

## **BRISTOL HEALTHCARE – 2006/7 – A VIEW FROM THE UBHT**

### **RLH interviews Roger Baird**

Roger Baird retired in December 2006 from being a Consultant Vascular Surgeon at the UBHT and Reader in the University of Bristol. His past appointments include a spell as Medical Director of the UBHT. Last year was High Sheriff of Bristol. The present contribution follows on a similar interview that RLH did with Derek Alderson, Professor of Gastroenterological Surgery, in July 2005. In that interview Derek expressed powerful opinions regarding the organisation of hospital medicine in Bristol (details of this interview are on the Med Chi website). The present interview, undertaken 16 months after the Alderson interview, addresses similar issues. The opinions expressed are in many ways different.

#### **Preamble**

Roger started by expressing the opinion that medical management is like becoming involved in the middle of a game of chess. "Your options are limited and you do not have the luxury of starting from scratch."

#### **A single Acute Trust for Bristol?**

Roger did not think that it was now practicable to pursue the idea of a single Acute Trust for Bristol. The first reason for stating this is that the Government is committed a choice agenda and believes that this will drive up standards. The issue of competition is closely related to the commissioning of services and is now largely undertaken by the PCT, although general practitioners and public health doctors have an important role. The creation of a single Trust would make the implementation of the choice agenda impossible to achieve. Additionally, a single Trust would probably be impossibly large. The Chief Executive's and Boards of the two Acute Trusts have enough on their plates already as providers – running the existing hospitals. The merger between Frenchay and Southmead continues to cause difficulties even now. The single Primary Care Trust will be a forum for the discussion of City-wide purchasing issues.

#### **Single acute hospital for Bristol?**

For a variety of reasons this is not now a practical proposition. Finding a large enough, accessible, site would now be impossible. Parking would remain a problem – whatever site is chosen.

#### **Integration of specialist services**

Roger expressed the opinion that this is an area where the issues have to be narrowed. Firstly, we can rule-out services that already exist on a single site – eg. plastics, renal medicine, oncology, and neurosurgery. This leaves us with 2 site services. These are mainly large volume emergency services – including general surgical and medical emergencies, O&G, A&E, and orthopaedics/trauma. These are some of the areas where the issue of collaboration requires to be examined. There is a problem with cross-site working which can be time-consuming and inefficient. The issue has proved to be challenging with the merger of Southmead and Frenchay although hopefully the problem will be reduced when the merger is properly developed.

In O&G there are approximately 5000 deliveries at each of the 2 main units. There is no great enthusiasm for moving this service on to one site. Similarly, it is difficult to see how emergency general medical and surgical services could be provided on one site – bearing in mind the volume of cases. Emergency medical services need to be provided in the 2 halves of the City.

Roger's speciality is that of vascular surgery. In 1999 a consultant-led emergency vascular surgery service was established for the City. The on-call surgical registrar calls the duty vascular surgeon when there is an appropriate emergency. A similar service exists with GI emergency work and renal transplant work. Roger indicated that similar arrangements exist in the medical field.

Roger pointed out that over the years there have been important consequences of the march of specialisation. For instance, breast surgeons and urologists no longer participate in the general surgical emergency take rota.

### **Multiple major trauma**

It could be argued that a single major A&E centre is required for patients with high severity injury scores. In talking about patients who have injuries to several different systems – eg. chest, abdomen, and head: Roger pointed out that the numbers involved are really rather small and the benefits of concentrating all major injuries in one place are offset by the loss of local services to the great majority with less severe problems.

### **Tertiary referrals**

Roger expressed the view that the more tertiary work that Bristol can do – the better. He gave the example of liver transplants, citing the experience of the Birmingham Liver Surgery Unit. In this field – you should aim to get a volume of tertiary referral work which extends beyond liver transplants only and includes complex liver resections. The most surgically challenging work for a wide area should be attracted and this is likely to produce the best possible results. Bristol should do everything possible to attract tertiary work.

### **Children's services**

The new Children's Hospital has been a great benefit for Bristol but it has come at a considerable cost. For instance, we have had to upgrade the A&E service for children. The costs of the huge development in paediatrics are not widely appreciated.

The principle of providing all paediatric services on one site is a laudable one and can provide difficulties – for instance in the field of neurosurgery and renal medicine.

### **The BRI site**

I suggested to Roger that the BRI site is hopelessly congested and environmentally pretty disastrous. Roger agreed that it is a crowded site but felt that it was no more crowded than the inner London teaching hospitals like St Thomas's or Guy's or even The London in Whitechapel. As far as car parking is concerned – the inner City site of the BRI is no worse than the John Radcliffe Hospital in Headington in the Oxford suburbs. Public transport is better in the City centre. It is Government policy not to provide public car parking space adjacent to public buildings.

Roger agreed that the old medical building on the south side of Marlborough street should be vacated by patients and indicated that many of these patients would be able to move into the new building that is being constructed on Marlborough Hill – the Cardiac Centre. Roger then pointed out that the 100 year old King Edward Building is now inadequate and is next in line for replacement. With the spread of antibiotic resistant organisms – we simply cannot nurse patients with sufficient separation in open Nightingale wards. Patients must be more widely separated from one another, with more single rooms and 2 and 4 bed bays

Roger said that another way of emptying the old, medical, building would be to move the laboratories from the top floor of the Queen's Building and to use the space for clinical care.

## **Other matters**

### **Fewer geographic sites**

Roger indicated that he used to operate at a number of different sites including the Bristol General, Ham Green, Cossham, and the Homoeopathic. These are any longer bases for surgical activity. There are now new operating theatres at the BRI, the Children's Hospital, and in North Bristol and in addition there are private hospitals – the BUPA Glen, the Chesterfield and St Mary's.

### **How will Independent Sector Treatment Centres fit in?**

The plan is that there will be 2 independent sector treatment centres who will undertake, particularly, "cold" surgery. One of these centres was opened at Shepton Mallet last year and is very busy with cataracts and hips. In future, the major acute hospitals would not have to carry the enormous burden of elective surgical work. Roger pointed out that the amount of elective work has increased greatly. When he came to the BRI about 20 abdominal aortic aneurysms a year were treated. Now the number is 60. There has been an increasing number of carotid endarterectomies, both at the BRI and North Bristol. This is making an impact on stroke prevention. More than 100 leg re-vascularisations, to prevent amputations, are undertaken yearly. In most surgical fields the amount of "cold" breast, joint, and cataract surgery has increased greatly. The types of general surgical work to be undertaken in the Independent Treatment Centres is currently unclear. It is likely that most varicose veins and hernias will be suitable.

Another important factor is that the length of stay in hospital has decreased greatly. Forty years ago a patient who had had surgery for bilateral varicose veins might be kept in hospital for 2 weeks. During the last 10 years most hernias and varicose veins have been performed on a day surgery basis. These are examples of the way that surgery is changing.

I then asked Roger whether it would be difficult to run an acute service if you were not at the same time running an elective service in the same place. I pointed out that we seemed to be moving to a situation where "cold" work will be done in one place and emergency work in another. Roger indicated that one of the advantages of the proposed arrangement would probably be that more patients could be dealt with as waiting lists shorten. He agreed with this in principle but pointed out that the considerable practical difficulties of multi-site working for surgical teams needed to be fully worked out.

I then asked Roger about the issue of training. He indicated that many of the straightforward cases such as veins and hernias, are now done by an associate specialist in the Day Surgery Unit. If these procedures are to be done off-site, there is the risk that training opportunities for SHOs and registrars in surgery and anesthesia will be lost.

### **The University**

I asked Roger his views about the University involvement with medicine. He replied that he thinks that Bristol is very lucky to have a well-established undergraduate medical school which provides enormous benefits to Bristol. We now have a big academic building, the Dorothy Hodgkin building, which is an index of the health of academic medicine in Bristol. Roger felt that overall the University leaders had done medicine proud, though the needs of academic surgery needed to be constantly safeguarded.

As far as undergraduate training is concerned, Roger commented that the pre-registration house officers are intelligent, well-motivated and adaptable and are quite as good as they were when he was a houseman.

## Research

Roger had had valuable research opportunities both as a Lecturer and later as a Senior Lecturer. This had helped him to write about 160 papers during his career. Research is an important part of training. It teaches you to think critically, how to judge the quality of research papers and how to evaluate evidence. Teaching hospitals comprise about 10% of acute hospitals in the UK. Those who work in them must aspire to the highest standards. This includes undertaking research themselves and offering research opportunities to those who pass through the teaching hospitals. Medical leadership in Bristol

In previous days much of the medical leadership in Bristol was provided by academics - professors like Bruce Perry, Howard Middlemiss, Robert Milnes Walker, Athol Riddell, Derek Russell Davis amongst others. Nowadays, that alone is not enough. This is partly a result of increasing medical specialisation. The professors exert leadership through their own specialities. As a result in clinical areas which lack a senior academic there is something of a hiatus in medical leadership. This is an important issue for clinical medicine. At the most basic level, if clinicians don't identify problems and try to do something about them, then the situation in their speciality worsens. Fortunately, he said, I see around me a new generation of talented clinicians who will develop professionally and articulate their views cogently, as their careers develop.

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## BULLET POINTS

### Roger Baird interview – Recent Trends in Medical Care in Bristol

#### General observations

- There is an increase in patient expectations. The Government is committed to providing choice.
- There is a relentless march of specialisation. Nowadays, the generality of surgery and medicine is largely confined to a emergency care.
- There is a gradual separation of emergency and elective work.
- There is a big increase in workload.

#### Medicine in Bristol

- A single Acute Hospital Trust for Bristol? No! It would be too big and would distract the executives from their current challenging tasks.
- A single acute hospital for Bristol? No! Not a practical proposition. The small number of patients with multiple major trauma would not justify such a move.
- A single major Accident and Emergency Department for the City? Not a practical proposition at the moment. The benefits to the small number of patients with multiple major trauma are outweighed by the disservice to the great majority of patients with less severe emergencies.
- How can the BRI site be improved? Patients must be moved to new re-provided wards – out of the old medical building and the King Edward building.
- Tertiary care. Bristol should attract as much of this work as possible. The greater the number of cases, the better the results are likely to be.
- Network provision of some specialist services across the City. This is already happening in surgery.
- Leadership in Medicine in Bristol. Very important. Improvement highly desirable.