Remembering . . . Charlie Granger

Charlie Granger, who died aged 50 this November, was a member of a highly successful team of consultant anaesthetists who work in the intensive care unit (ICU) at the Royal Lancaster Infirmary. Appointed in 1998, he was involved in all the developments that accompanied the (delayed) move of the unit to its current location in the Centenary building. His appointment was the fulfilment of a long ambition to practise intensive care medicine in Lancaster. He started here as a registrar in 1993 on the Manchester rotation. He interrupted his training with a successful two-year break in Vancouver, an experience which underpinned much of his practice and personal philosophy.

Intensive care medicine requires at its heart a strategy of consistent decision making and team work by its consultant staff demonstrating a strong corporate philosophy. Charlie recognised the importance of this at an early stage. His loyalty to the team was absolute but he rightly expected the same in return. His practice was based on clinical and research evidence and he had an intelligent grasp of changes in practice and how to introduce them. Combining the listening to other opinions with debate over management plans and his enthusiasm for teaching made for long ward rounds. There were the inevitable jokes about nurses needing packed lunches to do ward rounds with him and airborne objects – balls of paper, blunt instruments and liquid contents of syringes – were propelled around the unit lightening the mood. He had an irrepressible ability to come up with odd nicknames for staff, colleagues and friends that stuck. Often derogatory they were seen as a badge to the inner sanctum of Charlie's trust. He conducted a regular ward round at midnight when he was on call demonstrating that intensive care was a truly 24/7 profession. There was an intellectual rigour to the way in which he made decisions. Obstinacy was always backed up by evidence. He could be occasionally selective of the evidence but by being at the heart of the discussion, sometimes with this 'counterpoint' to providing a different point of view, he provoked thought and our need to justify our position.

Decisions regarding limiting treatment or withdrawing it, and dealing with relatives of the bereaved, are difficult in the charged environment of medicine. In the clinical- and resource-limited environment of a modern ICU such things require a very special sort of doctor. Not only was he master of such situations but he came to Lancaster with a pedigree – a research project on bereavement in ICU and an editorial to his name; as he recognised that up to a fifth of relatives of ICU patients had to face bereavement, so he had to be good at helping them.

His competitive streak was manifest in many ways. Friends recall that cycling trips became races, that he could fill a sail from the lightest of breezes, that groups of hill walkers were unable to persuade him of his navigational fault. To those of us who had mountaineering or sailing adventures to tell, he would listen but could and usually did better them: dehydration so severe resulting in visual disturbance due to loss of intraorbital pressure and a chest complaint that he blamed on a rare South American infestation. There is currently a wine bottle containing photographs and a return address bobbing in the South Atlantic – deposited there in memory of the final trip he had planned: Antarctica was his idea for the ultimate holiday. He had acquired a vast library in preparation.

He was an obvious target for management interest, and held the reins of the cross bay Critical Care Directorate for five years. This was a challenging time for the University Hospitals of Morecambe Bay (UHMB) Trust, which after four years of existence had only just begun to tackle the problems of resource management and common ways of working in two hospitals which had very different approaches. Change was necessary and he was prepared to take a lead.
Such changes Charlie embraced and tried to introduce them in a fair way relying on the force of debate and discussion to get the message across. As in the team work of intensive care he expected and gave honesty and loyalty.

As one of the last of the clinical directors he had a role in the process that led to the dissolution of the Directorates and the formation of Divisions. Such a fact of history prevents a direct comparison being made between him and postholders of the current management structure and raises an interesting question of what he might have turned his hand to had he had the opportunity, and whether, in contrast to the current fashion, he would have led from a clinical base at Lancaster. UHMB Chief Executive Tony Halsall, who recruited him early last year to head the local Patient Safety First Campaign, describes him as a tenacious advocate for the principles of the campaign, forever demanding assurances from managers that those working on the project should be committed to the welfare of patients. The current concept of intensive care 'outreach' – a mobile team of ICU staff who visit surgical wards to monitor observation charts and listen to concerns of staff – is less a consequence of the safety campaign than a reflection of his own foresight. The outreach service, designed to facilitate timely admission and prevent readmission, owes its existence to his advocacy. It has existed since 2005, well before such an idea became fashionable. As a similar example of foresight, he was 'bare below the elbows' years before infection control demanded it.

It is tempting to consider that the competitor, the adventurer, the medical manager seeking to deliver a solution to the challenges of the workplace could have a blinkered vision. But Charlie had clearly tackled the theoretical and human side of medical management with characteristic thoroughness, conceding even before the era of modern medical management that :

> *'As doctors, we have chosen to work in a highly competitive, achievement-orientated environment. As anaesthetists and intensivists, we have selected a speciality in which our high degree of personal autonomy, and our control over our environment, contribute to our job satisfaction. Yet, as individuals, we are faced with a growing burden of occupational stressors that fall outside our control, and with which we are poorly equipped to deal. Since we are unlikely to be able to reduce our exposure to these stresses significantly, we should take steps to improve our ability to deal with them.'* [1]

Charlie tackled the challenge of his illness and mortality with characteristic style and bravery. Those of us who waited for news respected the fundamental right of, and preserved his family's privacy, of his right to autonomy and of questioning and seeking second opinions. When lines of communication were made or audiences gained, the fighting and competitive spirit was clearly undiminished. The public exposure was borne with grace and fortitude. One is certain that he will have observed those who delivered his care with a professional eye: he had, after all, written part of the manual himself and had published some well considered advice for those who mourn his passing.

REFERENCE

1. Granger C, Shelly MP. Stressing out or outing stress. Eur J Anaesthesiol 1996;13: 543-6
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We are grateful to his colleague and friend Dr Maire Shelly, the Associate Postgraduate Dean to the North Western Deanery, for the following insight:

Charlie Granger: a loss to intensive care medicine

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In those days, trainees often came and talked to me about becoming involved in a research project and I particularly welcomed Charlie's approach. I remembered being on his appointment committee and being struck that his path to anaesthesia differed significantly from most other applicants. He had previously trained in general practice and, most notably, had taken time out to renovate a croft in Scotland. We talked about his interests and I suggested a project that offered a real challenge.

I was producing some guidelines on caring for the relatives of those who died on an intensive care unit (ICU) for the Intensive Care Society and we came up with a survey looking at current practices to support the bereaved. Charlie rose to the challenge with alacrity. He devised a questionnaire and sent 430 copies to all of the ICUs in the country. He analysed the results and wrote the paper – and when I say wrote, he somehow made it a work of literature as well as science. He enjoyed writing and made reading his manuscripts enjoyable. I was brought up with the short sentence, factual writing style beloved of scientific journals and it was exciting to read something that pulled you into the story of the project so that you became involved in it. The paper was sent off and promptly accepted – without the usual list of changes required. A testimony to Charlie's writing skill.

This collaboration led to others. The next subject was stress – staff stress rather than patient stress – and an editorial entitled 'stressing out or outing stress'. Charlie's take-home message was basically that acknowledging your personal response to the inevitable stresses of clinical medicine is a major step in dealing with those stresses and reduces the likelihood of burnout. His common sense approach to the subject helped many readers understand their own responses to stress better and take steps to manage their stress levels appropriately. Because he was able to communicate his messages in a way that was non-threatening and not seen as wacky or alternative in the extreme, his points could be received by his readers. As he said in the editorial 'denial is no cure.' Charlie had a way of challenging that most robust of coping strategies with compassion.

There followed several more reviews, editorials and chapters. All were characterised by Charlie's elegant writing style and sympathetic approach to these sensitive subjects. He was also a writer who respected deadlines, a precious trait for editors. His drafts were always on time and needed little modification or direction. A direct result of Charlie's work on bereavement is an increased awareness of the support needed by families whose relative has died on an ICU. Many critical care follow-up services include a service for bereaved family members. This