Another busy month for the College and more encouraging signs of progress in delivering the #CEM10 agenda.

We have had meetings with the CQC promoting our ideas for inspection standards in emergency departments, Monitor to argue the case for urgent tariff reform and HEE to finalise arrangements for the new emergency medicine ACCS posts and the overseas recruitment drive. At the time of writing we are still awaiting final applicant numbers for ST4 posts but the early signs are encouraging and suggest a higher fill rate for 2014.

I believe this last point is a vindication of the College’s endeavours. Some have argued that by drawing attention to our plight we were putting people off. My argument, and that of council, is that unless we address the root causes of our problems the situation will only worsen.

Nevertheless, the need for positive messages is important, and the proof of our strategy will be judged by reversing our recruitment and retention problems. To this end my conversations with the DH have been focused on tariffs and terms (ie, fairness for trusts and fairness for emergency medicine doctors. We hope to continue our dialogue with the DH to ensure ‘winter pressure’ monies are allocated much sooner to ensure maximum benefit is derived and that the spend is transparent so that commissioners are held accountable for the schemes they choose to invest in.

The media continue to report on the challenges facing accident and emergency departments, and much of this coverage is concordant with the messages of #CEM10. In particular, I would like to thank colleagues in York whose contribution to the Channel 4 Dispatches programme highlighted the iniquity of the financial framework that has deprived acute trusts of £1 billion in the past 3 years! HealthWatch England demonstrated that almost 20% of patients have attended for ‘non-accident and emergency’ reasons, highlighting the lack of accessible alternatives and supporting our call for co-located urgent care centres, a message reiterated by the NHS Confederation’s report ‘Ripping off the sticking plaster—whole system solutions for urgent and emergency care’. This report and its predecessor ‘Emergency Care—An accident waiting to happen’ really could have been authored by the College. They are short and succinct reports available online, and I would commend them to you.

The current feeling is that our message is being heard and that in most minds we are winning the arguments—indeed our Winter summit last week with an invited list of attendees from the DH, HEE, NHSE, NHS Confederation, BMA and other royal colleges emphasised considerable common purpose and agreement. We will build on this and aim to build consensus sufficient to influence party manifestos this Autumn. Turning once again to recent media coverage, and few of you will have missed headlines referring to exit block and its pernicious consequences—queues, stress and deaths. The College is redoubling its efforts to highlight the unacceptable consequences of crowding and exit block; we have even commissioned a short film to highlight the issue!

On a lighter note, those minded to do so will have noted that I have been interviewed by a number of journalists and broadcasters over the past 6 months. Highlights include John Humphries, Jeremy Paxman and Krishnan Guru-Murthy. More unusual was a radio interview with David Mellor and Ken Livingstone, but for the really unexpected, last week I found myself ‘live on air’ with LBC’s Dale Winterton! If only I had taken my supermarket trolley with me!

I will be attending the Hong Kong ICEM conference next month and look forward to meeting those of you who are also travelling afar. For those with shallower pockets or less time, I would encourage attendance at this years’ EuSEM conference in Amsterdam, and I am delighted to announce that the College, the Scottish Board and the host city of Glasgow have been successful in bidding for the 2018 EuSEM conference which will be combined with our Autumn Scientific Meeting. Well done to the Scottish board in putting together such a competitive bid.
I look forward to attending and listening to my successor at the AGM! I would like to end by thanking all those many people who selflessly give of their time, energies and expertise to the work of the College. The pressure on job plans, SPA activity and professional leave grows annually and yet, without the voluntary endeavours of fellows and members, the College would cease to exist and the NHS, patients and the public would be unimaginably worse off. While altruism is the ‘norm’ in emergency medicine, you may know of particularly selfless or meritorious work by fellows and members. I would be delighted to hear of such people and bring them to the attention of people who publish lists at New Year and on the Queen’s official birthday.

Clifford Mann

The 2013 EMS Expo: Conference catch-up

Sharing the learning...

A totally unofficial report of the EMS World Expo 2013 lectures attended by two conference delegates from the UK:

Dr Linda Dykes
Consultant in Emergency Medicine, North Wales

Dr Alison Walker
Consultant in Emergency Medicine, Yorkshire

See full notes from the conference at www.mountainmedicine.co.uk
Good medicine in bad places

If you found yourself sick at sea, hours from land, how much medical knowledge would you want from your rescuer? Hoping for a doctor or a paramedic? In fact, of the 4600 Royal National Lifeboat Institution (RNLI) crew members, less than 5% have any prior medical education. Once they join they get trained to the functional level of an NHS ambulance technician—in just 3 days.

Most search and rescue (SAR) activity in the UK and any medical care that might be required is carried out by volunteers without a medical background; those that have every day jobs, some of whom have significant learning difficulties, some to the point of illiteracy. So why do we not have medical professionals on every job? Tony Jones, the recently retired chairman of the UK SAR medical group, believes that medical professionals are not always the best people to take on a cave, mountain or sea rescue mission. “One of the key things we are trying to get over is that it can actually be inappropriate to have an experienced clinician working in an SAR environment, if it is an environment that is foreign to them. SAR personnel must be a specialist in their surroundings first, a rescuer second and a provider of medical care third”.

As an emergency medicine trainee in London, I understand a little about the delivery of high quality critical care inside of a well equipped and well staffed emergency room and the challenges your average emergency department faces. Replace that with the extreme environments regularly faced by SAR organisations, and treatment that would usually be straightforward at work and even in a home or at the roadside can become inappropriate, dangerous or impossible.

So how do organisations train ordinary people to provide the specialist subset that is SAR medicine? It is agreed that this highly specialised area of prehospital medicine should achieve the highest levels of care possible, but it has to be acknowledged that this ambition can be compromised in SAR environments. Competent rescuers are taught the medicine they need to know. As a result, they are usually the best medics available because they are the only people with the skills to reach and recover the casualty.

I volunteer for the RNLI, a voluntary organisation that, with the Maritime and Coastguard Agency, covers 1.25 million square nautical miles of sea and 10 500 nautical miles of coastline, 24 hours a day, 7 days a week. Last year the RNLI helped 30 822 people and saved 425 lives. Specifically, I am a Tower lifeboat crew member, the busiest of all 238 lifeboat stations. In 2013, we had 492 shouts and saved 24 lives. So I get to experience medicine in a most unusual environment, not to mention the fun of tearing along the Thames at 40 knots with blue lights and sirens. The RNLI has a unique method of teaching casualty care. The colloquially named ‘big sick, little sick’ takes 3 days to train the RNLI lifeboat volunteers and the seasonal lifeguards you see on 210 of Britain’s beaches every summer, from little or no medical knowledge to a level functionally comparable with that of an NHS ambulance technician. Centred around a detailed patient assessment and a set of protocols, all mapped out on waterproof check cards, the need for long term memory is removed, therefore reducing skill fade levels. This is backed up with the blended resources of the course manual and medical scenario cards, which all interlink with the individual’s check cards. It is recognised that this is the only course in Europe to have this totally blended approach of fully interlinked resources spanning treatment to training. The creator, Paul Savage, RNLI Clinical Lead and Clinical Operations Manager, was awarded an OBE in the last New Year’s Honours List, in recognition of his services in designing this whole approach that has revolutionised UK maritime safety.
But how much decent life saving medicine can you do with a pack of waterproof check cards?

There are a lot of aspects of prehospital lifeboat medicine that make it special. Statistics show that the whole drowning process usually occurs in seconds to minutes. Of those whose cause of death in confirmed as drowning, 67% are said to be strong swimmers and 55% drown within 3 metres of safety. Falling into cold water produces distinct physiological processes. Cold shock results from stimulation of cutaneous cold receptors within the first 3 minutes and causes a sympathetically mediated tachycardia, mass peripheral vasoconstriction and hyperventilation with an inability to breath hold, which can lead to life threatening arrhythmias and accelerated hypertension. Not being able to hold your breath when you are under water is far from ideal. After 3 minutes your muscles and tendons rapidly cool resulting in swim failure and an inability to perform lifesaving tasks, such as grabbing for a rope thrown to you. After 90 minutes the possibility of hypothermia arises and all of the medical problems associated with it. So there is a requirement for the lifeboat to be away from the pier in 90 seconds from the call coming in. But the fact that time is of the essence will come as no surprise to those familiar with trauma and emergency medicine.

One case recently experienced on the Thames takes us on an exceptional journey through casualty care on a London lifeboat. Tower lifeboat was launched to a man in the river who had entered the water off Tower Bridge. At the best of times, this means a 50 ft fall, the equivalent of falling from a fifth story window. The bridge has stone buttresses, and at low tide the river’s depth can be as little as 3 metres of safety. Falling into cold water of propellers, but it seems that plan A comes, hauled over the side of our orange boat. As Tower lifeboat is no stranger to suicide attempts, the boat has jets instead of propellers, but it seems that plan A might need some modification. The longer he stays in the water the higher the risk of losing him to a slipstream of current, and so plan B is launched; he gets into the boat by whatever means necessary. On the third approach, a crew member manages to grab hold of his clothing and in he comes, hauled over the side of our orange boat and into the bow where there is space to assess him.

The check cards take the crew through the initial assessment and find that he is responsive to voice, cooperative and, while dressed, his injuries are his head injury and potential spinal injury related to the fall. The casualty is laid down and his head wound is dressed, keeping his head still. Based on the mechanism of injury and some simple physiological parameters (raised respiratory rate and prolonged capillary refill), the patient falls into the category of ‘big sick’ and as such is time critical. The patient, with his potential spinal injury, is immobilised with a cervical spine collar and log rolled onto a new stretcher specially designed for the prehospital waterside environment. Once he is secured to the stretcher the collar is loosened and the casualty is transported head up.

As the casualty is ‘big sick’ he is monitored closely, with ABC reassessed every 2 minutes. During the first 2 minutes the crew gather a SAMPLE history but notice that he is becoming slow to respond. After reassessing ABC, the crew further expose and examine him, and find that he has four puncture wounds to his anterior abdomen, a sucking wound to his chest wall and a laceration to his left wrist. His trunk wounds are oozing but his wrist wound is bleeding heavily and is dressed with a pressured trauma dressing and elevated. This is followed by dressings of his abdominal wounds and chest wall.

He continues to deteriorate and loses consciousness. His respiratory rate increases and the crew breaks the seal on the chest dressing. He improves his GCS and his breathing settles. The boat lands at a local pier where the crew are met by a paramedic team from the London ambulance service. A full NATMIST handover is given and the patient is transported to the local trauma centre where they confirm an unstable cervical spine fracture with no neurological deficit as well as a depressed skull fracture and concomitant extradural haemorrhage. He had an open pneumothorax and required a chest drain. His abdominal wounds were assessed by CT, demonstrating a splenic laceration.

So, in summary, the patient had an unstable cervical spine injury, an intracranial bleed, an open pneumothorax, a radial artery bleed and a splenic laceration. The medicine that was performed included prevention of neurological disability by correct management of a spinal injury. The collar was loosened on securing the patient to the stretcher to avoid impedance of venous drainage and potentially raising intracranial pressure. The chest seal was broken when the patient deteriorated secondary to the development of a tension pneumothorax. There were treatment dressings applied to significant bleeds. All of it done by three people who had a 3 day course in casualty care.

The man survived after some time in ITU after neurosurgery, with prophylactic antibiotics in light of his extensive injuries. He required ventilation for a few days. Our last update was that he had engaged with mental health services and was getting support for the mental and emotional issues that had led to him feeling unable to cope. There were no long term medical or neurological deficits.

Life boating on the Thames and seeing the great medicine performed by volunteers in really challenging circumstances regularly warms my heart. RNLI casualty care has certainly improved my delivery of care outside of an emergency room. This has helped me at work by developing flexibility—having to work under my own initiative in rapidly changing circumstances. I also get the unique opportunity to interact with the ambulance service team in their usual setting, which has helped me gain a much better understanding and respect for the work that they do.

Laura Bland