Intended for healthcare professionals

Careers

Emergency medicine is in a spiral of deskilling, trainees warn

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Emergency medicine trainees have warned that they risk becoming deskilled because they are carrying out fewer procedures than their predecessors.

The Emergency Medicine Trainees' Association and the BMA held a meeting on 25 July to identify ways of improving trainees' working lives. Among the issues discussed at the event were concerns that emergency medicine doctors were becoming deskilled because they were relied on to triage rather than treat patients.

Sarah Payne, a year 5 specialty trainee (ST5) in emergency medicine, said, "A big problem we have is that you get these skills as a fairly junior trainee, but you then go to departments where you cannot practise them as higher trainees. When you become a consultant you have lost confidence in yourself. You then can't supervise your juniors to perform them, and it just becomes a self fulfilling cycle."

She added, "Unless we have consultants standing up saying, 'We can do this, I can do this, and I can support my trainees to learn how to do this,' then it's never going to happen. I work in a very good department, and we are very good at lots of trauma procedures. But all airways work is done by anaesthetists, because that's how it's always been done and because the consultants don't feel that they can support trainees to do it."

Other attendees at the meeting said that concerns about becoming deskilled were among the reasons why trainees moved from emergency medicine to other specialties, such as intensive care.

Kevin Reynard, dean of the College of Emergency Medicine, said that he "decried" the loss of the skills needed to do many practical procedures that had been performed routinely in the past. "We need to turn the clock back in that regard," he said.

He added, "When I saw a senior house officer in accident and emergency I was doing RSI [rapid sequence intubation] in the emergency department. As a higher trainee I wouldn't refer anyone to the ITU [intensive

treatment unit] unless they were ready to be wheeled up and ready to be plugged into the monitors upstairs. That's just what you did, and I think it's really sad that we've moved so far away from that."

However, Reynard acknowledged that this loss of practical skills was not occurring in all emergency departments. "Some departments are really good at doing those sorts of things," he said. "The disappointing thing is that we have so many consultants who are so young—in the first five years of their career—and yet they are accepting this approach as being more of a signposting-type service. It's in our power to do things differently."

Katie Archer, president of the Emergency Medicine Trainees' Association, said that consultants often call on a doctor from another department to carry out a procedure that could have been carried out by an emergency medicine trainee. She said that the association could help trainees to address this issue, as it was challenging for trainees to change such practices. "It's scary, going up to your boss and saying, 'Actually I can sedate this patient. You don't need to call the anaesthetist down, it's ridiculous; it will take me five minutes, when it will take them half an hour to come down,'" she said.

The trainees attending the meeting also discussed issues created by rota arrangements in emergency medicine. Tom Boon, an ST5 in emergency medicine, said that one of the key issues for rotas was that they needed to include protected time. "One of the things that would improve emergency medicine training would be an understanding that all rotas for higher specialist trainees should incorporate protected academic and personal development time," he said.

Tim Yates, deputy chair of the BMA Junior Doctors Committee, argued that employers should treat trainees as professionals when they planned their rotas. "They can't say, 'You're going to work this four hour block on a Tuesday, and then you're going to be on at 3 am the next day,'" he said. "That is not acceptable, unless it is acceptable to you as a professional—and I think in the majority of cases it isn't going to be acceptable. So we need the trust, our employers—the people who write the rotas—to respect us as professionals. And if we go to them and say, 'This is not an acceptable approach to rostering,' then that has to change."

Should we introduce trainees and medical students to the idea of uncertainty earlier in their careers?

- Yes
- No

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