

- 7 Bryan CS, Reynolds KL, Crout L. Promptness of antibiotic therapy in acute bacterial meningitis. *Ann Emerg Med* 1986;15:544-7.
- 8 Meadow WL, Lantos J, Tanz RR, *et al.* Ought "standard care" be standard of care? *Am J Dis Child* 1993;147:40-4.
- 9 Talan DA, Guterman JJ, Overturf GD, *et al.* Analysis of emergency department management of suspected bacterial meningitis. *Ann Emerg Med* 1989;18:856-62.
- 10 Wood AL, O'Brien SJ. How long is too long? Determining the early management of meningococcal disease in Birmingham. *Public Health* 1996;110:237-9.
- 11 Meningococcal Disease Surveillance Group. Meningococcal disease: secondary attack rate and chemoprophylaxis in the United States, 1974. *JAMA* 1976;235:261-5.
- 12 Thomson APJ, Sills JA, Hart CA. Validation of the Glasgow meningococcal septicaemia prognostic score: a 10-year retrospective survey. *Crit Care Med* 1991;19:26-30.
- 13 Riordan FAI, Thomson APJ, Sills JA, *et al.* Who spots the spots? The diagnosis and treatment of early meningococcal disease in children. *BMJ* 1996;313:1255-6.
- 14 Toews WH, Bass JW. Skin manifestations of meningococcal infection. *Am J Dis Child* 1974;127:173-6.
- 15 Jones DM, Kaczmarek EB. Meningococcal infections in England and Wales: 1991. *Communicable Disease Report* 1992;2:R61-3.
- 16 Nadel S, Levin M, Habibi P. Treatment of meningococcal disease in childhood. In: Cartwright K, ed. *Meningococcal disease*. Chichester: Wiley, 1995:207-43.

## First Asian Conference on Emergency Medicine

22-25 October 1998

The Society for Emergency Medicine in Singapore is privileged to host the First Asian Conference on Emergency Medicine. The conference is scheduled to be held on 22-25 October 1998. This conference will also see the official launch of the Asian Society of Emergency Medicine.

The Committee will be inviting world renowned experts to deliver lectures on pre-hospital trauma care, advanced imaging for multiply injured, aeromedical evacuation of the trauma patient, development of emergency medicine, issues and challenges for emergency medicine, emergency nurse triage, advanced training for emergency nursing, development of clinical practice guidelines, emergency department design, management issues at the emergency department, update on cardiac resuscitation, current trends on GI decontamination, elements of EMS, and pre-hospital triage and IT in emergency medicine. The preconference workshops will be held in the same venue, on focused ultrasound for the emergency physician, advanced airway management, and local anaesthesia techniques.

For further information, contact the Conference Secretariat, Academy of Medicine, Singapore, 16 College Road, #01-01 College of Medicine Building, Singapore 169854; tel: +65 223 8968; fax: +65 225 5155; e-mail: [monicaw@pacific.net.sg](mailto:monicaw@pacific.net.sg)

munity has used the service, and interestingly clients of all ages attended for treatment. Altogether 98% of the patients surveyed were happy to be seen by a nurse and were satisfied with the treatment they received. The level of transfers, referrals to clinics, and the number of clients treated by the ENPs suggest that all the fears and scepticism expressed before the start of the service appear to be unfounded.

The authors conclude that this study has demonstrated that given suitable training, protocols, and close liaison with a neighbouring

A&E department, nurses can provide an effective and worthwhile locally based service.

- 1 Stilwell B, Greenfield S, Drury V, *et al.* A nurse practitioner in general practise: working styles and patterns of consultations. *Journal of Royal College of General Practitioners* 1987;37:154-7.
- 2 Potter T. A real way forward in A&E: developing the nurse practitioner role. *Professional Nurse* 1990;5:586-8.
- 3 Woolwich C. A wider frame of practice. *Nursing Times* 1992;88:34-6 (11 Nov).
- 4 Baker B. Model methods. *Nursing Times* 1993;89:33-5 (24 Nov).
- 5 Royal College of Nursing A&E Association and Emergency Nurse Practitioner Special Interest Group. *Emergency nurse practitioners: recommendations of special interest group.* London: RCN, 1993.
- 6 United Kingdom Central Council. *The scope of professional practice.* London: UKCC, 1992.

**Hong Kong Academy of Medicine**  
**First International Congress, Hong Kong**  
 26-29 November 1998

**Challenges to Specialists in the 21st Century**

*Plenary lectures:* Challenges to the specialist beyond 2000; Evidence based medicine; Survival of the generalist in a specialist world; The quest for transplantation tolerance; The training of our specialists into the next millennium; Pain-free state: is it possible?

The scientific programme includes symposia on trauma, pain management, and substance abuse.

For further information, contact the Congress Secretariat, Hong Kong Academy of Medicine, First International Congress, GPO Box 41, Hong Kong; tel: 852 2515 5737; fax: 852 2505 3149; e-mail: [hkam@hkam.org.hk](mailto:hkam@hkam.org.hk)

workload as well as that arising from events such as this. Despite a 50% increase in A&E medical and nursing staffing levels, the temporary use of an extra observation ward and medically manned first aid stations at the party site, the huge patient numbers created major problems for both the A&E department and hospital facilities.

The natural focus of the Hogmanay celebrations was midnight on 31 December, but a myriad of additional events took place over several days on either side of this. The greatest patient numbers presented between 11 pm on New Year's Eve and 5 am on 1 January, but significant peaks occurred when patients presented later that day and again on 2 January (fig 1). This protracted nature of patient presentation led to prolonged and unremitting strain on staff and resources.

Alcohol intoxication was ubiquitous and was the single most important factor compounding the situation. Many patients and their relatives and friends were uncooperative and abusive. Difficulties were posed by even simple processes of care such as undressing patients, taking baseline recordings, x ray imaging, and instituting treatment. A permanent police presence was needed in the department over the three day period to protect staff and patients against violent outbreaks.

The inherent safety of the Hogmanay celebration is questionable. This year, underfoot conditions were hazardous because of snow. Crowd barriers and railings were bent by crowd pressures and the potential for a true major incident as a result of crushing injury is ever present. Subsequent press and personal reports emphasised the "appalling, dangerous crush" and "Hillsborough all over again."<sup>3 4</sup> Major delays in transporting patients by ambulances were reported, and if life threatening injuries had occurred, access would have been difficult for ambulance and medical crews.<sup>5</sup>

Plans are proposed to increase the numbers attending to over 500 000 for the millennium celebrations. At what point does encouraging people to have a good time constitute reckless irresponsibility?

We wish to acknowledge the help of Dr Colin Robertson in preparation of this paper and the extraordinary efforts of all members of staff in the accident and emergency department during the Hogmanay period.

- 1 Advanced Life Support Group. *Major incident medical management and support manual—a practical approach*. London: BMJ Publishing Group, 1995.
- 2 Gavalas MC, Miles SAD. Hospital response to disasters in the UK. In: Skinner D, Swain A, Peyton R, Robertson C, eds. *Cambridge textbook of accident & emergency medicine*. Cambridge: Cambridge University Press, 1997.
- 3 Wells M. Reveller's report. *The Scotsman* 1997 January 3.
- 4 Notarelangelo R. Cops launch probe into Hogmanay crush hell. *The Daily Record* 1997 January 3.
- 5 Thorpe N. Ambulance chief joins call for party review. *The Scotsman* 1997 January 4.

## Notice of Conference

### Emergency Medicine & Pre-hospital Care

Johannesburg, South Africa

7–9 October 1998

For further details, contact:

The Registrar, Emergency Medicine & Pre-hospital Care Conference, Strategic Business Services (Pty) Ltd, PO Box 1059, Oakdale 7534, South Africa. Fax: +27 (0)21 914 2890; e-mail: registrar@sbs.co.za

indication for skull x ray—none of these had sustained a fracture. Of the remaining 186 frontal head injuries there were two skull fractures and both of these had other indications for skull x ray.

**Conclusions**—Guidelines for skull x ray following paediatric head injury, particularly when the sole indication is soft tissue swelling, contusion, or haematoma following frontal injury, needs re-evaluation.

**A case of severe hypertension complicated by intracerebral haemorrhage and acute pulmonary oedema**

E J Rubython

*Accident and Emergency Department, Birmingham Children's Hospital, Ladywood Middleway, Birmingham B16 8ET*

A 54 year old man collapsed unconscious at home. On arrival at the accident and emergency department he was breathing spontaneously at a rate of 36 per minute and had a pulse of 84 beats per minute. His blood pressure was 300/140 mm Hg by both manual and automated methods. There was no appreciable difference in the pressure recorded between right and left arms. Glasgow coma score was 4 with extensor response and his pupils were equal but unreactive.

In the past he had apparently been investigated for diabetes and had been prescribed atenolol for hypertension. He had suffered no

significant previous illnesses and was a non-smoker.

His blood pressure rose steadily reaching a peak of 340/280 mm Hg but his pulse remained at around 80 beats per minute. Electrocardiography showed left ventricular hypertrophy with strain. He then developed acute pulmonary odema with copious, pink frothy sputum. He was given intravenous frusemide and was incubated and mechanically ventilated as his respiratory effort was deteriorating.

A working diagnosis of malignant hypertension complicated by probable intracerebral haemorrhage and acute pulmonary odema was made but phaeochromocytoma could not be excluded. After consideration of various antihypertensive agents he was commenced on sodium nitroprusside infusion and his blood pressure gradually fell to 200/150 mm Hg.

Computed tomography was performed which showed a large right parietal haematoma with mass effect and midline shift. This was not operable so he was transferred to ITU where he died 36 hours later.

Points for discussion: (1) Should we have worried about the possibility of phaeochromocytoma? (2) Did we use the most appropriate antihypertensive agent? (3) What level of blood pressure should we have been aiming to maintain?

**Heart failure out in the cold: the risks of an ecstasy tablet**

K Lendrum

*Accident and Emergency Department, North Staffordshire Royal Infirmary, Windsor House, Princes Road, Hartshill, Stoke on Trent ST4 4LN*

A young man was brought to the accident and emergency department in extremis by his friends. He had a respiratory arrest shortly after arrival due to gross pulmonary oedema and required immediate intubation and ventilation. He was found to be hypothermic with a core temperature of 30°C.

It later transpired that he had earlier ingested an ecstasy tablet and gone to sit outside because he felt unwell. He was found several hours later. His cardiac failure was associated with myocardial stunning. After a prolonged ITU admission he was discharged home.

Ecstasy is normally associated with hyperpyrexia. This unusual presentation is a reminder that drug intoxication may not present in a textbook fashion. The effects of ecstasy and the proposed hypothesis for the way in which this man presented are discussed.

**Major Incident Medical Management and Support (MIMMS)  
Courses 1998**

This is a 3 day course, teaching all aspects of the management of major incidents by medical, nursing, and paramedical staff. The course is available to healthcare workers from specialties where they are likely to form part of a major incident team.

There is an increasing number of courses in various locations.

*Auchterarder:* 21–23 August

Contact: Colville Laird, 07764 622275

*Manchester:* 2–4 July

Contact: Jenny Antrobus, 0161 8771999

*Guildford:* 13–15 October

Contact: Major Tim Hodgetts, 01276 604604

*St Mary's Hospital, London:* 16–18 June, 22–24 September

Contact: Shaun Stacey, 0171 725 6666

*Swansea:* Date to be arranged

Contact: Meinir Williams, 01269 851501

*Plymouth:* Date to be arranged

Contact: Tristan Evely, 01752 561305

*Belfast:* Date to be arranged

Contact: Christine Campbell, 01232 520500

*Lancashire Ambulance:* Date to be arranged

Contact: Frank Whiteford, 01772 773018

# Emergency Medicine

A reciprocal arrangement has been set in place with the *Journal of Accident and Emergency Medicine* and *Emergency Medicine* whereby the contents pages of the *Journal of Accident and Emergency Medicine* and *Emergency Medicine* will be published in the respective journals.

The contents page of *Emergency Medicine Volume 10, Number 1* appears below.

## Emergency Medicine

March 1998, Volume 10, Number 1

<b>Editorial</b>	3	Time to act <i>Peter Cameron</i>
<b>Guest editorial</b>	7	Medicolegal medicine—expert witness or medical whore? <i>John Raftos</i>
<b>Leading article</b>	9	What should medical students be taught in emergency medicine? <i>Anne-Maree Kelly</i>
<b>Original research</b>	12	Victorian nurses demonstrate concordance in the application of the National Triage Scale <i>Stuart Dilley, Pat Standen</i>
	19	Recognition of deficits of physical and cognitive function in the elderly by medical staff in the emergency department <i>Gideon A Caplan, William D Croker, Ann Brown</i>
	25	Outcome from prehospital cardiac arrest in Melbourne, Australia <i>Stephen Bernard</i>
	31	Trauma in the western region of Saudi Arabia <i>Mohammed Z H R Ansari</i>
	35	A pilot project of nurse clinicians in the Emergency Department of Radcliffe Hospital <i>Pat Naidoo, Stephen Brierley</i>
	38	Comparison of lignocaine 1% injection and adrenaline-cocaine gel for local anaesthesia in repair of lacerations <i>Cameron Dart</i>
<b>Case report</b>	45	Severe subcutaneous emphysema and pneumomediastinum <i>Craig Hourigan, Jack Bergman</i>
<b>Education and training</b>	49	Undergraduate emergency medicine education in a developing country: experience from Kuala Lumpur, Malaysia <i>Abdul A R Mohamed, Azhar A Aziz, Emily Goh</i>
	53	Integration of emergency medicine into the undergraduate medical curriculum at the Christchurch School of Medicine <i>Michael Ardagh</i>
	57	Emergency Medicine Fellowships in the United States <i>David McD Taylor</i>
<b>Book reviews</b>	61	Principles and Practice of Children's Emergency Care <i>Matthew O'Meara</i> Pocket Companion to Textbook of Critical Care <i>Greg M Sweetman</i>
<b>ACEM policies</b>	63	Use of intravenous sedation for procedures in the emergency department
	65	Role delineation for emergency departments
<b>College news</b>	71	President's message <i>Chris Baggoley</i>
<b>Society news</b>	75	President's message <i>Diana Egerton-Warburton</i>
<b>Letters to the editor</b>	77	Trial participation leads to a delay in thrombolysis for acute myocardial infarction <i>Robert Dunn</i>
	78	Thumb insertion technique for resuscitation using the laryngeal mask airway <i>Simon P Taylor, Alison M Berry</i>
	78	Abnormalities on radiographs may be normal variants <i>John M Ryan, Geoffrey Price</i>
	80	Computerising emergency department guidelines with an intranet <i>Harry Karipis</i>
	81	In reply <i>Richard Waller</i>
	81	Further praise! <i>Richard Cockington</i>
	83	Journal of Accident and Emergency Medicine contents page
	85	Noticeboard
	87	Journal search
		Information for contributors

A 20 year old male attended the accident and emergency department with a six hour history of increasing agitation and hyperactivity, associated with feelings of impending death and visual hallucinations. Fourteen hours previously he had swallowed four whole nutmegs and half a litre of vodka for a "buzz". Five hours after ingestion he experienced a tingling feeling in his hands and feet, which later spread to his whole body. He felt "detached from the world" and stated that everything appeared to move in slow motion. He subsequently experienced dry mouth, thirst, nausea, palpitations, and dizziness. This progressed to the state of high agitation in which he presented.

Physical examination revealed a flushed, agitated young man, fully orientated, with a tachycardia of 130/minute, blood pressure of 120/85 mm Hg, and a respiratory rate of 24/minute. He was apyrexial. Pupils were dilated (size 4), reacting briskly to light and accommodation. Neurological examination revealed hyper-reflexic upper and lower limbs. The remainder of the physical examination was normal.

Electrocardiography revealed a sinus tachycardia and laboratory investigations were normal. He was admitted for observation. His altered mental state persisted for 18 hours after admission (32 hours after ingestion) and the sinus tachycardia resolved after 20 hours. He was discharged 36 hours after admission, with psychiatric follow up arranged.

The spice nutmeg has long been used for purposes other than culinary. Not least among these is its use as a recreational drug, based on its purported euphoric and hallucinogenic properties.

Nutmeg's use in this context stems from the Crusades, and it has also been a well documented substance of abuse among prison inmates.<sup>1</sup> Nutmeg ingestion gained currency during the 60s and 70s, when it was touted as a cheap alternative to alcohol and other mind altering substances. Most of the published case reports date from this time, and describe toxic effects similar to our case.<sup>2</sup> The clinical course is generally benign and management is largely supportive, although cases complicated by hypotension, cyanosis, acidosis, coma and, in one instance, death have been reported. Hypertension can be treated with phenolamine, but sedatives should be used with caution as they may cause alternating drowsiness and delirium (information from the National Poisons Information Centre, Beaumont Hospital, Dublin, Ireland). Nutmeg comprises 5–15% volatile oils, of which myristicin is the largest fraction. Myristicin is metabolised to 3-methoxy-4,5 methylenedioxy-amphetamine (MMDA), a psychoactive sympathomimetic. It is postulated that this accounts for most of nutmeg's toxic effects.

While historically nutmeg appears to have enjoyed a reputation as a hallucinogen, in circumstances where the spice is taken in excess, a typical and unpleasant clinical syndrome ensues. This, presumably, is why nutmeg abuse is virtually unheard of nowadays, with teenagers more likely to encounter it at the dinner table than on the street corner.

G I QUIN  
N F FANNING  
P K PLUNKETT

*Accident and Emergency Department,  
St James's Hospital,  
Dublin 8, Ireland*

*(Correspondence to: Dr Gareth Quin,  
Royal Gwent Hospital,  
Newport, Gwent NP9 2UB)*

- 1 Schulze RG. Nutmeg as an hallucinogen. *N Engl J Med* 1976;294:849.
- 2 Payne RB. Nutmeg intoxication. *N Engl J Med* 1963;269:36–8.

### CS spray

EDITOR,—Breakwell and Bodiwala's article on the consequences of an accident and emergency (A&E) department of CS spray exposure is timely.<sup>1</sup> In 1996 the police service in England and Wales carried out a six month trial of CS aerosol incapacitant in selected forces.<sup>2</sup>

Police surgeons were involved in submitting reports where consent was given on the medical condition of those sprayed. Due to the involvement of the members the Association of Police Surgeons produced an information sheet *Crowd Control Agents: Clinical Effects and Management*.<sup>3</sup>

In August 1996 the Home Secretary announced his support for any chief officers of police wishing to issue CS to officers on the beat. Within the London area police officers are now being trained and the incidents of exposure are likely to increase.

A person arrested who has been sprayed with CS incapacitant spray will be examined by a forensic medical examiner (police surgeon) as soon as possible. However members of the public who may be involved are likely to present themselves to A&E departments for advice. It is most important therefore that A&E staff are prepared to deal with the clinical effects of crowd control agents.

MARGARET M STARK

*Education and Research Sub-Committee,  
Association of Police Surgeons,  
"Dubolly", 20 Sandy Lane,  
Cheam, Surrey SM2 7NR*

- 1 Breakwell A, Bodiwala GG. CS gas exposure in a crowded night club: the consequences for an accident and emergency department. *J Accid Emerg Med* 1998;15:56–7.
- 2 Kock E, Rix B. *A review of police trials of the CS aerosol incapacitant*. Police Research Group: police research series paper 21. London: Home Office, 1996.
- 3 Association of Police Surgeons. *Crowd control agents: clinical effects and management*. Harrogate: APS, July 1996.

### "Shop hopping"

EDITOR,—Napoleon called us a nation of shop keepers. We are now, I believe, a nation of shoppers. Some people shop unfunded. We call them shoplifters. They rely on a combination of stealth, speed, and occasional force. Here are two cases of a variant of shoplifting that I call "shop hopping". A shop hopper is an individual with a habit of regularly faking collapse in shops to avoid payment.

### Case reports

#### CASE 1

Elizabeth presented to our accident and emergency department at the Derbyshire Royal Infirmary in 1979. She had no general practitioner. She had a respiratory tract infection. She received antibiotics and soon recovered. She then was brought to our hospital practically every few days by the ambulance service for the next four years. The story was always the same. She "collapsed" with her shopping at the checkout of a food store. An ambulance was called. Well meaning shoppers put her shopping in the ambulance too—all unpaid for. Once in our department, she usually recovered quite quickly and walked home. She lived nearby and rarely stayed long

enough to be examined. No medical cause was ever found for these timely attacks. She became well known to all the emergency crews on the ambulances and was also well known to our staff. One of our sisters even shouted to her to "get up and get out" in Sainsburys. It worked that time but did not cure the habit. (The sister was nearly lynched.) The last time I saw Elizabeth she had collapsed with a stroke; she died soon after.

#### CASE 2

Patricia presented to our department recently with chronic back pain demanding analgesia. She had just come from Scotland and already had had a row with a general practitioner locally. She then expressed suicidal intent and was referred to a psychiatrist. Telephone calls to other hospitals confirmed her to be a "hospital hopper". However, the ambulance services of several counties knew her better as "the lady who collapsed in food stores at the check out". She then obtained free food as they conveyed her in comfort to the local hospital; this happened many times. She had come south on a shop and hospital hopping spree!

These two cases illustrate the habits of a "shop hopper". Neither patients had a good relationship with a general practitioner. These patients are a type of "hospital hopper", who purposely abuse the ambulance and hospital services for their gain. We, the taxpayers, foot the bill. Circulating pictures of such patients to shops would breach medical etiquette. Challenging such patients in a store does not cure them. The store cannot send a bill to the patient as the goods have not been through the till. The ambulance service cannot "boycott" these people as they have a duty to convey collapsed patients to a hospital. We doctors have a duty to examine all such patients. Such a collapse may be genuine. Once in a hospital, recovery is rapid, and they take their own discharge prior to the police arriving. Shops, hospitals, and the police need to recognise these people and become more vigilant. I cannot think of a better way to shop!

A FRASER-MOODIE

*Emergency Department,  
Derbyshire Royal Infirmary NHS Trust,  
London Road, Derby DE1 2QY*

### The Faculty of Accident and Emergency Medicine

#### Panel of Examiners

Applications are invited from consultants in accident and emergency medicine who have been in post for at least five years and who wish to be appointed to the Panel of Examiners.

The examination for the Exit Diploma of the FFAEM is currently held twice a year at various venues in the UK.

The closing date for receipt of applications is 1 September 1998.

Further details and an application form are available from: The Faculty of Accident and Emergency Medicine, 35–43 Lincoln's Inn Fields, London WC2A 3PN (tel: 0171 405 7071).

## Management training for specialist registrars in accident and emergency medicine

It has been noted by the Examination Board of the Faculty of Accident and Emergency (A&E) Medicine that recent entrants for the fellowship displayed a weakness in their knowledge of management issues. This has prompted a group of consultants within the Yorkshire Region, who are involved in specialist registrar training, to look at the issue of management training for specialist registrars in A&E medicine.

Concerned at the lack of dedicated management training for doctors in the specialty and following the success of the management training scheme at St Bartholomew's Hospital in London, along with the recent report presented to the Academy of Royal Colleges of the United Kingdom by Professor Cash, President, RCPE, and Dr Lindsay Burley, FRCPE and General Manager of the Borders Health Board, it was felt that the lack of training in relation to management and management issues should be addressed as a matter of high priority. They have decided to organise a five day residential course on management training to be held in the region, supported by the Yorkshire Deanery of the University of Leeds (Postgraduate Medical and Dental Education).

The report, presented by Professor Cash, was given unanimous approval for implementation throughout the UK and in all medical specialties; it centred around identifying ways of assisting doctors to contribute effectively (in their current and futures roles) to the increasingly complex

and changing NHS. This underlines the belief by the Yorkshire consultants in the need to provide management training to the specialist registrar (A&E), not only in their region, but to provide the opportunity for specialist registrars (A&E) elsewhere in the UK to have the opportunity in attending the course.

The course programme has been carefully put together based on the core curriculum proposed by the Academy of Royal Colleges and draws upon the experience and expertise of recognised experts in the field of management generally and clinical management within the NHS, as well as the syllabus for the Fellowship of the Faculty of Accident & Emergency Medicine.

The programme includes workshops and lectures with speakers drawn from senior consultants and managers in the NHS and experts in the appropriate areas, and will be supported by information technology and administrative staff throughout the course.

This innovative course is the first of its kind in the north of England and it is anticipated that the course will be held annually in order to secure the long term training needs of specialist registrars in the specialty of A&E.

J K GOSNOLD

Royal Hull Hospitals Trust

S M BARNES

Dewsbury Health Care NHS Trust

### Specialist registrars (accident and emergency) management training course

A five day residential course will be held at Harrogate on Monday 21 to Friday 25 September 1998.

This course is for the specialist registrar in his/her 4th/5th year aiming for their CCST.

Day 1—political and economic issues; funding and contracting; the future; introduction to work groups

Day 2—organisation styles; leadership skills; team building

Day 3—complaints; media and public relations; criminal negligence scheme for trusts

Day 4—employment law; recruitment selection; interview techniques

Day 5—policy and guidelines; use of information; audit and charter standards

The course has been designed specifically to provide the specialist registrar with an intensive, proactive, and interactive experience of management within the NHS.

The aim is to ensure that the requirements and criteria for the CCST curriculum are covered and that the delegate is provided with a good, solid foundation of basic management skills.

It is anticipated that the course will ensure that the specialist registrar will be able to contribute effectively to the developing NHS, by understanding all levels of the

NHS organisational structure and understand the role of the A&E consultant.

*Fee:* £800.00 inclusive of accommodation (full board).

*Venue:* Quality Kimberley Hotel, Harrogate (car parking available).

*Further details:* Mrs Jacqueline Brayshaw (Course Administrator), "Wheatcroft", Main Street, Great Hatfield, East Yorkshire HU11 4US (tel/fax: 01964 536821).