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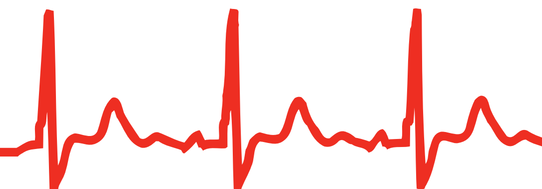
Emergency Medicine Journal
BMJ|Journals
SUPPLEMENT
May 2009



Obituary: Claire Epstein (1977–2009)

The death of Claire Epstein, at the age of 31, from bowel cancer, has shocked and devastated her family and friends, and left a significant gap in the medical community in which she was so highly valued.

Claire Hazel Epstein was born in Newcastle on 10 November 1977. The middle child of three, she remained at the centre of her close family throughout childhood and adulthood. She was educated at Durham High School, where her enormous popularity with both students and teachers made her the obvious choice for Head Girl, a role she undertook with just the right combination of humour and seriousness. Despite what her mother, Barbara, described as "an alarming lack of rhythm", Claire worked hard to overcome this to be involved in school plays and musicals. This determination was to become one of Claire's hallmarks in her chosen career of medicine.

Although Claire would have excelled in the Arts, of which she was very fond (especially History), her decision to specialise in science, in order to go to medical school, came as no surprise to her family. With their father, Howard, an orthopaedic surgeon, it was expected that at least one of the three siblings would follow in his footsteps and become a doctor. Claire's younger brother, Michael, elucidated at the funeral that the lot fell to Claire after a tense game of "rock, paper, scissors".

Claire's genuine desire to help people, along with her keen scientific mind, made her an excellent student at The Royal London and St Bartholomew's Medical School, where she graduated with honours in paediatrics in 2000. She went on to work in various hospitals in Brighton and North East London, and at the time of her death was a Specialist Registrar at The Royal London Hospital, where she had impressed the staff there (as everywhere else) with her energy, quick wit, brilliant clinical acumen and fantastic interpersonal skills.

Always the champion of the underdog, Claire never shied away from unpopular patients, and would frequently see more than her fair share of those with alcohol intoxication, anger issues and poor hygiene while her colleagues hid in the tea room. She delivered first-class health care to all, and did so with the wide smile on her face that became a trademark to all who knew her.

Despite having a specialist interest in acute medicine, consultants at RLH were quick to identify that Claire's first-rate clinical skills along with her attributes as a true team player would make her an excellent addition to the HEMS team,

and they had asked her to apply. Similarly, departments that she had previously worked in were also already starting to "court" Claire and tempt her into a consultancy post with them.

Although Claire was extremely well liked by everyone she came into contact with, she was no pushover at work. Despite listing "sleeping" as her only hobby on her Facebook profile, Claire was always punctual and was easily riled by colleagues' poor timekeeping. She would often say, as people sauntered into work late, "I realise that everyone is unavoidably late once in a while, but would you please have the good manners to run the last couple of hundred yards so that you at least look a bit flushed and out of breath?"

Her sharp wit was balanced by her unfailing loyalty and generosity to those she counted as friends. Claire would drive for hours, shop for days, babysit at the drop of a bottle of gripe water, cover shifts, offer practical advice (served with cake and Earl Grey tea) and cancel her own plans for any of these friends. She was spectacularly generous with her time, and also had a knack for buying the perfect gift at just the right moment for those she loved. For those friends, and her boyfriend David, Claire is simply irreplaceable.

Claire was diagnosed with an extremely aggressive form of bowel cancer at the end of January, and died just over two weeks after diagnosis. Throughout her illness, she retained the humour, dignity, determination and selflessness that had come to define her. Even in the last days of her life, her priority was to make sure that everyone else was ok. It is no surprise that Claire's last words (to the anaesthetist who came to intubate her) were "I'm sorry, I haven't cleaned my teeth". It is also no surprise that after her death on 12 February, her family found thank you cards for the staff who had cared for her, written several days previously.

Nowhere was the love, admiration and respect for Claire so apparent as at her funeral, at Rosslyn Hill Unitarian Chapel in Hampstead, on 28 February. It was so well attended—by school and university friends and teachers; colleagues from every hospital Claire had ever worked in, and friends and family—that many had to stand at the back in order to say their goodbyes to this exceptional young woman.

Claire Epstein is survived by her parents, Howard and Barbara Epstein, and her two brothers, Simon and Michael. She is buried at Highgate Cemetery.

Helen Parker, Deborah Finding

Consultant appointments March 2009

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 Robin Perry	North West Wales NHS Trust	Locum Consultant
Dr Thomas Hughes	John Radcliffe Hospital, Oxford	Consultant
Dr Simon Smith	John Radcliffe Hospital, Oxford	Consultant
Dr Jane Terris	John Radcliffe Hospital, Oxford	Consultant
Dr Abdul Jabbar	Nottingham University Hospitals	
Dr Gaynor Creaby	James Cook University Hospital	SpR
Dr Patrick Dissman	James Cook University Hospital	Locum Consultant
Mr Alex Johnston	James Cook University Hospital	SpR
Dr David Snow	Southport & Ormskirk Hospital NHS Trust	SpR
Dr Simon McKay	Southport & Ormskirk Hospital NHS Trust	Locum Consultant
Dr Peter Martin	West Suffolk Hospitals NHS Trust	SpR
Dr Lucy Glanfield	York Hospitals NHS Foundation Trust (taking up post after maternity leave)	SpR
Dr Mitesh V Davda	Princess Royal University Hospital	Locum Consultant
Mr Khalid Bashir	Bronglais General Hospital (Hywel Dda NHS Trust)	
Dr Paul Hill	Cumberland Infirmary (North Cumbria Acute Hospitals NHS Trust)	SpR
Miss Lisa Jane Lang	Warrington and Halton Hospitals NHS Foundation Trust	SpR
Dr Joanna E Scott	Leighton Hospital	Locum Consultant
Dr S Satchithan	Leighton Hospital	SpR
Dr Benjamin Loryman	Pilgrim Hospital, Boston	Locum Consultant
Dr Ian Levett	Worcestershire Royal Hospital	SpR
Dr J Acheson	Leicester Royal Infirmary	
Dr Paul Jennings	Airedale General Hospital	SpR
Dr Simon Binks	Gloucestershire Royal Hospital	SpR
Dr H Hollis	Royal Lancaster Infirmary	
Mr David Martin	Ipswich Hospital	SpR
Dr Haidar Reza Samiei	Doncaster Royal Infirmary	
Miss Kay Jeanette Stenton	Doncaster Royal Infirmary	
Dr James Crampton	Stafford Hospital	Locum Consultant

Pres blog

I write this at the end of a busy week which has included the College response to the report regarding Stafford Hospital, an excellent meeting at the College on Information, funding and workforce, and the March Council meeting of College.

The Healthcare Commission Report regarding the problems at the Stafford Hospital in previous years understandably attracted major media attention. It is important to note, however, that the comments reflected concerns regarding the standard of care provided throughout the entire hospital, not just the Emergency Department. We were pleased to note that there has recently been tangible, significant support and investment in the ED which now has four consultants in post. At the Information meeting, one of the most recent appointees was able to describe the current state of play at the Mid Staffordshire Hospital and it is clear that there is absolute commitment by the ED consultant team to provide the highest standards of care. In turn, I indicated that colleagues in Stafford have the full support of the College in delivering this care and that the College will help in any way required in the future. I also took the opportunity to write to the Editor of the local newspaper to reassure the public in Stafford regarding the transformation which has occurred and that they should have confidence in their local ED in providing care when required.

The issue highlighted continuing problems regarding the 4-hour target which I had the opportunity to describe on the Today programme, Five Live and Talk Sport (?!). In many ways, the 4-hour target has been a good thing, attracting focus and long overdue investment in our EDs. However, we all know that sustaining the 98% level has proved difficult and I have received a number of reports, particularly in recent months, regarding sustainability. This is a product of inexorable patient demand, both in terms of numbers and acuity, together with still a significant shortfall in the number of EM Consultants/Senior Middle Grade doctors in post in most departments, combined with limited inhospital capacity. This mismatch means that our managers, and then we ourselves, remain under significant pressure to comply. This can inevitably lead to premature/precipitate moving of patients from the ED, not always in the patients' best clinical interests. We have always indicated that a target of 95% would allow a degree of flexibility, still ensure that focus/investment occurred in order to sustain a service but would be achievable without unacceptable pressure on clinicians, "creative management" and inappropriate patient relocation.

On 18 March, the College hosted an excellent meeting on Information, funding and workforce with outstanding presentations by Nigel Brayley, Tony Shannon, Chris Moulton, Simon Eccles and Don MacKechnie. The lecture theatre at the College was full, with an audience which included emergency medicine colleagues, managers and commissioners. Many key points but the absolute crucial message is the issue of data returns reflecting activity in our EDs. The simple fact is that up to 50% of our ED attendances arrive as blank or unclassifiable returns. Crucially, this is information which PCT commissioners, the SHAs and the Department of Health use to inform strategy and funding decisions. It is perhaps, therefore, less surprising that misguided and incorrect assumptions regarding the ED casemix and activity are made by those distant to our EDs. In turn, it is perhaps a fraction more understandable that urgent care centres and other otherwise evidence-free evolutions should be suggested.

We all need to recognise this and act immediately. The key steps are:

- Please do whatever it takes to maximise coding compliance and accuracy within your ED—I know this is difficult but the importance cannot be overstated.
- Please liaise in person with your local Information Officer or similar who is responsible for returning data regarding ED activity. I understand that there is a requirement for these individuals to liaise with the Lead Consultant in the ED before data are returned to the Centre to ensure accuracy and reliability. However, my understanding is that this rarely, if ever, actually occurs. I know that many IT systems are non-compliant but our position in rejecting assumptions about the "Primary Care" component of our department activity is undermined in the absence of reliable data. Interestingly, however, discussions with colleagues from around the UK at the meeting on 18 March indicated that the experience of a range of Primary Care/Urgent Care Centre models was that the average number of patients who would satisfy an inclusion in this group is in the order of 10–15%—that is, the small minority of overall ED attendances and absolutely nowhere near the 50–60% number still repeatedly quoted by those in very powerful positions of influence, albeit at vast distance from the real world of our EDs.

John Heyworth

Contacting the editors

This supplement is edited by Mike Beckett (West Middlesex Hospital), Diana Hulbert (Southampton General Hospital) and Lisa Somers (Newham General). To contact the editors, please email: emjeditorial@bmjgroup.com

Simulation goes forth

Since our last article in June 2008 the College has developed a strategy for simulation with emergency medicine and this article is to give you an idea of what you can expect. Within the context of this article simulation refers to the use of full body manikins with a fully immersive setting often with the use of audio-visual facilities.

An initial survey run on the college website got 115 responses distributed nationwide according to the map.

This showed that the speciality has a number of individuals with a lot of experience of simulation and a wider number expressing interest in its use. From this, a meeting was held at the College in October where 24 people attended. This group then developed the College simulation strategy described in this article

The group recommended the use of simulation to teach a variety of skills at different levels of training:

- Common scenarios with established algorithms or guidelines (ST1–2)
- Rare but life-threatening presentations (ST 3–4)
- Non-technical skills/human factors (ST 5–6)

It was felt that non-technical skills should be taught at all years but the focus of training would increase in later years of training. These skills will be outlined in a further article to follow later in the year. It was not recommended for simulation to replace established life support courses

The group did support the future use of simulation for assessment once it is established in the curriculum. This clearly cannot occur until sufficient capacity for training is developed so that all trainees will have experienced simulation training at least three times prior to their CCST.

SO WHAT IS OCCURRING NOW?

- Development of an accurate map of established capacity and capability
- Development of regional simulation groups based around schools
- Development of an ED faculty in simulation
- Creating a bank of simulation scenarios using a standard template
- Creating an internet resource for simulation

Developing an accurate map of established capacity and capability

A further survey of each school is being conducted so that the requirements for and capacity to deliver simulation training can be assessed. Once this is completed we will be able to direct support to those regions that require it.

Developing regional simulation groups based around schools

These will be developed from the information gathered with the schools survey but please don't wait for this process. Contact your school head and offer to set up your school group and complete your school survey.

ED faculty development

This is being led by Adrian Boyle (adrian.boyle@addenbrookes.nhs.uk) and his group have developed a specialty-specific faculty course, the first one of which will be run at the Guy's Hospital in London on 16 April 2009. We also want those members of the college who are already working as simulation faculty to contact him so that we can map our resource and also validate you as a CEM simulation trainer.

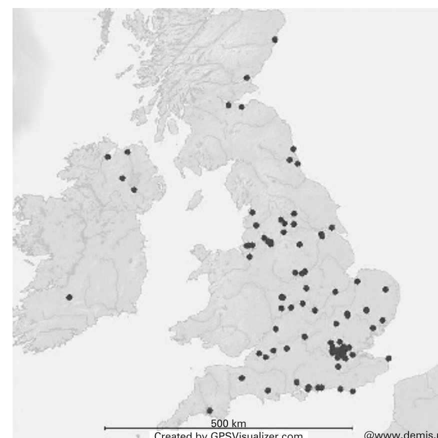
Creating a bank of simulation scenarios using a standard template

This work has been split into two parts. The development of a standard template for scenarios is being led by Iain Lennon (iain.lennon@nhs.uk). This will allow the College to hold a bank of scenarios for all College members to access that can be used on any type of simulator.

Steve Barden (steve.barden@bsuh.nhs.uk) is the lead for the simulation editorial board. They are developing a group of College certified scenarios and he is keen to be sent scenarios that you have already developed locally. This group plans to quality assure these and then develop a scenario bank as an internet resource.

Creating an internet resource for simulation

Andy Parfitt (andy.parfitt@gstt.nhs.uk) is developing a webpage to be hosted on CEM site with resources and discussion group. This will allow College-approved scenarios to be downloaded. This will be linked with the e-learning project with modules linked to scenarios.



Developing a simulation committee

The simulation committee structure is developing. We are still looking for a ST1–3 representative and have yet to appoint regional representatives. If you are interested please contact Peter Jaye (peter.jaye@gstt.nhs.uk).

We are also aware that in the rush to get moving with this project we have missed some people with great simulation skills. Please accept our apologies and contact Peter Jaye. There is still an enormous amount of work to do and we need you!

WHERE WILL WE BE IN 5 YEARS?

We hope that all trainees will be exposed to College-endorsed simulation teaching incorporating non-technical skills by 2012.

There will be an established, integrated simulation curriculum with an embedded research programme that will be on-going.

A concrete regional structure with capability and capacity to deliver training will be established. The development of simulation use for CPD will be ongoing. Lastly, simulation OSCEs will be introduced into MCEM/FCEM.

CONCLUSION

We hope this gives you an idea of the work that has been done so far and that you can expect to see developing. We are still keen for volunteers so please either contact Peter Jaye or your head of school and get simulation training going in your region.

Peter Jaye, Abigail Millett