

Is it time to rethink mobile medical teams?

In the United Kingdom the members of mobile medical teams that are deployed in the event of major incidents such as terrorist attacks are likely to be anaesthetic, general surgical, or orthopaedic trainees who are already on call. Two years ago a questionnaire was sent to 107 trainees in one NHS trust who had a potential role in a mobile medical team (*BMJ* 2003;326:762). Of the 77 who replied, just 11 knew what to do in that role, and none felt they were adequately trained. This lack of knowledge and training is not confined to one trust.

The NHS's guidance *Planning for Major Incidents* (revised after this article was written and shortly before it went to press) describes provision of on-site medical care and advice as one of five key roles and responsibilities for acute trusts in major incidents. It states that supplying a trained, equipped, and exercised team is essential. The only advice the guidance gives for teams is that protective clothing should be properly labelled; they should be skilled in basic life support and injury management in a hostile environment; and they should take only basic equipment. The guidance does not recommend who should be in the teams or what their level of experience and training should be.

In reality, hardly any training opportunities are available, so it is likely that team members will have no idea of their role, the organisation at a site, the equipment provided, or the triage system. A trained doctor may not be available to lead them in the casualty clearing station, as it would be unusual for a consultant to go with the team. A consultant may act as medical incident commander on site, but that role does not include clinical supervision in the casualty clearing station. Because trust managers can foresee the possibility of a major incident and can predict potential dangers, they could be liable in law if staff have not been properly prepared and work without supervision or have professional, physical, or mental problems on site or later.

This clearly inadequate provision is untenable, but recent developments make the current arrangements for teams even less practicable, if not impossible. The European Working Time Directive, the introduction of partial or full shifts, and the "hospital at night" scheme have had at least two consequences for teams. Firstly, it is more difficult to find opportunities to teach trainees. Instruction of all new trainees has to occur as soon as possible after they join to ensure continuity of the service. Secondly, at weekends and during out of hours periods on weekdays there will be only enough trainee staff to serve the needs of existing

patients. Thus it is now more likely that dispatching a team will put existing hospital patients in danger. Team members would also need supervision by a staff doctor, who would also need training.

If the current system is no longer safe or practicable, what is the alternative? The Department of Health should set clear standards for mobile medical teams. We should know who should be in them, what training and experience members should have, what equipment they should take with them, and what exactly their duties are. Trusts need this information for planning purposes.

One or more groups (depending on the city's size) of volunteer doctors should be recruited and trained in casualty management in major incidents. These doctors would comprise GPs and hospital doctors at consultant and staff grades who would not be needed immediately in their hospital. All teaching and training should be focused on those groups. They should be equipped with pagers; if a major incident occurs an alert could be sent out, and the first two members to respond would go out as the team doctors. After basic training, doctors should undergo regular training and spend a few days each year with the ambulance service to improve cooperation. Ambulance services rather than hospital trusts

should run mobile medical teams. Equipment could then be stored centrally with the ambulance service. The same idea could be applied to the hospital paramedical staff in the team. Teams should link with local immediate care schemes, if available, which should share the same training in dealing with major incidents.

Few training courses exist specifically for members of mobile medical teams. These courses should focus on specific clinical duties and how members link with the emergency services on site. It seems that the only regular course for mobile medical teams is that run by North Bristol NHS Trust and Avon Ambulance Service NHS Trust, with the cooperation of the Health Protection Agency. Its capacity is 60 participants a year.

Training and maintaining teams will be expensive, but if teams are to be provided at all they should be effective. They can be effective only if they are properly trained. If nothing changes, the current style of mobile medical teams—if they do manage to get to the site of the major incident—may well be more of a hindrance than a help to the emergency services.

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On reading Proust

"Your grandmother is doomed," says the doctor in Marcel Proust's semi-autographical masterpiece. "It is a stroke brought on by uremia. In itself uremia is not necessarily fatal, but this case seems to me hopeless..." The doctor is impatient, for he is an important man and has an appointment with the minister. There were no blood tests at that time, but the old lady takes to her bed and dies in considerable detail over the course of many pages.

Reading Proust is indeed a marathon. This is illustrated by the young man who began to read him in his teens. He read continuously, interrupted only for meals, firstly by his mother, later by his wife, then successively by his daughter, his granddaughter, and at last by the nurse in a retirement home. It is an appropriate story, because *Remembrance of Things Past* goes on for a long time. So hurrah for modern technology. It has produced 39 CDs that can be listened to on the way to work in about two months.

By now hundreds of critics have admired Proust's style, commented on the psychology of this complex creature, and on his description of the pains and pleasures of the "inverts" (having arbitrarily decided that the men sinned in Sodom, the women in Gomorrah), his complicated love affairs, and his descriptions of fin de siècle salons.

In her better days the grandmother was no more compliant than her modern counterparts, for as the doctor "called in to cope with a sudden feverish attack... and wrote out various prescriptions... my grandmother took these with a show of respect in which I could at once discern her firm resolves to ignore them all."

In society we meet Dr Cottard, a "more brilliant diagnostician than Potain," praised by everyone "for the quickness, the unerring judgment of his diagnoses," shy but compensating by assuming a repellent coldness, recommending sea voyages, or, more drastically, "purges, violent and drastic purges; milk for some days, nothing but milk. No meat. No alcohol," regardless of the patient's underlying condition.

The last chapters are about old age, when, released from a sanitarium, the narrator finds his old acquaintances white haired, some grossly obese, others shrivelled and bent over. Often he does not recognise them. Even the doctor has become old.

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