An interview with Professor Sir George Alberti

After training at Oxford Professor Alberti had a very successful career as Professor of Chemical Pathology at Southampton and later Professor of Medicine at Newcastle. He made many contributions to our understanding of diabetes and management of diabetic ketoacidosis. He was a most effective President of the Royal College of Physicians of London. At the time of life when many people are settling into retirement, he was asked by the Department of Health to take on the job of Emergency Services Czar. Many will have heard his talk to the Faculty annual meeting at Plymouth in November, and may feel encouraged that the Department of Health has recruited such a senior and well respected figure to this post. We talked to him about how he will approach the job.

Why were you asked to take on this role, and how long is it for?
When I started at the College I found that there were lots of specialist societies but no-one was looking after general medicine. So we continued and indeed strengthened our involvement in that. I felt sure we should be creating more acute physicians and through that work I was involved in Reforming Emergency Care. I think it’s a disgrace, the poor attention that successive governments have given to acute care, with so many important things to be done. Obviously ministers had to approve, but I was asked through Nigel Crisp to do the job. I have a one year contract like some of the other Czars. I could be kicked out in the next three weeks, or it might go on; I would anticipate for possibly two or three years.

And what are the scope and aims of the job?
Emergency care is now a number one priority with the government and needs sorting out. My own job is extremely woolly as to what it is, which I like because I can make of it what I want. What I think ministers see me doing is talking to the professions, discussing with medical and nursing colleagues and getting their input, which is terribly important, but also getting them on board for the need for change which I think is absolutely critical. They have the view, which may or may not be correct, that it is easier for me to talk to colleagues than our managerial branch, and we will get further that way.

Were you surprised that they didn’t ask someone with more background in emergency medicine?
I would contest that my roots are not in emergency medicine. As Professor of Medicine I did an acute take, one in seven for nine years. I am familiar with a lot of the problems, and have been pushing very hard that this is a whole system problem. I have also spent a lot of time with the present government working on skill mix, and also a lot of time trying to break down primary/secondary barriers. I certainly see the problems. Obviously the emergency physicians have to have the confidence that I am not “doing them down” or misunderstanding the problems. You will recall there was a report from the College on the interface between A&E and acute medicine: there are a whole series of areas where we have already worked together. I feel very comfortable working with some of the very good people we have in emergency medicine.

Do you think that there might be a carving up of what emergency departments do, minor injuries streamed off to be seen by GPs or ENPs, critical care seen by ITU type people, and medicine seen by acute physicians?
I think that’s a paranoid view. That’s the antithesis of the way I see it shaping up. I see that there will be one section of the hospital that is the acute care section. That means very good running and coordinating and I see emergency medicine specialists being the group who will actually coordinate, run, and make sure all the bits are working. I see the role of the emergency physician as growing rather than shrinking. I see much closer integration of acute medicine with emergency medicine in the longer term. I would see a joint operation looking after a medical admissions unit or whatever it’s going to be called, but I don’t see the acute physicians as taking over medicine in the emergency room.
Do you worry that you might be dispensable if you give the government a message they don’t like?

Not the slightest. I actually don’t give a damn. To me its much more important that the messages I give are honest ones based on what I’ve seen, heard, and thought because otherwise I would lose credibility. I am there to be honest. I am there to say things that it is awkward for conventional civil servants to say, and it is known that I say what I think. I know John Heyworth, Ian Anderson and Alastair McGowan say what they think, but they are perceived to have an axe to grind. It is useful that I don’t fit conventionally into any of the bits of the jigsaw, because I can and do stand outside a little.

What would you see as your three main challenges in this job, if you had to choose just three of many?

Number one is to make all 199 emergency departments get on board with new systems of working. Everyone focuses on the few very good or bad ones. We need to work with the other 150 in the middle as well. I can understand people sometimes don’t particularly want to change. Change is hard, but I find it exciting if it’s for the better. What we are trying to do is get a system that works.

The second big challenge is to keep the professionals going while we get more professionals on board. I know it can be fantastically hard, stressful work, and I’m serious about trying to get that bit of the equation right.

I think the third big challenge is getting all the bits together, particularly the ambulance services as part of the whole, rather than a totally separate entity. It is all about getting the right person in the right place at the right time.

How do you approach problems: how would you describe your managerial style?

My managerial style is to try and enthuse people because I think it’s exciting, and because at the end of it all we can provide a better service. At the centre of all this is the patient, not the hospital or primary care trust. There’s someone who is sick, or perceives that they are sick and is worried, and if we can keep everyone’s mind on that I think we’ll do well.

Are you still involved with metabolic medicine?

Yes, at the weekend I’m off to Belgium for the International Diabetes Federation, and I still have a research group in Newcastle, as well as now being in the Metabolic Medicine Group at St Mary’s Hospital.

What does your wife think of your new job?

She thinks there’s a need for this job and I’d bloody well better make it work.

Do you get time to relax?

I hill walk. I jog now and again. I go to the opera when I can, and every night in bed I read detective books.
Department of Health that additional resources will be needed to implement the strategy on a consistent and sustainable basis. The guidance is quite clear—departments are encouraged to set up the system in a limited capacity with current resources in order to identify the additional numbers of doctors, nurses, and other professionals required to set up the system to meet local demand. This will vary depending on the total number of new patient attendances and the local casemix.

One model might be a team comprising a senior doctor working with an experienced nurse, supported by an assistant responsible for dressings and other time consuming practicalities. This would allow the clinicians to interact and minimise delays.

Arrangements must be in place to deal with those patients for whom See and Treat will not be appropriate, for example complex wound management. Separate arrangements will be made for these patients, although many of the benefits of the See and Treat concept will still accrue.

- The emergency services collaborative is now under way and all departments will be involved within the next few weeks. This is concentrating on four areas of activity—See and Treat, CDU/observation areas, medical admissions, and surgical admissions. Funding is available for a project manager and data coordinator to assist with the initiative but there is no additional funding for permanent staff and no capital.

The collaborative represents a good opportunity to provide focus for the Reforming Emergency Care initiatives and ensure that change in practice actually occurs, not just in our departments but throughout the emergency care system.

- The new SITREPs are imminent. These will be available on the Department of Health website at http://www.doh.gov.uk, although not completely fudge free, these provide far more reasonable and detailed definitions of what (and importantly what does not) constitute admission. This will provide a realistic picture of the current state of play in our departments and allow those involved to target problem areas. As ever, if you are aware of misuse of these definitions, please do let me know.

- Our meetings with David Lammy, the Department of Health, and Professor Sir George Alberti continue. There is positive and constructive dialogue. I hope very much that the tangible outcomes will be delivered soon.

- An area of particular concern is the implications of the forthcoming new GP contract and how emergency cover will be provided in primary care, particularly out of hours. Our concerns have been represented to the Minister and Sir George Alberti. Although there is agreement that local primary care trusts have an obligation to ensure that arrangements are in place to provide out-of-hours emergency primary care, there is concern that a mass departure by GPs from their emergency care provision will leave such facilities unstaffed with profound implications for our departments.

I would urge all colleagues to establish dialogue as soon as possible with their local primary care trusts to establish the current state of play and discuss proposals for the future. One model is for the out-of-hour primary care facility to be co-located with the emergency department, although other areas may elect to establish satellite primary care facilities, with perhaps telemedicine or other links to the local emergency department.

JOHN HEYWORTH

News from BAETA

The last few EMJ BAETA updates and EMTEL messages have frequently mentioned the www.baeta.co.uk website. This is because we want to develop the site into the primary point of contact for information and resources for all emergency medicine trainees in the UK. Both the BAETA updates and EMTEL have been a very useful resource for us but there has been a (necessary) amount of duplication. They will both continue to be published regularly but the focus of each will change.

Future EMTEL messages will concentrate on the “bigger picture”. They will contain information about what meetings your trainee representatives have attended and what of importance was said at them—for example, changes in Faculty or examination procedures, consultant contract negotiations, subconsultants, and training and education issues. The EMTEL messages will come out via email every couple of months as before. If you are a trainee and want to be put onto the database then contact me.

The EMJ supplements are published with every issue of the EMJ so you only receive them if you subscribe to the journal or have access to a paper journal by another method. Also, as the articles are written with a two month lead time, it is difficult for it to contain current issues. These two factors mean that we will be changing the focus of the BAETA update to concentrate on the announcement of courses (for example, FFAEM revision, critical appraisal courses, etc.), conferences, and educational opportunities that are important for us, as trainees, to attend.

The website will include all the BAETA update and most of the EMTEL information and will continue to be developed as you wish. There will be information about committee members, who they are, and what they do for you. We are also developing a CTR database and hope in the future to develop more of a “FFAEM—how to do it” resource. Most of this can only come from you feeding back and providing information to us. We can help each other in this and that is what BAETA is about—trainees in emergency medicine.

This is my first attempt at writing the BAETA update since being elected as successor to Jason Smith. I hope the style and changes don’t upset anyone too much. Given what I have said, it would be remiss of me not to mention the BAETA 2003 conference, which is being held in Stirling on 8–10 October 2003. Further details will be available on the BAETA website, however if you are really keen contact Libby.Mcg@tesco.net.

I would like to thank Jason and all the other committee members for their support, in particular Steve Barden who is doing most of the web development. I hope I can continue their hard work and that this will allow BAETA to continue to prosper. Should you have any comments please do not hesitate to contact me.

STEVE JONES
President of BAETA;
steve.r.jones@bigfoot.com

www.emjonline.com
Round up of forum news from FASSGEM

The FASSGEM conference in Portsmouth was an unqualified success, with over 80 delegates enjoying a high class and varied academic programme as well as two very enjoyable and social evenings (including a formal dinner on board HMS Warrior). On the final day of the conference the FASSGEM AGM was held and I would like to take this opportunity to publish an abridged version of my report to that meeting.

“At the current time the medical profession within this country is facing a time of uncertainty and our specialty of accident and emergency medicine is facing a number of significant challenges and far reaching changes as a result of Reforming Emergency Care and the proposed restructuring of SHO training (unfinished business).

Notwithstanding all of the uncertainty and challenges, which abound at the current time, I feel that as a group FASSGEM can be pleased about the progress that we have made over the past year. I would like to highlight some of the positives with regard to FASSGEM:

- Membership—Our membership has grown considerably over the past couple of years and is continuing to expand. We have a regional structure of representatives with the vast majority of regions having their own elected representative to attend meetings and to act as a conduit for information back to their local membership. Through the newsletter and also the Emergency Medicine Journal insert I believe that our membership is kept well informed about the issues of the moment.

- Policy document on non-consultant career grades—The policy document on non-consultant career grade staff in accident and emergency medicine (which has had a long gestation period) has finally been brought to completion and was launched at the international conference in Edinburgh over the summer. This document has been ratified by both BAEM and the Faculty so that it now represents a definitive standpoint underwritten by both of the August bodies within our specialty.

- FASSGEM conference—The conference in Portsmouth was the first of our new style conferences organised and run entirely by ourselves. This represents a great milestone for us as an organisation and I would like to pay a particular vote of thanks to Dr Carolyn Hargreaves for her hard work and dedication to ensuring the success of the event. Conference 2003 will be held in Leeds in mid-November (the date still to be confirmed).

- Non-consultant career grade appraisal—The Department of Health has finalised guidelines on appraisal for non-consultant career grades and has produced the paperwork to support the process. The development of a separate appraisal system for non-consultant career grade staff represents an important step forward. Appraisal is part of the future for all medical practitioners and we must welcome this and use it to strengthen our position as non-consultant grade practitioners within the specialty rather than seeing it as being a threat.

- The BMA Staff Associate Specialist Committee (SASC)—The BMA now has a new committee for non-consultant career grade staff. This committee is in its infancy and at the current time there are constitutional questions about representation. It is important that as a specialty we achieve appropriate representation at this committee as we have the largest single body of non-consultant career grade staff of any specialty within medicine. I would encourage forum members to make contact with their local SASC representatives, and to consider putting themselves forward for election to regional committees, to ensure that the voice of our specialty and FASSGEM are heard appropriately throughout the country.

- Meeting with politicians—All three political parties are very much aware of the fact that accident and emergency departments around the country are under extreme pressure and that the specialty is one of the areas of public concern which is going to be a key election issue at the next general election.

I have been able to meet with a number of the key political players (representing different sides of the political divide) and through these meetings that I have had I have tried to raise the profile of non-consultant career grade staff in accident and emergency medicine and the role that non-consultant career grade staff have in helping to deliver some of the changes outlined in Reforming Emergency Care.

- Representation—FASSGEM is now very well represented at BAEM Executive and Council level at FAEM level and also within the BMA. The fact that representation at these august bodies has now been formalised represents an important step forward for us.

Despite all of the above positives there are still significant areas where progress has been frustratingly slow. The key area where we have failed to make progress is that of remuneration for non-consultant career grade staff.

The report of the Doctors Pay Review Body last year highlighted the problems but did not produce an appropriate solution to the inequality in pay which affects so many forum members. Through the political meetings highlighted above, I am endeavouring to get the message across that an expeditious solution is essential if we are going to increase recruitment and retention of non-consultant career grade staff within the specialty.

I am aware that many members may feel that the lack of progress on this one key issue is a failure; however, I would like reassure everybody that it is not for the lack of trying!

I would like to conclude my annual report by paying a tribute to all of my fellow officers and to the regional representatives for their work over the past year. I would also like to thank all those new members who have joined over the past year. Please spread the word to those of your colleagues who are not yet members!”

ANDREW NEWTON
Chair of FASSGEM (Forum for Associate Specialists and Staff Grades in Emergency Medicine);
apnewton@fairviewshipham.fsnet.co.uk