



The Joint Committee on Higher Training in A&E Medicine

The chairman, Jane Fothergill answers a few questions.

What does the JCHTA&E actually do?

The JCHTA&E is one of the three committees of the Faculty. The others are the Education and Examinations (E&E) Committee and the Research Committee; there is some overlap between the three. The JCHTA&E has as its core responsibilities the regular inspection and approval of all departments and rotations for higher specialist training in the UK and the regulations for training in A&E and its subspecialties. The chairman, honorary secretary, and administrator calculate each trainee's CCST date and confirm the content of their specialist training, as well as recommending them for the award of a CCST at the end of training. A JCHTA&E panel assesses all overseas-trained specialists who apply to enter to the specialist register. From next year the STA, which is the body that regulates all specialist training, will be replaced by the Postgraduate Medical Education and Training Board on which the Faculty will have direct representation as a truly independent specialty.

Who is on the committee?

We are a Faculty of several parent colleges and chose to have representation from them all, as well as from

FAEM and BAEM, on our higher training committee. Over the years this has proved invaluable and we have retained an element of this representation on our "new look" committee where chairmen or nominated representatives of regional training committees predominate. The new structure links Regional Specialist Training Committees in England, Scotland, Wales, Northern Ireland, and Eire directly into the JCHTA&E. This has already proved beneficial as we are capitalising fully on the practical experience of those who administer training locally.

Being a member of the JCHTA&E is hard work and I thank all who have contributed their time and energies over the past few years. I took over the chair from Jonathan Marrow in June 2004; he contributed eight years of his time and never seemed short of energy. Stella Galea, our excellent JCHTA&E Administrator, will be known to many readers, at least by name, and as a helpful voice on the 'phone. Stella is invaluable and with Wayne Hamer, the equally efficient newly elected honorary secretary, I think we make a good team. There are now just under 500 specialist registrars in A&E medicine—a 60% increase over the year, which is good news for the specialty. The increase in training numbers has, however, largely been confined to England so A&E staffing in Scotland, Wales, and Northern Ireland is falling behind.

What else is new?

We have revised our visit documentation so that it combines the application form and JCHTA&E visitors' inspection report. We hope this increases transparency in the process of recognising

departments for training specialist registrars. There are separate forms for recognition of training in general and in paediatric A&E medicine; all documentation and advice sheets can be downloaded from the JCHT section of the Faculty website.

The programme of regional visits continues, with increasing use of assessment by interview for selected departments in place of site visits. The specialist registrars' views on their training are always paramount and we

The EMJ supplement

From this issue, the *EMJ* will appear monthly. The supplement is also changing and will now appear quarterly as a double sized, eight page supplement. We hope this change will increase the scope of topics we can cover.

This is the last issue which has been put together by Sue Heels, our technical editor at BMA House. Since the supplement started in September 1999 Sue has had to deal with a constant stream of articles many of which are too short, too long, too late, or simply incomprehensible. She has tackled these problems with unfailing patience and good humour. Any polish and coherence the supplement may have is largely due to her high professional standards. She has our best wishes for her retirement.

Claire Folkes will take over from Sue for future issues. We look forward to working with her and wish her well with the challenges ahead.

Mike Beckett and Diana Hulbert
Editors



Stella Galea, Jane Fothergill, and Wayne Hamer.

continue to be most impressed with the enthusiasm and professionalism of our trainees, as well as with the quality of training available in the vast majority of departments.

Our regulations for educational recognition of training posts and rotations have been updated in the light of changes to service configurations in many hospitals throughout the UK. In some, a high quality service for patients and excellent training for specialist registrars has been maintained despite a reduction in on-site specialty backup. The challenge is to provide a good, balanced training rotation for each registrar and our updated regulations reflect this.

What progress has there been with subspecialty training programmes?

Our foremost subspecialty at present is paediatric A&E medicine. Demand for consultants with this training substantially outstrips supply but several trainees with CCSTs in A&E medicine and paediatric A&E medicine emerge each year. We welcome moves in many regions to identify posts offering specialist registrar level rotations geared to paediatric A&E medicine. The rather meagre allocation of 10 additional national training numbers for A&E medicine in England for this year has been allocated to paediatric A&E departments so that specialist registrars can gain subspecialty training in paediatric A&E medicine. Dual accreditation in

intensive care medicine is achieved by a brave minority of trainees who may then programme some of their consultant activities in ICM. The RCP has drawn up the curriculum for training in acute medicine as a CCST specialty and there are “medical” specialist registrars in post in five deaneries. As regards acute medicine as a subspecialty of A&E or intensive care medicine, the details are still under discussion and acute medicine is not yet a recognised CCST subspecialty. As soon as there is agreement we will post the details on our website.

What changes will there be to specialist training and accreditation over the next year or two?

One of the main changes that the PMETB is obliged by law to set up is assessment of experience as well as of training and qualifications, as a route to specialist registration. PMETB will oversee the framework for assessments across all specialties and general practice but the Faculty will of course tailor the process for A&E. The exact format of the assessment is not yet clear, and different processes may be applied to overseas applicants from those used to assess SAS doctors in the UK. The challenge will be to produce an evaluation that is robust and easily repeatable and which clearly and reliably demonstrates if a doctor is or is not able to work as a consultant in A&E medicine. It must be scrupulously fair and free from discrimination—for example, against doctors from different basic training backgrounds. The JCHTA&E will be responsible for processing all applications under the new legislation. Once the details of the evaluation process become clearer the details will be posted on the FAEM/BAEM website.

What other ambitions do you have for specialist training?

There are areas of overlap between the work of the JCHTA&E and the E&E

Committee. Peter Driscoll, the incoming Dean, and I hope to harness the expertise from both to continue improving specialist training. The new curriculum should allow us to be clearer about the particular knowledge, skills, and attitudes that a specialist registrar should have gained at the end of each year of training. This will be useful to both trainers and trainees and, together with improved appraisal and workplace assessment of performance, should better inform the RITA process. We need to ensure all trainees are optimally prepared for the FAEM examination. It may be that in time the examination moves to a modular format where some aspects are assessed earlier in the training and fewer left to the end; the E&E Committee is constantly refining what is already accepted as a fair assessment that is fit for its purpose. Trainees do, however, still find the transition from specialist registrar to consultant a difficult one. That tells us there are still improvements to make. These changes to training, appraisal, and assessment will need to accommodate the needs of SAS doctors and some of those from overseas who wish to enter the specialist register. The Faculty will soon be appointing an educator whose role will be pivotal in guiding these developments.

The delay in activation of PMETB has also precluded decisions being taken on the structure of run through training. The faculty hopes that a common stem training in post-graduate years 3 and 4 will include A&E, anaesthetics, intensive care medicine, and acute medicine; year 5 might include paediatric A&E and orthopaedics and the last three years be completed in emergency medicine. The JCHTA&E will clearly be closely involved in these changes as general and specialist training merge. We will also be involved in the accreditation of training posts at all levels in our specialty.

JANE FOTHERGILL

The new consultant contract—one year on

In October 2003, a majority of consultants and SpRs in England voted in favour of the new contract proposals, negotiated between BMA negotiators and a negotiating team from the Department of Health.

What was voted for was a contract that, for the first time since the NHS was inaugurated in 1948, limited the number of hours consultants were required to work and offered, for the significant majority, an improved rate of pay.

All consultants appointed since the beginning of 2004 will have been appointed to the new contract. Existing consultants had the option of accepting the new contract or remaining on the existing contract. Consultants who opted to remain on the existing contract can switch at any time but they will not receive any back pay.

Job content

The basic contract is for 40 hours work per week, consisting of 10 programmed activities of four hours each. Normally, this will be divided into 7.5 programmed activities of direct clinical care and 2.5 programmed activities for supporting professional activities.

Direct clinical care represents work “directly relating to the prevention, diagnosis and treatment of illness or injury”.

This includes:

- “Shop floor” work
- Emergency work during and arising from on-call
- Ward rounds
- Clinic activities
- Multidisciplinary meeting relating to direct patient care
- All administrative work relating to all the above

“Shop floor” work

BAEM has recommended that consultants schedule 5.5 programmed activities per week as “shop floor”. This will include not only the primary assessment of patients but also the direct supervision and teaching given on the shop floor to junior medical and nursing colleagues.

Supporting professional activities underpin direct clinical care and include participation in:

- Training
- Medical education
- CPD
- Formal teaching

- Clinical audit
- Job planning
- Appraisal
- Research
- Clinical management
- Local clinical governance activities

Supporting professional activities do not normally include *additional NHS responsibilities*—for example:

- Medical or clinical director
- Lead clinician
- Caldicott guardian
- Clinical audit lead
- Undergraduate or postgraduate dean
- Clinical tutor
- Postgraduate advisor

nor *external duties* undertaken as part of the job plan *by agreement* between the consultant and the employers—for example:

- Trade union (BMA) duties
- Inspection work for NHS organisations—for example, NCCA
- Work for FAEM or BAEM
- Work for government departments
- Acting as external member of an advisory appointment committee

Extra programmed activities

Any time worked over 40 hours should be paid in the form of *extra programmed activities*, calculated in whole programmed activities or 0.5 programmed activities only.

Some strategic health authorities have attempted to place a ceiling of 12 programmed activities on consultants, citing the European working time directive limit of 48 hours per week. This is based on a false premise. Consultants *can* work in excess of an average of 48 hour per week by signing an opt-out to this effect. In addition, if there is agreement for programmed activities to be worked in premium time (where a programmed activity is three hours long), 12 programmed activities would thereby represent fewer than 48 hours worked.

In emergency medicine, there is greater scope for working in “premium time”—that is, outwith the new contract’s definition of the “standard working week” of Monday to Friday 7am to 7pm. Consultants signing up to the new contract, including all new appointees, have no obligation to work any of their programmed activities in premium time. Any non-emergency work in premium time is by agreement only. “Non-emergency work” specifically includes any

regular programmed work in emergency medicine.

Problems with implementation of the new contract have arisen as a result of disputes between the hours a consultant considers he/she perceives he/she works and the management view of hours worked. This can be resolved by all consultants keeping a detailed work diary, covering the minimum of one full rota cycle. However, the more information available, the better the evidence in favour of the consultant in the event of an appeal.

New and replacement posts

All consultant posts now advertised should be for the basic 10 programmed activities with any extra programmed activities by agreement only. Consultants in post must ensure that new colleagues are not paid less for doing the same job—that is, all consultants on the same rota, undertaking the same duties should receive the same number of programmed activities.

On-call work

Time spent on “unpredictable emergency work”, when on-call, should be based on the weekly average of all the consultants, during a full rota cycle. Calculations should be based on the time spent on phone calls plus recalls to the department. When called back in to the department, time is measured from answering the phone to the time to returning home.

When calculating average out-of-hours workload, prospective cover for colleagues should be built in. Remember that by covering for six weeks’ annual leave, two weeks study leave, and statutory days you are likely to be covering nearly 10 weeks of each colleagues duties—that is, you do 52 weeks of on-call work in 42 weeks at the hospital.

Until March 2005 “unpredictable emergency work” is limited to one programmed activity per week and thereafter, the limit is two programmed activities but you can still get recognised for this work by pay or time off in lieu. If the work is sufficiently regular, it should be programmed as “predictable work”—that is, by direct clinical care programmed activities.

On-call category

Category A is paid where the consultant is typically required to return immediately to site when called or has to undertake interventions with a similar level of complexity to those that would normally be carried out on site, such as telemedicine or complex telephone consultations.

Category B applies where the consultant can typically respond by giving telephone advice and/or by returning to work later.

Disputes have arisen where trusts have argued as to the definition of the word “typically”. There is still disagreement between the Department of Health Consultant Contract Implementation Team (CCIT) and the profession as to how this should be interpreted. The CCIT has argued that “typically” means more than 50% of the time.

The view held by the BMA is that where a consultant is expected to be in a position to return to site immediately when called, irrespective of the number of times contacted, they should be in category A—that is, all emergency medicine consultants.

Availability supplement

This is paid to recognise the inconvenience of being on-call and is dependent on the number of consultants on the rota and on-call category.

Job planning

All consultants signing up to the new contract should have agreed, in writing, their job plan with their clinical manager. A number of consultants admit that they have agreed a specific number of programmed activities but have not agreed a written job plan, detailing how programmed activities are to be worked.

Location, time, and number of programmed activities should be agreed and documented. It is expected that while direct clinical care programmed

activities will normally be undertaken at the place of work, supporting professional activities may be worked flexibly by agreement.

Any regular fee paying work—for example, category 2 medicolegal work, should be included in the job plan. Where this causes “minimal disruption to NHS work” or work can be time-shifted, fees should be retained by the consultant.

Objectives

For pay progression to be achieved, a consultant must make every reasonable effort to meet the agreed, set objectives included in the previous year’s job plan. A consultant has no obligation to sign up to objectives that they consider to be unreasonable.

Resources

The job plan review also gives consultants the opportunity to identify resources required to do their job and achieve their objectives—for example, secretarial support, additional medical staff, office space, or IT.

If set objectives are not achieved due to lack of identified resources, previously agreed or any other factors outwith the control of the consultant, then pay progression cannot be withheld.

Mediation and appeals

Many consultants have been unable to agree their job plan with their clinical manager and have proceeded to the

mediation process with their medical director. If agreement still cannot be reached, a formal appeal takes place.

Consultants can appear in person before the appeal panel and take a representative with them.

The appeal panel consists of:

- A chair, nominated by the employer
- A representative nominated by the consultant
- A third member chosen from a list, approved by the strategic health authority and the BMA

The panel makes its recommendation to the trust board.

In summary, the key considerations to be given to the new contract are built into the job planning process which will be undertaken annually. An earlier job plan review can be requested should circumstances change before the proposed review date—for example:

- Fewer consultants on rota
- Increase in training obligations—for example, MMC
- Service reconfigurations

Further information and all the relevant documentation on the contract can be found on the BMA website www.bma.org.uk including an FAQ section.

Any further queries can be addressed to me via Julie Bloomfield at the BAEM office (julie.bloomfield@emergencymedicine.uk.net).

DON MACKECHNIE

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From the President...

We should now all be getting the feel of the impact of the new GP’s out-of-hours contract. We will be sending a questionnaire regarding attendances in December and I would be very pleased to hear from you. Please fill this in and return it to the BAEM office as soon as possible.

I would also like to hear how you are coping with your 98% four hour target. Despite what the Department of Health says, I think this target will be extremely difficult to hit and will be even more difficult to sustain especially in view of

the GP’s out of hours contract and also the implementation of *Modernising Medical Careers*. I still remain unsure who is going to do the service part of our job. I am certain we will have to spend much more time inducting and educating the F1, F2, and third year trainees. Please let me know through your regional representatives of any difficulties you are having.

As you are probably aware, the Way Ahead document is now available on the web and we will be using this as the basis for staffing in emergency departments from now on. Thanks to John Heyworth and Jim Wardrope for their

hard work and also to all those of you who helped.

May I take this opportunity to wish you all a Happy New Year. I am sure this year will present us with similar challenges to previous years but, as specialists in emergency medicine, we will do our best to deal with them!

One last piece of news—we may have the opportunity to move into new premises. Alastair is leading this project and he gives some details on p7. Alastair and I will be in close contact about this and we’ll keep you informed.

M J SHALLEY
President, BAEM

Round up of forum news from FASSGEM

The FASSGEM Conference 2004, held at the Kensington Close Hotel in London, was a very great success from an academic point of view. Attended by more than 80 delegates, the three day conference saw a more wide ranging and busy programme than any of our previous annual events. Thanks go to Dr Meng Aw Yong for organising it.

As predicted, the Annual General Meeting and the medicopolitical lectures were very lively, with many of the contentious issues surrounding non-consultant career grade posts being discussed at length. Full minutes of the AGM are available on the FASSGEM website (www.fassgem.org.uk).

Of major significance, a motion to bring about constitutional change to the constitution of FASSGEM was passed at the AGM and the key points of this constitutional change are as follows:

1. That the Chair of FASSGEM be elected for a period of office of four years as a single term.

2. The elections for Chair of FASSGEM should take place two years into the term of office of the existing Chair; such that there is a duly elected "Chair Elect". This would allow the Chair Elect to become familiar with the current political situation and to act as an assistant to the Chair, supporting attendance at meetings to ensure that a FASSGEM voice is always present.

3. On completion of a term of office, the "immediate past Chair" should become the FASSGEM representative on the Faculty Committee for a period of four years, as this will ensure continuity and familiarity with the current issues of relevance. The immediate past Chair will also then be in a good position to advice the Chair as and where appropriate.

4. In addition to the posts for current Chair, "Chair Elect" and "immediate past Chair" (Faculty representative), the following officers' appointments would also be elected on a four yearly basis.

- British Medical Association representation
- Minutes and correspondence secretary

- Membership secretary (ex officio)
- Website officer (ex officio)

5. The lead organiser for the annual FASSGEM conference may also be co-opted onto the FASSGEM committee for a period of one year before the conference, to include attendance at the FASSGEM committee meeting during that conference. The role of treasurer for the conference account will be taken over by the organisation committee for that year's conference.

6. Regional representatives should be elected in the current manner for each and every region (elected every four years). However, to facilitate and streamline committee meetings, the country will be divided into seven sectors: London, southern England, Midlands, northern England, Scotland, Wales, Northern Ireland, with only one representative from each sector attending committee meetings.

7. FASSGEM committee meetings will continue to be held at least twice a year at the FASSGEM Spring Conference and during the FASSGEM Annual Conference, however with a smaller committee regular group email contact will be maintained to improve the dissemination of information throughout the organisation.

A recent survey of all emergency departments in this country has highlighted the true breadth and depth of problems around staff grade recruitment and retention at the current time. A full copy of the survey report can be found on the FASSGEM website, however the executive summary of this report reads as follows:

- In summary, this survey has shown the very great extent to which emergency departments in this country are experiencing problems with staff grade recruitment and retention.
- Nearly 70% of departments currently have staff grade vacancies. Over 60% of departments have reported the loss of a staff grade practitioner to a primary care post (within the last year) and, moreover, half of all departments report that the last time they tried to recruit a staff grade practitioner they were unsuccessful.

- The comments received from questionnaire respondents eloquently summarise the main problem areas—namely the urgent need for a new contract, the need for staff grade practitioners to be given opportunities for career progression, the overwhelming need for staff grade practitioners to be offered reasonable and appropriate rates of remuneration, and above all the need to make staff grade posts in emergency medicine an attractive proposition in comparison to other posts that are available within the NHS at the current time (especially those in out-of-hours primary care work).
- The data on levels of staff grade satisfaction suggest that greater degrees of staff grade satisfaction are achieved in smaller departments where there are fewer consultants in post, presumably reflecting the fact that in such departments staff grade practitioners are given greater degrees of responsibility and accordingly feel more valued for the work that they do—an important message for all departments to heed, regardless of size or consultant staffing level.
- It is of significance that fewer than 40% of departments have an associate specialist in post at the current time. Given the current BMA recommendations on the upgrading of all eligible staff grades to associate specialist status, this would suggest that a significant percentage of trusts have either not heeded the advice from the BMA (or that trusts have chosen to block internal regrading of eligible staff grades to associate specialist status for whatever reason).

The FASSGEM Spring Meeting will take place in Southampton on 20 May 2005. A conference flyer for the event can be found at the FASSGEM website, or alternatively further information can be obtained by contacting either Dr Adel Aziz (amabdelaziz@yahoo.com) or Dr Andrew Newton (apnewton@fairviewshipham.fsnet.co.uk).

ANDREW NEWTON
Chair of FASSGEM

News from BAETA

Emergency medicine *should* be a great specialty in which to train and work. Unfortunately though, we live in a healthcare system with the four hour targets, European working time directive, inadequate staffing, *Modernising Medical Careers*, and so on. These issues combine to adversely affect both the quality of training we receive and the quality of care we deliver.

So what can we trainees do about it? Well, there are currently around 500 SpR trainees in emergency medicine in the UK; 10 years ago the *entire membership* of the Faculty was less than 500. We have a tremendous opportunity to get involved and help change emergency medicine in the UK...as well as a responsibility to ourselves, our patients, and future trainees to make it happen. If, like me, you're unhappy with the quality of UK emergency medicine training, or the skills that we're "allowed" to use, or our relationship with other specialties, then you need to get involved and do something about it. There are a number of exciting developments currently taking place which I'd like to discuss, but if we trainees don't play our part, we may not like the result...and we'll deserve what we get.

Core curriculum

The draft version should have been published by the time of this *EMJ* issue, so if you haven't read it yet, go and do it now! This is an extremely important document; the contents of the final version will define both the examinations and what we do clinically for much of our consultant careers. If you think skills in rapid sequence intubation should (or shouldn't) be a requirement for every ED consultant, or that ED consultants should (or shouldn't) manage patients for the first 24 hours of their care (as in Australia), make sure you have your say during the consultation process. The chance may not come again for a very long time.

College of Emergency Medicine

The Faculty is currently in discussion with the various Royal Colleges about the establishment of a College of Emergency Medicine, which would replace the Faculty and (probably) BAEM. Initial soundings have been extremely positive, and although nothing has been finalised, it could happen as soon as late 2005/early 2006! The

Faculty is also exploring the possibility of moving out of the Royal College of Surgeons and joining the Royal College of Anaesthetists when they move into Churchill House, their planned new building in central London. There appears to be major educational and financial benefits in doing this, but it should be made clear, this would *not* involve becoming a Faculty of the College of Anaesthetists.

Faculty textbook

This will be based on the core curriculum, and should be the definitive textbook for those working for the Membership and Fellowship examinations in emergency medicine. This project will only happen if both trainees and consultants commit to support the project by:

- Signing up to contribute to a chapter
- Agreeing to purchase the first two volumes in advance (at the discounted price of £100 v £140 full price for two volumes)

The publishers require commitments (that is, £100 "up-front", to be held by the Faculty) from at least 150 people in order to go ahead with the project: with 500 SpRs currently in training, I believe that the trainees alone should be able to achieve this number. I urge you all to get involved: to quote the outgoing Dean David Skinner, "The Faculty is nothing without the full support of its members". Regarding payment of book deposits, please contact the Faculty offices (faem@emergencymedicine.uk.net); to express an interest in a book chapter, contact Peter Driscoll, the new Dean (faem@emergencymedicine.uk.net).

FFAEM examination

Major efforts are ongoing to try and improve guidance for candidates and trainers following the problems with the FFAEM exam over the last few years. Peter Driscoll, Ruth Brown, and others from the Education and Examinations Committee have been rewriting the main information booklet, making the areas and depth of knowledge required much more explicit, and including past/example questions wherever possible. The aim is to get the document onto the Faculty website during January 2005, aiding candidates going for the April 2005 diet of the exam. Please feedback on this or any related issue to either

myself or the new Education and Examinations Committee representative who should be appointed this month (January 2005).

Training

Based on my own experience and after extensive discussion with colleagues across the country, I believe that the quality of UK emergency medicine training is poor in too many departments, certainly when compared to the quality of training seen in Australia and the United States. On the other hand, the view of the JCHTA&E is that "We continue to be most impressed with... the quality of training available in the vast majority of departments"*. I could be wrong (hardly unusual)...but if not, I suspect the reason for the disparity lies in the feedback we give regarding training departments, and the nature of its collection. The current system of giving feedback on a training post at the RITA has an inherent conflict of interest: "So, you feel that the training you've received over the last year has been very poor...Don't worry, we can arrange for you to do an extra year as an SpR to help make up the deficit, thanks for the feedback...".

I believe that as a matter of urgency, the trainees' association needs to work closely with the JCHT to implement a more robust system to allow honest feedback on training departments *and individual trainers* without fear of reprisal. To have, as has happened recently, trainees failing the Faculty exam due to inability to demonstrate basic clinical skills is clearly unacceptable, and begs the question, "Who has been responsible for their training for the past four years?"

This is my first time writing the trainees' column of the *EMJ* supplement, so please let me know if you have strong views on either the style or content. I will be in touch via email to all those on the EMTEL list; see the BAETA website for details of how to sign up. Many thanks to the current and outgoing BAETA committee members for helping me get my bearings over the past few months, and for your efforts during the past few years.

GHUFRAN SYED
President of BAETA; ghufran.syed@ntlworld.com

*Written report from the Chairman of the JCHTA&E to the Faculty AGM, 19 November 2004.

Regional faculty academic leads

For a number of years the Faculty has developed a network of regional research advisors to assist both trainees and consultants in emergency medicine undertake research and other academic work such as critical appraisal. The influence of these posts has been somewhat patchy—with some regions having excellent academic training and support provision, while other regions have little activity in this area. Many regions have regional academic days, an active critical appraisal training programme, and easily accessible advice for researchers. However there are also many regions that have few or none of these elements of academic support.

The Research Committee would like to strengthen the provision of academic support to emergency clinicians and trainees. The regional system is being reorganised, with the post now being called “regional faculty academic lead” (RFAL). A job description has been

written for these posts, which are expected to be closely aligned with the educational system and the STC. The key responsibilities of the RFAL will be:

- Organise an annual regional research day.
- Ensure that critical appraisal training is available within the region.
- Keep a list of projects in progress within their region.
- Keep a list of academic outputs from the region.
- To provide local peer review.
- To provide assistance with the local ethics application process.
- To know local sources of expertise.
- To attend the annual meeting of faculty research leads.
- Receive the unapproved minutes of the Research Committee.
- Give a report to each meeting of the STC.
- Nominate members of the Research Committee.

- Provide an annual report to the Chair of the Research Committee.

This will entail a significant commitment from an individual. We would suggest that about 0.5PA would be required to undertake these tasks. Nominations for the post would be made by the STC, and the appointment made by the Research Committee. These posts are important to the Faculty and should be recognised as such in assessment of performance awards.

We hope that these posts will provide a reinvigorated system of academic advice and training at a regional level, and give a uniform national pattern, so that every trainee and emergency medicine practitioner in the UK will have a local source of help and advice. We will publish the new list of RFALs in 2005 on the Faculty website. In the interim please contact the Faculty Office if you are unsure of the identity of your current RFAL.

FIONA LECKY
TIM COATS

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Churchill House

The Royal College of Anaesthetists (RCA) has recently purchased Churchill House, a 45 000 square foot freehold office block in Red Lion Square, London WC1.

A recent meeting of trustees of the RCA determined that an offer should be made to FAEM and to BAEM to become involved in the project. The Intensive Care Society and the Pain Society have already done so.

We have the opportunity to either lease office space or invest in the building and become partners.

There are well developed and detailed plans to create a 168 seat raked lecture

theatre in the basement, a conference, educational and examination facility on the next two floors, and to build a new council chamber as a top storey. As investment partners we would have rent-free use of these facilities as well as at least three times our existing office space.

While the building is structurally sound, there needs to be a considerable investment to make it fit for purpose. Nonetheless, preparatory work could be completed as early as September 2005.

The AGM of FAEM on 19 November 2004 authorised the Board to pursue the most favourable possible arrangements

To contact the editors:

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with a view to our becoming partners in this venture. We would wish to do so in partnership with BAEM who have agreed to the principle of joining us.

ALASTAIR MCGOWAN

Notice

We are up-dating the careers advice document the specialty produces and need your help:

- If you are interested in making promotional material including videos and interactive websites let us know—we need your skills
- If you have a photograph which defines the specialty in any one of its myriad guises we need it
- There will be a prize for the best image

Please contact us and send your images to:

ruth.brown@st-marys.nhs.uk or diana.hulbert@suht.swest.nhs.uk

Consultant appointments September to November 2004. 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
Adrian Boyle	Addenbrooke's Hospital	SpR, Addenbrooke's Hospital
John Criddle	Guy's and St Thomas' Hospital	Locum consultant, North Thames
Ulf H Demnitz	Royal Liverpool University Hospital	SpR, Merseyside
Nigel P F X Harrison	University Hospital, Lewisham	Consultant, Queen Mary's Hospital
Rachel C Hoey	Watford General Hospital	SpR, Watford General Hospital
Michelle F Jacobs	Watford General Hospital	SpR, Northwick Park Hospital
Lewis Jones	Royal Devon and Exeter Hospital (Wonford)	SpR, Derriford Hospital
Darren A Kilroy	Stepping Hill Hospital	SpR, North Western
Duncan J McAuley	Addenbrooke's Hospital	SpR, Norfolk and Norwich Hospital
Nicola McDonald	Guy's and St Thomas' Hospital	SpR, South Thames
Audrey McKelvey	Lagan Valley Hospital	SpR, Royal Belfast Hospital for Sick Children
Jennifer M Medcalf	Royal Shrewsbury Hospital	SpR, New Cross Hospital
Asim Shafiqat	Arrowe Park Hospital	Locum consultant
Robert A Simpson	Milton Keynes General Hospital	Unknown
Sarah E Spencer	Princess of Wales Hospital	SpR, Oxford
Christopher D Stevenson	Aintree Hospital	SpR, Royal Liverpool University Hospital
Aravinthan Suppiah	Royal Liverpool University Hospital	SpR, Merseyside
Beverley L Watts	Queen Alexandra Hospital, Portsmouth	Consultant, North Hampshire Hospital

The telephone

It is said that the very first message to be passed between the first pair of working telephones was a request for urgent medical help. Alexander Graham Bell used his prototype telephone to call for his assistant's help because he had spilled battery acid on his clothes. His assistant was able both to confirm the successful function of the new instrument and to administer first aid. This was in 1876.

In 1879 the *Lancet* carried an anonymous report from the USA about a doctor who was woken in the night by a mother who thought her child had croup. Mother was instructed to "lift the child to the telephone" so that the physician could hear it cough. "That's not the croup" was the verdict and apparently mother and child, as well as doctor, went to sleep content.

In 1880, the *Lancet* carried a brief notice that telephones had been installed at the Women's Hospital in Birmingham to connect the indoor and outdoor departments with the doctors' residences. Dr Jacob from Dublin is quoted as urging the use of telephones for better communication between resident staff and "honorary officers" (we would say consultants now). The editor wonders if this might not be a "needless aggravation".

In 1883 the editor was still uneasy. He feared that "to have a dozen telephone consultations in one day, or conversations that might be thought to supersede a consultation, would be a doubtful addition to one's advantage or repose".

Despite these worries, use of the gadget spread. In the usual flurry of suspicion about new things, a disease of "telephone ear" was soon described. In 1889, a French expert recommended sparing use of the instrument in the case of those whose ears are sound, and "absolute abstinence for those whose organs are already impaired". The features of the syndrome were nervous excitement, vertigo, and ringing in the ears. Today, ringing in the ears is commonly caused by someone else's mobile phone.

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