RCEM Curriculum

Prehospital Emergency Medicine

A Guide for Trainees and Trainers
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Who is this guide for and why?

We have written this guide for anyone following the RCEM Curriculum 2021 whilst also undertaking prehospital experience. It is intended to be of benefit to both trainees and trainers.

Experience undertaken in the prehospital environment is likely to benefit training in Emergency Medicine in a number of complementary domains described across the breadth of the RCEM Curriculum 2021.

Furthermore, it is an expectation of all EM clinicians following the RCEM Curriculum 2021 to have an understanding of Prehospital Emergency Medicine - syllabus item XC2. As a minimum this should include a basic understanding of the challenges and scope of practice in the prehospital environment, the ambulance service, triage and dispatch, and the interface with the Emergency Department. This will lead to a more complete understanding of the patient journey, the wider emergency medicine system, and the management of illness and injury. Whilst there are a number of ways this can be achieved, direct experience in Prehospital Emergency Medicine is one such route.

Defining Prehospital Emergency Medicine Experience

We recognise that 'Prehospital Emergency Medicine (PHEM) experience' is an increasingly broad term. It may include, but is not limited to, the following such activities:

- Shifts with the ambulance service
- Shifts with other prehospital organisations, such as St John, St Andrew, coastguard, and mountain rescue – providers of emergency medical care outside of the hospital
- Shifts undertaken with HEMS units, BASICS, or Physician Response Units providing Community Emergency Medicine
- Prehospital Emergency Medicine subspecialty training
- Aspects that may be relevant in event, crowd, disaster, and search and rescue medicine

It may be that this work is undertaken in an observer, voluntary or paid capacity, or a combination of each.

As this document will hopefully illustrate, it is very unlikely that equal weighting or contribution towards the curriculum will be found between these activities. However,

the document should provide the reader with a better understanding of how some aspects of training within Emergency Medicine according to the RCEM Curriculum 2021 may be acquired and evidenced through such prehospital activity, whilst recognising that the end point of the curriculum is that of a 'Day 1 Consultant' working in an Emergency Department in the UK.

The RCEM Curriculum 2021 and Prehospital Emergency Medicine

Setting the context

The design, purpose and format of the Curriculum, which all trainers and trainees should be familiar, is well described here: https://rcemcurriculum.co.uk/.

The 2021 Curriculum is a framework for a culture shift in training in Emergency Medicine. This is not a process of amassing long lists of WPBAs for each training year but instead recognises that training takes many guises which inform development towards the requirements of a Consultant in Emergency Medicine. The Curriculum structures this formative, outcomes-based approach around 12 broad Specialty Learning Outcomes (SLOs) which aim to encapsulate the essence of the breadth and depth of Emergency Medicine.

It is the role of the trainee to acquire skills that facilitate their progression in the SLOs of the curriculum and of the trainer to guide, mentor and facilitate that learning. The evidence of this process may take the form of WPBAs, but may more likely take the form of reflection, learning events, clinical activity, MSF and the judgement of the Educational Supervisor and the Training Faculty. At its heart is the concept of entrustment; the overall impression of the progress made towards independence.

In parallel to the SLOs the syllabus is a list of presentations and encounters underpinning the Assessment Schedule and Programme of Learning. This is a more dynamic document and will be regularly reviewed to ensure that its currency and relevance to the specialty is maintained.

What does this mean for experience in Prehospital Emergency Medicine?

The RCEM curriculum describes the speciality of Emergency Medicine in the UK and the standards that are needed to be met by those training within it. The 2021 Curriculum provides far greater flexibility to trainees and trainers in *how* that is achieved. The focus is on the development of the skills and the individual's needs in meeting and exceeding

those standards towards excellence, rather than using a long list of exercises as a surrogate demonstration of competence.

If the trainee feels they have undertaken an experience which has enhanced their development in one or more of the SLOs in Emergency Medicine, this can be evidenced and described as such.

The endpoint remains the practice of Emergency Medicine within a UK Emergency Department. However, acquisition of those skills may occur in any number of settings including theatres, ICUs, wards, outpatient clinics, ambulatory units or the prehospital environment. Similarly, there is no reason that practitioners in these fields, provided they are working at the level the trainee is aspiring (i.e. at a more senior level), cannot contribute to the evidence provided to demonstrate acquisition of this training as recorded in their 'ePortfolio'.

How might this be applied in practice?

It may be useful to illustrate the application of these principles with some examples. Any number of examples could be written - ultimately they will depend on the quality of the evidence provided and the learning gained by the trainee.

It should be emphasised that through any such activity the trainee will only be complimenting the evidence towards the various SLOs, rather than exclusively relying on prehospital experience and expecting an entrustment decision to be taken accordingly. For example, just because one may be operating as an independent practitioner in a HEMS unit it should not be taken as expected that a Level 4 Entrustment recommendation will be made in their FEG statement for SLO 3, where other evidence towards practice may be expected in order to demonstrate that expected of a 'Day 1 Consultant' in the ED.

The weighting of any evidence will vary from experience to experience and trainee to trainee.

Example A - Ambulance Control

A trainee has spent a day in an Ambulance control room with dispatch teams, a clinical support desk and 111 and 999 call takers, all managing patients requesting emergency care.

They have completed a reflection on their day and done some further reading around the development of ambulance services, dispatch models and triage tools, thinking

specifically about decision-making tools, clinical reasoning and the benefits and limitations of algorithmic approaches when faced with clinical uncertainty (SLO 2). Time spent with the clinical support desk was particularly interesting in starting to think about how not only to support colleagues' clinical queries, but also navigate the legal and ethical principles underlying healthcare delivery and better understand the many facets of emergency care available to patients (SLO 8).

Example B - PHEM Training

A trainee is undertaking a blended 2 year post in sub-speciality training in Prehospital Emergency Medicine working for a local HEMS unit. During this time they undergo an intensive training period followed by day to day practice in the delivery of prehospital RSI, sedation, resuscitation and trauma management. They complete a number of WPBAs with a senior in that service complimenting their procedural logbook and evidenced progress in SLOs 4 and 6.

During their time in the Emergency Departments they deliver teaching on these skills with particular focus on the non-technical skills required in the safe delivery of time-critical interventions with feedback taken on the sessions delivered and their educational approach informed going forward (SLO 9).

Example C - Secondment undertaken with a Community Emergency Medicine Service

Over this 6 month placement the trainee managed a number of patients with varying comorbidities, clinical and non-clinical complexities across a range of presentations (SLO 1 and 5) and interacted regularly with prehospital staff; learning from them, answering their clinical queries and assisting with management of cases with them (SLO 2). The trainee reflected on some specific learning from a few of these interactions, what it taught them about patient care, health-seeking behaviour and the patient journey, as well as how this may influence their in-hospital practice. The trainee clearly demonstrated more holistic and 'joined-up' thinking around patient care and how this may influence service design and departmental patient interactions and choices (SLO 8).

Example D - Observer shifts with ambulance service

A trainee has carried out a number of observer shifts with the ambulance service on both a double-crewed ambulance and a rapid response vehicle with a specialist paramedic. The trainee kept an anonymised logbook of the cases attended and her reflections on them around the assessment and disposition of physiologically stable but

varying complex patients (SLO 1). On two shifts she witnessed how the specialist paramedic supported crews at complex and time-critical jobs, including on cardiac arrests where treatment had to be terminated or CPR not commenced and, in particular, a very challenging paediatric cardiac arrest. She made some very poignant reflections on how the advanced paramedic led the team but also supported the family and welfare of the crews afterwards taking on a number of valuable lessons for her EM training and developing confidence in her own practice towards SLOs 3 & 5.

Quality Improvement and Critical Literature Appraisal (SLOs 10 & 11)

Quality Improvement and Critical Appraisal do not form part of the summative exam schedule as they did in the 2015 Curriculum. Instead, there is continuous assessment of Quality Improvement and Critical Literature Appraisal through Core, Intermediate and Higher training.

As we have established, the priority is trainee-driven, trainer-nurtured, skill acquisition over a period of time. It is expected and likely that trainees will engage with this learning in a variety of settings. This may include, for example, journal club activity in a HEMS team-meeting, or quality improvement work with an ambulance or prehospital provider, such that at various stages of training the trainee is engaging with activity that empowers them to be confident in these skills; challenging the breadth of their application, and applying them to practice as an Emergency Medicine Consultant.

Queries relating to the application of this document

These should in the first instance be directed to your Educational Supervisor and Training Programme Director, with escalation of matters arising usually then resting with the Head of School and Training Standards' Committee of the Royal College of Emergency Medicine with input from the RCEM Dean and/or Statutory Education Bodies as required.