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SUPPLEMENT

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Attention Europe! Doctors wanted for antisocial deployment. Moderate wages, long hours, miserable weather. Little recognition even in the event of success…

It was with little optimism that I boarded flight TP0329 to Lisbon on the hunt for the elusive emergency medicine middle grade doctor. A less than successful appointment 2 years earlier from Eastern Europe played heavily on my mind. My mood was considerably cheered, however, when I stepped onto the Portuguese tarmac to be greeted by clear blue late evening skies and a balmy 23°C—a far cry from a cold, damp and miserable September in Manchester. Why anyone would want to leave here for the damp and cold of the North West of England was beyond me. However, the two fully booked days of interviews that lay ahead proved that the demand was there.

How did I end up with two colleagues in Portugal one sunny Thursday evening?

THE PROBLEM

Emergency departments across the country are having the same difficulties—lurching from week to week looking for agency doctors to plug cavernous holes in the middle grade medical staffing tier. The dramatic escalation in emergency department attendances from 2003 onwards, combined with the increasing recognition that F2 and CT1/2 doctors cannot be left working without immediate middle grade support, has resulted in the need for emergency departments to provide 24/7 middle grade cover. Even with the most optimistic expectation of future consultant expansion, we are unlikely to be able to provide the eight or nine higher specialty trainees required in every emergency department. The shortfall is likely to be made up of 'specialty' doctors (SAS grade). It is not surprising, as the work intensity and proportion of antisocial hours increase and the pool of SAS doctors diminishes (modernising medical careers, changes in immigration rules) that an epidemic of middle grade gaps has spread throughout the country.

This epidemic reached our hospital around 2008 and has been building slowly since then. We have tried the usual remedies—improved terms and conditions for our remaining middle grades, agency locums, modest consultant expansion (08:00 to 24:00 cover 24/7). These measures have allowed us to maintain a safe service but have been at considerable expense, not just financially (employing long term agency locums) but also in terms of time and resources (constantly adjusting rotas and arranging last minute locums). We desperately need a stable middle grade tier, and standard recruitment within the UK is not working.

Given the difficulties with visa allocation for non-EU immigrants, we decided to focus our attention on Europe.

PREPARATION

To maximise our chances of getting good quality candidates and to make the process as smooth as possible, we opted to use an agency to advertise for candidates and arrange the logistics of the process. Our HR department and trust executive were fully committed and supportive of the initiative—no doubt in part fuelled by the cost of agency locums plus the ongoing risk associated with constantly covering shifts at the last minute. At initial preliminary meetings we discussed our needs (four doctors who would be able to rapidly move onto the middle grade tier of a UK emergency department) along with the proposed logistics.

We worked with HR and our medical imaging department to produce a 32 page colour booklet specifically tailored to international recruitment, covering the benefits of living in the UK and working for the NHS along with the specific attractions of our hospital, local area, amenities and teaching/mentoring offered.

From the offset we felt it important to stress the amount of mentoring and

educational support that would be offered to the new incumbents. All would be allocated an educational supervisor, be given a paper portfolio, and have access to study leave funding and equal opportunities for work based assessments (WBA) and level 1 ultrasound training. Their induction programme would cover the usual trust and department requirements for NHSLA but would also cover sessions on NHS infrastructure, how UK doctors are trained, etc. For the first week, the new starter would either be attending induction sessions or be supernumerary in the department, observing firsthand how we practice medicine here. We felt it important that they should have ample opportunity to ask questions, make notes, learn the terminology, etc, without the burden of having to make clinical decisions at the same time. Subsequently, they would work under direct supervision—presenting each of their patients and having WBAs—prior to moving to indirect supervision (like a standard middle grade) following a review of progress meeting with their educational supervisor.

THE TRIP

All hotels, flights and transfers were handled by the agency, as were the logistics on the ground regarding organising the candidates. Our team consisted of two emergency department consultants and the trust's senior medical staffing manager.

We arrived on Thursday evening and had 2 full days of interviews in a hotel next to the airport—four 1 hour interviews in the morning and four in the afternoon prior to flying back on Sunday morning. We were therefore interviewing from 09:30 to 18:30 in a hotel under the flight path, with sunset at 19:45 (there was definitely no opportunity for sunbathing!). Hence despite what our colleagues back home may have thought, this was definitely not a 'jolly'!

THE INTERVIEW

Our objective was to assess the candidate's language/interpersonal skills along with their medical knowledge. After the candidate gave us a brief overview of their career to date, we rapidly moved onto what was essentially a clinical viva, covering a representative range of clinical situations they would be expected to manage in a UK emergency department (see box 1).

The viva was, by necessity, fast paced and challenged the candidates to assimilate verbal and written English simultaneously and rapidly. It soon became clear that although many candidates had a good grasp of social English (already assessed by the agency), they struggled with rapid medical English.

The trip proved very successful. Despite not having a recognised specialty of emergency medicine, the candidates' clinical abilities across the range of questions was generally very good and on a par with UK ST3 trainees (we tested the viva prior to travelling out). They were clearly well used to working in busy challenging environments and seemed completely oblivious to the European Working Time directive! Not a single candidate had heard of it and none of their current working practices were compliant—it appears it is the British that like to follow the rules!

CURRENT SITUATION

One of the candidates has already started work, with the remaining due to join us in the New Year (we were able to appoint four with a further reserve list of two). The doctor who has started has already made a good impression and is currently in the second week of her induction process (seeing patients and presenting them) and will be shortly having her formal review to determine if she can move onto the middle grade tier.

In conclusion, this exercise has definitely overcome my fears of recruiting from Europe. There are keen enthusiastic doctors there who have the language, skills and ability to work in a standard busy UK emergency department. Using an agency made the process very easy for us. So, the next time you are recruiting middle grades and get applicants via NHS Jobs from Europe with no UK experience, do not just throw them in the bin—give them a rigorous clinical viva via Skype. You may be surprised by what you find!

Nick Laundy, Consultant in Emergency Medicine, Countess of Chester Hospital NHS Foundation Trust

Box 1

1. **Medical—collapse:**
   32-year-old woman, 'syncope'. Feels OK now. Wants to go home.
   a. Image - ECG = Mobitz II 2nd degree heart block
2. **Medical—ALS:**
   65-year-old man, collapses in the emergency department
   Image - ECG = VT (discuss pulse/pulseless)
3. **Trauma ATLS:**
   Motorcyclist thrown from bike
   a. Image - cspine peg fracture (discuss ATLS principles)
4. **Paeds sepsis:**
   1-year-old child with rash
   a. Image - meningococcal rash
5. **Minors:**
   26 year old man, fell playing Rugby.
   a. Image - Perilunate dislocation
6. **Psych:**
   15-year-old girl taken 40 co-codamol 12 hours ago
   (Discuss physical, psychological and child protection concerns)
7. **Communication role play:**
   Diagnosis of ♀ lung cancer.
   a. Image - Lung cancer

Pres Blog

It is the greatest of pleasures as president to address new fellows and members, as I did on the South Bank this December. Many parents attended, and some travelled many thousands of miles, making the day all the more poignant. It was humbling to meet the parents of Luka Randic a trainee in the NW who tragically died and whose memory is commemorated in the Luka Randic medal which I had the honour of bestowing for the first time upon Sarah Stibbards. His parents have suffered the greatest loss any parent can, and the college salutes them and is proud to honour their son.

It was great to award the FCEM to a doctor completing the Manchester MSc in emergency medicine. The scheme at Manchester Royal Infirmary was started in August 2008 as a reaction to the plight of non-training middle grades following MMC, and currently about 20 'senior emergency trainees' are employed across three sites. All are educated using the MSc in emergency medicine at Manchester Metropolitan University and are expected to progress through the examinations of the College. Congratulations to all who have initiated and supported this venture, which is also being developed in Portugal.

The College has been in its new home for almost a year and we have successfully transitioned from tenant to owner. This is a major milestone, achieved through the efforts of many. With ownership goes greater financial responsibility, and I would like to thank both the treasurer, Pete Goode, and the CEO, Gordon Miles, for navigating these difficult waters. Pete will retire from this post soon and the college is grateful for all his hard work and wishes him the very best.

The recent report of how future consultant remuneration, incentives, and clinical excellence and distinction award schemes may change will be of interest to many (see review body on doctors and dentists' remuneration, December 2012). Although at an early stage of the process, this document, describing the potential direction of travel, is recommended reading if you are to successfully plan for your financial future!

By the time this blog is published, the Francis report will have been released, and I am in the difficult position of predicting its precise contents. However, it will be an opportunity to reiterate those professional values that underlie best patient care and empower our fellows and members to adhere to them, knowing that they have the full support of the College. I also expect the report to powerfully confirm the need for trained emergency physicians in sufficient numbers to provide emergency care. The need for a properly funded and trained emergency care service has been argued for many years, and this report provides the catalyst to ensure this area is urgently prioritised.

The CPD event will be happening in Glasgow, 19–21 March, and will be of great value and is not to be missed—so visit the website for details asap and I hope to see you there!

Mike Clancy

Consultant appointments December 2012

The information for the consultant appointments is provided by the College and any errors should be notified to them and not the journal

Name	Hospital	Date appointed	Previous post
Raluca Ciornei	Wrighton, Wigan and Leigh NHS Foundation Trust	March 2012	
Malcolm McKenzie	Brighton and Sussex University Hospitals NHS Trust	September 2012	STR
Thomas Allen	Western Health and Social Care Trust	September 2012	Consultant
Campbell Brown	Western Health and Social Care Trust	September 2012	Consultant
Ian Crawford	Western Health and Social Care Trust	September 2012	Consultant
Manish Gaur	York Teaching Hospitals NHS Foundation Trust	November 2012	Locum consultant
David Wilson	Countess of Chester Hospital	October 2012	Consultant
Gillian Kelly	UCL Hospitals NHS Foundation Trust	October 2012	Consultant
Peggy Machin	UCL Hospitals NHS Foundation Trust	October 2012	Locum consultant
Rose Kogie-Henshall	Warrington and Halton Hospitals NHS Foundation Trust	December 2012	Consultant
Nina Maryanji	University Hospital Aintree	February 2012	STR
Nora Whitehurst Brennan	The Whittington Hospital NHS Trust	September 2012	SPR
Rebecca Whiticar	Oxford University Hospitals NHS Trust	September 2012	STR
Anthony Kehoe	Derriford Hospital	December 2012	Consultant
Stevan Bruijns	Derriford Hospital	December 2012	Consultant
Helen Yasmin Sultan	Cambridge University Hospitals NHS Foundation Trust	December 2012	Consultant
Claire Elaine Richards	Brighton & Sussex University Hospitals NHS Trust	December 2012	Consultant

Name	Hospital	Date appointed	Previous post
Peter Ahee	The Dudley Group NHS Foundation Trust	December 2012	Consultant
Tamsin Ribbons	Dorset County Hospital	December 2012	Locum Consultant
Spencer Cheung	Dorset County Hospital	December 2012	Locum Consultant
Seyed Jamal Mortazavi	Tabrizi Guy's and St. Thomas' NHS Foundation Trust	October 2012	STR
Brian Kennedy	Whipps Cross University Hospital	September 2012	Consultant
Victoria Cox	Calderdale & Huddersfield NHS Foundation Trust	December 2012	Consultant

Book review

The Casualty Officer's Handbook by Maurice Ellis

Maurice Ellis is revered as one of the founding fathers of emergency medicine, and this little book is a distillation of his wisdom and 10 years of teaching at Leeds General Infirmary. This slim volume, designed to slip into the white coat pocket, is the unpretentious forerunner of so many guides for worried junior doctors having to make difficult decisions under pressure. Ellis was known for his care and concern for the junior staff who worked under him. The book is beautifully written, well illustrated and, being first published in 1962, it is thoroughly obsolete. I have a copy of the first edition, found in a dusty pile of books left behind by my predecessor.

At that time there was clearly a need for a book of this sort. The preface states that it is designed..".... to help the newly appointed Casualty Officer, or the House Surgeon and House Physician who have to do duty irregularly in the casualty department. Such recently qualified men and women are often left alone with no senior available for advice....."

Looking through the pages it is striking how many changes there have been both in society and in the way medical care is delivered. There is a picture of the face of a stoker who suffered extensive blow back burns to the face, neck and hands. How many of those do we see today? A further photograph, taken 19 days later, shows full healing after application of burns paint as an outpatient. Tetanus is a particular concern in colliery accidents where pit ponies are employed.

And what changes in medical practice! Colles' fractures are all reduced in the department under general anaesthetic. Abscesses are incised in the department under general anaesthetic, and Ellis was particularly enthusiastic in the use of antibiotics, then still relatively new, in the treatment of abscesses. The treatment of metatarsal fractures requires a metatarsal bar to be nailed across the sole of the shoe. Routine use of ascorbic acid has been shown to significantly reduce infection rate in burns. Vigorous application of ethyl chloride spray to the skin over the pubis is both diagnostic and curative in renal colic ("much more effective than morphine").

Much of the book explains how to treat various orthopaedic injuries. There is a short chapter on the acute abdomen. The section on cardiac resuscitation suggests that this was perhaps not very often successful "... where ventricular fibrillation is likely to be present, ...a cardiac surgeon should be urgently summoned to carry out defibrillation".

What is surprising is that there is nothing at all on medical emergencies, apart from a couple of pages on poisoning (barbiturates, coal gas, poisonous plants). Surely even 50 years ago patients with asthma, heart failure, pneumonia or haematemesis must have called ambulances to come to hospital. No doubt many of these patients were successfully treated at home by their family doctors, but conditions such as hypoglycaemia and epilepsy must still have presented urgently to hospital. Clearly Ellis thought they were sufficiently rare or the treatment sufficiently well known by the most junior doctors that there was no need to include these conditions in his little book.

The book finishes with a medicolegal chapter. The junior doctor "is often summoned to give medical evidence in a court of law. This duty cannot be avoided". The advice given is crisp, simple and sensible.

This textbook is definitely not recommended for examination candidates, and quoting from it in MCEM or FCEM could be most unwise. However, if you can find a copy in your department or hospital library it is worth leafing through for its clear straightforward prose and to reflect on how far our specialty has come since its early days.

Supplement editors

This supplement is edited by Mike Beckett (West Middlesex Hospital), Diana Hulbert (University Hospital Southampton) and Lisa Somers (Barts Health NHS Trust). To contact the editors, please email: emjeditorial@bmjgroup.com