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Alastair McGowan—the thinking man's A&E consultant?

Alastair McGowan takes over the presidency of the Faculty in November. We asked him about his background and his plans for the future.

Tell us how you came into emergency medicine

I come from a family farming background on the west coast of Scotland and really wanted to be a farmer. Since that wasn't a realistic option I went in to medicine. I trained in Edinburgh, and at first set out to be an anaesthetist. I most enjoyed working in the resuscitation room so I asked Keith Little, who had just been appointed as a consultant in Edinburgh, how to get to be an A&E consultant like he was. He told me to do a medical rotation and get the MRCP, and when I'd done that he gave me a registrar job. This was in 1983. In 1984 he advised me to go for the next senior registrar job that came up, and that happened to be in Leeds. I've been in Yorkshire ever since. I was initially appointed as a consultant in Wakefield in 1986. I stayed there until a job came up in St James's in 1992.

How do you manage your clinical sessions at St James's?

We have five consultants, 4.4 whole time equivalents. Each of us takes one late shift a week, so our clinical shifts would be 8 am to 3 pm, or 2 pm till 9 pm and then on call. Then at weekends we work 9 am till 3 pm both days and then on call. That's what it says on paper, but I can't remember ever getting away on time from any shift.

What will be your aims during your tenure as President?

The first one has got to be working with the Association in unravelling the implications of *Reforming Emergency Care*. The potential here is just huge. There can be no doubt about how seriously the government are taking this issue, nor the scale of changes envisaged. This will be a new era for emergency medicine. Skillmix, manpower, and training issues as well as our relationship with primary care and other specialties, especially acute medicine, are central. At the minute we seem to be looked upon reasonably favourably by the Department of Health.

The second is that we need to continue to attract extremely bright young people into the specialty, and give them the kind of medicine that is challenging, exciting, and rewarding. To that aim there are two interfaces that we need to strengthen, one with acute medicine, the other with anaesthesia and critical care. I think with the long awaited paper about SHO reforms, we might be able to seize an opportunity to develop a common basic professional training in general medicine, emergency medicine, anaesthesia, and intensive care.

What do you think of a merger of the Faculty and the Association?

I think there is a wide consensus for a merger of function between the two. This does not necessarily mean the Association should cease to exist. The Faculty is a charity, and I understand that if we should get a Royal Charter this specifically prevents us from acting as a lobbying group for our practitioners—in theory it would exist purely for the benefit of patients. So there may be a role for the Association to continue, although as a smaller body than it currently is. We need more focused and detailed talks with the Association. I think this is a matter we should explore soon as I don't think the uncertainty has been good for the Fellowship and Membership. We should also explore working more closely with other organisations. We are currently discussing our future developments with several of our parent colleges but with especial attention on the Royal College of Anaesthetists and the Royal College of Physicians.

Perhaps our future would be better served, and indeed so might be our patients, by a Royal College of Emergency Care embracing other professional groups, not just doctors. This might include paramedics, nurses, and other professions allied to medicine. I think our best future is even beyond that. Many people think the country has too many Royal Colleges. Patients and the profession might be better served by groupings of colleges that have commonality of interest and function.

Where do you think emergency medicine would fit in such a grouping?

I genuinely believe that we have an increasing overlap with critical care and acute medicine. I think the thrust of *Reforming Emergency Care* will tend to focus us towards the upper pole of acuity of unscheduled care. We, of course,

have a very important role in the management of minor injuries. Parts of that role may change but neither the workload nor our overall contribution will diminish. I don't think it is set to grow significantly, however. I think our role in acute medicine might.

I should say here that one of my worries about coming to the role of President is that, given my background in medicine and anaesthesia, my perspective on the specialty might be thought to be different from colleagues who have come in to this work from a surgical background. From many discussions with many colleagues I don't think it is. I would want Fellows and Members to be reassured that having spent 19 years in a hands-on clinical role in emergency medicine I do have a realistic view of the range of work that we undertake. I also think I have a realistic view of some of the political and service pressures that we are likely to face.

Tell us about your work in the postgraduate deanery.
Alongside emergency medicine, my big professional interest is in medical education, specifically in assessment, so I was lucky to be appointed Postgraduate Clinical Tutor when I came to St James's. There were huge changes coming through with Calmanisation, with lots of development opportunities. After this I was appointed Assistant Postgraduate Dean. In both of these roles I learned an enormous amount about implementing often unpopular changes with large numbers of consultants of varying specialties, each with their own agenda. I feel confident that as a result of that experience I would now be better at herding cats than I was before.

I have moved away from the deanery now to make time for the role as President, but I have no intention of losing my interest in education.

What is your recipe for happy, fulfilled trainees?
I think trainees should feel that they are led by role model clinicians, and I have throughout tried hard to spend my quota of time on the shop floor dealing with cases as they come in and leading from the front. Trainees also need to be allowed to practise challenging, exciting, and demanding medicine. We have to give them the scope to do that. You then have to give them the type of medicine to practise they will enjoy, and give them scope to extend and develop their own practice in the future.

And how are we to engage the large force of "non-consultant career grades"?
Without them the provision of A&E care in this country would cease tomorrow. They constitute a group of doctors who need to see that they have career development opportunities just as much as registrars. They too must feel that they are working alongside colleagues who are providing credible leadership and providing them with challenging medicine to practise. There is a lot of debate as to how they might interface in future within a new band of non-consultant professionals that I think the government are seeking to produce.

And what are your faults?
Well, I am not a good completer/finisher, especially of tasks that I am not really motivated about. Colleagues should be reassured though that I am extremely motivated about most of the work I see looming in front of me. I also have an excellent team of officers, many of whom have skills that will make up for any deficiencies I may have.

Are you good at picking battles?
I have made some stunning errors but I have learnt a lot.

What do you do to relax?
I have a wonderful family who keep me sane. I'm interested in antiquarian books and hillwalking. I have bought a house in the far west of Scotland near where I grew up. This is my retirement plan. There are 26 houses and a pub!

News from BAETA

The Annual BAETA Conference was held in Bristol in September, and was again well attended with delegates from all over the country. A programme combining education, updates on current issues, and a stunning social diary contributed towards making it well worth the trip, and I'm sure I can speak for all when I congratulate the organising committee for doing a grand job. Several items that will have a direct impact on our future working lives were discussed, including the proposed consultant contract and the unfinished business document regarding proposed changes to the SHO grade. More information can be found on the BAETA web site. On that note, many thanks to Steve Barden who has redeveloped the BAETA web site, which should prove to be another useful resource in our quest to get information out to trainees around the country. Check it out at www.baeta.co.uk, and let us know if you have any suggestions about what should be on it or how it could be improved.

Clinical topic reviews
We are all going to have to cross the CTR bridge at some point, and we are attempting to create a resource of previous CTRs to help those starting their topic reviews to get an idea of what they are all about. If you wouldn't mind your CTRs being used in this way, please send them by email to Steve Barden who will post them on the web site.

Coming meetings
A reminder that the Annual Scientific Meeting of the Faculty is being held in Plymouth on 21–23 November 2002. There will be a BAETA business meeting at 1500–1600 hours on Thursday 21 November, so get yourselves along to catch up on the news. Next year's BAETA Conference is in Stirling, provisionally 24–26 September. Further details will be available on the BAETA web site.

Finally, congratulations to Simon Walsh, who was elected as the new trainee representative to the CCSC, and to Steve Jones, who was elected as my successor to the post of President. I will still be around to work together with Steve and ensure a smooth transition for the first few months; I'm sure Steve will do a great job and I wish him all the best. Thanks to you all for the support I've received during my term in office.

JASON SMITH
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Coming soon.....

In the next issue of the *EMJ Supplement* there will be an interview with Professor Sir George Alberti, the newly appointed Emergency Tsar, whose brief is to "SORT OUT THE PROBLEMS".

Mergers, reconfigurations, and how to survive them

Think it doesn't apply to you? Read on.

Many of us in the accident and emergency (A&E) world are being subjected to mergers and reconfigurations. Sometimes they are ostensibly driven on a quality agenda with the declared aim of improving patient care. If so, A&E staff may find themselves supporting and even driving the process. Sadly more often the driving forces seem to be money, junior doctors' hours or, even empire building. Certainly some physicians push for mergers with the honestly stated aim of being able to step down from the general medical take and just practice their subspecialty.

This little essay is from a battle hardened warrior hoping that my experience will enable others to prepare for what is coming to many.

Trust mergers have yet to be shown to save money despite the commonsense expectation that there will be economies of scale. In the NHS at least any savings seem to be offset by the increased inefficiency of a larger organisation, often over several sites.

Junior doctors' hours are being driven inexorably downwards and this will continue for some years. Each merger seems to be accompanied in a flurry of appointments of various non-career grade doctors, staff grades, then Trust grades and now clinical fellows. It seems inevitable that mergers as a means of tackling junior doctors' hours problems will only be Bandaids that will address this year's problem and fail to address next year's or the year afterwards. This article is too short to comprehensively discuss the implications for A&E and general medicine as the SHO career structure changes to further diminish their service commitment, but mergers do not seem to help. There is a little hope ahead for those of us dependent upon SHOs to provide a service: Professor Sir George Alberti, the newly appointed emergency care tsar, has described their service commitment as "experiential training".

And what about quality? Quality for whom one might inquire? As further and further reconfiguration occurs after merger for convenience, the services available on one of the merged sites steadily diminish. More and more patients are shunted between sites for specific investigations or treatments. When specialised equipment is only available on one site then such movements may be deemed necessary, although whether it is cheaper to move patients than provide the equipment on both sites may be a moot point. Fortunately it comes out of a different budget so the financial impact may be invisible.

So how do you know it is coming?

Apart from mutterings in corridors the first formal marker is a meeting about "emergency care". This will consist of a workshop facilitated by somebody from an academic department of health economics.

The participants, depending on the size of the Trust, will be roughly 50 people of whom 47 are non-clinical from the acute Trust and from the Community Trust. The other three people will be clinicians. Usually one A&E consultant or perhaps a senior nurse from A&E. The other two will be senior consultants in medicine and surgery. Both of these people will know all about how care is provided to emergency patients because they did casualty officer jobs 20 to 30 years ago.

This meeting will be encouraged to dissect A&E medicine into its component parts. Groups will then be asked who else could provide this service if it was not provided in A&E. In the current climate there will be a particular emphasis on "intermediate care". Any protests from the A&E consultant that intermediate care, access to nursing homes, minor injuries units, district nurses, social services, and so on is not currently available 24 hours a day 365 days a year will be dismissed. The comment will be along the lines of, "We are not looking at what can be done at the moment but what could be done in the future with restructuring". The A&E consultant will be heard vainly muttering that social services are not interested in 24 hour service and that district nurses went into the job because they like the hours, but will be ignored.

Once that meeting has produced its strategy document with a title along the lines of, "A grand picture for the future" it is down hill all the way.

There will now be openly enthusiastic formal meetings and corridor meetings between clinicians about the opportunity of working in a larger unit. Visits will be made to beacon sites where a variation of what is hoped for has apparently been made to work. The health authority will host meetings of managers from all the sites involved. They will launch a grand Intermediate Care Strategy. This strategy will keep several management consultancies in Ferraris for years, consume huge quantities of senior managerial and clinical time, and will result in, perhaps, one patient who would otherwise have been admitted each day going somewhere else. This somewhere else will be staffed by nurses, occupational therapists, and physios most of whom have been recruited from the already depleted Acute Trust staff.

After many meetings the time will come to decide on the name for the new Trust. This is when you know what has really happened because there is no such thing as a merger. It is a takeover by one Trust of another. How do you know if you have been taken over? Your hospital will be the first name of the new Trust. If it is the Moscow and St Petersburg Trust then Moscow has been taken over. The new senior management will largely be appointed from St Petersburg, with a couple of token appointments from Moscow. The management offices will move to St Petersburg. It will be virtually impossible for anybody from the old Moscow Trust to gain access to senior managers of the new Trust unless they make an appointment two weeks in advance and take half a day off so that they can travel there. Of course any claims of favouritism when it comes to capital bids, staffing requests, etc, will be vehemently denied. There will be grand statements about transparent even-handedness. But we all know that if you can happen to meet the chief executive in the cafeteria you will be better looked upon than Dr Ponsonby-Smyth from "the other site".

Having decided to go ahead with the merger then there is the exciting period of public consultation. The local press, and if you are really lucky the national tabloids, will always find members of the public and/or the medical profession who will speak vehemently for or against the proposed merger. The public consultation is really a smokescreen. It permits the most vociferous to have their say but does not actually affect anything. It gives people the chance to get petitions together. There may be protest marches or candlelit vigils. There will certainly be furious exchanges in the letters pages of the local papers. Some hapless consultant will be persuaded to stand on the platform at these meetings and explain either how wonderful or how unavoidable it is. For years afterwards they walk, heads bowed, along the corridors muttering to themselves, and any body else who will listen, "I should never have let myself be talked into it".

Inevitably there will be enmity between the consultant bodies. The specialist in hallux nail transplants will declare that he cannot work with his opposite number because he is too radical/ conservative/impossible to get on with. At worst there will be quiet asides to colleagues, "I don't know how she has got away with treating patients like that for so long". If the Trusts were in competition with each other in the happy days of the free market and money following the patient then this animosity will be all the greater.

How to survive

Do not get involved in the fighting. You will almost certainly have to work together in the future. The public consultation has no influence. If the local people support it all well and good, if they do not then the Secretary of State will overrule the populace unless he or she is pursuing some other political agenda. If the majority of your population base actually vote for the party not currently in power then there will be no chance of effective political questioning of the decisions being made.

The first and most vital step is to get on friendly terms with your opposite numbers. This is a shotgun wedding. You do not have to be in love to get married but for the relationship to survive you hope that love will develop.

No matter what you heard about them during the free market years they are likely to be good people. They too are A&E consultants who want to provide quality care for their patients. They have the same frustrations that you do whether it is beds, the unavailability of the medical registrar, the stroppy orthopod, the ineffective bed manager or whatever. There is more in common between us than things that divide us in the A&E world.

Start to discuss how you are going to work together. Will both departments survive or will one close or become a minor injuries unit? By working together we not only make our own experience better but also make it better for those around us. The nurses for years will have said that the Moscow Royal Infirmary has always dumped the patients they don't want on St Petersburg or the Moscow nurses will say that St Petersburg General Hospital has always fiddled their Sitreps. If we, as consultants are talking to each other and presenting our opposite numbers as good people the whole process will happen more smoothly.

And when it finally happens try to get the teams, as a minimum, to socialise with each other—the Christmas do, the booze cruise, the summer party. They will then discover that, in contrast with expectations, they people from the other site(s) do not have two heads, they are human beings who share the same excitement and frustrations in emergency medicine.

What of the future?

More of the same. Professor Sir George Alberti made it clear in his presentation in Leeds on the 17 September 2002 that he thinks there are too many acute hospitals. If we want to work towards 24 hour working by everybody who helps to diagnose or treat emergency patients then some of the acute hospitals have to close. It is impossible to provide 24 hour cover by radiologists, pharmacists, or even A&E consultants on the existing number of sites.

The light at the end of the tunnel holds out some hope but, as Alastair McGowan said in Leeds, it is more likely to be the 12.47 from Cleethorpes.

You are highly likely to be merged and reconfigured and not just once.

ANON

Round up of "Forum" news from FASSGEM

This news sheet should arrive with you in the week preceding our annual conference in Portsmouth (12–15 November). Obviously we hope that you have already booked your place for this, if not then a few late booking slots are available on a "first come first served" basis (Contact Carolyn Hargreaves chargreaves@doctors.org.uk).

Following the conference a review of the proceedings and the minutes of the FASSGEM AGM (15 November) will be posted on the BAEM web site.

Pay for NCCG doctors in emergency departments remains a thorny issue, although the Department of Health recognises the problem and is indeed supportive of the urgent need to review NCCG working conditions and remuneration; it is inevitable that this will not take place until the consultant contract has been finalised and agreed.

During the FASSGEM conference we are privileged to be welcoming the Hon David Lammy (Minister for Health) to talk to us on "Reforming emergency care—the NCCG role".

Another challenge for the future which threatens to be upon us before we have the present "sorted" is the proposal to reform SHO training. The Department of Health document *Unfinished Business* contains full details of the outlined proposals for change. The implications are obvious for NCCGs and although it is a threat it is also a great opportunity for us to get things right along the lines of the single spine structure.

ANDREW NEWTON
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Briefing on BMA and CCSC matters.....

As a result of the much publicised changes in BMA committee structures NCCGs now have their own craft committee (which is in the process of formation at the current time).

As a result of overwhelming support in a questionnaire circulated last year it is anticipated that this committee will be developing proposals for a single spine structure for NCCG posts.

A development meeting was held on 25 September 2002. The proposed craft committee structure will be based wholly upon regional representation rather than proportional representation or specialty based representation.

Although proposals have been made to amend the European specialist medical qualifications order to enhance entry into SpR and consultants posts, to date the combined Royal Colleges have denied knowledge of this. Mohib Khan (Chair of BMA NCCG Committee) has requested a meeting with representatives from the combined Royal Colleges to explore this issue further.

Although NCCG salaries have not been included in the DDRB pay review, an external working group is being established and will utilise the supportive PWC survey conducted last year to negotiate further on this.

The CCSC A&E subcommittee have met on two occasions this year and although concerns were expressed about non-standard trust posts, the subcommittee were fully supportive of the FASSGEM policy document. They were also supportive of the SHO modernisation proposals; however, issues were raised on the impact on NCCG numbers and career progression as a consequence.

MENG AW-YONG
FASSGEM CCSC Representative