FACULTY OF PRE-HOSPITAL CARE

STUDENT & TRAINEE GROUP

Career Insight

Career Insight:

Dr Emma Butterfield

Intensive Care Trainee and current **HEMS Doctor with East Anglian Air Ambulance** (EAAA)

Interviewer: Reuben Alexander, FPHC STG East of England Representative

Editor and Graphic Design: Dr Sophie Riley, Chair of the FPHC Student and Trainee Group

Please tell me about your career pathway?

I did my foundation jobs in the West Midlands. In my F3 year I worked in Mexico in a small hospital and in Honduras in a little primary health clinic in the rainforest, and I locumed in the emergency department to fund that.

When I got back, I did ACCS-EM Training in London for three years and then went to Australia where I did two years of full-time aeromedical retrieval in Queensland. Then I spent six months working in the emergency department in Darwin (Australia) and working part-time in an immigration detention centre. Then I moved to Cairns (Australia) where I worked in ICU and did retrieval part-time.

When I came back to the UK I spent a year as a clinical fellow in ICU in Cambridge, followed by 15 months as a HEMS doctor with East Anglian Air Ambulance. Then I worked in Sierra Leone for four months before starting ICM training in London last year, which I've combined with a job flying for EAAA part-time.

You've been across the globe practicing medicine, what led you to want to go abroad to all these different places?

My interest has always been in humanitarian medicine, by which I mean trying to ensure health equity - distributing healthcare resources according to the humanitarian principles in the national population and globally. So I've always been interested in working with organisations that seek to do that - which has led me to work in interesting places.

My interest has always been in trying to provide health care to the people who need it most because I believe that healthcare is a human right, and we have a social duty as humans to try to look after one another.

A follow-on question from that is, is during your work in Latin America, are you able to speak Spanish or the local languages? Was there a linguistic barrier in that area of the world?

Yes, I speak Spanish. But most of my patients spoke Tzotzil or Tzeltal as their first language in Mexico and Garifuna as their first language in Honduras. Often with the patients in Mexico, I was very dependent on the interpreter from Tzotzil or Tzeltal to Spanish, so there was certainly potential for miscommunication, particularly as I was then often thinking in English. I think working in your second language makes you reflect a lot on the nuances of communication - there is so much potential for misunderstanding. It has certainly reinforced my admiration for our innumerable colleagues in the UK who speak English as a second or third language, and who nonetheless communicate effectively.

From your experience working both in hospital and out of hospital, what are the biggest differences between the two environments?

> I think the biggest difference is that Pre-Hospital I know exactly what kit I have, and exactly where it is. I know the paramedic or nurse who I'm working with normally very well.

I know exactly what our skill set is as a team, and I know what is beyond our skill set. By contrast, working in a hospital those things are often unclear, particularly as a trainee who's rotating between hospitals. You do have more people, resources and expertise available, but often you don't know what kit's available, where it's kept, or if it's working. You often don't know the people you're working with. And that makes it much harder to know the capabilities of the team at any given moment.

When did you know you wanted to do Pre-Hospital Care and was there someone or something that inspired you to do so?

My interest has always been humanitarian medicine, the Pre-Hospital component came much later. I've met lots of inspirational Pre-Hospital doctors, nurses and paramedics, but the initial trigger for my interest was during my ST3 year at the Royal London. I remember watching the HEMS consultants there run trauma calls and manage a busy shop floor. They seemed unflappable, and knew how to make things happen, which I was really impressed by and thought, "I would really love to have that skill set".

In medical school you learn *what* should happen, but not *how* to make it happen, and to be effective, you need to know both.

What are the biggest challenges in Pre-Hospital care for you?

I already mentioned the practical challenge of finite resources, but that's easy to anticipate,

and in some ways is more of an advantage than a disadvantage. You learn to do what you can with what you have and where you are, which is also very translatable to humanitarian work.

> The challenge that I didn't anticipate was the emotional aspect. In hospital, we see families and patients who've received devastating news and are in a very acute phase of coming to terms with that. However in the Pre-Hospital environment you see people even earlier in their trauma, grief and shock. And that is even more immediate and heartbreaking.

The deaths that you bear witness to in the Pre-Hospital context can be very different. You see quite a lot of trauma death and seeing that, particularly in the place that it's occurred, where you can see the fatal consequences of miniscule decisions, really brings home the inevitability of death, and the fragility and preciousness of life.

What lessons from Pre-Hospital care have you applied to your in-hospital practice?

The first thing I learned is familiarity with kit. In hospital often there is a surplus of kit, and there is an assumption that it will just work. Sometimes that's not the case. Learning how to check and charge and reassemble bits of kit has been incredibly useful.

The next thing is teamwork. All of us have been taught to allocate roles and to communicate directly and not make assumptions. But in the Pre-Hospital environment you become used to being really direct about declaring what you think the situation is, what you think needs to happen, what the jobs are, allocating jobs, and then asking people if they can fulfil those roles. And you get way more comfortable with it. I find that really useful.

Similarly, with that I think one of the key decisions in Pre-Hospital is often dichotomised as "Scoop and run" or "Stay and play". Is this a pathology that can only be treated in a hospital? In that case our goal is to get to a hospital as soon as possible. Or is this a pathology for which the Pre-Hospital team offers the same level of care as an in-hospital team? In that case the Pre-Hospital team's focus should very much be on providing the best quality care here and now.

The same applies to in-hospital scenarios. With a severely septic patient in resus, the focus doesn't need to be on transferring them to the ICU: resus has the same resources as an intensive care unit. The focus should be on delivering excellent critical care. Geographically, where the patient is in the hospital is not going to be the determinant of their outcome. Conversely, a patient with non-compressible haemorrhage needs to be in an operating theatre, which is the only place their pathology can be treated. Learning to quickly

differentiate between those scenarios, and being able to inject momentum where necessary, are key skills I've learned pre-hospital.

Where do you see Pre-Hospital Care developing in the future?

Looking ahead, I believe it would be a sensible thing to differentiate between Pre-Hospital care and out-of-hospital care. At the moment both get bundled under the banner of pre-hospital care, and they're not the same. In my mind, Pre-Hospital care is the care you deliver enroute to a hospital in an acutely unwell patient who is always going to need a hospital admission.

And out of hospital care is the care you deliver to a patient who doesn't necessarily need to go to a hospital. Like an urgent care paramedic going to see someone in their home with an exacerbation of COPD, giving them a nebuliser and a rescue pack, and allowing them to stay home.

I think out of hospital care is really becoming increasingly important because hospitals are not great places for people. Hospital admission can be unpleasant, dehumanizing, and incapacitating. It's far better to treat people at home if their home is a safe place for them to be. I think there's going to be a huge expansion in out-of-hospital care. Telehealth and the increasing recognition of the clinical skill sets of non-doctors are going to be key to implementing that.

What advice would you give to those looking to be involved in Pre-Hospital Care?

> The most important thing is to "know your why" - really reflect on what aspect of Pre-Hospital care interests you and motivates you.

If you're motivated by helicopters or working around high-performance machines, you might be equally fulfilled being an F1 race doctor. And, conversely, if the aspect of Pre-Hospital care that really interests you is being a bit remote and making do with finite resources, you might be really fulfilled doing expedition medicine or going to work in Antarctica or working on a cruise ship. In the same vein, if you're interested in research, if you're interested in volunteering, if you're interested in quality improvement, if you're interested in fundraising, all of those are ways to connect with the prehospital community.

> If you pursue your true interests, you'll end up being very good at what you do because your heart will be in it. Also, if Pre-Hospital care has taught me one thing, it's that we each have one life, and it's very finite. You should enjoy it.

Acronyms:

ACCS: Acute Care Common Stem
COPD: Chronic Obstructive Pulmonary Disease
EAAA: East Anglian Air Ambulance
EM: Emergency Medicine
F3: Foundation 3
HEMS: Helicopter Emergency Medical Services
ICM: Intensive Care Medicine
ICU: Intensive Care Unit