Interview with Professor Chris Gray

The Editor went to Newcastle to interview Professor Gray shortly before he took up his duties as the new Medical Director of the Trust. This is a summary of their discussion.

Ed: Thank you very much indeed for agreeing to be interviewed so that the readers of the Journal can find out a little bit about you. Can you first of all tell us about your roots and where you come from?

CG: People who meet me very soon will realise that I'm a local lad – born and bred in the North East of England, in Northumberland. So I'm not quite a Tynesider by origin. I was educated in the North East and am a graduate of Newcastle University. I did what used to be called my general professional training in Newcastle before moving to Edinburgh as a Senior Registrar where I was their first English Senior Registrar in the department of medicine – which was an interesting introduction to Scottish Medicine! Following this I came back to the North East, which was my calling, and certainly the calling of my wife. It was always destined that I would come back to the North East! That's a synopsis of where I was, where I am and how I came back.

Ed: Are you from a medical family?

CG: I'm not, no. My father was a scientist, so the science was there.

Ed: Was his science connected with medicine?

CG: No. Not at all.

Ed: Your main interest is in elderly medicine?

CG: A physician with a special interest in the elderly was the old term for it. I was dual accredited in General Medicine and Geriatric Medicine – which again was the old term, but very politically incorrect! But I have practised stroke medicine for the vast majority of my career as a consultant. I was a consultant for nearly twenty years and probably fifteen of those years I devoted to stroke medicine.

Ed: Your clinical base has been in Sunderland?

CG: That's correct. I spent fifteen years in Sunderland. I had my Newcastle University Chair in Geriatric Medicine. But I delivered a clinical service and ran my research team in Sunderland.

Ed: Are you still based in Sunderland?

CG: No. My chair sits with Newcastle University but as the Postgraduate Dean I currently work full time here in the Deanery where I've been for the past three and a half years.

Ed: So you don't have any clinical duties at the moment?

CG: Not at present, no. I've continued my research interest during this time, but my final PhD student will graduate this summer, so that closes my clinical research programme down quite nicely.

Ed: When you move to Durham and Darlington, will you keep your research interest?

CG: I don't see that as a priority. I would certainly like to maintain a degree of research interest but I think my priority is getting back up to speed in clinical practice.

Ed: But you will keep your chair?

CG: Yes, that's a personal chair.

Ed: So they can't take that off you?

CG: No!

Ed: So you would anticipate when you join us that you will have some clinical sessions?

CG: That's correct. The intention is that I will do a clinic each week in TIA and really try and participate in the activities of the clinical team in terms of postgraduate education and training.

Ed: Will you be based at the Durham end or the Darlington end or both?

CG: To be determined! Clearly there is an interest on both sites and I just need to match the detail to the job plan.

Ed: You've published a lot on stroke. Can I ask which is the paper you're most proud of?

CG: Gosh. Well I should say at this point that the paper I'm most proud of is my first ever publication which was in *The Darlington Postgraduate* [predecessor of this Journal] – but that goes back to about 1985. I couldn't find it last night but I still have a copy somewhere! But the paper with the biggest impact was in the *Lancet Neurology* which was a randomised controlled trial called GIST-UK for which I was the chief investigator. It was multi-centre study looking at glucose modulation following acute stroke. It was and still is the largest randomised trial of this in acute stroke to date.

Ed: Apart from your SR job in Edinburgh all your jobs have been in and around the North East?

CG: That's correct ... although I went to Sunderland. That's in the Deep South!

Ed: You have a family?

CG: I have two sons. My eldest is a graduate lawyer who's doing his training contract at the moment with a firm in the City of London and my youngest is trail blazing in politics as an undergraduate. Neither of them has followed my path into medicine.

Ed: Are you pleased or disappointed they haven't gone into medicine?

CG: One side of me is disappointed and another side is quite relieved actually. I'm quite competitive and I would hate it if they had done something in medicine and then competed with me perhaps.

Ed: Do you have any interests outside medicine?

CG: I do yes. And this takes me into my lifetime's passion and perhaps eccentricity. I'm a lifelong surfer, and I'm probably the only senior academic in medicine who is! I've done this since I was a child. I used to surf competitively.

Ed: A real surfer dude?

CG: I'd like to think I am, but I'm balding and ageing and arthritic now! But I still surf quite seriously and try to get into the water every week throughout the year.

Ed: Where do you usually do that?

CG: I live in Tynemouth, so I surf there and anywhere more exotic if I can wangle a holiday. So over the years I've managed to get to some of the major breaks around the world. It's my way of relaxation and completely different to medicine.

Ed: Do the family join you in it?

CG: My eldest surfs. The rest of them don't.

They're sick of sitting on beaches stranded miles from anywhere. So it's very much a personal interest. But I have a real love of the sea, so if I'm not surfing I'll go fishing or scuba diving. I've always had hobbies around the sea.

Ed: You don't sail?

CG: I do sail.

Ed: What sort of sailing do you do?

CG: I've sailed 30ft boats. We've been around Turkey, the Med, Greece. So as a family we've done quite a number of sailing holidays. We used to do a bit of small boat sailing as well.

Ed: If we can get back to the more mundane world of the NHS – in the wake of Mid Staffs and Francis I must ask how you think this will affect the way we work and the way we think of ourselves and our patients.

CG: Mid Staffs needs to be put into the context that the vast majority of doctors do the right thing at the right time, but perhaps around them sometimes the systems don't work. I think there is a danger that the professions come away from Mid Staffs feeling very damaged from this, and we need to be reassured where we are doing things correctly. And we need to support clinicians, nurses and all the other professions who are doing a very good job and be supporting the systems which are safe and effective as well. So I think the challenge going forward is about system reorganisation as much as anything else. There are variations in all organisations – good practice and practice that is less than good. But we do need to keep in context that the vast majority of patient contacts are problem-free and very well received. But there is a lot to learn from Francis. I don't think we should be falsely reassured that we're all doing a good job – far from it. But we each individually as clinicians need to look at our practice, look at the systems and really align them to patient expectations as we go forward. I think we are somewhat behind in what we deliver and what patients expect.

Ed: Our Trust has been through quite a bit of turmoil in recent years. What part do you think the Medical Director can play to improve morale?

CG: That's one of the real challenges I look forward to addressing. It probably isn't peculiar to County Durham and Darlington that consultants, clinicians, healthcare professionals are very disillusioned. They have gone through reform in many organisations. What we have to do as doctors is understand our role as leaders. If we can't take this forward then no one will. So we have to support ourselves as leaders, we have to develop ourselves as leaders and actually influence from a leadership position. This is very different from influencing as a clinician. We can't always get what we want but we have to learn how to negotiate and how to compromise with other professions with new patient pathways to try and improve things. We can turn change round to be a positive. But you have to get engagement, and for those who don't engage we have to understand what it is that's stopping them, what the barriers are, what the problems are and understand why their journey has led them to a point where they feel they can't engage.

Ed: Related to that, could I ask you to look in your crystal ball. How different do you think the NHS will look in five or ten years, particularly in the North East?

CG: The North East is quite an isolated health economy. If we were to compare

ourselves to London or the Midlands it is very different. Our patients rely on local hospitals, local communities delivering care. I have no doubt that with the new reforms there will be more external providers of care, and in some instances they will provide very good, high quality care. So I think there will be a new element of competition, and we will need to meet the challenge of this as traditional providers of care. Rather than fearing that, we should look on this as being quite exciting. Because we are the experienced providers of care and if we believe that we are good at what we do we should be able to meet that challenge. We have to have a confidence about that, but how it will look in five years time – I think that is very difficult. The political landscape will change as well.

Ed: It has been said for a long time that there are too many hospitals in the North East. Do you think there are?

CG: I think there are, yes. If you look at the geography and the population there are too many hospitals. But actually as one who has looked after older people throughout my career, they need local healthcare services. The question is – what do you call them? If you call them "hospitals" and expect them to provide the traditional comprehensive range of services then – yes – there probably are too many. But if we look at local providers of care who provide services to local communities which are appropriate, then there probably aren't. So it's about reorganising services and establishing what is core for the community.

Ed: Do you think the concept of polyclinics might be part of this?

CG: "Polyclinic" is a bit of a damaged term in a sense that where they were implemented they didn't really work. The current hospital in a sense is a polyclinic. As we look forward we will have multi-professional polyclinics under the umbrella of a hospital which provides core services and is a central resource for education and training, for research and leadership development and also career development. I see the hospital as very focal to the local healthcare community, but not necessarily having to provide everything as we go forward.

Ed: Turning away from medicine again, I always like to ask what book you would take if you were cast away on the mythical Desert Island. The Bible and Shakespeare are there already.

CG: I find that quite difficult. I'm a scan reader. If I have a novel the challenge is to finish it. If I'm on a rail journey of an hour and a half it has to be read in an hour and a half, or a flight of four hours it's read in four hours! If I'm on a desert island with a book – for me as a surfer that would be heaven. But I'm really interested in natural history, so I'd probably want to read Attenborough's books.

Ed: We'll see if we can bind those into one volume for you. And I suppose your luxury would be a surf board?

CG: No, because a surf board is a basic requirement.

Ed: But you wouldn't be allowed to use it to escape!

CG: That's right. But my luxury would be a golf club and an unlimited supply of golf balls. I'm not a good golfer – my sons beat me every time. So the opportunity to practise uninterrupted would be fantastic.

Ed: We'll try and organise that for you, and thank you very much indeed for talking to me.