

## Elections to the Council of the College

A call for nominations for the Council of the new College has been sent out by the Electoral Reform Society who will be conducting the elections. Nominations have to be returned by the end of June, and the election will be in July. This aim of this article is to highlight the importance of these elections and to urge members of the College to vote.

### WHY IS THE COUNCIL IMPORTANT?

The Council is the governing body of the College and is responsible for all major decisions and for College policy. This is a key point in the development of the specialty and the need for an active and strong Council is obvious. The College will continue to be heavily involved in training. The College believes that all non-training doctors working in Emergency Departments should register

with the College for recertification of specialist practice. All doctors above FY2 will need to have some contact with the College. Key decisions and policy on continuing professional development, training, exams, service and professional standards will be made by the Council. The College will be relevant to you all; this is a chance to have your say on who will be making these decisions.

### WHO IS BEING ELECTED?

Table 1 summarises the posts involved in the current elections. Your "region" or "nation" will be defined by your work address (unless not currently employed).

The Chairs of the Regional and National Boards will become the focus for local EM advice. They will be the initial point of contact for service and professional EM issues for all Fellows and Members in their

constituency. The President of EMTA and Chair of FASSGEM will lead these national organisations and champion the views of trainees and SAS doctors within the College.

### WHY DID I NOT RECEIVE NOMINATION/ VOTING PAPERS?

To hold office in the new College or to vote you have to be a member in good standing of the new College. Part of the conditions of the Royal Charter was that elections had to be held within six months of the merger of the old College and BAEM. To hit this deadline, we had to set a cut-off date for the database to send to the Electoral Reform Society. Thus, applications received after 30 April 2008 are not eligible for nomination or voting in this election.

### WILL THERE BE OTHER ELECTIONS?

Yes, in the autumn we will be seeking nominations for other members of the Regional/National Boards including the Vice-Chairs, and regional EMTA and FASSGEM representatives. If you have not been able to vote in this election then you will be able to take part in this subsequent process, but only if you are a member in good standing with the College.

### SUMMARY

Please vote in these elections. It is important that the new Council has a mandate to take forward the work of the College.

Jim Wardrope

**Table 1** Posts involved in the current elections

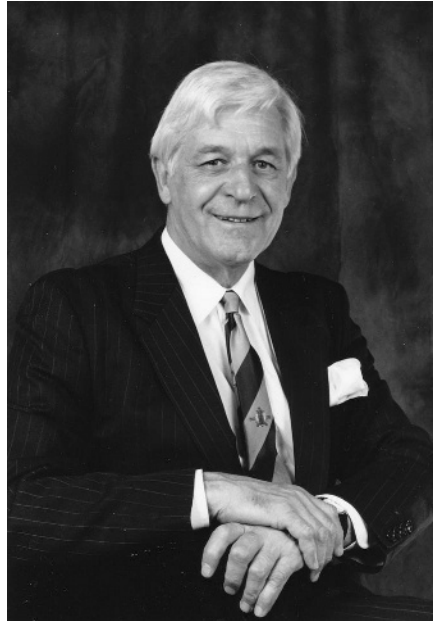
Post	Eligible to stand	Elected by
President-elect	Fellows	Fellows and Members
Chair of Regional Boards	Fellows in the region	Fellows in region
Chair of National Boards	Fellows in the nation	Fellows in the nation
President of EMTA	Members in training	Members in training
Chair of FASSGEM	Associate Fellows, Members, Associate Members in SAS posts or other non-training grades	Associate Fellows, Members, Associate Members in SAS posts or other non-training grades

# Peter J F Baskett

*Emergency physicians will have been saddened to hear of the death of Peter Baskett. His influence on the practice of resuscitation and pre-hospital care has been immense. The widespread acceptance of resuscitation guidelines is a tribute to Peter's energy and commitment. His obituary in the BMJ in June recorded his many achievements in a wide variety of areas. The following notes record his special contributions to the practice of resuscitation.*

It is with the deepest regret that we announce the death of Peter Baskett, the Editor-in-Chief of *Resuscitation* and prominent member of the Board of the European Resuscitation Council. The extensive contribution that Peter has made to medicine in general, and cardiopulmonary resuscitation specifically, will appear in *Resuscitation* as a special article in the series "Resuscitation Greats".

Peter Baskett starting lecturing and teaching in cardiopulmonary resuscitation (CPR) soon after his appointment as Consultant Anaesthetist to the Royal Infirmary and Frenchay Hospital, Bristol, UK in 1966; he has been at the forefront of resuscitation in Europe and elsewhere in the world for 40 years. He was a Founder Member of the Resuscitation Council (UK), which was established formally in 1984. In 1989, Peter was appointed as Chairman of the European Resuscitation Council (ERC) and remained a very active Officer and Board Member of this organisation right up to his death. As a member of the International Liaison Committee on Resuscitation (ILCOR) from 1995 to 2000, Peter developed the international guidelines on airway management during resuscitation, and healthcare professionals across the world respected his



Peter Baskett (26 July 1934–18 April 2008)

expertise on this subject. In 1994 Peter published one of the first studies on the use of the laryngeal mask airway for in-hospital resuscitation. In 2005, in recognition of Peter's contributions to resuscitation the American Heart Association awarded him as a "Resuscitation Giant".

Peter was greatly respected within his principal specialty of anaesthesia; he was a Past President of the Association of Anaesthetists of Great Britain and Ireland (AAGBI), and served as a member of council of the Royal College of Anaesthetists. Peter was also President of the World Association for Emergency and Disaster Medicine, Chairman of the British Association for Immediate Care

(BASICS), and President of the International Trauma, Anaesthesia, and Critical Care Society (ITACCS). Peter was made an honorary life member of the AAGBI, BASICS, the Resuscitation Council (UK) and the ERC.

Peter Baskett played a leading role in promoting both citizen CPR within the UK community and advanced life support (ALS) courses within hospitals throughout Europe. He personally introduced the ERC ALS course into more than 20 countries in Europe and the Middle East. Until very recently, he continued to teach, on a voluntary basis, on approximately 25 ERC ALS courses each year. Peter had been Editor-in-Chief of the journal *Resuscitation* from 1997. Under his leadership the journal grew significantly in quality and status. Peter authored over 170 scientific publications and edited five books on resuscitation and emergency medicine. Along with Douglas Chamberlain, Peter introduced advanced training for ambulance personnel in the UK; these individuals evolved into what we now know as paramedics. Peter was responsible for introducing premixed nitrous oxide/oxygen (Entonox) as an analgesic for use by ambulance personnel in the UK.

Alongside every great man is a great lady. Vital to Peter's success was the tremendous and unfaltering support that he received from his wife Fiona. The strength of her support, along with that of Peter's son Simon and daughters Lucy, Olivia and Beatrice, was demonstrated most overwhelmingly during his final and prolonged illness.

The name of Peter Baskett is familiar to the resuscitation community worldwide. He accumulated a staggering number of achievements and they impacted significantly on many disciplines. He is a great loss to the ERC.

## Consultant appointments April 2008

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
Dr David Matthews	Leighton Hospital, Crewe	SpR
Dr Jaimie Coleman	Nottingham University Hospitals	Locum Consultant
Dr Gareth Grier	Royal London Hospital	SpR
Dr Fenella Wrigley	Royal London Hospital	Consultant
Dr Jacqui Munns	Whipps Cross Hospital, London	SpR

# Why an Emergency Physician in Cambodia?

There is increasing interest among UK healthcare professionals about using their skills for the benefit of others in developing countries. This is recognised by the government in their commissioning of, and response to, the Crisp report earlier this year.<sup>1</sup> Schemes such as VSO have always been popular with doctors, and some royal colleges—for example, The Royal College of Paediatrics and Child Health—have long recognised the training benefit of time spent in another culture.

There are many links emerging between hospitals in the UK and developing countries; in Wessex we have established the Cambodian Rural Healthcare Partnership between the South Central Strategic Health Authority (SHA) and a non-governmental organisation responsible for integrating health, education, farming, infrastructure and conservation in North West Cambodia.

The project covers a poverty stricken rural area of approximately 100 km<sup>2</sup> with a population of 6000–10 000. There are a few buildings designated as health facilities but these are not clean or maintained, and the local hospital is more than three hours' drive away on a mud road in the dry season. There are no doctors in this area; staff have a mixture of training from one month observing to two years nursing in the local hospital. The only conditions recognised are respiratory and gastrointestinal infection, malaria, pregnancy and trauma.

Through the partnership we aim to provide multidisciplinary NHS healthcare staff to support, train and improve the capacity of the local staff and develop a culture of continuing professional learning.

Although it is a rural setting with little recognisable health care, far removed from a busy challenging emergency department, I would like to present some of the benefits of a deployment to an Emergency Medicine Specialty Trainee.

The Emergency Medicine training curriculum aims to develop a rounded, appropriate Emergency Physician.<sup>2</sup> The ideal characteristics and skills are listed at the end of the document. The successful achievement of these is crucial to the functioning of departments, hospitals and the NHS.

In common with many others the curriculum includes a generic skills

component. I argue that many of these skills can be learnt and refined in the environment of the Cambodian partnership. Therefore I have extracted the objectives, required knowledge, skills and attitudes from the curriculum that I feel would be developed by working in Cambodia. They are in the order in which they appear in the curriculum.

## G1.1: GOOD CLINICAL CARE—HISTORY AND EXAMINATION

In Cambodia the history taking will be difficult as it will be through an interpreter. The trainee requires confidence in their clinical examinations; they will be reliant on their basic skills. There are no imaging facilities or blood tests available routinely; there are no other clinicians to ask to confirm or refute their findings.

### Curriculum aims

- ▶ *To be able to take a focused history from patients in all circumstances. To encourage the difficult historian and actively encourage and explore alternative ways of communicating.*
- ▶ *To be able to clinically examine patients and detect and interpret relevant clinical signs.*
- ▶ *To value the diversity of cultural backgrounds.*

## G1.4: GOOD CLINICAL CARE—DECISION MAKING

Due to the limited resources available in rural Cambodia trainees must be comfortable compiling differential diagnoses and managing them appropriately without confirmation by further investigation.

As in the UK, it is important to plan the future care of the patient correctly, to understand the implications of that decision on the patient and the options available locally. Clinicians may need to alter their approach to patients to be accepted within the local culture yet still gain the information they require and deliver the best care possible. They will need to develop alternate strategies and techniques to manage this and may face some ethical dilemmas in doing so.

### Curriculum aims

- ▶ *Manage uncertainty of diagnosis in the emergency setting and make appropriate decisions based on what is best for patient and minimal risk.*

- ▶ *Be able to plan future care either as an inpatient, discharged to primary care or followed up in a special clinic. Evaluate the benefit of hospital-based treatment versus community care for a given condition in a particular patient.*

## G2.1: COMMUNICATION SKILLS—WITH COLLEAGUES

One of the aims of the Cambodia project is to improve the practise of the health workers in the area, a group with little theoretical knowledge and limited practical training. Any chance of success depends on excellent communication skills, a flexible attitude and a willingness to engage. When communicating across language barriers non-verbal messages assume greater importance. Setting an example and spreading a message via one's own behaviour will be the most influential tool. The trainee will learn to recognise the benefit of simple measures to change practise.

### Curriculum aims

- ▶ *Know the principles of good communication—and use of verbal and body language to communicate. Be aware of the importance of communication in patient care and the risks associated with poor communication.*
- ▶ *Utilise language and tone to convey messages in an appropriate way.*
- ▶ *Approach others with an open mind and be approachable.*
- ▶ *Be willing to listen to others and to try to appreciate their point of view.*
- ▶ *Be flexible and prepared to change opinion in the face of valid argument.*
- ▶ *The Emergency Department should be a place of excellence for team working; effective communication between team members is essential for safe care.*

## G2.2: COMMUNICATION SKILLS—TEAM WORKING

The trainee in Cambodia will be working alongside the project health coordinator; the local health workers; traditional practitioners; and NHS allied health professionals also working outside of their normal role. Good team working skills and an open mind are essential to achieve results. The trainee will need to think “out of the box” in order to solve problems and recognise that it may not be the healthcare team that is the answer. Other agencies such as schools, sanitation workers, commune chiefs and religious leaders can be useful partners.

### Curriculum aims

- ▶ *The emergency practitioner must be able to work within a large disparate team who*

do not work regularly together and who when they do meet may be under considerable stress.

- ▶ Be respectful of others' skill and knowledge and understand the role of colleagues and work with them effectively.
- ▶ Be a positive team member.
- ▶ Listen to the concerns of others including team members and be proactive in dealing with those concerns.
- ▶ Approach other people with an open mind.
- ▶ Know the principles of team leadership and the skills that are required.

### G3.2: MAINTAINING GOOD MEDICAL PRACTICE—AUDIT AND CLINICAL OUTCOMES

As the project aims to support and develop the health service provision trainees will be involved in directing this development. Audits will be used to evaluate effectiveness, appropriate clinical guidelines need to be written and monitoring clinical outcome will be key to measuring success.

#### Curriculum aims

- ▶ Put the results of audit and clinical outcomes into the strategic planning and business case of the department to influence the direction of the department.
- ▶ Access and appraise the literature and other national guidelines to set an audit standard. Know how to apply the outcomes of audit to support and develop best practice.
- ▶ Be aware of good practice in writing recommendations.
- ▶ Appreciate variation in practice and the reasons for variation.
- ▶ Appreciate the value of monitoring clinical outcomes in daily work.

### G3.4: MAINTAINING GOOD MEDICAL PRACTICE—INFORMATION MANAGEMENT

There is currently no form of patient record for this area of Cambodia, developing a system is an early aim of the project. Alongside this is a need to improve communication between the different levels of the health service—that is, rural outposts to district hospitals and district hospitals to tertiary expertise. The trainee will be involved in designing, using and evaluating a system using the most appropriate technology available.

#### Curriculum aims

- ▶ Understand the importance of population level health information in managing healthcare systems.
- ▶ Utilise information and communication technology to improve patient care in the clinical setting.
- ▶ Be open to new technology in supporting patient care.

- ▶ Be acquainted with the principles of clinical coding and workload monitoring in the department and their use for staff, budget and other clinical resource management.

### G4.1: PROFESSIONAL BEHAVIOUR AND PROBITY—PROFESSIONAL ATTRIBUTES

Trainees in Cambodia will live in the project headquarters alongside other workers—rangers, conservationists and educationalists—and work in local villages, often in local houses. The physical environment will be different and challenging, communication back to the UK will be limited and colleagues will have backgrounds, cultural beliefs and attitudes that may be very foreign. To succeed trainees will require a flexible attitude, a willingness to adapt and robustness.

#### Curriculum aims

- ▶ Adapt to change and work with new staff and colleagues.
- ▶ Be able to self-motivate even at times of stress or discomfort.

### G6.1: EDUCATION—DEVELOPING OTHERS' LEARNING

Three key aims of the project are:

1. Improving the support for, and development of, clinical knowledge, skill and attitude.
2. Developing an enthusiasm for life-long learning among healthcare workers, a concept that does not yet exist.
3. Improving the community awareness of health needs and management of minor injuries and illnesses.

Currently there is no acknowledgement of chronic illness and a lack of knowledge of simple hygiene and first aid (open fractures are treated with raw eggs). Most of the educated population were killed in the genocide, therefore the country has been left without role models.

This is an important but difficult education task for the trainee. They will attempt to influence people with a variety of backgrounds so will need to be flexible in their approach and develop a useful method of evaluation.

#### Curriculum aims

- ▶ The practitioner should be able to plan, deliver and evaluate learning programmes for others.
- ▶ Set learning objectives or outcomes that are appropriate to the learner and the topic.
- ▶ Facilitate learning in the clinical environment by encouraging questions,

supervising practice and giving feedback on performance.

- ▶ Utilise existing departmental resources for teaching.
- ▶ Support others in identifying their learning needs and outlining how they will meet those needs.
- ▶ Motivate others to learn and encourages a good learning environment.
- ▶ Value the different styles of learning in the learners and adjust the teaching style accordingly.

### A37: MANAGEMENT

Involvement in the project will expose the trainee to senior managers and leaders in all aspects of the NHS health care. The project sits within the SHA and utilises support and mentoring from many different professionals to achieve the required service development. This exposure provides insight into the different skills that exist within the NHS, and how to use them effectively.

To achieve service development one needs to influence change. A range of skills is required including passion; vision; commitment; the ability to write an argument; belief in the vision; the ability to persuade—in person, on the phone, via email; doing adequate research; using and getting around the system. This is as crucial in the NHS as it is in Cambodia, which provides a forum to practise and refine the skills required.

#### Curriculum aims

- ▶ The clinical leader in emergency medicine must possess and demonstrate management skills in order to enhance the quality of patient care. Access appropriate senior management and engage in discussion regarding development of the service.
- ▶ Value the contribution of managers and clinicians to the overall management of the health service.

To conclude, I hope that I have demonstrated that there is a lot to be gained from the deployment of an Emergency Medicine Trainee to Cambodia and the amount it will contribute to the development of a useful Emergency Physician in the current NHS.

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1. **The Crisp Report on Global Health Partnerships: the UK contribution to Health in Developing Countries, and the formal Government Response.** Available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_083509](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083509).
2. **Clancy M.** The FCEM Curriculum; Version 3, April 2006.