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SUPPLEMENT

November 2004

Professor John Henry

John Henry was the first professor of emergency medicine at London University, based at St Mary's Hospital. At a well attended meeting at the Royal Society of Medicine on 8 September colleagues from emergency medicine and toxicology met to mark his retirement and the achievements of a remarkable career. John's immense learning, easy approachable manner, and lack of any pretentiousness have made an impression on all who know him. Professors never really retire, of course, they just take on new challenges. He has all our best wishes for the future.

Emergency medicine research

The world of the National Health Service has its own culture, distinct from the much more amorphous and multifaceted academic world, which can be extremely confusing to those looking at it from the outside. At the end of each NHS day, you wend your way home, feeling tired but contented, often rejoicing in the fact that you may even have helped some people. Once you enter the academic world, you feel your day is never done, with grant applications (nine out of 10 turned down—that can be disheartening), projects to manage, and financial targets all still to be met. Yet this is the route that enables all specialties to develop and thrive. And some of us must put ourselves forward and tread this path. Emergency medicine needs an academic presence more than most. We are a still a fledgling specialty, having emerged from the shadow of absentee orthopaedic surgeons within living memory, and being regarded as lesser mortals by the established specialties.

My seven years as an emergency medicine doctor have shown me what a marvellous specialty we are, with strong bonds of fellowship and cooperation combined with a "can-do" approach. It is on these strengths that we need to build a high quality academic base for the future. We should take the example of Lewis Goldfrank. He became Director of Emergency Medicine in Bellevue Hospital in New York back in 1979 and developed an emergency medicine residency against quite fierce opposition. At that time, emergency medicine has a similar status to ours at present in the UK. He put all his energy into teaching and research, and the fruits are now there for all to see. Emergency medicine is a thriving and respected specialty, able to select the very best candidates, and the research output is prolific, with academic departments flourishing throughout the US.

Why do we need research?

Few would deny that we need research in our specialty. In the first place, there are many things we do without knowing how well—or even whether—they are helping our patients. We therefore need to consolidate the evidence base for our practice. This will lead to more sound practice and better morale, as well as improved patient care. Our own department's motto, *Scientia vincit timorem*—"Knowledge conquers fear", precisely illustrates this point.

How can this be achieved?

Those working in emergency medicine are on the spot 24/7, willing and available to diagnose and manage acute conditions, often at times when other specialties are tucked up in bed! The motto of the Faculty of Accident and Emergency Medicine *Semper sucurrimus aegris*—"we always help the sick"—underlines this availability. This type of research cannot be left to the other specialties—it is our right as well as our duty to take forward research in emergency medical situations. Interestingly, the motto of the American Academy of Emergency Medicine is "When minutes count". One of the areas where research is most needed is the "golden hour", where correct and timely interventions can make a massive difference to the outcome. These conditions include resuscitation, major trauma, surgical emergencies, myocardial infarction, sepsis, stroke, head injury, and many others.

The accident and emergency department presents such a vast canvas that focus is necessary. Once a specialist area has been chosen, it enables a steady progression in that particular field. This expertise should in time lead to respect

and acknowledgment by other academics and clinicians.

Where do we go from here?

We need support from the whole specialty, and we need active support systems, such as the Faculty's website and the network of regional advisers, so that research can be encouraged. Research should also be built into the training and the career structure. Research methodology must be learnt together with an understanding of the virtues needed by a clinical academic in the field of emergency medicine. Quite clearly, an inquiring mind is essential, but the real rewards are won by hard work, tenacity, self discipline, honesty, integrity, and trust of one's colleagues. However, on another plane we also need academic departments with their own major specialist interests, and a balance between basic and clinical research. The universities consider academic groups of 20 to 30 people to be viable. We have a long way to go before we reach this level and enter the Research Assessment Exercise from a position of strength! At the same time, we need to enter into collaborations with basic scientists and with other clinical disciplines as colleagues and equals since both sides have such a large amount to give and to benefit from by an honest and frank partnership.

We have the rationale and the ability, and we have the hunger to establish ourselves in research. Our survival depends on it. I wish those at present involved in emergency medicine research every success for the future. If there is any way I can play a part in this progress, I would be happy to do so.

JOHN HENRY

Round up of forum news from FASSGEM

By the time this is published, our annual conference at the Kensington Close Hotel in London will only be a few days away. Those of you who have already booked for this will, I am sure, be looking forward to a stimulating, educational, and sociable three days in London (I look forward to meeting you there).

If you have not already booked for the conference then I am afraid that you have missed your opportunity for this year—however, may I take this chance to remind you that any FASSGEM member can attend the FASSGEM AGM on the morning of Friday 26 November at 0900 in the Conference Room at the Kensington Close Hotel. There is no charge for attending the AGM and no advance booking is required, however to facilitate catering and compliancy with fire regulations, it would be much appreciated if you could email your intention to attend to me (apnewton@fairviewshipham.fsnet.uk).

With regard to the AGM, we will have a significant number of key issues to discuss this year:

- The stalling of negotiations on the ''new contract'' for non-consultant career grade doctors.
- The delay in establishing PMETB.
- The continued loss of middle grade doctors from our specialty to primary care.
- Our relationship with (and representation) on the subcommittees of the British Medical Association.

In addition to the very significant topics of national relevance listed above, the AGM also represents an opportunity for us to revisit and redefine our constitution. In accordance with the current constitution, advance notice of one year was given of this at last year's AGM and accordingly at this year's AGM we will discuss the roles, responsibilities, and duration in office of the FASSGEM committee members and we will also review the roles, responsibilities and election of regional representatives. The aim of this constitutional review is to ensure a maximisation of the efficiency with which we run FASSGEM without involving those members who put themselves forward for committee responsibilities in too onerous a schedule of extracurricular commitments.

On the subject of communication, it is time that we reviewed and overhauled our website. The website is a very useful tool to enhance communication and increasingly is being used as a source of dissemination of information about educational meetings, as well as a conduit for the dissemination of updates on the political agenda with regard to the status of the non-consultant career grade.

The biggest single step that we could take to improve our website would be to find somebody to act as a webmaster (at the current time this is contracted out to an IT provider and as a result of their lack of familiarity with the specialty and their geographical remoteness, some problems have been experienced with keeping the website as up to date and as vibrant as we would like it to be). If you would either like to volunteer for this post or if you would like to nominate somebody then please contact me as soon as possible.

I would like to give advance notice of our spring meeting next year. This will take place on Friday 20 May 2005 in Southampton. Further details will be circulated as soon as they become available.

We are still searching for a venue for next year's annual conference. A number of proposals have been received already and the final decision on the venue will be taken at the annual conference this year. Therefore if you have a burning ambition to host FASSGEM 2005 in your home town and you have not already declared this ambition to me, please get in touch without delay.

ANDREW NEWTON
Chair of FASSGEM (Forum for Associate Specialists and Staff Grades in Emergency Medicine); apnewton@fairviewshipham.fsnet.uk

Emerging role of the consultant paramedic

Paramedics were first introduced in the UK in 1971, by Douglas Chamberlain in Brighton, only three months after the first similar programme in the USA. The Brighton paramedics were initially authorised only to defibrillate and to interpret 12-lead ECGs, although they could admit patients directly to the coronary care unit on the basis of their diagnosis. As experienced was gained and confidence grew, other interventions were permitted, including endotracheal intubation, intravenous cannulation and drug administration, and intracardiac injections.

A number of similar schemes followed in various parts of the UK but in 1982 the Department of Health and Social Security (DHSS) declared a moratorium until evidence had been gained of the benefit of ''extended'' training for ambulance staff. The University of York undertook this study and reported in 1984 that there were indeed clinical and economic benefits to be obtained. It was not until 1986, however, that a standard national paramedic curriculum was developed, and the DHSS issued advice to the effect that ambulance services wishing to implement the associated training programme could do so. Unfortunately, it was emphasised that such developments were at the discretion of each chief ambulance officer and would not attract additional funding. Consequently, many decided discretion was the better part of valour and chose not to instigate a paramedic service. Finally, after a particularly serious episode of industrial action by ambulance staff in 1990, the government of the day set a target of having at least one paramedic on every front line ambulance by 1996.

Recent milestones in the development of the paramedic profession have been the introduction of mandatory state registration in 2000, and the development of national clinical guidelines for paramedics by the Joint Royal Colleges Ambulance Liaison Committee. This body was established in 1986 by the DHSS to provide medical advice regarding the clinical practice of paramedics, and includes representatives from each of the medical, nursing, and midwifery Royal Colleges. Less than two years ago the British Paramedic Association was established to provide a professional body representing the interests of paramedics, acting in the same vein as the BMA does for doctors. It can be seen that although the paramedic profession is relatively new, it is rapidly increasing the pace of its development.

The first consultant nurse posts were introduced in 1999. The post of ''consultant therapist'' was announced a year later in the NHS strategy document *Meeting the Challenge* and provided a similar development opportunity for allied health professionals (including paramedics). The aim of these posts is to provide a career pathway that encourages highly qualified health care professionals to stay in clinical practice, rather than moving into management.

There are a number of requirements common to all nurse and allied health professional consultant posts. Each must be approved by a panel established by the relevant strategic health authority, the membership of which will include representatives from the pertinent professional body, a higher education institution, and senior NHS managers. The subsequent appointments panel must also include representatives from the professional body as well as managers from the appointing NHS trust and university.

All consultant posts include a joint appointment with a university, and candidates must be qualified to at least masters degree level. Job descriptions are broadly similar, and are required to include four core functions. The primary function, which must make up 50% of the post, is expert clinical practice. This requires that the post-holder function autonomously, managing their own case load and applying clinical judgment to provide best practice. The consultant must be a national or international expert within their speciality, and use evidence to develop care pathways and clinical guidelines.

The second core function is that of professional leadership, providing expert advice and input into the development of clinical practice and clinical governance. The third function is research and development, including the identification of gaps in the evidence base and the facilitation and conduct of research to address these. The fourth function is leadership in education and professional development through publication, lecturing, and acting as a link with universities.

To place these in the context of the paramedic profession, the need to develop autonomous expert clinical practice is perhaps being driven hardest by the imminent transformation of out-of-hours primary care services. It seems likely that the burden of these changes will fall most heavily on ambulance services and emergency departments. To address this, the Changing Workforce Programme has developed pilot ''emergency care practitioner'' programmes. These provide qualified paramedics and nurses with 15 weeks training to provide out-of-hours care to patients with apparently minor injuries and illnesses. Not surprisingly, such restricted training mandates for protocol-directed care, rather than autonomous practice. Experienced clinicians might argue, however, that the complexity of decision-making involved in accurately identifying and managing patients with minor problems is too great to allow the construction of simple decision-support and treatment algorithms. This suggests the need to educate practitioners working in the out-of-hours setting to a level at which they can safely practice autonomously within loosely defined evidence based guidelines rather than inflexible protocols. According to Quality Assurance Agency descriptors for university qualifications, autonomous practice maps to masters level degrees, as required of all consultant level appointees.

Currently, paramedics are almost entirely dependent on their medical colleagues to provide clinical advice and direction through local paramedic steering committees, the Joint Royal Colleges Ambulance Liaison Committee and, more recently, through the appointment of medical directors in ambulance trusts. Although this support has been (and will continue to be) essential, the development of specialist clinical expertise is one of the hallmarks of a true profession. Consultant paramedics represent an opportunity to develop this intraprofessional advisory capacity.

The evidence base that informs the practice of pre-hospital care is even thinner than that for in-hospital emergency medicine. Combining any topic relating to paramedic practice with the term ''randomised controlled trial'' in a literature search engine is likely to result in a nil return. Consultant paramedics will increase the support available for developing research programmes that will provide a firmer evidence base for current practice and future developments. Their links with universities will also facilitate the movement of ambulance training from its current vocational base to higher education institutions, providing a greater breadth and depth to the education of ambulance personnel.

Ultimately, the main effort of consultant paramedics must be the development of an evidence-led ambulance profession better equipped to manage the whole variety of patients that they encounter in their day-to-day practice: not just the 10% who have life threatening emergencies.

MALCOLM WOOLLARD
Director, Faculty of Pre-hospital Care Research Unit/Senior Lecturer in Emergency Medicine

News from BAETA

Examinations

The start of November heralds the second diet of the new FFAEM examination. You may recall that the last examination caused much concern after the unexpected failure rate. Current candidates, I am sure, are aware of the new emphasis and have tailored their revision accordingly. We wish them well, as we do the candidates for the MFAEM in late November.

BAETA 2004

Each autumn BAETA hold its own conference and this year was no different. This year we were hosted by the trainees of the All Wales Scheme in Cardiff and all round it was an excellent affair. Once again my dancing was less than impressive but, as has been pointed out, this is a lifelong burden.

As ever the success of these events is driven by the enthusiasm and hard work of the organisers. This was again mirrored by the delegates who helped to provide an attentive audience for the speakers. All in all, the conference was a great success and we look forward to 2005 in Nottingham.

Courses and meetings

The Lister Institute in Edinburgh is again running their five day ''Paediatric Emergency Care'' course aimed at basic and (early) higher trainees. The dates this year are the 8th–12th November and the price remains a whacking £550. Kay Leslie is the coordinator and she can be contacted at the Lister or via email: kay.leslie@nes.scot.nhs.uk.

The FAEM Annual Scientific Meeting is being held in Leeds from the 18th–20th November. This is the big UK emergency medicine research meeting and is a must for presenting your research. It may be too late to book but if you do come remember to attend the BAETA meeting.

The Royal College of Physicians of London are again holding a one day conference (on the 22nd November) titled ''Emergency Medicine''. This time it boldly targets ''physicians at all levels who deal with emergency admissions or acutely ill medical patients''. A similar mistake has been made to last year as A&E consultants have again been invited to speak. Maybe they knew what they were talking about. The full price cost is £190 for the day with discounts for college members. For more information call 020 7935 1174 ext 300.

Shortly after the Faculty meeting is ''Trauma 2004: Roadside to Critical Care''. This is grandly announced as the Anaesthetic Trauma and Critical Care (ATACC) First International Trauma Conference and takes place from the 22th–24th November in Liverpool. The cost is £400 but the programme looks excellent. Contact www.trauma.org for more information.

EMTEL

The Emergency Medicine Trainees E-mail List is a quarterly information service provided by BAETA. Its aim is to provide core information on work and training issues for trainees of all levels nationally. If you want to be included on the list, contact me at the address below. We will require some information from you: your grade, region, and (if appropriate) CCST year. This information is confidential and is required to manage the database properly; it is private and is not used for any other purpose.

If there are any matters that you want to raise please do not hesitate to contact me at the address below. I hope to meet some of you at the Faculty meeting; otherwise I wish you all festive greetings and all the best for the New Year.

STEVE JONES
President of BAETA; steve.r.jones@bigfoot.com

Consultant appointments July to September 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
Yasmin N Ashraff	Newham General Hospital	Locum consultant, North East Thames
Joydip Banerjee	University Hospital of Leicester	Locum consultant, Trent
Peter A Cutting	General Infirmary at Leeds	SpR
Alan K Fletcher	Northern General Hospital	Locum consultant, Trent
Rachel Hoey	Watford General Hospital	SpR, North Thames
Julian A Humphrey	Barnsley District General Hospital	SpR
Michelle Jacobs	Watford General Hospital	SpR, North Thames
Samuel I P John	Sandwell and West Birmingham Hospital	Consultant, Birmingham
Bruce W Martin	Hope Hospital	SpR, North Western
Pamela E Nash	Morriston Hospital	Consultant, Neath General Hospital
Caroline A Smith	West Middlesex University Hospital	SpR, North West Thames
Leigh K Urwin	Neville Hall Hospital	SpR, Northern