All change on the life support course

To be honest, the only reason why I went on the life support course was to get the tick in my revalidation box.

It was the 15th such course I have attended. The first few had been part of a schoolgirl obsession with learning to save lives: girl guides, St John Ambulance Brigade, lifesaving club. By the time I was 12, I had filled a shelf with trophies won for cardiopulmonary resuscitation (CPR). You could have timed my chest compressions with a metronome.

This early training carried me through assessments at medical school and beyond, including a short case for the Membership of the Royal College of Physicians. As the 3-yearly refresher courses became compulsory, I turned up, repeated my hard-wired routine and collected my certificate. Easy.

This year was different. I discovered that basic life support has (not before time) become a system issue.¹ The course leaders told us we would not be assessed purely — or even primarily — on the choreography of our CPR movements, since 80% of avoidable deaths are not due to poor CPR technique. They can be explained by the 'Swiss cheese' metaphor: multiple, individual, or team failures, each relatively minor in isolation but which line up as the scenario unfolds, with disastrous consequences for the patient.

Long before we were given the opportunity to get intimate with a manikin, we were invited to shed our stereotypical mental image of sudden, unexpected collapse in a previously stable patient. Most cardiac arrests are, apparently, predictable — and many are preventable by responding mindfully to early signs of deterioration. The hospital 'crash team' is usually also the 'pre-arrest emergency team' and prefers to arrive walking rather than sprinting to advise on preventive management.

But staff are often reluctant to call '222' in the absence of a dramatic collapse — especially in organisations whose blame culture leads to them being punished or ridiculed for a false call. We role-played crying wolf in the absence of a wolf, and using the false call as a learning opportunity for the wider team.

When we finally got to pump the dummy, I found that the static one-off scenarios of

yesteryear ('this patient is a 65-year-old male found collapsed and pulseless, please proceed') had been junked in favour of full-on, action-packed mash-ups. We took turns being the team leader or variably skilled bystanders. Only the leader should be making the decisions; those given a humble job must do it reliably and stay focused on the unfolding action. You have to learn to shut up.

We dealt with scenarios that changed rapidly and unpredictably as the course leaders called out twists to the plot. Many such twists were technological or organisational, not physiological. 'The phone isn't working'; 'There are no more bags of saline'; 'The assistant has frozen in panic and can't help you.' All this was to hone and test three additional critical factors in effective life support: situational awareness, real-time judgement, and team improvisation.

We learnt about the importance of post-incident de-briefing, reflection, and audit: essential to maximise learning and generate the organisational-level data on which evidence-based recommendations can be built.

Finally, we learned about post-cardiac arrest syndrome; a state of physiological vulnerability with a high propensity to decompensate and re-arrest, especially because it occurs in a context where staff consider that the crisis has just been averted (hence, mindfulness is low and monitoring may slip).

My 15th basic life support certificate has just arrived in the post. And for the first time since the girl guides, I think I may pin it proudly on the wall.

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DOI: 10.3399/bjgp13X668258

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