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The Society for Education in Anaesthesia UK

Summer 2022 Newsletter

Inside this issue

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Professor Cyprian Mendonca

Join SEA-UK Today

Be part of a growing network of passionate educators in anaesthesia across the UK

The Society for Education in Anaesthesia UK is an organisation that works to provide high quality networks and professional development opportunities for education in anaesthesia in the UK and overseas. SEA-UK is here to provide the advice, support and resources you need to excel your career as an anaesthetist, trainer, educator and leader.

There are a wide range of benefits in becoming a member of SEA-UK that we feel would be valuable for you. These include:

Keeping up to date

- Receive updates on the latest developments in educational methods with the biannual SEA-UK newsletter
- Our new website provides the latest updates in education, making it easy to navigate and find the resources you need

Free webinars

- Join and access our webinars for free

Attending CPD accredited meetings and workshops

- Discounted access to SEA-UK conferences and workshops will keep up to date with the latest developments in education in anaesthesia

Learning from others

- SEA-UK online forums provide a space for like-minded educationalists to network and share experiences and discuss future ideas for education and training (available on our website)

Collaborating with others

- Discuss the latest issues and innovations regarding the Royal College of Anaesthetists' training curriculum and the opportunities and challenges for trainees and trainers
- Get support from trainers and educators from across the UK

Building your portfolio

- Submit articles on educational topics for free. These are published in our biannual newsletter or in the RCoA Bulletin magazine
- You will be a member of 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

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Kind regards

Cyprian Mendonca	Peeyush Kumar	Claire Halligan	Umair Ansari
President SEA-UK	Secretary SEA-UK	Treasurer SEA-UK	Webmaster SEA-UK

Letter from the Editors

Dear Reader,

The six months since our last Christmas newsletter has seen a number of developments for the SEA-UK. There have been some big changes in the committee, with the esteemed Dr Sue Walwyn stepping down as President. Congratulations to Professor Cyprian Mendonca in his new presidential role, and also to Dr Claire Halligan as the new treasurer. At the beginning of this year we welcomed two new members to the committee, Dr Sam Lillywhite, specialist registrar from University Hospitals Bristol, who wrote for our December newsletter, and Dr Rachel Holmes from Harrogate District Foundation Trust, an ACCS anaesthetics trainee with an interest in medical education. These doctors, as trainees, act as key liaisons between the SEA-UK and are here to help encourage the next generation of UK anaesthetists to get involved with the educational and funding opportunities offered by our society.

We continue to develop our online resources. Our webmaster, Dr Umair Ansari, has been working hard on creating a forum for sharing ideas between fellow educationalists, and making an educational resources section with links to documents on appraisal, feedback, mentoring and doctors in difficulty.

The SEA-UK continues to grow with 270 members. Our very popular annual scientific meeting was held in Warwick in May with 58 abstract submissions to our poster competition. 52 individuals were selected for poster presentation, reflecting the quality of work these trainees have produced. Each of these individuals was given a membership to SEA-UK for one year. Congratulations to Dr Nicki Russell our winner of the oral presentations, who gave an excellent presentation on 'Levelling the medical hierarchy: a novel method for teaching emergency front of neck access'. Also congratulations to Dr Sreyashi Sen and colleagues who won the poster competition with 'Managing the aftermath of death in theatre: introduction of simulation based workshop'. Our guest speakers were outstanding, and we have included summaries of what they had to share in this newsletter. Our next ASM is booked in the beautiful Cambridge on the 14th May 2023, see page 5 for details and keep an eye out for poster presentation submissions and tickets.

In our mission to stay up to date with UK anaesthetic education, we have also decided to develop our logo, with in-house designs being worked up by our logo team: Dr Rachel Holmes, Dr Sam Lillywhite and Dr Peeyush Kumar. We encourage members to vote on their favourite design, which can be seen on pages 20-22.

We look forward to presenting a webinar for AAGBI on 22nd September on 'FRCA exams - the road to success' where the SEA-UK will discuss the exam format and top tips for trainees. There is a discounted price for SEA-UK and AAGBI members. Also keep an eye out for our next Bulletin article, written by Dr Sam Lillywhite.

There are many opportunities for our members, see what you can gain from being a member on page 2, with details of how to join at the end of the newsletter. Look out for opportunities to write for SEA-UK, and we are pleased to publish some excellent review articles written by members in this newsletter.

Wishing you all a wonderful summer, good luck to those who have new postings this August and we look forward to seeing you at our ASM next Spring. Don't forget to follow us on Twitter @SEATWEETUK.

Yours faithfully,

Claire Halligan
Editor in Chief

Rachel Holmes
Junior Editor

Featured photgraph page 1
"Newborough"
Photograph courtesy of Dr Jacqui Points, Wrexham Maelor Hospital

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Letter from the President

Professor Cyprian Mendonca

Welcome to the SEA-UK Summer Newsletter 2022

I hope you all are enjoying the sunshine and warm weather. As the pandemic restrictions have eased off, I am very pleased to see a rise in face-to-face educational meetings and conferences. One of the disadvantages of virtual meetings is being suddenly cut off from the environment, just a blank screen in front of you whilst eagerly waiting to talk to someone in the team. Another, which is even worse, is when a meeting ends suddenly mid-sentence! Our recent face-to-face annual scientific meeting in Warwick was extremely successful. After long tiring MS teams and zoom meetings, the ASM provided a great opportunity to meet like-minded people and to share our ideas and experiences.

We are continuing to run free webinars, giving our members the opportunity to keep up to date with new developments in medical education. In collaboration with the Association of Anaesthetists, we also have a webinar in September highlighting the format of the FRCA exam and providing practical tips for trainees preparing for the FRCA exams. Our SEA-UK webinar in November will focus on developing reflective and professional anaesthetists.

We have essay competitions and four educational grants available each year. Please let trainees in your department know about these opportunities and encourage them to get involved and apply.

Next year's ASM is scheduled for 15th May 2023, in Cambridge, the theme being trainee support and development. Please save the date and visit our website for further details.

Wishing you all an enjoyable time and well-deserved break this summer.

Cyprian

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SEA-UK Annual Scientific Meeting 2023

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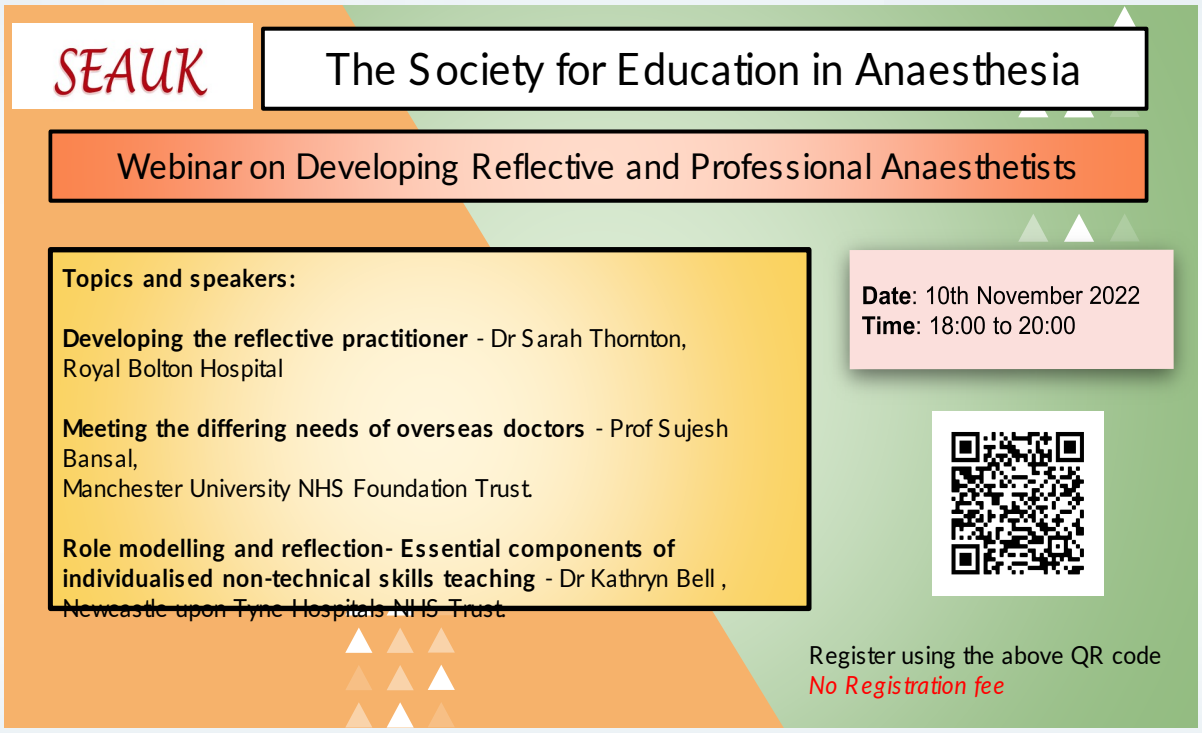
SEA-UK Webinar November 2022



ASM KEYNOTES

Role of the CEO in provision of high quality medical education

Prof David Loughton, Chief Executive The Royal Wolverhampton Trust

S*ummarised by Dr Rachel Holmes, Junior Editor for SEA-UK*

Professor Laughton gave a very insightful talk at the annual scientific meeting on his career and his dedication to medical education. He has a background in engineering and has a wealth of experience working in the NHS in leadership roles.

Having worked in numerous hospitals around the West Midlands, he also helped establish Warwick University's Medical School (WMS) and secured £400 million funding for the Coventry New Hospitals Projects which houses the WMS clinical skills building. He is now the longest serving chief executive in the NHS, having held this position at Wolverhampton since 2004. He has turned around one of the country's 17 most financially challenged hospitals to one rated highest in satisfaction for medical students and top 5 in the country for junior doctor satisfaction.

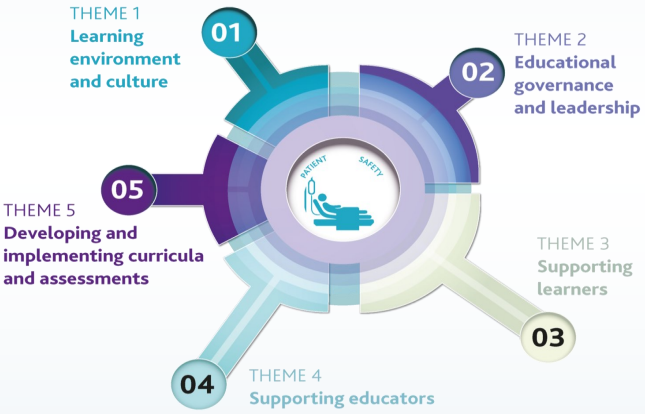
His mantra is simple, contented staff leads to better patient care. Education, promotion opportunities and fair pay are key to staff satisfaction. By ensuring these three things, staff recruitment and retainment are guaranteed.

Supporting Educational Faculty

Prof Sailesh Sankar, Consultant Endocrinology,
Director Medical Education-UHCW, Associate Postgraduate Dean,
HEEWM

Summarised by Dr Claire Halligan, Editor in Chief for SEA-UK

This was a really engaging and thought provoking presentation exploring the needs and challenges to supporting medical educators. Promoting medical educators is one of the key themes when it comes to setting standards in post graduate and medical undergraduate training.



There are some real challenges in terms of balancing service provision and education, such as political, economic, legislative as well as environmental and technological barriers. The workforce is also changing and supervisors need support with this, so they can provide good supervision. Increasing numbers of IMG doctors are being employed to support services and we need to support these doctors in terms of training and job progression. Supervisors need training and support on how to provide supervision to a diverse group of trainees from different cultural backgrounds.

Being a supervisor is a multifaceted role and barriers to effective supervision are numerous such as proximity (e.g. LTFT), inadequate number of trainers, work pressures, knowledge (e.g. different portfolios), COVID-19 (e.g. sickness, burnout).

Educators are an integral part of the NHS and such need to be recognised, valued, supported and have their role developed over time with adequate training.

The role of a medical education faculty was explored and benefits highlighted.

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

Summarised by Dr Sam Lillywhite, SEA UK Council member

Dr Cliff Shelton gave a fascinating and highly relevant talk on the place of sustainability within the new curriculum. He began with a brief history of sustainability within anaesthesia, in particular how we as a speciality have identified the key causes of CO_2 emissions within our practice. He gave an insight into how effective initiatives to decrease volatile anaesthetic and nitrous oxide use have been on the national level. It was useful to see how anaesthesia emissions fit into the larger picture of NHS emissions as a whole, particularly given the NHS target of being 'net zero' by 2040.

Dr Shelton then described how the topic of sustainability has been integrated into education both at an undergraduate and postgraduate level. At the postgraduate level in anaesthesia, the new stage 1 curriculum details the expectation that trainees should be aware of the environmental impact of their practice and the principles of sustainable practice. This integration is also now being seen in other healthcare curricula, notably now being integrated into the midwifery training programme.

With the increasing integration of sustainability into the postgraduate curriculum Dr Shelton then detailed a host of ways in which these new curriculum requirements could be met by trainees progressing through their careers. He highlighted a useful eLearning resource available on the RCoA website and 'e-Learning Anaesthesia' (e-LA) website which could be used to evidence knowledge of the key concepts of sustainability. Dr Shelton recommended this resource as a useful introduction to the topic before going on to detail a myriad of practical ways to get involved in sustainability projects within the workplace.

Dr Shelton is the environmental lead in his department and advised any interested trainees to get in touch with their lead to see what current quality improvement (QI) projects are ongoing. He detailed a particular project at his trust involving the measurement of how much nitrous oxide was being used by the anaesthetists during cases compared with how much the trust was purchasing. This simple research project revealed the trust was purchasing 450 times more nitrous than was being used. A simple intervention (disconnecting nitrous from machines and having two cylinders available if required) led to a 4% decrease in the CO_2 footprint of the entire trust. Dr Shelton detailed how there are numerous similar simple projects within the field of sustainability that trainees can target within their trusts to produce effective change.

Dr Shelton went on to discuss how involvement in these topics could be used to evidence a number of competencies within the stage 2 and 3 curricula. Dr Shelton also gave an introduction to the fellowships available through the 'Centre for Sustainable Healthcare' for any trainees interested in pursuing this topic further.

Supervision of MTI trainees and locally employed doctors

Dr Sujesh Bansal, Associate Director of Medical education
Director: Manchester International Fellowship Programme

Summarised by Dr Atideb Mitra, SEA-UK Council Member

Dr Sujesh Bansal shared his experience in creating the ideal educational environment for supervising Medical Training Initiative (MTI) trainees and locally employed doctors (LEDs).

MTI trainees and LEDs now comprise a substantial proportion (around 5000 i.e. 19%) of the UK workforce. However less than half the overseas trained doctors experience uneventful career progression and there is a statistically higher probability of referral to GMC. Dr Bansal provided an insightful analysis into the causes of differential attainment including a broader understanding of *cultural nuances* in **leadership structure**, **supervision models** and **feedback** delivery which impact effective team-working. He proposed an effective strategy of early high impact educational interventions to provide support to this group of trainees often using illustrative examples.

Dr Bansal suggested that supervising a multi-cultural team requires a broader understanding of leadership structure across cultures. The relatively more **egalitarian** and consensual leadership structure in UK sharply contrasts top-down hierarchical structure in India, China or Saudi Arabia. Cultural differences in communication including assertiveness and emotion also affect team-working. Similarly, there is a cultural difference in supervision style as UK trainers are likely to be **emotionally inexpressive and non-confrontational** and provide indirect negative feedback. This contrasts feedback styles adopted in India or US leading to a risk of **misinterpretation of feedback**. It therefore imperative that there is a mutual understanding of these subtle cultural nuances. To address this issue Dr Bansal advocates a two-pronged approach. A programme of enhanced induction and supervision of overseas trainees but also a training day for trainers to specifically prepare them for the challenges of this role.

The success of the MTI programme rests on a process of **robust recruitment**, **enhanced induction** as well as **enhanced educational supervision**. He proposes a strategic approach advocating allocation of placements and supervisors based on the educational needs of trainees and enhanced programme of induction focussing on social linguistic skills to improve **cultural competence**. He proposes early risk assessment based on ESR/MSF and a questionnaire to identify specific targeted interventions.

Dr Bansal pointed us towards the available resources for IMGs including the Welcome to UK practice conference (GMC) the standardised induction and support guidance.

Dr Bansal emphasised the importance of the first ES meeting within the first two weeks and an MSF in the first three months. Overseas graduates often have diverse experience with areas of considerable expertise interspersed with areas of relative inexperience. The ES should explore the trainees career aspirations personal and family situations including intention to appear for professional examinations in formulating a short term (3 months) and a long-term PDP.

Dr Bansal emphasised the role of pastoral support provided by ES as well as a **buddy system**. Looking into the future he proposed a session on **how to supervise IMGs** as a part of standard ES training days. He also proposed a session on the **effect of culture on team-working** for all IMGs as well as UK trained doctors to promote cohesion within a multi-cultural team.

Coaching and Mentoring Skills

Interactive Session by Dr Rebecca Viney and Mr Matt Driver

Summarised by Professor Cyprian Mendonca, President of SEA-UK

Rebecca Viney and Matt Driver delivered an interactive session on 'Coaching and Mentoring' and facilitated the understanding for the need of coaching and mentoring in the day-to-day life of doctors. "Coaching and mentoring are learning relationships which help people to take charge of their own development, to realise their potential and achieve results which they can value". The General Medical Council recognises that coaching and mentoring skills are important for ensuring doctors deliver safe, effective and efficient patient care as soon as they start a new job. Coaching and mentoring should be differentiated from other development roles such as patronage, appraisal, educational supervision and management. The objective of both coaching and mentoring is to facilitate personal and professional development of a mentee. The key qualities of a coach include a high level of self awareness, genuine interest in others, open and approachable style, humility, integrity and confidentiality.

The session involved delegates in pairs taking part in active listening exercises. Delegates were asked to think of someone who had a strong positive influence on their development and growth, why they influenced them and what their influencing behaviours were. Then they explained these to each other in their pairs, and delegates had to practice and appreciate the role of active listening skills. There were further group exercises exploring core skills and qualities of a mentor and coach . The session enabled the delegates to learn the principles of mentoring and coaching.

This house believes that poor performance is related to poor decision making

Opposer — Dr Mark Stacey, Consultant Anaesthetist, UHW, Associate Dean, HEIW

Summarised by Dr Sue Walwyn, Past-President

The end of the day is nigh and attention is sagging. Why not have a debate from two experts who can present their opinions gently and humorously thereby persuading the audience? No parliamentary debate or classic competitive debate here - after all this is an educational conference. Both the debate format and the question: "Bad decision making is responsible for poor performance" were chosen with this in mind. Dr Mark Stacey opposed this statement, following on from Professor Byrne.

Mark with his interest in trauma management and publications on decision making, particularly under stress was a natural choice. He made a persuasive stand looking at how we make decisions as individuals, in particular with respect to the process and skill. Theories include the classic "hypothetic-deductive" model , processes including the information gathering, synthesis and testing of a hypothesis and the subsequent feedback reflection, or the Pierce "abduction" model is more of a feeling informed by pattern recognition.[1.] The process of pattern recognition may well be informed by experience and the knowledge of common probability.

Mark argued that decision making is a skill and a product of a complex series of influencing factors, hence it is not the decision but the decision making process that is at fault. Reason classifies errors into those which are "knowledge, skills or rule based"[1]. Taking Mark's point, the errors may occur because of lack of training, support or inappropriate teaching environment. Skills are similarly affected by environment and circumstance, although particularly in craft specialties, judgement is arguably more important and more open to influence from both external factors and internal bias. Application of current rule bases and guidance are also open to poor interpretation and associated error or poor performance. Internal bias can be seen as an important factor affecting decision making within anaesthesia.

Bias itself is a broad term, but Stiegler classifies the most important as:

- confirmation bias (looking for any factors that confirm one's preset hypothesis)
- visceral bias (the different treatment process for patients who are accepted as different. For example using a particular technique for an individual on non evidence based grounds)
- omission bias (the lack of activity such as in the need for a surgical airway)[2]

Other forms of bias include anchoring which leads to an Occam's razor situation, whereby the lack of options for a solution limit the possible outcomes. In loss aversion bias the individual prefers to stay with the familiar, possibly to the detriment of considering the alternatives.

Daniel Khaneman a psychologist with an interest in behavioural economics, talks about this is his book "Thinking Fast and Slow" [3]. He classifies decision making into system 1 and system 2. Mark referred to this as an illustration of how we make decisions and how the quicker intuitive system 1 can be prone to error, especially under pressure where we opt for the familiar.

The point of the debate was how to address this problem. Not only is there a need to look at the psychology underpinning decision making but also how we teach. Mark refers to Dan Willingham here: somewhat contentiously he refuted the idea of learning styles and felt that good teaching would achieve much more than sticking to the learning styles approach. The following person he quoted was Ericsson who suggests that to improve a skill we need to push ourselves beyond our safety zone. Lastly it was Brailsford - performing it right, as we all know about the Sky cycling team.

By the end, Mark had persuaded the audience that we need to look at this as a skill and how it exists in the community of environment, we need to address each area and performance is the cumulative outcome, not the direct result. However as Mark said at the end, he could have argued either view and both were complicated. As Victor Hugo wrote in Les Miserables; “the straight line, a respectable optical illusion which ruins many a man”.

1. The thinking doctor: clinical decision making in contemporary medicine. Trimble, M. Hamilton, P. Clinical Medicine 2016 Vol 16, No 4: 343 -6
2. Cognitive processes in Anesthesiology Decision Making. Stiegler, MP. Tung, A. Anesthesiology 2014 Vol 120: 204 - 17
3. Khaneman D. Thinking fast and slow. London: Penguin Books, 2012

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This house believes that poor performance is related to poor decision making

Proposer— Prof. Aidan Byrne, Co-Lead for Quality, Swansea University
Summarised by Dr Tracy Langcake, SEA-UK Council Member

To answer this question we first need to understand: what is meant by a poor decision and how do we make decisions?

It's common to think of the brain as a digital computer. Using an analogy about car engine management unit being the 'brains' of the engine, as it is programmed with knowledge and has sensors. The brain consists of neurones that fire like an electronic circuit, data processors and memory stores similar to a digital computer. They are good at simple, accurate, reliable and unbiased.

A better analogy is thinking of the brain as an analogue device like a carburettor. It is a collection of seemingly unrelated bits that when put together in a specific relationship can make quick decisions. Research has been done suggesting that it's not the neurones that process information, but rather the individual dendrites, which affect those around them. The brain should be considered as a single functional unit, with an enormous collection of dendrites with massive interconnectivity. Depending on the sensory input your brain will shift into a particular mind state which will influence behaviour. An analogue device is fast, but not precise or reliable and are good with complex and resistant the damage.

What he argued is that all our past experiences, from internal and external factors during embryonic development, as well as the immediate external environment will affect how your brain develops and will lead to our current mind state. So our brain is a constantly on, constantly changing and shifting analogue computer based on what's happened previously and what's happening around it in the moment and the output is what we call decisions.

Decision making is a highly complex and complicated process, dependant on the current environment, recent experiences and a mind state built up over years of experience, trial and error and emotions. It's important to note that emotions play a huge part in decision making.

How do you get the right decisions? If you do something once there is a temporary change within the dendrites of the brain, but if something is done repeatedly there is a more permanent change within the brain – sustained deliberate practice. This hardwires that mind state into your brain and the more often you use deliberate practice the more reliable and accurate the outcomes. A deterrent to this is learning using modules which can be done without forming permanent changes to our mind state as the learning is not practiced and therefore only causes temporary changes. Theory without practice can be disadvantageous - learning in an isolated practice can be detrimental since you could learn bad practices/habits and it is then extremely difficult to 'unlearn' them as they have been hardwired into the brain.

Poor performance IS related to poor decision making, but only if we recognise what is actually happening within the brain. Our brains are analogue devices that need experience, development and care to make the right decisions.

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Are we doing enough to teach TIVA?

Dr Simon Saward
Core Anaesthetic Trainee, Aneurin Bevan University Health Board

Total Intravenous Anaesthesia (TIVA) is an essential skill for an anaesthetist [1] and the benefits are numerous - it is vital that we as anaesthetists have the ability and confidence to provide an anaesthetic safe for a patient with malignant hyperthermia (MH), or for those at increased risk of post operative nausea and vomiting (PONV). These are only a few reasons why it is important that we feel confident in providing a TIVA anaesthetic and this can be evidenced by the greater emphasis placed on TIVA in the new RCoA 2021 curriculum [2]. Furthermore, National Audit Project 5 (NAP-5) showed that the large contributory factor to accidental awareness under anaesthesia when using TIVA was a lack of training [3].

As a core anaesthetic trainee, my confidence in using TIVA is significantly lower than that of a traditional volatile anaesthetic. In order to explore the confidence levels and training experience of the other trainees, with the aim to gather attitudes and feelings, a survey was sent to all the anaesthetic trainees in our Health Board (Wales). The electronic survey explored trainees' exposure to TIVA, whether they felt it an important skill, the training they'd had, confidence/competence levels of performing a solo TIVA anaesthetic, and whether they felt more TIVA training would be beneficial.

The results of the survey showed that all felt it was important to be confident in providing TIVA, despite this, only just over half of the respondents felt that they would be confident in providing TIVA solo. Approximately eighty percent felt that they had not received enough TIVA training during core training, approximately only ten percent had attended a formal TIVA training session at each level of training, and around ninety-five percent felt a formal TIVA training would be beneficial. Breaking down the survey into the different stages of training it was clear that the core trainees were, perhaps understandably, the least confident, with approximately ninety percent feeling unconfident in using TIVA solo. The feeling that formal TIVA training would be beneficial spanned across all stages of training.

Despite it being an important skill for all anaesthetist and now a core part of the new RCOA 2021 curriculum, the difficulties and roadblocks in learning TIVA are potentially numerous. Not every consultant practices it, the variety of models, the perceived rigmarole and complexity involved, lack of pumps, lack of exposure, and the 'fear' of awareness are to name but a few.

Having identified a common theme amongst trainees' attitudes towards TIVA training and education, the aim is to work with consultants in the department to provide a more formal TIVA training session; the idea being to incorporate this into the novice teaching programme so that trainees are exposed to TIVA early and given a basic method for a TIVA anaesthetic. This is not to say that there is only one way to perform a TIVA anaesthetic, rather the aim will be to give a starting point for trainees to begin their TIVA practice, and from there it can be developed and adapted as required for increasingly complex patients.

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References

[1] Nimmo, A., Absalom, A., Bagshaw, O. Et al. Guidelines for the safe practice of total intravenous anaesthesia (TIVA). *Anaesthesia*, 2018. 74(2), pp.211-224.

[2] Royal College of Anaesthetists (RCoA). 2021 Curriculum for a CCT in Anaesthetics. Version 1.0 August 2021 p68 + p99

[3] Pandit J, Cook T. Accidental Awareness during General Anaesthesia in the United Kingdom and Ireland: Report and findings. NAP5,5th National Audit Project of The Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland. London: RCoA; 2014 (https://www.nationalauditprojects.org.uk/ NAP5report?newsid=1187#pt).

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

Striving for excellence: assessment and the excellent trainee

Dr Anna Greenwood
ST6 Anaesthetics, Leeds Teaching Hospitals NHS Trust

Excellence is 'the quality of being outstanding or extremely good'[1]. We perceive and measure excellence in anaesthetics through quality and criteria met, for example the Royal College of Anaesthetists' Clinical Services Accreditation (ACSA) scheme[2]. We can report excellence using schemes such as Learning from Excellence (LfE)[3], where those acting above and beyond can be recognised. We use the identification and measurement of excellence to share good practice, ensure safe patient centred care and facilitate reflective and iterative improvement[2].

So, what of the excellent colleague? We can all easily identify a consultant or trainee who inspires us with their excellent practice. These positive outliers use the same resources as the rest of us, yet they excel in the face of the same adversity. Arguably, we should be proactively learning from these individuals and feeding back their solutions into the system (positive deviance[4]). A nice contrast to reactively responding to errors, which has been a mainstay of improving patient safety since the 1990's[5].

Anaesthetists have tried to pin down the complex qualities of an excellent anaesthetist[6,7,8]. The traits identified include fundamental clinical skills, proactively striving for improvement, open-minded innovation and communication at all levels. This includes humility, enthusiastic teaching and a pastoral support of trainees, going the extra mile, and positive relationships with patients. Cultivating a picture of a well-rounded individual who also utilises the anaesthetic non-technical skills (ANTS) of task management, team working, situation awareness and decision making.

Assessment plays a key role in inspiring the next generation of trainee anaesthetists to strive for excellence, underpinned by role modelling, and the creation of the right environment[8]. The role of excellence in anaesthetic training assessment goes 'beyond ensuring competence […] to recognise and promote excellence'[6]. The GMC mandates excellence through their design of the curriculum and training programmes[9]. The new curriculum appears to allow for this, through advancing beyond a spiral curriculum that adds the next layer and suggests you just need to be 'good enough'. The new 'outcomes based holistic approach' incorporates developments in medical education and addresses the needs of anaesthetists in training, patients and the wider NHS'[10], and thus 'serves as a scaffold to the achievement of excellence'[11].

Using assessments, we can we learn from excellent trainees. The SLE (supervised learning event) encourages meaningful conversations; utilising frameworks and signposting excellent practice. It can record the identification and measurement of excellence. The trainee anaesthetist is expected to have an increasingly supervisory role, and will complete SLEs for more junior trainees. This is relevant to their own portfolio as a record of their reflective practice, building upon the understanding and beliefs of the practice, and the development of judgement and wisdom of the Professional Artistry of the Anaesthetist[12]. Importantly, the critique of which aspects of a trainee's practice are excellent will allow for reflection upon why and how this was achieved. This may be fed back into the understanding of their practice, and gives the opportunity for the practice itself to be disseminated to others in future encounters. This will help both those struggling trainees, and those who are meeting the standard but could have their skillset improved, freeing up time and mental capacity to work on other skills.

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We need to remain cognizant of excellence and its role in assessment and training. In the same way we are taught to assess and support the under-performing trainee, it is still imperative that we nurture and promote excellent practice too. Using the SLE and meaningful learning conversations to provide support, and to feed-back the learning into training, we are ensuring support for and are striving for overall excellence at all levels of anaesthetic training.

1. Excellence (2022) Available online: https://lexcio.com/en/definition/excellence [Accessed July 2022
2. Donald, F. (2022) The president's View A NEW STRATEGIC APPROACH FOR THE COLLEGE *Bulletin* (RCOA), Issue 131, January 2022, 4-5.
3. LfE (2022) *LfE Homepage.* Available online: https://learningfromexcellence.com [Accessed July 2022]
4. Lawton, R., Taylor, N., Clay-Williams, R. & Braithwaite, J. (2014) Positive deviance: a different approach to achieving patient safety. *BMJ Quality & Safety*, 23(11), 880-883.
5. Vincent, C. & Amalberti, R. (2016) *Safer Healthcare: Strategies for the Real World*. Cham: Springer Open.
6. Smith, A.F. & Greaves, J.D. (2010) Beyond competence: defining and promoting excellence in anaesthesia. *Anaesthesia* 65, 184-191.
7. Smith, A.F., Glavin R. & Greaves J.D. (2010) Defining excellence in anaesthesia: the role of personal qualities and practice environment. *Anaesthesia,* 106(1), 38-43.
8. Shelton C.L. & Smith A.F. (2013) In pursuit of excellence in anaesthesia. *Anaesthesia*, 110(1), 4-6.
9. GMC Excellence by design: standards for postgraduate curricula (2017) Available online: https://www.gmc-uk.org/-/media/documents/excellence-by-design---standards-for-postgraduate-curricula-2109_pdf-70436125.pdf [Accessed July 2022]
10. RCOA curriculum 'The Handbook' (2021) Available online: https://www.rcoa.ac.uk/sites/default/files/documents/2022-01/RCoA%202021%20Curriculum%20Handbook%20final%20v1.2.pdf [Accessed July 2022]
11. Shippey, B. & Nixon, M. (2021) Defining standards: the 2021 Anaesthetics Curriculum part two. *Bulletin* (RCOA) Issue 126, March 2021, 34-35.
12. Shippey, B. & Nixon, M. (2021) Defining standards: the 2021 Anaesthetics Curriculum part one. *Bulletin* (RCOA) Issue 125, January 2021, 48-49.

SEAUK

STrIPEs - an MDT Simulation Teaching Programme In Obstetric Anaesthesia

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Collaborative learning is of increasing importance in anaesthetic practice. In the light of the Ockenden enquiry, the mantra that "staff who work together must train together" could not be more significant. Indeed, the 2021 MBRRACE report also emphasises the importance of working as an effective multidisciplinary team (MDT). Birmingham Women's Hospital is a tertiary centre responsible for more than 8,000 births a year and cares for obstetric patients with complex medical pathologies, such as cardiac and liver disease. Collaborative learning in this setting is central to working as a cohesive unit and we identified the opportunity here for a MDT teaching program.

STrIPEs (Simulation Training in Perinatal Emergencies) is a monthly MDT teaching program which focuses on emergencies in obstetric anaesthesia. Scenarios include themes such as failed intubation, local anaesthetic toxicity and maternal cardiac arrest. Candidates from both anaesthetics and obstetrics are invited to work together through various scenarios, with the sessions facilitated by an anaesthetic and an obstetric registrar. The focus is not solely on the management of the scenarios, but also on human factors and team-working between the different specialties. It provides an opportunity to learn from each other and to discuss our priorities and thought processes, away from the demands and distractions of the labour ward.

The sessions are two hours and cover two simulated emergency scenarios, each followed by a debrief, a short teaching session and a group discussion. We use SimMom to aid us in creating dynamic, evolving clinical situations that unfold in response to the team's actions. We recruited additional staff such as midwives and consultant colleagues to act in the simulation to give the session authenticity. The debrief was framed around the diamond debrief technique and we encouraged input from consultant colleagues to guide the discussion.

Enthusiasm for an MDT teaching program was palpable from the outset, and I believe most clinicians can relate to the benefits of such a program. Of particular note, the debrief and discussion after each scenario is where most collaborative learning takes place. Feedback from the candidates was overwhelmingly positive, with a particular emphasis on the advantages of learning about each other's perspectives.

The complexities of different departments, each with unique demands and workloads, meant creating a teaching timetable was a challenge. I found that the key to working well together was to dedicate sufficient time upfront to establish goals and construct a robust timetable. Looking forward, I hope that STrIPEs can evolve to include teaching even more members of the multidisciplinary team, such as midwives and operating department practitioners (ODPs).

Tips for setting up an MDT teaching program:

- Dedicate sufficient time at the start of the project to establish common goals.
- Keep scenarios pertinent to all teams involved. We paired scenarios that were more relevant to anaesthetists (such as local anaesthetic toxicity) with scenarios that were more relevant to obstetricians, to keep each teaching session applicable to all.
- Create a timetable before starting and book equipment and rooms well in advance to minimise disappointment due to unanticipated clashes and cancellations.
- There are added benefits to holding the session in a realistic clinical environment, but the nature of emergency work means that labour ward rooms and theatres may be in use on the day. Always have a back-up location booked that can be used. Alternatively, a sim theatre suite is a great option, if you have access to one.
- Keeping teaching appropriate for a specialty that is not your area of expertise can be a challenge, so have back-up faculty from both specialties available to step up in case of sickness.

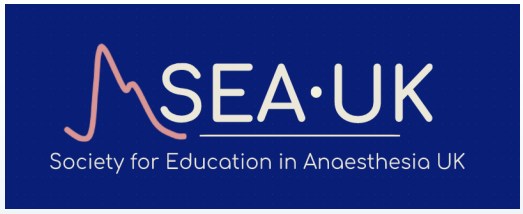
Redesigning the SEA-UK Logo

Drs Rachel Holmes, Sam Lillywhite, Peeyush Kumar
SEA-UK committee logo team

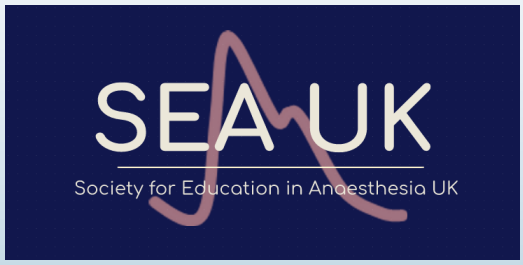
The SEA-UK's logo has been in its original classic format for a number of years. With some new members in the committee we have been putting our heads together to come up with a fresh way to represent the society. We believe the logo should be vibrant, modern, pleasing to the eye. It should incorporate an anaesthetic 'vibe' and be timeless, representing the SEA-UK for years to come.

All designs have been produced 'in-house' and we feel it is important for you, our members, to be involved in helping to decide which logo would represent our society the best. We present to you a few designs which we have shortlisted, and have provided a Survey Monkey quiz for you to complete to vote on your favourite. (please scan the above QR code).

Logo 1 (above)



Logo 2 (above)



Logo 3 (above)

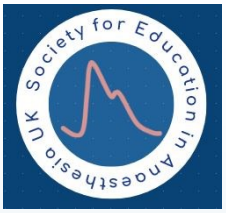
Logo 4 (above)

Scan to vote

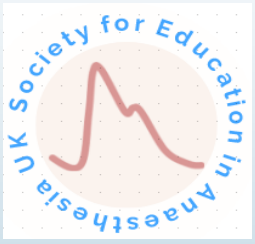
Logo 5 (above)

Logo 6 (above)

Logo 7 Original logo (above)



Emblem 1 (above)



Emblem 2 (above)

Emblem 3 (above)

Scan to vote

Emblem 4 (above)

Emblem 5 (above)

Let the logo team what you think!

Please complete our survey at:

https://www.surveymonkey.co.uk/r/77LNGJF

Or scan the QR code (above)

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SEA-UK Essay Competition 2022

Essay Questions

Trainee Prize: £50

-80% Less Than Full Tim Training (LTFT) should be the new normal. How will this affect the future workforce?

Medical Students £50

-Should undergraduate teaching dedicate modules to professionalism?

DEADLINE: MIDNIGHT on FRIDAY 30th SEPTEMBER 2022

Please send your submissions to Dr Peeyush Kumar (Abstract Co-ordinator) at secretary@seauk.org with a copy to Mrs Cath Smith (SEA-UK Administrator) at administrator@seauk.org as a Word document.

Guidance tips

Please include:

Entries are now invited on the above essay titles from medical students and anaesthesia trainees (CT1-ST7).

Only one author per entry will be accepted.

All entries will be anonymised and judged by members of the SEA UK committee. The judging panel looks for well-written entries that demonstrate critical thinking and reflective practice.

Maximum 1200 words (excluding title and references). Please use Times New Roman size 12 font and double line spacing.

Maximum five references can be cited using Vancouver style. References must be numbered sequentially as they appear in the text.

Winners will also receive complimentary registration to the 2023 SEA UK Annual Scientific meeting.

The winning essay will be published in the SEAUK Winter Newsletter.

Any further queries should be emailed to secretary@seauk.org.

SEAUK

SEA-UK Educational Grants

SEA(UK) Educational Grants We are pleased to invite members to apply for one of 4 x £500 educational grants. Criteria: SEA UK grants can be used towards any prospective educational research and quality improvement activities that falls within the broad interest of education in anaesthesia.

Funding may be sought for:

- Travel to undertake and educational activity that is generally not available in the region.
- Travel to present the original research activity
- Educational activities that develop education for anaesthetists and must be above the widely available activities
- Necessary fees for access to data or to complete the project that can be justified

Applicant must already be a SEA-UK member to apply (or join at time of submission).

Specific Exclusions: No retrospective funding can be given. We cannot subsidise OOPE. We cannot support teaching on courses and postgraduate courses.

All publications must acknowledge SEA UK as a funder. On completion of the activity a report, including an 800-word article for the newsletter, is expected. You may be invited to speak at our ASM

How to apply Application: Use 1-inch margins max, strictly in 11 point Arial script, single spaced, submitted as a word doc or pdf file. Page 1: Single page detailing title of project, applicants (names, positions, qualifications, contact numbers and emails). Page 2: The body of application must be no longer 500 words. This should include details of the project undertaken and the costings involved. Please send applications to:administrator@seauk.org. Deadline for submission is TBC

SEAUK

SEA-UK Membership

Membership fees:

Full membership is £25 per annum paid by standing order

How to join:

https://www.seauk.org/join-seauk

or download and fill in the **STANDING ORDER FORM** (available on www.seauk.org)

Please send to:

Cath Smith

Benefits of joining:

- Receive updates on latest developments in education
- Bi-annual newsletter
- Free webinars
- CPD accredited meetings and workshops
- Learn from others in our educational forums
- Updates regarding curriculum changes for trainees and trainers
- Build your portfolio
- National influence within anaesthetic education
- Opportunities for website development
- Discounted entry to ASM