APRIL 2022

Bulletin

The magazine for members of the Royal College of Anaesthetists

Using 360-degree video to teach practical procedures from the 2021 RCoA curriculum

When opinions interfere with research

Getting to the heart of the College

Trainee issue

The changing landscape of training in anaesthesia

Page 14

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RCoA Events

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APRIL

Anaesthetic Updates
20 April 2022
Online

AaE: Teaching and training in the workplace
27–28 April 2022
Edinburgh
FULLY BOOKED

Cardiac Disease and Anaesthesia Symposium
28–29 April 2022
Online

MAY

Leadership and Management: The Essentials
4–5 May 2022
Edinburgh

FICM Annual meeting: Fit for the Future
6 May 2022
RCoA, London

Airway Workshop
10 May 2022
RCoA, London

After the Final FRCA
13 May 2022
RCoA, London

Anaesthesia 2022
17–19 May 2022
Manchester and online

AaE: anaesthetists' non technical skills (ANTS)
27 May 2022
Online

JUNE

Anaesthetic updates
7–8 June 2022
Online

FPM Pragmatic Management of Chronic Pain Study Day
8 June 2022
RCoA, London

FICM ACCP Conference 2022
10 June 2022
Newcastle upon Tyne

AaE: An Introduction
14 June 2022
Online
FULLY BOOKED

AaE: Teaching and training in the workplace
15–16 June 2022
RCoA, London
FULLY BOOKED

JULY

Primary FRCA revision course
July – Autumn
Online

Final FRCA revision course
July – Autumn
Online

SEPTEMBER

Hypnosis and hypnotic communication in the management of patient anxiety
15 September 2022
RCoA, London
New event

Anaesthetic Updates
28–30 September 2022
RCoA, London

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

Book your place at rcoa.ac.uk/events

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From the editor

Dr Helgi Johannsson

Welcome to the spring edition of the *Bulletin* – the trainee edition. I want to thank Drs Sen and Thoms for their excellent work in curating this issue, which is certainly relevant to all of us despite being labelled the 'trainee' issue.

When I wrote my last *Bulletin* editorial in December I was looking forward to being away on a beach over Christmas, and to my 50th birthday. I am now looking forward to taking exactly the same trip over Easter, having had to cancel Christmas, thanks to Omicron visiting the household. I know many of my friends and colleagues were in the same situation, and on a personal level I am extremely glad our work and personal lives are slowly returning to normal.

Over the last two years we have all had to adapt, and the process of training has changed beyond recognition. Necessity is certainly the mother of invention, and it's been very interesting reading about some of the ways technology is being used to teach and train – virtual reality, 360-degree video, and I'm sure at some point in the future we will enter the Metaverse and be able to experience teaching and training through an entirely different world.

None of this, however, will ever replace face-to-face experience. The way we interact with our patients and with each other cannot be entirely taught using virtual reality, and the article on anaesthesia and the English language shows us just how subtle the way we communicate can be. Our choice of words matters, the intonation we use makes a difference, and subtle body language changes can make the difference between a positive experience and a traumatic experience for our patients. Do we say 'a sharp scratch' or not? I remember once supervising a trainee who kept using phrases like 'you'll feel like you've had a couple of gin and tonics' and asking what sort of drink the patient wanted. The patient eventually asked the trainee to stop talking about alcohol, they were a reformed alcoholic and really didn't want to be reminded of their extremely traumatic battle with addiction.

I really hope you've seen a change in the way the College conducts its business over the last few months, and I'm looking forward to more changes in the future. We have changed the way we communicate, and I hope you will agree that it's open and honest, and simply more human. I am also delighted to welcome the seven new Council members to the fold. I am particularly pleased that we have better representation from Council members at the beginning of their consultant careers. I hope you agree that they reflect the diversity of the specialty, and I know they will do an excellent job in their representation of their members. It is also with sadness that I say farewell to some great representatives of the profession who have now become friends through our work together. I must particularly thank Dr Williams for her article and her hard work as SAS representative – Dr Kumar has some (metaphorically) big shoes to fill.

The President's View

LET'S TALK ABOUT WHAT'S IMPORTANT TO YOU

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Dr Fiona Donald
President
president@rcoa.ac.uk

In my New Year message, I shared our new College five-year commitment,[1] setting out an ambitious strategy for the future underpinned by a set of values to guide our way in achieving them.

It is not enough to simply have our values written on a poster – it is important that you see them in action in everything that we do.

It was with this in mind that we recently held the first of what will be a regular series of *Let's Talk* meetings with our members on Zoom. We wanted to hear what was on your minds and what was important to you. It is also important for you to have access to speak with the College Council and staff members directly.

All members are welcome to take part in the *Let's Talk* conversations. The next one is on 27 April 2022, and you can book your place at: rcoa.ac.uk/events/lets-talk.

We have an open agenda each time, although if there are topics you'd like to bring up in advance then let us know so that we can make sure there is someone from the College with expertise in that area in attendance.

The aims of *Let's Talk* are:

- connecting our members to the College representatives and staff team
- shaping the focus of the College's work based on member feedback
- fostering mutual understanding and relationships
- developing connections between members.

A diverse group of members joined our first *Let's Talk*, including a number from overseas. The discussion was free-flowing and brilliantly chaired by RCoA Council member, Dr Helgi Johansson. Thank you to everyone who joined the conversation.

The following areas were covered:

- ICU workforce and curriculum options
- Certificate of Eligibility for Special Registration (CESR) – how can we inform and promote this option to anaesthetists?
- workforce challenges – what can we do to minimise the gaps in career pathways?
- reflecting our members working in independent practice
- conference content – striking the balance for our members between clinical content and wellbeing sessions
- examinations – overseas delivery and CPD/ training equivalence points.

The final part of the event was an online networking opportunity, about which a few of us were sceptical but it was, dare I say it, enjoyable! The conversation was refreshing and supportive. If this is not something that you would normally stay for, I would say give it a go and see – you might be pleasantly surprised. It's a chance to talk peer to peer with people and share thoughts and ideas.

It is not enough to simply have our values written on a poster – it is important that you see them in action in everything that we do.

Let's continue talking at *Anaesthesia 2022*

Let's Talk will also have a 'listening post' at *Anaesthesia 2022*, staffed by both College teams and College representatives.

The team is hoping to gather your input on the benefits and services you have as part of your membership. As well as online and in-person activities, we will also be making space for all fellows and members to let us know what is important to them via short, snap-shot surveys focused on specific topics to check feelings around issues and initiatives.

We will send these to all members, or selected groups with a special interest in the subject, so that we can get as wide a view as possible from you. Some of these topics we already have in mind, for example how can we make positive changes to membership benefits to increase the value to you? However, we do expect new topics to arise as we meet more regularly with you.

If you have any ideas or thoughts please connect with us via the Membership Engagement team by emailing: engage@rcoa.ac.uk.

If you have any comments or questions about any of the issues discussed in this *President's View* or any other subject, I would like to hear from you. Please contact me via: presidentnews@rcoa.ac.uk

Reference

1 RCoA Strategy (rcoa.ac.uk/strategy-vision).

LET'S TALK

What our members are saying about Let's Talk

"Great chance to speak to the College Council directly, and voice any queries."

"Great to meet people all around the world."

"A very impressive event coming at the right time."

The next one is on 27 April 2022, and you can book at: **rcoa.ac.uk/events/lets-talk**

It is also important for you to have access to speak with the College Council and staff members directly.

Your College thrives because of its strong and active membership. As we are keen to involve you in our work to help shape future strategy, we've created numerous volunteering roles for fellows and members within the College.

Whether you have ten minutes or ten hours a month, or whether you can travel or prefer to engage locally or remotely, there is a role for you. We value your time and support.

If you are interested in finding out more about current opportunities, take a look at the Get Involved pages of our website at:

rcoa.ac.uk/membership/get-involved

Bulletin

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All contributions will receive an acknowledgement and the Editor reserves the right to edit articles for reasons of space or clarity.

The views and opinions expressed in the *Bulletin* are solely those of the individual authors. Adverts imply no form of endorsement and neither do they represent the view of the Royal College of Anaesthetists.

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CEO Update

Jono Brüün, RCoA Chief Executive Officer

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AN UPDATE ON OUR COMMITMENT TO YOU

With the summer sun fast approaching – the transition to our new College strategy is also heating up. Our five-year commitment will bring a renewed focus on ensuring that the College's membership is at the heart of everything that we do.

Improving members' experience of the College

The values that I outlined in my last *CEO Update* underpin our strategy. They will form the basis of how we will support and interact with members. As a College, we will always strive to be friendly, helpful and supportive to our members, and we are enhancing our training, systems and processes to ensure you experience this from us in a timely way. An illustration of this can be found in the way we listened to your feedback about online experiences and created *My RCoA*. The online portal launched towards the end of 2021 is designed to make it easier and quicker for members of the College or its Faculties to manage their data and access services. *My RCoA* is a new member benefit, developed using feedback from membership surveys, and serves to allow you greater engagement with the College and control over how your information is held by us.

It's not just the new technologies that are coming on stream that will help put the needs of our members first. Our recently launched *Let's Talk* meetings, as detailed in this month's *President's View*, also give us an opportunity to be open and responsive, meeting you wherever you are in the UK or across the world to talk openly about the issues you care about. These open and reflective conversations will be key for teams at the College to understand what's important to you and how we can best support you when you need us.

The staff team, under my leadership, is determined to keep on improving the ways in which we positively and respectfully support our fellows and members across all their interactions with us. Whether it's attending one of our *Let's Talk* events, providing feedback after attendance at an event or DMing us on Twitter – there are a plethora of ways for you to be heard. In the coming months, we'll share more ways in which we can continue the conversation with you. We want to learn from your honest, constructive, and valuable views – only then can we be sure that the support we provide is right.

Not only do we recognise the need to provide valuable experiences for our members, we also understand our responsibilities to patients. We want to make sure that the patient voice is integrated with the work of the College, increasing our engagement with this important group will mean that voice is heard. Through our work, including with the Lay Committee, we are exploring how we can collaborate with patients and the public to learn from their experiences and to help them understand the role of anaesthesia and perioperative care in an accessible way.

Reviewing our examinations

We know that the learning and assessment opportunities we provide are vital. We are committed to continuously improving our examinations, to make sure that they are delivered in line with best practice. To help us in this process we have been working with Professor John McLachlan who has been carrying out an external review of the FRCA, FFICM and FFPMRCA examinations. His remit is to give an independent assessment of fitness for purpose of our exams, with scope extending to include IT, systems, budget and staffing levels. We are also looking at the impact of exams on the wellbeing of candidates and examiners alike. This is an important review, with wide-ranging outputs and the potential to shape our examinations provision for many years to come. I look forward to sharing the results with members in general, and our Anaesthetists in Training in particular, in the weeks and months ahead.

Separately, we have responded to the wishes of many of our candidates and examiners by offering in-person exams for the first time since the start of the pandemic. This was announced at the beginning of the year, with changes taking effect from April.

We have learnt to adapt to the changes that the pandemic has demanded of us all. Our Events team has harnessed the opportunity and now many of our events going forward will take a hybrid format – opening up learning and networking opportunities to people with caring responsibilities, or not based in London. For example, we are looking forward to welcoming delegates to *Anaesthesia 2022*, a hybrid event, allowing people from across the globe to attend.

Our commitment to you, our membership is central to everything that we'll do going forward. It is you, that I, RCoA Council and staff want to hear from in order for us to know how we are doing. We aim to be more open and clearer in our approach – we may not always get it right, but the intent is there, and your feedback is vital to keep us following the right path. We look forward to supporting you on your professional journey to care for your patients.

For more information about our *Let's Talk* events visit: **rcoa.ac.uk/events/lets-talk**

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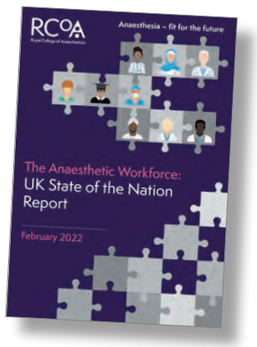
NEWS IN BRIEF

News and information from around the College

The Anaesthetic Workforce: UK State of the Nation Report



A report from the College warns that more than eight million operations per year will be cancelled or delayed by 2040 unless anaesthetic workforce shortages are addressed.

The RCoA's *The Anaesthetic Workforce: UK State of the Nation Report*, paints a stark picture of cancelled operations due to a desperate shortage of anaesthetists. While the long-term view is one of eight million cancelled operations each year, the situation today is similarly bleak, with a weary workforce, burnout and staff sickness exacerbated by a 1,400 shortfall of anaesthetists.

Currently, there are six million people on NHS waiting lists. The report shows that without investment in training posts for anaesthetists the situation will only worsen.

Find the report on the RCoA website at: rcoa.ac.uk/uk-state-of-the-nation-report

National 'Prep, Stop, Block' protocol

The Safe Anaesthesia Liaison Group (SALG) and the Regional Anaesthesia UK (RA-UK) have published a new national Standardised Operating Procedure (SOP) to prevent wrong side block. The updated procedure, Prep, Stop, Block, enhances the message of 'Stop Before You Block' – the 'stop' moment should occur just before needle insertion.

The campaign was devised by SALG and RA-UK in 2011, which had significant success but was not being interpreted consistently across different healthcare settings. In 2018 the Healthcare Safety Investigation Branch investigated the causes of wrong side regional anaesthetic block and invited SALG to formulate a standard, national policy. The resulting working party, led by SALG, included representation from the Royal College of Anaesthetists Simulation Working Group, RA-UK, the Faculty of Pain Medicine, and NHS Improvement recommended the new 'Prep, Stop, Block.' SOP.

For more information please visit the SALG website at: bit.ly/3My0TMU

Bulletin minimises its environmental impact in 2022 and beyond

We wanted to update you on some important changes to the *Bulletin*, as well as reminding you of how you can access it.

There are now two ways to access the *Bulletin*. As well as the quarterly printed version we will be adding an online version later in the year. This means that you'll be able to get all the same high-quality content in a digital format. Currently the digital version of the *Bulletin* is the pdf on the RCoA website.

These changes come as many titles including the *British Journal of Anaesthesia* (*BJA*) and the *British Journal of Anaesthesia Education* (*BJAEd*) have announced moves to digital formats in recent months.

As a reminder, members can access the *BJA* and *BJAEd* via the My RCoA portal. We have also produced a 'how-to' guide and video to show how to access the portal and the journals which can be found at: bit.ly/3GoEm1g

Paediatric Imaging under General Anaesthetic

The College is pleased to announce the publication of *Paediatric Imaging under General Anaesthesia*. The College worked with the Association of Paediatric Anaesthetists, the Association of Anaesthetists, the Royal College of Paediatrics and Child Health and the Royal College of Radiologists, as well as parent representatives, to develop this consensus statement on best practice for requesting, vetting and consent for non-invasive diagnostic procedures under general anaesthesia in children and young people. This addresses the safety recommendation made to the RCoA in the Healthcare Safety Investigation Branch (HSIB) report titled *Undiagnosed Cardiomyopathy in a Young Person with Autism*.

Refugee Doctor Buddying Scheme

The Royal College of Anaesthetists in partnership with the Association of Anaesthetists and Refuaid launch the Refugee Doctor Buddying Scheme. The initiative aims to provide support for anaesthetists forced to migrate who wish to continue their career in anaesthesia within the NHS. Participants in the scheme will have settled status in the UK and be able to work without restriction.

The buddying system is key to orientating refugee doctors into the healthcare system in the UK - to help with this transition we are looking to appoint anaesthetist buddies with experience of arriving in the UK as an International Medical Graduate (IMG) who can help offer advice and guidance for those in the scheme to settle well and thrive.

If you are interested in being involved or know someone who might – take a look on our website at: rcoa.ac.uk/membership/get-involved

CT3 Equivalent Post Survey Results

The Royal College of Anaesthetists, the Association of Anaesthetists and the British Medical Association would like to thank all the anaesthetists who participated in our recent CT3 Equivalent Post Survey.

We had 183 respondents, of whom 71 per cent had previously applied for higher anaesthetic training. 78 per cent of respondents applied for their current post with the aim of achieving CT3 competencies, with 65 per cent in a post which was specifically advertised as being CT3 equivalent. While 68 per cent said the post met their expectations, with 11 per cent saying it exceeded them, 17 per cent stated their current post fell below expectations.

More details about the results of this survey can be found on the College website at: rcoa.ac.uk/news/ct3-equivalent-post-survey-results

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NEWS IN BRIEF

News and information from around the College

Don't forget to book your place for our flagship conference, *Anaesthesia 2022*, taking place next month.

The conference (from the 17–19 May 2022) is being held at the iconic Old Trafford Stadium, home to world-famous Manchester United FC. Delegates will also have the opportunity to join online as well.

The conference will be opened by Andy Burnham, Mayor of Greater Manchester, who is very excited to be bringing anaesthetists together for our first time in Manchester. Followed by a packed programme, you will hear from local legends and international icons, including Nick Watts, Chief Sustainability Officer at NHS England, who is delivering a keynote lecture as well as Colonel Lucy Giles, President of the Army Officer Selection Board, who will give a talk on leadership.

We are also very excited to announce that we will be welcoming Sir Alex Ferguson, former Manchester United Manager back to his football home to deliver a guest lecture.

No matter what stage of your career, *Anaesthesia 2022* has something for everyone. The programme offers the chance to learn, stay informed and network with your peers.

We are really looking forward to seeing you in Manchester or online in May so block out your diary and book your place now.

Visit rcoa.ac.uk/anaesthesia to book and view the programme.

Returning to face-to-face examinations

The College is returning to face-to-face delivery for OSCEs and SOEs in the FRCA, FFICM and FFPMRCA exams from the week beginning 25 April 2022.

We have held all our exams online since the start of the pandemic, so that we could continue to support the careers of anaesthetists, intensivists, and pain specialists even though travel and social contact were restricted.

As previously announced, the College made a commitment to online exam delivery until April 2022 but promised to make a decision before then about whether to remain virtual or return to the pre-pandemic face-to-face format. Uncertainty as to the impact of the Omicron variant prevented us from taking this decision sooner, but with greater stability and having discussed it with the GMC, we are confident now is a good time to return to face-to-face.

Now, with restrictions eased and having looked at candidate and examiner feedback, our Board of Trustees has confirmed we will return to face-to-face sittings for the SOE and OSCE components of FRCA, FFICM and FFPMRCA exams, with the written CRQ and MCQ components remaining online.

We will keep details updated on our website at: rcoa.ac.uk/examinations

ACSA update

A number of departments of anaesthesia have been recently awarded their first accreditation under the Anaesthesia Clinical Services Accreditation (ACSA) scheme.

These are: Manchester University Hospitals NHS Foundation Trust – Wythenshaw, Northumbria Healthcare NHS Foundation Trust and The Christie NHS Foundation Trust. In addition, St Helen's and Knowsley Teaching Hospitals NHS Trust have successfully been reaccredited under the scheme.

Other news from the ACSA Team includes that, by agreement with hospitals, onsite visits have now resumed as part of the ACSA review process.

For information on ACSA, please see the relevant section of the RCoA website at: rcoa.ac.uk/acsa or contact the ACSA Team on ACSA@rcoa.ac.uk

e-LA
e-Learning Anaesthesia

Valued online learning tool

The College's interactive e-learning programme, e-LA, saw over 590,000 individual learning sessions launched in 2021 by 35,000 active users. e-LA is most well-known for supporting trainees in preparation for their exams, however that's not all with the learning material in modules 8–14, designed for consultants and SAS doctors. We are constantly updating the wealth of articles, MCQs and structured learning on e-LA with the latest updates in Module 7, Module 3 as well as the revision guides and sustainability sections.

For more information about how to access e-LA visit our website at: rcoa.ac.uk/e-learning-anaesthesia

Welcome to our newly branded podcast channel

The College has launched: *Anaesthesia on Air*, a podcast channel which brings together experts from various sectors of anaesthesia in conversation to discuss all things related to our specialty.

From clinical topics to wellbeing and sustainability, *Anaesthesia on Air* will tackle timely issues as well as invite speakers and commentators to debate the future of the specialty. The rebrand of RCoA podcasts includes slick new music as well as a vibrant and striking logo to ensure listeners can easily identify it.

Graham Blair, Director of Membership, Media and Development, Royal College of Anaesthetists said:

"RCoA podcasts have been going from strength to strength and my hope is that Anaesthesia on Air, will bring even fresher, ever more timely content to listeners. Our aim is to invite and amplify voices in the anaesthetic arena as well as other thought-leaders from sectors with relevant insight into the specialty. We are excited about sharing the content we have planned, and to continue to grow our listenership with an open dialogue providing valued and informative content."

We are always looking for new content, so if you have any ideas, or would like to get involved, please contact us at: podcast@rcoa.ac.uk

Guest Editorial

Dr Soumen Sen
RCoA Anaesthetists in Training Committee
trainee@rcoa.ac.uk

Dr Susie Thoms
RCoA Anaesthetists in Training Committee

The changing landscape of training in anaesthesia

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Resilience, flexibility and adaptation to the new environment. These are the ways we are training – and learning to train.

It has been more than two years since the COVID-19 pandemic changed the way we live, work and look at life. We have had to cope, grow and adapt to both the varying social changes and the numerous transformations to the way we work. From 'Covid intubation drills' to 'red' or 'green' theatre lists and wards, our fundamental working landscape has changed.

Education and training continues to be an integral part of our lives, especially as we need to be up to speed with the transformations as quickly as possible. This has led to a drive to seek out new ways to deliver training, with the virtual model allowing us more flexibility and convenience and reducing our carbon footprint. Furthermore, in 2021 the new RCoA curriculum was launched, changing the ethos in the way we think about and practise training.

Change is never simple, and transitions are rarely straight forward. We all go through the 'Kubler Ross change–acceptance cycle' [1] in different ways and will be at different stages of the process. We are all going through these transitions and must work together to help each other progress.

Anaesthetists are ultimately great innovators and adaptors and are always seeking new ways to work and learn. From Archie Brain's invention of the laryngeal mask airway to David Gaba's innovation with patient simulators and revolutionising simulation practice, anaesthetists have been at the forefront of clinical and educational change and innovation.

The necessity of maintaining education and the drive to find new ways of teaching has led to two exciting examples of how 360-degree video and virtual realities are helping to deliver anaesthetic and emergency medical teaching. Dr Cat Bounds and her group at Queen Victoria Hospital are using 360-degree video technology to create example videos of practical procedures in anaesthesia that are all mapped to the new curriculum. Over in Wessex deanery, Dr Thomas Judd and Dr Rachael Ford are using virtual-reality technology to teach life-support simulation scenarios to medical students.

Both of these groups are using new technologies to maintain and assist the delivery of training. The virtual landscape is endless, and the scope for training in this environment is full of potential. Could we be learning in an educational 'Ready Player One' world in the years to come?

Journal clubs have been a mainstay of many anaesthetic departments, but with constantly changing rotas and jobs and in multi-site environments, reliability can be difficult. Drs Adam Eddie and Jamie Gibson have transformed their journal club during the pandemic and created a hybrid virtual and on-site event, reliably growing their attendance and allowing for a multi-site discussion at the three sites of University Hospitals Sussex. They have kindly shared their fomat and how they achieved this, and have given tips for you to recreate their success at your own trusts.

Contrary to the stereotype of anaesthetists 'enjoying their role' as they 'don't have to talk to patients', we are highly skilled at effective and empathetic communication. Our skills at verbal anxiolysis are vital at so many critical aspects of the patient journey, especially when we treat patients preoperatively when they may be apprehensive and feeling at their most vulnerable. Language is an ever evolving tool, and it is important to review the way we communicate. Dr Doug Morgan eloquently writes about how we use language in our patient interactions and suggests a discussion of the traditional anaesthetic and theatre vernacular and how there is a potential for change.

It is now almost a year since the introduction of the new anaesthetic curriculum, and we are continuing to learn about, understand and unravel the potential of the changes. There are many resources available for many groups of trainees and trainers, and the College is keen on showcasing any innovative ways of support and learning. Dr Ross Holcombe-Law and Dr Paul Jackson are both CT3+ trainees who have developed a support network to assist their peers with guidance and shared experiences for those completing the Stage 1 top-up year. Their network is another avenue to ensuring that all training groups have a variety of ways to share their voice.

In the current world, we have many sources of information and forums where we can express our thoughts and provide feedback. Twitter is one of these outlets and, while it can be polarising, it may be useful to see what the 'global' sentiment is. Dr Devan Williams has done just that, and has used 'sentiment analysis' to compare all the 'Medical Royal Colleges', offering ideas of how to take this forward and use this tool in the future.

We hope that you enjoy reading these articles and hope that they will inspire you to continue working hard to create new ideas and strive to keep improving your own working and educational environments. We hope you enjoy the edition and have a great summer ahead.

Reference

1 Elizabeth Kubler Ross Foundation Change Curve. (ekrfoundation.org/5-stages-of-grief/change-curve)

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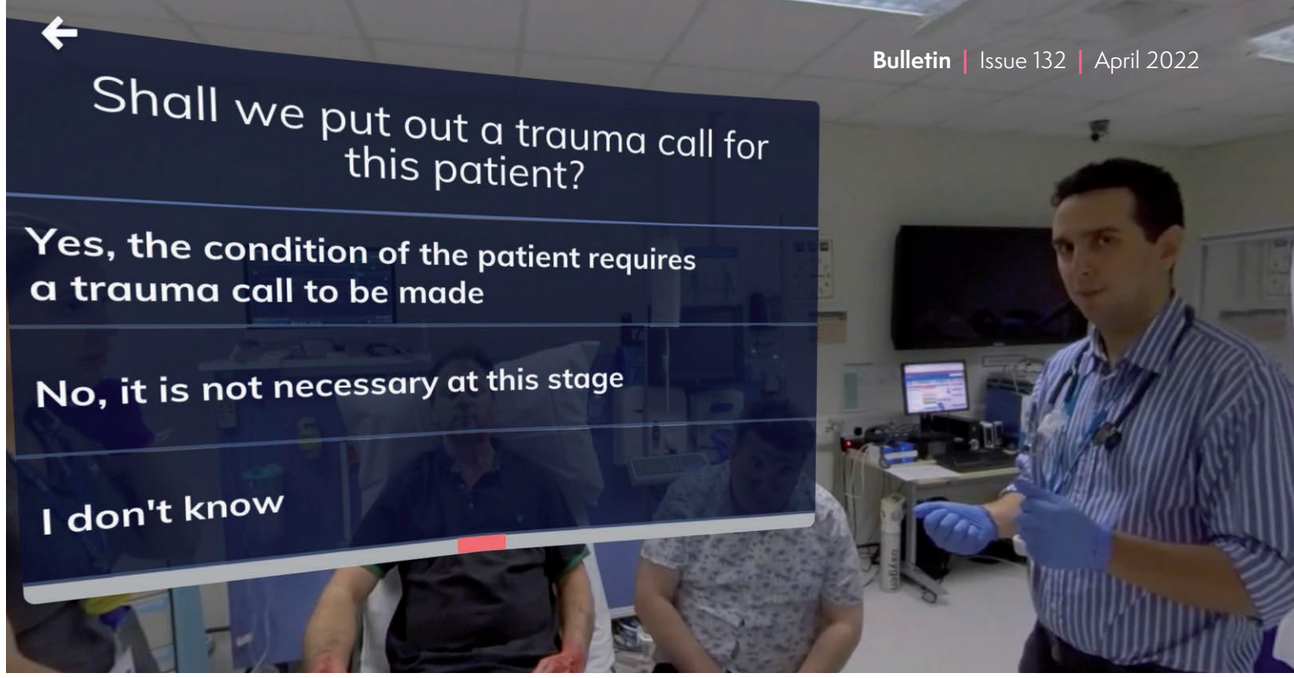
VIRTUAL REALITY IN ANAESTHETIC TRAINING

Simulation training is well established in anaesthetic training. The RCoA recently referred to simulation as a 'proven and powerful tool for learning in healthcare at the level of individual and team-based practice. As a training intervention, it can support and enhance the development of basic or more advanced technical skills'.[1]

Running high-fidelity simulation has two main issues: cost and time. High-fidelity simulators are expensive to run and maintain, often requiring a sim technician. Delivering simulation training is time intensive for facilitators, and there is limited access to simulation-suite facilities as the use of simulators has been taken up across medical specialties. COVID-19 has further impacted on access to simulation training, with social distancing limiting the number of participants, and the higher demand for simulation training due to loss of real-world opportunities. This has led to exploration of new and novel techniques to deliver training.

Using virtual reality (VR) is something that is being increasingly discussed in medical education. Although the term 'virtual patients' is not new to this area, we need to understand what it means. Educational literature suggests that interactive patient scenarios are described as virtual patients, despite rapid technical advances that would support more complex applications.[2] The potential for VR in anaesthesia is wide ranging, from emergency situation management to practical skills.

So why is VR not already incorporated into anaesthetic training? This question seems more puzzling when you see how the airline industry is adopting virtual and augmented reality to train pilots.[3] Can virtual-reality training really be comparable to simulation training? We carried out a pilot study to look at the use of virtual-reality training as an adjunct to simulation training for medical students. This involved medical students with no prior resuscitation training who were recruited and underwent Hospital Life Support training. Students then either received no further teaching or were given access to a VR resuscitation scenario via their phone to use with a cardboard VR headset. Students were then assessed during a simulated cardiac arrest, and during the scenario they were scored on their performance. A further assessment was performed three weeks later, during which time the intervention group still had access to the VR scenario. The results showed that both groups of students performed better in the follow-up assessment, but the VR group performed better than the control group in both tests. So, VR training appeared to have a positive impact on performance and reduced skill-fade. Students in the VR group also reported feeling more competent in performing these skills than the control group. These encouraging results suggest VR may be effective in delivering aspects of anaesthetic training.



Screenshot of 360-degree video showing interactive questioning during a trauma scenario – taken from the Virti app

The main challenges facing VR are similar to those facing simulation, namely cost and expertise in delivering the training. High-end virtual reality headsets cost upwards of £700.[4] One way to tackle the cost is to replace the VR headset with a smartphone.

A further cost is the time and money required to develop and design VR simulations. 360-degree cameras and VR development applications on smart phones are now readily available and allow development of scenarios with minimal technical training.[5] A bank of scenarios would be easy to develop and, if accessible to all anaesthetists in training, could prove much more cost-effective than simulation training.

The second major issue is can VR training really be comparable to simulation training or at least be another adjunct to use alongside simulation? Further research is required to answer this and to understand how the technique can be most effectively employed.

In summary, VR technology has reached a point where it is becoming more accessible and is cheaper to access. With ever-increasing clinical pressures and the difficulties for clinical staff in keeping up their competency-based training, VR has an important role to play in limiting skill-fade. The benefits of its low time demand, and reduced faculty needs gives it a real benefit over simulation training. The future of VR will rely on interested individuals becoming skilled in its development.

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Declaration: Virti supplied the technology support to run the pilot study.

Using 360-degree video to teach practical procedures from the 2021 RCoA curriculum

The COVID-19 pandemic has presented significant challenges to the delivery of training in anaesthesia. Cancellations to elective theatre lists have reduced training opportunities, and anaesthetic techniques have been adapted to the changing demands of a global pandemic. When learning practical procedures, repetition is vital to achieve improvement.[1] With disruption to training, it has been increasingly difficult for anaesthetists in training to gain practical experience and develop competencies.

Following COVID-19 there have been substantial advances in online teaching methods that allow for social distancing. These have been successfully utilised for training and professional development and to widen opportunities to participate. However, teaching practical procedures online is more challenging, as students may feel detached from the clinical environment. 360-degree videos are an ideal teaching tool to address this issue, allowing the learner to gain an immersive experience of clinical procedures in real-time.

360-degree video

360-degree video is a technique that creates a simulated environment around the user, who is immersed but is unable to interact.[2] The user can become fully absorbed in the clinical setting, and this allows for a better understanding of the ergonomics. It provides the opportunity to watch the task flexibly and repeatedly, which is the key to successful simulation but is difficult to deliver in a traditional simulation environment.[3]

We describe an innovative use of 360-degree video technology

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in anaesthesia training. The 2021 anaesthetic curriculum in the United Kingdom[4] includes a list of practical procedures for anaesthetists to learn during their training. We created 360-degree videos mapped to the curriculum, which demonstrate core practical procedures in a simulated clinical environment. The aim has been to help trainees to develop their skills in these practical procedures using an affordable and accessible method.

Method

Videos were developed by a team of senior anaesthetic trainees with guidance from anaesthetic consultants and the simulation lead. First, we identified a list of practical procedures from the anaesthetics curriculum for which videos could be created. A cinematic storyboard and script for narration was created for each procedure. We also produced a list of simulation equipment, scene direction notes and, a plan for camera and actor positioning.

A simulated theatre environment for filming was created and a combination of actors and mannikins were used. We aimed to replicate the clinical setting as closely as possible, using identical equipment and ergonomics to those used in everyday practice. Procedures were filmed by the Virtual Reality in Medicine and Surgery (VRiMS) team[5] using 360-degree video equipment. The unused 360-degree video space was utilised for 'camera-in-camera' streaming of additional video perspectives, allowing users to choose the view they prefer by altering their head position when viewing on a virtual reality headset. After filming, the videos were annotated and edited for image and sound quality. Supplementary images were added, such as real time ultrasound videos showing needling technique for regional anaesthesia blocks.

A pilot video was shown on virtual reality headsets to a group of anaesthesia trainees attending a training day. Feedback was obtained to refine future videos and improve the learning experience. Comments were largely positive, and trainees felt engaged by the immersive experience. The videos were uploaded to the VRiMS website for educational use by anaesthetists in training.

Conclusions

360-degree video has been used extensively in other industries such as aviation, where it has contributed to reducing human error and improving safety.[3] In healthcare, 360-degree video has been shown to increase knowledge-gain compared to screen-based learning and improve outcomes in surgical training.[3] 360-degree video has been used as a training tool in 10 surgical specialties hosted by the VRiMS team. To our knowledge, this is the first use of 360-degree video in the context of the anaesthetics curriculum in the UK.

This innovative technique offers great advantages in the current climate, as learning can occur outside high-risk COVID-19 areas, maintain social distancing and provide vital clinical-setting visualisation. 360-degree videos offer a unique and accessible resource to supplement practical experience. Currently, videos cover core practical procedures, and further work will expand the video library to cover practical skills at all stages of the RCoA curriculum.

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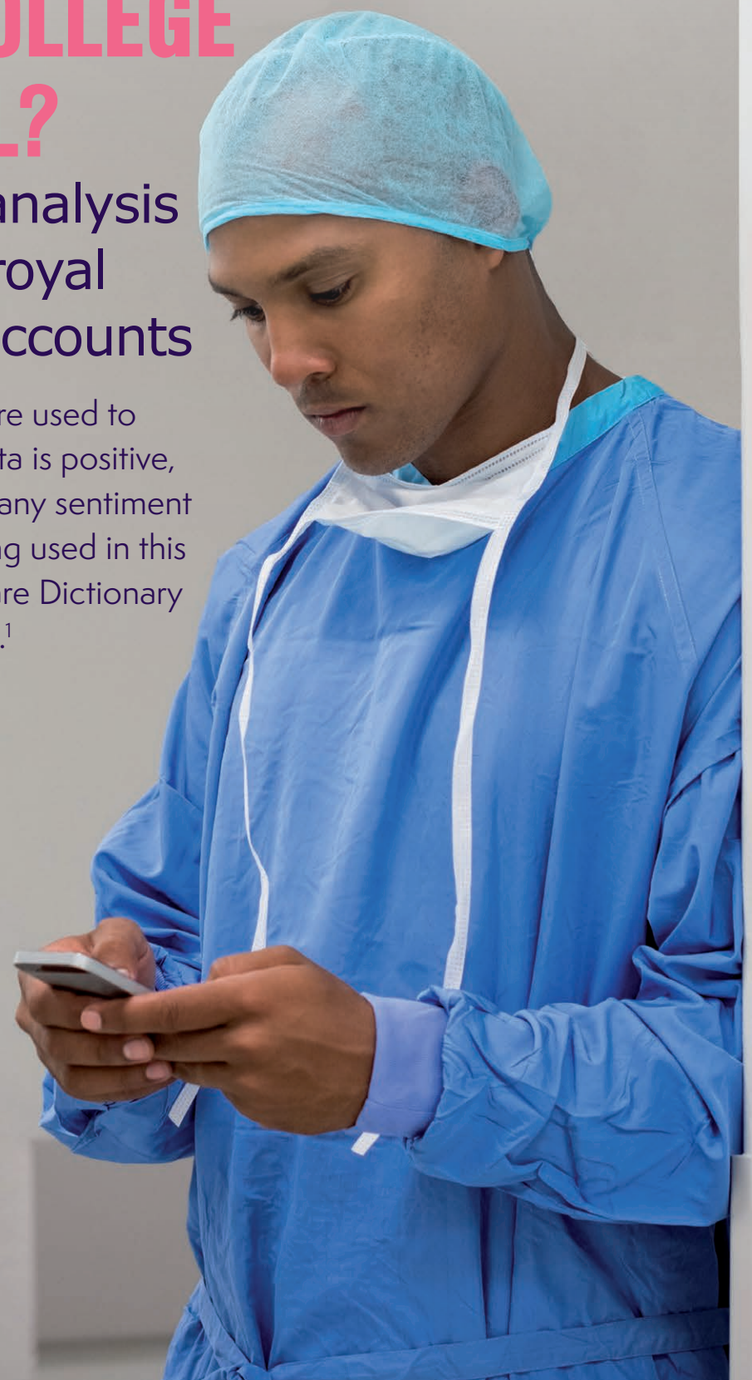
WHO'S THE HAPPIEST COLLEGE OF THEM ALL?

Using sentiment analysis to score medical royal colleges' Twitter accounts

Sentiment-analysis techniques are used to determine whether language data is positive, negative or neutral. There are many sentiment analysis models. The model being used in this case is the VADER (Valence Aware Dictionary for Sentiment Reasoning) model.[1]



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In this model, every word is given a score: neutral words such as 'a', 'the', or 'and' are allocated a score close to 0; positive words such as 'happy' or 'good' get positive scores, and negative words such as 'sad' or 'bad' negative scores. In addition to this, the more emotive a word is, the higher the score. For example, 'ecstatic' receives a higher score than 'happy' as it is deemed more positively emotive. Modifiers are also included, so that multipliers like 'very happy' or 'HAPPY' score more than just 'happy'.

Once all the words have been assigned a value, a compound score is given to the block of text indicating its overall positive or negative value within a range between –1 (strongly negative) and +1, (strongly positive). This can be described as a normalised, weighted composite score.

Method

The tweets from the twitter accounts of all members of the Academy of Medical Royal Colleges were downloaded using a Python twitter API (Tweepy).[2,3] Retweets, messages @ the college, and images could not be included in the sentiment analysis. VADER sentiment analysis was applied to each individual tweet, with each then obtaining a compound score. The scores were then averaged across all the tweets for the same college to give a total score. This was then plotted against the number of tweets downloaded to create Table 1.

Table 1 Sentiment score against number of tweets for various colleges

College	Twitter account	Compound score	No. of Tweets
Royal College of Surgeons of Edinburgh Faculty of Dental Surgery	RCSEdFDS	0.5998	62
Faculty of Public Health	FPH	0.515537	1,238
Royal College of Anaesthetists	**RCoANews**	**0.440355**	**2,564**
Faculty of Intensive Care Medicine	FICMNews	0.415225	1,467
Royal College of Pathologists	RCPath	0.411779	2,191
Royal College of Physicians	RCPhysicians	0.399135	2,586
Royal College of Surgeons	RCSnews	0.39129	2,661
Royal College of Surgeons Of Ireland	RCSI_Irl	0.390822	1,526
Royal College of Surgeons of Edinburgh	RCSEd	0.383934	2,599
Royal College of Physicians and Surgeons of Glasgow	Rcpsglasgow	0.383058	2,405
Royal College of Physicians of Ireland	RCPI_news	0.37134	1,799
Royal College of Physicians of Edinburgh	RCPEdin	0.364815	2,755
Faculty of Sport and Exercise Medicine (UK)	FSEM_UK	0.36084	1,359
Faculty of Sexual and Reproductive Health	FSRH_UK	0.354228	2,072
Royal College of Radiologists	RCRadiologists	0.350371	2,330
Faculty of Pharmaceutical Medicine	FacultyPharmMed	0.346715	967
Royal College of the Obstetricians and Gynaecologists	RCObsGyn	0.341929	2,460
Faculty of Dental Surgery	FDS_RCS	0.339257	647
Royal College of Ophthalmologists	RCOphth	0.337028	1,996
Royal College of Paediatrics & Child Health	RCPCHtweets	0.311165	2,436
Royal College of General Practitioners	Rcgp	0.304345	2,801
Faculty of Occupational Medicine	FOMNews	0.266272	1,121
Royal College of Emergency Medicine	Rcollem	0.245584	1,675
Royal College of Psychiatrists	Rcpsych	0.159059	3,001

Sentiment analysis could be applied to assess the reputations of the various colleges in the handling of specific events or as a way of assessing the response to announcements

Results

As we can see from Table 1, in the Twittersphere the 'happiest' of all the colleges is the Royal Colleges of Surgeons of Edinburgh's Faculty of Dental Surgery. It is, however, interesting to note that this is also the account with the fewest tweets (62 total tweets), and that the vast majority of these were promotional tweets for various courses and awards; there were no tweets from 2020 onward. Thus, negativity associated with the pandemic is perhaps missing.

The account with the most tweets, that of the Royal College of Psychiatrists, had the lowest sentiment-rating, and therefore had either the most neutral, or most negative tweets out of all the colleges. Without further in-depth analysis of all 3,000 tweets scores, I can only hypothesise the reasons. There may have been campaigns for better services or improvement to the specialty, and the negative scores might have been a reflection of points being highlighted.

As both of the above are extremes, there appears to be a tenuous link between the number of tweets and the positivity, with colleges that tweet less tweeting more positively. Nevertheless, once a trend line is created, the R^2 value is 0.1684, demonstrating a very weak correlation.

Other colleges of particular note are the Faculty of Public Health and our own RCoA, who rank as the second and third most positive colleges. Notable colleges, such as the Royal College of Emergency Medicine and the Royal College of General Practitioners, feature rather negative tweets.

However, the vast majority of the colleges are all in a moderately positive range of between 0.3 and 0.45. This may be due to temperateness of the language posted on these accounts, (with strong emotional language rarely being used), and the large amount of promotional material, such as courses and exams available, found on these accounts.

Discussion

Although it is not the most sensible use for sentiment analysis, this exercise was undertaken to look at it as a viable research tool. It could, in theory, be applied to assess the reputations of the various colleges in the handling of specific events (eg, exams/application cycles) or as a crude way of assessing the response to announcements such as policies or reactions to a new guideline.

Outside of twitter, sentiment analysis has been shown in a recent article in *Anaesthesia* to be a good way of objectively assessing large amounts of freeform data.[4] However, as highlighted by some of the results above, although a score can be created by analysis of twitter feeds, on their own these are rather meaningless, and there are many pitfalls. And so, just using sentiment analysis as a tool to say the overall feedback was positive or negative may not be enough.

It may be possible to repeat multiple cycles of sentiment analysis, or plot them over time, to see changes and trends over time.

Further research

Further research, using similar tools in Python could be used to look into the sentiment of retweets towards organisations, or even other professional bodies such as the GMC, BMA or NMC.

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THE CORE ANAESTHETIC TOP-UP SUPPORT NETWORK

The Core Anaesthetic Top-up Support (CATS) Network has been created by, and for, CT3 Equivalent (Stage 1 'Top-up') anaesthetists within the UK. It stands as an all-encompassing hub for key updates and information assisting with completion of the stage 1 top-up year, enabling application to ST4 entry to the new 2021 anaesthetic curriculum.

The 2021 Anaesthetics Curriculum divides training into Stages 1, 2 and 3. Stage 1 consists of three core years, four within ACCS, with entry into Stage 2 at ST4 level (the first entry commencing in 2023). The absence of an August 2022 ST3 recruitment round, has created a large group of doctors who have completed core anaesthetic training on the 2010 curriculum, but do not hold ST3 posts.

In response to this the RCoA has released guidance on CT3 (Stage 1 'top-up') equivalent posts. This guidance aims to provide a structure for doctors taking up non-training anaesthetic roles with evidenced learning outcomes and experience required for application to ST4. Despite this, as a cohort of 'non-trainees', individuals may not benefit from the organisational and supportive elements present in a formal training programme. Furthermore, this group of doctors lacks regional or national representation.

This is reflected in the results of the College's CT3 Equivalent Post Survey,[1] which demonstrates variability in study leave, study budget allowance, educational opportunities and even the comparative annual salary of posts. Anaesthetists described a significant burden of balancing clinical work with training requirements plus the pressure to find additional activities to boost competitiveness for application to ST4. Of most concern was the 60 per cent of respondents reporting negative feelings about both life and their future in anaesthesia.

The CATS network

The CATS network has been created to provide assistance and improve representation for doctors that are undertaking an anaesthetic CT3 Equivalent Year.

We aim to:

- build a cohesive network of UK anaesthetic doctors aiming to achieve CT3 equivalence
- provide a platform to share experiences, ideas and concerns
- improve regional and national representation of this cohort
- act as the 'eye and ears' of its members, bringing key updates into one easily accessible information source
- liaise with the RCoA and other relevant organisations on areas of uncertainty
- assist with queries and provide a means of feedback to members.

It is easy to join the network by subscribing to updates through the CATS network website at thecatsnetwork.co.uk, or following our regular updates on twitter @theCATSnetwork.

We look forward to hearing from you and hope to make life that little bit easier for this valuable cohort of unique doctors working towards the certificate of completion of training (CCT) in anaesthesia.

Reference

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JOURNAL CLUB: REAPING THE REWARDS OF VIRTUAL MEETINGS

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With its inception, University Hospitals Sussex NHS Foundation Trust now encompasses three acute district general hospitals and a university teaching hospital. We have subsequently transformed our journal club from a single-site ad-hoc endeavour into a weekly meeting with multisite departmental buy-in and a reliable attendance of more than 20 people.

Now more than ever, with the advent of the 2021 anaesthetics curriculum, there is a move away from hardened clinical domains to a rounded emphasis on generic and specialty-specific domains. 'Research and managing data' and its new weighting within the curriculum shows the need for refined skills of critical appraisal, understanding of statistical techniques and the assessment of the quality of research. Journal clubs offer important opportunities to develop and evidence many of these capabilities, in addition to developing presentation skills and guiding clinical practice using the most recent evidence.

Running over the past 15 months, we have developed a journal club delivered at noon every Friday that has quickly become engrained in training. The host site rotates weekly between the three main hospitals and the meetings are available to view virtually and on-site in dedicated spaces. This has greatly increased uptake among anaesthetists in training and the consultant body. Details of the meeting and paper are emailed out at the beginning of the week with important pointers on how to critique the paper. WhatsApp reminders are posted to training groups on the day and efforts made by consultants to facilitate attendance.

Active participation in critical appraisal and discussion is encouraged by the meeting chair, as is attendance from clinicians with a special interest in the subject area. Presenter feedback is electronic, accessed by way of a QR code forming the last slide of every presentation. This leads to the generation of near-immediate feedback, providing evidence for portfolio upload and has led to significant engagement in the feedback process.

This format has proven a superb forum to critique papers, comment on the validity of research, and debate the implications of the findings locally. Starting up a journal club similar to this should not seem like a major undertaking but instead something achievable to motivated departments and something that is ultimately rewarding and enjoyable.

Figure 1 Tips for the successful running of journal club

Our tips for success	Rationale/comments
Nominate a cross-site journal lead	With an interest in critical appraisal To assist with paper selection To liaise with presenters To share appraisal templates
Nominate motivated site-specific journal club leads	Higher trainees known locally are a help – for rota creation to act as chairs of meetings
Department lead and consultant/rota-master buy-in	For sustainability
Send a weekly email	For pre-release of paper As pointer to other important literature
Host on a regular weekday at a convenient time	To maximise attendance
Offer on-site and virtual attendance options	To maximise attendance
Record on virtual platform	For upload to trust Cloud service provider To allow those who cannot attend to view
Engage local experts on the week's topic	To promote topical discussion
Keep the duration short	30 minutes works well To limit impact on clinical activity
Dedicated departmental space	With computer, microphone, webcam and large screen
Presentation to focus on key areas	Existing literature summary: single-slide Summary of the paper: factual, unbiased Critical appraisal: strengths, weaknesses, relevance and impact
Final slide showing QR code	Providing feedback for the presentation With comments box to feed back on journal club

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ANAESTHESIA AND THE ENGLISH LANGUAGE

The delicate use of language is an essential tool for the anaesthetist. We often have limited time to build rapport and establish trust in patients who are vulnerable and frequently stressed. We scoff as we listen behind the curtain to the surgeon as they clumsily 'consent' a now terrified patient.

Yet while we pride ourselves on being good communicators, there are many words and phrases in our collective lexicon that we use unthinkingly that are at best unhelpful and at worst disastrous. In this article I will discuss some of those pieces of language that, in my opinion, we could excise to the benefit of all.

I like to think of a patient's worry and stress levels like an old mercury thermometer. They start at a certain temperature, and this will go up and down depending on how their various interactions in the clinical environment go. A bad phrase might push them a little up the thermometer scale, but in the wrong patient it might be a lot. And if they are already starting near boiling point, you've got to be careful.

In '*Politics and the English Language*', George Orwell tells us:

'A scrupulous writer, in every sentence that he writes, will ask himself at least four questions, thus:

1 What am I trying to say?
2 What words will express it?
3 What image or idiom will make it clearer?
4 Is this image fresh enough to have an effect?

And he will probably ask himself two more:

1 Could I put it more shortly?
2 Have I said anything that is avoidably ugly?'

It's this last point that I will mostly focus on, the avoidably ugly.

But before that, consider this:

'When one watches some tired hack on the platform mechanically repeating the familiar phrases... blood-stained tyranny, free peoples of the world, stand shoulder-to-shoulder – one often has a curious feeling that one is not watching a live human being but some kind of dummy, the appropriate noises are coming out of his larynx, but his brain is not involved.'

When I read Orwell here, I immediately think of:

'Don't worry, you're not going to fall off the bed...too much paperwork.' Ha-ha!

Anyway, I digress – back to the avoidably ugly.

'Are you hitting bone?' The consultant says standing behind the floundering anaesthetist in training failing at their spinal. Now imagine you're that patient. You haven't slept, you're looking at the midwife who won't stop staring at your CTG with wide eyes, and you've just been told there's an oh-so-teeny-tiny chance that you're about to be paralysed. Then the boss, the boss no less, talks of hitting bone. 'Are you feeling periosteum?' This would peacefully fly over the heads of most.

'Needle in the back of your hand.' Does the needlephobe really want to hear the word needle? Some patients even go on to think that a metal needle is actually left behind and are then scared to move their arm. Why not try, 'Flexible plastic tube'?

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'Sharp scratch'. I don't want to get into the debate of nocebo vs not warning the patient at all, but come on, that's the same line that the F1 who took 40 goes in A&E said. You don't need to associate yourself with that brand.

'Sorry, we're attacking you from all sides...'. Fine, 99 out of 100 patients won't give this a second thought. But we deal with patients who have histories of literally being attacked. We can avoid negative imagery that could be taken the wrong way. 'Sorry, there are lots of things going on at the same time.'?

'You'll feel like you've had a few beers/wines/G&Ts.' Again, absolutely fine for the overwhelming majority, but why bother risking it in the recovering alcoholic who now has negative associations with alcohol? Patients are so suggestible in the anaesthetic room – if you tell them, 'Most people start feeling nice and floaty, like any worries are fading away', that's probably what they will experience.

'This is going to sting/ache up your arm.' Propofol again. You don't need to prime them to feel this. Why not try, 'This might be cold, but it will pass.'?

'Hedgehog milk.' Hedgehog milk? I am seven years old and thinking 'Is it milk from a hedgehog or milk made of hedgehogs?' Either way, I don't want it. Why not, 'Here's some milkshake, tell me what flavour you want to taste'?

The space for this article is not large enough for all the silliness we say, but I hope these brief illustrations create some thought and maybe even a discussion or two.

I'll leave you with Orwell.

'...If thought corrupts language, language can also corrupt thought.'

WHEN OPINIONS INTERFERE WITH RESEARCH

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Anaesthesia is often viewed as both a science and an art form. But increasingly over the decades we have seen scientific research contribute more and more to our day-to-day anaesthetic practice. With increasing recognition that the anaesthetic care we provide truly and significantly impacts upon our patients' outcomes and experience, research in anaesthesia has more impetus than ever.

In anaesthesia it is not uncommon to find a divided opinion, but in recent years fundamental clinical questions have begun to be answered by randomised controlled trials (RCTs) focusing on clinical care.[1] These answers have allowed us, as clinical anaesthetists, to continue to improve and develop the evidence-based care that we provide for our patients.

Equipoise

The constant and vital factor in answering any anaesthetic research question is 'equipoise'. Equipoise is the assumption that there is not one definitive 'better' intervention present during the design of an RCT. But perhaps more important is the concept of personal equipoise, where the clinician has no personal preconceived preferences toward the ability of one or more of the interventions to have a better outcome. Lack of personal equipoise, when the treating clinician already has a preference despite inadequate scientific evidence, has shown itself to be a significant barrier to allowing our specialty to answer key questions through research. One recent study showed that participation in a randomised trial comparing two acceptable treatments is almost always a less popular option than choosing one of the treatments based on pre-existing knowledge and belief.[2]

Consider two intraoperative treatments, A and B, both in use in the NHS for minimising postoperative nausea and vomiting. A systematic review concludes that we don't know which of the two is most effective. A national multicentre RCT is underway at your hospital. A research nurse approaches you to include your patients who have consented in the trial today – do you agree to? Some clinicians will agree with the trial's equipoise and provide the treatments randomised by the trial. Some may already strongly prefer treatment A or B based on their personal views or experience and so deny the patient the chance to take part. The trial therefore takes much longer than expected to recruit the number of patients needed, costs more than funded for, and is slower to answer an important research question. Whether research-focused clinicians or not, a challenge we therefore face as a specialty is with our own personal equipoise in such a scenario.

Respecting our patients' rights

The question is what do we think about this as a community? Do anaesthetists with preferences have grounds to justify their decisions as care providers? Is this acceptable in the context of a patient who has a right to enroll in an appropriately governed research trial?

The answer is no doubt complex and relies on a delicate balance between ethics, patient-specific clinical decision-making, evaluation of the evidence, and personal experience. What we do know is that we have a duty to provide safe care, but also to improve care for future patients while respecting our patients' right to participate in research.

Figure 1 NIAA position statement on clinician equipoise

NIAA National Institute of Academic Anaesthesia | Association of Anaesthetists | Anaesthesia | RCoA Royal College of Anaesthetists | BJA

Clinician equipoise on applied research

A position statement from the NIAA founding partners

A positive research culture within medicine is necessary to ensure all patients have the opportunity to participate in safe clinical trials. Understanding and ensuring clinician equipoise is an essential part of this culture. The founding partners of the National Institute of Academic Anaesthesia (NIAA) agree on the following statements –

- Individual patients have the right to participate in safe clinical trials. This opportunity should be supported and promoted by treating clinicians. Patients should be allowed to make their own decision about taking part in research.
- Inequity in access to research means a patient's opportunities to participate are often determined by which hospital they are treated in. This variation is not acceptable.
- Objective research is need to understand clinician equipoise towards randomised trials and the challenges this creates for researchers. In particular, we need to understand the balance between a clinician's concerns about patient safety and their pre-existing views about the clinical effectiveness of trial treatments.
- This research should inform the development of solutions which are widely acceptable to the perioperative community.

The National Institute of Academic Anaesthesia and founding partners have recognised the significance of this issue and released a position statement on clinician equipoise to our community (Figure 1). Over the coming months we are hoping to unpick this complex issue within anaesthesia research, and better understand how our clinical equipoise impacts on the decisions we make for patients within research trials.

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For more information about the NIAA please visit **niaa.org.uk**

THE SCIENCE OF WELLBEING

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Clinician wellbeing is a vast topic. During the COVID-19 pandemic, in which anaesthetists have continued to play a key role, wellbeing has become an increasingly popular topic.

The role your job plays in your own wellbeing can vary vastly between individuals and may change over time. Anecdotally, during the waves of the COVID-19 pandemic some people report that they found work had a positive impact on them, especially during national lockdowns. They describe how they were their 'best person' while at work – enjoying the interaction with others, the challenges of clinical practice and the meaning that structured work provided for them. In contrast, others reported the opposite, with work being a major stressor and the cause of anxiety and other negative emotions.

Regardless of the cause, it can be difficult to recognise that your own wellbeing is suffering, let alone to know what can be done to improve it. Sadly, there is not a one-size-fits-all approach to improving wellbeing that will work for everyone. It requires the individual to reflect on the situation they are in and to dedicate some time to explore ways in which they can make positive changes to benefit their own wellbeing.

Without wanting to fall into the trap of lazy stereotyping, there are some common personality traits that are seen in a lot of anaesthetists. *CareerExplorer*[1] describes a 'typical' anaesthetist as 'investigative and enterprising', and says that 'they are usually quite natural leaders who thrive at influencing and persuading others'. The key to clinicians adopting a new practice is that success in this is often closely linked to the value placed on the evidence-base supporting it.

Anaesthetists are usually very familiar with reviewing scientific papers and evaluating trials relevant to clinical practice – in fact this is a skill that is taught at medical school and continues throughout working life. However, most anaesthetists are less familiar with evaluating evidence relating to social sciences and human psychology.

Studies on wellbeing interventions are difficult to conduct because clinician wellbeing is such a personal thing. It is multifactorial and affects individuals differently at different times, which can confound results. An understanding of the basic principles of human happiness can help individuals to identify what elements are adversely affecting their wellbeing, as well as to find strategies that might work for them to improve it.

'*The science of well-being*'[2] is a free online course, provided through Yale University and run by a leading expert in positive psychology, Professor Laurie Santos. To date, it has been accessed by 3.6 million people worldwide. It is available in 10 different languages and currently has an average rating of 4.9/5.0 from thousands of reviews. It is an online version of the 'Psychology and the good life' class, run on the Yale campus. The online version has become the most popular course in Yale's 319-year history.

The course is designed to be completed over ten weeks and requires a couple of hours of your time each week. It can also be completed flexibly to fit in with your own schedule. In the course, Professor Santos reveals misconceptions about human happiness and annoying features of the mind that lead us to think the way we do, and then presents the research that can help us to make meaningful change to improve wellbeing. It reviews the evidence on the science of happiness, human expectations and biases, and promotes science-backed habits that can improve your wellbeing. The course involves six weeks of theory and a four-week 're-wirement' period in which you engage in a series of challenges designed to increase your own happiness and build more productive habits. The aim is for you to prepare and successfully incorporate a specific wellness activity into your own life.

We've all become familiar with the concept of the 'R number' to indicate how transmissible a virus is. Emotions are contagious too. Social contagion is the spread of emotion from one person to another, and evidence shows that kindness – and that is both kindness to yourself and to others – is more transmissible than COVID-19. Research suggests that if you try these re-wirements as prescribed on the course you should experience a boost in your mood and overall wellbeing.

Word of this course has spread within our anaesthetic department, and our colleagues report the positive effects it has had on them. We wanted to highlight this course to a wider audience as we feel that the scientific, but individualised, approach may benefit anaesthetists and help them to improve their own wellbeing.

We think that completing '*The science of wellbeing*' online course will help people to view their work through a different lens. By implementing various interventions to improve our own wellbeing we believe we can help and inspire kindness in others.

References

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Complaints involving anaesthetists during the pandemic

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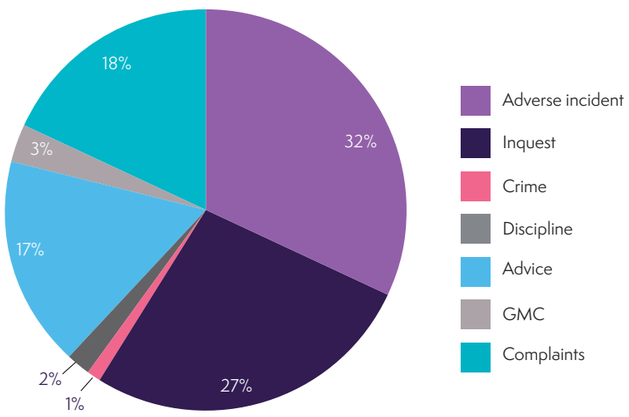
The past two years have been a challenging time for the medical profession, and all specialties have been affected by the impact of the pandemic. Most patients and their families have been understanding of the implications this has had for patient care. However, an analysis of cases reveals that anaesthetist members of the Medical Defence Union (MDU) have needed support more than ever.

Many anaesthetists raised medicolegal queries on our 24-hour advisory helpline, and in addition we opened more than 500 case files for members between the first lockdown in March 2020 and the end of 2021.

Figure 1 shows a breakdown of the types of files dealt with, with the majority being adverse incidents, coroners' inquests and complaints.

Figure 1 breakdown of file types for the period 31 March 2020 to 31 December 2021



Complaints and adverse incidents

The most frequently raised complaints and adverse incidents included drug errors, wrong-side blocks, awareness during anaesthesia, and complications arising from treatment. Common themes related to the pandemic included:

- delays in patients being transferred from one hospital site to another for treatment, and the availability of intensive care beds
- delays in surgery, particularly elective surgery. These were generally directed to the surgical specialty involved, with minor input from the anaesthetist member
- complaints from relatives where a patient with COVID-19 was not deemed suitable for admission to ICU. These were typically patients where ventilation was likely to be prolonged and survival unlikely.

These types of complaints emphasise the importance of detailed documentation of discussions between colleagues and multidisciplinary teams, discussions with the patient if appropriate, and involvement of the family as early as possible. Such difficult conversations generally had to take place remotely, and relatives were not able to see their loved ones face-to-face. Reference to relevant guidance at the time, either national or local to the specific hospital, was relied upon in justifying decisions about admission to ICU and the ceiling of care provided

- communication issues and the use of remote consultations. This was something clinicians had to get used to very quickly with very little training in advance. However, guidance on this did quickly follow from a number of bodies.

Inquests and fatal accident inquiries

Despite coroners' inquests being delayed during the pandemic, we assisted 140 anaesthetists with inquests over the period. This was significantly more than 115 similar files being opened in the same period for 2018–2019. Many cases centred on delays in inter-hospital transfers and the availability of ICU beds rather than the care provided by anaesthetists or intensivists. Cases also related to delays in patients seeking help, issues with remote consultations and the limitations of these in assessing patients, and delays in emergency treatment due to staff shortages and patient numbers.

Other advice

Other queries raised by anaesthetist members included requests for advice about the provision and appropriateness of PPE and COVID-19 testing and vaccinations. Queries about testing and vaccination included patients refusing testing prior to admission or refusing to wear face masks. Members were also concerned about their redeployment and working in specialties outside their usual practice where they may not have the most up-to-date knowledge.

Concerns are that, as memories fade of the challenges faced during the pandemic, those holding the profession to account – regulators like the GMC, the courts and indeed employers – properly take the COVID-19 context into account. The GMC has acknowledged the difficult circumstances that doctors have been working under and has sought to reassure registrants that this will be taken into account if a complaint is made to them.

Dealing with a complaint or adverse incident

If you are asked to provide your comments in relation to an adverse incident, or complaint:

- seek advice from your medical defence organisation as soon as possible, even if you don't feel that you are vulnerable to criticism
- refer to the relevant clinical records rather than relying on your recollection
- provide an open, honest and factual response, stressing where any lessons are learned or measures put in place to prevent a recurrence
- avoid commenting on the care provided by colleagues or providing your opinion about what happened
- provide clear explanations for your decision-making and management and, where possible, make reference to clinical guidelines or local policies
- write in a measured, professional and sympathetic tone, referring to the patient by name and avoiding medical jargon – the patient or family may see your report at some point
- address any specific questions put to you by the complaints team that are relevant to your involvement
- discuss the incident with a senior or trusted colleague, and show that you have reflected on what has happened. Mention any learning points or professional development activity
- apologise where appropriate. Even if you don't feel you could have done anything different, it's important to acknowledge patients' and/or relatives' concerns and say sorry
- if you receive a complaint directly, involve senior colleagues and your hospital complaints team to ensure that the proper process is followed along with any statutory duty of candour obligations.

Being involved in complaints can be upsetting for patients and colleagues alike. Seek support from your peers or your medical defence organisation if you are facing a complaint – don't go it alone.

Communication is the key to avoiding potential misunderstandings.

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Undetected oesophageal intubation

In the January edition of the *Bulletin*, (pages 28 and 29), we outlined the steps we were taking following the death of a patient caused by a missed oesophageal intubation.

Glenda Logsdail was a fit and healthy 61-year-old when she died in August 2020. The College was identified in the coroner's report as being a body that could help prevent similar future deaths.

We have been working with the Association of Anaesthetists and the Difficult Airway Society in working through a timetabled action plan to address areas where we can help.

As part of the ongoing actions, the College has been amassing resources that teams and individuals can use for training and discussion purposes.

They build on the College's *No Trace = Wrong Place* video, which shares the important message that during cardiac arrest, if a capnography trace is completely flat, oesophageal intubation should be assumed until proven otherwise.

They also bring in how to spot and address human factors – these played a part in the circumstances leading up to Mrs Logsdail's death.

The materials include:

- a set of flash-cards, based on a model developed by then simulation fellow Dr Tom Burr and piloted at East Kent Hospitals NHS Foundation Trust. These set out various scenarios for teams to discuss in training sessions and empower people to speak up and challenge each other
- links to articles talking about how human factors sometimes cause breakdowns in communication, and how to overcome this.

Videos from presentations include:

- Professor Tim Cook presents *The avoidance of undetected oesophageal intubation*
- Dr Lewys Richmond presents *Missed oesophageal intubation*
- a discussion from the RCoA Winter Symposium, with personal experiences from the clinical team close to the case
- *Human factors and ergonomics in airway management*, with Dr Fiona Kelly.

All the materials, and links to articles and presentations that discuss the issues surrounding Mrs Logsdail's death can be seen at: rcoa.ac.uk/prevention-future-deaths

The College would like to acknowledge the dignity and bravery of Mrs Logsdail's family who, like Martin Bromily before them, seek to work collaboratively and constructively with all of us to prevent a similar tragic loss of a life.

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GPAS UPDATE 2022

Since 2016, the *Guidelines for the Provision of Anaesthetic Services* (GPAS) has been developed using a rigorous, evidence-based process accredited by the National Institute for Health and Care Excellence (NICE). Following a detailed review of the processes used by the RCoA to produce GPAS, we are pleased to announce that the accreditation has been renewed until May 2026.

This is excellent news. The assessment by NICE found that the scope and purpose of the guidance produced was clear. Guidance development involved a range of professional stakeholders and target users of the guidance. The processes used are systematic and transparent, and consider the strength of the evidence and the balance of risks and benefits. The processes used for reaching recommendations and the peer review process of the guidance were clearly outlined. There is a regular update process supported by annual searches for new evidence. The guidance was found to provide clear recommendations, and the content and format of the guidance was felt to be suitable for the specified target audience.

One suggestion received from NICE for improvement in the future was to increase the involvement of lay or patient representatives involved with each GPAS chapter from one to two. This is a suggestion that we welcome, and we will be implementing this in the future, increasing the patient input into the development of GPAS guidelines.

The GPAS 2022 chapters were published in early February 2022 and are now available on the RCoA website. Chapters that have undergone full review this year include Emergency Anaesthesia, Burns and Plastics, Ophthalmics, Paediatrics, and Obstetrics.

We have recently started a full review of chapters, including Anaesthesia Services in the Non-theatre Environment, Cardiac and Thoracic anaesthesia, Day Surgery, Neuroanaesthesia and Trauma and Orthopaedic anaesthesia. The new version of these chapters will be published in GPAS 2023.

It is a great credit to all of the GPAS staff at the RCoA and to all of the GPAS authors involved in writing and reviewing the chapters, that this accreditation by NICE has been renewed for another term.

GPAS recommendations underpin the RCoA accreditation process (ACSA), helping to maintain high standards in the delivery of anaesthetic services throughout the UK and leading to improvements in patient safety.

The GPAS chapters can be found on our website at:

rcoa.ac.uk/gpas

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Surveys, surveys and more surveys: why is there a need for organisational surveys?

Every year, anaesthetists are asked to complete a number of different surveys. These can be directed to the department, such as the current Sprint National Anaesthesia Project (SNAP) Organisational Survey and the 7th National Audit Project Baseline Survey. These surveys ask for your time and energy to find the correct information from often clunky IT systems and from databases held by administration staff.

Before starting our research roles, we felt that there had to be a better, more efficient way of getting information about our health service's organisation and processes. What we have both found is that the best and most accurate information about the reality of how local hospitals run comes direct from local clinicians. The role of centralised data held by agencies such as NHS Digital has grown dramatically in recent years, but the datasets do not describe all elements of healthcare, especially the details of how clinical services are organised and specifics regarding how patients are managed. Despite being fortunate to have a National Health Service, we do not have nationalised services and protocols consistently running throughout the UK, and we don't record often essential information in centralised digital agencies.

Surveys are characterised by a structured or systematic sequence of questions which generate a dataset that will enable a research question to be answered.[1] Anyone who has ever produced a survey will be aware that its production has been far from the seemingly simple task expected. It is easy to structure the survey badly, ask the wrong question, phrase the question in a confusing manner or make the survey impossible for the respondent to answer; this results in frustration and an incomplete survey.

Our projects, the SNAPs and NAPs, have both used surveys to uncover important findings directly from anaesthetists.

The SNAPs

SNAP-3 will describe the epidemiology of frailty, multimorbidity and delirium, and their outcomes in older surgical patients. Our organisational survey is currently open, with 129 responses and still counting! It will enable us to describe perioperative medicine services across the UK; we look forward to sharing more results with you soon!

SNAP-2 used a survey to assess availability of postoperative facilities for high-risk patients. The aim of the survey was to describe and compare the critical-care, enhanced-care, and normal-ward-care availability for surgical patients according to hospital types and health systems. SNAP-2 received 164 responses (a 94.8% response rate) from UK NHS trusts, and collected information from 52 hospitals in Australia and New Zealand.[2]

SNAP-2 was therefore able to describe how many hospitals had on-site critical-care facilities (91.8%, n=283) and their average provision (median 2.84 [IQR 2.11-4.39] critical-care beds per 100 hospital beds). The survey also demonstrated the less favourable staffing of surgical wards in the UK compared to Australia and New Zealand.

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These results were not extractable from existing sources. Critical-care bed numbers by trust/hospital are available through the Scottish Intensive Care Society Audit Group and NHS England, but do not appear to be publicly available from Welsh or Northern Irish sources. The survey was essential to the publication of this valuable information.

The National Audit Projects (NAPs)

For more than 10 years, the NAPs have supported improvement in patient care thanks to the support of the anaesthetic community. Individual anaesthetist and departmental/organisational surveys were first introduced in NAP5 and have featured as part of the methodology in each subsequent NAP. These surveys explore individual anaesthetists' experience, attitudes to, and opinions about the topic of study in each NAP, but on a national scale. They are supported by an organisational survey that examines relevant departmental processes and practices. This structure is suitable for subsequent mapping of individual and departmental changes in response to the completed project, though the extent to which this has been done could be improved.

In 2011, the NAP5 baseline survey was sent to every consultant and SAS anaesthetist in the UK, and from it we learned about the availability and use of depth of anaesthesia monitors.[3] NAP6 asked all UK anaesthetists about their perspective and attitudes, including drug avoidance related to perioperative anaphylaxis.[4]

The NAP7 Baseline Survey captures information from anaesthetists and anaesthesia associates relating to perioperative cardiac arrests. Despite the pandemic, we have received nearly 11,000 responses to the individual survey, corresponding to approximately 70% of the UK anaesthetic workforce. The organisational survey will supplement the individual data with information about departmental organisation and preparation for a perioperative cardiac arrest, including resuscitation equipment and provision of wellbeing and debrief facilities.

Conclusion

Unfortunately, there is no centralised system enabling extraction of specific data related to research questions. Organisational surveys therefore remain invaluable in assessing current practices, structures and policies across the UK and in aiding us as we try to improve anaesthesia practice and patient safety. We are once again very grateful to anaesthetists for their continuing support.

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Clinical Leaders in Anaesthesia Network (CLAN)

WHY NOW MIGHT BE A GREAT TIME TO BE A CLINICAL LEADER

The last two years has been a challenging time. As a clinical leader, I have felt responsibility for maintaining the service throughout the pandemic while trying to positively contribute to the wellbeing of our staff. Many have suffered poor mental health, financial distress, grief and other challenges both inside and outside work. So it has been important to carefully balance the needs of our patients with those of our staff.

I have also reflected on what motivated me to pursue a clinical leadership role in the first place: a desire to make a difference beyond the usual boundaries; a belief that the future could be brighter; a sense of responsibility to serve; a natural curiosity by saying yes to opportunities; a desire to grow, to get closer to achieving our potential and discover what a well-led team is capable of; and a deep sense of satisfaction helping patients and peers. All of these remain an enormous privilege.

You are not alone

One of the great discoveries of joining the Clinical Leaders in Anaesthesia Network is meeting leaders from across the UK. I have been struck by the number and depth of capable, highly motivated leaders in anaesthesia, all with their motives to lead. We have all been tested, some of us in ways beyond our imaginings, although it has been a rich learning experience too.

Anaesthetists across the UK have led radical change throughout the pandemic. Examples include:

- anaesthetists in training pausing their training to flexibly deliver care wherever needed, sometimes at the expense of their own careers
- supporting our intensivist colleagues with the creation and staffing of surge-sensitive critical care areas
- huge flexibility around job planning, often providing 24/7 resident consultant cover
- delivering Covid-secure surgery, transforming our theatre teams and environments
- innovating with the use of virtual and digital preoperative assessment
- creating new day-case pathways
- evolving prehabilitation care and surgery school to manage the impact of COVID-19 on health
- creating new postoperative facilities such as virtual wards.

These are huge achievements, enabled (or forced on us!) by the ruthlessness of a rampant pandemic. The learning has been huge too. We have learned that when the climate is right and the purpose is clear we have an incredible capacity for change. And we learn the power of testing new ways of working: when successful, we learn how to provide better care; when unsuccessful, we learn that our theory to improve care wasn't quite right so we evolve our thinking. This mindset of exploring new ways of working is fundamental to improving care.

So what does this mean for us now?

The pandemic and its consequences, such as the NHS backlog and the impact of COVID-19 on population health, will linger. The NHS backlog is predicted to rise to 15 million people (the same number as live with chronic health, or more than half of all working adults). Delays to elective surgery are leading to a rise in non-elective admissions. Bed availability is scarce due to the impact of winter and COVID-19. Staff are struggling with their wellbeing, and absence has seen record highs. Meanwhile, patients have record-breaking waits for surgery and cancer outcomes are deteriorating. The need is stark. The threat is real.

When faced with threat, the choices can be simplified into denial and avoidance, or action. Self-efficacy is a concept originally proposed by the psychologist, Albert Bandura, and is defined as: 'an individual's belief in their capacity to execute behaviours necessary to produce specific performance attainments'.

The challenge for clinical leaders is to build self-efficacy in our teams, to nurture our talents, and to give space to enable creativity and innovation to thrive.

Sounds great. How do we do that?

One reality of leading change is the 'intention–action gap' – the difference between what you want to do and what you actually do. Getting started is often difficult, as you may lack confidence or the capability to make the change a reality.

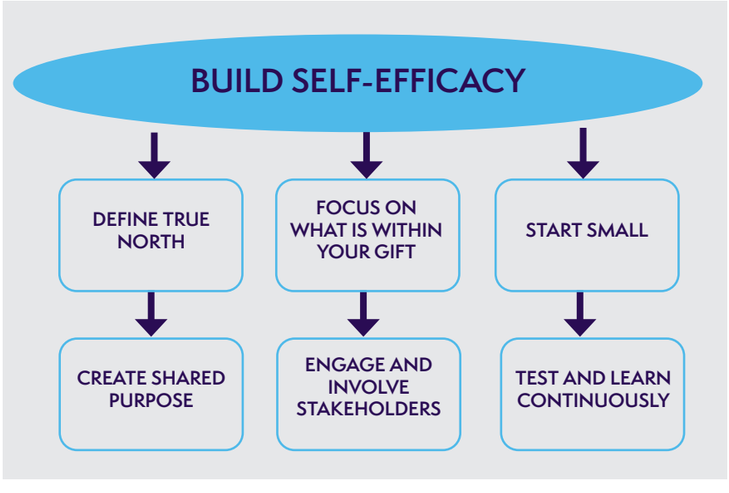
The message-map shown in Figure 1 below summarises how to approach change, focusing on building self-efficacy in our teams.

Firstly, be clear about your 'true north' and ensure that it revolves around your patients and staff. Involve stakeholders early and help to create a shared purpose. Remember, it is the patient-facing interface where most improvements are made, so involve the subject-matter experts – our frontline teams.

A common mistake is to add complexity, which makes improvements feel insurmountably difficult. Simplify the problem and focus on what is within your gift. Where confidence is low, start small – for example, you can test a new way of working on one day and for one patient. That way, any risk may be mitigated while the learning can be large; then increase the scale of testing as your confidence builds. Finally, don't forget to share any learning, being honest not just about successes but about failures as well – you, and those with whom you share them, will learn a lot from them.

Being a clinical leader is a challenge and an opportunity. With the right mindset and by building capability in leadership and quality improvement, the next few years could be a rich period for clinically-led improvements in care.

Figure 1 Message-map



GETTING TO THE HEART OF THE COLLEGE

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As we start to embed the College's new five-year commitment, Council member Dr Ramai Santhirapala reflects on the importance of being a values-based organisation.

Why are the College's values important?

In 1992, an exciting new organisation seeking to innovate and evolve anaesthesia in the UK was granted the accolade of a Royal Charter; it became the Royal College of Anaesthetists. The motto for this organisation, '*Divinum sedare dolorem*', translates to 'it is praiseworthy to alleviate pain'. Thirty years on, as a specialty, we enable high-risk women to give birth safely; we allow patients to have surgery without going to sleep; we facilitate the preparation of patients for surgery, directly affecting their outcomes; and our reach is demonstrably far beyond the UK. However, while the outer face of anaesthesia might have changed, the values that underpin why we do what we do are timeless. To my mind, taking the opportunity to delineate these is time well spent.

I feel that our College values not only underpin all the College's activities but also inform how we act as individuals, as a team and as an organisation. They are the very heart of the College. They are the foundations upon which our specialty is built. They allow clarity on all our decisions: when the road ahead is unclear, we can ask 'does this match our values?' Outwardly, these values enable others immediately to relate to and recognise the purpose of the organisation that is our Royal College.

What aspects of the values are particularly significant?

I think the answer to this question depends on perspective, and many of us clinicians wear multiple hats. As a clinician, 'caring and supportive' has to be front and centre. As outlined in the value, being thoughtful, respectful and responsive means being perceptive to the needs of patients and also colleagues. While knowledge and technical ability are the key underpinnings of our role, what moves the needle from a mediocre to an excellent day at work are those softer skills and human factors. I say this from both the perspective of workforce wellbeing and perioperative outcomes.

This leads me to my role as a member of the College. Through this lens, the values that are most important are 'innovative and progressive'. Anaesthesia itself, however controversial its exact origins, was an innovation that transformed the delivery of surgery, and we should never forget that. Increasingly, innovation in the 21st century is a blend of research and quality improvement methodologies. The College has already achieved many successes through multiple research and quality improvement networks and snapshot projects. We are and continue to be innovators and, as a member, I want to know that the College will always strive to be both ahead of the curve and a learning organisation.

This transitions nicely to my role as a Council member. When I joined Council, I wanted to know I was joining an open-minded and responsive organisation that was also 'just and fair'. I wanted assurance that I was working with people who were open to new ideas and welcoming of differing perspectives. As a Council member, it is a privilege to represent 25,000 members both within and outside the UK. Being a Council member carries the responsibility of challenging assumptions, both our own and those of others, and ensuring that we act without bias. The College can only be the voice for the specialty if it is willing to listen first without judgement. An example of this are the membership surveys carried out during the COVID-19 pandemic that highlighted concerns from anaesthetists in training, SAS doctors and consultants around burnout, exam-anxiety and career progression. Through the most intense time our profession has ever seen, our members still valued the opportunity to talk to us about what concerned them.

In summary, differing values have differing prominence depending on the roles that we play in our working lives. The summation of them forms the foundation of the work we do and the service we provide.

How will the values influence the wellbeing work with the College?

In 2017, even before the pandemic, our College survey reported that 85% of anaesthetists in training were at high risk of burnout. We know from work in other countries that this is a reasonable estimate, and that this situation has been exacerbated internationally by the pandemic. While the experience of the pandemic should not underpin what we hope to be unchanging values, it highlighted with absolute transparency the challenges for our specialty. Being open-minded and responsive have never been so important for the reasons I have already outlined. However, if we look at the wider context of wellbeing, other values become relevant. The role of being caring and supportive in relation to wellbeing needs the least explanation. While this sentiment is obvious – that is people can only achieve their highest potential in an environment that is nurturing, the practicalities of ensuring this is consistently the case for every anaesthetist irrespective of background or geographical location is our challenge. How about just and fair? Inclusivity and wellbeing are interlinked: understanding experiences that are different to your own (cultural competence) and creating an environment of psychological safety lies at the heart of transparent conversations. This brings me nicely to close my article on 'open and responsive'.

Tired teams make mistakes, and this adversely affects patient outcomes. Collaborative networks such as the Safe Anaesthesia Liaison Group, our sustainability strategy, COVID-19 clinical guidance website and the Centre of Perioperative Care have all revealed that we are successful at tackling complex problems with innovative approaches. My aspiration for the College is that workforce wellbeing will be another example of our talent for innovation – we must strive for excellence for both our workforce and our patients.

Read more about our five-year committment at:
rcoa.ac.uk/strategy-vision

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SAS and Specialty Doctors

‘SO LONG, AND THANKS FOR ALL THE FISH

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Many of you will recognise the Douglas Adams quote. It seemed more appropriate than trying my hand at Latin and embarrassing myself. This will be my last article as one of your SAS Council members and I was asked to reflect on my time at the College.

The first thing is to say what a privilege it has been to serve on Council. From wide-eyed innocent to Chair of the Finance and Resources Board was quite a journey. I now have a good understanding of charity finance, much of which will translate across to trust finance and has been very useful for me as a trustee of a small village charity. Throw in an SAS workforce survey and a sustainability strategy, and those are the big pieces of work that I am most proud of.

During my time on Council, I have become friends with such wonderful individuals that I would have been nervous of approaching previously. My illustrious colleagues are all very human and supportive in a way that I would have found hard to believe if I had not experienced it at first hand. I am looking forward to keeping Madam President to her promise of a visit to see my garden in the summer.

I feel we are making progress as SAS grades. Our College is a front runner in recognising the contribution that SAS doctors make to service delivery and how that talent can be nurtured into leadership roles. I know that this is not the universal SAS experience and that there are still some examples of exploitative practice, but the #SASByChoice hashtag is a great example of confident SAS doctors speaking up. Representing our College on the Academy SAS Committee gave me an insight into how far some specialties must come to catch up with us.

I was asked to write an Academy paper on leadership development which you can find on the Academy website.[1] This has been a particular interest of mine – how to encourage SAS doctors to put themselves forward for leadership positions, and how the system should develop them and make them confident that they have the skills for it. There is still work to be done, but seeing people like yourself in senior positions can only be a good thing. I hope I have gone some small way to showing SAS colleagues what is possible. I stood for election to Vice-President in 2020. Although I was unsuccessful, it was about laying down a marker. I did it because valued colleagues asked me to, and I confess to a sneaking desire to be the ‘first’. It won’t be me, but it will be someone in the future.

Instead, I turned to the opening as Clinical Lead in my own department. This is not a job I would have considered if I had not been on Council. Council gave me the confidence to give it a go. (I seem to have a bad habit of picking up demanding jobs when nobody else wants them.) It has been by far the most challenging work I have undertaken, and definitely the most stressful. But when you are tested, there is the opportunity to learn and grow. Staying in your comfort zone is easy, but can lead to complacency and stagnation.

The introduction of the new SAS contracts has been interesting. The College stands back from contractual issues but has a role in quality and standards. The Advisory Appointments Committee process should be used for recruitment to the new Specialist grade. The RCoA and Association of Anaesthetists SAS Committees have been keeping a close eye on what is advertised, and it is quite surprising. There seems to be poor understanding of what the contract is for, with some strange adverts. Hopefully, this will improve, and we will see a genuine career pathway available to SAS doctors for the first time since the closure of the Associate Specialist grade in 2008.

So now my thoughts turn to ‘what next?’ This was a question posed by my appraiser in December. I will have a bit more time (Council duties are pretty demanding) for me to do things I value for myself, such as enjoying my allotment and garden. But busy, committed professionals find it hard to just let go, and I will miss being at the centre of professional activity. With all the knowledge accumulated, I will be working with the College finance director on a long-term financial plan. This is a big piece of work and something I did not have capacity for with all the other College commitments.

There is still the sustainability work to hand over. I have already offered to get more involved in the delivery of the Green Plan in my own trust, and I can be a more reliable participant in our theatre sustainability group.

Will there be other opportunities? Undoubtedly! While I am looking at only five years until the option of partial retirement, you can get a lot done in five years. It will be good to put a bit more focus on my clinical work, especially pain medicine. I am still just a doctor who wants to do the best job for her patients, but that can encompass so much more than direct patient contact.

Reference

1 Leadership development for SAS doctors and dentists, Academy of Medical Royal Colleges. (bit.ly/3phRy1z).

Faculty of Pain Medicine (FPM)

Practical pain management and ongoing work

Dr Paul Wilkinson
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This is my last report from the Professional Standards Committee of the Faculty of Pain Medicine. It has been a great privilege to serve as chair for the last six years. On a personal level, I would like to thank all the committee members over these years for their tireless work. I do believe that, due to their great effort, the FPM has not only strengthened standards of clinical practice but secured itself as a stakeholder in many wider areas of healthcare.

Regarding recent updates, NICE have recently produced guidance on assessment and management of chronic pain in the over-16s[1], which has caused considerable professional anxiety and dominated attention in recent months. In a recent survey by the Faculty of Pain Medicine, the vast majority of members disagreed with the guidance on management of primary pain and fewer than 15 per cent of those surveyed use the diagnosis of chronic primary pain in clinical practice. The opinion of many clinicians is that the current NICE guidelines are almost irrelevant as an aid to everyday patient-centred pain management. Worse still, sole reliance on NICE guidance will lead to a needless increase in suffering of specific groups of patients and failure in our ultimate aims of care to reduce the impact of distress and disability in an individual patient. To best address the needs of patients with chronic pain and lack of practical guidance in the NICE guidance the FPM has produced a document titled *Practical Pain Management in Specialist Care*[2] to assist clinicians. This important first document sets out the FPM's position and gives general principles to follow. In the future, the FPM will provide guidance focusing on practical pathways of care, integrating treatments with credible treatment rationale, and emphasising safety and consent.

The Professional Standards Committee has been active in many other areas and continues to transition from COVID-19-orientated work back to core work. The updated *Core Standards for Pain Management Services* is complete, and this is the crucial backbone of clinical practice. We have recommenced an important piece of work creating a National Cancer Pain Network and further work to implement core standards through redevelopment of a gap-analysis tool (to name but a few) which will continue under my successor.

Reference

1 National Institute for Health and Care Excellence. Chronic pain (primary and secondary) in over-16s: assessment of all chronic pain and management of chronic primary pain. *NICE Guideline NG193*, 2021. (nice.org.uk/guidance/ng193).

2 Practical Pain Management in Specialist Care, *Faculty of Pain Medicine*, 2022. (fpm.ac.uk/media/3466).

Faculty of Intensive Care Medicine (FICM)

WORKFORCE DEVELOPMENT AND SUPPORT

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Medical workforce shortages have been one of the biggest challenges for all NHS organisations, with national training numbers (NTNs) alone unable to meet demand. To fill these gaps, significant increases in non-NTN posts have been tried, but there remains an urgent need for increases in NTNs to sustain current critical care services and, even more, to build a medical workforce to meet future demand.

Locally employed doctors (LEDs)

These locally developed posts are popular among international medical graduates (IMGs) as well as with doctors within the UK looking for support with exams or for getting into training. The posts can also be useful to explore the specialty or subspecialties or to get experience in research, leadership or medical education before making career-defining decisions. They also form an excellent way of supporting junior doctors with career progression and of attracting them to the specialty.

The Medical Training Initiative (MTI)

This is a national scheme allowing limited numbers of doctors from low- and middle-income countries to work in the NHS for two years. Apart from clinical experience, IMGs also develop non-technical skills in the fields of leadership, management and medical education, which will also benefit patients and healthcare systems in their home countries. The Global Fellowship Scheme, which is similar to the MTI, is for doctors from high-income countries.

Specialty and Associate Specialist (SAS) doctors

These are experienced doctors with a minimum of four years of postgraduate experience, of which two years are in the relevant specialty. The ability of some of these doctors to work independently also helps with service provision, but they need to be supported to develop areas of interest, including taking on managerial roles.

IMG support

Significant numbers of these posts are taken by IMGs, who often have an excellent knowledge base and clinical skills but require support in getting used to a new healthcare system and a new country, and to culture, communications skills and other areas of practice new to them such as end-of-life care (ethics), and multidisciplinary team working. To make the transition smoother, this requires a structured induction programme followed by a supernumerary period before working on the on-call rota.

Certificate of Eligibility for Specialist Registration (CESR)

CESR provides an alternative route for specialist registration. Departments with a better understanding of the CESR process and those able to offer specialist placements are quite popular among these doctors, who are an excellent group of experienced clinicians who can be very valuable members of the team. They are able to support services at senior level and also as future consultants.

Conclusion

The key to addressing staff shortages is the flexible ability of organisations to provide appropriate support and learning opportunities, and to offer career progression and care for their health and wellbeing, and to make people feel valued as part of the team.

Further reading

1 *Guidelines for the provision of intensive care services. Faculty of Intensive Care Medicine & Intensive Care Society* 2019.

2 *The state of medical education and practice in the UK*, 2020, *GMC*.

3 Medical Training Initiative – applicant information, *RCoA*.

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A review of CPD event-accreditation during 2021

We traditionally use this edition of the *Bulletin* to provide an update on the operation of the CPD accreditation scheme during the previous 12 months. The College continues to welcome event applications from NHS trusts and hospital boards, registered charities, and specialist societies and associations.

The benefits of accreditation include that the reviews are completed by clinicians who are experienced in the subject area, and that approved events are featured on the College website and on the Lifelong Learning platform.

During 2021 we received a total of 800 applications for CPD event-accreditation, which was an increase by 124 on the previous 12-month period. COVID-19 had impacted upon the number of events being held during 2020, and moving into 2021 around two-thirds of events were arranged 'virtually'. CPD accreditation can still be applied for for these types of events, although they must feature some form of interactive learning – eg, the opportunity for participants to be able to directly ask questions of the faculty either at the end of each of their sessions and/or in a scheduled round-up session or panel discussion at the end.

The majority of applications received during 2021 were accredited for the CPD amount applied for, although in around one-third this was only the case when further information had been supplied by the applicant. Examples included the need to provide the posts/titles of the faculty members, to show the timings for the various sessions being delivered, and to strengthen the learning outcomes to assist with more meaningful reflection.

The College remains extremely grateful to all of the CPD Assessors for their continuing time and expertise in this essential role. If you would be interested in learning more and getting involved, please contact cpd@rcoa.ac.uk or visit rcoa.ac.uk/get-involved/cpd-assessor.

Focusing on the CPD functionality within the Lifelong Learning platform, since its implementation in November 2019, more than 100,000 personal activities have been added and reflected upon while the system now includes details of more than 2,400 accredited events. To save time and duplication of effort, please always search for the event you have attended – this can be done by title or date – before creating a new CPD activity, and remember that our user guidance is available at: bit.ly/CPDUserGuide.

In conclusion, and hopefully as an indication of a return to more normal times, the start of 2022 has been extremely busy with 148 event applications received by the end of February.

PERIOPERATIVE JOURNAL WATCH

Dr Ross Holcombe-Law, CT3, Kent, Surrey and Sussex Deanery
Dr Michael Jones, CT2 ACCS Anaesthetics, Kent, Surrey and Sussex School of Anaesthesia

Perioperative Journal Watch is written by TRIPOM (trainees with an interest in perioperative medicine – tripom.org) and is a brief distillation of recent important papers and articles on perioperative medicine from across the spectrum of medical publications.

Influence of sugammadex versus neostigmine for neuromuscular block reversal on the incidence of postoperative pulmonary complications: a meta-analysis of randomised controlled trials

This meta-analysis of randomised controlled trials (RCTs) compared incidence of postoperative pulmonary complications (PPCs) between patients receiving sugammadex versus neostigmine for reversal of neuromuscular block (NMB).

Searches identified 14 RCTs from eight countries, involving 1,478 adult patients undergoing surgeries with general anaesthesia; 725 received neostigmine and 753 received sugammadex.

Sugammadex was associated with lower risk of overall PPCs compared to neostigmine (OR:0.62, CI:0.43–0.89, *p*=0.01). Analyses of PPC categories showed sugammadex was associated with a much lower risk of postoperative respiratory failure (OR:0.60, 95% CI:0.38–0.97, *p*=0.04). Results may be attributed to the more rapid and complete NMB reversal achieved by sugammadex, inferring superiority over neostigmine for patients at high risk of developing PPCs

Jia-Feng Wang *et al*. *Perioperative Medicine* Sept 2021; 10:32 doi.org/10.1186/s13741-021-00203-6

Airway events in obese vs. non-obese elective surgical patients: a cross-sectional observational study

Obesity is increasingly prevalent in the UK. This cross-sectional observation study was conducted over two days in March 2018 across 39 London hospitals, aiming to determine the proportion of obese patients and incidence of airway events in an elective surgical population. Of 1,874 patients in the study, incidence of obesity was 32% compared with 26% in the general UK population ($p < 0.0001$).

89 minor airway events occurred and were more likely in obese patients (RR:2.39, 95% CI:1.60–3.57) (Defined as: desaturation SpO2< 90%; failed mask ventilation; supraglottic airway device (SAD) problem; aspiration; airway trauma and difficult intubation; or recognised oesophageal intubation). Airway events occurred more with use of SADs in obese vs. non-obese patients (RR:3.46 [1.88–6.40]). The data suggests obesity is more common in the elective surgical vs. general population, with minor airway events being more common in obese vs. non-obese patients.

M Shaw *et al*, *Anaesthesia* Dec 2021; 76:1585–1592 doi.org/10.1111/anae.15513

Effects of preoperative physiotherapy on signs and symptoms of pulmonary collapse and infection after major abdominal surgery: secondary analysis of the LIPP SMAck-POP multicentre randomised controlled trial

The LIPP SMAck-POP trial found that a single preoperative session with a physiotherapist teaching breathing exercises to start immediately postoperatively was associated with a significant reduction in postoperative pulmonary complications (PPCs) (adjusted hazard ratio 0.48) versus a booklet alone. This ad hoc analysis of the trial involving 432 patients responded to questions over validity of PPCs as a useful outcome and reviewed the impact on specific clinical outcomes.

Key findings included reduction in oxygen requirements (RR 0.49; 95% CI 0.31–0.78, p=0.002), positive sputum cultures (RR 0.17; 95% CI 0.04–0.77, p=0.01) and antibiotic prescriptions (RR 0.52; 95% CI 0.31–0.73, p=0.01).

The authors point to previous favourable analysis of cost-effectiveness and suggest uptake of the intervention in preoperative clinics.

Boden I *et al*, *Perioperative Medicine* 2021;**10**:36 doi.org/10.1186/s13741-021-00206-3

The effect of perioperative dexmedetomidine on the incidence of postoperative delirium in cardiac and non-cardiac surgical patients: a randomised, double-blind placebo-controlled trial

Postoperative delirium (POD) is associated with increased mortality, and may be linked to long-term cognitive dysfunction or even dementia. This trial adds to the evidence supporting the use of dexmedetomidine in high-risk patients, with a POD incidence of 18% versus 44% with placebo (p=0.031). 60 patients were randomised to either placebo or an intraoperative dexmedetomidine infusion which was continued postoperatively and titrated to Richmond agitation–sedation scale -1–0.

Compared to previous trials, this trial focused on patients at higher risk of POD (age ≥ 60, major cardiac or open abdominal surgery, planned postoperative intensive care). No significant difference was seen in cognitive dysfunction, mortality, or quality of life at 90 days. The authors highlight the need for larger studies powered to detect impact on these longer-term outcomes.

Norden J *et al*, *Anaesthesia* 2021;**76**:1296–1299 doi.org/10.1111/anae.15469

The College is committed to developing a collaborative programme for the delivery of perioperative care across the UK: cpoc.org.uk

Pauline Elliott
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Dr Sam Black
RCoA Lead for Patient Information

Patient perspective

INFORMATION WITH IMPACT

Pauline Elliott, Chair of the College's Lay Committee, and Dr Sam Black, Consultant Paediatric and Perioperative Anaesthetist and the new College Lead for Patient Information, talk about plans and ambitions for effective engagement with patients and the public.

PE: Hi Sam. Great to talk to you! Congratulations on your appointment. How are you feeling about your new role?

SB: Thanks Pauline!

I'm excited about joining a team that's passionate about producing high-quality patient information (PI). With long surgical waiting lists, or 'preparation lists', we can focus on shared decision-making (SDM) and informed consent, especially in the light of the Montgomery ruling.

My interest in PI, SDM, and communicating risk arose during my training in perioperative medicine. Also, I worked on various projects as a consultant, including leading the SDM script working group for the Centre for Perioperative Care/Academy of Medical Royal Colleges 'Choosing Wisely' UK animation: Peter's Journey.

The College's PI group has been brilliantly led by Hilary Swales, El Fabbrani and team for the last six years. Fantastic leadership has led to development of accredited resources for patients, including *Fitter Better Sooner* (FBS) and videos for children/young people. The College's translated resources reflect our multicultural society, and have been downloaded worldwide. Hopefully, my new ideas will add to this trusted patient information, helping people to understand their perioperative journey and empowering them to ask questions and engage in decision-making about their care.

PE: I know you're a passionate advocate for meaningful engagement with patients, both adults and children. How do you think we can develop links between high-quality PI and SDM?

SB: High-quality and timely PI is of increasing importance as one facet of SDM. Along with valid consent, it helps patients decide what matters to them most. It also helps them prepare questions to ask their clinicians during consultations.

PI needs to be accessible to all groups of people in various formats, in the ways they prefer and find easy to understand. This may be through animations, videos, leaflets (paper, online or via QR codes to read on phones/tablets) infographics, and easy read.

Patients need to be involved in information design. We can also learn from focus groups, feedback, and research trials such as 'Optimising SDM for high-risk major surgery' (OSIRIS), to understand what patients really need to help them make informed decisions about their care.

We're making headway in adult SDM. However, the 2020 children and young people's NHS patient-experience survey revealed that less than half of children/young people said they were involved 'a lot' in decisions about their care/treatment, and 1 in 3 said they didn't always understand what staff said. I hope good quality information, including videos and animations, and feedback from children will help us find out what they need to understand their care.

PE: There seems to be quite a lot of PI around already. Can we do more to ensure we have a joined-up approach to information and SDM?

SB: GMC guidance says that doctors are required to support SDM and consent as fundamentals of good practice, so working towards high-quality, trusted PI should become embedded within the SDM journey. This requires close collaboration with the Centre for Perioperative Care and its partners to drive forward SDM and PI.

We're going to reach out to pre-assessment clinics across the country, highlighting the resources we've produced in collaboration with various colleges and societies. Also, each resource will undergo rigorous user-testing before publication.

The College's risk infographics are a powerful tool which can help start off the SDM conversation in a user-friendly, easy-to-digest way.

PE: What do you see as the next steps for PI at the College?

SB: It's vital we measure the impact of the resources produced on patients, to improve existing information and identify new ways to meet patients' needs by developing/seeking validated tools.

A biennial survey already goes out to pre-assessment clinics across the country to find out how our information is used and can be improved.

We're also working on ways to ensure patients, College members and other healthcare professionals know about the extent of our fantastic resources through social media, a pre-assessment leads network, and future College meetings.

We're also updating the FBS toolkit to support patients on 'preparation lists'. That's so important in the current climate. We'll continue to collaborate with partners to expand and refresh our PI resources to engage and empower patients of all ages.

It's a really exciting time for perioperative medicine and PI, and I'm really pleased to be part of this collaborative journey to create a world-class resource bank for all patients.

PE: Thank you very much Sam. It's clear that you'll bring lots of energy and enthusiasm to your role. The College's Patient Information Group will definitely enjoy working with you to achieve your ambitions for effective patient engagement in SDM.

Where can I find more information?

Choosing Wisely' UK animation: Peter's Journey

Patient information leaflets and video resources
rcoa.ac.uk/patientinfo/leaflets-video-resources

Fitter Better Sooner
rcoa.ac.uk/fitterbettersooner

Optimising Shared decision-makIng for high-RIsk major Surgery (OSIRIS)
pomctn.org.uk/OSIRIS

Risk at a glance
rcoa.ac.uk/risk-glance

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ST5 Anaesthetic Registrar
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SEAUK

Society for Education in Anaesthesia UK (SEAUK)

New developments in the virtual learning environment

The virtual learning environment (VLE) has become a familiar part of the teaching landscape for many students. During the COVID-19 pandemic 65 per cent of anaesthetists in training reported a reduction in adequate training opportunities.[1] This form of online learning provides a way of delivering high-quality theoretical or practical courses while abiding by social distancing guidelines, and throughout the pandemic VLE has offered a lifeline to students and teachers across much of the medical profession.

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A key benefit of VLE is that it allows teachers to widen their audience bases to include out-of-area students and enables these students to attend or replay the course in their own time.

One of the challenges of VLE is adapting the delivery of education to meet the different learning styles of students. Students learn in different ways, whether this is through listening, practising a skill or observing others. A number of options are available to overcome these diverse learning styles of students:

- incorporating alternative media, such as video presentations of simulation scenarios, allows for audience participation, and this is particularly useful in teaching nontechnical skills
- interactive quizzes and questions can be incorporated to evaluate how well students are learning using the online platform and potentially integrating a flipped classroom method. This will enable assessment of knowledge and skills
- interactive flow charts can enable students to understand algorithms more easily
- synchronous education can incorporate direct interaction between students and a range of contributors, from expert speakers to patients.

Virtual reality

Teaching the technical skills in anaesthesia, such as airway management skills, often requires a hands-on approach. Technology Enhanced Learning (TEL) programmes were introduced by Health Education England in 2013, and these incorporate both virtual reality and augmented reality, allowing technology to bridge the perceived gap.[2] Although the integration of technology into training is well established within other sectors such as aviation and engineering, it is often underutilised within healthcare.

Virtual reality allows students to practise practical skills with some form of sensory feedback and provides the ability to manipulate images to understand difficult anatomy. Virtual ward rounds have been found to be engaging and to stimulate learning among medical students.[3] These can be delivered within a 'safe' environment that respects infection control and prevention protocols.

Recently developed tools have allowed adaptations to be made to current anatomical airway models to provide digital 3-D images viewable through virtual-reality goggles or through the camera of a laryngoscope.[4] This feature can be used as an adjunct to products such as the ORSIM bronchoscopy simulator, which has been shown to provide a training opportunity for teaching awake fibreoptic intubations.[5] An added advantage is that the simulator is portable, allowing its use in courses and skills labs with limited space.

Augmented reality

'Augmented-reality' describes the class of systems that use computers to overlay virtual information on the real world. The system will allow students to practise technical skills without touching a real patient and will provide them with the visual feedback they could not otherwise obtain. It will allow a teacher to simultaneously train local and remotely located students. Goggles such as Microsoft 'Hololens' are used to provide 3-D experience of performing technical skills.

A potential advantage of augmented reality over virtual reality is the way it allows the student to practise technical skills while still being able to interact with their immediate environment and others around them. After completing the course, the teacher's role could be extended to include peer mentoring as a way of providing an ongoing learning opportunity and supporting the student in applying their newly acquired knowledge to real-world scenarios.

Social media could be incorporated more, allowing for greater integration of different online resources. This could provide a way for students to keep up to date with latest developments and identify other organisations with which they could collaborate and enhance their learning. Designing a specific app for mobile devices would provide a quick reference and link to various learning resources.

VLE is an important way of delivering medical education to a wide audience base, allowing students to interact with the platform to further develop their knowledge. By using more advanced technology, the effectiveness of this teaching platform could be enhanced to make it a more holistic way of delivering high-quality teaching.

References

1 Pal S *et al*. Mitigating the impact of Covid-19 on training. *Anaesthesia News* 2020 (bit.ly/3sxqaic).

2 Guidelines for commissioning technology: enhanced learning in the NHS. Health Education England. (bit.ly/3MbUPtj).

3 Hofmann H *et al*. Virtual bedside teaching rounds with patients with COVID-19. *Med Educ* 2020;**54**:959–960.

4 Alismail A, Thomas J, Daher NS, *et al*. Augmented reality glasses improve adherence to evidence-based intubation practice. *Adv Med Educ Pract* 2019;10:279-286.

5 Baker PA *et al*. Evaluating the ORSIM Simulator for assessment of anaesthetists' skills in flexible bronchoscopy: aspects of validity and reliability. *Br J Anaesth* 2016;**117**:i87-91.

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MEET YOUR NEW COUNCIL MEMBERS

DR ELISA BERTOJA

Consultant Council Member
University College London Hospitals
NHS Foundation Trust

Elisa has been a consultant in anaesthesia and perioperative medicine at University College London Hospitals since 2008. Graduating in Italy, she also trained in Germany and the UK. Her clinical interest lies in anaesthesia for complex major surgery (cardiovascular, thoracic and upper-GI) alongside her active involvement in medical education. She is a Primary FRCA examiner and an educational supervisor, and was a College Tutor in anaesthesia and a training programme director to foundation doctors. As chair of her anaesthetic department, Elisa is an advocate for fairness and equality, and she is known for standing up and openly voicing the feelings of her colleagues.

On the basis of her international background and her current involvement in training, Elisa is keen to make the route to anaesthetic CCT and the FRCA exam fit for the 21st century. She is aware of the pivotal role of SAS and non-UK-trained doctors in our healthcare system and wants to make sure their treatment is fair and transparent.

Elisa is very sociable; she loves spending time with her friends and family, and travelling (when possible) to see the beautiful world we live in. If she hadn't gone into medicine, her interests would have been in architecture or geology (specifically vulcanology).

DR TONI BRUNNING

Consultant Council Member
Worcestershire Acute Hospitals NHS Trust

Toni qualified from the University of Birmingham and completed all her anaesthetic training in the West Midlands region.

Prior to election to Council, Toni has held several roles at the RCoA. She is a College Tutor and sits on the Lifelong Learning Platform (LLP) Reference Group. She was involved with the LLP since its inception, contributing to its development, launch, and ongoing improvements.

Her clinical interests in anaesthesia include obstetrics, paediatrics and trauma. She has a wider interest in clinician wellbeing and is a certified lifestyle-medicine physician.

She has completed a masters degree in medical education through the University of Dundee. She currently sits on her trust's Senior Education Committee as part of her role as the Champion of Flexible Training.

Outside of work, Toni likes to spend time in nature with her family and dogs. In the past 12 months she has discovered the joys of outdoor wild swimming, something which she has gone on to introduce to her friends and colleagues. She has continued this throughout the year, even when the water temperature drops and it becomes 'ice swimming'.

If Toni wasn't working in anaesthesia she'd have been a particle physicist, having declined a degree place studying nuclear and particle physics to read medicine instead.

DR SATYA FRANCIS

Consultant Council Member
University Hospitals of Leicester

Dr Satya Francis qualified from Madras University in 1991. Following her anaesthetic training at Stanley Medical College in India and at Birmingham and Leicester Schools of Anaesthesia, she was appointed as a consultant at University Hospitals of Leicester in 2004.

She is an obstetric anaesthetist, and she also has a special interest in colorectal and perioperative medicine. She has been a College Tutor, a Foundation Training Programme Director, an Undergraduate Lead, and Simulation Lead for Foundation anaesthetists in training.

She is an Honorary Senior Lecturer, Clinical Academic Tutor and Academic Champion for anaesthesia at Leicester Medical School, and a Final FRCA examiner and lead for clinical SOE. She is committed to fostering an environment of inclusivity, respect and trust, and aims to promote the wellbeing and morale of anaesthetists in training and the anaesthetic workforce at large.

She enjoys reading, yoga and hiking, and is an amateurish cyclist.

Her initial passion was paediatrics, anaesthesia being a close second; she certainly has no regrets and has never looked back.

PROFESSOR MIKE GROCOTT

Consultant Council Member
University Hospital Southampton
NHS Foundation Trust

Beginning his second term on Council, Professor Mike Grocott is the Professor of Anaesthesia and Critical Care Medicine at the University of Southampton, consultant in Critical Care Medicine at University Hospital Southampton NHS Foundation Trust, director-designate of the Southampton NIHR Biomedical Research Centre and an NIHR Senior Investigator. He served as Vice-President of the College (2019–20) and is deputy-chair of the national Centre for Perioperative Care (CPOC).

Mike graduated from St George's in 1992 and was appointed senior lecturer at UCL in 2005. He was the founding director of the NIAA Health Services Research Centre (2011-2016), chaired the National Emergency Laparotomy Audit (2012-2017) and served on the board of the Faculty of Intensive Care Medicine (2014–17). He chairs the board of the National Institute of Academic Anaesthesia and was formerly the NIHR CRN national specialty group lead for Anaesthesia, Perioperative Medicine and Pain. He is an adjunct professor of Anaesthesia at Duke University, North Carolina, USA and an honorary professor at University College London.

He lives in the New Forest with his wife, Denny – anaesthetist, intensivist and perioperative physician – and with three young children and a chocolate working cocker spaniel. If he wasn't working in anaesthesia, Mike would be heading for the mountains (again).

PROFESSOR ANDREW SMITH

Consultant Council Member

Royal Lancaster Infirmary

Andy is a consultant anaesthetist at the University Hospitals of Morecambe Bay NHS Foundation Trust, and Honorary Professor of Anaesthesia and Perioperative Medicine at the University of Lancaster. He is also Director of the Lancaster Patient Safety Research Unit at the trust. He graduated from the University of Newcastle in 1988, trained in general medicine and anaesthesia in Manchester, and took up his consultant post in 1998.

His clinical interests include 'awake' airway management and regional anaesthesia. He received a Foundation Award from the Association of Anaesthetists in 2017 in recognition of his contribution to patient safety and education in anaesthesia.

Outside work, he likes playing and listening to most types of music, cycling, fellwalking and trail running.

If he wasn't working in anaesthesia, he might have ended up doing something involving foreign languages and European travel.

DR SARAH JANE THORNTON

Consultant Council Member

Bolton Hospital Foundation Trust

Sarah qualified from Leeds University in 1991. She created her own ACCS programme as a junior doctor, and then discovered the joy of anaesthetics – and never looked back.

She took up her consultant post with an interest in critical care in the year 2000 at Royal Bolton Hospital – a big district general hospital in a socially deprived area.

She has always enjoyed education, and took on the role of trainee rep on the STC during her anaesthetic training. As soon as she was able, she took on the role of College Tutor in 2003, in between fitting in three kids. After that she was appointed higher Training Programme Director in 2007, then in 2013 Head of School of Manchester for two years, and then Head of School for Manchester and Mersey from 2015. She is passionate about trainee wellbeing and has tried hard to look after her School during the pandemic.

Outside of work, she fosters guide dogs, likes running and skiing, and loves spending time travelling with her sound-engineer husband and kids.

If not an anaesthetist she would like to have been an international geologist or a spy!

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DR SUNIL KUMAR

SAS Council Member

University Hospitals of Morecambe Bay NHS Trust

Dr Sunil Kumar qualified in 1998 from Jawahar Lal Nehru Medical College Belgaum, Karnataka University India. He was trained in anaesthetics in West Yorkshire (Leeds, Bradford, Huddersfield and Halifax). He attained membership of the RCoA and Fellowship of the College of Anaesthetists of Ireland. He was appointed as an SAS anaesthetist in the year 2006, and is currently an Associate Specialist at University Hospitals of Morecambe Bay NHS Trust.

Dr Kumar's main areas of interest are trauma and obstetric anaesthesia, along with remote procedural sedation.

Outside anaesthesia, he is passionate about lifestyle medicine and always keen to empower and educate as many people as possible in fraternity and community to live long and healthy lives by leveraging simple lifestyle changes. He is a certified Lifestyle Medicine Physician consultant and holds a Lead Tutor position for the British Society of Lifestyle Medicine. When he is not working, Sunil is busy spending time with his family, ideally outdoors. He is a keen walker and nature photographer, and a big Bollywood fan.

If he had not become an anaesthetist, he would have been a metabolic medicine physician or an artificial-intelligence engineer.

DR RASHMI REBELLO

Anaesthetist in Training Council member

Milton Keynes University Hospital NHS Trust

Dr Rashmi Rebello qualified from Kasturba Medical College, Manipal, India in 2013 and completed postgraduate anaesthetic training in 2016 in India. Following graduation, she cleared her PLAB exams to work as a trust-grade doctor at Kettering General Hospital. She then attained her registrar training number in 2019 in the Thames Valley Deanery.

As a new member of Council, she endeavours to be an active advocate for the welfare of her fellow colleagues and to promote trainee retention. Having worked in two different healthcare systems and being unconventional in her own training path, she would like all anaesthetists to be well supported on entry into the system and on their varied training/work paths irrespective of their background or life choices. She is very keen to engage with both trainees and trainers to achieve the above. Her areas of clinical interest include obstetrics, regional, pain and patient safety.

Outside of work, she loves travelling, trying out different cuisines, and anything Bollywood!

If she was not working in anaesthesia, her dream would be to get into the field of organic farming.

Interested in joining Council from March 2023?

Vacancies for the next election will advertised from June 2022, with the application process opening in September. Get in touch with elections@rcoa.ac.uk if you have any questions.

Research and audit: e-learning resources

Dr Jason Walker, Editor of the Research and Audit Programme, e-Learning Anaesthesia
jason.walker@wales.nhs.uk

For many, the first steps into research and audit can be difficult; there seems to be an awful lot of material to master, and much of it is daunting. It was with this in mind that the original *Research and Audit Programme* was launched in 2010, as a collaboration between e-Learning Anaesthesia, the Anaesthetic Research Society and the Academy of Medical Royal Colleges. A curriculum was developed by Professor David Rowbotham, and a number of e-learning sessions were written by a selected group of experts. The programme comprises 12 sessions, each taking less than an hour to complete—meaning that it is possible to cover all the material in about a fortnight if you were to work through a session per day.

While the sessions don't promise to make you an expert in the various fields, they form a very good foundation for anybody wanting to become involved in academic medicine. Where relevant, the sessions contain links to further material, and as with all e-learning for health resources, there are frequent knowledge checks to facilitate learning.

The programme has recently been updated and modernised. In some instances, new authors have come on board to give a fresh perspective on the topics covered, and all of the material has been reviewed to make sure that it remains up-to-date.

The full list of topics covered is shown in Table 1.

The programme is paired with the *Perioperative Improvement Science and Management* (PRISM-ed) Module, which provides a useful resource on delivering quality improvement in healthcare.

Full details of how to access both modules can be found at: e-lfh.org.uk/programmes/research-audit-and-quality-improvement

Table 1 The 12 Research and Audit core module e-sessions

Session	Author
Epidemiology: basic principles	Paul Silcocks
Meta-analysis and evidence-based medicine	Jason Walker
Audit: basic principles	Andrew Smith
Searching the journal literature and locating papers	Linda Ward
How to review a paper	Charles Reilly
Formulating and writing a research proposal	Jonathan Thompson
The regulatory environment for conducting research within the NHS – research governance and ethics	Elizabeth Kettle
Designing a randomised controlled trial: basic principles	Matt Wiles
Clinical studies part one: cohort studies and measures of association	Jason Walker
Clinical studies part two: study design	Jason Walker
Systematic reviews	Iain Moppett
Qualitative research: basic principles	Cliff Shelton, Rachel Elvey, Naomi Cochrane

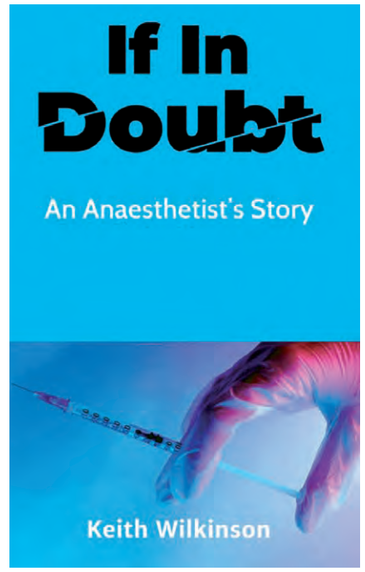
BOOK REVIEW

IF IN DOUBT...

by Dr Keith Wilkinson

Book review by Professor Jaideep J Pandit,
Professor of Anaesthesia, University of Oxford

Anaesthetists should be encouraged to write more about their personal careers and experiences. This would not only create a repository of interesting (historical) cases and how they used to be managed, but also potentially raise the profile of the specialty through the art of an autobiography.



The 'Lives of the Fellows' hosted by the College is an attempt to do this, but is all too brief in its potted biographies.

Now, retired anaesthetist Keith Wilkinson (who has also written the book 'Manx Murders') has provided us with a detailed account of what it was like to be an anaesthetist between the 1980s to near the present day. He describes his life from A-levels to his last day of work. Drawing on real-world experiences, he describes cases which include some that may seem routine but which nevertheless provide insights into the anaesthesia science and practice of the day. Readers will enjoy comparing the approaches used then to solve clinical problems with those available today – constrained as those older approaches were by lack of technology and equipment.

Several aspects of Dr Wilkinson's career are striking. He worked very hard (for most of his career on-call one in every four nights and weekends), and the focus on patient care shines through on every page. He was required to know almost every aspect of anaesthesia (from critical care to obstetrics and even palliative care) – very different from the super-specialisation we see today. And – apart from some experiences abroad – he was based for several decades on the Isle of Man, which is a very unique setting for an anaesthetic career (this contrasts with the much more mobile careers of today's anaesthetists).

That said, there are several aspects that I would have liked to read more about. For a period when the NHS and its structure changed dramatically – from the internal market through to doctors' strikes and new staff contracts – I would have liked to hear more of how these seismic shifts affected working life (if at all). It would have been interesting to understand how anaesthesia research and specific innovations influenced practice over the decades, and if there were any reflections on how such innovations were received at the front line (hesitation in acceptance, or rapid adoption). I personally found the layout of the text a little dense, and it might have helped to break chapters up with subheadings to assist the reader by highlighting the topic or point being made in the sections. An index at the end would have been useful, especially to link to the people and characters mentioned.

But, all in all, this is a good read. It should set the pace I hope for others to follow suit. Anaesthetists in training would learn a lot from reading just one or two of the cases that Dr Wilkinson describes. Notably, all proceeds from the book are directed to the charity NSPCC.

More information about the Lives of the Fellows can be found at:

rcoa.ac.uk/about-college/heritage/lives-fellows

Alan Dronsfield, later professor, (left) with his chemistry set

Professor Alan Dronsfield
History of Anaesthesia Society and
Emeritus Professor, University of Derby
archives@rcoa.ac.uk

AS WE WERE...

A mystery local anaesthetic of yesteryear

In 1953 my parents bought me a Lott's Chemistry set. Having enthusiastically completed all the fairly tame experiments in the accompanying booklet, I was soon seeking further stimulation. I decided to combine random pairs of chemicals from the kit, hoping to induce some spectacular reactions. But, as I found as my chemical career progressed, random combinations seldom react in a way to fascinate eight-year-old schoolboys or, indeed, those in pursuit of a doctorate. Knowledge of the properties of each chemical, and some insight into their potential reactivity, greatly assists Nature in facilitating a benevolent outcome.

But it is not always so. In the late 1870s, the Russian pharmacist, A Drygin, was studying under the supervision of Alexander Borodin, a former doctor and, from 1862, professor of chemistry at the Imperial Medical-Surgical Academy of St. Petersburg. (Borodin is now much better known for his secondary vocation as a musical composer.) Like my juvenile experiments, they chose to react two apparently random chemicals, urea and quinine, unwittingly creating a long-acting local anaesthetic that was in use for a decade or so in the early 20th century. However, this choice of compounds may not have been entirely random. Borodin had previously investigated the chemistry of urea, and Drygin might have had a professional interest in quinine. This alkaloid had been an effective remedy for malaria from the early 1600s. By the second half of the 19th century it was seen as a miracle drug, and advocates promoted its use in hair tonics, spermicides, de-worming pills,

Choosing to react two apparently random chemicals they unwittingly created a long-acting local anaesthetic that was in use for a decade in the early 20th century.

and much more. Though Borodin and Drygin never explained their choice of reagents, maybe they wondered if the *weakly basic* urea might react with *weakly acidic* quinine hydrochloride. And indeed, it did, after a fashion. A crystalline product was obtained which analysed as $[C_{20}H_{24}N_2O_2.HCl + CH_4N_2O.HCl].5H_2O$, essentially a molecule of quinine somehow attached to a molecule of urea. Though chemically merely a mixture of the two, its physical properties were quite different. Quinine hydrochloride is only sparingly soluble in water and so cannot be injected, but the Borodin/Drygin product was remarkably soluble: at 17°C it dissolved 1:1 in water. Mainly it was used as an alternative to the oral administration of quinine, particularly to ward off malaria or alleviate its fevers, but it had some less obvious uses such as to treat whooping cough.

But its local anaesthetic properties were only recognised some decades later, on the other side of the Atlantic. Henry Thibault, a physician in Arkansas, USA, was unable to tolerate oral quinine to treat the then endemic malaria so, in 1905, he self-administered the 'double hydrochlorate of quinine and urea' by injection. Ever cautious, he repeated his initial injection and 'found that when the second injection was given in the area infiltrated by the first, there was no pain caused by the needle or the infiltration of the fluid....this anaesthesia lasted from 24 to 48 hours'. By chance, he had discovered a local anaesthetic alternative to cocaine, the eucaines, and the recently developed procaine. In his 1907 paper he extolled its 'manifold' advantages, including its safety (compared to the notoriously unpredictable reaction to cocaine injections, including collapse or even death), cheapness, ubiquity, and (again unlike cocaine solutions) stability during long boiling to achieve sterility. He argued that the prolonged anaesthesia it caused, reported variously as hours or days, was a significant advantage. Keen to claim the credit for this discovery, he listed a few operations in which he or other local practitioners had used it: amputation of a finger, circumcision, removal of a fatty tumour, topical application to numb the skin prior to curettage of leg ulcers, and more.

Like so many medical discoveries, some years of initial enthusiasm was followed by more critical evaluation. It compared unfavourably with the increasingly popular procaine, particularly in dental surgery. A 1914 report damned use of quinine/urea in dentistry on account of its side-effects, which included local haemorrhage, sloughing, swelling, and even gangrene. And, despite Thibault's enthusiasm, patients found its long duration of action often disagreeable and sometimes frightening.

No one really knew how this local anaesthetic actually worked. It possessed neither the ester nor amide groups that characterised the other 'locals', and some questioned if it really worked at all: 'In concentrations of 1–2%...the drug has no more anaesthetic effect than ordinary saline solution or slightly acidulated water'. Perhaps the time has come to reinvestigate this strange material. If any anaesthetists are brave enough to institute a trial, I'll use my chemical skills, first practised in 1953, to synthesise a sample pure enough for injections!

Edited by Professor Pete Ellis, Emeritus Professor, University of Otago, Wellington, New Zealand.

Condensed and personalised from Dronsfield A and Ellis P. Quinine-urea dihydrochloride: a short-lived, long-acting local anaesthetic. Proc. Hist Anaes. Soc. 2017;50:79-91.

Please see the heritage and archive information on our website:

rcoa.ac.uk/heritage

LETTERS TO THE EDITOR

If you would like to submit a letter to the editor please email **bulletin@rcoa.ac.uk**

Dr Helgi Johannsson

Dear Editor,

Never Too Young...

I recently attended a virtual work experience event for potential medical school applicants. This had talks from several specialists, including heart surgeons and forensic psychiatrists. However, this did not include any anaesthetists.

As I understand, anaesthetists form the largest number of hospital specialists. But there is no information for applicants on how to become one on the RCoA website. On ringing the RCoA events department, I was told that the college doesn't run any events aimed at sixth formers. Nor could I find anything run by any anaesthetic department in the UK.

Similar events run by the Royal College of Surgeons and the Royal College of General Practitioners are hugely oversubscribed.

Most applicants are struggling to access work experience placements because of COVID-19. A virtual event aimed at sixth formers will go a long way in helping us understand the role of anaesthetists in the hospital – most of that understanding comes from books and television series which exaggerate, mislead and do not give us a true picture of the training and expertise needed to become an anaesthetist. Often, anaesthetists are misrepresented with shows like Greys' Anatomy, showing an anaesthetist simply deserting a patient being operated on during a bomb threat! This extends to social media, where Doctor "Glaucomflecken" implies being an anaesthetist is an easy feat.

Courses for applicants are catalysts in widening participation and improving recruitment in the long term – and whilst we may not be able to organise events under concrete buildings, sitting on rows of creaking chairs, virtual webinars and programs provide us with some assurance and certainty in our long journey to becoming medical professionals.

Ayesha Nusrath
Derby High School

Dear Editor,

Whilst reading '#CallMe: A simple change. How have we all missed this for so long?'[1] I found it resonated with me as a patient and as a doctor. I've been known by my middle name since I was born due to parents' preference for a name, and how the name flows.

As a patient I have felt the disconnect when 'Sara James' has been called and suddenly realising 'oh that's me!'.

Addressing patients by their preferred name is vital to enable engagement and build rapport through all stages of life, from small children to the elderly. We are all familiar with the conversation about 'Doris' in bed 4 who likes to be called 'Maureen' that is regretfully sometimes met with a lack of empathy.

As a doctor, I have experienced a hospital refusing to put my middle name on my ID badge as they hadn't been notified of my name preference by medical staffing. My professional email address uses my first name which can be confusing for colleagues even after years of knowing me by my preferred name.

I recently heard an ODP ask a patient how they would like to be addressed when they were in the anaesthetic room. Going forward I'm going to incorporate this into my conversations with patients and colleagues.

Hopefully the #CallMe initiative spreads through the NHS for patients and staff alike.

Dr Lisa James, Anaesthetic Fellow
Wirral University Teaching Hospital

Reference

1 #CallME: A simple change. How have we all missed this for so long? *Bulletin*, January 2022

Bulletin | Issue 132 | April 2022

NEW TO THE COLLEGE

The following appointments/re-appointments were approved (re-appointments marked with an asterisk).

Regional Advisers Anaesthesia

Yorkshire and the Humber South

Dr Martin Feast to succeed Dr Sumayer Sanghera as RAA for South Yorkshire

Deputy Regional Adviser

Severn

Dr Tom Simpson to succeed Dr Ted Rees as DRA for Severn

West of Scotland

Dr Susan Smith to succeed Dr Drew Smith as DRA for West of Scotland

College Tutors

East Midlands

Dr Siti Hajar Muhammad Abdul Basar (Glenfield Hospital) in succession to Dr Anand Gore

KSS

Dr Tara Bolton (Conquest Hospital) in succession to Dr Chris Scanlan

London

Central London

Dr Ciara Donohue (Royal Free Hospital) in succession to Dr Daniel Soltanifar

Northern

Dr James Briscoe (Cumberland Infirmary) in succession to Dr Sally Eason

North West

Mersey

Dr Clare Quarterman (Liverpool Heart and Chest Hospital) in succession to Dr Anurodh Bhawnani

North West
Dr Amy Hobbs (Royal Bolton Hospital) in succession to Dr Kanekal Srirangadarshan

Oxford
Dr Amisha Burumdayal (John Radcliffe Hospital) in succession to Dr Andrew McGill

Yorkshire & the Humber

West
Dr Heidi Hackney (Leeds General Infirmary) in succession to Dr Rachel Johnson

Scotland

West of Scotland
Dr Adam L Capek (Glasgow Royal Infirmary) in succession to Dr Susan Smith

*Dr Nithin Roy (Institute of Neurological Sciences, Glasgow)

Wales
Dr Stanley Jose (University Hospital of Wales) in succession to Dr Haitem Maghur

*Dr Anna Roberts (Morriston Hospital)

*Dr Suman Mitra (Ysbyty Gwynedd, Bangor)

To note recommendations made to the GMC for approval, that CCTs/CESR (CP)s be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in Anaesthesia, or Anaesthesia with Intensive Care Medicine or Pre-Hospital Emergency Medicine where highlighted.

December 2021

Imperial
Shamir Najmin Karmali DUAL ICM

Kent, Surrey & Sussex
Alister John Seaton

North Central London
Julia Elizabeth Benham-Hermetz

North West
Henry Collier
Martyn Robert Habgood

Northern Ireland
Claire Lesley Montgomery
Katie Eleanor Sarah Megaw

Severn
Sarah Louise Jarvis DUAL ICM

South Yorkshire
Laura Jane Pengelly

St George's
Natalie Gena Gravell

Warwickshire
Nafeesa Akhtar

West of Scotland
Michael McCusker

January 2022

Barts & The London
Anuvidya Durairaju Reddy
Hannah Faith Lewis

Birmingham
Andrew Philip Owen DUAL ICM
Stuart William Reilly

East Midlands
Martyn Barry Jones DUAL ICM

East of England
Amit Vilas Gadre

Kent, Surrey & Sussex
Catherine Patricia Lloyd
Kate Blethyn DUAL ICM
Lucia Urgenia Misquita
Nnamdi Ifeanyichukwu Udezue

Mersey
Jonathan Keith Taylor
Andrew Veal
Jamie Stephen Keough
Katharine Lydia Kennedy
Luke Winslow
Melissa Louise Evans
William Harry Angus DUAL ICM

North Central London
James John Hambly
Derek John Brunnen
Douglas Blackwood
Osatohanmwen Dickson Osagie

North of Scotland
Donald Andrew Irvine

North West
Alia Mahmood
Christopher William Tennuci
Matthew Newport
Thomas Heaton DUAL ICM
Yzzam Hammoud

Northern
David Mark Pye DUAL ICM
Donna Kelly DUAL ICM
Fui Woon Yong
Mitchell Liam Rothwell Cole
Richard Bentley

Northern Ireland
Matthew John Devine DUAL ICM
Rachel Sarah Helen Irwin

Severn
Emma Kate Jenkins
Mark Oliver Eveleigh

South East London
Peter James Dannatt
Ayub Khan
Jonathan Geoffrey Perry DUAL ICM
Lucy Florence Dancy

South East Scotland
Kieran Philip Nunn DUAL ICM
King Hay Cheong
Kyle Gibson DUAL ICM

South Yorkshire
John Maher Slattery DUAL ICM

St Georges
Emily Louisa Young

Warwickshire
Rajeev Misra

Wessex
Christopher Couzens DUAL ICM
James Alan Wigley

West of Scotland
Philip Henderson DUAL ICM
Tammar Tareq Jasim Al-Ani

West Yorkshire
Alistair Gordon White DUAL ICM
Dina Sid Ahmed Yassin
Paul Underwood
Sanjay Bhandari
Victoria Louise Boardman

ERRATUM

Due to a clerical error in the College's database, Dr Emily Spence who completed training in North Central London was erroneously listed as having completed training in Kent, Surrey and Sussex in the January 2022 issue. We apologise for this oversight. The online version of this issue will be corrected accordingly.

DEATHS

With sadness, we record the death of those listed below.

To submit a Lives of the Fellows form for publication on our website (rcoa.ac.uk/lives-fellows-biography-listings), please contact archives@rcoa.ac.uk

Dr Christopher Barron Girvan, Downpatrick
Dr Alistair Lack, Salisbury
Dr Donald Harry Short, Somerset
Dr Laurence Frederick Marks
Dr Alun Owen Davies, Stowmarket

APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

The College congratulates the following fellows on their consultant appointments:

Dr Paul Crowest, East Surrey Hospital

Dr Matthew Devine, Ulster Hospital, South Eastern HSC Trust

Dr Jenny Firth-Gieben, Leeds Teaching Hospitals NHS Trust

Dr Andrew McKendry, Bradford Teaching Hospitals NHS Foundation Trust

Dr Matthew Newport, East Lancashire Hospitals NHS Trust

Dr Laura Pengelly, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Dr Andrew Selman, Evelina Children's Hospital, London

Dr Jon Taylor, Walton Centre Foundation Trust, Liverpool

Dr Fui Woon Yong, Freeman Hospital, Newcastle Upon Tyne

RCoA
Royal College of Anaesthetists

Fitter Better Sooner

Endorsed by

Royal College of General Practitioners

Royal College of Surgeons

The College has developed a toolkit that offers patients the information they need to prepare for surgery, including the important steps they can take to improve health and speed up recovery after an operation.

The Fitter Better Sooner toolkit consists of:

- one main leaflet on preparing for surgery
- six specific leaflets on preparing for some of the most common surgical procedures
- an animation which can be shown on tablets, smart phones, laptops and TVs.

You can view the toolkit here:
rcoa.ac.uk/fitterbettersooner

We have also created printable posters, flyers and stickers to help you signpost patients to the toolkit. The animation can be shown on TVs in waiting areas. You can find all these additional resources and instructions on how to download the animation in MP4 format (or request a version in PowerPoint) on our website here:
rcoa.ac.uk/patientinfo/healthcare-professionals

Please share this toolkit with colleagues in both primary and secondary care settings.

It has been shown that people who improve their lifestyle in the run up to surgery are much more likely to keep up these changes after surgery.

MSA Mersey School of Anaesthesia

"If you feed the children with a spoon, they will never learn to use the chopsticks."

★REMOTE LEARNING COURSES★

Final Stagings of the Video Viva Club

for the

Primary SOE Examination May 2022
Final SOE Examination June 2022

Starting 5-6 weeks before the Exam

A peer learning opportunity to improve your readiness for the Primary/Final FRCA SOE via the use of video conferencing software.

Benefits Include;

★A national network of peers★
★A safe and informal space to practice Exam technique★
★Opportunity to record & play back your Viva sessions★
★Support and advice from Faculty who have recently passed themselves★
★Discount fee & priority application for the associated Viva Course★

Please 'Register Interest' via the Website

Final FRCA Written CRQ E-Club

for the

Final Written Examination September 2022

Starting April 2022

A peer learning opportunity to improve your readiness for the Final FRCA Written via the use of our new, bespoke online platform.

Benefits Include;

★ Timed & Disciplined Practice ★
★ Acquisition of useful Answer Guidances from Other Members ★
★ Valuable Motivation towards Sustained Revision ★

Candidates are urged to join before April 2022 to gain Maximum Benefit.

Please Apply' via the Website

★FACE TO FACE COURSES★

Primary & Final Viva Courses

for the May & June 2022 SOE Examinations

The return of the 'Magic Roundabouts'
An Online 2-Day Intensive Course
Peer-to-Peer
Practice, Presentation & Technique

DATES TBC **~50 AVAILABLE PLACES**

The Booker Course

for the September 2022 Final FRCA Written Exam

An Online 5-Day Intensive Course, Including:
12-Question CRQ E-Papers & Review
SBA Sessions & Presentations on Key Points on Various FRCA Sub-Specialties

AUGUST 2022 **90 AVAILABLE PLACES**

We have been working on a timetable for the safe reintroduction of our **In-Person Courses** in 2022.
Visit our website to **Register Your Interest** in order to receive updated information.

Courses	Dates 2022/2023		Capacity
Primary FRCA SBA/MCQ	8th - 12th August 2022*	October 2022	70
Final FRCA SBA/MCQ	15th - 19th August 2022*	February 2023	70

*Please note these are *provisional* dates and have not been finalised at the time of advert.

Keep an eye on our Website or Social Media Channels for confirmations and updates.
www.msoa.org.uk

PLEASE NOTE:

Trainees planning on taking part in MSA Courses must appreciate that the MSA Courses are designed for Exam Preparation only, and include:

- *Exposure to Exam Style Questions*
- *Opportunities to Practise*
- *Learn & Fine-Tune Exam Techniques*

They are not designed to Teach. The advice to Trainees is that they should only attend MSA Courses when they consider themselves adequately Prepared for the Imminent Examinations.

NHS

Project
toothfairy

'Project Tooth Fairy' has been commissioned by NHS England in response to the growing paediatric dental waiting times across London which have been further compounded by the recent COVID-19 pandemic.

Interested in being part of an exciting project to help reduce children's dental waiting times?

If Yes Project Tooth Fairy is perfect for you!

We need your skills and expertise to deliver this project

We're looking for anaesthetists that are interested in bank sessions, individual sessions or sessions in blocks if you would like to work more than one day in a row. Some remuneration for travel will be included in your pay.

The unit is due to open in October 2021. It will have three operating theatres and will provide day case, non-complex dental procedures for 2-16 year-olds, classed ASA I and ASA II.

If you're interested in joining the team, please contact:
Corinne Stannard (Paediatric anaesthetic lead) - corinne.stannard@nhs.net
or Hope Sadio (Senior project manager) - hope.sadio1@nhs.net

Covid-19 has exacerbated poor oral health in children and has resulted in lengthy waiting lists for paediatric dental treatment under general anaesthesia.

To clear this backlog, we're setting up Project Tooth Fairy - a collaboration between North and South Thames Paediatric Networks, the London Paediatric Dental Network and Barts Health NHS Trust – that aims to combat these waiting times by providing additional paediatric dental capacity at The Royal London Dental Hospital.

Cardiac Disease and Anaesthesia Symposium

28 – 29 April 2022 | Online

Speakers include:

Dr Helen Higham
Oxford

Human factors and the cardiac patient

Professor Pierre Foëx
Oxford

Arterial hypertension: Are there still challenges?

Professor Sean Gaine
Dublin

Pathophysiology of pulmonary hypertension

Dr Charlotte Manisty
London

Cancer drugs and heart failure

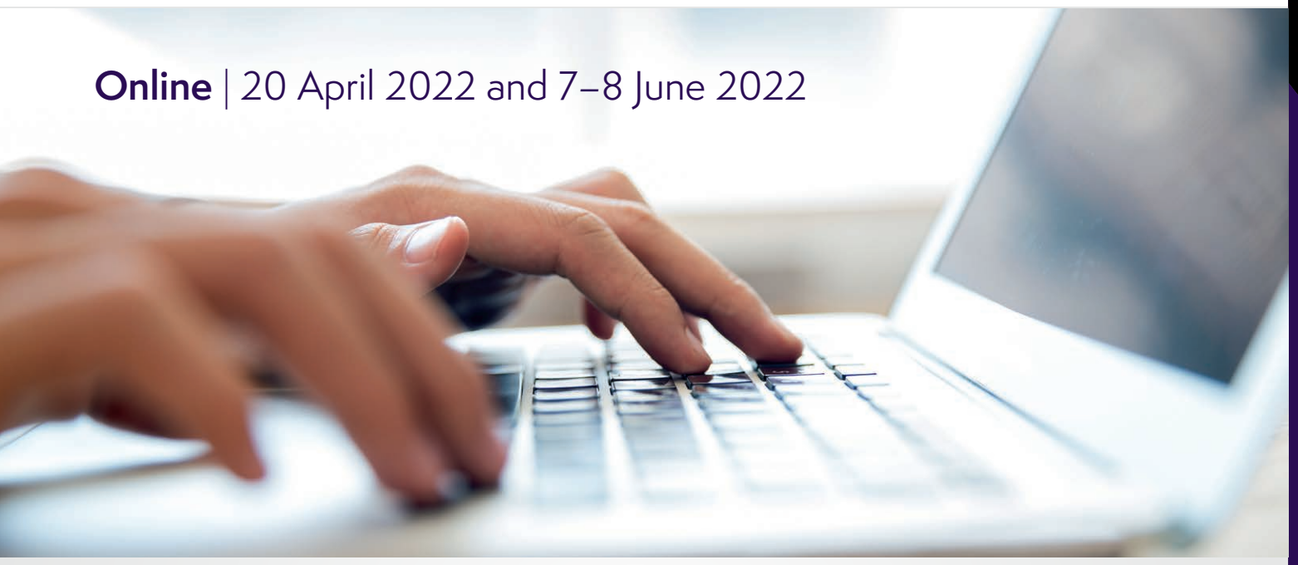
Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

Book your place at rcoa.ac.uk/events

Registration now open

Anaesthetic updates

MEET | LEARN | DISCUSS



Online | 20 April 2022 and 7–8 June 2022

Aimed at anaesthetists and perioperative clinicians of all grades, these events draw together speakers with national and international profiles to give updates on anaesthesia, critical care and pain management.

Call for abstracts for 7–8 June 2022 course

The judges would like to receive abstracts on 'Innovation in Anaesthesia – my recipe for you'

Trainees are key innovators in the hospital; sometimes stumbling upon or thoroughly researching and improving a technique/discussion/problem that has not had a solution thus far. We would like to invite you to share this at the RCoA Anaesthetic updates conference.

The closing date for entries will be midnight on **Sunday 1 May 2022**.

Further information can be found: **rcoa.ac.uk/events/anaesthetic-updates-23**

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

After the Final FRCA:
making the most of ST5-ST7

13 May 2022 | RCoA, London

Hear from recently appointed consultants on how to build your career in anaesthesia.

You will gain valuable insight into various clinical sub-specialties such as:

- obstetrics
- paediatrics
- neuro anaesthesia
- cardiothoracic anaesthesia
- intensive care medicine
- pain medicine.

In addition, the importance of your own wellbeing and getting the work/life balance right will be discussed along with ways in which to build your portfolio and CV.

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

REVISION COURSES

Open from July until the Autumn exams

Primary FRCA Online Revision Course

Final FRCA Online Revision Course

These courses include:

- video lectures
- Powerpoint presentations
- mock exams
- chat room for discussion between trainees
- the opportunity to send in questions to lecturers and receive feedback.

Book now at rcoa.ac.uk/events

ANAESTHESIA ON AIR

Royal College of Anaesthetists

Listen to highlights from our conferences and events as well as specially recorded conversations with subject experts.

If you wish to be featured on one of our podcasts or would like to suggest a topic, please email **podcast@rcoa.ac.uk**

Recent podcasts include:

- Dr Fiona Donald: The RCoA Presidency & Me
- SNAP 3 – Frailty and delirium: what's it all about and how to get involved
- GPAS (Guidelines for the Provision of Anaesthesia Services) – The Good Department
- Reflections on COP26 and sustainability

You can listen to the RCoA podcast in many places: RCoA website, Apple Podcasts, Google Podcasts, Amazon Music, Audioboom and Spotify or the podcasting platform of your choice.

ANAESTHESIA 2022

17–19 May 2022

Hybrid Event
Manchester and Online

KEYNOTES FROM:

DR NICK WATTS
Chief Sustainability Officer NHS England and NHS Improvement

COLONEL LUCY GILES
President Army Officer Selection Board

DR JENNY HARRIES OBE
Deputy Chief Medical Officer for England

GUEST LECTURE

SIR ALEX FERGUSON CBE
Experience with a brain injury

Book your place at: rcoa.ac.uk/anaesthesia