



Emergency Medicine: the evidence that actually decides applications

Built from the GMC Emergency Medicine SSG and RCEM guidance. Confirm current figures on the live SSG.

THE ALLIED SPECIALTIES (THE MOST COMMON CAUSE OF FAILURE)

- Anaesthetics, at least 3 months WTE**
A dedicated placement with logbook, airway and procedural evidence, reflections and assessments. Resus-room intubation alone is not enough.
- Intensive Care Medicine, at least 3 months WTE**
A dedicated placement with reflective cases, transfer competence, resuscitation and consultant-observed assessment.
- Acute Medicine, a period is desirable**
May be achieved in the Emergency Department if the role carries enough of the acute medical take. Make it explicit in the evidence.
- Paediatric Emergency Medicine, recommended**
Real paediatric exposure covering child protection, paediatric medicine, trauma, mental health and community awareness.

THE EVIDENCE SPINE (EMERGENCY MEDICINE SSG)

- ESLEs: at least 6 over 3 years, 3 in the last 12 months**
Extended Supervised Learning Events. Consultant-observed shifts capturing floor leadership, supervision, flow, risk and disposition.
- Reflective cases: 50 per year, 150 in total**
Across Emergency Medicine and Acute Medicine, including a proportionate number of paediatric cases. Track paediatric cases separately.
- WPBAs across the 12 SLOs**
Mini-CEX, case-based discussion, DOPS and ACAT spread across adult and paediatric major and acute presentations.
- FRCEM and in-date ALS, ATLS and APLS**
Fellowship is close to essential. Out-of-date life support courses are a frequent and avoidable reason for shortfall.



Mapping, referees and a 90-day plan

GOVERNANCE, RECENCY AND REFEREES

- A completed audit cycle that closes the loop**
Evidenced by reports, slides, publications or guidelines produced as a result. A missing loop is a frequent reason applications are sent back.
- Recent evidence: 5 to 6 years**
Primary evidence expected within five years of submission; the SSG gives precedence to skills and experience from the last six years.
- Four structured-report referees**
At least two should have completed an ESLE with you in the last 12 months. Brief them early and give them your CV.
- Map every piece to an SLO**
Evidence is structured against the 12 Emergency Medicine SLOs plus 2 ACCS outcomes. Upload to the matching section of the application.

90-DAY EVIDENCE PLAN

- Days 1 to 14: map against the live SSG**
Download the current SSG, email the RCEM CESR team (cesr@rcem.ac.uk), and audit your evidence against the 12 SLOs and the allied components.
- Days 15 to 30: confront the allied gap**
Decide how you will evidence Anaesthetics and Intensive Care Medicine. If your post cannot deliver it, plan a placement or a move now.
- Days 31 to 60: start the rhythm**
Begin fortnightly reflections, book your first ESLEs, plan WPBAs across the SLOs, and check ALS, ATLS, APLS dates and FRCEM progress.
- Days 61 to 90: brief your referees**
Identify four referees, ensure at least two will complete a recent ESLE with you, and start or close an audit cycle.

Is your post producing this evidence?

BDI Consultants places senior doctors into Emergency Departments that support Portfolio Pathway development: unselected case mix, a paediatric stream, access to Anaesthetics and ICM, and consultants who observe and report.