



## BASICS at its Best—an interview with Charles Deakin

*A small item in the news recently was the prosecution of a man who attempted to murder his father by stabbing him in the chest with a kitchen knife. The patient was in cardiac arrest, but was saved by Charles Deakin, a BASICS doctor who performed a thoracotomy on the bedroom floor.*

### Tell us a little bit about yourself

I trained in London and started out wanting to do cardiology, but career prospects were so bad that I thought I should look at another acute specialty. I changed over to anaesthetics and never looked back. After about a year I got a job with HEMS in London. I spent 6 months flying around London with the air ambulance and had a fantastic time: it really transformed my outlook on life and gave me the skills and confidence to carry on with prehospital care. I then did 2 years of cardiac anaesthesia before ending up as a cardiac anaesthetist in Southampton. I have continued my involvement with prehospital care: its obviously very different doing it in your own car compared with a helicopter. I think it's the pre-hospital side of things that keeps me sane after a day in the cardiac theatres.

### Tell us about BASICS in Hampshire

BASICS is the British Association for Immediate Care, a voluntary scheme that exists in some parts of the country to



provide doctor assistance to the ambulance service. In Hampshire we have about 25 doctors; roughly a third anaesthetists, a third from emergency medicine and a third GPs. Currently the ambulance service page us about 1000 times a year, and the nearest available doctor usually attends. I go to about 200 incidents a year. It presents quite a few challenges but is very rewarding. You work with paramedics who are a great bunch and can make a real difference to the patients outcome.

### How often do you think you save a life as a BASICS doctor?

It's difficult to know but I would say about every couple of months.

### Tell us what happened with your thoracotomy patient

This was last December, I was visiting the Ambulance Headquarters when a gentleman dialled 999 and said he had been stabbed in the abdomen. He actually collapsed on the phone while he was talking. It was about a 15 minute run and I turned up about 5 minutes after the ambulance crew. The crew were doing basic life support, and there was a single stab wound over the left lower lateral chest wall. The knife had a 12 inch blade and the question was whether it had gone up into the chest or down into the abdomen. He could quite easily have arrested from hypovolaemia due to a splenic injury. I had a quick look at the patient: there was absolutely no cardiac output with good massage, the neck veins were very distended and there was dullness to percussion in the left chest consistent with a haemothorax. He was in an agonal rhythm with only a single complex per screen, so there was only a very small window of time to achieve anything for him. I thought it was worth a go because there was really nothing to lose with this patient.

### Was it a difficult decision?

Yes it was. On the one hand there was nothing to lose with but on the other hand turning up to the emergency department with a patient's chest that you have opened is something that you need to be able to justify. I would say about 2 minutes to decide, quite quick careful thinking.

So, armpit to armpit, 5<sup>th</sup> intercostal space down to the intercostal muscles with the scalpel and then tear with your

fingers up to the sternum and then cut through the sternum with some tough scissors and then you're done. So once the chest was open, it was fairly obvious that I had made an appropriate decision because as I opened the left side of the chest, a good litre or so of blood came pouring out from a haemothorax so there was certainly a lot of bleeding going on that had contributed to his arrest but once the chest was open, then the pericardium was visible which was blue and bulging and quite clearly wasn't a normal appearance, so I then incised the pericardium from top to bottom with a scalpel and about 500ml of clot came out straight away followed by the heart which popped out and started to beat, it was as simple as that, yes.

#### Were you relieved?

Well it was fantastic because yes, it was a big relief. My biggest worry was that I was making the wrong decision and so I was very relieved when clinically what I had suspected was proven when I looked in his chest. Once the heart appeared and

started beating, then we knew that we were on with a real chance of saving his life. There was then blood ejecting through the stab wound in the left ventricle which then made it very easy to actually see where the injury was and put some stitches in just to stop the bleeding and at the same time he then started breathing, I hadn't delayed by intubating him prior to doing the thoracotomy.

#### Where was the stab wound?

Apex of the left ventricle. So it was slightly round the back. I had to lift the heart up out of his chest and turn it over to get to the stab wound which obviously didn't help with the blood pressure, but it was spraying all over the room and quite difficult to control at first.

Afterwards we had quite a lot of difficulty getting him down a steep flight of stairs on a stretcher, but we gave him two litres of fluid and by the time we got to the emergency department his systolic pressure was 150. We cooled him and ventilated him on Intensive Care for 48 hours. When he

woke up it was clear he had sustained some hypoxic brain damage: he was in hospital gradually improving for 3 months and is now home and is self caring and essentially returned to a normal life.

#### How do you feel about it now?

Well, it's the fourth time I have done a prehospital thoracotomy, it's the first patient that's actually survived to go home. Only about 10–15 of patients do after a prehospital thoracotomy, because of the severity of their injuries. It's very rewarding, it makes prehospital care worth while when you have these patients that can be saved by intervention. It slightly frustrates me that BASICS continues to be an unfunded charity and that he's only alive because I happened not to be in theatre that day, that there had to be someone around who could respond to the call. These sort of jobs make me even more determined to improve the status of pre-hospital medicine so that doctors are available on a routine basis to deliver an appropriate standard of care rather than an ad hoc basis through a charity.

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Consultant appointments April 2007. 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
Dr Robert ANDREWS	St Mary's Hospital, Isle of Wight	Consultant, Kingston
Dr Elizabeth M CHRISTIAN	Guy's and St Thomas' Hospital	Consultant, King's College
Mr Andrew J CURRAN	Lancashire Hospitals (Chorley & South Ribble)	Locum Consultant, NorthWestern
Miss Francesca GARNHAM	Guy's and St Thomas' Hospital	Consultant, Chelsea and Westminster
Dr Helen GOLDRICK	Lancashire Hospitals (Chorley and South Ribble)	SpR, North Western
Mr Christopher LLOYD	Northampton General Hospital	SpR, East Anglia
Dr Maria B LYNCH	St Mary's Hospital, Isle of Wight	Consultant, Kingston
Mr Suneil M RAMNANI	Princess Alexandra Hospital, Essex	SpR, Yorkshire

## Jane Fothergill and the Training Standards Committee

The Training Standards Committee is the successor to the JCHTA&E as the College committee responsible for maintaining training standards in Emergency Medicine. After 7 years as Honorary Secretary and Chairman, the meeting of the Training Standards Committee (TSC) on 17 May was the last to be chaired by Jane Fothergill.

Jane's unique contribution to this important area can hardly be overstated. Her uncanny ability to see through the

fog and confusion surrounding complex issues and to deal directly with the core of the problem have impressed all who have seen her at work.

Frequently the TSC has to deal with delicate issues of local hospital politics. Jane always manages to do this with fairness, charm and persuasion. She usually gets effective action without bruising sensitive egos. Many trainees have unknowingly benefited from her tactful diplomacy.

The skilled gymnast makes his sport look easy. Jane makes chairing a committee look easy, even with a long and difficult agenda. How many people can make a busy 6 hour meeting finish on time? Frequently the TSC meetings have to deal with many opaque and almost unreadable documents. It is a pleasure to

watch Jane dissect the latest guidance from a Deanery or Department of Health paper and with humour and common-sense separate the few important points from the dross.

Everyone who has been involved with registrar training over the last few years will be grateful to Jane for her tremendous efforts. The chair of the TSC now passes to the capable hands of Wayne Hamer. Nick Jenkins is the new Hon Secretary, while Stella Galea continues her pivotal role as TSC Administrator.

Jane hopes to have more time to devote to her department in St Johns Hospital in Livingston. She has our gratitude and our best wishes for the future.

JONATHAN MARROW  
MIKE BECKETT

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## For debate: increasing hours

The increasing availability of consultant emergency physicians "on the shop floor" can only be laudable. Over the last decade or so, the 9.00am to 5.00pm Monday to Friday arrangement has been extended, and this continues at an ever-accelerating pace. As consultant numbers increase, we have been able to be present into the evenings and at weekends. Presumably the eventual aim is to have a consultant presence on a 24/7 basis.

I believe that four main factors have enabled this development: a genuine wish to provide a better service for our patients, an increase in consultant numbers, pressure from managers (particularly in relation to the four hour target), and pressure from our peers.

Peer pressure has played a particularly important part and should not be underestimated. We have all heard our fellow consultants boast that they are working until 7.00pm, 9.00pm, midnight, 2.00am, etc. They are also working on Saturday mornings, Sunday mornings, all day Saturday, all day Sunday, Bank Holidays, etc. What heroes! The macho spirit is alive and well in 21<sup>st</sup> century Emergency Medicine.

We have also been to meetings—long and boring meetings—with colleagues who have announced that, after the meeting, they are going on to a full shift in the emergency department. Like many other consultants, I have recently spent a full day with colleagues shortlisting candidates for ST programmes, as dictated by MMC. A number of colleagues were going on to an eight hour shift in the emergency department, after eight hours shortlisting. This is a 16 hour day, excluding traveling time. No one should be working for 16 hours, particularly a combination of hard mental work requiring close concentration, followed by hard physical work "on the shop floor".

While acknowledging the benefits to patients, I would like to make the following observations.

1. I am not aware of any trial that has proved consultant presence out-of-hours is of benefit to either patients or staff, although I acknowledge that this is probably/possibly self-evident.
2. Consultants in other specialties attend meetings during normal working hours and do not then put in extra hours to compensate.
3. Consultants in other specialties do not admire us for working unsociable hours. On the contrary, they think we're mad. They stick to

9.00am to 5.00pm as much as possible, except in the private sector, of course.

4. These 16 hour double shifts are unsustainable.
5. The macho element of medicine should have become an anachronism, and a joke. I well remember a macho surgeon telling me that he never had time for lunch. But he could not explain how he managed to get so fat.

Do not let yourself be taken for granted. I remember the story (possibly apocryphal) of the sister who was running two consultant out-patient clinics, both due to start at 9.00am. At 9.30am she received a message that one of the consultants had been found dead that morning. When she gave this information to the patients, one stood up and announced, "But I've been waiting since nine o'clock!".

It is essential to provide the best possible service to our patients, but emergency physicians need to realise that they cannot keep the NHS working by their personal Herculean efforts. Give the patients the best service you can, but not at the expense of your own health and family.

JOHN BACHE

# College update

Diana Hulbert and Mike Beckett do a great job in producing interesting articles for the supplement. College business seems to bore most people but there is so much happening I am grateful for the opportunity to bring you up to date. All of this information and more is on the College web site.

## MEDICAL TRAINING APPLICATION SERVICE (MTAS)—THREE IMPORTANT POINTS

Do not to confuse MTAS with Modernising Medical Careers (MMC). The College has had some significant concerns about MMC, for example the move to 4 month posts and the lack of flexibility in run through training, but MMC has provided the opportunity to modernise our own training. We have been receiving consistent feedback that “secondments” were no longer fit for purpose. You had told us that more anaesthetic and intensive care training was required. The new pattern of emergency medicine training should provide a much more evenly skilled workforce. We could not have achieved this without MMC.

The MTAS system did not work properly. We have asked that there should be an independent review to investigate the reasons for this terrible situation. However, the immediate aim is to get the right doctors into the right posts by August. The specialty has been gearing up for MTAS for the past 6 months. We knew there would be major stresses on juniors and consultants and the service still had to be run. There have been calls to abandon MTAS and go back to the “good old system”. We estimate that over a 1000 doctors are applying for Specialty Registrar posts. The old system would be swamped by all these doctors applying for many deaneries. Some might be appointed at an early interview only to pull out when made a better offer at another interview. The view of almost all the trainers involved is that we should support the work of the Review Group. There is no ideal situation to this mess, we have to find the solution that tries to

redress the unfairness to those not short-listed but is fair to those already given interviews.

MTAS has become the focus for the resentment that has been building within the medical profession over the past 5 years. In common with many professions, we have felt that the Government no longer valued professional advice. MTAS was so obviously flawed it has united and mobilised the profession. It has also caught the attention of the media. There is a lesson for the Colleges, while pragmatic working with the Department of Health and the government is often the best policy, there are occasions when it is best to give a clear message of disagreement. We knew that the proposed system would have trouble in sorting candidates’ abilities. Many suggestions we made to improve selection were discounted. What we did not do was to publicly voice our concerns, “bad things happen when good men do not speak out”.

## ACUTE AND URGENT CARE

The College submitted a robust response to the consultation document, *Urgent Care a Direction of Travel*. In our view this document was deeply flawed, a view shared by a number of other Colleges and the Academy. We have followed up this response with the Department of Health and ministers. We also thought this issue might be of wider interest and concern, and our document was quoted in the medical press, in some national newspapers and on Radio 4. The effect of our comments on Department of Health policy remains to be seen but we will continue to voice our concerns in this area.

## REORGANISATION OF SERVICES

The Academy of Medical Royal Colleges have been asked by the Department of Health to produce a report outlining views on the provision of acute services in emergency care, paediatrics, obstetrics, elderly care and cardiovascular care. The College of Emergency Medicine is leading the project along with the Royal College of Physicians (London). The document is nearing completion and sets out some key principles and standards in Emergency Medicine. The specialty has had significant

input into the document. It is due to be published in May.

## PREHOSPITAL CARE

This is an increasing area of work for many Fellows and Members. The College had a request from a member to set up a special interest group within the College, to act as a focus for those involved. The College sees this as an opportunity to explore how we should react to a number of areas of involvement such as acute care for major trauma and serious illness, the interface with General Practice and Urgent Care, medical care for large events and Emergency Care Practitioners. The College will set up a small group to take undertake a scoping exercise and advise the College how we should proceed. A number of other bodies are already active in this area and an important part of the work of the group will be to liaise with other organisations. Hopefully this group will report in the Autumn.

## CPD

The government has published a White Paper on the regulation of doctors (the follow up to the Donaldson Report consultation). The main recommendations have been published. These recommendations will require the Colleges to lead on the development of specialty specific standards of specialist practice. The Colleges will have to set up systems to ensure that they certify, at regular intervals, that the individual career grade doctors meet these standards of practice. The College expects that all career grade doctors in Emergency Medicine will have to register with the College of Emergency Medicine for this recertification process. These are huge tasks and the College is setting up a CPD group to advise on the best way forward.

Our initial view is that the process of recertification of specialist practice should be a continuous process rather than a “big bang” every 5 years. In this way any areas of weakness can be identified and rectified. However, it is likely that some “test” of skills will be required. The CPD group has been asked to develop these ideas and then the College will consult with Fellows and Members.

JIM WARDROPE