BMJ Publishing Group

Emergency Medicine Journal

SUPPLEMENT

May 2001

John Heyworth—an interview with the new president of the BAEM

Tell us something about your career so far
My father was a psychiatrist and it seemed the natural thing to follow him into medicine. I went to medical school in Manchester in the glorious seventies, and after teaching anatomy, I put together an *ad hoc* surgical SHO rotation. I then joined the Royal Navy to "broaden my horizons" as it said in the advert—that was an entertaining period of personal development. After I left the Navy I became a senior registrar in Hope hospital, Salford and Preston, before becoming a consultant in Portsmouth in 1989. After six years there I moved to Southampton.

Why did you choose A&E?
Initially I wanted to be a trauma surgeon, but it became clear that this specialty didn't really exist in the UK. I joined the Navy as at the time it was one of the few areas in which there was training in A&E medicine. I think the nature of A&E suits my personality. All the cliches apply—it's unpredictable, exciting, hard work, but ultimately rewarding. Of course I enjoy the stimulation and activity when critically ill patients arrive in the department, but I think one comes into A&E to do the entire range of the work including minor injuries and illness. I think that unless one accepts that we deal with the entire workload, then one is probably in the wrong specialty.

Do you see yourself as a shopfloor consultant?
Yes I do! I think the prime role of a consultant must be clinical: other activities such as management, teaching, research, and audit are essential but secondary. With limited consultant numbers it is often difficult to strike the balance between these competing demands.

Who in emergency medicine would you say has made an outstanding contribution, or would you regard as a role model?
I've always been impressed by Tony Redmond and his approach to the improvement of emergency medical care. He has shown how enthusiasm and motivation deliver real change.

Can you outline your plans for the future, in particular as regards the relationship of BAEM with the Faculty?
I think the Faculty and Association work together very well, but I am not sure we are a large enough specialty to afford the luxury of having two bodies to represent us. I am concerned that our profile in dealing with the Department of Health and other specialties is diluted by the fact that there are two bodies. I think a merger of the two to maintain and enhance the strengths of both would be in the best interest of the specialty in the long term. The recent referendum indicated the strength of feeling in support of a merger, and I think if the merger could result in a College, that would be a major step forward for the specialty. I think a time scale of about two years may be a reasonable time to deal with the issues involved in becoming a College. To become a College is relatively straightforward, but gives limited influence in the medical hierarchy. Unfortunately the logistics and detail required to become a Royal College may take several years to implement; I think that becoming a College will fulfil most of our requirements at this stage, and we can hopefully progress to Royal College status in due course.

What do you see as your other main challenges as president?
We need to ensure that our pivotal role in the provision of emergency care in the UK is recognised, and that the

Department of Health and other professional bodies are aware of the opportunities and potential of our specialty to make a huge contribution to the improved delivery of emergency care. This after all is one of the government's main aims.

Secondly, we should be absolutely clear about the role of the specialty, to ensure consistency in what we are aiming to provide in our departments. There may be additional special interests, but there must be a consistent core so everyone understands what to expect from an A&E department.

The third point would be to achieve sensible workforce planning to meet the demands of our departments, by increasing middle grade and consultant presence. In conjunction with our nursing colleagues, this would raise the standards of patient care we deliver.

What are your views on the A&E Modernisation Group report?
It is extremely disappointing and regrettable that the Modernisation Group report has not been published by the Department of Health, particularly given the vast amount of work which Mike Lambert and his team put into this project. I hope their recommendations will eventually see the light of day in some form—there is no doubt that this work will benefit departments across the country immensely.

Matters related to A&E are often mentioned in the press—trolley waits, violence against staff, etc, with little comment from the Association. Do you think BAEM has a sufficiently high public profile?
I think it has improved in recent years, but we still need to publicise ourselves more than we do at the moment. Perhaps in the past we have been too reactive in our media profile and we need to be more pre-emptive, raising issues in the media and publicising our concerns. We must be careful however that the evidence we have to support our view is consistent and reliable or our credibility will be reduced. Once we have that information we should have no hesitation in going public to publicise issues where there has been no response from the centre.

Are you concerned for the future of the specialty?
I think this is a critical time in the evolution of the specialty. During the past two years or so the government has raised the profile of emergency care in the health debate. Models of emergency care have been proposed which identify the need for high quality patient care in resuscitation, the management of the acutely ill, and treatment of moderate/minor injuries. All of these are areas in which accident and emergency medicine has developed expertise and training programmes during the past 30 years and is therefore ideally placed to lead the forthcoming initiatives. Unfortunately, this potential is not universally recognised. This may be a product of the wide range of activities which departments undertake and the continuing flawed perception that A&E specialists are interested principally in trauma as opposed to other aspects of emergency care. I am concerned that the impression of the specialty sometimes related by senior representatives of Colleges and other bodies is inaccurate, perhaps based on a perception of what A&E may have been like when they were SHOs rather than recognising the sweeping changes which have occurred in the interim. The Association and Faculty have to ensure that all parties who are in a position of influence are informed and educated as necessary.

Unfortunately, the continuing largely SHO based service with long waits and sometimes a variable standard of care can lead to misconceptions regarding the level of care across the emergency spectrum which our departments could provide given adequate resources and staffing. This is frustrating as everyone in the specialty works incredibly hard to provide the highest possible standards of care despite being chronically under-resourced to deal with a workload of increasing volume and complexity. There are numerous examples across the UK of superb and innovative projects to improve the quality of care of patients presenting as emergencies. If this expertise can be recognised by the Department of Health and attract the necessary investment, then the true potential of the specialty can be unleashed and fulfilled.

What do you think of the journal since you left it?
I am delighted by the way it has progressed. I think Peter Driscoll and Jim Wardrope have done an outstanding job.

And what do you think of the supplement?
I think the supplement is without doubt the most important publication in the current international emergency medicine literature!

Recent consultant appointments, October 2000 to March 2000

The information for the consultant appointments is provided by the Faculty and any errors should be notified to them and not the journal

Name	*Hospital*	*Previous post*
John Black	John Radcliffe Hospital, Oxford	Locum Consultant
Adrian Clements	South Cleveland Hospital	SpR
Derek J Harborne	Royal Albert Edward Infirmary	Consultant, Princess Royal Hospital, Haywards Heath
Vikki Holloway	Northampton General Hospital	SpR, NW Thames
Anne-Marie Huggon	Greenwich District Hospital	SpR, Lewisham Hospital
Adrian M Kerner	Dewsbury and District Hospital	SpR, Dewsbury and District Hospital
Mark Nicol	Leighton Hospital	Locum Consultant, Bolton
C Dean Okerere	Dewsbury and District Hospital	SpR, General Infirmary Leeds
Yogdutt Sharma	Tameside General Hospital	SpR, Basildon Hospital
Elizabeth Symonds	Hereford Hospital	Consultant, Birmingham Children's Hospital
Amanda Wellesley	St Richards, Chichester and Bognor	SpR, Royal Alexandra Hospital, Paisley
John Wright	Royal Victoria Infirmary, Newcastle	SpR, Glasgow Royal Infirmary

Lessons in communication—the Great Heck train crash

Major incidents come in various forms. Often they present the emergency services with injuries of great similarities, such as in the Piper Alpha disaster and the Paddington train crash or the age of victims, such as the shooting of the children in Dunblane and the machete attack at the nursery school in the Midlands. All major disasters resulting in casualties, however, present one common problem, that is communication. The tragedy that occurred on the train track at Great Heck was no different. The site where the accident occurred, however, made communications difficult, both being off road and also being sited on the borders of North and West Yorkshire. Response, therefore, involved the Tees, East & North Yorkshire Ambulance Service NHS Trust (TENYAS) and West Yorkshire Metropolitan Ambulance Service (WYMAS). The border was also a division of police services; the fire service response also involved different brigades. These services communicated with each other and rapidly set up their bronze, silver and gold command stations, TENYAS taking prime control. The hospital services were informed of the incident just before 7.00 am (less than a hour after the collision occurred), Pontefract immediately placed staff on MAJAX standby, calling in the hospital's trauma team, made up of on-site medical staff and the on-call consultants of anaesthetics, general surgery, orthopaedics, and naturally A&E services. Internally, the senior nurse on duty assembled nursing staff from within the hospital area to assist with the initial arrival of patients and when the switchboard initiated the full MAJAX procedure at 07.20 am, staff were already beginning to assemble within the accident department.

It is not uncommonly noticed that in these major disasters patients appear with remarkable speed after the alert to the hospital; on occasions where the locality of the incident is near, patients have arrived before the alert has been received. On this occasion patients arrived within 28 minutes of the initial standby. Communications within the media resulted in the first radio broadcast, to my knowledge, occurring less than 50 minutes after our initial alert.

Our major incident policy includes a radio link between the department and WYMAS but as TENYAS had the lead role, supplementary contact was made to the site by mobile phone. This enabled the department to be constantly updated on the number of patients being despatched from the scene allowing some coordination of patient movement within the department to accommodate. This is not ideal in circumstances where mobile phones can be at risk from overload. Communications within the hospital are also essential, a process not dissimilar from the gold, silver and bronze controls is instigated, allowing wards, theatre, imaging, pathology, and other support services to be constantly updated. Communication within the clinical area is also vital, particularly as the unit was split into three, for resuscitation (three bays), serious injuries (12 trolleys), and a minor injuries facility which we set up within an adjacent outpatient area. The medical teams within the trolley area were closely supervised by an ATLS instructor, to optimise patient care. From previous major incidents involving Pontefract A&E, it was identified that staff attending from other areas were not always familiar with A&E staff who could help them to locate resources needed. An armband system has been developed to make A&E staff identifiable. Allocation of staff attending proved difficult as the event occurred shortly after the traditional "changeover" time of medical staff. This caused difficulties in identifying staff with particular skills, most importantly, those who were ATLS providers.

Other communication systems also have to be set up, importantly the provision of a casualty bureau, which is the responsibility of the local police. This system has undergone a recent change in that although a team of officers are located within the A&E environment, allowing rapid collation of casualty information, this information is now sent and collated in London. As this information is transmitted by fax, it is important to ensure the relevant fax machines can "talk" to each other as IT failure is known to occur (and did)! A large number of the region's hospital services were involved with a large unknown number of passengers making the central coordination role in London even more vital.

The "need to know" and even the "right to know" culture of the public is evident in this type of disaster. The spotlight is currently on NHS services, increasing pressure on hospitals to respond appropriately. Due to recent rail tragedies, another one involving trains was of particular media interest. It is important, therefore, to provide a means to communicate basic facts at all times, respecting confidentiality and privacy of both patients and their relatives. The location of press and media, naturally separate from clinical area, must be such to enable relatives to arrive and depart at will without pressure. When the time comes methods must also be arranged for discharge without media contact, a facility which was almost always requested. The media are doing a job and need respect and help, particularly as they have deadlines for both press and the news bulletins. It is wise to have the help of a trust employed media specialist, who can identify the appropriate person to give to interviews and also to arrange timing to satisfying media requirements wherever possible. Although it is important that the national media are facilitated, do not forget your local press who will still be around long after the national press leaves. Although in this incident the treatment of patients was concluded shortly after midday, the A&E involvement in management of the press continued for over 48 hours. This possibility should be identified in any hospital's major incident policy.

Politicians and the NHS Executive are likewise interested in the aftermath of such catastrophes. Visits need to be managed sensitively and although, as with the media, direct contact with patients is requested, this should only be allowed with consent of the individuals. Several patients on this occasion wished to speak directly with our local MP to convey their thanks to the emergency services. Request for press interviews were denied.

It is not to be forgotten that other external organisations are affected greatly by such tragedies. In this instance Great North Eastern Railway, who, as a result of their train and passengers being involved, also had responsibilities and needed to be kept informed. They were able to provide counselling staff, expert in the consequences of such accidents, and this was particularly appreciated.

I must also mention communications with tertiary referral centres, in particular, neurosurgery and cardiac surgery. These specialties need to be updated as to the possibility of their services being required and also when it becomes clear that no further transfers are likely. This will be written into our future major incident policy.

After stand down and final transfer of patients from A&E an initial debrief was arranged inviting all involved, to inform them of the up to date information regarding patient numbers and their injuries and care. Those not directly involved in clinical care don't know these facts, but

it is important that they are told. A large more formal debrief has also been arranged.

Thanks to all staff has been conveyed by letter to individual departments, by email, on the hospital intranet and lastly by the trust's team brief process.

During the initial stages of this incident we received telephone offers of specialist service, help, and advice from centres outside Yorkshire for which we were grateful. Staff were particularly touched by a fax from Welwyn Garden City A&E department, signed by nursing and medical staff, stating their thoughts were with us. They are still, I am sure, involved in the aftermath of the Hatfield crash which we know will continue for some time to come.

Departments must always be on alert for the sudden influx of casualties, our next incident was within seven days!

MIKE PLAYFORTH

Consultant in A&E,
Pontefract General Infirmary,
Clinical Director A&E Services,
Pinderfields & Pontefract NHS Trust

News from BAETA

Communication update

Emtel (the Emergency Medicine Trainees email List) is now up and running and those of you on our database have now received the first couple of messages. This is potentially an excellent method of distributing information, so please support its use. There are currently about 140 subscribers—if you would like to be added to the database please let us know.

The BAETA web site has been updated, and will continue to be updated at regular intervals. It can be viewed at http://www.baem.org.uk/baeta.htm.

Training

The curriculum for higher specialist training in emergency medicine has now been revised, and will soon be distributed to all trainees by the Faculty. A new training record has also been created to improve the existing log book, with emphasis on self assessment and the development of a structured training plan to address areas where further experience is needed. This document should prove to be a useful addition to all SpR training programmes, and further details will be disseminated by the Faculty in due course.

Finance

Good news on the financial front. At a recent meeting, it was decided that BAETA should indeed receive financial support from its parent body, BAEM. It was agreed that a healthy balance should be maintained in our account, which this year will amount to a subsidy of approximately £2000. Many thanks to all those involved in securing this funding, which will allow us to continue to run our own events at both the BAEM and Annual Faculty meetings, as well as the Annual BAETA Conference.

Forthcoming conferences

- The BAETA Conference this year will be hosted by the Defence Medical Services at the Queen's Hotel in Portsmouth, from 7–9 November. Preparations are well under way, and further details will follow in this column and on the web site above, but it's never too early to book study leave!
- The Trauma Care Conference, an international conference targeting all specialties involved in the management of trauma patients, is being held in Edinburgh, 5–8 June. For details or a prospectus, call 01794 511331.
- The Faculty Scientific Meeting will be held in London, 15–17 November (contact 020 7405 7071).

As a reminder, at both the BAEM Conference and Faculty Meeting, there is a BAETA Business Meeting and a social programme for all interested trainees.

Contact details

If anyone has any comments or issues they would like to be brought up in this column or in other forums of discussion, or information they would like to be passed on, please contact either myself or one of the committee members below. We can only be your voice if you tell us what to say.

JASON SMITH
President, BAETA
Royal London Hospital, Whitechapel, London E1 1BB
jason.smith20@virgin.net

CHRIS BIGGIN
Honorary Secretary, BAETA
Chris.Biggin@northumbria-healthcare.nhs.uk

JONATHAN BENGER
Members' Representative on the Faculty Board
JB@sectae.org.uk

Multitasking

Consultant interviews can be challenging at the best of times, but Vikki Holloway, who was in late pregnancy, experienced regular contractions in addition to the usual package of interview demands. The committee probably assumed she kept pausing in her answers to collect her thoughts.

However she was appointed to the post, and after downing a glass of fizz, headed off home and gave birth to a healthy baby girl less than 8 hours after becoming a consultant.

New consultant and Charlotte are doing well: our congratulations to both.

Management of minor injuries

Alan Leaman gave his view on the management of minor injuries in the January supplement. Not everyone agrees with him. Follow the correspondence in the electronic letters page at www.emjonline.com

To contact the editors write to:

Mike Beckett and Diana Hulbert, Accident and Emergency, West Middlesex University Hospital, Twickenham Road, Isleworth, Middlesex TW7 6AF (tel 020 8565 5486, fax 020 8565 2516, email kwalsh@bmjgroup.com).