



The patients voice on the CEM board – an interview with Anthony Priddis

The Rt Reverend Anthony Priddis is bishop of Hereford, but sits as a 'layman' on the board of the College of Emergency medicine. His role is to ensure that however heated the discussions may become, the needs of the emergency patient and the public do not get forgotten. Since there are some robust personalities on the board there may be times when an ecclesiastical training is useful. We asked Bishop Anthony about his background and his work as a board member

Q. Tell us a bit about your background and how you came into the Church.

I was ordained in 1972 after going through theological college. This was not something I had planned to do! At school I enjoyed most and was best at science subjects, and did maths, physics and chemistry A levels. I went to Corpus Christi College, Cambridge and read Natural Sciences specialising in biochemistry in my third year. I had intended to go and work in industry, but God got in the way and I ended up going to theological college instead. I worked as a parish priest in a council estate in New Addington then in High Wycombe and a few miles away in Amersham. I was asked to become Bishop of Warwick 10 years ago before moving to Hereford two and a half years ago.



The Rt Reverend Anthony Priddis

Q. How did you get involved with emergency medicine?

With a scientific background I have always had an interest in some aspects of medicine. As a parish priest I had close links with hospitals: I was hospital chaplain when we lived at Amersham, and part of the hospital chaplaincy team at High Wycombe. Part of my role was the care of hospital staff so I was more aware than some might be of the pressures upon

them. I became involved in Emergency medicine about 10 years ago when David Skinner, who was a member of our congregation at Amersham asked me to be the lay person on the Special Assessment working group for A&E, which he chaired.

Q. How do you see your role on the College Board? Is being a priest a help or hindrance in this?

My own feeling is that my background as a priest helps my understanding of the patients view, not least because of all the time I have spent in hospitals visiting people who are sick, and working as a hospital chaplain. My understanding is that I am on the Board very definitely as a lay person to ask the 'idiot question' and to express a non-medical view. I am not there as an Anglican Bishop, or indeed as a priest, though like any of us I cannot be other than what I am.

Q. What do you think of the way the Board works?

I very much value the open way in which it is run. Despite having many people of great ability on the Board, it is not controlled by just one or two, but genuinely looks for contributions from each person with their own particular gifts and insights, as well as those of the other colleges that are represented. Indeed, it seems to me that the breadth of the Board is a real strength. One of my personal hopes is that emergency medicine with its very strong collaborative

base between doctors, nurses, paramedics and others might forge the way by eventually having a wider College that can involve everyone more fully than the present Board does.

I think the Board is served by excellent officers and staff who give a vast amount of time and energy over and above their hospital jobs. Emergency medicine benefits from their contribution far more than it might realise.

Q. Do you think hospitals provide a good model of multi-racial working for society as a whole?

Yes, I think UK medicine does provide good models of racial and religious tolerance, because it sees patients as

people and respects them in their individuality and need, valuing each one.

Q. Do you agree with George Bernard Shaw's view that all professions are conspiracies against the public?

I don't regard professions as 'conspiracies' against the public or anyone else. I take the point, however, that professionals should not be seen or felt to be simply defending their own corner or position. That seems to me to be why it is important to have a lay member on the boards of emergency medicine and other medical disciplines. We all need reminding of the big picture, what we are really about in serving the needs of one another.

Q. Do you always travel dressed as a bishop? How do people react to you?

Ever since I was ordained I have mostly travelled dressed as a priest, and nowadays dressed as a Bishop, so I get used to the reactions of people around me. If for some people talking to a bishop is a new experience, then I hope and indeed mostly find that after a while they get used to me and treat me as the human being I am. Mostly I prefer to be 'up front about being a bishop by dressing as one rather than being incognito.

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It is important to have a member of the public on the College Board to ask questions from the patient's position. The Bishop fulfils this role extremely effectively and brings a calm and compassionate voice to the table.

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Presidential Desert Island Discs

We thought it would be interesting to find out a little bit more about our current and past presidents, what better way than offering them the option to tell us their desert island discs. Just imagine, these people are stuck on a desert island with no emergency department for miles. There are no 4 hour targets, MMC is but a distant memory and urgent care centres no longer matter. They have been given a copy of the Bible and the complete works of Shakespeare; what eight tunes would keep them happy; what book would they want to read and re-read and what luxury might they wish to take with them.

Martin Shalley (BAEM President)

Songs:

- Marie is the name of his latest flame, Elvis Presley
- Little Red Rooster, Rolling Stones
- Proud Mary, Ike and Tina Turner
- Red Red Wine, UB 40
- Slavesia Il Vento from Cosi Fan Tutti, Mozart
- Prisoners' Chorus from Fidelio, Beethoven
- Canon and Fugue, Pachelbal
- All right now, Free

Book: A short history of nearly everything, Bill Bryson

Luxury: Electric guitar and amplifier [and an electrical supply?]

Jim Wardrope (CEM President)

Songs:

- Flowers of the Forest, Scottish traditional
- Pawn in their Game, Bob Dylan
- The Boxer, Simon and Garfunkel
- Jumpin' Jack Flash, Rolling Stones
- Concierto de Arunduez, Rodrigo
- From the Cliffs, Walter Carroll
- Protecting the Veil, Taverner
- 9th Symphony, Beethoven

Book: The Hitch Hiker's Guide to the Galaxy, Douglas Adams

Luxury: spade [don't be ridiculous] OK a guitar then

John Heyworth (Past President BAEM)

Songs:

- Bach's Goldberg Variations, Glen Gould
- Music for Airports, Brian Eno
- What's so funny 'bout peace love and understanding, Elvis Costello or anything by him
- Saturday, Sparklehorse
- White album, The Beatles (or anything by them)

- Lotus on Irish Streams, John McLaughlin and the Mahivishnu Orchestra
- Ornithology, Charlie Parker
- In between days, The Cure

Book: Wisden Almanac

Luxury: Inexhaustible female recreational companion [absolutely not allowed], Milk chocolate digestive biscuits [you are not allowed to have any food] oh all right then a football

Alastair McGowan (Past President CEM)

Songs:

- Won't get fooled again, The Who
- Moondance, Van Morrison
- Shelter from the Storm, Bob Dylan
- There's a Guy Works Down the Chipshop Swears He's Elvis, Kirsty McColl
- Helpless, Kd Lang
- These Foolish Things, Ella Fitzgerald
- Sad Eyed Lady of the Lowlands, Joan Baez
- Caledonia, Dougie McLean

Book: The Poet's Quair edited by Rintoul and Skinner (the standard text in Scottish schools in the 60s and 70s, deeply nostalgic and still inspiring)

Luxury: Pen and paper

Long live secondments

It wasn't until the first of my secondments that I happened upon one of the huge and hidden advantages of spending time in another department. As Lisa Clark said in October's supplement, they were frequently of dubious education value pre curriculum. Often caught in an educational limbo when in other specialities, we are more senior than their SHOs, but not functioning at their SpR level either. Experiences are varied. But look beyond personal learning objectives to the bigger picture, and much is to be gained.

In my hospital, the emergency department and the paediatric admissions unit are two ends of a very long corridor, at opposite ends of the building. This geographical distance has become a social, educational and team-building barrier. Rarely do the two teams engage, unless across a resuscitation bed in a pressured situation. The paediatrics team are out of their comfort zone with different staff and equipment. We don't know them either, and can be defensive and over-

sensitive to criticism. The nurses have very few joint activities. So it was with trepidation that I started on the long hike to the paediatric wards and my secondment.

For the first few weeks, I felt like I had a bull's eye on my belly. The criticisms from both sides were launched through me to the other party. Like a diplomatic envoy, I learnt to edit the feedback from one side to the other, playing down the numerous groans and emphasising the occasional compliment. The paediatrics nurses were very impressed with your observation chart, I'd say to the EDP on returning to resus. A suspicious glance. The emergency department sister says thanks for creating a bed so quickly, I'd report to the paediatric assessment unit, while handing over a patient. A nod and a pout. And who better to address the emergency department deficiencies that an emergency department team member? An audit of our referrals to the paediatrics team gave interesting results that I could feed back in a non-threatening way, and make changes on both sides. More senior reviews in the emergency department by

us, more facilitation to urgent clinic appointments by paediatrics. Many people had worked hard to establish links for some time, from arranging joint meetings to dummy resus runs. These plans were in the offing already and much more ambitious than my shop floor negotiation. Having someone with a foot in both camps, even just for a few months, can ease change, resolve conflicts and promote communication. Slowly, slowly I hope relations are improving and everyone, not least myself, is having a better time of it as a result. Long live secondments and their bridge building potential.

Katie Wright

There have been many discussion over the advantages and disadvantages of secondments ever since they first became part of the A&E training. When we no longer have them a useful interdepartmental link will have gone. However, perhaps the rotating F2 doctor will in future take on this role?

DCH

Consultant appointments December 2006. 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	Previous post
Lisa NIKLAUS	Newham General Hospital	Locum Consultant

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FASSGEM

The annual FASSGEM winter conference took place in Bath between 21st and 24th November (ok, not quite in winter) and was almost single handedly organised by Dr Andrew Newton. The conference was acclaimed as a great success for both its academic and social components. My recognition and gratitude go to Dr Andrew Newton for his enormous amount of work in making sure that Bath 2006 followed the tradition of excellent FASSGEM conferences held in past years. We were privileged to count with the presence of Dr Jim Wardrope as one of the key speakers

who also praised the quality of the programme.

The AGM took place, as it is now traditional, during the last day of the Conference when I had the honour to take over Dr Andrew Newton's duties as chairman of FASSGEM. Once again my gratitude goes to Dr Newton for so many years of hard work on behalf of FASSGEM and I hope to be able to continue his line of work.

Our next meeting will be FASSGEM Spring conference, which is now

confirmed to take place on Friday 18th May 2007 in Churchill House. Our next winter Conference will take place in Norwich and will be organised by Dr Caroline Shaw. Further details will be announced on the web site.

JUAN BALLESTEROS

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Acute winter Pct encephalopathy

This is probably a disease that has been around for some time, and may be recognised by many. However, it does not seem to have been previously described in medical textbooks. A brief description of some features of a typical case may help recognition in the future.

This is a condition of disordered thinking that affects primary care trusts as the end of the financial year approaches. A typical case will involve the conviction that the local emergency department is seeing large quantities of inappropriate primary care attenders, and may even be making a small profit under the 'payment by results scheme'. The PCT will blame the emergency department for this, forgetting that the main cause is the fact that it has run down the local out-of-hours GP service.

In several recent cases the PCT has put members of its staff in the local emergency departments to redirect people to their GPs. We have heard of several distressing episodes where foreign visitors and people who are clearly unwell have been told to make an appointment to see their GP. A patient collapsed in the waiting room having been told that her sensation of nausea and faintness did not justify a hospital visit. There was even a case where accompanying relatives have been told that they needed to be registered with a GP and should not have come to the hospital. Each referral back to primary care, however ill-advised is triumphantly entered onto a spreadsheet as evidence of our inefficient ways of working. Patients redirected often sneak back unnoticed to the department after 5pm when the PCT staff have packed

up and gone home, exhausted by a hard day spent arguing with misguided members of the public.

The trouble is that this data, gathered by the PCT staff by various ruses and devices will be tidied up and reappear in sanitised form as polished powerpoint presentations. These will be presented to Trust board meetings held far from the front line. They will show incontrovertible evidence that the emergency department should smarten up: stop seeing inappropriate patients, and to justify a substantial funding cut.

Those who work in the emergency department can however remain confident that although the funding may desert us, the patients never will.