

# Emergency Medicine Journal

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Group

SUPPLEMENT

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## First major event in Churchill House

The College and BAEM offices were moved into Churchill House in August 2006. The accommodation is already making a big difference to the staff. In addition we have made use of the meeting rooms and the conference/education facilities. One of the first events to use the education facilities was a CEM examiners workshop on the 20<sup>th</sup> October. Thirty two Fellows of varying experience joined four facilitators and the Dean to enjoy a day of discussion, exploration of current issues in assessment and to practice examining



on each other. The rooms provided light and airy accommodation with space to

move around. It proved a good rehearsal for the Fellowship exam that was held in early November and for the Membership that will be held in January at Churchill House. The College and BAEM are currently drawing up plans to run one day educational workshops on a variety of different subjects as well as ensuring best use of space for meetings and other events. All Fellows and Members are invited to look round the facilities and to visit the staff in the offices. The telephone number is 0207 404 1999.

RUTH BROWN

## A home of our own

Many members and fellows will be disappointed that the College has been unable to raise the money to buy our own share of Churchill House. Our rental agreement does however enable us to enjoy its excellent facilities, as those who have been involved with the recent FCEM exam will testify. Our tenancy gives the specialty a 5 year period in which to consolidate and develop a longer term plan. In the short term we needed the Churchill House scheme – we could not stay in the cramped College of Surgeons space, but cannot yet afford a suitable building of our own.

This year we look forward to the BAEM and the College coming to a satisfactory conclusion. This should give the specialty a clearer view of what the College is doing for us and why its future is important. We would like the wider public to see that potentially everyone who uses the Health Service has an interest in a strong College of Emergency Medicine. Well respected organisations find it easier to get grants, donations and to exert political influence. There is certainly a need for a clear statement on the importance of the care of the emergency patient in the convoluted reorganisation that constantly affects the NHS.

In 5 years we will have more members, and we should have more money in the bank. Sharing Churchill House with the anaesthetists was never going to be a really satisfactory long term solution. We hope that after the elections to the merged College Board later this year we will see some serious planning for suitable permanent accommodation.

Happy New Year!

DIANA HULBERT  
MIKE BECKETT

## Training in Intensive Care Medicine

This short article sets out to demonstrate the rationale for training in intensive care medicine (ICM) and to indicate how trainee emergency physicians can obtain access to this training.

### BACKGROUND

The development of the specialty of ICM in the UK from an obscure activity, in which anaesthetists managed medical patients in ventilatory failure, to a major specialty in its own right has taken about half a century. During this period technological advances and improvements in medical knowledge and treatment have taken place that were unimaginable at the time of opening of the first Intensive Care Unit (ICU) in Oxford in the fifties. This development has been reflected in the growth of the Intensive Care Society (ICS) since its formation in 1971. The ICS represents the interests of not only intensivists but all those working in the specialty and provides a comprehensive educational service. The first meeting of the Intercollegiate Board for Intensive Care Medicine was on 17 September 1996 and "training" added to the title to prevent a clash of acronyms with the Irish Board for ICM. Amongst other things the stimulus for the establishment of the IBTICM was the recognition that the general quality of intensive care, and particularly training in, and organisation of, ICM had fallen behind that of many other countries and the perception was that a solution would lie in an intercollegiate approach. Much published work supports the view that patient outcomes are better when patients are managed by intensivists rather than by the admitting specialist.

### ROLE OF THE INTERCOLLEGIATE BOARD

The Board has been charged by the Royal Colleges with the responsibility of regulating training in ICM. Specifically its remit is to "determine the duration, content and assessment of training in ICM" and to "recommend minimum standards for intensive care units recognised by the Colleges for training". In 1998 the Intercollegiate Board introduced the Diploma in ICM and in 2002 gained approval from the Specialist Training Authority for its curriculum leading to a Joint Certificate of Completion of Specialist Training (CCST). This has evolved, with the advent of the Postgraduate Medical Education and Training Board, into a Certificate of Completion of Training (CCT) that may be obtained jointly with Anaesthesia,

Emergency Medicine, Medicine or Surgery. Formerly, the specialty attracted predominantly anaesthetists but now those interested in practising intensive care medicine are drawn from a range of medical specialties and emergency medicine. Anaesthetists still predominate, but there are growing numbers from the medical specialties and emergency medicine interested in obtaining training in ICM. It is disappointing that this interest has not so far been matched by surgical trainees, especially considering the importance of intensive care management to outcome in surgery. The demand for training in ICM amongst trainee emergency physicians has surprised most intensivists and some Training Programme Directors and Deans responsible for emergency medicine.

The increasing complexity of medicine in general and surgery in particular has driven NHS Trusts, particularly Foundation Trusts, to regard the provision of intensive care as central to the achievement of both clinical and financial targets and this has fuelled both an increase in the number of intensive care beds and the importance in which ICM is held in Trusts.

### HOW CAN EMERGENCY MEDICINE TRAINEES TRAIN IN ICM?

#### Joint CCT

Superficially, the answer to this is simple: meet the criteria for the emergency medicine training programme, and for a programme of training in ICM. In practice it is a little more complicated. The criteria for a CCT in Emergency Medicine are well known to you. To change this to a Joint CCT with ICM requires the following to be added (although some training in ICM might be counted towards the primary specialty programme):

1. 3 months training in ICM at SHO level (preliminary training)
2. 6 months training in acute general medicine, but three months training in emergency medicine and 3 months of acute general medicine are acceptable
3. 6 months training in anaesthesia
4. 6 months general ICM training as an SpR (Step 1)
5. 12 further months training in ICM (Step 2)

Appointment to a joint programme is by competitive entry and is made before the end of year three of the SpR programme (ie, before the end of year five of Specialty Training in the programmes starting in August 2007). To obtain a joint appointment it is necessary for the candidate to have an NTN in the primary

specialty, in this case Emergency Medicine. Of the training modules above, the last must be taken whilst in the joint programme, the first is clearly taken before application for an NTN and the middle three may be taken either before or after appointment to the joint programme, although some ICM training programme directors may find it difficult to find suitable anaesthetic and medical placements. From August 2007 it is anticipated that the Specialty Training programme in Emergency Medicine will comprise, in its first two years, the Acute Care Common Stem (ACCS) programme. One year of this programme includes a range of three to nine months of each of Anaesthesia and ICM and will provide an opportunity to obtain Preliminary Training in ICM and the competences appropriate to a six month training programme in Anaesthesia. The other year will comprise 6 months of emergency medicine and 6 months of acute general medicine. Thus, with a suitably tailored Anaesthesia/ICM ACCS year it is possible to obtain all the required complementary specialty training within the new emergency medicine programme, leaving only 15 to 18 months of ICM training to complete a Joint CCT in emergency medicine and ICM. The ACCS programme has been presented to PMETB and we are optimistic that it will be available from August 2007.

Entry is fairly competitive and of recent appointments in the London Deanery about 60% go to those with anaesthesia as a primary specialty and the remainder to those with medicine or emergency medicine.

#### Intermediate Programme

For those trainees who are in the current scheme and who wish to familiarise themselves with ICM rather than obtain a CCT in it, there is an intermediate programme, which was designed for those intending a sessional commitment to ICM. For a trainee in an emergency medicine this programme would comprise the above components, less the 12 months of Step 2 training, and its completion is acknowledged formally by a letter from the Intercollegiate Board.

#### EXAMINATIONS IN ICM

For trainees on the Joint CCT programme, it is only required that the workplace-based assessments are successfully completed, along, of course, with the requirements for examination in the primary specialty. There are two readily available examinations in ICM:

1. The UK Diploma in ICM, administered by IBTICM

2. The European Diploma in ICM administered by the European Society for Intensive Care Medicine.

The major difference between the two is that the first requires a dissertation, although this may be replaced by a thesis that has already earned the trainee a higher degree.

### EFFECT OF MMC ON THE JOINT CCT IN ICM

The Intercollegiate Board has submitted a curriculum for the joint CCT modified from the competency-based curriculum that has been in use since 2002. This has produced 55 CCTs by September 2006 and there are a further 200 or so at various stages in the programme in the UK. The major changes associated with the ST grade relate to the mechanisms, as yet not completely agreed, by which trainees will obtain access to the complementary specialties and the replacement of fixed times of training by indicative times in

which the competencies will be acquired. Further modifications to the curriculum will be made to incorporate the elements of the curriculum developed by the CoBaTrICE (Competency Based Training for Intensive Care for Europe) project ([www.cobatrace.org](http://www.cobatrace.org)). This project incorporates a syllabus and competencies and a comprehensive series of links to educational resources.

### IS IT NECESSARY TO HAVE A CCT IN ICM TO PRACTISE INTENSIVE CARE?

Finally, for those who have left it too late in their primary specialty training, it must be remembered that it is not a requirement to be on the Specialist Register in the specialty of one's consultant appointment. It is therefore possible for a CCT holder in any specialty to apply successfully for a post in ICM. Appointment must be made on the basis of curriculum vitae, interview and references, all

mapped against the person specification. For those who wish to follow this path, it would be appropriate to have covered the curriculum for training in ICM to intermediate level and to seek a letter of confirmation of completion of training from the IBTICM. It must, however, be borne in mind, that Consultant posts in ICM are becoming ever more competitive and an orthodox approach is more likely to secure a successful application. More information about training in Intensive Care Medicine is available from the IBTICM website: [www.rcoa.ac.uk/ibticm](http://www.rcoa.ac.uk/ibticm).

CHARLES GILLBE

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SECRETARY

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Consultant appointments November 2006. The information for the consultant appointments is provided by the College and any errors should be notified to them and not the journal

Name	Hospital	Previous post
John O'HARE	Craigavon Hospital	SpR
Jacqueline A LYNCH	Salisbury District Hospital	Locum Consultant
Adam HUGHES	Salisbury District Hospital	SpR
Lee GRAY	Salisbury District Hospital	SpR
Jason S D KLEIN	Salisbury District Hospital	SpR
Alastair MCILWEE	Ulster Hospital	SpR

## Working with the ambulance service

Anyone who has ever been part of a receiving trauma or cardiac arrest team cannot fail to appreciate the crucial role the attending ambulance crew have in determining a successful outcome, or otherwise for the patient.

My interest in prehospital care and the ambulance service began in the dark ages when an industrial dispute was threatened by crews at the suggestion that they should measure and record the patients pulse and blood pressure. Over the past three decades there has been enormous development in the skills, knowledge and expertise of ambulance staff. Front line crews are exposed to some extremely harrowing and distressing situations, often in the dark and at extreme climatic conditions. They never fail to surprise me with their enthusiasm and thirst for knowledge.

In addition to the traditional role of responding to life threatening emergencies, today in many parts of the country ambulance emergency care practitioners are working in conjunction with primary care teams in the assessment of patients with both minor and major injuries and illness in their homes. In many cases this prevents an unnecessary referral to the nearest emergency department. As with any rapidly developing service lessons are being learned but from the perspective of an emergency department doctor it is far easier to influence something if one is involved at a senior level.

My current job plan involves working 2 days a week as Medical Director for the local Ambulance trust, usually Tuesdays and Thursdays and the remainder of the time as a Consultant in Emergency Medicine. The beauty of this is that if I have a "bad day" in one site the following day I am somewhere else. This provides a useful perspective. My role as Medical Director has given me insight into the workings of an NHS Trust board and an appreciation of the amount of control and bureaucracy from the centre. I now have a greater understanding of the way in which the NHS functions. I can appreciate the pressures our managerial colleagues are under and have learned that it is naive as a clinician to function in an environment where we insist on optimum patient care without taking in to account the financial consequences.

Some doctors working for ambulance services respond along with front line crew. This is often done as part of a scheme or rota with similar colleagues. Others such as the staff on HEMS offer an extra tier of expertise in the pre-hospital environment. There is significant geographical variation in the availability of such support.

The Department of Health undertook a nationwide review of ambulance services in 2004 and published it under the title of Taking Health Care to the Patient. One of the recommendations of this document was to reduce the number of ambulance trusts in England and Wales from 32 to 12. The resulting mergers are currently causing a great deal of unsettlement in many areas. Part of the agenda is to save

senior management costs by economies of scale without any reduction in service to the patients. It is also envisaged that there will be further development of the emergency practitioner numbers and skills and much greater integration with primary care and other out of hospital services. In short this should mean improving patient choice and hopefully prevent unnecessary transfers to hospitals. The impact of ECPs has already resulted in reductions of as much as 40–50% of patients being transferred but as the number of ECPs is small this has not yet had a significant impact on most emergency departments.

There is a national group of Ambulance Service Medical directors and advisors. Most of us are parttime and not all have full voting rights on boards. The individuals come from a variety of medical backgrounds but most from accident and emergency, Primary Care or Anaesthetics. The Faculty of Pre-hospital Care based in the Royal College of Surgeons in Edinburgh is in the process of seeking accreditation for prehospital care as a specialty with its own CCST, although it is envisaged that most doctors will seek dual accreditation with another relevant specialty.

Working with an ambulance service provides a huge number of possibilities from flying in helicopters to involvement in policy at a national level. With more school children expressing the ambition to become a paramedic rather than a doctor there is undoubtedly a challenging and interesting future!

GILLIAN BRYCE

### To contact the editors:

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## CORRECTION

We would like to apologise for the omission of Johan du Plessis' name from his piece titled, Expedition Medicine—a novice relates, in last months supplement