SEA UK

Winter Newsletter 2019

President and Secretary reports

ASM 2020

Packed with great articles about education in anaesthesia

@seatweetuk

21st SEA UK Annual Scientific Meeting

Monday 23rd March 2020

Being held a stone's throw away from William Shakespeare's hometown

Why not spend the weekend visiting the houses of Shakespeare's family and watching a play at RSC theatre?

- A fantastic day with renowned speakers covering a variety of educational topics tailored to trainees, non-training grades and consultants alike.
- Great networking with like-minded individuals with interest in education
- Learning alongside colleagues and competing for our generous prizes.
- Attend the ASM and get free membership of SEA UK for a year.

If Sunday evenings leave you wishing that the weekend could go on and on like Rose and Jack's love in Titanic then we propose you swap the ship for a narrowboat and head to Stratford upon Avon with us in 2020.

(Details on back page)

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From the Editors

Welcome to our Winter edition of the SEA UK newsletter. We hope in the midst of Christmas preparation you will devote time to read the interesting educational articles.

In this edition, you can read a variety of personal reflections on education starting from secondary school student who wish to pursue career in medicine to consultants who recently pursued higher educational qualifications. The article from Dr Janet Barrie gives us an overview of a structured approach for building up educational portfolio whilst Dr Santana-Vaz further explores the post FRCA life of a trainee and challenges of pursuing educational qualifications. If you are a pre-fellowship trainee-then Dr Ramachandran's practical tips may be useful for your exam preparation. Educational methods and how we learn is constantly evolving, the article from Viola informs us how the anatomy teaching in medical schools has taken a new shape. The article on Anatomy revision course for primary FRCA further highlights why anatomy knowledge is an essential element for trainees sitting FRCA exam. In medical profession all clinicians are required to take leadership roles at various levels on a daily basis and Dena in her article describes how this is hidden in the undergraduate curriculum. The traditional competency based education is subject to criticism and Dr Jonathan Dilley in his article explains the role entrusted professional activity for workplace based assessment. An appropriate support mechanism is crucial for trainees returning to work after a break in their training and enhances patient safety. Dr Attwood and Dr Bower enlighten us on the HEE SuppoRTT programme. Finally, Dr Sue Walwyn in her article informs us the value of respecting each other and how we can ensure both trainees and trainers can feel valued in their workplace.

Wish you all a Merry Christmas and enjoy the festive season.

Professor Cyprian Mendonca
University Hospital, Coventry

Conor Dalby, CT2 University Hospital Wales

From the President

Welcome to the SEA UK winter newsletter. As a small society we contribute to the national educational stage in many ways and it is always striking to see how members, both council and not, find time to develop their own educational portfolio as well as show dedication and commitment to the national educational arena, in spite of the day job, organising local courses and home life. This newsletter demonstrates how our trainees are similarly committed to education and educational development.

The articles are inspiring and show an approach and dedication which goes beyond simply fulfilling curricular competencies. However, an insight into how to overcome curricular requirements or even hurdles is useful for both trainers and trainees; as is the case with the article on learning for the exam and beyond the FRCA.

In the past we have looked at trainee wellbeing and coping mechanisms. Currently there is an acceptance that not only we are trying to support doctors who are experiencing difficulties, but also trying to pre-empt these difficulties. One area is how, in the time of “Enhancing junior doctors working lives”, we value trainees and correspondingly, trainers. Have a thought in your department and in addition to the trainee forums or coffee and a gas, how you can introduce initiatives and let us know.

Curricular changes are well under way and this will be a time of change for all. SEA UK would like to know you have managed the changes and supported your trainees in this transitional period. As a society we are also involved in the Anaesthetists as Educators programme and run an annual Advanced ES course, co-badged with the RCoA. Our next course is in January 2020, to be held at the Royal Armouries in Leeds (still time to book your study leave).

As it is our 21st year we have a few extra plans for our ASM. Please look at the excellent programme and book your study leave, as well as encouraging trainees to contribute abstracts and essays. In addition, we have past presidents attending the ASM and an essay prize for medical students. It will be a great day, in a historic geographic location, but the success depends on your support.

Dr Sue Walwyn

President of SEAUK

Training Programme Director

Yorkshire School of Anaesthesia

From the Secretary

Greetings for the festive season.

SEAUK has an exciting year ahead for its members. We had two new council members elected over the summer. Dr Claire Halligan from South Wales and Dr Atideb Mitra from North East England. SEAUK Council members are geographically widespread to represent all of UK.

Those of you who are interested in joining the Council, please keep lookout for election notification early next year. We should be requesting nomination for one consultant and one trainee post on the council.

Over the next year, we are planning to revamp our website with exclusive members-only area. Once the new addition to the website is launched, new members will be able to join online, manage their membership and make use of educational resources.

Our next Annual Scientific meeting is a 21st Anniversary meeting, being held at Warwick on the 23rd March 2020. Warwick and Stratford-upon-Avon are perfect for spending time over the weekend followed by earning 5 RCoA CPD credits from the conference. The programme has a wealth of educational topics for trainees, non-training grade anaesthetists and consultants. For the first time, there is going to be a debate in the ASM, on need for higher qualification for educational supervisors. In addition, ASM is a great networking opportunity for all those who are interested in teaching and assessment.

Please register today and do not miss the early-bird registration fee at https://bookcpd.com/course/sea-uk-annual-scientific-meeting-2020. There are special category rates for PAA and medical students.

Please encourage your colleagues to join SEAUK (www.seauk.org).

Peeyush Kumar
Secretary – SEAUK
Consultant Anaesthetist
University Hospital Coventry
secretary@seauk.org

SEAUK 2020 call for abstracts

Closing date: **21st January 2020 by 5pm**

Submission email: secretary@seauk.org and adminstrator@seauk.org

Those that are selected for oral presentation (top six) and poster display will be informed by end of January 2020. This will give them opportunity to register at early-bird fee. The posters are not judged.

For further details visit: https://www.seauk.org/asm-abstract-guidance/

SEAUK 2020 Essay competition

For Medical Students

Applications are invited from medical students studying in the UK and are the sole author of the essay. The top judged essay will be published in SEAUK's Summer newsletter and student will be awarded with a certificate and a prize at ASM on 23rd March 2020 at Warwick.

Closing date: 12th February 2020, 5:00 PM

Word limit: 750 words

Topic: *The student's need to learn overrides the patient's right to refuse to see students. Discuss.*

Submission by email, in word format, to secretary@seauk.org

For Anaesthetic trainees

Applications are invited from CT1 – ST7 Anaesthetists and are the sole author of the essay. The top judged essay will be published in SEAUK's Summer newsletter and awarded with a certificate and a prize at ASM on 23rd March 2020 at Warwick.

Closing date: 12th February 2020, 5:00 pm

Word limit: 750 words

Topic: *Does the ARCP process help or hinder professional development?*

Submission by email, in word format, to secretary@seauk.org

Development and recognition as an educator: navigating the maze

As you develop as an educator a bewildering number of options become available and it is easy to get lost in the maze. This article aims to bring a bit of structure and direction to this process.

Routes aimed at achieving instructor status for a specific course

These are typified by the Resuscitation Council/Advanced Life Support Group Generic Instructor Course (RCUK/ALSG GIC) or the Advanced Trauma Life Support Instructor course (ATLSI). Potential instructors are identified at provider courses and have to complete the relevant instructor course before instructing. The GIC is recognised by RCUK and ALSG for any of their courses but not by the Royal College of Surgeons (RCS) for ATLS. The ATLSI however is recognised as equivalent to the GIC so if you want to instruct in both courses it makes sense to complete the ATLSI.

Completion of the GIC (but not ATLSI) confers eligibility for membership of the Academy of Medical Educators, of which more later.

Some other courses identify potential faculty from a range of sources but accredit via an apprenticeship model rather than via an instructor course. This confers eligibility for that course but not a recognised 'badge'. It does however contribute to a portfolio of experience. Still other courses are recruited to by means of 'are you free to teach on such-and-such a date?' Is it worth doing? Only if you want to teach the relevant course. Many of us began our educational careers via this route.

Anaesthetists as Educators (AaE)

This is a suite of programmes administered by the College. Most people begin with the Introduction course which covers the principles of adult education with practical applications which are developed further in the other courses. Completion of the Introductory day and the two day Teaching and Training in the Workplace, together with completion of reflections, conveys eligibility for AoME membership. Together the full suite cover the main aspects of education in anaesthesia, but people can pick and mix.

Is it worth doing? Yes as an introduction to anaesthetic education, as a taster for further study at PG level or as part of a programme of CPD in education to maintain clinical supervisor (CS) /educational supervisor (ES) recognition.
https://www.rcoa.ac.uk/anaesthetists-educators-aae

A formal postgraduate qualification in medical education

There are a large number of universities offering a plethora of PGCert/PGDip/MA/MSc courses with a wide range of different emphases. In general they offer a range of 10 or 20 credit modules with 60 credits being required for a PGCert, 120 for a PGDip and a dissertation (+/- further modules, in which case the dissertation may be shorter) for a Masters.

The choice of course depends on a number of factors:

- The range of modules offered. Some courses have a focus, e.g. on workplace-based education or sim.
- Access: If there are compulsory face-to-face sessions can you easily get to them? If the course is entirely by e-learning then does this suit your style of learning?
- Assessment, both type and timing. Simultaneous preparation for assignments and consultant interviews may be very time consuming.
- Funding. Some Health Education England (HEE) regions have funding linked to a specific programme. If you want to do a different course you may have to self-fund.
- How much do you actually teach?

Is it worth it? Yes for a chance to look in detail at an area of interest and get a thorough grounding in and critical understanding of the principles. There is a move towards requiring College Tutors and onwards to have at least a PGCert. This will take time to develop, if indeed it ever does.

Academy of Medical Educators (AoME)
The AoME was established as a platform for driving up standards in medical education and for accrediting individuals against these standards. The AoME's standards formed the basis for the GMC's generic standards for trainers for CS and ES recognition and revalidation so are familiar to all with CS and ES status.

There are four levels of recognition:

- student membership for students
- associate membership for those interested in medical education but with no direct professional involvement or whose involvement is at the early stages.
- membership.
- fellowship.

Most people enter at membership which can be either by submission of a portfolio of evidence or by completion of a recognised course. Most PGCerts automatically confer eligibility for AoME membership. Two other routes for membership are completion of the GIC, and of two of the AaE courses as discussed above which provide a straightforward pathway for those who are not yet ready to commit to a PGCert. There are also a number of private providers who deliver courses which are recognised for membership. Fellowship is by submission of a portfolio of evidence and guidance is available on the AoME website.

Is it worth it? Increasingly yes for those who want to develop a career as a medical educator at Trust/HEE regional level. It is increasingly recognised by or required by panels for educators in these roles.
https://www.medicaleducators.org/Membership-Grades
https://www.medicaleducators.org/Our-Accredited-Courses

Advance HE, previously known as the Higher Education Academy

This is the pathway for recognition as an educator in higher education/university sector and is not specific to medical education. There are four categories of fellowship ranging from Associate Fellow for those commencing their careers to Principal Fellow for those involved in higher education at a strategic or national level. Most enter as Fellow, unless you have involvement in educational leadership. The website has a self-assessment tool to gauge the appropriate level to target your application.

Is it worth it? Yes, if you are planning a career with a heavy engagement with university education (particularly if directly employed by a university) for whom it is pretty much compulsory and may be an appraisal objective. Otherwise, probably not.
https://www.advance-he.ac.uk/fellowship#categories

Faculty of Surgical Trainers (FST)
Organised by the Royal College of Surgeons of Edinburgh, the FST was established to:

- 'promote and enhance the role of the surgical trainer
- support and develop surgeons in their role as surgical trainers
- increase the profile and recognition of surgical education and training
- disseminate the message that excellent surgical training means excellent and safe patient care.'

There are three levels, of which only Associate Membership is open to non-surgeons. Most enter as Members with Fellowship also available.

Is it worth it? Probably not for anaesthetists but an interesting development. We don't have an equivalent - do we need one?
https://fst.rcsed.ac.uk for the keen!

Declaration of Interest
ATLS and MOET instructor, involved in the AaE Advanced ES day, hold an MA and Fellowship of AoME, haven't bothered with Advance HE. Views are my own.

Dr Janet Barrie, Consultant Anaesthetist, Royal Oldham Hospital

Higher training in medical education: opportunities and challenges

There is a growing expectation for doctors to have formal training in how to teach. The General Medical Council views teaching and mentoring as components in Good Medical Practice[1] and as an outcome for newly-graduated doctors[2], and specialty colleges include similar outcomes in postgraduate training[3]. Professional development opportunities within medical education have grown considerably, including short-courses, e-learning modules, and higher training. There are reportedly 31 institutions in the UK offering higher programmes in medical education, demonstrating the demand for this training[4].

Inspired by a Postgraduate Certificate in Medical Education course I undertook at Brighton and Sussex Medical School (BSMS), I subsequently completed a Masters in Clinical Education at King's College London. In both I completed a range of modules crossing education research and theory, and learnt new teaching methods. In 2018, I started a doctoral degree in medical education at BSMS, and moved to less-than-full-time training for both anaesthetics and this degree to enable this.

Both opportunities have taught me a lot about medical education and research, as well as how both undergraduate and postgraduate medical training operates. At King's, I was mostly taught by teachers, educationalists and academics whose specialisation was medical education, so also learnt about education practices outside of healthcare and how this could benefit medical education, whilst at BSMS I have mostly worked with clinicians who, like me, embarked on careers in medical education alongside clinical practice, and subsequently I learnt more about developing medical education in a healthcare institution and career pathways.

Formal post-graduate training in medical education connects theory, research and practice, and furthers engagement in lifelong learning, academic skills like appraisal and academic writing, interdisciplinary learning, and motivation for developing institutional educational practices[5]. Opportunities are increasingly accessible with full-time, less-than-full-time and distance learning options.

A Post-Graduate Certificate in Medical Education commonly has compulsory modules exploring learning theory and the practice of teaching, and the Post-Graduate Diploma extends learning to explore education research. Both have optional modules varying with institution; commonly including curriculum design and development, interprofessional learning, assessment, simulation-based training and technology-enhanced learning. A Master's degree requires a research project and dissertation, enabling exploration of areas of interest in-depth and education-research under the guidance of experienced researchers. Completion of higher programmes often enables individuals to become Fellows of the Higher Education Academy and Members of the Academy of Medical Educators.

Doctoral degrees which include an MD (Doctor of Medicine) and PhD (Doctor of Philosophy) enable further study, focused on research, and support individuals in developing their career towards a clinical-academic, or academic direction in medical education. Both degrees have similar assessment requirements, the key difference is time; MDs are two-years full-time equivalent or longer, and PhDs at least three years[6].

There are challenges to undertaking higher study in these programmes, such as completing requirements outside of employment, shift-patterns and training, particularly when modules or data collection for a research project may require availability at certain times, and expense associated with tuition fees. There

is also little known about formal career pathways in medical education and the recognition of this type of post-graduate training due to these careers being relatively recent, however increasing professionalisation of medical education is occurring helping to address this[4].

My training in medical education has driven my further interest in this developing field through the inspiring individuals I have met, and I believe there are significant benefits to this type of training. However, it is vital to consider the best route to achieve personal aims, for example programmes heavily focused on research may not be optimal if entering further training to improve teaching technique. These concepts of learning how to teach and learning about education are important for considering the most appropriate opportunity. The growing interest of policy-makers and institutional leaders towards the potential of medical education as a professional specialty in its own right, makes it an exciting time to undertake higher training in such a rewarding field.

[1]General Medical Council, Good Medical Practice (2014)

[2]General Medical Council, Outcomes for Graduates (2018)

[3]Royal College of Anaesthetists, CCT in Anaesthetics, Annex D, Higher Level Training (2010)

[4]Sethi A, Ajjawi R, McAleer S et al. Exploring the tensions of being and becoming a medical educator. BMC Medical Education (2017) 17:62

[5]Madi M, Hamzeh H, Griffiths M et al. Exploring taught masters education for healthcare practitioners: a systematic review of literature. BMC Medical Education (2019) 19:340

[6]MD vs PhD- which should you study? Available at: https://www.postgraduatesearch.com/advice/medical-dentistry/md-phd-which-should-you-study/ap-23402/

Dr Sonia Akrimi

ST6 Anaesthetics, Brighton and Sussex University Hospitals NHS Trust

Research Fellow, Brighton and Sussex Medical School

PhD by published work: A route for post graduate qualification

The GMC quotes “Every licensed doctor who practices medicine must revalidate. Revalidation supports you to develop your practice, drives improvements in clinical governance and gives your patients confidence that you're up to date.”

Nearly three years ago, during my educational appraisal, as an undergraduate academic lead, I was encouraged to pursue a higher qualification. On reflection, I had considered a post graduate qualification almost 15 years ago during the early part of my consultant career, however due to busy academic and clinical commitments, I never managed to progress beyond a postgraduate award. With some hesitation, I agreed with my appraiser that I would pursue a further higher qualification.

I was attracted by the Warwick University advertisement on PhD by published work. I have been actively involved in airway research and published a series of papers, I thought of attempting a PhD via this route. I registered with the Warwick postgraduate online application system and completed the application process which took me nearly three months. (https://warwick.ac.uk/study/postgraduate/research/phdbypublishedwork)

Fortunately the application system allows multiple visits and saves entered data. Following my first submission, I received an unfavourable decision from the research degree officer indicating that they hadn’t found an appropriate supervisor for my project “advancing technology in airway management.” Subsequently, I personally met with an experienced PhD supervisor and requested them to supervise me. He looked at my series of publications and selected seven papers, which were likely to demonstrate a cohesive body of work. My publications were centred around plan A and Plan D of the DAS 2015 guidelines for managing difficult intubation.

The application process started again, luckily most of the information was saved on the system therefore it wasn’t a tedious task. Along with the application, I needed to upload two additional documents. 1. Contextual information of published work which described the significance of each paper, number of citations, the profile of the journal within which the paper had been published, and a brief description of contribution to various stages of original work. The submission process also required uploading copies of all certificates related previous qualifications, a copy of my Curriculum Vitae and a proposal detailing the PhD topic. I was also requested to produce the transcripts of my primary qualification. Finally, my application was reviewed by the University and I received an unconditional offer. I was surprised to see my fee structure was automatically branded as overseas (I graduated overseas!). I completed a University fee assessment questionnaire and with some luck, being Warwick University staff, the fee was settled for University staff fee. Once the fee was paid, I was enrolled as a PhD student. Well-structured guidance from my supervisor helped me complete the application process smoothly. On reflection, at this point I had already completed nearly one third of my PhD work.

PhD Thesis involves a covering document between 5,000 to 10,000 words setting out the relationship between the Works presented and the significance of the Works as contribution to original knowledge. In addition, a full bibliography of all papers published, copies of all papers submitted and a declaration from all co-authors should be included in the document.

The University expects the student to meet their supervisor at least once a month and a brief summary should be recorded on an online platform (https://tabula.warwick.ac.uk). These meetings were very helpful and ensured that the drafts were revised and the Thesis writing progressed smoothly. The seven papers selected for my thesis were nicely grouped into four categories: Managing unanticipated difficult intubation, avoiding difficulty with facemask ventilation, advances in awake intubation and emergency airway rescue. The discussion part of the Thesis included how the work has led to further research and publications, strengths and weaknesses and the future direction of research in the field.

Monthly meetings with my supervisor provided me with appropriate guidance. A critical appraisal of papers enabled me to understand the limitations of my methodology and how further research publication has occurred on the same topic. The most important aspect of writing the Thesis is to strictly follow the University guidance for structure and format of the Thesis.

Following successful submission of the Thesis, a viva date was arranged. In my case the viva was conducted by two external examiners. A typical viva may last for nearly 2 hours. I was asked to provide a summary of my work, followed by a series of questions and discussion on individual papers. The discussion included my contribution to individual papers, limitations of my studies, the impact of my results and future direction for research based on my work. I passed the viva with minor corrections. Over the next two weeks, I revised the Thesis and re-submitted it, which was approved by the external examiners. Then, I submitted the hard-bound copy of my Thesis to the University.

Practical tips for PhD by published work

So, if you have wealth of well cited publications on a similar theme and would like to pursue a higher qualification, a PhD by published work may be for you.

- Choose 3 to 7 publications on a similar theme, more publications and higher number of citations would be favourable, as this helps in writing the significance of your work. Your publications should be based on original knowledge or research.
- Choose a University which will offer a PhD by published work and understand the criteria and fee structure. Some Universities may only approve their staff for PhD by published work.
- Approach your supervisor early for advice and jointly select the papers.
- Choose an appropriate title for your Thesis which matches the theme of your chosen papers.
- Approach your co-authors, you are likely to require declaration from the co-authors on your contribution to work conducted.
- Draft the contextual information regarding the publications and revise it. You may have to perform a thorough search for citations of your work, impact of your work and profile of journals in which your work has been published.
- Ensure that you have original copies of all certificates related previous qualifications.
- Read the University guidance thoroughly before drafting your Thesis.
- Read your papers several times to understand what is missing and how you could have improved your own work.
- Start drafting the Thesis early, as it needs several revisions before final submission.
- A thorough search for citations of your work through google scholar and reading the article where your work has ben cited will help you understand how your work has further contributed to the original knowledge.
- Finally go through the Thesis submission checklist before submission, ensure the word count is correct and no typographical errors exist.
- Following submission, use any available time to prepare for the viva. Importantly understanding the limitations of your work, how your methodology could have improved and the impact of your work.
- Following the viva, revise the Thesis, following approval from external examiners, submit the hard bound copy of the Thesis to the University.
- Following receipt of the hard bound copy of the Thesis the University Steering Committee will approve the award.

If this challenge is for you, I wish you all the best!

Cyprian Mendonca

An honest view of life beyond FRCA

For most trainees beginning their anaesthetic journey, looming in a galaxy far away is the FRCA also known as Mount Everest. Reaching the summit takes many expensive, all consuming years by the end of which you find yourself crawling to the peak hopefully without having endured too many cuts and bruises along the way.

Don't get me wrong; some Ellen MacArthur's circumnavigate the exams with all the grace afforded to the sugar plum fairy. I, meanwhile, found myself amongst a sea of oysters elatedly clutching onto our rather more 'well earned' pearls.

So, what to do after surviving the Square of Red Lions? Well after indulging in a glass or two of the most expensive plonk ever, I left Churchill House pondering this very question. Two years and half a maternity leave later, I feel just about ready to share my thoughts.

The truth is after getting those all-important four letters; once it sunk in that it actually happened; I felt how I imagine Road runner did when Wile E. Coyote finally caught up to him: utterly exhausted. I would like to say I have been in hibernation since, but even a Siberian salamander is only in deep freeze for up to six months at a time.

My recent extracurricular inactivity could be attributed to fatigue from appropriately increased workplace responsibility; to new subspecialty exposure and associated learning; or to the excitement of getting married, moving house and having our first baby. But honestly, I have been enjoying life again. Being able to say yes to casual meet-ups with friends, to vitamin D soaked family barbecues; to dinners cooked from scratch involving all of my 5-a-day and without a dessert of audit project in sight.

Newsflash, I don't feel guilty. In light of the recent morale and workplace fatigue studies, my personal prioritisation over the last couple of years has undoubtedly helped keep my mental health intact. For many of us, trying to balance personal life events with career goals can feel like walking a tightrope. You could say I embarked upon this balancing act early, completing a postgraduate diploma in medical education over two years during core anaesthetic training.

In truth, achieving this required many late nights after busy on-calls reading about educational theory, discussing learner assessment techniques in online forums, maintaining a practical teaching portfolio and completing eight modules each assessed by a three-thousand-word essay. Whilst I have probably made this sound as appealing as a Marathon des Sables without training, my passion and thorough enjoyment for education carried me through the challenging literature reviews and long essays.

My biggest suggestion for those considering throwing their teaching hat into the ring would be to choose their depth and type of study wisely. There are at least sixteen Academy of Medical Educators accredited universities offering formal medical education qualifications, the alternative to which would be a shorter taster such as our very own 'Anaesthetists as Educators' RCOA course.

If you have selected the former and the institution options make you feel like a rabbit staring into oncoming headlights, I would suggest first deciding on a face-to-face or distance-learning course. The latter I argue is the only viable option for full-time trainees unless your deanery has taken a shine to trainee SPA activities or you are studying alongside a teaching fellowship/ OOPE. Second, consider fees which can range from being partially

or fully sponsored if associated with certain teaching fellowships to around the £3500-£4000 mark for a postgraduate certificate.

Thirdly narrow your choices by modular content and assessment style: ‘which approach would you like to take to crack the egg?’ if you will. Finally, choose when. I would say the vast majority of my peers complete a medical education qualification in latter training; one of my supervisors grouped it with ‘consultant application CV fodder options’. Advantages I found from completing my qualification earlier were that it gave me confidence planning and delivering teaching sessions, insight into my own learning styles (helpful for reflective learning and exam revision strategies), and also an extra flick to my wand during specialty training selection.

What’s next for me? After finishing my maternity leave, I know it will be time for me to finish growing up and leave behind the world of lunchtime naps, children’s storybooks and mummy meet-ups. After diving back in at the deep end and reminding myself how to swim I hope to try my hand at studying medical law and ethics, a subject I feel is underrepresented in our curriculum and have little insight on. But in all seriousness, if you do choose to pursue a postgraduate qualification, pick an area you enjoy and are passionate about. In the words of Peter Pan’s creator: “nothing is really work unless you would rather be doing something else”.

Dr Natasha Santana-Vaz

Specialty Trainee

Warwickshire School of Anaesthesia

FRCA exam – another challenge in my life?

There are several challenges in life and passing the FRCA exam is one of them. With pass rate averaging 60 -65%, I felt this, one of my greatest challenge. Every trainee has their own learning method and techniques of preparing for the exams. In the midst of busy clinical work, travelling to work and varying level of responsibility of family and social life, there is no easy solution. It is important to plan the exam preparation well in advance. Here I would like to give you some valuable tips from my own experience of passing final FRCA.

Written Exam

- Start early, work hard so that you have minimum of 3-4 months solid revision for each section of the exam. Reading the intermediate level curriculum can reduce unexpected questions**.** The exam is set from this. Make sure you have read it early so you know the breadth of knowledge required.
- The exam pattern has changed. It has become more objective but extremely specific. Please read the CRQ instruction and reading the exam reports under resource for exam candidates is helpful to understand how and why some questions were poorly answered.
- Past question papers are available on RCoA website. I used nifrca http://www.nischoolofanaesthesia-finalfrca.org.uk where all previous SAQs are collected and grouped by specialty. I did not rely on their answers, instead I referred BJA education article on the same topic and made my notes. I personally took a print out of the previous questions (last 10 years) from RCOA https://www.rcoa.ac.uk/tags/exam-papers and kept glancing through them as a means of revision.
- Reading through recent BJA education articles and opinion from consultants in various specialties, helped me to create my own hot topic list.
- Mind-maps a useful tool of revision. Mind-map is a type of diagram representing all of the information you need to learn. Mind-maps enable one to organise information better visually, through the use of branches and sub-branches. Luckily, I found http://www.frcamindmaps.org/contents.html which includes almost the whole curriculum divided by subspecialty.
- For CRQ, unlike preparation for an SAQ where you might be listing 10 things in the answer, now should focus on the prioritising the top 4 most commonly occurring/important factors from those 10.
- Most importantly ensure that the handwriting is legible
- I think e-learning is the best way to move forward for SBAs and MCQs. Like primary, solve all questions till you reach almost 100% in each set. Please look through RCOA example questions and even viva questions. I personally found the more I revise SAQs /CRQs, the more knowledge is built up to answer MCQs.
- Some of the national exam preparatory courses are useful. You will be able to understand your weakness and helps you to plan your revison.

Structured Oral Examination

- Most of the hard work you have already done in preparing for written exam. Most important element is practicing strictly under exam condition to structure and delivery the answer in an well organised fashion and gaining time management skills.
- Keep reminding yourself that it's the last mandatory exam.

- The revised exam format depicts that the total marks in SOE is 48. Out of these, 32 marks are based on basic sciences and the short cases related to it. It is essential to rebuild the knowledge on basic sciences, especially on anatomy and clinical measurement.
- During busy working life, it is important to have a structured time table. I did my revision for clinical SOE during the evening hours after clinical work, as I felt I did not need much energy to revise a clinically related topic. On the other hand, I did all of my basic science revisions on weekends, on off days and early morning before work.
- Practicing viva is an essential part of preparation and the more you practice and more questions you face, the better you get at it. I did practice a lot with consultants at workplace (carry a book along with you and just ask any consultant to ask you from it). This helps you build confidence as well as expose you to parts you might need a bit more reading on.
- Another useful tip is to make use of voice/video calling to practice with friends you can't meet up with (WhatsApp or Skype) which helped me take a good break from solo studies. A good study buddy for VIVA makes a difference!
- SOE preparation courses help to build confidence and gives you a chance to practice answering questions that may most likely be repeated in exams.

Do not forget to read the RCoA guide to the FRCA Examination. And remember there is no substitute to hard work, the harder you work the luckier you will get!

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Technology Enhanced Learning: How do we learn anatomy?

The method in which anatomy is taught in medical school varies. Additionally, with the improvement in technology, there are now many different ways in which anatomy teaching can be supplemented. The aim of this article is to explore the various approaches in which anatomy can be taught.

Cadaver dissection

Anatomy underpins the practice of medicine, without the knowledge of bodily structures, how would it be possible to arrive at a clinical diagnosis? The term anatomy comes from the Ancient Greek: ἀνατομή, which literally means to cut up. Therefore, the first method to be discussed in this article will be cadaver dissection. Cadaver dissection has been an integral part of medical curriculum since the 18th century. It is an active way of learning that gives medical students an opportunity to appreciate the three-dimensional architecture of the human body and how it relates to other important aspects of medicine such as physiology, as well as important internal variations. In addition to this, as well as giving students an opportunity to practice surgical skills without harming a patient, it also introduces and builds upon key concepts such as death, patient respect, team work and communication. However, the use of cadavers has decreased over the last couple of decades for many reasons such as the decrease in bodies being donated to medical sciences and high preservation costs.

Prosections and Plastinated Prosections

An alternative to cadaver dissection is the use of wet prosections, which are pre-dissected cadavers. This allows maximisation of scarce resources such as time, cadavers, trained professionals to educate a high number of students. Another method that lends longevity to cadavers is plastination, where water and fat is replaced by polymers such as silicone. This allows visualisation of anatomy along with decrease wear and tear of the specimens but does have a limited tactile experience.

Time in the dissection lab is often supplemented by other resources, for example lectures and summary notes created by anatomists give students a decent foundation on which to build their knowledge.

Three-dimensional models and virtual simulation

In addition to the above, to further grasp the orientation and spatial relationships of anatomical structures there are virtual dissections that represent the human body in a three-dimensional model present online or on DVDs; a resource that has the advantage of being accessible outside the dissection lab. This virtual representation of the human body has been further developed into virtual simulation where students are able to interact and even distinguish between different textures of various tissues. Virtual simulation has also been incorporated into speciality training and is regarded as vital part of training whilst maintaining patient safety. Therefore, not only is virtual simulation a useful tool in gaining anatomical knowledge but can also provide students with an insight into certain specialities.

Real time images and three-dimensional reconstruction

With the rapid improvement in imaging techniques, images derived from ultrasound, endoscopies, magnetic resonance imaging, and computerised technology provide another resource for learning which can be manipulated to focus on particular aspects in a variety of views. These radiological images can also be used to reconstruct structures via three-dimensional printing and therefore demonstrate the variation in anatomy seen in the population. Since radiological techniques are being incorporated into the process of post-mortems, this method of teaching anatomy may become more widespread.

In conclusion there are many methods to teach anatomy with varying amounts of participation. Which method is best is difficult to determine, however an integrated approach utilising the increase in computer assisted learning might be best. When it comes to anatomy teaching at medical school how to teach is not the only important consideration, when and by whom also play a key role. Majority of teaching occurs in pre-clinical years and is not readdressed, and perhaps involving older year students in teaching can help keep anatomical knowledge renewed thus giving junior doctors confidence in their anatomy knowledge.

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Anatomy revision course: a resilient foundation for the primary FRCA OSCE

Speaking from experience, the primary FRCA curriculum is overwhelming! My focus leading up to the written and the OSCE/VIVA was purely on the basic sciences. I neglected the anatomy revision until the 3-hour bus journey to London the day before the exam. A stressful and inefficient way of learning! Furthermore, it was difficult to get any OSCE practice. The opportunity for VIVA revision is plentiful, so long as you seek them out when on a list with a consultant, but the OSCE, exam conditions setting, is hard to come by. These factors, including the fact that revision costs for the exam can be the equivalent of a couple of nice holidays, inspired us to set up a low-cost anatomy OSCE course.

Course Structure

To keep costs low, we used a teaching room that was attached to the library in our trust, that we could use as staff members. We planned to run two short OSCEs with 8 stations in the morning and 8 stations in the afternoon. We wanted to keep it as close to exam conditions as possible, so had 5-minute stations, but we then gave 2 minutes after each station for real time feedback for the candidate, before moving on. Looking through exam resources, including recalling the exam we had undertaken, we designed the stations based on common topics. To try to help recall, we designed a small booklet with each stations question in it, where candidates would write their answers. This meant that they could take that home with them, and annotate it how they see fit, and use it as a revision aid. The time in between the morning and afternoon sessions, we had a series of mini lectures that covered helpful hints and tips to revise key topics and mnemonics. Our departments also had a spine and a couple of other models that we were able to borrow for the stations. A cost of £10 per candidate was enough to cover lunch for everyone involved.

Feedback

We had great feedback from the candidates on the course, 100% of who would recommend the course to others. They found the handouts useful, the opportunity to gain OSCE practice was appreciated, and ultimately, covering anatomy was valued, as many admitted to not addressing that area of revision yet. This was just a week before the exam!. We took on board some constructive feedback, like adding on radiology stations, and tried to improve our mini-lectures. Since starting the course, we are now on our third iteration and the course fee has ballooned to the dizzy heights of £15 per candidate, but the feedback we have received is that it is still great value for money.

There is a saying that the half-life of exam knowledge is 2 weeks, which is certainly my excuse when I still get asked things like “What is the equation for the reaction in sodalime?” We thought, that

at the peak of our primary FRCA knowledge, we should put it to greater use, and start this revision course. Once the leg work had been done preparing the materials for the first course, it has been more straight forward to reproduce. We would encourage other trainees to consider setting up a similar revision course to try address the needs that they maybe had during their own revision – like anatomy revision, and OSCE practice, that we had. The course has also been a great opportunity for us to experience the organization side of this project, and we have a new found appreciation for staff who undertake such a task. It has been fun, challenging, and rewarding, and we have ultimately been able to help fellow trainees. Why not give it a try!

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Dr Jennifer Myo, CT2 UHW, Cardiff

A journey through anaesthesia training in the UK: My experience as an overseas trainee

"Pick the highest mountain to climb on and the dullest days to shine on - Aisha Chaudhary"

My journey in the United Kingdom began in autumn 2016. I had just completed my M.D Anaesthesia (a three-year structured training programme) in India, got married and moved to UK. It was a new country, new culture, new faces and the start of an amazing adventure. When it came to the stage of applying for GMC license, there was an ocean of information and I was completely lost. Being in the UK, I was not eligible to apply through Medical Training Initiative (MTI) route. So, my only options were to go ahead with the PLAB exam or sit the Primary FRCA. If I had to take the fellowship exam that would mean being at home and studying, while I was eager to work. Hence, I decided to go down the PLAB route. Fortunately enough, I managed to find a mentor, who provided me further guidance and arranged a clinical attachment form me in a teaching hospital. At this stage I had passed the written PLAB and was due to sit the OSCE component of PLAB and the clinical attachment couldn't have come at a better time. It was a great opportunity to meet people in various roles in the anaesthetic department and also understand the working of the NHS. I absorbed the cultural differences and worked on my communication skills with patients and staff. Although it was a short three-week clinical attachment, I had gained so much from it. As soon as I got my GMC number I started applying for jobs. My only shortcoming was that my target area was limited due to family commitments. I was successful in securing a trust doctor job at a district general hospital.

My time as a trust grade doctor was turbulent with ups and downs. There wasn't much guidance and information on how should I progress further in securing a training post. I looked at the ST3 scoring sheet and made a map for myself. I discussed with my clinical supervisor about the lists and experience I needed and was really lucky to be in such a supportive environment. I also reached out to the wonderful team of consultants who helped me in various aspects such as teaching, audit, quality improvement projects and even that extra 5 minutes to listen to me was extremely useful. The best advice from a consultant was, if you don't ask, you don't get it!. Some doors may close but you don't know which may open and change your life. I had my share of failures with exams and projects those didn't work out. I almost gave up the thought of getting into training or anaesthetics altogether. But I am grateful I had such a wonderful support system in terms of my family and my department who would always bring me up to fight another day.

Once I was ready to go ahead with the interviews, I spent good time researching the entire process and how to prepare for it. When it came to ranking the deanery of my choice, many told me to apply to the least popular deanery or else I wouldn't get a position. I had worked really hard on my CV and there was no reason why I couldn't apply to the region of my choice. Today I am a ST3 Anesthetics trainee at the Thames Valley deanery. Nothing is Impossible!

So, if you are a Trust grade doctor or have overseas experience in anaesthesia and applying for a training post, following are some helpful tips

- Have an aim and plan out your goals. It is very easy to lose track in the large amount of evidence you need to provide.

- Study the ST3 scoring sheet in depth. It makes you aware of your shortcomings and helps you plan your personal development plan.
- There is no substitute to hard work. Many don't want to attempt the PLAB exam and hope for a job via other schemes. If you have the patience that's fine but don't be afraid to take up any challenge if it gets you closer to your goal.
- We must accept our failure; we have our egos held up high with our past accomplishments but every day is a school day. Be humble, accept defeat and work harder the next time.
- Give yourself a break. It's a rat race and it's amazing what the human body can deal with. But realise when you need a break and take it!

To help people on their journey and share information I have created a facebook group and blog with over 3500 members and increasing.

Facebook group: Anaesthesia Jobs and training in the UK

Blog: https://anaesthesiainuk.wordpress.com

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Education on empathetic communication, "Just a sharp scratch coming."

"When pleasant words are easy, bitter words to use,

Is, leaving sweet ripe fruit, the sour unripe to choose", Saint Thiruvalluvar circa 4th century BCE

Editor's Perspective

- A structured training for technical elements of clinical procedures performed on awake patients already exists.
- Communication with patients with negative words can enhance their anxiety.
- Communication using positive words is more likely to reassure the patients.
- There is a need for structured training on how best to communicate the clinical procedures with patients. This can be incorporated into early part of medical and anaesthetic training.

Although doctors are highly trained professionals with vast knowledge and skills, subconscious and subtle compromises in patient-doctor communication can deeply affect patients' experience. One of the key indicators for quality in healthcare is patients' experience.

With any communication, there can be three choices of tone: positive, negative or neutral. The same fact can be conveyed in different ways eliciting different responses in the patients. Whilst a positive statement can enhance patient spirit and engagement, a negative sentence can perpetrate harmful effects. Negativity in the clinician's tone, may enhance patients' distress, anxiety and a greater sensitivity to existing symptoms. These effects can be minimised by improved communication. I conducted a survey amongst secondary school students in order to learn more about the impact of patient-clinician communication. I chose four common clinical scenarios, namely:

- Explaining a procedure
- Diagnosis of condition
- Describing the side effects of a medication
- Referring to a specialist

For each of the above scenarios, I prepared three sentences with varying tones: positive, negative and neutral. The sentences were verified by senior clinicians with an interest in patient-clinician communication. A survey was designed with Google Forms and the link was distributed through email. Participants were given the option to rate each sentence on a scale of 1 to 5, with 1 being the most reassuring, and 5 being the most worrying. In total 389 students participated in the survey, and the results were analysed using Google Forms.

A common phrase used by many doctors in explaining a minor procedure is, "I am going to inject local anaesthesia, sharp scratch coming and it may sting a bit." I included two other tones in my survey, namely:

- "I am going to inject local anaesthesia."
- "I will give you numbing medicine which will make the procedure comfortable."

Whilst about 35% of the respondents felt worried with the common phrase used by doctors, “...sharp scratch coming.” and “I am injecting local anaesthesia”, this proportion shrank to about 7% with the positive tone, “I am going to inject numbing medicine…” Similarly, about 71% of the participants felt reassured by the positive words, “...make you comfortable.”, as opposed to less than 30% with the negative or neutral tones. An identical trend was noticed within the other clinical scenarios (describing side effects etc.).

Clinicians can produce positive response through empathic communication, which in turn improves health outcomes. Researchers and specialists have proposed certain principles in the hospital that can be incorporated to reduce anxiety and distress in patients. Examples of the principles include:

- Providence of encouragement and support
- Giving patients a sense of autonomy and humanity
- Building patient-clinician relationships
- Using more positive word choices to describe treatments, prognoses and diagnoses.

Education in empathic communication is likely to have a beneficial effect by facilitating a positive mindset and hence a positive health outcome.

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Medical leadership: A missed opportunity in the undergraduate curriculum

The 1967 Cogwheel Report, the Griffiths Report in 1983 and the Darzi Report of 2008 called for the need for doctors to take a greater role in leading and managing their organisations. Despite some of the reports being over 50 years old, the concept of incorporating medical leadership into the profession is still novel.

The emphasis on medical leadership occurred following the findings of the public inquiry led by Robert Francis QC into the shocking failures that occurred at Mid Staffordshire NHS Foundation Trust. The report raised many questions about the leadership and organisational culture that allowed hundreds of patients to be harmed or die unnecessarily. Therefore, in order to continue promoting patient safety and care it is essential for clinicians to exercise 'strong, ethical and patient-centered leadership'. This growing need for leadership has led to the General Medical Council (GMC) listing it as one of its core competencies. Evidence suggests that leadership qualities affect patients, healthcare system outcomes and finances. Hospitals with higher rated management practices have been shown to deliver a higher quality of care and to have better clinical outcomes, including lower mortality.

Although leadership has been listed as a core competency by the GMC, there is a lack of formal leadership and management teaching in the undergraduate curriculum. Therefore, the aim of this article is to explore some opportunities for leadership in the undergraduate curriculum. There are three main components within medical education: the formal curriculum, the informal curriculum and the hidden curriculum. In order to include leadership within medical training, it is important to utilise all three avenues of teaching.

Formal Curriculum

Firstly, the formal curriculum should include taught sessions for students. There are many programmes that have an extensive list of topics that should be covered when delivering medical leadership. However, I would like to focus on the best way to deliver these teaching sessions.

The most effective method in delivering the teaching would be to follow a Problem Based Learning (PBL) model. In a PBL setting, learning is triggered by a problem that needs resolution. This strategy offers a framework that supports active and group learning and believes that effective learning takes place when students construct ideas through social interactions and self-directed learning. Studies looking at the effectiveness of PBL showed that it developed students' reflective, critical and collaborative skills. This allows students to explore the topics effectively through discussion and to think about them critically instead of rote learning the facts to pass exams.

Informal Curriculum

The informal curriculum refers to learning experiences gained from other agencies outside a formal setting such as extracurricular activities. Students should therefore be encouraged to take part in activities that develop their leadership skills including taking part in sports teams and being on a society committee. These are all activities that many students take part in. Yet, many students fail to form a link that the position they are in is a position of leadership. For example, students on a MedSoc committee are constantly managing others, organising events, dealing with budgets and finances. It is important that medical educators empower students to recognise that they are developing a strong leadership skill set by taking part in extra-curricular activities and to encourage them to do so.

Hidden curriculum

The hidden curriculum is an influential concept in medical education. For this reason, I would like to focus on how we can utilise it in a way to reap its many benefits, without placing too much onus on medical schools to adopt it.

The hidden curriculum is defined as 'a set of influences that function at the level of organisational structure and culture including, for example, implicit rules to survive the institution such as customs, rituals and taken for granted aspects.' Many students, especially in the early years, learn by example from healthcare professionals whilst on placement. This opportunity should be recognised and used for delivering medical leadership training. There are many healthcare professionals holding leadership positions within the NHS such as consultants, ward managers, nurse sisters and medical directors. It would therefore be useful for students to shadow professionals within these leadership roles and learn by example. They will be able to learn their day-to-day role, learn how they manage large groups of individuals and how they communicate. A dedicated medical leadership specialty placement would facilitate learning these skills.

Finally, there are some negative connotations attached to this method of learning. Some believe that it adopts a 'ritualised' professional identity, emotional neutralisation and acceptance of hierarchy. It is also important to ensure there are barriers in place to prevent students adopting a dismissive culture as was portrayed in the Mid-Staffordshire enquiry. Medical students should be constantly reminded to act with integrity and honesty, to reflect on poor performance and to disclose any malpractice.

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Entrustable professional activities in anaesthetic training

Competency based training entered into UK training schemes around the time of the millennium and has become the overwhelming basis for postgraduate training. Since it's origin in 1950's from educational psychologist Ralph Tyler's idea, competency-based education (CBE) moved to systematically focusing on predetermined outcomes, instead of the experiential version that had preceded it. Student centered approach to learning was the foundational concept of CBE.

Despite its outward advantages, many have criticised its implementation and the sole reliance on it for assessment and progression. The high value of being signed off, measuring only what can be easily measured (Talbot, 2004), being seen only as a tick box exercise (Glass, 2014) or of purely being of benefit for the regulator and assessor but not for the trainee (Grant, 1999) are all critiques that have all been levelled against competence based training. It is also recognised that individual learners learn at different rates (Ten Cate, 2017).

At around the same time, the Dutch were introducing the CansMED framework for training (a Canadian framework for competency-based training). One of the instigators of this framework was Ten Cate. The Netherlands had seen the introduction of a competency-based framework for nurses and anecdotally there was a feeling that the aspect of practical delivery had been lost in the transition (Royal Australasian College of Physicians, 2016). In response to this, he came up with the idea of Entrustable Professional Activities (EPAs) to reconnect assessment to practice or in his words "*operationalise competencies*'. He describes an EPA as '*a unit of professional practice, defined as a task or responsibility to be entrusted to a trainee once sufficient specific competence is reached to allow for unsupervised practice. EPAs are independently executable within a time frame, observable and measurable in their process and outcome, and suitable for entrustment decisions*'(Ten Cate, 2005).

Entrustment as a concept, although perhaps not termed in that way, will be familiar to anaesthetists. As trainees progress, we entrust them with progressively more complex tasks. With a novice you tailor your supervision, you are with them in the theatre, moving to outside the theatre doors, to the coffee room, to the office and finally to home. With each step, we assess the trainee's ability and distance ourselves relative to their chance of success. Once we are out of the theatre suite we have entrusted them with the case, we acknowledged the element of risk that exists and that all parties are comfortable with it.

In 2017 the GMC published Excellence by Design: standards for postgraduate curricula (General Medical Council, 2017). It refers to a simplification in assessment to make it clearer to trainee what they have to achieve and suggests a framework of 15-20 higher-level learning outcomes. The RCoA has responded, on their website regarding the content of the 2020 curriculum, citing EPAs as a potential way to enact this. *'In keeping with the desire to simplify, and reduce the burden of assessment, the GMC has also suggested that workplace-based assessment moves away from separating out individual elements of performance, and replace them with more global assessment of whole clinical tasks, or 'Entrustable Professional Activities'*(RCoA). A laudable aim, although the only study to date that has attempted to describe the whole

anaesthetic curriculum in EPAs has come up with 45 EPAs (Wisman-Zwarter *et al.*, 2016), not the 15-20 suggested by the GMC.

The curriculum is changing, EPAs are likely to be part of the outcome of this process, hopefully, they will reconnect competency-based training to the practical job at hand.

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Health Education England's supported return to training (SuppoRTT) programme

RCoA records show that 52% of consultants who gained their CCT in 2018 took time out of programme during their anaesthesia training.[1] Although there are comprehensive guidelines in place, and return-to-work support is typically better than most other specialties, provisions are still very variable between different hospitals and regions. In some specialties and in some geographic areas, returner support has until recently been virtually non-existent. As part of the ACAS Junior Doctors' Agreement in 2016, HEE was tasked with developing evidence-based, innovative approaches to "remove as far as possible the disadvantage of those who take time out (of training)".[2] The aim of the Supported Return to Training (SuppoRTT) programme is to improve the return-to-work experience for trainees from all specialties, who have taken time out, for whatever reason. Following a call for ideas that received responses from doctors in training and their representative bodies, educators and medical royal colleges, HEE outlined 10 commitments to support trainees with their return to training. These included coordinating and centralising a defined process for exit, time out and re-entry to the training programme, ring-fencing funding for doctors to access resources in support of their return, enabling educational supervisors to better support trainee returners, developing a "menu" of bespoke return to training approaches for trainees and collaborating internally and with the wider system to raise the profile of returners' voices.[3]

For one year from Autumn 2018, we were employed, along with 8 other clinical fellows (at on average 0.4 wte), to work at both a regional and national level on HEE SuppoRTT workstreams. Through collaboration with HEE staff, the wider medical community and external stakeholders, we made significant progress in bringing the SuppoRTT project to life. Clear guidelines are now in place on the process that all trainees returning to a training post in England should undertake (Fig. 1), as well as process compatible user-friendly forms. Databases have been developed, which enable the collection and management of the information collected by the SuppoRTT forms; information that can be used to signpost trainees to the support and resources that they can benefit from. Alongside structured meetings with their supervisors (pre, during and post leave), every trainee will be eligible (if required) for a period of enhanced supervision upon their return to work, ensuring that no returning trainee will find themselves unsupervised or working in an on-call capacity until they are ready to do so. We have developed guidance for and are providing delivery of national and regional mentoring programmes and are working towards making KIT and SPLiT (Keeping In Touch and Shared Parental Leave in Touch) days more transparent and more easily accessible. KIT-equivalent Return to Training Activity (RTTA) day funding has also been made available, providing equitable support for non-parental leave returners. Generic and specialty-specific return-to-work courses, apps, online platforms and "toolboxes" that trainees can access have been developed, including the innovative MySuppoRTT.com app and website, which allows a trainee to input their details and find the best return resources available to them.[4] Resources designed to "educate the educators", such as online and face-to-face courses, are already improving trainee support, as well as the culture surrounding the return process. Each deanery's HEE office now hosts a user-friendly SuppoRTT webpage, where both educators and trainees can find out more about SuppoRTT in their region.

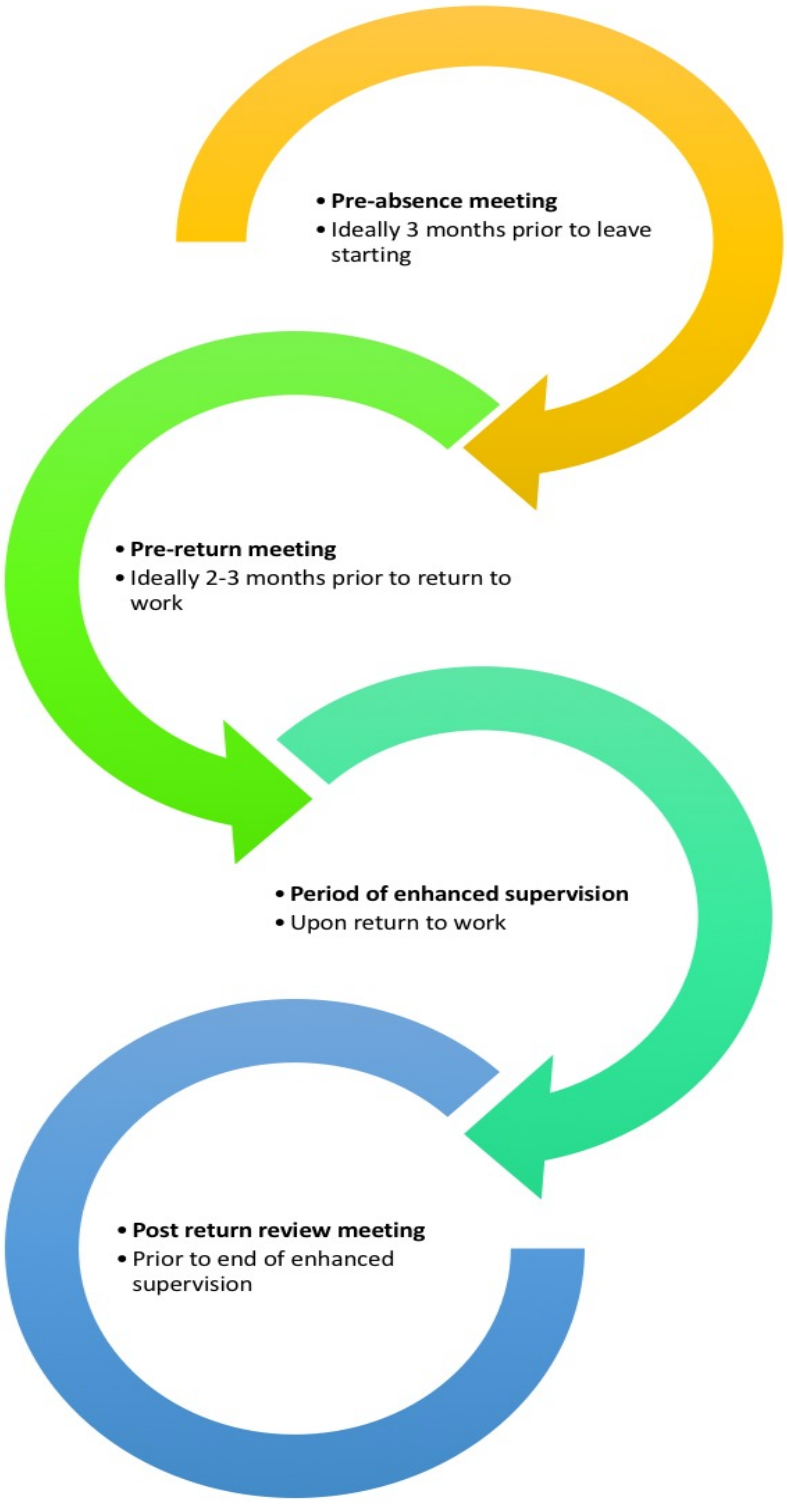

Figure 1: An overview of the SuppoRTT process

As well as the obvious impact on patient safety, highlighted by the well-publicised Bawa-Garba case, structured and comprehensive support for returning trainees is also serving to improve the trainee return experience. With highly regarded courses such as GASagain and well-established return-to-work guidelines,[5,6] anaesthetic training in the UK is ahead of the curve when it comes to supporting trainees returning to work. Designed to be compatible with existing processes, the work of the SuppoRTT programme will help to enable

the safest possible return to work for all returnees, both within anaesthesia and in other specialties. The next team of clinical fellows have started in their roles and funding is ongoing, thereby ensuring the continued evolution, establishment and sustainability of the project. For more information on Supported Return to Training and to link to the SuppoRTT webpages for your region, please visit https://www.hee.nhs.uk/our-work/supporting-doctors-returning-training-after-time-out.

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What makes us feel valued?

Morale, wellbeing and mental health are highly publicised topics of interest at the present time. Unsurprisingly this current popularity extends to the healthcare setting with lots of work being done recently, in particular by the Royal College of Psychiatrists. Within the private sector it is widely accepted that making employees feel valued indirectly improves productivity, loyalty, retention, open communication and overall improves wellbeing. Furthermore, when translated to the healthcare setting, further benefits may be seen in both patient care and safety. Feeling valued is not just feeling appreciated, feeling valued is an overall feeling of worth supported by repeated expressions of gratitude reinforced by positive and constructive feedback. A recent report by the Royal College of Anaesthetists published in December 2017, looked specifically at the mental health of anaesthetic trainees and identified that 61% of those in training felt that their job negatively affected their mental health. The key message from this report was “we need to listen to our younger colleagues: it is the system in which they are expected to work and train is the problem”. With this in mind we wanted to explore the concept of “feeling valued” amongst current anaesthetic trainees in Yorkshire.

A regional survey amongst trainee and trainers

We distributed surveys to anaesthetists in training throughout Yorkshire over a period of 2 weeks using SurveyMonkey®. We obtained 66 responses to our six questions, which revealed some key themes amongst our widely distributed trainee group. We asked trainees to score how valued they had felt over the previous 12 months. Most trainees overall felt valued over the that time period with a median score of 74 out of 100. We then provided trainees with a number of statements asking them to give them a rating on how much each of them had contributed to their “feeling valued”. Of these, the biggest contributing factors were trainers with an enthusiastic and positive attitude and feeling respected by others within their organisation. Trainees also felt that feedback; both constructive and positive were key factors when it came to feeling valued. Additional areas that seemed to be important to our trainee responders included having a non-exploitative rota, support with obtaining study leave and time allocated for quality improvement and audit activities. As well as making our trainees feel valued, all of these factors are compatible with an effective educational environment. Lowest scoring statements included being allocated to do solo lists, being involved in decision making related to factors within the organisation and being provided with a forum to discuss

departmental and training issues. We then asked trainees to tell us about specific things that had made them feel valued in the past. We received a variety of responses but most notably the vast majority of trainees cited feedback from colleagues and mostly consultants as being central to their previous experiences of feeling valued.

We then asked consultants attending the Yorkshire School Conference to respond to an almost identical survey. We hoped to draw comparisons between trainees and trainers in the same region. We obtained 25 responses with consistent themes emerging. 16% of consultants felt undervalued in the previous 12 months compared with 24% of trainees. However, when asked about factors contributing to “feeling valued” similarities arose, a positive and enthusiastic attitude from colleagues and feedback both constructive and positive being most noticeable, mirroring the themes important to trainees. In addition, when we asked for free text responses relating to personal experience of feeling valued feedback from others including colleagues and trainees were dominating areas.

So, what next?

It seems that we are all very alike, both trainees and trainers want to feel valued and achieve this largely from their interaction with others. This is not unique to us; it is well established that human beings have fundamental needs. Maslow famously described the hierarchy of needs where, once we have achieved our basic physiological and safety needs, we seek to achieve needs relating to self-esteem and ultimately success and recognition. We are urging our trainers to use the information we have obtained to help our trainees feel more valued. We hope that this will ultimately improve the working environment for everyone including patients. There are numerous challenges faced within the NHS today, some remain too difficult to address but feedback and thanks are free, the biggest cost is time.

Dr Kim Caines
Specialist Trainee
Yorkshire School of Anaesthesia

Dr Sue Walwyn
President of SEAUK
Training Programme Director
Yorkshire School of Anaesthesia

Society of Education in Anaesthesia UK (SEAUK)

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Revalidation FOR ANAESTHETISTS

21st Annual Scientific Meeting
Monday 23rd March 2020
Hilton Warwick/Stratford-upon-Avon, CV34 6RE

08:30-09:15		**Registration**	
09:20-09:30		Introduction and Welcome	Dr Sue Walwyn President SEA UK
09:30-10:10		**Keynote 1**	Chair: Dr Sue Walwyn
		Assessment: Priorities and pitfalls	Dr Anne Taylor
10:10-10:30		**Annual General Meeting**	
10:30-10:55		**Refreshments**	
11:00-11:45		**Workshops**	
	1	Supporting the returning trainee	Dr Victoria Bower
	2	Simulation in Assessment	Dr Carl Hillermann
	3	Second Victim	Dr Shirley Remington
	4	ARCP for non-trainee doctors	Dr Dipesh Odedra
11:45-13:00		**Free Papers**	Chair: Dr Peeyush Kumar
13:00-13:40		**LUNCH**	
13:40-14:20		**Keynote 2**	Chair: Mr Russell Ampofo
		GMC priorities for education and training	Professor Sue Carr Deputy Medical Director, GMC
14:25-15:10		**Workshops (as above)**	
15:10-15:30		**Refreshments**	
15:30-16:30		**Debate** This house believes that every ES should have higher educational qualification	Chair: Prof. Cyprian Mendonca
		Proposer	Dr Shireen Edmends Head of School HEE West Midlands
		Opposer	Dr Chris Carey Associate Postgraduate Dean HEE Kent Surrey Sussex
16:30-16:45		**Presentation & closing address**	Dr Sue Walwyn

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SEAUK

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21st Annual Scientific Meeting

Monday 23rd of March 2020

Hilton Warwick/
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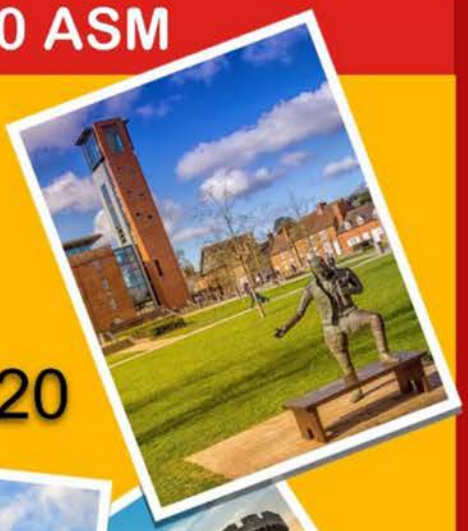

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