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ACCIDENT + EMERGENCY

ELECTIVE REPORT

PRE-HOSPITAL MEDICINE WITH LONDON AMBULANCE SERVICE

06/05/13-07/06/13

1. Compare the main conditions seen pre-hospitally to those seen by a GP.

Generally the conditions I saw pre-hospitally were more acute than those seen by the GP, as would be expected. However for many calls it would have been more appropriate for the patient to have made an appointment with their GP or minor injury centre than to call an ambulance, for example someone with knee pain who was able to walk.

I saw a huge variety of injuries and conditions covering a wide range of specialties and in very young to very old, much like a GP would. However in the pre-hospital environment it is most likely that you wouldn't know the patient or have access to their past notes, unlike a GP who may know them very well and should have access to information about the patient before they enter their room at the surgery. Also as a GP it is your role to manage whatever happens over the long term rather than deal with the immediate problems and hand them over.

The types of call tended to change depending on the time of day and time of the week. It was much more common to be dealing with alcohol-related problems and assaults in evenings and over the weekend. LAS figures show that over 7% of calls to the area of London I was based at are for alcohol-related incidents and this is the experience I had too, especially when I was on weekend night shifts.

2. Discuss the different pathways of entry into hospital

For most of the calls I went to the patients were transported in the ambulance to the most convenient A&E department, where they were seen as they normally would if they had gone there by themselves.

There were trauma calls that went straight to a major trauma centre with a team of specialist doctors, nurses and healthcare assistants waiting to take over the patient as soon as they arrived at the hospital and were handed over.

For patients with a suspected stroke there is a pathway taking them to the nearest hyper-acute stroke unit, where they would have been assessed by specialists for the most effective treatment as quickly as possible.

For patients with ST elevation myocardial infarction or new left bundle branch block seen on ECG, there was the ability to take them straight to a cath lab for percutaneous coronary intervention, bypassing A&E and allowing for rapid management.

Other pathways include a falls pathway for elderly patients to help manage their risk of further falls, where a falls team will go and visit them at their home.

On Friday and Saturday nights there is also an alcohol recovery centre in Soho specifically for those patients who have had too much to drink. This service allows hospital beds in A&E to be freed up for other patients, whilst still allowing them to be monitored and discharged once sober.

3. How are common presentations dealt with in the pre-hospital environment compared to within the hospital?

What you can do for a patient out of hospital is obviously more limited than what you can do in hospital, and for paramedics management is based a lot on protocols and flowcharts, however the main principles are the same. Most cases I saw were not immediately life-threatening so I took a history and examined the patient as I would in hospital, although they were briefer histories than a full clerking. Relevant observations were taken and initial management started according to the working diagnosis.

Immediate management of life-threatening conditions is effectively the same although could be more complicated due to difficulties with the environment and having fewer members of the healthcare team around to do different jobs.

4. How will my experiences with the London Ambulance Service in the pre-hospital environment help me to be a better doctor in the future?

I wanted to get more experience of pre-hospital and emergency medicine as this is a pathway I think I may be interested in following in my future as a doctor. By going out of hospital I was able to get a different experience of acute medicine than that I already had from being on my A&E placement, as I was with the people who were usually the first on scene to see the patient and start their management.

It was a challenge to turn up and have very little idea what to expect and who the patient would be. Most of my patient experiences so far I have had some background knowledge of the patient either from their referral letter or past notes, but this was not the case in this environment. A good point from this was that when taking a history I didn't already have a preconceived idea about what the problem may be, it was all taken from patient cues, which I felt meant I was less likely to miss something or go off in the wrong direction.

It was interesting to be out of my usual comfort zone of a hospital ward or clinic room and be in the patient's own environment at home, or out on the streets. I now have a better understanding of where patients have come from and what they have been through which will affect how they may be feeling on arrival into hospital.

It was interesting and a little frustrating to see just how many calls were for matters that would have been much more appropriate for patients to see a GP for, go to a walk in centre or even attend A&E by making their own way there. Even more frustrating was that many of these were

regular callers which I met even in the short few weeks I was with the ambulance service. I think that when giving advice in the future to patients about seeking further help and medical advice once they have left hospital or after an appointment, it is important to remind them of the different services available that are appropriate for different situations.

On a more practical side I was able to improve my skills in taking basic observations, setting up and reading ECGs and conducting primary and secondary surveys of a patient.

I feel that my communication skills have improved as I was exposed to more anxious patients who needed reassurance in sudden urgent situations that I had not previously been exposed to. There was also a lot of time spent with relatives and friends in the ambulance, who were often more worried than the patients themselves. There was also sometimes the need to get collateral stories from members of the public about a patient if they were unable to give a history themselves.

Another valuable experience was to be at handover of patients in A&E for a variety of calls, including to the triage nurse, resus or the trauma team and to get an idea of the main things needed in these different types of handovers. It was useful to gain a better insight into the roles of these other members of the MDT and to see it from the other side.

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