MBMJ Profile . . . David Telford

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David Telford is a consultant microbiologist who works across the three main hospitals in the Morecambe Bay area. Although recently retired, he has returned. He is well known and respected across the trust and has been a highly influential figure not just in microbiology but in the wider issues that face the NHS, having been Medical Director during the early days of the University Hospitals of Morecambe Bay Trust. The *Journal* reports on the man and his life.

Early beginnings

David Ronald Telford was born on 11 December 1947, in Keswick, and educated at Keswick Grammar School and Manchester University. He admits to finishing his pre-registration year with only the vaguest idea of a life as a hospital doctor – general practice had never appealed.

It was in 1972 that David had his first taste of clinical pathology. He spent a year as a senior house officer (SHO) in clinical pathology, which meant covering all the major pathology disciplines.

This was at a time in which auto-analyser machines did not exist to perform what we consider standard biochemistry and haematological investigations. Junior doctors were involved in doing the basic investigations, which could be very time consuming. You would either ask for a white cell count or a haemoglobin count; asking for both would be met by frosty responses. Microbiology was one of the subjects that he was was exposed to in these years. It caught his imagination.

Microbiology at that time was still very much a laboratory-based discipline as opposed to now, when it has evolved into more of a clinical role, with medical microbiologists not as involved with the laboratory side as microbiologists of yesteryear.

However, by 1975, David had started to miss patient contact and it was then that he was offered a position in Monsall Hospital to work as an SHO covering infectious diseases over the Christmas period. This then turned into a longterm post of two years. During this time, and a subsequent two-year post, he had exposure to a huge amount of infectious diseases, as well as diseases such as diphtheria.

He was at this point still in two minds whether to take up a career in medical microbiology or infectious diseases. The time spent on a clinical ward, however, was well spent according to David because he got a broad exposure to the clinical side of medicine as well.

During this period, he took up a senior registrar post created by the Manchester Area Health Authority as a sort of bridging post between infectious diseases and medical microbiology. Here, he spent another three years until 1979.

Whilst on this attachment, David saw the light. 'Infectious diseases' was under threat as a speciality, with only a very few consultant posts available. The professor with whom he shared this observation had clearly failed to anticipate the opportunities that the epidemic of HIV would offer the profession!

In 1979, David took up a post as an assistant microbiologist at a regional public health labaratory in Leeds, the forerunner of the modern Communicable Diseases Centre. It was here that he was affiliated with the regional cardiothoracic centre in Leeds, and an appreciation of the clinical side of microbiology began to grow, as he was involved with the considerable burden of post-operative infection management. The opportunity to move out of the big city environment came in 1983 with his appointment in Lancaster.

It was in these early years before working in Lancaster that he had shaped himself to becoming a new type of microbiologist. The role of microbiologists was increasing, as a whole host of new pathogens had come to light, as well as antibiotic resistance. This needed a doctor who was more in touch with the 'shopfloor' ward life, as well as the laboratory, and wider public health issues as well. David had experience in all these areas, so it was a natural transition towards the post of consultant microbiologist.

Lancaster

His appointment coincided with a new dawn for the profession of microbiology. Infection patterns began to change. A whole host of new infections began to emerge, from Legionnaire's to AIDS. Antiobiotic therapy became much more sophisticated as resistant organisms flourished.

Modern medical treatments were creating more vulnerable patients to infection with unusual infections. International travel had begun to increase and travellers were coming back with exotic tropical diseases. Food poisoning cases had increased. Media attention during this period had started to increase considerably in regards to infection.

It was during this time that microbiology skills had to shift up a gear to keep up with this new phase of infection development. David concentrated on building links between the microbiology department and the users, and the profile of the department rose during the 1980s. Hospital infection became a matter of public concern. The traditional approach was to address this through hospital infection control committees. He had observed that these rarely achieved anything and he preferred to work through the existing medical structures. It is a matter of some personal pride to David that the Lancaster infection control committee only met once in the 24 years after its inception!

Despite this, audits showed infection levels were acceptable. Even now, the Lancaster and Kendal hospitals have not experienced the levels of antibiotic resistance seen elsewhere and our antibiotic expenditure is the lowest in the region. Again, there is no evidence that our clinical outcomes are poor.

Infection control takes him into all areas of the hospital and this has given insights into hospital life which are not available to most clinicians. These have proved invaluable in management roles and fuelled an abiding fascination with hospitals as organisations.

Working with David as his SHOs, we were able to get a first-hand glimpse at what this all meant. Typical weeks involve meetings with various different departments of the hospital. We sat in on a meeting with the building works managers, whilst a discussion took place in regards to the enormous effort that goes into preventing legionella outbreaks in the hospitals. On another occasion, I went to another regional meeting in regards to swine flu outbreaks and a further meeting with the Communicable Disease Centre consultant in regards to new cases of tuberculosis outbreaks in the Morecambe Bay area.

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David's engagement with the many agencies that have to work in a hospital was an important factor in defining his style as Associate Medical Director and, subsequently, Medical Director, for the University Hospitals of Morecambe Bay Trust, which latter role he accomplished between 1998 and 2006. He was very involved in developing the clinical governance of the area. His description of the role of the medical director as a non-executive director who 'wasn't quite a part of the management team and not quite a part of the medical establishment' fitted well with his job as a clinician – the skilled outsider who is brought in to sort out conflict. It was a job that he enjoyed thoroughly, however; and being in the 'middle', he was able to form a bridge between the two sides.

His return to clinical activity was inevitable, however, and precipitated by a shortage of consultant microbiologists in Lancaster. He decided to take up this post again and has continued this up and until 2009, when he officially retired in October. However, David still works part-time, splitting his time between the Royal Lancaster Infirmary and Furness General Hospital, as well as attending local meetings about infection control issues and teaching medical students.

Our wide-ranging discussion identified a number of issues about which he feels very strongly

Microbiology dropping off the undergraduate medical curriculum
The issue of the loss of microbiology as a formal under-graduate subject is a matter of great regret, aside from the professional esteem of seeing it taught. It is, like radiology, one of the few subjects which truly runs into every single aspect of medical care in all disciplines.

He considers that microbiology was taught as a support for classic infectious diseases. At the time when the curriculum was developed, microbiology was about diagnosing or providing laboratory confirmation for tuberculosis, diphtheria and others – diagnosing specific infections. Nowadays, it is concerned with picking up organisms that are part of our microbial flora. He is undecided whether this may at times do more harm than good, or whether it contributes to patients' conditions becoming more settled, due to newer and steadier practice than before. In the post-infectious disease era, basic science training assumes a new importance.

Doctors now come across infection in vulnerable patients; for instance, patients with HIV, cancer or autoimmune disease, and more generally, vulnerable patients such as elderly patients or very weak, frail patients. More sophistication in its management requires modern basic training and without that basic education in medical school doctors will fail their patients. Furthermore, the lack of emphasis on microbiology at an undergraduate level stunts recruitment at postgraduate level, and leads to alienation of the microbiologist from the clinical situation: doctors are happy to call for advice over a specific infection such as reported *mycobacterium tuberculosis* or *salmonella typhi* but less inclined to understand and make sound decisions on more common infections.

Traditional medical education vs. problem-based learning, the current medical education
He is unsure about this. The strength of problem-based learning is that it is claimed to produce doctors who can think more, who can reflect more and who can set their education objectives much better than those who presented with formal lectures. So, in terms of developing critical faculties, it is better than the old system. Some form of priority setting in education terms would seem to favour the teaching of microbiology. Of the 80 or so antibiotics listed in the British National Formulary, only ten to 15 of them are used widely by doctors. For somebody starting, out it is difficult to know which ones these are until they come across them. There is a danger of cramming heads full with knowledge which is not relevant and this makes for wasteful education.

Formal lectures are a good way of teaching or highlighting critical issues such as clinical presentation, seminars and more formal structure knowledge presentation. This should help students find their way through the masses of information, however, as opposed to spoon feeding them, as was most common in the old traditional way of medical teaching.

Shortage of microbiologists in the UK
The Department of Health values microbiology as a specialty, as evidenced by the formal pronouncement of the Health Care Code of Practice that all trusts should have 24/7 access to microbiology services; but he feels that the critical nature of the recruitment problem has yet to be recognised. His own return to clinical practice was brought about by a manpower crisis for which there is no current solution. There are few training posts even now, not enough to replace the current consultants.

European Working Time Directive (EWTD)
The view of the older generation of doctors, as well as the Medical Royal Colleges, particularly the College of Surgeons, is that trainee doctors are getting reduced clinical exposure, which is having an impact on their level of experience and clinical confidence; they are emerging now less comfortable and less confident in advanced medical practice than doctors were ten to 15 years ago. Amongst the issues he fears is that this results in a lot of stress-related issues among the younger consultants because they are not well prepared for the pressure of consultant life. Part of this is down to the EWTD. His own personal view, not uncommon for his generation, is that a vocational subject such as medicine needs more emphasis on experience than formal training. But he does acknowledge the value of having flexible, family-friendly and part-time contracts to bring up families, even if training becomes protracted.

On the other hand, it is not appropriate to have people making life or death decisions while working hours which are illegal in civil aviation and road transport – he sees the need for a balanced approach. The proposal which is circulating around parts of America and Europe for 80 hours per week would be a better way of assuring good quality of clinical exposure. EWTD reduces the amount of clinical exposure and clinical experience, which results in trained staff being less comfortable, with less and less confidence. He doesn't see the option of doubling the training time to be viable.

Revalidation

Although revalidation is an entirely understandable response to recent highlighted medical problems, it has to be remembered that most doctors have already kept up to date. The danger is that the revalidation exercise become another bureaucratic exercise with a series of hurdles that are not necessarily rooted in clinical experience. As doctors mature in medicine their experience becomes more important than their knowledge. Experience is quite a difficult thing to examine. There is a danger in devaluing the experience for the expense of formal training and assessment. If revalidation gets the balance wrong, it will not improve medical standards, it will detract from them. So there is a danger it would not improve patient care and might produce a mediocre homogeneous standard. It could be quite difficult to be imaginative in caring for people in a much more regulated environment that revalidation might bring with it. Most of the older doctors who qualified in different medical education systems are uncomfortable with it and mass retirement is a real threat that has to be faced. He also concedes that the real problem doctors with personality problems, the ones who are doing dangerous things, would also be good at covering their tracks with revalidation. Formal revalidation is not necessarily the way for detecting serious malpractice.

Final thoughts

The job of the consultant microbiologist is one where there can be a great deal of difference in the way it is practised. What has endeared David Telford to many of the clinical staff of the hospital is his accessibility, approachability and willingness to get involved in wider-ranging issues apart from microbiology.

It is for these reasons that he will be missed as he retires from his post as consultant microbiologist and we wish him every success in his future endeavours.

THE LEESE BEQUEST

The Leese bequest is a sum of money which was left to the old postgraduate medical centre at the Royal Lancaster Infirmary (RLI) in the early 1980s. The benefactor was a local woman, Mrs IB Leese, who suffered from cardiopulmonary problems for some time. She was treated by local GPs and hospital staff at RLI and she decided that as a childless widow she would leave money 'for any purpose in furthering the educational work and teaching of the education centre, with the intention of helping heart and lung sufferers'.

Mrs Leese's bequest became a trust, administered until recently by local retired doctors. An annual lecture on a relevant subject was sponsored by this trust and held in the old postgraduate medical centre, and applications could be made for a grant from the trust for study or activity which fell within its remit.

The trust has now transferred to University Hospitals of Morecambe Bay Trust (UHMBT) where it is overseen by the Research and Development sub-committee. This committee welcomes applications for funding from UHMBT staff for research projects which would benefit patients with cardiovascular or respiratory problems. Awards are given for those projects deemed to fulfil the qualifying criteria and are proportional to the costs the projects are expected to incur.

We encourage all trust staff, clinical and non-clinical, to apply for funding from this bequest for any work which would help patients with heart or lung problems.

Applications are welcome at any time.
Please contact Alison Harry on extension 46485 or email alison.harry@mbht.nhs.uk