC has written further guidance on the CPD, which became available in April 2004. I have updated our 2003 guidelines in line with these and the Department of Health guidelines on appraisal. The 2005 guidelines are available on the Faculty website.

Appraisal guidelines

In view of the developments with appraisal over the last few years, I have now formalised guidance on appraisal in emergency medicine, which includes a summary of contents of an appraisal interview and the expectations of appraisee and appraiser. This document has been approved by the Faculty board and is available on the Faculty website.

Revalidation guidelines

Revalidation, although delayed, is inevitable and in line with other Colleges and faculties I have written a document on guidance on revalidation defining the criteria and standards for emergency medicine and evidence required to show these standards are maintained by individuals. The standards of emergency medicine are based on the new curriculum, which will be available from 2007. This document has been approved by the Faculty board and is available on the Faculty website.

Recording CPD

Currently, the majority of practitioners collect paperwork or certificates demonstrating that we have attended conferences or courses to improve our standards in emergency medicine practice. This can either be kept together in a folder, which is eventually used for appraisal, or just kept separately and collated whenever the annual appraisal is due.

One of my aims as director of CPD is to assist colleagues in their recording of the CPD. This should make it easier when gathering the information for appraisal and hence revalidation. Initially this has been done with 2 forms, which are now on the website:

Standard CPD form

There is a standard CPD form present on the Faculty website available for download by all colleagues. This standard form can be used under each category of CPD, which would include good medical practice, maintaining good medical practice, teaching and training, working relationships with colleagues, and relationships with patients.

On each of these forms the following can be recorded:

- Title of the course or conference
- The date of the event
- A brief summary of the event or activity
- The number of hours of CPD accredited
- Record of whether it was study, annual or professional leave
- Personal objectives of the CPD activity
- Reflective notes on the CPD activity

Annual CPD report form

This form can be downloaded from the Faculty website to enable fellows to summarise their annual CPD activity on one sheet, which can be used in their appraisal folder.

Future developments

CPD Online Administration by the Faculty

An alternative method of developing CPD online administration would be for the Faculty to design, with the website manager, CPD online administration, which would be easily accessible by each individual would maintain confidentiality. There would be the standard form, as previously described, for recorded CPD activity under the following headings:-

- Good Medical Practice
- Maintaining Good Medical Practice
- Teaching and Training
- Working Relationships with Colleagues
- Relationships with Patients

The number of hours under each heading would be automatically totalled and put on annual activity report available for the fellow. This could be used in the appraisal and revalidation. The forms for individual CPD could be downloaded for appraisal and filled in on line.

Courses and Conferences

Further assistance to colleagues could be provided by giving information on their continuing professional development courses and conferences via the

website and have an area so that the fellows can comment in confidence about a particular course or conference they found useful or otherwise.

CPD Forum

This is another area which could be provided on the website where fellow colleagues could flag up specific problems they had encountered whether they are clinical or managerial and ask if anyone else had dealt with this type of situation so as to provide an informal confidential advice system between colleagues.

I would be grateful if anyone has some strong views or are keen to support this development to feedback to me via the Faculty office.

The Faculty provide workshops on CPD topics at the Annual scientific meeting and CPD topics are covered at the BAEM conference.

Some Fellows have difficulty attending conferences for a number of reasons. I have found, by sending a questionnaire to the fellows, that a number of you have great difficulty in either obtaining study leave due to shortage of staffing or target attainment. Others have had difficulty in obtaining funding due to the Trust capping funding.

Thus Continuing Professional Development needs to be brought to colleagues in other forms and I am therefore exploring other avenues.

One aspect is E-learning, which is currently being piloted by Taj Hassan and colleagues. Another possibility is having some aspects of CPD in the EMJ.

The topics presented as CPD should be based on the new curriculum.

I am open to ideas and if anyone is interested in developing new concepts in delivering CPD please contact me via the Faculty office.

JACKY HANSON
Director of CPD

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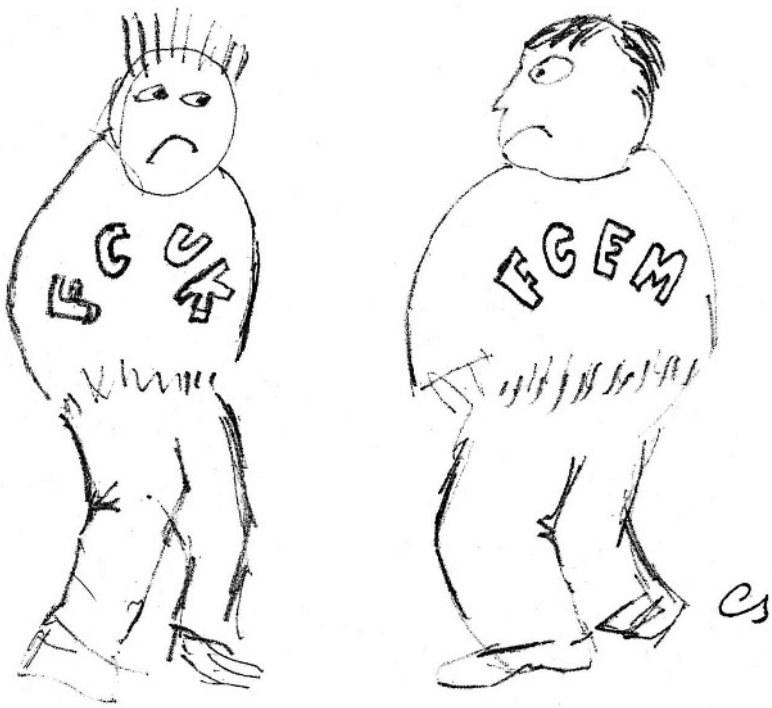

HOW DO DEANERIES WORK?

There are currently 21 Deaneries in the UK: Eastern (Cambridge); Kent, Surrey and Sussex; Leicestershire, Northamptonshire and Rutland; London; Mersey (Liverpool); Northern (Newcastle-upon-Tyne); North Western (Manchester); Northern Ireland; Oxford; Scotland (East); Scotland (North / North East); Scotland (South East); Scotland (West); South West Peninsula; South Yorkshire and South Humber (Sheffield); Trent (Nottingham); Tri Services (Royal Navy, Army, and Royal Air Force); Wales (Cardiff); Wessex (Winchester); West Midlands (Birmingham); and Yorkshire (Leeds).

Each of these Deaneries is led by a Postgraduate Dean. The Postgraduate Deans meet on a monthly basis in the Conference of Postgraduate Medical Deans (COPMeD). COPMeD acts as a focal point for contact between the Postgraduate Deans and other organisations, such as the various Royal Colleges and Faculties, GMC, BMA, Medical Research Council (MRC), National Association of Clinical Tutors (NACT), National Institute of Clinical Excellence (NICE), and NHS Executive. There will also be close relationships between the Postgraduate Deans and the newly established PMETB.

COPMed has a useful website (www.copmed.org.uk), which provides links to a large number of other websites.

The Postgraduate Dean will also have close relationships with the local Universities, specifically the Deans of the Medical Schools in order to ensure a smooth transition from undergraduate to postgraduate education, and the various Professors in order to facilitate high quality research opportunities.

The Postgraduate Dean has overall responsibility for the functioning of the Deanery, but also has duties on a national basis. Each specialty has a ''Lead Dean'' and therefore each Lead Dean will have a number of specialties, for which he or she takes particular responsibility. For example, the Lead Dean for Emergency Medicine is currently the Postgraduate Dean in Aberdeen. Each Postgraduate Dean will also represent COPMeD on various national organisations, committees, working parties, etc.

The precise details of the workings of each Deanery vary from Deanery to Deanery. This article gives general guidance but your own Deanery may vary to a greater or lesser extent.

The Postgraduate Dean is supported by Deputy and/or Associate Postgraduate Deans and also by the Director of Postgraduate General Practice Education (a member of the Committee of General Practice Education Directors, COGPED) and the Postgraduate Dental Dean (a member of the Committee of Postgraduate Dental Deans, COPDEND), each of whom will have their own supporting staff. There is also a number of supporting managerial and administrative staff. Each Associate Dean will, in turn, have a number of specific responsibilities, such as overseas doctors (including arranging permit-free training), flexible training, inter-deanery transfers, doctors in difficulty, specific groups of doctors (Foundation Years, SHOs or SpRs), specific groups of specialties, modernising medical careers (MMC), assessments (RITAs), hospital visits of inspection, etc.

Each specialty will have two key links with the Deanery. These are the Regional Specialty Advisor and the Programme Director. The Regional Specialty Advisor is appointed by the relevant Royal College or Faculty and will advise the Deanery on the requirements of the specific Royal College or Faculty. Clearly there are considerable differences between the various Royal Colleges in terms of entry qualifications required for training, length of training, examination structure, logbooks/portfolios, curricula, subspecialty training, etc, and it would be impossible for a Postgraduate Dean to know all the finer details of the different organisations. The Programme Director is responsible for organising the rotations, to ensure that each trainee receives satisfactory training opportunities. The Programme Director often (though not always) also serves as the Chairman of the Specialty Training Committee.

The educational structures within the various Royal Colleges and Faculties are organised by bodies such as the Joint Committee on Higher Training in Accident and Emergency Medicine (JCHTA&E), the Joint Committee on Higher Medical Training (JCHMT), the Joint Committee on Higher Surgical Training (JCHST), and the Joint Committee for Postgraduate Training for General Practitioners (JCPTGP).

The Deanery will have close relationships with the Trusts within the Deanery. The educational relationship is principally via the Postgraduate Clinical Tutor (and Associate Tutors) of the Trust. The Postgraduate Clinical Tutor will be responsible for training within the Trust and will have regular meetings with the various educational supervisors and Royal College tutors within the Trust. The College Tutors are appointed by the various Royal Colleges to represent the educational requirements of the Royal College within the Trust. The Postgraduate Clinical Tutor will be intimately involved with working practices within the Trust, including junior doctors' hours, particularly in connection with establishing rotas, which are compatible with the European Working Time Directive (EWTD). The Postgraduate Clinical Tutor will have responsibility for agreeing study leave with the trainees (and their educational supervisors) within the Trust, and may also become involved with issues involving annual leave, sick leave, unpaid leave, maternity leave, compassionate leave, removal expenses, and travel expenses, often in consultation with the Postgraduate Dean. The Postgraduate Dean will also have a business/financial relationship with the Trust.

The Deanery will enter into contracts with the various Trusts to ensure that Trusts (and General Practices and Health Authorities) provide a suitable learning environment to meet the requirements of the trainees, as defined by the various Royal Colleges, Faculties and Universities. In some Deaneries, one specific Trust is responsible for holding the contracts for all trainees, regardless of whether or not they ever work at that specific Trust.

The various training posts within the Deanery are advertised and appointed through the offices of the Deanery. Prior to advertisement, the Postgraduate Dean will need to approve the post. He or she will take advice from the Regional Specialty Advisor and the Programme Director. In the case of a Specialist Registrar appointment, the Postgraduate Dean will ensure that a National Training Number (NTN) is available, in discussion with the Lead Dean for the specialty when necessary. The Postgraduate Dean will also need to ensure that funding is available, which may require discussion with one or more Trusts. The Deanery is also responsible for the actual recruitment procedures, including shortlisting and interviewing.

To contact the editors:

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The Deanery will arrange specific courses, such as courses on management, appraisal skills, teaching, legal and ethical issues, interviewing skills, employment law, assertiveness, etc. The Deanery thus provides some continuing professional development for consultants and other non-training grades.

From the above, it becomes obvious that the organisation of postgraduate medical education is complex. It is largely dependent upon ''networking'' between the Deaneries, Royal Colleges and Trusts. There is always the potential for conflicts of interest, particularly between educational opportunities and service commitments of trainees. When representing the Deanery, it is essential to remember that the educational opportunities of the trainee always take precedence over all other considerations, apart from patient safety.

JOHN BACHE
Associate Postgraduate Dean, Mersey Deanery, Consultant in Accident and Emergency Medicine, Leighton Hospital, Crewe, UK

UK EMERGENCY MEDICINE SPR TRAINING: THE NEED FOR CHANGE

Over the past few years there has been increasing recognition that trainee performance needs to be assessed regularly and in a robust manner to ensure adequate training. Foundation programmes have seen the introduction of formalised assessment tools (and a requirement to use them) for the first two postgraduate years. The development of the MFAEM and changes in the FFAEM exams have greatly improved assessment on entry to and exit from the SpR grade. Over the next few years, there will be a move towards much more robust assessment of trainee progress during the SpR grade than we have seen previously (Peter Driscoll, Faculty Dean, personal communication).

Unfortunately, assessment of the quality of training delivered by a training post has not yet received the same level of attention. The practice of tying trainees' feedback about training posts to their own RITA assessment has meant that many trainees feel inhibited from giving critical feedback for fear of retribution. The JCHT has worked hard to improve the quality of training and is keen to take trainees views into account when inspecting training posts but JCHT inspections are resource-intensive and infrequent. Even when problems are identified, the JCHT appears to have few levers that can directly influence individual training posts other than the 'nuclear' option of withdrawing recognition of the post. In the view of many trainees I meet, the current system does not result in meaningful improvement within a timescale relevant to an individual trainee: the 'crap' jobs in a region on day one of SpR training are still the 'crap' jobs when the SpR finishes, with little sign of change...

If Emergency Medicine training is to continue to improve, we need to identify those trainers who provide excellent training, as well as those who do not. Both trainees and trainers deserve to know such information about departments in their region: trainees in particular need this information to make informed decisions when choosing training posts. In early 2006, EMTA will therefore be setting up a system to collect and publish anonymous feedback from trainees regarding their experience of their training posts. Safeguards will be in place to ensure both the anonymity of the trainee and the integrity of the information received, and this information will then be made publicly available on the EMTA website. In the short-term, this information will provide trainees with a valuable resource to help them choose training posts; in the longer-term, our hope is that departments will have to compete to provide the best possible training in the eyes of their trainees, raising standards everywhere as a result. However, this will only happen if we trainees have the courage to provide honest, critical feedback about both good and bad training that we've received: visit the EMTA website today, and let's all 'do our bit' to improve Emergency Medicine in the UK (www.emergencymed.org.uk/EMTA).

EMTA Conference 2006

Turning to less weighty matters, this year's conference in Poole on the south coast is shaping up to be the best ever: Great speakers, skills workshops, a careers fair looking at EM portfolio careers, multiple social events... all for under £400 including accomodation! Don't miss out, see EMTA website for more details.

GHUFRAN SYED
President, EMTA

A ROUND UP OF FORUM NEWS FROM FASSGEM

The FASSGEM Conference 2005 held in Glasgow was a great success academically with a very wide range of excellent quality clinical presentations.

Regrettably the attendance at the Annual Conference this year was not as good as it has been in previous years. This was particularly disappointing given the excellent quality of the presentations at the meeting.

Thanks are due to Dr John Burns for all his hard work in organising the Annual Conference this year.

We have surveyed FASSGEM membership about future conferences (thank you to all who took the time to respond to the questionnaire). The overwhelming majority of FASSGEM members have indicated that they remain fully supportive of a regular Annual Conference and the majority of the respondees have indicated that they would like this Conference to be of three or four days duration, taking place during a working week rather than over a weekend.

With the results of this survey in mind, I would be very keen to hear from anybody willing to host the 2006 FASSGEM Conference as soon as possible.

Our Spring Meeting for 2006 will be held in Wrexham. Full details and an application form can be found on the FASSGEM section of the Emergency Medicine website (www.emergencymed.org.uk).

SAS contract negotiations

The latest indications from the BMA is that the negotiations on the new SAS Contract are proceeding well. You are reminded that regular updates on the progress of these negotiations can be obtained by logging on to the BMA website and subscribing to the 'SAS Update Newsletter'. You do not have to be a BMA member to be eligible for this service.

PMETB

The inevitable teething problems have affected the processing of initial applications by PMETB, at the time of writing we are still awaiting firm indications as to how those that have applied for Article 14 recognition have fared. As soon as further information is available an update will be published on the FASSGEM website.

Merger of BAEM and FAEM

With the merger of the Faculty and the Association, the representation of FASSGEM within the re-organised specialty body will change. A working party consisting of members of the Association and Faculty Executive Boards (including representation from FASSGEM) will be working on this issue over the forthcoming months. If required, the opinion of members will be sought via the email cascade. If you are not signed up to the email cascade, then you may miss the opportunity to express your opinion – to subscribe to the FASSGEM email cascade please contact Dr Andrew Newton on email fairviewshipham@btinternet.com, stating your work address and giving details of your post.

One change that has already taken place as part of the intending merger is an amalgamation of the Publication Committees of the Faculty of Emergency Medicine and the Association. We now have our own FASSGEM representation on this Publications Committee and I am pleased to say that Dr Adel Aziz has taken on this responsibility on our behalf.

DRANDREW NEWTON
Chair of FASSGEM

What is in a name?

The name of our specialty is now Emergency Medicine (see regulation 4(6) of SI 2004/2947).

The Certificate of Training is now awarded in Emergency Medicine. However, we have to leave in the reference 'also known as Accident and Emergency' to ensure we are not in breach of our obligation in Annex to directive 93/16/EC.

Changing the signage around the country however, will take years as it involves spending money.

As to changing hearts and minds, that also could take a while, maybe beginning with the BBCs new drama 'ED'.