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THE SOCIETY FOR EDUCATION IN ANAESTHESIA (SEAUK)

WINTER NEWSLETTER

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EDITOR
Dr Claire Halligan, Consultant Anaesthetist, Wrexham Maelor

Inside this issue

Picture top right courtesy of Dr Stefan Coghlan, Consultant Anaesthetist Wrexham Maelor Hospital

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Join SEAUK today (https://www.seauk.org/join-seauk) and be part of a growing network of passionate educators across the world.

The Society for Education in Anaesthesia is an organisation that works to provide high-quality networks and professional development opportunities for education in anaesthesia in the UK and overseas.

SEAUK is here to provide the advice, support and resources you need to excel your career as an anaesthetist, a trainer, educator and leader. There are a wide range benefits of being a member of SEAUK that we feel would be valuable for you. Briefly, these include:

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- SEAUK members are invited to submit articles on educational topics that are printed in our newsletters and other publications, including the RCoA Bulletin.
- Become a member of SEAUK, an organisation that has a national influence on Anaesthetic education and development

Thank you for your time and we look forward to you joining us here https://www.seauk.org/join-seauk

Kind regards

Sue Walwyn	Peeyush Kumar	Cyprian Mendonca	Umair Ansari
President SEAUK	Secretary SEAUK	Treasurer SEAUK	Webmaster SEAUK

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Letter from the President

Welcome to the SEA UK winter newsletter!

Firstly, thank you to the contributors of the newsletter who have managed to keep on advancing medical education while balancing the challenges of 2021!

We've had a busy year and the face of education and delivery has changed with the intorudction of online learning, hybrid conference delivery and the explosion in supportive technology. We haven't managed to adapt to the long days of TEAMS but the facility to stay at home and the ability to facilitate greater exposure has been very positive for SEA-UK. The articles enclosed are evidence of research in this area.

Don't forget to leave space in your diary for the ASM in May, the webinar in March and make your trainees aware of the grants offered to our members.

All is left is to wish you a very merry festive season!

Sue

Dr Sue Walwyn, Consultant Anaesthetist and TPD, West Yorkshire

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22nd SEAUK ASM

The Society for Education in Anaesthesia

2022

Annual Scientific Meeting

Coaching & Mentoring Skills

Supporting Educational Faculty

Sustainability in Anaesthesia

Knowledge vs Performance: A debate

Hilton Warwick (M40 J15 Warwick Hotel)

Date: 26/05/2022

Programme: Lectures & Workshops TBC

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ANNUAL SCIENTIFIC MEETING

Thursday 26th May 2022

09:00	Introduction and Welcome	Dr Sue Walwyn President SEA UK
	Session 1	Chair: Prof. Cyprian Mendonca
09:15	Role of CEO in provision of high quality medical education	Prof. David Loughton Chief Executive The Royal Wolverhampton Trust
09:45	Supporting Educational Faculty	Prof. Sailesh Sankar Associate Dean, HEE, West Midlands
10:15	Questions & Answers	
10: 30	**Refreshments**	
	Session 2	Chair: TBC
10:50	Sustainability in Anaesthesia Training: Meeting the Requirements of the New Curriculum	Dr Cliff Shelton Consultant Anaesthetist, Wythenshawe Hospital Senior Clinical Lecturer in Anaesthesia Lancaster Medical School
11:15	Supervision of MTI trainees and locally employed doctors	Dr Sujesh Bansal Associate Director of Medical Education Consultant Anaesthetist Manchester University NHS Foundation Trust
11: 40	Questions & Answers	
11:50	Coaching and mentoring skills: necessities for today's doctors.	Dr Rebecca Viney Rebecca Viney Associates London
13: 15	**LUNCH**	
14:00	**AGM**	
14:15	Free Paper Session	Chair: Dr Sarah Fadden
15:15	**Refreshments**	
	Session 3	
15:30	This house believes that poor performance is related to lack of knowledge	Chair: Dr Claire Halligan
	Proposer	Prof Aidan Byrne Co-Lead for Quality Swansea University
	Opposer	Dr Mark Stacey Consultant Anaesthetist University Hospital of Wales Associate Dean, HEIW
16:30-16:45	Presentation of prizes and closing address	Dr Sue Walwyn

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Final MBChB Assessments in the Covid era

Dr Kalpanee Wijendra BMedSc (Hons) MBChB
Clinical Teaching Fellow
University Hospitals Coventry & Warwickshire NHS Trust

During the Covid pandemic, the education domain has undergone considerable ramifications. In particular medical education, as the medical curriculum relies heavily on patient contact. At the onset of the pandemic, the Association of American Medical Colleges took a stance to suspend clinical rotations and issued guidance which included medical students avoiding any activity involving direct patient contact. Many countries, including the UK, adopted a similar strategy. As the pandemic progressed social distancing measures continued to pose a constant disruption to medical education. This led to the redesign of the current structure of teaching and assessments. There was a global shift towards online teaching and examinations using software such as MS Teams and Practique to overcome problems faced by social distancing restrictions.

In many countries clinical and written exams were postponed, cancelled, delayed or more commonly have been replaced by online examinations. One third of medical schools in the UK had Objective Structured Clinical Examination (OSCE) cancelled, whereas only four medical schools within the UK adjusted the above examination using simulated patients instead of real patients. Important examinations which have high validity such as the Objective Structured Long Examination Record (OSLER) were continued in some institutions such as Warwickshire Medical School via online modalities. Although this prevented students from missing out on the OSLER completely, the clinical examination and extraction of clinical signs part of the assessment was omitted due to its virtual nature. It still preserved the obtaining of a history, considering diagnosis and then finally the problem-solving element. When considering the utility of assessments these modifications may have significantly affected the educational impact. This is predominantly because removing the clinical examination of the patients from the OSLER removes the "does" aspect of Miller's pyramids and the assessments focus solely on "knows" and 'knows how". In terms of feasibility of the OSLER, due to the remote nature of the examinations, real patients who would have otherwise been unable to participate in the examinations due to ill health and being high risk for Covid-19 were able to participate in these examinations virtually, therefore patient recruitment for the online examinations were comparatively easier.

Since the easing of Covid-19 restrictions in 2021, medical schools have decided to continue most examinations face-to-face, with some modifications. The recruitment of real patients for the face-to-face examinations, especially for OSLER style of examinations have shown somewhat a challenge. Most patients who used to participate in these examinations have had a deterioration in health since the pandemic. It was also found that some patients from the existing data bases have also unfortunately passed away during the pandemic. Many patients have ongoing anxieties around being in hospital environments. Therefore, recruiting patients for the upcoming face-to-face examinations is becoming increasingly hard. The recruitment of examiners has also become a great challenge. During the pandemic the temporary halt on clinics and elective services freed a lot of clinical time and clinicians were able to remotely help during medical school examinations. However, since all medical and surgical services have resumed, due to increasing service demand, it is much harder to recruit clinicians to medical school examinations.

In addition, sickness and isolation of colleagues, adding increased demand on clinical services. This means that contingency plans must be in place for when facing examiner absences, this may be having to remove some OSCE stations on the day of the examinations or having preventative measures such as recruiting surplus of examiners in case there are unanticipated absences.

Technical challenges faced during online examinations included problems with the quality of audio and video, downloading and streaming errors, problems with access such as logging in and or poor internet quality, potential for breach of security during examinations. The instructor, simulated patient and the student needed technical skills in managing the software or the programme used for examinations which required training, which needed more time and resource allocation. Therefore, having virtual examinations also had its own set of challenges.

Difficulties associated with psychological wellbeing caused increased incidents of anxiety and depression on a group of people with this problem already prevalent. Interestingly, a cross-sectional study showed that burn out, depression, anxiety and somatic symptoms rates decreased during online learning. Remote learning and examinations conducted in the comfort of one's own home may have accounted for the above observations.

In conclusion, the unprecedented covid-19 pandemic caused many challenges to medical education in both delivering teaching and assessing medical students. Significant changes were made to the curriculum and the mode of teaching in order to preserve the integrity of medical education. The ramifications of the necessary changes are yet to be observed in the future, however medical education continue to navigate through these challenging times with the lessons learnt along the way.

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Educational and Training Innovations and Interventions Necessary for Maintaining Excellence in Anaesthetic Education

It's the little things that mean so much

Adrienne Lee[1], Alina Van Hien[1], Jim Blackburn[1], Lorraine Alderson[1]*
University Hospital Plymouth NHS Trust, adrienne.lee@nhs.net

University Hospitals Plymouth is a large teaching hospital that provides a wide-ranging mix of complex, intricate, and sometimes high-risk surgery. Anaesthesia can be demanding and testing at any time and during an era of stretched services, educational opportunities are always precious.

"Croissants and Cases" is an innovative approach to learning that anaesthetic trainees in Plymouth developed during the pandemic. It is a trainee-led breakfast meeting that runs weekly, offering a safe space to discuss interesting and difficult cases. It allows for peer-learning and a forum for peer support across a large anaesthetic department. It provides a personal touch that has sometimes been difficult during multiple waves of Covid-19.

The hybrid meeting is held each Wednesday morning from 07.15 to 08.00. Trainees can meet face-to-face (socially-distanced) or join virtually via Microsoft Teams. Attendance is non-compulsory but rather for trainees to join when they want to. No significant advanced preparation is required; we focus on keeping the meetings 'semi -formal' and encourage reflection and discussion.

The meetings are held under Chatham House Rules: this is emphasised every week to ensure a safe, non-judgemental, supportive environment for honest discussion. There are two trainee leads that organise every session. They advertise and co-ordinate cases to be presented and set up the virtual platform. A small group of consultants take turns to facilitate meetings, guiding learning conversations and reflecting their own experience to help trainees deeply appreciate challenges within presented cases.

Any trainee can present a case - whether it is a difficult situation, a significant event or a clinical conundrum. If no one has a case, the consultant brings a case from their own experience to explore thinking and generate learning.

Topics presented so far include: difficult airways, transfers, maternal haemorrhage and ethically challenging cases, death in theatre, complex pharmacopathology, theatre team behaviour, authority gradients and more!

At the end of the session, feedback is collated anonymously via QR codes and trainees are able to obtain case-based discussion assessments as part of the supervised learning event. Where significant institutional or departmental learning is revealed this is anonymously cascaded via email and our departmental monthly CME meeting.

Croissants and Cases has been extremely well-received, with a mean of 8.2 trainees/session (range 4-16 trainees) and a spread across all training stages. Our feedback indicates that trainees highly value the chance to meet informally alongside the opportunity to learn together with consultant input. The open nature of the forum encourages participation across all training grades.

Croissants and Cases is a simple idea that has made a tangible difference in our department; reinforcing educational and professional relationships and providing a space for reflective peer to peer learning. The element of time together over some food is as important as the learning opportunity - trainees arrive before the working day (or post nights) to share in the social and educational elements.

In an era where so much is expected of our junior doctors, it's the "little" things that really do make a difference.

Maintaining excellence with declining learning opportunities - Awake Fibreoptic training in Bristol

Samuel Lillywhite, Specialist Registrar, University Hospitals Bristol, samuel.lillywhite@nhs.net

A key part of our skill set as anaesthetists is being able to perform airway management at an expert level. In practice this ability comprises a number of both technical and non-technical skills which change over time as technology and research push our profession forwards. This dynamic can create areas of our practice which, though deemed vital, prove difficult to develop expertise in.

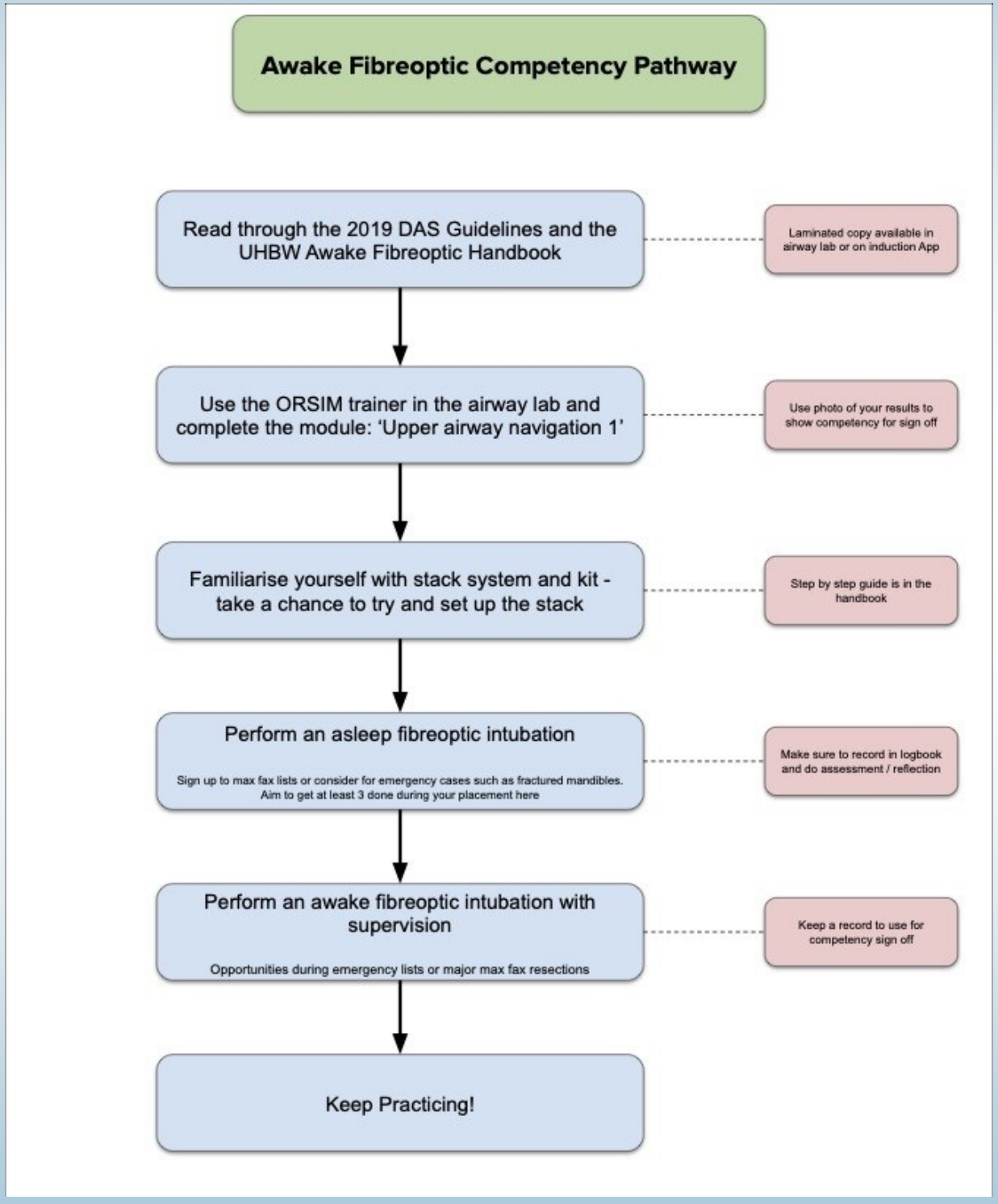
At University Hospitals Bristol (UHB) we have noted a decline in the number of training opportunities available to perform Awake Fibreoptic Intubations (AFOIs). This trend has been ongoing for several years, driven by changing patient demographics and the introduction of video laryngoscopy, it has been exacerbated recently by the COVID-19 pandemic and the desire to minimise aerosol generating procedures.

To address this mismatch, we have moved from an experiential apprenticeship model of teaching AFOI towards a more formalised skill and competency-based approach. An informal training pathway (fig 1.) was developed and introduced to guide trainees as to how to go about developing the key skill components required to perform AFOI. A handbook detailing how to set up scopes was written to simplify this procedure for new trainees. We also adopted the recently published DAS Awake Tracheal Intubation guidelines to produce 'Recipe Cards' (fig 2.) outlining a suggested simple method of topicalising and sedating patients for AFOI.

This approach can help guide novice learners and prove less daunting to those developing their practice by providing benchmarks and steppingstones to reach the goal of expertise with AFOI. This compartmentalising of specific skills has also allowed us to use computerised trainer models (ORSIM©) to develop practical skills without requiring a large number of procedures on real patients. As learners progress along the training pathway, they are encouraged to move from the trainer models to performing asleep fibreoptic intubations and flexible naso-endoscopy.

Formative assessments using both the ORSIM trainer module system and colleague feedback are used to move towards supervised practice on real patients with normal anatomy. The stated aim of this project is to allow guided, structured practice in elements of AFOI that do not require a real patient to master.

We strongly believe that in an environment where a trainee may only achieve 5-10 AFOIs during their entire training it is vital that each of those learning experiences is maximised. By providing a pathway by which the components of AFOI that do not require a real patient (i.e., Scope set up, scope handling, manoeuvring) can be mastered, we hope to ensure that the learner can focus on developing expertise during those increasingly rare real patient training opportunities.


Awake Fibreoptic Competency Pathway
Read through the 2019 DAS Guidelines and the UHBW Awake Fibreoptic Handbook
Laminated copy available in airway lab or on induction App
Use the ORSIM trainer in the airway lab and complete the module: 'Upper airway navigation 1'
Use photo of your results to show competency for sign off
Familiarise yourself with stack system and kit - take a chance to try and set up the stack
Step by step guide is in the handbook
Perform an asleep fibreoptic intubation
Sign up to max fax lists or consider for emergency cases such as fractured mandibles. Aim to get at least 3 done during your placement here
Make sure to record in logbook and do assessment / reflection
Perform an awake fibreoptic intubation with supervision
Opportunities during emergency lists or major max fax resections
Keep a record to use for competency sign off
Keep Practicing!

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AFOI WITH Sedation Technique

USE THE AFOI CHECKLIST TO SET UP EQUIPMENT

↓

Start Oxygenation via nasal sponge or HFNO

↓

Start Remifentanil at 1-3ng/ml (avoid initial large bolus)

Consider small dose midazolam if second anaesthetist present - 0.25mg increments with adequate time to see effect - ↑risk apnoea

↓

Topicalise

Co-phenylcaine spray to chosen nostril (125mg lidocaine/bottle)

Lidocaine 10% sprays to oropharynx (10mg Lidocaine/ spray)

Lidocaine 10% sprays to nose and nasopharynx

Optional - insert nasopharyngeal airway with lidocaine paste into nostril

↓

Suction Oropharynx to test topicalisation + remove secretions

If topicalisation inadequate the further sprays of 10% lidocaine (max dose lidocaine = 9 mg/kg topically)

Remove Nasopharyngeal airway if used for topicalisation

↓

Insert scope to just above cords, if cord movement increase Remifentanil to 4-5 ng/ml to provide small bolus

↓

Ask the patient to breathe in, advance through the cords to above carina

↓

Railroad Tube, remove scope once end of tube visualised with carina distal on image

↓

Attach circuit, check CO2 trace and induce anaesthesia then inflate cuff

AFOI WITHOUT Sedation Technique

USE THE AFOI CHECKLIST TO SET UP EQUIPMENT

↓

Start Oxygenation via nasal sponge or HFNO

↓

Topicalise

Nebulised Lidocaine 5ml x 4% - allow time to work

Co-phenylcaine spray to chosen nostril (125mg lidocaine/bottle)

Lidocaine 10% 2 sprays to each side of the oropharynx (10mg Lidocaine/ spray)

Lidocaine 10% 2 sprays to Nares/inferior turbinate

Optional - insert nasopharyngeal airway with lidocaine paste into nostril

↓

Suction Oropharynx to test topicalisation + remove secretions

Remove Nasopharyngeal airway if used for topicalisation

↓

Use Spray as you Go Technique (see handbook) with 2ml x 2% Lidocaine aliquots as required (spray at least once above, once at and once below the cords)

Up to Maximum 9 mg/kg Lidocaine topically

↓

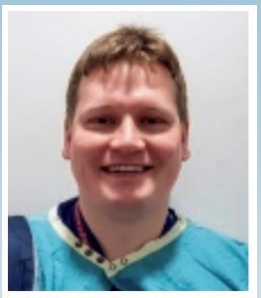
Once through cords advance to above carina

↓

Railroad Tube, remove scope once end of tube visualised with carina distal on image

↓

Attach circuit, check CO2 trace and induce anaesthesia then inflate cuff



Virtual FRCA Exam- Practical Tips

Dr Carl Groves
Specialty trainee, Warwickshire school of anaesthesia

The Covid pandemic has left its mark across most areas of life and the FRCA exams are no exception. The Royal College of Anaesthetists moved all the examinations for both the primary and final examination into a virtual environment to allow trainees to continue to progress with their examinations despite the ongoing situation. As the situation going forward remains uncertain and with cases again on the rise, it looks like virtual examinations are here to stay for the foreseeable future.

The virtual exam is different to any other exam we have sat; it carries all the stress of the face-to-face sittings but in your own living room wearing a suit (and slippers). Some will find it a better experience, and some will find it harder but no matter which camp you find yourself in, it must be treated like any other exam.

The virtual exam format retains all the challenge and vigour of traditional exams so proper preparation is just as important. Face to face practice with peers, senior trainees and consultants remains very useful and worth spending time on but it is also useful to practice the viva over video call so you can get used to speaking and answering questions to a computer. Video practice also allows you to check your camera position, adequate lighting, centring of yourself on the screen and how you appear to those watching.

One of the added problems of virtual exams is the need for reliable technology; it only adds to the stress levels if your internet connection or computer fails mid-exam. The college have produced a useful set of guides (link below) to set out the minimum system requirements as well as a system check to ensure all is working on your computer. Also, make sure that you have a high-speed stable internet connection. I would suggest doing this sometime in advance so any problems can be rectified. It is possible to sit the exam in your place of work but again check this in advance as there may be issues with the hospital's IT equipment and firewall which may prevent the exam software from working correctly. The college will send an email containing details of the Practique system used for the exam and how to access it. The platform requires you to download the exam system ready for the day itself. This can take some time, so it is recommended to do it in advance.

A note on the written examination. The college is currently using software from Testreach, the principles are similar as for the viva with candidates logging into the platform at the given time either from home or a place of their choice. Candidates are monitored remotely via webcam by an invigilator who can also see the candidate's computer screen. A sweep of the room is carried out before the exam using the candidates webcam before being allowed to complete the questions.

This brings me on to the environment: where you choose to sit the exam. It is important you think about this carefully; you don't want the dog barking or the neighbour's building work putting you off mid-answer. Try to choose somewhere where you will not be disturbed, which is quiet, with good lighting and as mentioned a reliable internet connection. If required, you may have to find nearby quiet hotel room with good internet (WiFi access) connection. In case the internet problem occurs on the day or during exam, be prepared to use hot spot from your mobile phone (provide you have good mobile signal).

The night before the exam, check your clothes are ironed and ready, eat well and try and get a good night's sleep albeit from experience this is easier said than done!

On the day itself the exam will start with a video call briefing with one of the exam organisers and all the candidates. This is to go through the exam, give you your login details and to explain what to do if there are any issues or if you get disconnected. They will also give an emergency mobile number in case of problems. Once the briefing is complete candidates will be invited to join their exam on the Practique platform where the examiners will guide you through the questions. Most questions will have resources which the examiner will ask you to look at. You will be given time to review these before being asked the questions.

As with the face-to-face exam there is usually a gap between the two sessions of at least a few hours. I would suggest not using this time to revise but to have a decent meal and relax before having to return to the second session. I chose to watch a film in this time but whatever helps you to clear your mind would be beneficial. The second session will start with returning to the video call briefing before logging onto the Practique system.

After the exam it can all seem a little of an anti-climax as you will log off and it will be all finished. This is the time to take a break from your studies, you will have earned it by that point!

My top tips:

Make sure that you have a quiet space where you won't be disturbed
Check your computer is compatible with the system well ahead of time
Use a desk top computer (preferrable) or a laptop with reasonable size screen
Make sure your internet connection is fast enough
Learn how to hotspot using your phone as a back to internet
Keep simple headphones ready
Practice video calling with programmes such as Zoom, so that you get used to talking to a computer
Get feedback from those you practice with to make sure you're facing the camera, adequate lighting, at the right distance and speaking at the right volume

References:

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Educational journey through video conferencing Platforms in Yorkshire

Dr Tamer Abouzied, Dr Sue Walwyn, Mid Yorkshire Hospitals NHS trust

The Covid-19 Pandemic has significantly influenced the conduct of teaching and exams in anaesthetic training. From the very first day, everyone in medicine realised the urgent need for an alternative method to deliver teaching. Almost instantly, several platforms for video meetings emerged as a potentially practical solution. In this article, we explored our very own experience with few of the most widely used platforms.

ZOOM

At Yorkshire school of anaesthesia, we take pride in the hugely successful exam practice sessions we organise prior to each FRCA exam sitting. Although this has traditionally been face to face, we adapted the process to run remotely via Zoom. Zoom is widely preferred for its functionality, with an easy invitation process, browser and application access with smooth content sharing options. Good connectivity and reliability is paramount for OSCE environment.[1] Gallery view, if enabled, allow up to 49 participants per screen, making pre-exam meetings easier to conduct. Creating breakout rooms could be time consuming and is not fool proof. Keeping the examiner in one room while moving candidates around sounds easy to perform, but having to repeat the process every few minutes, necessitates a dedicated facilitator to organise. We found the option of having a countdown timer with one-minute warning, unique to Zoom at the time, an extremely useful tool for OSCE practice sessions.

Zoom has had bad press for safety and governance issues, and failing to provide an end-to-end encryption. [2] Although theoretically, this may not be an issue when conducting exam practice, it could become problematic if patient's confidential data to be shared. This has deferred some regional hospitals from using Zoom.

Webex by Cisco

This was the first platform available for provision of our 2020 regional anaesthetic teaching in Yorkshire. Setting up a meeting on Webex is relatively a slow process, nevertheless, we felt that once it is up and running, the rest goes on smoothly. It was not till late 2020 when Webex introduced the breakout room option.[3] Hence, our experience with Webex on exam practice, has been so far limited to one mock OSCE session. However, the feedback from the day, particularly on using breakout rooms with countdown timer feature, was nothing short of satisfactory.

Speaking of feedback, it is worth mentioning that using Google forms to collect feedback, was much more effective than the conventional paper format, enabling the organisers to send detailed feedback letters to the presenters, supplemented with graphical representation of feedback data.

Microsoft Teams

Despite initial functionality issues, MS Teams has improved dramatically throughout the year. It's becoming one of the most popular platforms, with 147 million active daily users in April 2021.[4] Although a download is necessary, it will soon be an integrated part of Windows 11.[5] MS Teams has got many hidden useful features, It allows sharing, lobby, messaging function and storage of chat. Sharing presentations in the form of an uploaded PowerPoint, rather than sharing desktop screen or tab, is one handy feature, allowing better to access chat comments.

Managing permissions allows people from the same organization, instant access into the meeting bypassing the lobby. All the chat and files shared during the meeting, can be stored on the chat tap for later access. Organizers can download a copy of the attendee list. So overall, MS teams has been working well for teaching session and courses not requiring extensive breakout rooms' usage.

A major point of criticism frequently highlighted, was that creating meeting links has not been always a straightforward process, as it needs to go through the calendar.

Blackboard

Blackboard[6] is an online learning platform currently used by Leeds University. We used it to conduct a few airway case-based discussion meetings, aimed for fewer than 10 people. It does have a very handy Whiteboard feature, offering a favourable classroom feel. It also provides online polls, improving interaction with the audience.

However, the video meeting section in Blackboard, works only through the browser and the interface could only display 4 participants per screen. Concerns raised about the reliability to use Blackboard[7], seemed to have gained some validity since we ran into trouble on separate incidents, using breakout rooms for a university education course, and later for a mock SOE exam.

Conclusion:

The practical experience on using online platforms for providing medical teaching, has improved considerably over the past year. When it comes down to choosing which platform is best, decision would largely be guided by budget and the variable demand for different functions.[8] We suggest using either Zoom or Webex for the mock OSCE or Viva exams as they are the most suited for the high turnover breakout rooms. Teams and Blackboard may be better for meetings and presentations, although this is changing rapidly as platforms continue to develop. If videos are to be used, third party platform like Vimeo or Youtube could be used which addresses issues of storage and accessibility. If live polling is a consideration, then in addition to the poll function on teams via Forms app, other platforms such as Vevox, Slido or even SurveyMonkey can be used. Using these functions can improve attentiveness and involvement [9], also, will provide the trainer with immediate feedback. It is only a matter of time before the platforms incorporate a facility which provides an automatic level of feedback

Table showing comparison for useful feature when used for education or courses.

Program	Participant per screen	Whiteboard	Breakout room countdown timer	Live poll
BlackBoard Collaborate	4	Included	Not available	Available
Cisco WebEx	5-6 (default) 16 (Grid view) allow 16	Included	Available	Available
Microsoft Teams	Up to 49	Microsoft Whiteboard (Separate app)	Available	Forms (Separate app)
Zoom Video Communications	25 up to 49	Included	Available	Pre-created Polls can be launched

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My experience of the Virtual FRCA exam

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As a self-confessed technophobe I was apprehensive at the thought of a virtual FRCA exam. Rather than being greeted at the College doors and then dumbly herded to the appropriate station at the correct time, I was going to have to competently interact with my computer and all whilst trying not to forget how to interpret an oesophageal doppler trace!

I had passed the final written exam in March 2020 amongst the last set of candidates enjoying a physical exam paper. As a trainee in the West Midlands this meant a trip to Birmingham's botanical gardens, which provides a charming backdrop to what is otherwise a rather miserable ordeal.

The June 2020 SOE was unfortunately cancelled but with the anxiety and uncertainty that came with a global pandemic I cannot say that I was in the right state of mind to attempt it.

And so, at some ill-defined point in 2020 my partner (also an anaesthetic registrar) and I put an end to our lockdown re-decorating and experimenting with vegan cooking in order to focus on passing the December final SOE. Where this would have previously involved going in early or staying late at work to accept viva practice from generous consultants or peers, these sessions could be held online at a mutually convenient time. In fact, it was more appropriate to practice using Zoom, WhatsApp or MS teams as this would more accurately mimic the 'real thing'. As well as the components of the Clarke electrode I needed to consider the components of a good virtual interview, taking into consideration the lighting, sound quality and making sure the camera wasn't pointing up my nose. Virtual practice allows you to see yourself fiddling with a pen, looking down too often or not smiling enough. And if you don't catch it in the moment, you have the dubious pleasure of recording the practice to watch back later. One of the consultants responsible for FRCA teaching in our region organised an extensive timetable of SOE practice, pairing the availability of consultants and post-fellowship trainees with that of the candidates. The quantity and quality of our preparation increased enormously. The move from reality to virtual revision also meant that courses, something I've relied on heavily throughout the exams, could be delivered in the comfort of my own home without the need to travel great distances, pay for hotels or eat too many takeaways. The virtual environment offered me my healthy lifestyle.

As the exam neared, we familiarised ourselves with the college's online platform, Practique. We checked our 'personal IT system', ensuring it was up to date, had enough RAM and that Google Chrome was installed. I read the 16-page manual cover to cover, worrying that every new piece of IT knowledge that I was acquiring would be at the cost of a useful exam fact. My partner and I requested not to take the exam on the same day fearing that our internet speed wouldn't cope and nor would we. We also requested that the maintenance work that had been going on in our apartment building be put on hold for just the two days that we needed quiet.

The day of my partner's exam came. We set up the desktop computer on the dining room table, cunningly positioned to take advantage of the fastest WIFI we could deliver as well as the best lighting and acoustics. She had downloaded the exam on Practique using the ID and password given and had also received a Zoom meeting link for the pre-exam briefing. She had her passport, phone, two sheets of A4 paper and a pen. I wished her luck and left the room.

I tried to distract my nervousness for her with some light revision of the NAPs. Then the fire alarm went off. I couldn't believe it but thought at least it shouldn't last long, it's probably just a test. It wasn't a test and it didn't stop. I went out to investigate and try to turn it off but it was impossible. She was permitted to phone me to ask whether it would soon stop but I could not reassure her of this. A short while later she came out and reported that her exam had been voided. She then relayed this message to a group of sheepish looking workmen adding that their insistence on doing a bit of light sanding could have cost her career. After a few rounds on the punch bag and some mindful breathing exercises she was fortunately able to re-take her SOE 1A & 1B with a helpfully truncated break before the afternoon's SOE 2.

As for my exam, things went along without incident. The Zoom briefing felt rather like being at the college with the usual reassuring faculty there to make everything clear and straightforward. They gave instructions about which group I was in and what my pin number was. Using Practique was simple. I put in my pin number, selected the correct exam and pressed 'connect'. The examiners asked to see my ID and then the exam began. There were thumbnails of the resources and artifacts, which provided helpful hints of where the question was leading (but these must not be opened until instructed to do so). There was a two-step process for ending each exam by first clicking 'logout' and then 'finish now'.

And this is where it felt different. Rather than gathering my belongings and piling into the Square Pig to debrief with other equally relieved candidates I found myself sitting alone in the quiet of my living room not really sure what had just happened.

The good news is that my partner passed the SOE and a few months later I also passed on my second attempt.

A virtually delivered exam wasn't as bad as I imagined. I have first-hand experience of how the exam is supposed to work and second-hand experience of how problems are managed. The faculty are there to support you to do your best and perhaps try even harder to minimise stress. Benefits of the virtual exam include the ability to practice in the exact environment in which you sit the exam allowing for more realistic preparation. There is also a substantial saving in time, money and stress by not having to travel to and from the college. Just bear in mind that you will have to pour your own drink when it's all over.

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Equality, Diversity and Inclusion through the Hull University Teaching Hospitals (HUTH) buddy system: From an International Medical Graduate perspective

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Dr Simon Cousins ST4
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RCOA supports MTI scheme which allows doctors from low and middle income countries to undertake anaesthesia training within the NHS for a maximum of 24 months[1]. I was fortunate enough to be employed by HUTH and was excited to come and work in the UK; however, I found the first few months arduous and challenging due to unfamiliarity, different culture, different teams and the NHS.

As part of the onboarding process in Hull, novice trainees are buddied up with more senior trainees during long shifts in areas like theatres, intensive care unit and obstetrics during the initial few months before they could go solo. This onboarding process helped me with the 3 Cs of Culture, Connect and Clarification.

My work started just prior to the COVID pandemic and was deployed to work in the ICU affecting my wellbeing and morale as I felt lonely away from home, family and close friends. However I felt supported having had an excellent educational supervisor and things started to become positive when I started my Obs module. I was buddied up with a senior trainee with whom I have worked in ICU previously.

Having a familiar person as a buddy and with some previous obstetric experience, I was soon able to integrate with the busy obstetric unit. I was able to get to the grips of various procedures and protocols. Having recognized my previous knowledge, skills, experience and being asked an open question at the start of each shift “What support will I need today?” not only helped to improve my knowledge but also to gain trusts with the midwifes, show confidence in my attitude and also to open up a friendly communication with patients, nurses and ODPs. My decision making skills greatly improved having been exposed to challenging scenarios i.e. difficult epidurals, grade I LSCS and major obstetric haemorrhage and when to seek help under a friendly learning environment with periodic feedbacks and personal reflections. We also shared the values of our culture and shared food during breaks that helped with my overall wellbeing.

This ally ship lasted well beyond the workplace and with a supportive department we worked together and managed to do some QI projects to improve patient pathways. The peer assisted learning sessions, primary virtual vivas and revision days by the Hull ICE initiative helped me pass my OSCE and SOE. After passing my examination I got involved with the Hull ICE and collaborated with other hospitals in the region, started contributing to regional 12@12 virtual teaching and felt inclusive as well as valued.

Having benefitted from this buddy system with successfully gaining my IACOA and core competencies it was my turn to be a buddy to a new trainee in obstetrics. There was some initial fears and anxiety as how well to support a new trainee together with the level of autonomy and freedom to be given in addition to responsibility and ownership of one’s action. However with time this fear was soon allayed with the confidence, bonding and the comradeship ensued.

In summary a friendly and familiar buddying system does reduce the stress of learning, improves morale and sense of support and enhances overall psychological well being[2] However, being a buddy to a new trainee does come with responsibility and may be some training and guidance in mentorship will enhance this experience.

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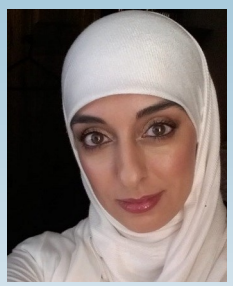

Workplace based assessment: A necessary evil?

Dr Nafeesa Akhtar
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Being a good doctor is hard. Training a doctor to be competent can be more challenging.

How do we learn and assess competency? How do we differentiate between those who just scrape by and those who excel? With the help of a workplace based assessment (WPBA)?

For learners whilst navigating the path of doctorhood, and specialising to be nearly as good as we think we are, we need goal posts. Those set by our supervisors and others who may give us informal feedback, if any, and those set by our peers, as we compare ourselves to those around us. But more importantly we need formal goal posts, set by a body and designed around a curriculum.

From the point of entering training, we enter a field somewhat blindly, and to progress to the next stage we need to prove competence. These are in the way of objective assessments, to allow us to define learning and performance at each level of training. These assessments should be varied in how they allow skills and knowledge to be demonstrated and also standardised to allow for fair and consistent appraisal across the board. Pragmatically, we need to know what we should be able to do, the (slick) skills we need to have, the sound knowledge to support this and how good we need to be. The goal posts and expectations of a FY1 compared to a ST7 doctor and then senior consultant are very different, and so they should be.

For the trainers, I would say most 'assessment' is done subjectively, and can include corridor conversations with other consultants or trainers. As useful as this may be in a clinical setting, it is not an endorsed or meaningful in way of documenting progress through a learning cycle, or providing objective judgement on competence. Again, this is done by way of WPBAs. Many times, in medicine we can observe how setting parameters empowers and encourages people to achieve targets. This may be oxygen titration on a ward, knowledge of when to start an inotrope, or training of healthcare professionals to recognise what they are expected to achieve within a certain timeframe. Doing this in a standardised way allows for structure with the possibility of dynamic learning. The trainer is teaching what is expected and should be taught as per a curriculum and not only what they 'think' should be taught, because 'their way is the best way'.

I believe the issues experienced relate to how invested a trainer and trainee are in the learning cycle surrounding WPBAs. In an ideal world, trainers should be trained on how to assess, how to give structured feedback and be able to reflect on this. Feedback should relate to a curriculum, be resourceful and these exercises practiced. In reality there is not enough protected time for this, most of those who train do so because of their self-motivation and willingness to support the trainee.

Equally on this spectrum are trainees who will prove competence with the 'bare minimum' and those who offer some self-appraisal and are able to reflect and critique their practice. I believe the latter is crucial, because of the inevitable progression of the trainee becoming the trainer.

With the new changes in the RCOA curriculum and the process by which modules are completed, the approach to WPBAs and learning may change. It may encourage a better blend of formative and summative assessment, resulting in more effective learning and evaluation of performance. This will only be effective if both the learner and trainer are invested in the process and adapt accordingly.

Whatever your views regarding WPBAs, or how you choose to complete them I recognise they are necessary. More than a tick box exercise, they exist to provide evidence to others and yourself about the skills and knowledge you hold. This becomes particularly important as your responsibilities change and as you progress in your role as a doctor, and become part of the cohort training the next generation of professionals.

Zambia Anaesthesia Development Program: The bidirectional benefits of a remote International partnership

Dr. Palbha Jain, Dr. Holly Andrews, Dr. Ryan Ellis, Dr. Maria Kansenga, Dr. Hazel Mumphansha

Acknowledgements: Dr. Sonia Akrimi & Dr. Emma Coley

The Zambia Anaesthesia Development Program (ZADP) was established in 2012 to support the delivery of safe anaesthesia in Zambia, where currently there are only 0.49 physician anaesthetists per 100,000 people1. The international partnership has allowed the bidirectional transfer of core knowledge and skills as well as development of additional key areas such as quality improvement and research.

Although face-to-face collaboration has been temporarily suspended since the outbreak of Covid-19, this has enabled the development of the ZADP remote teaching fellowship. There are presently four fellows (all UK anaesthetics trainees) actively involved in co-ordinating teaching with Zambian trainee anaesthetists. This includes seminar-based teaching sessions, journal clubs, morbidity and mortality (M&M) meetings, quality improvement project mentorship and exam practice viva sessions. Regular needs assessment and formal feedback takes place within each of the learning forums, allowing ZADP and the local tutors to keep the educational materials relevant.

Use of videoconferencing platforms has allowed session regularity and continuity of learning, whilst maintaining clinical duties at a time of significant pressure within the Zambian healthcare system. Features such as recording and remote connectivity mean that trainees need not be physically present at the time of session delivery and may also access content at a more convenient time if unable to join live. The positive impact of this approach has been seen with the graduation of five trainees despite the difficulties faced during this pandemic.

Additionally, Zambia has recently seen establishment of a new training programme at Ndola Central Hospital. Use of online platforms for trainee teaching has enabled shared learning between the two training institutions, supported by both local and international faculty.

Local faculty believe that the increased flexibility of online partnerships has improved attendance and allowed involvement of international specialist faculty for both teaching and examinations. There is also the potential to increase interaction with trainees globally by collaborating with international organisations. Zambian trainees have found the mentorship program, increased consistency of journal club and stimulating multidisciplinary discussions arising from M&M case presentations particularly beneficial. Although they would like to see the return of in-country fellows, they have found that there are clear advantages of online learning.

For those based in the UK, the experience so far has been enriching and stimulating. Despite the well documented challenges that come with internet-based collaboration, it has given fellows the opportunity to improve skills in leadership, management, innovation, and clinical governance. Insights into the educational and clinical challenges of the pandemic abroad have challenged understanding of the role of the anaesthetist and given a new perspective to the methods of practice in the UK.

The ZADP remote fellowship was fostered out of a well-established relationship and the advantages are evident. Although the aim is to reinstate in-country fellowships, we strongly believe that remote support has helped continued prioritisation of training despite the challenges faced during this pandemic. The process is ever evolving and we hope to take the lessons we learn and develop the role further, maximising the scope of bi-directional education in international partnerships.

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Social media and technology in anaesthesia training- friend or foe?

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Social media is defined as websites and applications that enable users to create and share content or to participate in social networking. The use of social media has undergone a significant surge in the last number of years with websites such as Twitter having over 330 million active monthly users in 2020. Twitter has become the predominant social media platform for medical education, with the development of free open-access medical education, or FOAMed, as created initially by emergency physicians. With a growing role in the technological world, it is easy to see how social media and online technology can influence education and training in anaesthesia. In order to for this to be beneficial in maintaining standards we need to embrace the positives with the caveat that we are aware of the downsides to social media and technology.

In 2020, the world faced an exceptional challenge with the COVID-19 pandemic, where all aspects of healthcare were challenged, including education and training. Anaesthetists and intensive care physicians were at the forefront of the frontline as we battled and continue to battle this disease. Due to the increased demands on our service and the impacts on training, we were all forced to adapt to change. The role of social media and technology was rapidly adopted in anaesthesia training. We have adapted to provide teaching and training via online video social media platforms such as Zoom or Microsoft Teams. Instant messaging platforms such as WhatsApp have been used to rapidly disseminate important information and guidelines. The speed at which anaesthesia trainees needed to adapt and learn was helped by the use of technology. With clinical information coming from multiple sources, it is important however to ensure that the most important, accurate information filters through. Information chaos leading to alert fatigue is well recognised in the healthcare environment. We live in a technological era where we can be easily accessed by emails, text-messaging and social media alerts; the magnitude of the potential for alert fatigue should be acknowledged.[1]

Anaesthetists have been at the forefront of the medical community in recognising the importance of wellbeing and identifying ways to maintain it. Alert fatigue can potentially have a detrimental effect on this. Whilst individuals can mute messages and review them at their own convenience, consistently categorising messages according to level of importance or the timeframe within which they should be read, using a traffic light system for example, could help facilitate this. Online teaching and training, combined with a lockdown, has for many, provided many more opportunities to log onto events which would otherwise be inaccessible. However, due to the constant availability of events such as webinars and courses, anecdotally many have reported 'over-doing it' and a resultant reduction in their personal time, which can have a detrimental impact. Whilst online video social media platforms have provided an excellent resource for continuing the delivery of anaesthesia training during the pandemic, many of the subtle benefits of attending face-to-face teaching are difficult to replicate including interaction, determining understanding and shared learning. Teaching and assessing practical skills also remains a challenge via online platforms. So, whilst embracing social media and technology have been beneficial for maintaining anaesthetic training particularly during the pandemic, and their on-going benefits remain, we will need to continue find ways to ensure we manage its use, get more out of it, and ensure learning outcomes are being achieved.

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Optimising the anaesthesia placement: An undergraduate's perspective
Dr Hashim Khan (Medical Student)

Placement is the rare opportunity for the medical student to experience 'actual' medicine, after being kept seemingly miles away from patients and reality. The ideal anaesthetic placement would therefore be one that involves patient contact, practical skills and succinctly conveys the nature of anaesthesia.

An optimal anaesthesia placement promotes exposure to patients to improve communication, comfort in clinical settings and understanding of the illness framework. Preoperative assessment with history taking and prehabilitation with health promotion facilitate this patient interaction effectively(1). These situations allow students to elicit information in a difficult real-world scenario promoting skills such as how to take a history. Additionally, in prehabilitation, students will learn to discuss difficult health issues with patients, promoting change persuasively but without judgement. This results in finetuned abilities in active listening, explanation, and putting patients at ease. All of these are clearly transferable communication skills preparing graduates looking into any specialty.

Anaesthesia is a pragmatic specialty involving both general and specific procedural skills(1). For instance, cannulation can be taught to undergraduates effectively and in a reflective manner in anaesthesia. Experiential learning and feedback can build on existing skills to develop a student comfortable with cannulating in a mostly independent but supervised fashion. From the beginning students should be urged to practice skills by their supervisor in a manner where patient safety is prioritised. In a supportive and encouraging learning environment, proactive students will complete core competencies with quality and confidence.

Often very little anaesthesia is in the preclinical curriculum, and so joining anaesthesia is not a natural thought. Therefore, there is a need to foster the desire to pursue anaesthesia. The placement offers a short time for students to observe the empathetic and caring nature of anaesthesia which will influence their career path. When a time for asking questions about anaesthesia is specially designated, a relaxed environment is created, and students can better understand anaesthesia, training and aspects not seen in placement.

The pandemic has emphasised the need for resilience within healthcare education, maintaining standards in the face of overwhelming obstacles to traditional teaching methods. The blending of online and in-person approaches has become a permanent change to undergraduate teaching. I believe that blended learning should be incorporated into placement, distance learning has been shown to be useful in supplementing the teaching of practical skills(2). It further means that students have greater control over their time management and can consolidate their learning after the placement. The consequence is that blended teaching supports students learning beyond placement with greater autonomy leading to improved satisfaction and more competent graduates.

Anaesthesia is an incredible vehicle for medical education, yet it currently has a very restricted contribution, limited to the clinical years. By maximising exposure to patients and encouraging student participation in an alien environment, a placement for producing clinicians will be developed. I believe that by increasing blended learning and simulation, learning can be maximised, and outcomes optimised.

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