Training in emergency medicine

ABSTRACT

One of the key challenges faced in emergency medicine is to provide effective training so that clinicians feel valued and supported in the roles they undertake. While there are numerous areas of exemplar practice nationally this article details two areas of particular focus for the Royal College of Emergency Medicine: supporting trainees' return to formal training programmes and developing specialty and associate specialist doctors in emergency medicine.

In the last 50 years emergency medicine training has greatly changed. More trainees take time out of training and as more women chose emergency medicine, maternity leave may feature more prominently. The transition of life away from medicine to busy emergency departments is daunting. This may be a difficult time for a doctor and this article outlines how to improve this experience by providing insight into how to approach this.

In 2002 unpublished Royal College of Emergency Medicine data for trainees showed a 78% male to 22% female ratio. In 2017–18, the ratio is 53.7% male: 46.3% female. Approximately 14% of trainees are on an out of programme placement, 3% are on maternity leave and 8–10% are less than full time.

A trainee's story

Training continuously since graduation, I took a years' maternity leave after CT2.

Before returning to work in the emergency department I recertified my Advanced Life Support qualification. Extremely nervous before and during the course, I realized upon reflection that my absence from medicine hugely impacted my confidence and perception of clinical practice.

Subsequent research showed that the General Medical Council (2012) guidance on continuing professional development states that a doctor who continues to hold a licence to practice during a career break is expected to keep up to date and seek advice from their college and appraiser on support that may be needed upon returning to work.

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The Academy of Medical Royal Colleges (2017) guidance on returning to practice says:

> **It is the professional duty of the doctor to ensure that they are up to date, competent and safe to return to practice.**
> **An absence of three or more months seems more likely to affect skills and knowledge.**
> **Some evidence suggests that greatest decline in skills is in the first few months.**

Post-baby, discovering that it was my responsibility alone to be fit to practice was daunting and, to me, unacceptable. A 1-day refresher course was my proposal; the returning to the emergency department course was the result.

A trainer's story

The exact requirements of trainees returning to emergency medicine after more than 3 months off needed proper description. Each trainee has bespoke needs and there was little practical information available to create an emergency medicine course. The only solution was to talk with trainees in similar circumstances and create a trainee-designed course. The hope is that future iterations will be led by a diverse group of trainees.

Background

In order to enhance doctors' working lives Health Education England (2018) has placed a focus on supported return to training. The Royal College of Emergency Medicine Training Standards Committee recognizes changing trainee populations and aims to support those who have taken time out of training. This article describes a regional emergency medicine trainee-led initiative.

The returning to the emergency department course in Yorkshire and Humber was the first step taken to support doctors back into the emergency department.

This 1-day refresher pilot course ran on 4 July 2018 in the Barnsley Simulation Suite. The objectives were to:

- Discover the needs of trainees using pre- and post-course questionnaires
- Provide common emergency department scenarios
- Revise practical skills
- Update on relevant guidelines.

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Seven trainees attended the course, all of whom were on maternity or adoption leave.

The structure of the course included emergency medicine updates, covering common tasks such as application of a Thomas splint, suturing, radiology reviews, low- and high-fidelity simulation for adults, paediatrics, neonates, trauma and conscious sedation.

Results

Seven candidates attended (all ST3 or above), all on maternity or adoption leave. The faculty comprised six emergency medicine physicians and two nurses.

The trainee needs which were identified were:

1. Learning to speak medical language again
2. Reassurance that they could still do their job
3. Managing critically ill patients
4. Working out how to give advice again
5. Leading an emergency department team.

The programme was run in a non-judgmental, supportive environment, encouraging sharing of personal experience and giving the opportunity for trainees to voice their concerns.

Feedback responses

1. Increased confidence 100%
2. Relevant and realistic content 100%
3. Focus on communication was considered important
4. Group management of simulations were preferred with a nominated 'lead' allowing the option of 'asking a colleague' and team support.

This course empowered trainees to be honest about their anxieties about returning to work and highlighted the need to ensure regional return to work guidance is properly publicised.

Impressive ability was observed among trainees who were 'finding their feet again' when provided with some very challenging scenarios.

Looking to the future

Trainees favoured running this on a bi-annual basis.

Scenarios will remain challenging, focussing on non-technical skills and clinical skills.

The returning to the emergency department course gave trainees the opportunity to speak honestly about their needs for returning to work. More support was identified as a requirement for this group of trainees who may experience difficulties. This article focuses on trainees who have been on maternity or adoption leave and the recommendations may need future additions from a more diverse group.

Recommendations

1. The need for a more holistic approach to returning to training – in trusts and schools of emergency medicine
2. Ensure that the clinical supervisor is aware of the absence before their first meeting
3. Involvement of rota coordinators in ensuring a safe phased-return working pattern
4. Reminders regarding keeping in touch days
5. Trainer awareness of the psychological challenge of returning to emergency medicine
6. Mentoring support options
7. Dedicated one-to-one shop floor supervisor support during phased return
8. More regular clinical supervisor contact
9. Development of an internal trainee support network.

With these recommendations the authors hope that emergency medicine doctors will be able to successfully juggle their training needs with other significant external challenges during their return to training in the emergency department.

Developing specialty and associate specialist doctors in emergency medicine

Background

As pressure on emergency departments has increased so too has reliance on specialty and associate specialist (SAS) doctors. The term 'SAS doctor' includes a number of senior doctor job roles: associate specialist doctor, specialty doctor, staff grade doctor, clinical assistant, general medical practitioner and hospital practitioner among others. Associate specialists, specialty and staff grade doctors often work at consultant level.

This group has been described as the dependable backbone of the NHS medical workforce providing high quality safe care throughout the 24-hour period 7 days a week. This contribution has not always been valued or supported. The interim report of the Emergency Medicine Taskforce found many of these doctors were working unsocial hours, had job plans with little or no provision for continuous professional development and felt unsupported both within their department and in their organization. As a result, highly experienced doctors were leaving emergency medicine for areas like general practice which was seen to hold more opportunities for higher salaries and improved working hours.

NHS trusts began struggling to populate SAS rotas, particularly overnight and at weekends. This led to a vast expenditure on locum doctors of variable quality and/or very junior doctors being largely unsupervised in emergency departments, particularly overnight and for extended periods at weekends.

The Royal College of Emergency Medicine Forum for Associate Specialist and Staff Grade Doctors in Emergency Medicine identified the following factors leading to attrition:

- Non-sustainable rotas with high frequency of out of hours work
- Poor morale within the department or perceived lack of respect
- Poor working environment with high stress levels
- Poor pay and conditions
- A perceived inequality with higher specialty trainees.

In 2012, the General Medical Council found there was a lack of information about SAS doctors, that they had less access to support than other doctors and were less likely to have their practice formally assessed. Yet they are incredibly experienced

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KEY POINTS

- The changing population of emergency medicine trainees means that there are increasing numbers of trainees taking time out for medical, personal or parental reasons.
- Returning to work in emergency medicine after a period of absence presents challenges from clinical, leadership and communication perspectives: confidence in all these areas can be improved with appropriate focus, support and preparation.
- Valuing, developing and supporting specialty and associate specialist doctors is vital as we work towards a sustainable workforce in emergency medicine.
- Completion of training through the Certificate of Eligibility for Specialist Registration route is an increasingly popular means of entering the specialist register and should be supported by employing trusts.

and competent health-care professionals who deliver clinical services alongside consultants and other medical workers. They take part in the processes of revalidation, appraisal and job planning. The Emergency Medicine Taskforce claimed a clearer definition of a career pathway tailored to their needs, coupled with the opportunity to pursue the Certificate of Eligibility for Specialist Registration (CESR) route for those who wish to do so, would enhance the working lives of this important group.

Emergency medicine leading the way

It is fair to say that the specialty of emergency medicine has led the way in developing and supporting these individuals. Over 70 trusts now have emergency department-specific SAS doctor development programmes.

This has partly been driven by necessity in view of the much publicized workforce challenges and partly by the key role that SAS doctors have played in the specialty over the past 10–20 years.

There are four main areas that have been at the heart of this work:

1. Efforts to make staff feel valued
2. Support for all individual SAS doctors to progress along their chosen career trajectory (this may or may not include CESR)
3. The creation of a flexible, family-friendly rota and/or self rostering
4. Secondments or protected time out of emergency medicine.

These workforce developments do not operate in a vacuum nor do they come about organically. They are almost invariably clinically led. Strong clinical leadership is fundamental to ensuring any staff retention scheme can succeed. In many cases this is needed to challenge the status quo within an organization in order to establish new methods of practice.

Certificate of eligibility of specialist registration

For those SAS doctors who wish to become emergency medicine consultants then many trusts (often with Royal College of Emergency Medicine guidance) are now supporting individuals with their CESR applications. The CESR is a means by which doctors who have not completed an approved deanery training programme can be entered on the specialist register. It is a competency-based process where the trainee provides a portfolio of evidence that demonstrates that his/her training, qualifications and experience meet the requirements of the emergency medicine certificate of completion of training curriculum.

Successful completion of the CESR process results in entry onto the specialist register and the doctor will then be able to apply for emergency medicine consultant posts in the traditional way.

The process itself involves collation of a range of evidence covering the four domains as set out by the General Medical Council (2018). The evidence is then reviewed by the General Medical Council and the Royal College of Emergency Medicine CESR panel to ascertain whether there is sufficient evidence for entry onto the specialist register.

Conclusions

Workforce solutions in emergency medicine require creative thinking, innovation and a multi-dimensional approach if we are to sustainably match capacity to the ever-increasing demand. Two examples of this have been highlighted in this article. As never before we must strive to value individuals and work with them to ensure that clinicians continue to wish to pursue a career in this amazing specialty. **BJHM**

Conflict of interest: none.

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