FACILITATED ELECTIVE IN PHEM

London Ambulance Service

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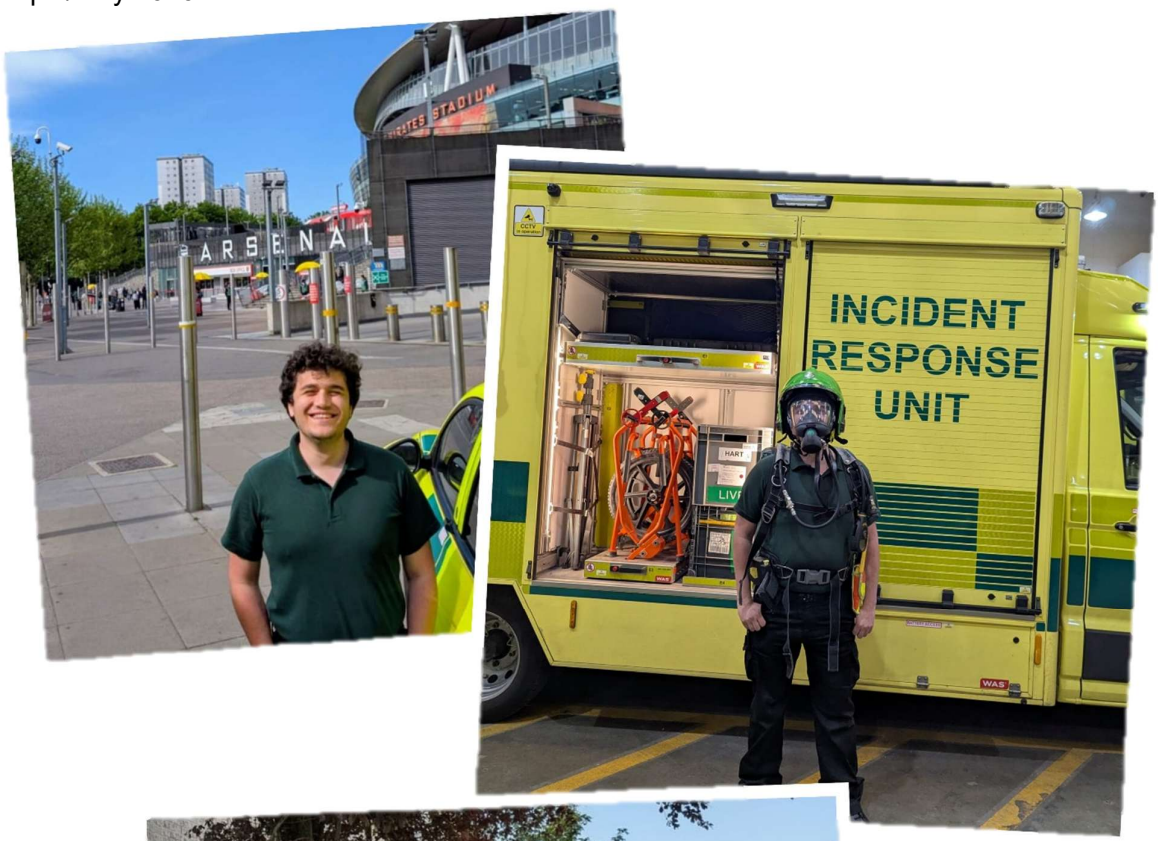

Placement Overview

At the end of my fourth year of medical school, I was selected by the Faculty of Pre-hospital Care to undertake a facilitated PHEM elective with the London Ambulance Service (LAS). This was an amazing experience, spending 5 weeks observing a range of resources. This included time in the control room and clinical hub, Double Crewed Ambulances (DCA), Fast Response Units (FRU), Advanced Paramedic Practitioners in Critical Care (APPCC), Tactical/Joint Response Units, the Hazardous Area Response Team, the Mental Health Joint Response Car, and London's Air Ambulance's (LAA) Rapid Response Vehicle, as well as event medicine cover at the London Marathon and a clinical governance day.

This report details the some of key experiences from these 5 weeks, broken down into the reflections and lessons I learnt from some of these resources, along with some anonymised cases to illustrate these.

Reflections

Control Room, Clinical Hub and Dispatch

My elective started with a day at LAS HQ, observing call handlers, dispatchers, the clinical hub (staffed by paramedics doing in-depth telephone triage and guidance), and the urgent care, critical care, and LAA desks. It was eye-opening to see the difficulties call handlers' face: difficult conversations with emotional or angry patients; frequent language barriers; and the challenge of extracting useable, accurate information over the phone. This helped me understand the paucity of information I'd often later see paramedics receive before arriving on scene, and the confusion when the actual job on arrival didn't match the dispatch information.

I also saw the constant juggling act of too many jobs and not enough crews, and was impressed by how well handlers covering neighbouring areas worked together, dynamically swapping crews between areas to respond as efficiently as possible. Sitting in on the critical care and LAA desk, I listened to calls where these enhanced resources were being considered for dispatch, including relatives receiving telephone-guided CPR instructions for a family member in cardiac arrest. This was emotionally challenging, and a good reminder of the human being on the other end of every call.

This day really demonstrated how difficult information can be to gather in the pre-hospital sphere, and how therefore important it is to assess a patient with a wide diagnostic net rather than focussing down too early based on previous information.

Double Crewed Ambulance

Two days on a DCA in north London gave me a really varied caseload, from minor injury and illness through to some severe mental health presentations and septic older patients. It was interesting, and at times upsetting, to see the living conditions some patients were in. The crew were welcoming and let me get properly stuck in, taking histories and doing examinations on undifferentiated patients in a completely different setting to the hospital, which was a great way to practice those skills. I spent a lot of time with the crew discussing

management and onward planning, particularly the decision of when to convey a patient to hospital and when best to leave patients at home.

This gave me a much better appreciation of some of the reasons behind conveyances that hospital staff can find frustrating. The paramedics were often limited by their lack of access to investigations that would let them safely leave someone at home. It was reassuring to see the steps LAS are taking to address this, including a clinical support desk staffed by an ED doctor that crews can call to discuss and potentially safely leave borderline patients at home, and urgent care paramedics who can attend and perform skills such as on-scene wound closure. We had an urgent care paramedic attend one of our patients, a known epileptic who'd sustained a laceration during a seizure, and prevented an unnecessary conveyance and admission by suturing their laceration closed.

These shifts helped me appreciate the unique interface between socioeconomic factors, patient-centred care, and emergency care that pre-hospital medicine sits in.

Fast Response Unit

FRUs are used to attend more urgent calls, category 1 and 2s, quicker than DCAs can get there. As they don’t convey patients they’re less likely to be held up as hospital, and hence can arrive on scene and initiate treatment until a DCA arrives to convey. On my 3 FRU shifts we attended cardiac arrests, status epilepticus, a stabbing, and suicide attempts amongst others.

The first cardiac arrest we attended presented interesting challenges for human factors. The patient was in a dark room with inadequate floor space for 360-degree access, up a cramped first-floor staircase. We had to quickly flip a bed and move furniture once the second crew arrived in order to create enough space to work. A clinical team manager (CTM) arrived shortly and took over running the resus, and set up mechanical CPR on the patient, which was my first exposure to it outside of simulations. It noticeably changed the dynamics of the resus in that once it was running, the scene notably felt calmer, likely as we weren't constantly rotating people in and out of the small space to swap chest compressions.

Despite ALS being started very soon after the initial phone call, we unfortunately didn't get a good outcome. I then observed my crewmate breaking the news to the family. He had an excellent mix of matter-of-fact and sensitivity in his delivery, giving the relative time to process while being very clear about the key facts. The CTM lead a very good debrief afterwards. She checked in on me personally and also genuinely asked for my perspective on how they'd done, since they don't get much exposure to in-hospital resuscitation. I found this was an excellent attitude to learning from other healthcare professionals, something which I want to emulate after graduating, especially since the prehospital resuscitations I saw were run more efficiently and calmly than most of the in-hospital resuscitations I've seen. The CTM was candid that she felt she could have deployed the mechanical CPR more smoothly, it being her first live use of it, and the other paramedics offered to run more sims with her afterwards.

I felt this attitude to debriefing and learning was brilliant, and this along with the breaking bad news I observed has really stuck with me, and given me some communication skills I will be bringing to my future practice.

Advanced Paramedic Practitioners in Critical Care

LAS APP-CCs can bring enhanced knowledge and skills, such as critical care drugs, video laryngoscopy, and point-of-care ultrasound, to the most serious calls, generally major trauma and cardiac arrests. On my shifts I observed intubation in a difficult environment using video laryngoscopy, point-of-care ultrasound used to assess cardiac contractility intra-arrest, and analgesia of a severe burns patient.

I also saw a ROSC on scene, which then had a challenging post-ROSC extrication, and then transfer to hospital with ventilation and titrated inotropes en-route as the patient was still very haemodynamically unstable. The handover to the receiving hospital was excellent, with good closed-loop communication where the critical care paramedic asked the receiving doctor to repeat back the critical pieces of information, which I hadn't seen done so deliberately before.

While the extended skills and knowledge brought to jobs by the APPCCs were of course important, I was most struck by the calmness that they brought to the scenes. While these were often once-in-a-year jobs for the DCAs, they were normal for the APPCCs, and their decisiveness and composure clearly rubbed off on the rest of the team. I aspire to one day be able to bring this level of calm to emergency situations.

London's Air Ambulance – Rapid Response Vehicle

LAA’s RRVs are staffed by a HEMS doctor and a paramedic, and provide the same advanced interventions as their helicopter, though without the ability to convey a patient. They bring enhanced and critical care skills, especially for trauma, to patients across London.

There was a lot of downtime on the shift I observed, which gave me a good chance to talk to the LAA doctor about future career plans, what I should be doing to stand out, and current trends in the field. When on a job, I observed prehospital emergency anaesthesia for status epilepticus, which was interesting to watch. The LAA doctor briefed everyone on scene about what was about to happen and asked for silence throughout, unless someone saw something dangerous developing, helping control a key human factor. On top of that, an in-depth checklist was used with full pre-checks: backup oxygen, backup airway including a front-of-neck-access plan, backup drugs, backup suction, and backup access/IO all ready before starting.

Having seen in-hospital RSIs go wrong before with no backups prepared, and the panic that follows, it was good to see a more structured and safe approach. I think this approach should be used far more in-hospital, and I will definitely take this forward when I graduate.

Conclusion

Across this elective I saw prehospital care delivered at every level, from a DCA crew attending borderline patients in the community, up to HEMS-led anaesthesia and major incident response. The recurring theme for me was how much good prehospital care depends on non-clinical skills: managing human factors, communicating clearly under pressure, open and honest debriefs, and a willingness to learn. I was constantly grateful for how welcoming the paramedics and other staff I worked with were, getting me involved, answering my questions, checking in on me, and asking for my opinion. I learnt a lot about pre-hospital care that I will bring into my future practice, but also greatly enjoyed driving around London on blue lights, chatting with crews at station, and visiting as many coffee shops as possible. This placement has reinforced my long-standing interest in emergency medicine and pre-hospital emergency medicine as a career direction, and has taught me a lot about how to work effectively in high pressure situations. If anyone wants to know any more about what the elective was like or advice, feel free to send me an email (C.Tullar@doctors.net.uk).

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