ISSUE 3 | April 2022
Irish Emergency Medicine Trainees Association

IEMTA Newsletter

Engage, Educate, Inspire

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Dear Trainees,

As Spring approaches, I am sure we are all hoping and looking forward to some sort of reprieve to the onslaught we have faced over the Winter. All Emergency Departments are facing long wait times, boarded patients and staffing difficulties, and I know many of you have taken on extra shifts and certainly extra stress while working.

An improvement in the weather however is of course not a solution to these problems. IAEM have issued press releases to describe the pressures faced by Emergency Departments nationwide. I together with other NCHDs' representatives recently met with Minister Donnelly on your behalf to discuss challenges facing NCHDs and the daily realities of our work. The Minister in his response agreed to maintain lines of communication and apprise us of developments. We will continue to strive for improvements for both NCHDs and Emergency Medicine.

Spring also means another highlight on the IEMTA calendar – the ASM! This year it's in beautiful Sligo (no bias here of course). It will be a hybrid day, with a morning of online talks and an afternoon of adventure activities with surf or turf options! It's a great opportunity to meet up again in person and I hope to see many of you there. It is also a fantastic opportunity to showcase original research, case reports and QIPs.

As always, please reach out to your Committee members if you have any issues you want to discuss or raise. We work for you and are always happy to discuss issues and ideas.

Keep looking after yourselves as well as your patients.

Kindest Regards,

Orla

Dr Orla Kelly

IEMTA President

IEMTA ASM

RETRIEVAL +RESCUE

30TH APRIL SLIGO

Morning talks: in person and online

THE ENVIRONMENTALLY DIFFICULT AIRWAY
/ Jason VanDerVelde & Simon Walsh

SPINAL INJURIES IN THE FIELD
/ Tim Nutbeam

PREHOSPITAL CODE RED
/ David Menzies

HUMANITARIAN RESPONSE TO EUROPE'S REFUGEE CRISIS
/ Marghertia Difino

BEYOND MEDICINE IN DISASTER RESPONSE
/ Abdul Safras

ORAL POSTER PRESENTATIONS
/ Selected winners

Afternoon workshops followed by evening craic

OCEAN RESCUE
Pete Conroy

Big wave surfer, lifeguard, paramedic and Advanced Wilderness Life Support instructor.
Location: Strandhill beach

PHEM MASTERCLASS
Lisa Cunningham

EM consultant and HEMS doctor
Hands on teaching and high fidelity moulage
Location: Benbulbin

Preparing for a career in Humanitarian Medicine

Dr. Jimmy Lee
@jimhealy9

What is Humanitarian Medicine?

There are several definitions floating around out there but the definition is often summarized in some form of “emergency medical assistance to people affected by armed conflict, epidemic, malnutrition, natural disaster, and exclusion from health care”.

Is this a recognised subspecialty area?

RCEM has newly formed the Global Emergency Medicine Committee and one of their aims is to develop Global EM as a sub-specialty. Fellowship training is more well-established in North America, but in recent years, many NHS Trusts have begun to develop and advertise Global Health & Humanitarian Medicine Fellowship posts. These typically involve 6 months of EM, combined with 3 months of ID or HIV and some 3 months of research/training.

“Emergency Physicians are often said to be perfect for the area – being adaptable, quick thinking, and innovative”

What specialty is best suited for Humanitarian Medicine?

The fact that “Emergency Medicine” is in almost every definition of humanitarian medicine really solidifies the point that EM is one of the most useful specialties in humanitarian medicine. As the proverbial swiss-army knife of humanitarian medicine, we can be deployed to conflict areas, epidemics, or any of the areas of need mentioned in the definition above. In particular, the characteristics of Emergency Physicians are often said to be perfect for the area – being adaptable, quick thinking, and innovative. These are core traits for EPs, but may be traits that may take more time to develop for other specialties. Having said that, humanitarian medicine could be considered as a subspecialty area of just about every specialty.

When is the most appropriate time to start?

This really depends on the job. Ensure the situation you are getting yourself into matches the level of your training. The vetting process by the organisation should do that anyways, but desperation can sometimes land you in places you should not be. The standard should never be lowered simply because the people you serve have no better option.

As EM Trainees, I feel a minimum level would be at least ST5 or above (at least 2nd year SpR), and I would certainly recommend having done your Paediatric SpR rotation before you go.

Who should I work with?

Choosing a humanitarian organisation to work with is probably the most important part of the process. Do your homework – as EPs, we are natural sceptics. Look for key factors in your research with regards to transparency, funding, and governance. Consider the 3 principles of humanitarianism – Independence, Impartiality, and Neutrality. Does your organisation hit all the marks?

As the great Prehospitalist John Hinds once said, “Are your intentions honourable?” – This should be at the core of your research, and perhaps a question you should ask yourself as well.

What are some key skill sets to work on?

Teaching & Quality Improvement

Become an instructor on courses, become the departmental teaching coordinator, volunteer to teach at the medical school. Quite a bit of your clinical responsibilities in Humanitarian Medicine involve training. Familiarise yourself with Quality Improvement as much of your non-clinical time will be in Quality Improvement Projects.

Ultrasound

A lack of imaging capability puts more of an emphasis on bedside ultrasound, and as a specialty that has championed point-of-care ultrasound since its inception, we are well positioned to develop this skill. Try to get at least your Level 1 certification, and perhaps a bit of background in Level 2 techniques. Be mindful, however, not to overstretch your capabilities, as POCUS can sometimes be seen as a bit of a magic wand when there is no advanced imaging available. If you can't do comprehensive pelvic ultrasound here, there's no reason you can suddenly do it in a humanitarian setting (without further training).

Tropical Medicine

Do everything you can to attain your Diploma in Tropical Medicine & Hygiene. This is awarded by examination by the Royal College of Physicians (UK) after completing what is typically a 3 month (full-time) to 12 month (part time) course. Course providers are listed on the RCP DTM&H website but it should be noted that several universities now make their course available to take online.

Wilderness Medicine

Though not always directly applicable to hospital medicine, there are several similarities in these subspecialties. In particular, an ability to innovate and adapt with low resources is a common theme. Ireland has several wilderness medicine courses available, with shorter weekend courses like WildMed held in Mayo, as well as the longer full week courses, with WEMSI in Wicklow.

Disaster Management

There are a considerable amount of non-medical components to humanitarian medicine, and an understanding of the complexities of disaster management are essential. Several universities in Ireland provide short courses on Disaster management, and these can be completed as weekly night courses over several months.

"There are a considerable amount of non-medical components to humanitarian medicine, and an understanding of the complexities of disaster management are essential"

Public Health

Though probably the more laborious of the skills I've mentioned here, attaining a Masters in Public Health is one of the most advantageous educational degrees one can hold in humanitarian medicine. It provides an ability to look at global health with a new, more analytical eye, and sparks new ideas for local innovation and systems design.

There are several MPH programmes available to do Part-Time and by distance learning. In Ireland, courses are offered by UCD, UL, and TCD (Global Health). In the UK, some of the more prestigious universities offering the MPH include the London School of Hygiene and Tropical Medicine and University College London. By doing these even quarter-time (over 4 years), one can nearly pay for the entire MPH via the Training Support Scheme.

"…attaining a Masters in Public Health is one of the most advantageous educational degrees one can hold in humanitarian medicine"

Languages

Not to be forgotten, having a second language helps your application for many humanitarian organisations.

If you are still deciding on which one to learn, consider French, Spanish, and Arabic as common languages spoken in many of the regions you may be sent to work in.

How does one fit in a career in Humanitarian Medicine with a stable career at home?

There are several avenues one can follow, each with a varying level of ability to balance a career at home.

Regular Emergency Deployment

Becoming the "Emergency Physician for the world". I think anyone who wishes to work in humanitarian medicine must first work *in the field* to get a true understanding of the complexities of the subspecialty. You cannot teach or create programmes that are designed for these complex situations if you have never practiced in it yourself. Having said this, many experienced colleagues of mine have oft quoted that regular deployment to humanitarian disasters is not a healthy endeavour for one's mental health, and can easily lead to burnout. Asking your consultant colleagues to cover you for 3-6 months on one months' notice is never a way to win a popularity contest (or land you a permanent job) either.

Train-the-Trainer

Probably the most popular arena, as it allows for more control over when you make yourself available. It can typically be done in a short-burst style that befits one's annual leave allocations and can leave one with a sense of fulfilment. Be mindful that some programmes don't always consider the local context, and this is a common reason for programmatic failure. What works in one LMIC (Low and Middle Income Context) may not be suitable for the next, and equipment and stock-out can lead to one teaching concepts and techniques that are decades away from making a reality.

"…it becomes apparent very quickly after working in the field that often the only way to make significant long-lasting impact is in prevention and improved systems design"

Organisational Governance

For many who start off in humanitarian medicine, it becomes apparent very quickly after working in the field that often the only way to make significant long-lasting impact is in prevention and improved systems design. As one gets more involved with humanitarian organisations at a more operational level, it becomes more and more difficult to maintain the same level of clinical practice. There is no one path to achieving this balance, but it would appear that shared-consultant posts or taking locum consultant posts with years-on/years-away are options many have taken.

It is sometimes thought that working in low-income contexts limits one's scope as a clinician, but there is nothing further from reality. The improvisation, creativity, as well as the attention to detail in the oft lost art of the clinical exam that is required to work in this context has opened my mind to the possibilities of what an Emergency Physician can do. The value of an Emergency Physician as a true generalist, in this context, is immeasurable. It has been a privilege to work with many new colleagues in this field, and in short, look forward to working with them again in the future.

Dr Jimmy Lee is a final year ASTEM Trainee and a keen advocate of Humanitarian Medicine

Education Updates

Dr Callum Swift
@Wild_Med

Annual Scientific Meeting 2022

IEMTA is delighted to announce the line-up for our Annual Scientific Meeting on the 30th April in beautiful Sligo, themed ***'Rescue and Retrieval'***. In the morning there will be a number of exciting talks, available to watch online or in person in Sligo.

Kicking off the day we have Cork retrieval legends **Jason VanDerVelde** and **Simon Walsh** running through the environmentally difficult airway. After that, **Tim Nutbeam** talks on the emerging practice and latest evidence around prehospital spinal extractions. Tim is clinical lead for Devon air ambulance, co-host of the PHEMCast podcast and Honorary Professor in Prehospital Critical Care Retrieval and Transfer University of Plymouth. Next up is Clinical lead for Ireland's central trauma network and Irish PHEM pioneer **David Menzies**, talking about the nightmare scenario of a prehospital Code Red. Our focus then pivots to humanitarian and disaster medicine, where we have two Irish trainees, **Marghertia Difino** and **Abdul Safras**, talking about their own experiences at the centre of two very different disaster responses.

To round the morning off we will have live poster presentations from the selected finalists before announcing the winner.

In the afternoon we have two very special workshops for those wanting some hands-on experience. The first is ocean rescue with **Peter Conroy**: Peter is a big wave surfer, lifeguard, chair of the Irish Tow Surf Rescue Association, paramedic and Advanced Wilderness Life Support instructor. He provides in-water assistance to surfers in some of the most dangerous waves on Earth. Participants will be donning wetsuits, getting wet in Ireland's wild Atlantic Ocean, and learning some of the fundamentals of Peter's trade: water safety, ocean rescue, logistics of a rescue and the management of medical emergencies such as drowning and hypothermia in the field. Plus, if conditions allow, there will be an optional surf lesson!

The second workshop is a PHEM masterclass with **Lisa Cunningham**: Lisa is an emergency medicine consultant and practising HEMS doctor. A pre-hospital emergency medicine specialist, she splits her time between her native Mayo and her UK HEMS job, retrieving and treating the sickest patients. You will be donning the hiking boots and sunglasses (or rain jackets!) and going for a hike in Sligo's beautiful mountains, learning along the way some of the fundamentals of Lisa's trade: the assessment and stabilisation of prehospital casualties, haemorrhage control, limb splinting, packaging and moving patients and co-ordinating rescue. The day will culminate in a high fidelity multi-casualty sim!

IEMTA Videos:

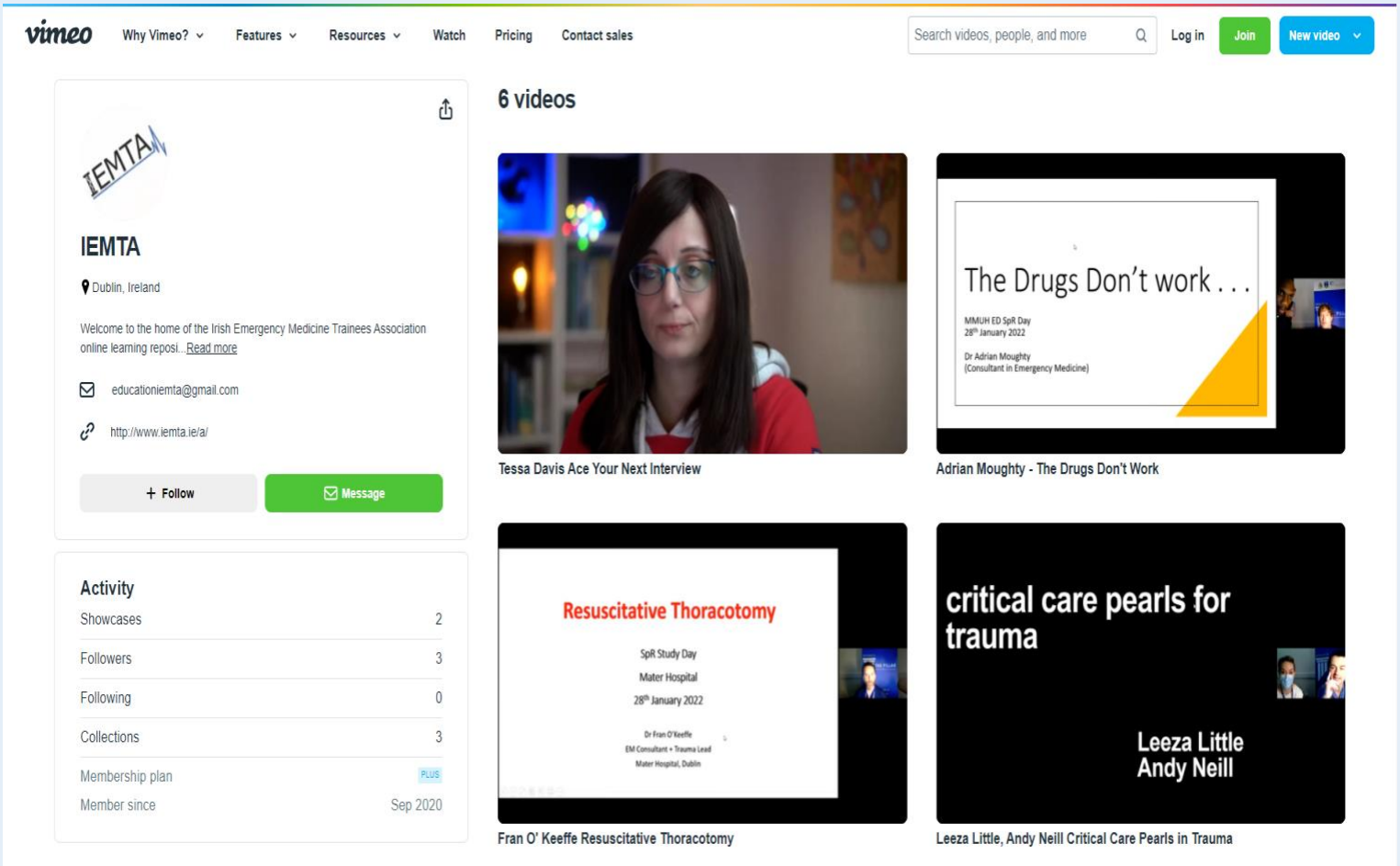
IEMTA is working hard to build our **FOAM Éire** resource: an online compendium of high quality educational videos, free for all to access.

We have some superb videos already online, including **Tessa Davis** on how to ace your consultant interview, **Adrian Moughty** on Toxicology in the ED, **Fran O'Keefe** on Resuscitative Thoracotomy**, Leeza Little** and **Andy Neil** with some critical care pearls for trauma**, Cian McDermott** and **Callum Swift** talking you through ultrasound guided vascular access, **Jo Kelliher** on Resuscitation and most recently **Dani Hall** and **Ross Fisher** on how to give the perfect presentation. So loads of high quality content to get stuck into on a rainy day, and more on the way!

If you are interested in recording a talk or procedural video, please get in touch!

FOAM Éire content can be accessed by visiting

https://vimeo.com/iemta



SimWars

Dr Genevieve Callander @IAmGenevieveGC
Dr Tiarnán Byrne @TiarnanByrne
Dr James Condren

SimWars is an inter-varsity simulation competition for healthcare students in Ireland which was established in 2017 by two then-final year medical students - James Condren and Tiarnán Byrne. Having been introduced to medical simulation while on placement abroad, they recognised how valuable simulation could be for healthcare students in Ireland and determined to set up the first national simulation competition for students.

The first SimWars competition took place in February of 2017 at University College Dublin. It was a successful event, which laid the groundwork for the expansion and development that followed.

As the competition has grown, James and Tiarnán have continued in their role as leaders of the event's planning and evolution, supported by clinicians, students and allied health professionals. The expansion of the competition led to the need for an official organising committee, which now includes medical, nursing and paramedic representation.

The SimWars community goes far beyond the organising committee - students spend months before the competition training under the mentorship of a variety of trainers, ranging from fellow students to consultants, and dozens of healthcare professionals are drafted in to judge the competition. With the culmination of the competition (pre-covid) being an evening social, SimWars provides a great opportunity for students and professionals to get to know each other as people, laying the foundation for friendships and mentorships that continue beyond the competition.

The goal of SimWars has always been to bridge the gap between theory and practice by providing a friendly competitive environment to develop and test practical skills and knowledge. This goal remained at the forefront of planning and development in the face of the COViD-19 pandemic. The many challenges posed by the pandemic forced the 2020 organising committee to switch to a virtual format using online resources, innovation and that key SimWars ingredient - teamwork - to provide students with this valuable learning opportunity at a time when so many other opportunities disappeared. This virtual format was developed further and used successfully for the 2021 competition, which had the highest number of competitors the competition has seen, boding well for the future of SimWars and of emergency medicine in Ireland (www.simwars.ie).

Having now officially come under the umbrella of IAEM, The SimWars committee was delighted to return to an in-person competition on March 12th this year. 18 teams from all 6 medical and nursing schools in Ireland competed with over 100 competitors. Of particular thrill, was to see the increasing number of nursing students become involved. The committee would also like to thank Dr Alan Watts in particular for his extensive commitment and guidance, particularly with the virtual and 2022 competitions.

SimWars 2023 will be held next Spring in RCSI.

Dr Genevieve Callander is an Intern and a former SimWars coordinator & EMSSI Chair

Dr James Condren is an SpR in Emergency Medicine and a co-founder of SimWars Ireland

Dr Tiarnán Byrne is a CSTEM 3 Trainee and a co-founder of SimWars Ireland

Documentation of Cardiac Arrest

Dr Barry Keane
@BarryKeane15

Cardiac arrest is one of the most significant events dealt with in the healthcare setting. In 2019, there were 2564 cases reported to the out of hospital cardiac arrest register (OHCAR)[1]. Have you ever wondered what to write as part of your medical records, or struggled to record your notes at the end of a cardiac arrest? Are you aware of any guidelines to assist your documentation? The Medical Council of Ireland (MCI) provides guidance on documentation to ensure its accurate, contemporaneous and confidential recording[2]. Unfortunately, MCI does not provide specific guidance on documentation of patients presenting in cardiac arrest. These notes are most commonly written after the resuscitation has finished. The retrospective nature of documenting these notes, along with distractions and challenges such as understaffing, overcrowding and burnout can lead to the omission of key components of the resuscitation effort. Being cognisant of this presents an opportunity to improve and standardise our documentation of cardiac arrest.

The documentation of cardiac arrest is important, as it facilitates audit, quality improvement and review of out of hospital cardiac arrest presentations both locally and nationally. Your notes are used to generate reports for the coroner, audit practice, and for use at clinical risk meetings. It is therefore imperative that they are accurate and comprehensive.

Patients in cardiac arrest are managed in a standardised fashion in accordance with Advanced Cardiovascular Life Support (ACLS) principles. There is no reason why we cannot also document our management in a standardised fashion. In 2011, a paper published by Allan et al postulated a number of key components to an adequate cardiac arrest medical record[3]. The Emergency Department at St James's Hospital has introduced a cardiac arrest document to supplement their ED notes. Their proforma is based on the recommendations from Allan's paper. This has demonstrated improvements in the recording of essential elements of cardiac arrest presentations to the ED by an average of 84%[4].

Perhaps it is time for the adoption of a national standardised document in relation to the recording of cardiac arrest, as we have done with trauma in recent years, which would allow the efficient, accurate and timely recording of this most significant presentation to our Emergency Departments. One might argue that this represents another "box-checking" exercise to add to our workload. However, cardiac arrest represents one of the more unique presentations to us in the ED, in that no two are the same. They are managed in an algorithmic fashion, but the initial history, pre-hospital interventions, ED interventions and outcomes differ in so many ways to make it a welcome comfort that one standard record be available to help us chronicle one of our most difficult challenges in medicine, the resuscitation.

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Clinical Pearls

Urine pH directed antimicrobial therapy

Dr Sean Croughan @InsertNameHere

Did you know that the urine pH can help guide antibiotic choice for simple cystitis? A recent study of over 65,000 urine samples demonstrated that a pH of > 8 is associated with high rates of nitrofurantoin resistance (1). This is likely due to the action of the Proteeae organisms (Proteus species, Morganella morganii, and Providencia species). They are a common cause of UTIs, especially in patients with long-term indwelling catheters and usually demonstrate resistance to nitrofurantoin (1-3). Proteeae species represented 4.4% of urine samples at pH 5–7, 24.4% at pH 8–9, and 40.0% at pH 9.

Proteeae species produce urease, which increases urine pH. The antibacterial effect of nitrofurantoin is dependent on urine pH. Urine pH > 8 greatly reduces its effectiveness. At urine pH 5-7, 80% of urine samples were sensitive to nitrofurantoin; however, this percentage decreased to 66% for urine pH 8-9 and 55% for urine pH 9. Causing nitrofurantoin to go from being one of the most effective antibiotics at pH 5-7 to one of the least effective at pH >8.

So, the next time you look at a urine dip in a cystitis patient, take a quick peek at the urine pH. If it is >8 consider an alternative to nitrofurantoin such as trimethoprim.

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The King LT Supraglottic Airway

Mr Shane Devlin @Shane_Banjo

Introduction

Advanced airway management is crucial in ensuring your patient has an adequate airway during resuscitation. For Irish EMT's, Paramedics and Advanced Paramedics, advanced airway management is indicated in the patient who is in cardiac arrest, apnoeic, or if all of the following are present: GCS <3, SpO2 <92%, respiratory rate ≤9, and bag-valve-mask (BVM) ventilation ineffective.[1] In the prehospital environment, it is not always feasible or safe to attempt endotracheal intubation (ETI), and so this is where supraglottic airway devices (SGA's) come in.

Supraglottic Airway Devices (SGA's)

SGA's were originally developed for the operating room as an alternative to bag valve mask (BVM) ventilation alone, and have since migrated their way into the prehospital arena.[2] Supraglottic airways are just that: they sit above the glottis to act as a conduit for the passage of air and so visualisation of the vocal chords is not necessary for insertion. It's a 'blind' insertion technique. The AIRWAYS 2 trial showed that in adult out of hospital cardiac arrest (OHCA) patients, there was no difference in neurological outcomes between an SGA and ETI at 30 days, [3] and a later study showed no difference in outcomes again at 6 months.[4]

Previous research suggests that in order for paramedics to achieve a 90% success rate at intubation, students would have to perform 15-25 intubations during their clinical training,[5] and doctors require performing at least 3 and supervising at least 5 intubations per year to maintain proficiency.[6] SGA's require considerably less training to achieve competency, and one study found that ICU nurses were able to ventilate efficiently on the first airway attempt with the king LT in 100% of cases, making it very appealing to prehospital clinicians.[7]

The King LT

The King Laryngeal Tube, first approved for use in 2003, [8] is a supraglottic airway placed 'blindly' into the hypopharnyx. It is widely used by the National Ambulance Service (NAS). There are 2 inflatable balloon cuffs, one distally that occludes the oesophagus to help prevent aspiration, and one proximally in the posterior oropharynx to stabilise the device (Figure 1). These are inflated simultaneously with a syringe. A ventilation port sits in between these 2 balloon cuffs, with the opening above the oesophagus and facing into the larynx to allow for ventilation. There is also a second lumen available for orogastric suctioning.

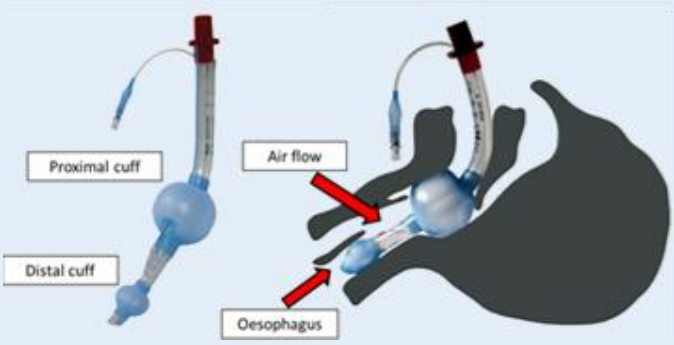

Figure 1: King LT inserted in the airway

The King LT has been shown to be inserted faster with an improved first time success rate and less training to proficiency time than tracheal intubation in numerous simulation studies, [9,10,11] and a large randomised clinical trial showed that the use of the King LT tube in OHCA was associated with an increased survival rate at 72 hours compared to tracheal intubation. The King LT group was also associated with favourable neurological status at hospital discharge. [12] As cardiac arrest management requires significant cognitive bandwidth to coordinate airway management, chest compressions, rhythm checks, vascular access and drug delivery, an airway device that is faster to insert with less attempts may help the Paramedic with scene management.

Sizes

The King LT comes in 7 different colour coded sizes, relating to a particular height for adults and weight for paediatrics (see Figure 2). Each LT contains a colour coded syringe for ease of cuff inflation.

How to Place it

Remember trying to dodge the oesophagus the last time you intubated? This time, we're aiming for it. The tube is lubricated first, then 'blindly' inserted into the hypopharynx, with the distal tip ending up in the upper oesophagus. You will feel resistance on insertion at this point. Using the colour coded syringe, inflate the required amount of air correlated to the tube colour, and this should stabilise the device and occlude the oesophagus. [13]

Attach your BVM and ventilate, looking for adequate chest rise. Attach your filter, EtCO2, a catheter mount and a bite/block and you're good to go. ***Note: as intubation is classed as an aerosol generating procedure, it is not authorised for Advanced Paramedics during the current COVID 19 pandemic, making the King LT the primary advanced airway device used in the prehospital environment at the minute.***

So there you have it. You've secured the airway without lengthy checks and chord visualisation with direct laryngoscopy, and now you can go about the rest of your treatment plan for your patient. It's easy to use, and allows for more cognitive offload for the Paramedic in highly complex resuscitations. This may be swapped for an endotracheal tube in hospital, but the research shows that in the prehospital phase of care, it's as good, if not better than intubation. All hail the King (LT).

King LT Size Chart							
Size	0	1	2	2.5	3	4	5
Colour	Clear	White	Green	Orange	Yellow	Red	Purple
Cuff Volume	10ml	20ml	35ml	40ml	50ml	70ml	80ml
Weight/ Height	<5kg	5-12kg	12-25kg	25-35kg	4-5ft	5-6ft	>6ft

Figure 2: King LT sizes in ascending order [13]

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ITERN: The Next Frontier

Dr Etimbuk Umana & Dr Jeff Mulcaire
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@JeffreyMulcaire

It has been another very successful year for ITERN with many exciting updates. From the successful completion of our third ITERN facilitated project in EDEL, to the development of the ITERN Site Lead and Regional Rep structure, ITERN has gone from strength to strength, and has shown how a strong research network can facilitate and enable the successful completion of high-quality research projects by Irish EM trainees.

Following a call for projects in December 2020, over 10 proposals were submitted and underwent committee review, with four projects chosen for adoption by ITERN.

Emergency Department End of Life (EDEL) study

EDEL is an amazing study which assessed the opinions and knowledge of emergency physicians around the provision of end-of-life care in the ED. The NCHD Lead for the EDEL project is Dr Saema Saeed and Prof Conor Deasy is the consultant lead. ITERN rolled this study out to 23 EDs and achieved over 400 responses to the survey (A big **THANK YOU** to all who participated). This response has shown incredible engagement with this study and, indeed, the provision of end-of-life care in the ED. Results of EDEL will be reported in the coming weeks so keep your eyes peeled for what we can learn from this and what we can do to improve end-of-life care in our EDs.

Chest Drain in the ED Audit (CHEDA)

Our next study, **Chest Drain in the ED Audit (CHEDA)** will be coming your way shortly. Congratulations to Dr John Legge for securing the IAEM Research Bursary for CHEDA. This study will aim to gain a better understanding of what complications are associated with ED inserted chest drains and use the information gathered to inform quality and safety improvement. Dr. John Legge is the NCHD lead, while Mr Alan Soo is the Consultant lead for CHEDA. We look forward to getting this project off the ground in the coming months!

Covid Emergency Response Assessment (CERA)

ITERN collaborated on the **Covid Emergency Response Assessment (CERA)** with our UK colleagues in TERN. This study looked to quantify the degree of psychological distress and trauma experienced by emergency, anaesthetic, and intensive care doctors during the first wave and third wave of COVID-19 in the UK and Ireland.

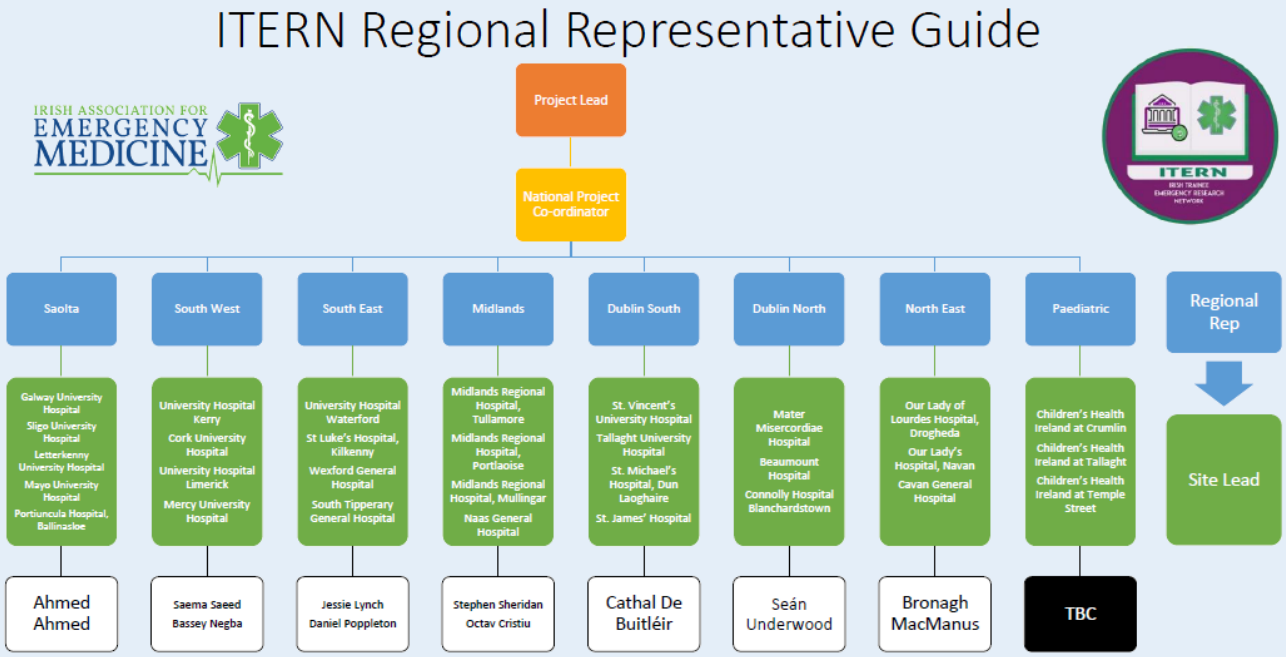
This project had 3 publications in the Emergency Medical Journal (EMJ) (link), British Medical Journal Open (BMJOpen) (link) and British Journal of Anaesthesia (BJA) (link). The headline findings were of high levels of psychological distress and trauma during the peak of the waves with a natural recovery during the deceleration phase. Our intensive care colleagues had the highest rate of psychological distress and trauma amongst the 3 groups. All ITERN collaborators received certificates and had their names indexed as collaborator on PubMed for being sites leads in their respective ED.

TERN Top Ten

ITERN also took part in the TERN top ten which was well received in June 2021 (link). In addition the November edition of the TERN Virtual Journal Club (VJC) was facilitated by ITERN (link). ITERN will be undertaking future TERN top ten and VJC. This is open to NCHD who would like to participate. If you're interested send us an email.

CERA and EDEL showed us the power of collaboration within and across disciplines, and substantiates ITERN's goal of demystifying research for EM NCHDs. We also aim to involve NCHDs in practice changing research, and in the process of knowledge translation, making these skills and experiences available to all. Lastly, the past year has seen the successful expansion of ITERN, and increased involvement of trainees across our network, with the appointment of ITERN Regional Representatives adding to our network.

We would encourage anybody with an interest in getting involved in research or with ITERN to keep an eye out for site leads for upcoming projects or contact us directly if you would like to join the team team@itern.ie (http://itern.ie/).



Flexible Training & Out of Programme Experience

Dr Susan Ui Bhroin @UiBhroin

In line with other postgraduate training bodies and international training programmes, ICEMT have developed several options for trainees to access flexible training and out of programme experience. The policies in relation to these options are available on EMNow.

Out of programme experience is available to ASTEM trainees from year 2 onwards with ICEMT advising that years 2 and 3 are the optimal time to avail of this option. The amount of time taken is decided on an individual basis, however a minimum of six months is allowed. There are three categories of out of programme experience which ICEMT will consider requests for.

These are:

1. Out of programme for research
2. Out of programme for clinical experience
3. Out of programme for career break.

Together these cover almost any reason you could want to take a break from training!

Flexible training is currently available by two means: the HSE flexible training scheme and the ICEMT job share policy. The HSE flexible training scheme provides funding for up to 32 trainees across all specialties, nationwide, to work on a part-time basis. These trainees are supernumerary. Given that this programme is hugely oversubscribed, ICEMT has developed a job share policy. Job sharing works on the basis that two trainees will share one full-time post with each trainee working 50% of the hours. The aim of the job share policy is to retain doctors within the medical workforce who are unable to continue training on a full-time basis. Applications for job-sharing are made directly to postgraduate training body and are open to ASTEM trainees.

ICEMT are committed to accommodating flexible training for those who are interested and welcome applications for both flexible training and out of programme experience

Irish Emergency Medicine Trainees Association

www.iemta.ie

Your suggestions for improvement are welcome!