FACULTY OF
PRE-HOSPITAL CARE

STUDENT & TRAINEE GROUP

Career Insight

Career Insight:

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Please tell me about your career pathway?

I graduated from Leeds university having done 6 years of medical school as I'd done an intercalated degree as well. Then I got my foundation programme jobs in West Yorkshire, had done F1 and F2 and then took an F3 as I didn't think my portfolio was really strong enough to apply for ACCS so used that time to do some extra bits and bobs, some courses. Then I applied for ACCS emergency medicine back when it wasn't ultra-competitive and got in in West Yorkshire. I was a run through trainee - which most people are now but at the time there used to be lots of uncoupled trainees – but I knew I was going to come out the end as a consultant in West Yorkshire. So I did CT1, 2 and 3 and then had a fellowship at Mid Yorkshire hospitals as a Pre-Hospital clinical fellow between ST3 and ST4. Unfortunately, that was probably only 6 months worth of actual experience because then it was Covid, so I did the back end of that as a clinical fellow at mid Yorks through Covid and then went back to ST4. I was approaching the end of ST6 and had been doing voluntary Pre-Hospital stuff all the way from about CT2 onwards. So that initially was as a Community First Responder (CFR) with the ambulance service. Then I joined West Yorkshire Medics Response Team which is sort of a BASICS organisation that is really aimed at providing training opportunities for doctors in Yorkshire to access prehospital emergency medicine – it's a doctor paramedic car based team, and I'd been doing that all the way through training. I was sort of in a position where that was all I'd really done and I'd not felt able to apply for a PHEM training post because it would involve moving out of the region which I wasn't able to at that time. I was sort of at a juncture where I was coming to the end of ST6, applying for substantive consultant posts, and

maybe accepting that I'd have to access a career in PHEM from some other odd self-made alternative route. I'd applied for a consultant job at Leeds and there were supposedly 4 posts then there were only 3 and I didn't make that third post so they said that they'd get in touch with me in a couple of weeks. There was nowhere else advertising for consultant jobs so handily the right people pushed the Lincs and Notts clinical fellow job under my nose and I applied for that, and interviewed for that. By the time Leeds had got back to me that they had a consultant job ready for me to start in August, I'd been successful in applying for the Lincs and Notts clinical fellow job. Thankfully Leeds were happy enough to defer my start date for 12 months whilst I went off and did my fellowship.

That was a real sliding doors moment for me – had those events not happened in the order that they'd happen I'd have, I say 'just', just been a substantive consultant in Leeds, but I got the fellowship which was great. And that opened up tons of doors as I'd done a proper HEMS fellowship and had some on the books paid Pre-Hospital experience. That was a 6 month full time post at LNAA and 6 months in ED at Northern General. And after the 6 months full time HEMS, I was then kept on as a HEMS doctor. Its sort of a bank working/locum working/zero hours contract set up with the charity which is how we all do it.

I finished my fellowship, took up my consultant job at Leeds and in that time Yorkshire Ambulance Service had advertised the MERIT role which is a doctor-paramedic critical care car with a major incident role, so I applied for that. By January 2025, I ended up with 3 jobs: 10 PA contract with Leeds as an EM consultant, 2 and a bit PAs with Yorkshire ambulance service as a merit doctor and then ad-hoc 3-4 HEMS shifts a month as a HEMS doctor LNAA.

> "I sort of went from famine to feast in terms of a prehospital portfolio of work."

What inspired you to become involved in Pre-Hospital Care?

> "I never actually wanted to be a doctor, I always wanted to be a paramedic. I think the idea of working in an environment outside of a hospital always appealed to me."

I liked the variety that Pre-Hospital primary care provision offers, medical trauma and everything in between – Obs and Gynae, loads of stuff, which, once you specialise as a doctor you don't

get anymore as you just stay very much in your lane. Even as EM consultants there's some stuff that's just not part of our job role anymore as specialities have just taken them on themselves. Paramedicine always really appealed to me for that reason.

I had my sights firmly set on being a paramedic. Then, as it came to university applications, I spoke to a careers adviser for paramedicine at Sheffield Hallam who was like 'you probably have the grades to think about medicine instead' and he introduced me to the concept of doctors doing Pre-Hospital emergency medicine. So I explored that instead and pulled on that thread and I applied to medical school instead. Thankfully I was successful because I'd written my personal statement for UCAS very much aimed at medical school and predictably Sheffield Hallam paramedic course were like you definitely want to be a doctor not a paramedic, so we're not going to offer you a place, we're no ones second choice, which is absolutely fair play to them. Had I not got into medical school I'd have ended up doing Biomedical Science which would have been an alternative route eventually, a bit longer journey but it was lucky that Leeds let me in as Sheffield Hallam weren't interested in having a wannabe doctor on their paramedic course.

Essentially as soon as I started medical school, and throughout the rest of my training, this has always been the end goal. To have reached it is somewhat surreal really. To have ended up here after 10-11 years of training with a feast of Pre-Hospital exposure and experience, I consider myself very lucky.

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

> So I think the thing that is most useful to either doctors or prospective doctors who want careers in PHEM is diversity of exposure.

PHEM comes in many forms and really diverse level of acuity and exposure - and doctors I think can make themselves really useful in the Pre-Hospital environment, not just as part of a team that provides extended surgical skills, and RSI's and all the rest of it – I think particularly as emergency medics, our knowledge of the lowest of acuity to the highest of acuity comes in really handy.

It's the same with paramedics who come from the road into a critical care paramedic role. They're just as happy picking up an older person off the floor, checking them over, making sure that they are ok, you know that clinical acumen comes in really handy. So as a medical student or as doctor looking at a career in PHEM, you have to have sampled all of the different aspects of it. So find

ways to get exposure to events medicine, sports medicine. Yes, absolutely expose yourself to working with the ambulance service because it is a very unique perspective on doing the job. I always describe it as – you think you know how to look after a trauma patient until you go out and do it on a roadside or in a third floor flat. It's the environment which makes the medicine difficult – so putting yourself in that environment – even if it's, like I did it in the beginning as a Community First Responder. You're going to breathlessness or cardiac arrests, you know CAT 1 jobs that perhaps turn out to be nothing but you're still sat in someone's living room, you're still talking to them, you're still working out how you're going to get them from their third-floor bedroom out to the ambulance. Those are the things that make the medicine hard as a doctor in that environment. So just putting yourself in that, even if it's with low acuity stuff, is ultra useful. Plus, working alongside the other associated services, working with police, working with fire and rescue, working with all the different levels of people working for the ambulance service, and getting used to that, is really important because as a prehospital doctor you will then be leading those flash teams. Knowing who everyone is, what gets them engaged in a job, how to utilise those different individuals on scene.

With the benefit of hindsight, I should have been doing that from the first year of medical school, and I just wasn't, and I think that made the rest of it a lot harder. Thankfully I was offered the opportunities early on in my training to make up the difference but the competition for places is only getting higher and higher, its only getting more and more competitive, so I think even if 5% of your time from year one of medical school is devoted to dipping in to Pre-Hospital stuff – some event medicine work, St Johns ambulance all that sort of stuff, is gold dust 10 years later when you're applying for that HEMS fellow post because it just shows that you know what you're doing. It implies that you've done all of the experiential pre-reading to then step out of a helicopter or critical care car and exist in that environment.

> "In my experience, the medicine is the same as it is in hospital. You might have less tools, you might have less drugs but the medicine, the patients are the same. It's the environment that is the challenge, and it's the flash teams that are the challenge."

I have the luxury in ED of knowing everybody, when you've worked there for long enough, which is a true luxury. I can look at someone, I know their name, I can ask them to do a job and I know that they're competent to do that job, or maybe it's not within their competency so I need to ask someone else. You know, when we turn up to a job, I don't know anybody's name, I don't know anybody's competencies, I'm lucky if I recognise a face.

That could mean that the two of us as a team are in it together or it could mean that we need to engage with that team already with the patient and motivate them to progress the patient care in the direction that we as the enhanced care team think it needs to go.

> I think you need to have existed in that environment before you consider apply for a PHEM training post or HEMS fellowship.

I think also for yourself, because I think they are the rabbit in the headlight moments for HEMS doctors when you're like 'oh god, this is a busy confronting scene, with people with 20 years in the ambulance service, who are now looking at me, as to like what do we do doctor?', and that job isn't for everyone. I think there's a lot of potential to be morally injured by putting yourself in that without having exposed yourself to it where you're not the decision maker, where everyone's not looking to you. I remember being there as a CFR and being pretty anonymous, which was great. You could just do a set of obs, stand back and just watch everyone get on with it, and soak up the atmosphere and the way people speak to each other and it was just brilliant. You learn so much by being an observer, and so doing something that allows you to stand back and watch that environment early on in your career, I think is invaluable.

What are the greatest challenges involved in Pre-Hospital Care for you?

When you're actually on the job, some of the biggest challenges are skill maintenance – I've just been on for the past 48hrs and we've not made a patient contact. How do you maintain your skills and your clinical currency in the peaks and troughs of just the nature of the beast of enhanced care team work, sometimes the jobs just aren't out there when you're on shift. So how do you manage that? How do you reassure yourself and your colleagues, that when that jobs does come in, your skills and your competencies are as tuned up as they can be. I think that's one of the biggest challenges in the job.

I think outside of the job, there is still the acknowledgement that you are probably going to have to commit a fair bit of your free time, to sort of almost take care of the first point. There aren't many people who make a career just of Pre-Hospital Emergency Medicine and I would maybe argue that its hard to do that because I think you get quite a warped view of what medicine and things look like. We benefit from having a 'day' job if you like, because that day job then really helps you do your 'hobby' job I guess if you like, of the Pre-Hospital work – plenty of people make it work but personally, I think they're very complementary roles.

But that means that I have to have a day job, so therefore I have to have a bolt on to my day job. I know when I got the MERIT job, I spoke

to my clinical director about dropping some PA's but I'd literally been in post for about 2 months and predictably they weren't amenable to me dropping 2 PA's just after starting as a 10 PA consultant. So that was a trade-off – that was sacrificing some of my free time that I was gaining by going onto a consultant rota. By the same token, I do my HEMS stuff essentially in my free time – although it is paid, you are still sacrificing what would have been free time to go and do it.

That has an impact. I think if you can put mitigations in place for that then that's fine. I definitely know colleagues who are burning the candles at both ends to try and do as much as they can and still have a family life and still do all those things. By its very nature, the job that we do can lead to those situations where – you know, I've been on shift and out of the house for the last 3 days, I do a difficult job today which I'm still thinking about when I get home tonight, but I then really want to be at home, be present and engaged at home life, but I've just stepped out of an environment with big swings in adrenaline, potentially some stuff that we need to mull over in the next week and metabolise but you want to go home and enjoy your family time as well.

I think that balance is really hard to strike – there is a sacrifice there I think as a clinician that you have to make. Now, do I think that's necessarily a bad thing, that individuals have to perhaps go a bit above and beyond everybody else to work these jobs? I think there's two sides of that coin.

I think it means that some people won't be able to do that who would have made very good Pre-Hospital clinicians but for whatever their circumstances are, they can't sacrifice that time and therefore miss out on being that flavour of doctor that they actually really want to be. What I hope is the trade-off for that is that the people who end up in those roles really really want to be there, and hopefully are the best people to be in those roles because they're the top 5-10% of people in that they really want to be there - now it's nice for me to include myself in that, which I don't, I was lucky enough for the stars to align for me to get this job but, I think it's like any job which has a tier of performance above the day to day work where you have that trade off where we sort of need you to be the best of the best because we're going to put you in environments where you're going to have to be the best. But how are we going to get you there – maybe that means that you as an individual are going to have to do things that other people perhaps aren't prepared to do to get yourself there.

> “I've had lots and lots of colleagues along the way through training who've had an interest in this and who for whatever reason pushed it by the wayside. I think they'd be really interesting people to capture, asking them why didn't you end up doing HEMS, did you consider it and if so why didn't you end up doing it?”

> I hope that, because generic training is getting a lot more accommodating to real life, that the by-product of that is that accessing a career in PHEM will do as well.

I benefit from being a run through trainee, I had rapid progression through training, rapid progression to consultancy which just meant that at the times that these jobs were coming out I was eligible to apply for them, because I was already a consultant. There were plenty of people who were less than full time for whatever reason who weren't eligible to apply for them simply because they were less than full time and I'd overtaken them if you like, in training. And I guess that's just the luck of the draw, and the choices that we make.

I think one of the biggest pros of Emergency Medicine training was when we moved to less than full time working, which has retained so many excellent clinicians who ten years ago would have given it up to go and do some other job which they perceived to have a better work life balance than emergency medicine. I hope that because those people have been retained in training, those people will then end up in PHEM because they've stayed in a speciality that can do it. I hope they don't have to sacrifice perhaps what people 10 or 15 years ago had to sacrifice to get the jobs that they have. I hope that doesn't continue, but I think that is a challenge, that there is some sacrifice involved in order to keep momentum to get where you need to go.

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

I'm a bit swayed by some of the stuff that's being banded about at LNAA at the moment. We should be the service that offers something beyond an algorithm. The people who can offer directed, targeted, patient centred Pre-Hospital Emergency Medicine. That might mean getting out sexy kit, sexy drugs, doing extra stuff or it might mean the exact opposite. Not doing some of the stuff, because we know that the patient centred outcomes aren't in favour of intervening. We should be able to, when we arrive on scene, all of the really good stuff that's been done already can continue, we don't need to get involved in that, because all of the other excellent stuff is happening. We should be there because there is something extra, either decision making or kit wise or knowledge wise that we can have the luxury of bringing to that patient's care.

I have huge empathy for my colleagues at work who have been in their ED consultant jobs for 20 years and have found it really hard to access meaningful CPD, meaningful knowledge. I have the privilege of working alongside people who are pushing the boundaries of the speciality every day. I am gifted that knowledge just by virtue of working in the job with them, I don't have to seek that myself. I tune in to 2 hours of CPD every week with

LNAA if I can and just sit there and absorb as much of that goodness that other people have put the leg work in. and my day job colleagues don't have that opportunity. So, if we can be those people who are at the absolute forefront and up to date on all the research and the new stuff coming in, that knowledge is what we should be bringing to each job.

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

> I'd say it's the drive to be 10 steps ahead of any clinical situation. As a leader it's my job to know everyone else's job inside out, and to be able to anticipate the next steps for the patient and to prepare for them.

In the pre-hospital setting this minimises our on-scene time and makes treatment plans slick and effective. In hospital, these transferrable skills help build efficiency into the team and in resus, they help get the patient to definitive care in a safe and effective way.

Acronyms:

ACCS: Acute Care Common Stem
CPD: Continuing Professional Development
CFR: Community First Responder
CT: Core Trainee
ED: Emergency Department
HEMS: Helicopter Emergency Medical Services
LNAA: Lincs and Notts Air Ambulance
MERIT: Medical Emergency Response Incident Team
PA: Programmed Activity
PHEM: Pre-Hospital Emergency Medicine
RSI: Rapid Sequence Induction