Global health experience of staff working in UK emergency care: a reflexive thematic analysis

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ABSTRACT

Background and aims There is growing recognition among practitioners worldwide of the benefits of practising emergency medicine in different countries and healthcare settings. A recent survey by the Royal College of Emergency Medicine found interest and experience in global health (GH) work among college members, but many struggled with barriers that limited their contribution to this work. This study aims to understand the role of GH experience by emergency care practitioners and how it interconnects with the National Health Service and UK practice.

Methods Anonymised semistructured interviews were conducted from August to November 2022 on a purposive sample of UK emergency care practitioners who had previously undertaken GH work. Reflexive thematic analysis was used to analyse and present their experiences in this field.

Results The three key themes from the analysis were that emergency care is a specialty well positioned to contribute to GH settings; practitioners feel this contribution confers benefits to both the individual and their healthcare system; and the current structure of UK emergency care training presents barriers to maximising the benefits of these experiences.

Conclusion The perceived benefits of GH involvement to the emergency care and base organisation are manifold; as are the skills offered by this practitioner group. Readily accessible funding, networks, mentorship and support from training programme leadership were all identified as ways of improving the quality and frequency of meaningful GH involvement.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ There is a growing interest in global health (GH) among high-income country emergency care practitioners. Benefits of GH work to the broader cohort of high-income country healthcare workers have been demonstrated; however, barriers to this work exist.

WHAT THIS STUDY ADDS

⇒ Focusing on emergency care practitioners in one high-income country (the UK), using semistructured interviews, this study identified three key themes: emergency care is a specialty well positioned to contribute to GH settings; practitioners feel this contribution confers benefits to both the individual and their healthcare system; and the current structure of UK emergency care training presents barriers to maximising the benefits of these experiences. Respondents perceived that this work had potential for reducing burnout and attrition, enhancing more rapid skill acquisition and re-engagement with the specialty.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study adds to evidence for increasing the integration of GH work into emergency care training in high-income countries.

INTRODUCTION

There is evidence of significant engagement in global health (GH) work by UK emergency care staff. A 2019 survey conducted on behalf of the Royal College of Emergency Medicine (RCEM) indicated that at least 7.5% of RCEM members had been involved in GH work.[1] The survey found that over a third of respondents' careers had significantly benefited from these experiences, and over half of them called for GH to become a key focus of the college's work.[1] A similar survey of emergency medicine (EM) trainees in Australia found an even higher proportion of respondents had undertaken GH work, 18.2%, and over 85% were keen to do more.[2] Lack of funding and protected time to develop meaningful GH experiences were referenced as key barriers in both surveys.[1–3]

Emergency care practitioners' relevance to the global burden of disease is exemplified by research showing that over half of all deaths in low-resource settings could be addressed by improvements in emergency care.[4] In addition to the direct patient benefits, the benefits of undertaking GH work may also extend more generally to the staff involved and the systems in which they work. A 2022 survey found that EM residents in the USA with GH experiences attained higher achievements across all residency competencies, including medical knowledge, skills and professionalism.[3]

However, little is known about the detailed experiences of UK emergency care practitioners (doctors, nurses and paramedics) who have undertaken GH work and how this has impacted their practice. The aim of this study was to construct a nuanced and detailed understanding of: the perspective of emergency care practitioners who have undertaken GH work; their lived experience and how these experiences interconnect with their work in the emergency care sector on their return to clinical practice in the UK.

METHODS

Study design and epistemology

To undertake this qualitative study, anonymised semistructured interviews were conducted on a purposive sample of UK emergency care practitioners who had previously undertaken GH work. Reflexive thematic analysis was used to analyse and present their experiences in this field.

The study followed the 'Consolidated Criteria for Reporting Qualitative Research (COREQ)' checklist. The research was conducted within the epistemological framework of contextualism, arguing that multiple accounts of reality are possible and may indeed conflict, and the context by which these realities are experienced is key to shaping them.

Recruitment and inclusion criteria

Participants were identified using a list of UK-based emergency care practitioners who had signed up to the RCEM 'Global Health Mapping Project'.[5] This is a mapping platform developed to connect those working in UK emergency care who have been involved in GH work. GH work was defined as having been involved in access-limited, resource-limited or context-limited healthcare. Participants were asked to join our study via email between April and July 2022.

Of the 81 potential participants identified and contacted, 21 responded and 20 interviews were undertaken.

Data collection

Data was collected through in-depth, semistructured interviews, conducted using video teleconferencing software (Zoom Pro, V.5.13.11) by two members of the research team. Participant information leaflets were sent, and written consent was obtained from each participant prior to interview. Two interviewers were used to improve availability and to vary interviewer positionality. Each interview was aimed to last 30–60 min.

The topic guide (online supplemental appendix 1) was developed by the authors following review of the available literature and identifying the knowledge gaps. This was iteratively reviewed and amended throughout the study in response to their interview experience and global review of the audio recording. Field notes were taken following interviews, and each interview was recorded and transcribed verbatim by a professional transcription service. Transcripts were also returned to participants for comments and to check accuracy.

Analysis

Anonymised transcripts were analysed using Braun and Clarke's six steps approach to reflexive thematic analysis depicted in figure 1.[6] Data was organised using data management software (NVivo V.12.7.0).

Primary inductive analysis was undertaken alongside the interview process, highlighting potential emerging themes. Data was discussed regularly during research team meetings to refine, challenge and develop the thematic structure.[7] Reflexive journals were kept by all team members to reflect on their positionality throughout the study. Interviews were completed when it appeared that thematic saturation had been achieved, evidenced by progressively reducing new ideas.

First order codes were captured, adjusted, combined and expanded to form higher order parent codes or subthemes. Finally, themes were identified, defined and named.

To triangulate the data and support the creation of codes, as well as search and review the themes, an outsider researcher (with GH and EM experience but no prior knowledge of the topic guide) was provided with the anonymised transcripts. They then coded the data independently and developed a set of themes which were then reviewed and consolidated with the original ones by the whole team.

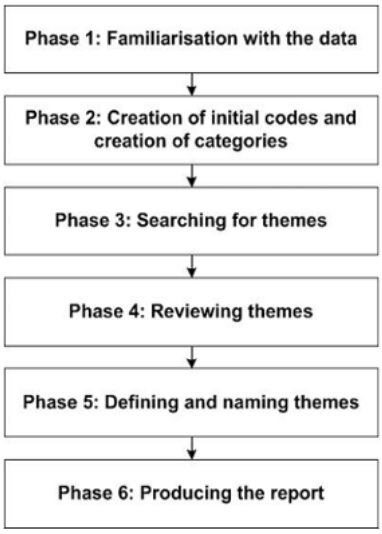

Figure 1 Six phases of reflexive thematic analysis—adapted from Braun and Clarke.[6]

Patient and public involvement

Due to the nature of the study looking at the experiences of emergency care practitioners, patient and public involvement was not sought as part of the methodology.

RESULTS

20 participants were interviewed before thematic saturation appeared to have been reached (table 1). The mean interview length was 36 min (range: 22–59). Doctors with a wide range of experience were interviewed, from 3 years postgraduation up to

Table 1 Characteristics of the interview participants (n=20)

Characteristics		Participants, n (%)
Profession	Doctor (consultant)	**6** (30)
	Doctor (registrar and above)	**9** (45)
	Doctor (pre-registrar)	**3** (15)
	Paramedic	**2** (10)
Gender	Male	**9** (45)
	Female	**11** (55)
Age	21–25	**1** (5)
	25–30	**1** (5)
	31–35	**8** (40)
	36–40	**4** (20)
	41–45	**2** (10)
	46–50	**2** (10)
	51–55	**1** (5)
	>56	**1** (5)
Postgraduate GH qualifications	Diploma (Diploma of Tropical Medicine and Hygiene or Diploma in Conflict and Catastrophe Medicine)	**9** (45)
	Masters	**2** (10)
	None	**9** (45)

GH, global health.

Figure 2 Geographical distribution of GH activities undertaken by participants (countries worked in by participants marked in red). GH, global health.

retired consultants. Two paramedics were interviewed; however, no nurses responded to the interview invitation.

Participants reported 71 separate GH activities across 37 countries. Activities undertaken included clinical service, policy and system development, research, education and training. The geographical spread of these activities is represented in figure 2.

The following headings represent key, overarching themes that emerged, with subheadings breaking down the main contributory subthemes (figure 3). Themes and subthemes are presented with selected quotations to evidence them. Subthematic examples of these quotations are presented in table 2 with the full list in online supplemental appendix 2.

Emergency care is a specialty well positioned to engage in GH activity

A strong theme that emerged was that emergency care practitioners are particularly well placed to undertake GH work. Participants reflect that their skills, attributes and experiences enabled them to be especially useful in lower resource settings.

> A lot of the attributes that make a really good EM physician…make good attributes for working in low resource settings. P15

In fact, some participants were drawn into the specialty for this very reason.

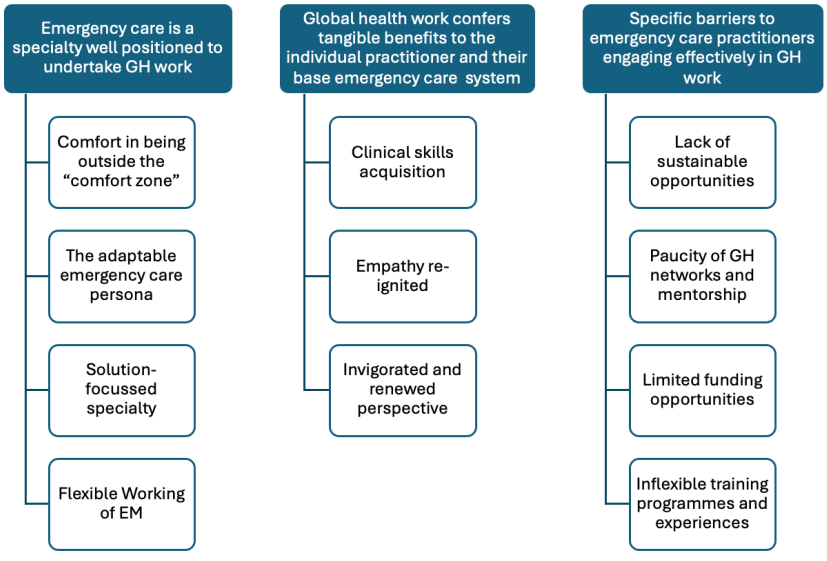

Figure 3 Themes and subthemes represented graphically. EM, emergency medicine; GH, global health.

Table 2 Examples of subthemes with representative quotations

Subtheme	Representative quotes
The adaptable emergency care persona	'I have done everything from running mobile clinics to in-patient feeding for malnourished babies…EM is quite a flexible mindset. You are like okay, this isn't what I normally do, but I can do a little bit of most things and I can learn to do new things' P27 'In a refugee camp with [International NGO]… I was managing a little field hospital and was essentially like managing a [expletive]chaotic ED' P21 'When resus is full and you have another sick person you have to be inventive, it forces it. I think being able to just pull your sleeves up and get stuck in when the going gets tough is…what makes EM pretty special' P15 'You have to climb in the back of the ambulances and treat people… in the UK, you're used to finding ways around problems. That adaptability, that's essential' P1
Empathy reignited	'It has genuinely softened my heart to see the need of people who really need it…I hope that makes me a better doctor and, therefore, able to care for all comers here' P6 'It gave me a lot more insight into some of the difficulties that (asylum seekers)…face in the UK, who don't speak English, who need to seek emergency care…I had a lot more empathy…a lot more time for patients like that' P1 '(Patients who were born outside of the UK) want people who are able to register some empathy…A lot of UK trained people will stay in the UK forever and ever, but I think there are so many other races and colours and creeds here now that some element of how we deal with these people respectfully is probably quite important' P31 'A bit more awareness of … different cultural contexts, especially when you're having those difficult conversations, how to make them culturally appropriate' P12 'Experience to people from diverse backgrounds, perspectives…negotiating between people coming with initially different ideas and coming to a common agreements is a common practical skills we do in EM' P20 'There's quite a lot of saviourism, people coming and going, I've got skills, I want to share them…people often have very good motives, but then there's a huge missing knowledge when it comes to cultures, and how to work in different cultures, and how to share knowledge in ways that isn't… getting people to think about that beforehand will be hugely beneficial' P1 'Anything that RCEM…do with GH, they need to be engaged in helping clinicians within the UK decolonise their minds. I cannot tell you how many people…come to [multiple countries in Africa] and judge by their standards and expectations. No that we shouldn't expect…higher standards… but thinks look different, things work differently' P 14
Lack of sustainable opportunities	'I spent so long actively looking and I couldn't find anything. … I couldn't find anything from EM that was really that inspiring or looked particularly useful or sustainable' P5 'I'd love to do something, where I can be actually useful and not just a parasite on a poor country?' P6 'There could be better communication of opportunities as well. I think there's a lot of appetite for it and I think if we had put out a job for a fellow with GH interest, we would have loads of people apply, but at the moment people…have to make their own opportunities' P11 'If we had a proper network of people where you could do it… that's the one thing I'd really love to see take off' P6 'There's a lot of knowledge and learning and systems that are already out there that are in place, but it's just about connecting the dots that people can learn and not have to reinvent the wheel' P24

ED, emergency department; EM, emergency medicine; GH, global health; NGO, Non-governmental organisation; RCEM, Royal College of Emergency Medicine.

> I deliberately went into Emergency Medicine because I wanted to work globally as part of my career….it fits well. P20

Comfort in being outside of the 'comfort zone'

Participants highlighted how the broad knowledge base of emergency care practitioners was particularly useful in settings with undifferentiated patients where access to diagnostic equipment and tests was limited.

> In delivering absolute emergency care, you don't need many resources. You need training, and a certain amount of basic equipment. P19

> We take pride in being able to deal with whatever walks through the door, and I think this is the main skill that is really translatable. P15

On top of this, being generalists allowed participants to manage high acuity patients even when there was no easy access to other resources.

> And what's nice about it as well is we're one of the few remaining generalists in the world…medicine's become more and more specialised, so us and GPs can sort of do everything, and that's what you need when you're in environments with limited resources. P21

The adaptable emergency care persona

It was frequently stated that the very nature of EM (and the current UK working conditions) builds practitioners who are resilient, adaptable and show initiative for problem solving. These skills were felt to lend themselves to a GH role where other specialties may not be so willing or comfortable.

> You have to climb in the back of the ambulances and treat people in the UK, you're used to finding ways around problems. That adaptability, that's essential. P1

> I think being able to just pull your sleeves up and get stuck in when the going gets tough is…what makes EM pretty special. P15

Solution-focused specialty

Participants put a focus on how the crowded departments where they work in the UK equipped them to take a solution-based approach to the challenges of working in low-resource settings.

> When resus is full and you have another sick person you have to be inventive, it forces it…The EM skillset benefits low resource areas in terms of a collaborative approach, in terms of lateral thinking, in terms of solution-based focus. P15

> (EM skills involve) Coming up with out-of-the-box solutions for difficult situations… and trying to keep your head and doing the best you can. P2

Flexible working of EM

The working patterns of emergency care practitioners, particularly consultants, were also recognised as lending themselves to GH work. Flexible working hours, annualised rotas and not needing to commit to chronic patients were all cited as improving the ability to go and do work outside of the UK.

> For me emergency medicine has been a good way to get into it because of the annualised rota, and because of the lack of continuity of care… has helped. P11

> There's quite a lot of flexibility often built into the consultant work schedule. P20

GH work confers an array of tangible benefits to the individual emergency care practitioner and their base emergency care system

A wide variety of beneficiaries of GH work were listed by participants, which included the individual undertaking the work (clinical and non-clinical benefits) as well as the value added to the National Health Service (NHS) on their return.

> In terms of the organisation I'm going to be…bringing new ideas, quality and training. In terms of the NHS, it's giving me or giving them someone who has a little bit more clinical practice in terms of experience and exposure. So… all parties are benefiting from that global health work. P10

Clinical skills acquisition

The clinical experience gained abroad, particularly procedural, paediatric and trauma skills, were often described as more valuable than those that would have been gained during the equivalent time working within the UK. Participants frequently commented that in GH work, they were careful not to overstep their competencies or practice skills, just as they would not working at home. However, the sheer volume led to accelerated improvements in clinical skills.

> My trauma skill set, I learned more in six months in South Africa than I did in my entire time in EM the UK just with the volume of patients you see. P24

> We probably had two or three paediatric resuscitations a week… I'm going to be a consultant next year, so those (leadership) skills will be needed. P5

With increased exposure to higher caseloads and higher acuity presentations, participants described improved confidence and competence at managing even the most crowded and stressful ED shifts. These skills were also highlighted as being particularly transferable to recent disasters within the UK, from major incidents to the COVID pandemic.

> Compared to some other clinicians of my grade I was relatively unflappable… so that prepared me well for working in a pandemic and working in a major trauma centre. P14

> If you look at… people who responded to [a mass casualty event in the United Kingdom] those who'd had overseas experience managed it better. They can deal with uncertainty better. P19

Empathy reignited

Several participants explained how work in areas with a clear need helped develop a compassion that permeated through other facets of their work. This empathy was defined by others in terms of improved 'cultural competency' following their GH experiences.

> It gave me a lot more insight into some of the difficulties that (asylum seekers)…face in the UK, who don't speak English, who need to seek emergency care…I had a lot more empathy…a lot more time for (them). P1

> (GH work) has genuinely softened my heart to see the need of people who really need it…I hope that makes me a better doctor and, therefore, able to care for all comers here. P6

Invigorated and renewed perspective

Some found GH experiences allowed them to cope with the stresses and strains of their usual healthcare system without decompensating, burning out or struggling.

> It increases job satisfaction. Particularly in EM, which can become tiresome, stressful, mundane almost. If you go and work in an environment where your skills really make an immediate difference, it's very reinforcing. P19

> (GH experiences are)…stepping stones to a more fulfilling and more sustaining career in EM. It only enriches people by having these experiences. P4

An important perspective described was an appreciation that UK emergency departments are becoming increasingly resource poor in terms of space and personnel. Participants described skills being honed in resource-poor environments becoming increasingly transferable.

> Obviously, there's like a huge amount of emergency medicine in resource constrained settings, which is essentially what we are now in the UK. P20

> Nobody can deny how challenging things are right now, but if you come to it with a positive framing, your attitude and ability to actually make a difference is so much better. P15

Specific barriers to emergency care practitioners engaging effectively in GH work

Despite the multitude of benefits described by participants of undertaking GH work, many discussed barriers to accessing and maintaining such experiences throughout their training programmes.

Lack of sustainable opportunities

Nearly all participants described challenges in accessing meaningful opportunities in GH, with concerns about sustainability and appropriate local benefits when considering these.

> I spent so long actively looking and I couldn't find anything. … I couldn't find anything from EM that was really that inspiring or looked particularly useful or sustainable. P5

Others called for better communication of the GH opportunities that are already out there, or a single platform to provide easy access to them.

> There's a lot of knowledge and learning and systems that are already out there … it's about connecting the dots so that people can learn and not have to reinvent the wheel. P24

Paucity of GH networks and mentorship

A clear subtheme emerged when participants described how they were able to seek out GH opportunities, which was relying on informal networks, nepotism and chance encounters for getting access to these.

> It was just really lucky…one of the consultants I worked with…I was just chatting to him about what I wanted to do and where my interests were, and he mentioned that he had done this programme… I feel you have to be in the right place at the right time. P30

Once working in clinical positions, some participants struggled with a lack of supervision, particularly while navigating the often ethically challenging GH environment.

> There are obviously lots of ethical questions and things that come up…It would have been good, to have someone who has expe-

rience in GH, to talk me through the decisions I'm making, and things I'm getting involved in, and the impact of my actions, and to challenge me in those ways. P2

Limited funding opportunities

Most participants described taking significant pay cuts or self-funding their GH opportunities, which has acted as a deterrent for continuing experiences and has prevented other colleagues from ever getting experience in the field.

> Most people do…take unpaid leave and take time and fund themselves…which isn't particularly sustainable. P8

Some participants even explained that despite their work being in lower-middle-income countries, the need for self-funding made these opportunities paradoxically more accessible to wealthier, more 'financially free' practitioners.

Inflexible training programmes and recognition of what constitutes training experience

Another barrier to engaging in GH which was highlighted was the inflexibility of training programmes, with local training programme directors (TPDs) often unwilling to allow time out of training or out of programme experiences (OOPEs).

> It's entirely dependent on my TPD signing the OOPE form…it will be dependent on the individual, whether they've heard of GEM <global emergency medicine> and whether it's something they support or not…it makes my career aspirations very uncertain. P20

Some participants even describe having to 'quit training posts' to continue a career involving GH. However, some of the consultant respondents explained there was more potential for involvement in GH activities after gaining 'consultant privileges'.

DISCUSSION

Every participant interviewed in this study highlighted the tangible benefits from their GH work, both personally and for their base workplace on their return to the UK. Procedural, paediatric and trauma skills were all highlighted as areas that were upskilled during GH work, as well as resource allocation and managing higher volume and acuity caseloads. Hayward *et al* found that EM residents from the USA who had undertaken short-term GH experiences scored significantly higher marks, across all competency-based milestones assessed during training (including medical knowledge, skills and professionalism), than those who had not.[3] Our study adds UK evidence to a small but growing pool of research on the specific impact of GH work on emergency care practitioners and vice versa. In recent years, the UK has started to offer GH fellowships for those in emergency care, with RCEM providing a practical framework for organising them.[8] As well as calling for more availability of fellowships, our participants also made the case for a subspecialty training route in GH, as is offered in the USA.[3]

The benefits described in the study went far beyond the improvement in competency of its practitioners. Participants felt more able to manage crises, insidious problems of fiscal constraints and departmental overcrowding by feeling more 'resourceful' and 'efficient' than colleagues who had not undertaken GH work. This resonates with an economic model put forward by Health Education England, which found that health practitioners who had undertaken international volunteering programmes were more productive at work than those who had not.[9]

Pertinent to the current workforce crisis in UK emergency care, participants also described the 'invigorating' properties of doing GH work, allowing them to 'retain compassion' and help reduce future 'burnout'. Although often intangible, GH work was found to be a 'missing piece' for happiness and sustainability. The RCEM workforce survey in 2021 found that 59% of respondents (doctors, nurses and physician associates) had experienced burnout following the second wave of the pandemic, and 50% were considering either reducing their hours or taking a career break.[10] This is particularly pertinent following recent research showing that in the NHS, hospitals with lower turnover rates for nurses and senior doctors are associated with better health outcomes for patients with emergency hospital admissions.[11] GH work may be an area that RCEM could advocate for to attain the concluding goal of its report, to ensure 'appropriately trained, happy, healthy and well supported' emergency care practitioners.[10]

Despite the benefits of undertaking GH work, nearly all participants described difficulties in undertaking it, particularly while in UK training programmes. Even though there is an inherent flexibility of rosters and work schedules in the specialty allowing for GH experiences, this was predominantly described by consultants, with trainees feeling much more restricted in their ability to access these. The interviews supported the findings of the RCEM survey, where a lack of guidance, supervision, funding and protected time during training were identified as key barriers.[3] These were also reiterated in survey studies from Australia and Canada.[1 12] In many cases, participants described 'lucky' encounters as the springboard into their GH experience, with others highlighting the lack of accessible GH 'resources' or 'networks' in the UK. The RCEM Global Emergency Medicine committee has been encouraging the development of regional GH hubs, with the most prominent of these, The Global Emergency Care Collaborative (GECCo) founded in 2020.[13 14] Even with growing access to a GH network, the lack of available funding was prohibitive for many participants, paradoxically and ultimately making these experiences only accessible to the wealthy.

Limitations

The purposive sampling relied on having participated in the Global Health Mapping Project and voluntarily replying to the invitation email, with a response rate of 25%. Although this methodology contributes to finding information-rich cases, these participants are likely to be a particularly engaged cohort and possibly not representative of all emergency care practitioners who have undertaken GH work in the UK. A majority of participants were registrar or consultant-level doctors, and a minority were paramedics, with no nurses participating. The lack of involvement of nurses and paramedics may have been due to the channels through which the study was published, namely RCEM and GECCo.[13] As such, the results should be only cautiously extrapolated to non-doctor emergency care practitioners.

Some participants had roles within RCEM and in particular on the Global Emergency Medicine committee, which meant they had valuable insights into the topic but also had a potential conflict of interest when discussing the role of RCEM during the interviews.

The positionality of the researchers may have influenced the conclusions drawn. This subjectivity in interpretation is a necessary part of reflexive thematic analysis but needs to be acknowledged. CC-I, AJNJ, SW, AT are all EM physicians who have prior interest and experience in GH. AJNJ has been developing the

GECCo, and both AJNJ and CC-I are members of the RCEM Global Emergency Medicine committee.

The research team maintained sight of these potential influences during reflexive discussions and diary keeping throughout.

CONCLUSIONS

This study indicates that GH experiences benefited both the individual and the wider UK healthcare system. Emergency care practitioners described feeling well placed to undertake GH work, yet they feel training programme leadership and the RCEM could do more to support them to develop a career which could involve GH. Easier access to funding, widening the GH network, improved mentorship and more support from training programme leadership were all identified as ways to improve access to GH careers.

Future studies should aim to quantify the individual and wider healthcare benefits of GH within the UK, an example of which has already been demonstrated in the USA through competency-based reviews of clinicians who have undertaken GH experiences.[2]

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Contributors SW was the main author of the manuscript with editorial oversight by AJNJ. SW is the guarantor. The topic guide was developed by SW, CW, AJNJ and CC-I following review of the available literature and identifying the knowledge gaps. This was iteratively reviewed and amended throughout the study by SW and CW in response to their interview experience and AJNJ's global review of the audio recording. Primary inductive analysis was undertaken alongside the interview process by AJNJ, highlighting potential emerging themes. First order codes were captured by SW and CW, adjusted, combined and expanded to form higher order parent codes or subthemes. Finally, themes were identified, defined and named. To triangulate the data, an outsider researcher AT (with global health and emergency medicine experience) with no knowledge of the topic guide was provided with the anonymised transcripts (interviewer questions were removed—but in part revealed on a transcript-by-transcript basis if a response could not be interpreted without the question). AT coded the data independently and developed a set of themes which were then reviewed by the whole team.

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