

Pres Blog

Welcome to the first EMJ Supplement Pres Blog. Not actually a blog—but it is from the Pres and the aim of this monthly part of the Supplement is to keep you updated regarding College activity. This month's understatement is that there is a lot going on—there is a veritable weekly tsunami of activity involving the College, which of course reflects the high profile of the College of Emergency Medicine and emergency medicine.

Where to begin...? The impact of the implementation of the European working time directive is now causing real consternation pretty much universally. We have had compliant rotas for some time, but are of course significantly affected by the impact of the working time directive on the so-called supporting specialties, particularly surgical but also medicine and paediatrics. This is causing significant gaps in supporting specialties rotas. The danger here is that there will be an assumption that the extra work can be mopped up by the emergency department. This historical default must be rejected but there is a real opportunity for emergency medicine in this otherwise fairly depressing scenario. First of all, the role of the emergency department is now being increasingly recognised as an opportunity to provide an experienced assessment of patients, using our clinical decision unit/observation facilities optimally and ensure that patients are admitted to other specialties as and when indicated. No additional work can be undertaken in emergency departments without the increased EM-trained workforce resources in place to meet this new demand, and of course in many departments we are still

catching up with a significant underinvestment and workforce shortfall. However, the working time directive issues could be a very helpful lever in the drive for consultant expansion in emergency medicine—one of the primary objectives for the College in the next few years.

The College will be carefully monitoring the impact of the implementation of the working time directive on emergency department activity during the next few months through the board chairs and survey monkey technology.

The other major service issue predominant at present is the various primary care/urgent care initiatives. Although in some areas a true collaborative model with primary care can work successfully, the fact is that most of these models are driven by a financial agenda rather than clinical need. As such, the drive from the Primary Care Trust is about saving money, unfortunately in turn underpinned by wholly incorrect assumptions regarding the emergency department casemix, with continuing trust in fundamentally flawed figures suggesting that 60% or so of our patients are "primary care" (whatever that actually is). Departments in which models from primary care have been tested on this basis have proved unsuccessful as they realise that the "primary care" workload in most emergency departments is in the order of 15–20% and, of course, the vast majority of patients attending the emergency department require the expertise of clinicians trained in emergency medicine rather than others.

The big problem here is the continuing difficulty with payment by results and

tariffs that provide Primary Care Trusts and others with these misguided financial incentives. We are working very hard with the Department of Health to try and ensure that the payment by results tariffs reflect the clinical context, a concept that was clearly previously not fully understood within the Department of Health. I hope that we can work towards a much more flexible arrangement; one that truly reflects emergency department casemix and also accurately reflects the benefits of the admission of patients to our clinical decision unit without such admissions being regarded as economically inefficient and therefore punitive. Overall, we want the commissioners to recognise the benefits of investing in emergency department activity, not the rather expensive and unproved alternatives that are consistently frustrating and disappointing for us all, including our patients.

Within the College, as previously promised, we are pursuing the options for a home of our own—a College of Emergency Medicine headquarters. Our current landlords at the Royal College of Anaesthetists are aware of this intention and there is no suggestion of impending separation anxiety. Brilliant management of the College finances means that we can realistically look at property and consider renting and buying options. We are currently undertaking some work to look at the acreage we will require now and in the foreseeable future and defining those activities that we would want to have in a building of our own, ie, administration and meetings with perhaps education, courses and exams being held elsewhere. There is a wide range of property available in London and we are very much hoping that this planetary alignment will allow

us to make this move in the relatively near future.

As also promised, we are now pursuing royal appellation. The decision-making process remains rather opaque and occurs in the Ministry of Justice rather than the palace. Very strong suits in our favour include HRH The Princess Royal being our royal patron and the whole cachet of emergency medicine. We have significant

highly impressive detail beneath these headlines and we intend to build on the inauguration momentum, although the timescale for granting us formal appellation is simply impossible to predict. During the past few weeks I have visited the presidents of some of the major colleges in London, including Regents Park and Lincoln's Inn Fields, the General Practitioners and the Academy of Medical Royal Colleges and

mentioned our intention to pursue royal appellation. There has only been support for this project, which is regarded as the natural next step.

Best wishes,

John Heyworth

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The Diamond Rock and Ice Ultra Marathon

Having left school and attended the Royal Military Academy of Sandhurst, I decided to follow a career in medicine and studied at Birmingham University. Having always been passionate about sport, this was reinforced while recovering from an unfortunate stabbing incident (of which I was on the receiving end) when I was out celebrating the end of my third year exams! I have since recovered and moved to Southampton to work, and have undertaken multiple sporting endurance events including marathons, 180 km bike races and triathlons. It was, however, only after a close family friend lost her battle with breast cancer that I decided to take things one step further in an attempt to raise money for charity...

Set in the Arctic Tundra and considered by many to be one of the toughest races on Earth, the Diamond Rock and Ice Ultra

Marathon consists of six marathons in six days at temperatures of -40 degrees. Not only does one have to endure the hostile climates, icy dry winds and constant threat of hypothermia, but participants are also required to be self-sufficient for the six days and nights, thereby adding the necessity of towing all your possessions on a sled for the 225 km journey. Competing in this race, in which 70% of entrants drop out on day one, should not only push me to the limits of my physical endurance, but it also offers the chance of winning the prize of a \$15,000 diamond, which would readily be donated to charity!

- To sponsor, visit <http://www.donate-tobreastcancer.org/edwardgilbert>

Edward Gilbert

ACCS Trainee, Wessex



Edward in training.

The College of Emergency Medicine Spring Scientific Conference 2009

The College of Emergency Spring Conference takes place at Brighton from 20–22 April with a fabulous academic programme, exciting social events and a green theme—BRIGHTON ROCKS!

There is still time to book a place if you hurry—go to the College website and follow the Conference links (<http://www.cembrighton.co.uk> and <http://www.collemergencymed.ac.uk>; go to conferences and courses/Spring 2009).



Brighton pier.

Passing the CTR

The FCEM examination is intended to confirm that the trainee has attained the required standard to work as a consultant emergency physician. It is a stressful time for the trainee with two days of oral examinations and objective structured clinical examinations. Trainees should have read the examination regulations and guidance (available at www.collemergencymed.ac.uk) for all parts of the exam, which are updated in November every year. Advice and descriptions of the how marks are allocated in the different sections are provided. This knowledge could help the candidate considerably. Between 1 in 4 and 1 in 5 candidates fail the Clinical Topic Review (CTR) section, and this paper provides advice for candidates on this section.

WRITING YOUR CTR

The CTR is the candidate's opportunity to demonstrate mastery of the topic that they have chosen. It should be considered a project that takes at least 12 months to complete. You cannot start too early!

Step 1: Choice of topic and preliminary search

Candidates should choose a clinical topic that is both worthwhile and interests them. It is not essential to frame a three-part question, although candidates find this helpful in many cases. It is recommended that candidates undertake preliminary literature searches to identify the evidence and establish whether there is sufficient evidence of good enough quality to form the basis of a worthwhile review of the literature. The sooner this preliminary review is done the better—if there is limited or poor quality evidence then candidates should move to another topic or rephrase their original question. Candidates are electing to start their CTR too late and discovering the amount of work required impacts on their revision for other sections of the exam.

Step 2a: Confirmation of topic and definitive search

Having completed the preliminary search and decided on the definitive topic, complete the search. Record the search terms and present in a brief and understandable manner how your search was conducted and its results (a flow diagram can be useful).

Step 2b: Planning your own work

It is now of the utmost importance to include personal work. This should be planned, if not completed, at an early stage so that there is time to complete a comprehensive and worthwhile project (see below).

Step 3: Appraisal and synthesis of the evidence

Candidates will need to be able to undertake searches of the common databases (ideally with librarian advice), be able to categorise their papers into the different levels of evidence and be able to critically appraise the best papers. It is important to be able to integrate the papers into a coherent and cogent summary from which rational conclusions can be drawn.

Step 4: Summary of the evidence into a digestible form

Candidates may use tables to convey information about their papers—this facilitates understanding and enables comparison. The tables should not be included in the word count, but candidates should note that complex wordy tables do not work well.

Step 5: The implications of the CTR for the candidates practice should be fully discussed

Appendices may be used for work related to the CTR—eg, audit forms, guidelines—but should not contain text that is essential to understanding the CTR.

Marking scheme

It is recommended that the candidate refers to the marking scheme and understands how to achieve marks in each section.

Own work

There are significant marks for additional work which is of the candidate's choosing but it will need to be started early if it is to be worthwhile. Candidates should consider:

- ▶ Comprehensive surveys (those done at the last minute, poorly constructed, with poor response rates are counter-productive)
- ▶ Describing and measuring the impact of the implementation of change in practice that is based on their CTR by

for example the introduction of a new technique, diagnostic test or therapy.

- ▶ The CTR may have been the basis for further additional research and candidates should describe what they have done and to what stage (eg application for ethical approval through to recruitment, analysis and write up).
- ▶ A well constructed audit cycle centred on their CTR.

The more complete and the more work you have put into it the better—a total of 8/46 marks are awarded in relation to your personal work. Work started in ST5 is unlikely to be successfully concluded.

NB Candidates will disadvantage themselves when they have failed to follow the instructions including the word limit, submission dates and reference style.

Preparing for the Viva

Candidates will benefit from having formal practice Vivas with their trainers, using the College scoring system as a framework.

Candidates must read and re-read their CTR (especially immediately before the exam) and may well be able to anticipate the examiners questions based on the areas in the marking scheme. Preparing well-constructed summaries that address each of the areas of the marking scheme that can be offered in response to questions is a source of confidence and achieves good marks.

Candidates should have identified those areas of potential weakness in their CTR—and should be prepared to respond to criticisms with well constructed reasoning or suggestions for improvement

The Viva (40% of the mark)

Candidates are allowed to bring their CTR with them to the Viva, together with important supporting papers. The Viva is for 15 minutes and is the candidate's opportunity to show mastery of the topic. They should be confident and self-assured, making sure they describe and justify their chosen areas and are able to describe their search, appraisal and synthesis process as well as their conclusion and implications that follow from it. Candidates must describe their personal work. Examiners will ask about unclear or contentious areas, and will have read the key papers and undertaken their own literature search. Candidates should be able to talk logically in a structured way, making sure they cover all the areas for which there are marks within the 15 minutes. If candi-

The written contributes 60% of the marks which are distributed as shown in the table

	Poor	Acceptable	Outstanding	Total marks
Topic/title	Long, unclear boring	One line and very easy to understand	Short punchy and arresting	0/1/2
Presentation and layout including spelling and formatting	Multiple spelling mistakes, incorrect underlining/ use of bold, tables poor	Minimal spelling mistakes, grammar acceptable and tables can be understood	No spelling or grammatical mistakes, excellent use of language, tables simple and demonstrate relevant points	0/2/4
Clinical dilemma clearly identified and right question asked to solve the dilemma	Unclear what the main question to be answered is, or dilemma stated but search and CTR not relevant to solving the problem	Question stated but no background or relevance stated.	Well-phrased problem which is given relevant background and should provide the answer to the clinical dilemma	0/1/2
Reason for choosing stated	No personal relevance stated	Some relevance to personal practice	Clearly states why the issue interests the author in their own practice	0/1/2
Literature review	Search not described appropriately or inappropriately completed	Search outlined with minor flaws in strategy	Good search strategy clearly defined	0/1/2
Appraisal of literature	No attempt to critique papers quoted	Some attempt to evaluate standard of papers	Good evaluation of the standard of evidence presented	0/2/4
Synthesis of and conclusions from evidence	No summary of evidence or conclusion presented	Some summary but no overall conclusion from evidence	Good overview of all the papers synthesised into overall conclusion	0/2/4
Additional other work—value and standard	No additional work	Additional work limited as survey or small audit	Good quality original research that enhances CTR	0/2/4
Makes suggestions for how changes personal practice	No suggestions for change in practice or suggestions are unjustified	Limited suggestions to change practice, or not based on own literature review or own work	Good clear suggestions as to how this will change practice, justifiable from the literature review and own work	0/2/4
			Total	/28

CTR viva scoring system

	Below standard	Standard	Above standard	Mark
Why chosen—relevance to emergency medicine	Not able to justify	Partial justification	Convincing justification that topic relevant to clinical practice	0/1/2
Conduct of literature search	Unable to describe literature search, significant papers missing	Reasonable search but at least one missing relevant paper, describes search adequately	Appropriate search, papers relevant and well referenced, deals with questions on search and describes process including grey literature, etc	0/1/2
Critical appraisal	No comment on quality of evidence	Clearly comments on quality—identifies some weaknesses	Able to judge quality of any reference cited, give reasons for judging as high quality or poor papers	0/2/4
Synthesis of evidence	No in-depth evaluation of evidence simply regurgitation	Can summarise evidence but unable to give balanced judgement	Good appraisal of current thinking and identification of limits of evidence. Able to judge whether evidence should influence practice	0/1/2
Relevance to clinical practice	No application to clinical practice	Can apply generally to EM work	Able to give clear indication of how this work changes practice in real terms	0/2/4
Evidence of other work	No evidence of personal work	Good summary of work done but limited relevance or contribution	Good summary of work and justifies how relevant to the topic	0/2/4
			Total	/18

dates have identified shortcomings with their CTR they should address how they would do things differently in the future.

FUTURE OF THE CTR

The CEM intends to pilot CTRs being assessed at a regional level and outside of the FCEM examination in autumn 2009. It is proposed that candidates would be examined by two FCEM examiners who would assess their CTR and conduct the Viva under exactly the same rules and

conditions as the FCEM CTR section. The local examiner must not be the candidate's trainer, and the other must be from out of region. A sample of the CTRs will be re-marked centrally as part of the ongoing quality assurance programme.

It is intended from November 2010, if the pilot is successful, that those trainees who have successfully completed their ST4 ARCP who would not be taking the next diet of the FCEM may choose to have their CTR examined locally on one

occasion (this is to encourage the candidates' best attempt rather than multiple poor attempts) and if successful would be exempt from the CTR section of the FCEM diet. Unsuccessful candidates will have to sit the CTR section of the FCEM exam as presently occurs.

**Mike Clancy and Ruth Brown,
on behalf of CEM**