SEAUK

Summer newsletter 2019

Inside this issue

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President's blog

Welcome back to the SEA UK 2019 summer edition. We have had a very successful ASM in Edinburgh this year. As always, it provided us with new ideas and opportunity for growth. Keynote speakers JP Lomas and Ed Horowitz explored current issues with morale, need for trainees and training environments. Maintaining Trainee health and morale has been and continues to be an integral part of our role as educators. The AAGBI surveys and publications on the issue have since reinforced the message of not only Lomas and Horowitz's talks, but also Sangeeta Mahajan's on trainee mental health.

The day also included workshops on *Educational Leadership* by Rebecca Baron, *Education for Behavioural Change* by Ben Shippey and *Educational Development* of SAS doctors by Kirstin May. Lastly, Cleave Gas delivered an excellent talk regarding rare but serious issues in training anaesthetists and the hidden curriculum essential for individual development.

Many thanks to the local organisers Sarah Fadden and Samantha Warnakulasuriya and of course to our wonderful administrator Cath Smith.

This year, SEA UK welcomes non-Anaesthetists to join the association. This progression deserves note and further publicisation. Further changes have included three council members finishing their term in office. Many thanks to them for all their hard work and dedication. In an effort to reduce the size of council, we have decided to replace these wonderful members with one individual. We will be sending out request for council nominations at the end of August. Please note that self-nominations are also welcome.

We look forward to seeing you at future SEA UK badged events, such as the *Advanced Educational Supervisor* course and our next ASM in March 2020.

Kind Regards,

Sue Walwyn
President of SEA UK

From the editors

Along with 2019 sun shine and blue bells, I welcome you to read the summer edition of the SEA UK newsletter. In this edition, you can read the reports from our very well organised Edinburgh ASM. I am sure you find these reports interesting and of high value in your day to day life as educational leaders and particularly the recent hot topic mental health and suicide prevention. The article from Dr Sannaki further emphasises the consequences of fatigue and burn out amongst trainees. Our trainees are blooming with wealth of educational projects and innovative ideas. You can explore these further in this issue by reading tales from Drs Siriwardena and Tebbett

We aim to improve our services and extend our support and resources to trainee anaesthetists. During this year we will be planning to add more educational material on our website. We welcome your suggestion on how we can reach you more and improve the resources

Wish you all great Summer, enjoy the sunshine and boost your vitamin D reserve.

Dr Cyprian Mendonca

Dr James Sylvester

ASM Keynote– Educational Leadership

Dr Rebecca Baron

"Although, all anaesthetists have to take on various leadership roles, the training doesn't always prepare for this".

The workshop started with the analogy of doctors as a brick wall - the bricks being our knowledge, and the mortars what makes us effective. Sadly, we know that mortar is difficult to make (or teach?) - and I felt that this was a theme that carried well across the ASM this year.

The NHS Leadership Framework and Healthcare Leadership Model were both referenced, but they tend to describe outcomes rather than explaining how to achieve these. So, we explored some new thinking in models of Leadership - Heimas & Timms's description of new power which seeks to channel the authority as compared to old power which hoards it; and Julian Stodd's model of social leadership. We agreed that trust is essential to good leadership and is difficult to build but easy to lose. We acknowledged the role of "influencers" - even before Instagram apparently 3% of people influence 85% of what happens.

So how can we develop ourselves as leaders? We looked at the "7 habits of highly effective people" by Stephen Covey and how they relate to oneself, interactions with others and looking after ourselves. We discussed eating ugly frogs (!) - an analogy for completing the most difficult task first, thus giving a sense of satisfaction and progress. New Leaders (Daniel Goleman) are positive and spread cheerfulness and warmth. Leadership "pickles" state that "your team is always watching you, what they see is what you will get". Finally, John Adair's action centred leadership described the need to plan for task, team and individual.

We moved onto looking at leadership styles and how in healthcare there is often a focus on pacesetting and commanding leadership styles. We discussed inspirational leadership through a model based on Shakespeare's Henry Vth. The theatrical analogy is particularly relevant given the need to "act" in a certain way as leaders. We explored the attributes of Good Kings, Great Mothers, Warriors and Medicine Women and reflected on which style we were; and then discussed the inner traitors of each style and the potential pitfalls of these.

Finally, we thought about the leadership behaviours we have observed and developed and what feedback we can receive on these, and what development opportunities there might be for us.

And we were left with the question - "What will I do tomorrow and next week?" Well, I will try to develop my strengths as a Great Mother and Medicine Woman, and to better understand and utilise my Good King and Warrior colleagues. I will remember that culture eats strategy for breakfast and aspire to spread cheerfulness and warmth in my team.

Sarah Wimlett

ASM Keynote– Morale

JP Lomas

JP commenced by referring to the 2009 Boorman report on health and wellbeing in NHS staff (available on NHS employers website) and the 2013 Francis report into Mid Staffs. The Francis report unfortunately demonstrated that many of the issues raised by Boorman were evident in the events leading to the Mid Staffs enquiry.

He then referred to the RCoA trainee morale survey, which was undertaken when he was one of the trainee reps on the RCoA Council. JP said that some of the free text comments submitted with the survey results were 'harrowing' and in the light of these the headline statistics from the survey were not surprising. He then reflected that many of the issues highlighted by trainees applied to consultants as well as the stressors were the same for both groups. However consultants may be more empowered to tackle these issues.

Having set the context he described the educational equivalent of Maslow's hierarchy of needs. From the bottom up this comprises:

-being paid correctly and on time - an issue for many trainees who do not have a lead employer system

-non-exploitative rotas, particularly pressure to fill rota gaps.

-time to do audit etc - trainee overload is a real threat and few trainees have time in their working week to undertake the activities for which career-grade staff would have have SPA. Non-clinical work should be of educational value and ideally relate to the trainee's career goals.

Promotion of trainers hobby horses should be avoided.

-cohesive trainees - time and space for trainees to bond leads to increase support amongst the trainees. Formal schemes such as Balint groups and Schwartz networks can help but are rare in hospital medicine.

-wellbeing - the top of the pyramid.

Not only does the same apply to consultants, but a cohesive consultant body leads to better supported trainees.

JP then opened the discussion to the floor and a wide-ranging conversation ensued. Amongst the topics covered were the importance of role modelling, both positive and negative influences. A further topic was resilience and resilience training, with the distinction drawn between resilience as part of handling the aspects of life which can happen to anybody and 'resilience' as a fig leaf for expecting doctors to function within a broken system when it is the system which needs changing.

A thought provoking and wide ranging talk which set the scene for the rest of the day.

Janet Barrie

ASM Keynote-
Education in a litigious environment

Ed Horowicz

The term litigation is intrinsically linked with perceptions of professional and clinical inadequacy (Bourne et al, 2017). Ed Horowicz, senior lecturer in Healthcare Law and Bioethics from Edge Hill University Medical School spoke about the importance of litigation in medicine as it gives patterns into patient safety incidents leading to reduced harm and information on factors that lead to patient dissatisfaction and litigation. He touched on the RCoA's statement "Medicolegal and ethical dilemmas in clinical practice are increasingly common and many doctors feel ill-equipped to manage them"

Without the understanding of the litigation in our practice, we will have a gap in our knowledge and do the defensive practice. This can lead to poor patient care. Ed then described the discussed few recent high-profile scenarios and explained that under the law the standard of care expected is same and courts do not differentiate based on the experience of the practitioner. In the end the audience was briefed on consent, supervision and reflective practice. Overall the lecture was very informative.

Peeyush Kumar

ASM Keynote– Educational Never Events

Cleave Gass

Dr Cleave Gass, Head of School of Anaesthetics and ICM, London referred to a serious clinical adverse event and described how education would have prevented that event. The event demonstrated a classical example of Swiss Cheese model where the various holes were aligned and finally led to a clinical adverse event. He further explained how a sequence of flaws resulted into a catastrophic event. The key elements included changes to the list with a very short notice, trainee was scheduled to work in an isolated environment, with an inadequate hand over and without appropriate supervision.

Role of education in preventing serious adverse events
"Promoting excellence: standards for medical education and training" document from GMC sets out standards that organisations are responsible for educating and training medical students and doctors in the UK are expected to meet.

Requirement 1.13 states that organisations must make sure learners have an induction in preparation for each placement that clearly sets out:
a their duties and supervision arrangements
b their role in the team
c how to gain support from senior colleagues
d the clinical or medical guidelines and workplace policies they must follow and
e how to access clinical and learning resources.
Requirement 1.14 states that handover of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.

Requirement 1.8 states that organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor.

The tragic case of Jack Adcock who died from sepsis in 2011, further highlights the role of appropriate induction, supervision and support to trainees.

How can education contribute to improved patient safety?

-Trainees should never be delivering a service without an induction and appropriate supervision.
-Trainees returning to work after a period of absence should be appropriately supported as

using return to work programme.
-Trainees should only cover rota gaps if the risks are identified and risks signed off and held by senior management.
-There should be a system where trainees are able to contact senior help.

The Cappuccini test standard states that 100% of trainees must have immediate access to consultant advice and assistance. It has been identified that supervision of juniors is a recurring problem in the current environment due to inadequacy of staff numbers and increasing emphasis on 'lean' methods of working that do not leave capacity for supervisory cover. The consultant also need competent cover to his own patient whilst assisting the trainee in another theatre.

The Cappucini test can be conducted at workplace by identifying the juniors and SAS doctors doing solo lists. They are approached as ked following two questions
Who is supervising you?
How do you get hold of them?
Based on the answers to above two questions, the named supervisors are then approached and asked
Who are you supervising?
What are they doing at the moment?
Answers to these questions can be used to improve the supervision process in the Department.

RCoA Guidelines for provision of Anaesthesia Services (GPAS) sets out further guidance for appropriate supervision. "Departments of anaesthesia should ensure that a named supervisory consultant is available to all non-consultant anaesthetists (except those SAS anaesthetists that local governance arrangements have agreed in advance are able to work in those circumstances without consultant supervision) based on the training and experience of the individual doctor and the range and scope of their clinical practice. Where an anaesthetist is supervised by a consultant, they should be aware of their supervisor's identity, location and how to contact them.
In conclusion a good induction programme, appropriate mechanism for supervision of trainees and a good hand over process can mitigate clinical adverse events and contribute to patient safety.

References
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3. Ladher N. Criminalising doctors BMJ 2018; 360 doi: https://doi.org/10.1136/bmj.k47
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Cyprian Mendonca

ASM Workshop-
Education for behavioural change

Dr Ben Shippey

Training in medicine is always changing and training in anaesthesia is no different. We have traditionally looked at the knowledge and skills of our trainees and assessed their progress based upon those. However, there is a movement towards looking at the values and attributes of anaesthetists and this is where Ben Shippey's workshop, "Education for Behavioural Change," was focussed.

We started by splitting into groups and as an ice-breaker trying to find some common ground outside of medicine. There were the stereotypical anaesthetic runners, cyclists, gym go-ers and my group, the visually impaired.

Ben led half the group to think about what made a good colleague and the other half what made a bad one. Most of the characteristics that were expressed involved their values and attributes such as reliability and good communication, with only a few mentioning their knowledge or skill set. Interestingly, we noted that the vast majority of our time as educators is focussed on these knowledge and skills rather than what we deemed made our best colleagues. Perhaps a change is needed?

We soon realised, whilst trying to define an assessment profile for these less obvious attributes, that it is much easier to focus on the aforementioned knowledge and skills. So, what can we do about this? We all felt that we needed to start to look at these areas but how to do it? This workshop was the start of this process. If we, as educators, start to look at these areas when teaching others then it will start to change our practice.

The next step was to try and put this into practise. Ben showed a video of a mocked up theatre scenario with a senior registrar struggling with an anaesthetic that wasn't going quite to plan! In our small groups, we tried to role play giving feedback on some of these less talked about attributes. I think it is fair to say that we all found this a little bit difficult. Approaching the way our colleagues communicate and manage a team is not something we generally approach face to face and is too often anonymously looked at during a multi-source feedback or 360 degree appraisal. From my own personal experience, it felt like I was pulling the character of my colleague to shreds and not just her anaesthetic skills- something definitely to improve on.

We concluded by agreeing that we need to start looking outside of the usual core of anaesthetic training such as "let's look at you inserting that cannula" to "let's look at the way you interact with the team today" and perhaps start to suggest these to our trainees when discussing what they want out of their time with us as educators.

Sue Welwyn

ASM Workshop– Education for SAS Doctors

Dr Kristin May

Kristin has worked as a staff grade and latterly associate specialist doctor for over 16 years and has worked extensively within the College and the BMA to raise the profile of and opportunities for SAS doctors within the NHS. She brought this wealth of experience to the workshop.

Kristin began by signposting to three resources:

'Maximising the potential: essential measures to support SAS doctors' published by HEE and NHS improvement.

'Working together – crossing boundaries, inspiring and supporting our SAS doctors' published by the RCoA.

'The medical training initiative programme at the Diana Princess of Wales Hospital' by former council member Omer Farooq in the March edition of the College Bulletin.

SAS doctors are a diverse group and their reasons for entering the role vary. Doctors in the formal SAS role (staff grades and associate specialists) have access to study leave and at least 1 session per week for SPA activities. However in recent years many doctors are employed on a variety of 'trust grade' or 'clinical fellow' contracts. These posts have terms and conditions set at Trust level, are often short term and may have minimal access to study leave or time for SPA activities. However doctors in all of these positions have the same requirement for appraisal and revalidation and should be given the resources to achieve this. They are not entitled to an educational supervisor or to support from the College Tutor, yet many would benefit from regular input from an experienced, recognised trainer as they seek to develop their expertise and careers.

Accepting that these were stereotypes, Kristin gave the group four scenarios and asked us to apply the above principles to these situations. These were:

A UK-based trainee who enters the SAS grade due to difficulties with training progression

An experienced international medical graduate doctor from a prestigious institution recruited directly into an SAS post in a UK DGH.

An experienced UK SAS doctor who has developed expertise in a particular area and is the departmental 'go to' person for advice.

A doctor in their late 50s with a heavy on call commitment.

The discussion was wide-ranging and included such areas as:

- Exam support and preparation
- Career support and guidance
- Credentialing
- Local and national opportunities for recognition of expertise
- The SAS doctor as appraiser or educational supervisor
- International medical graduates and enculturation, including social support
- Retirement planning
- Coming of the on call rota

Perhaps most importantly, not making assumptions about what the doctor 'wants' or 'needs'.

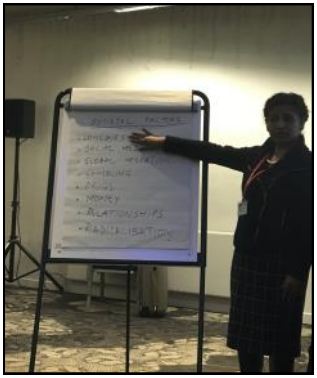
Kristin delivered a wide-ranging and thought-provoking workshop which will help me appraise SAS colleagues. I was previously unaware of the first two resources, but they have been added to the departmental collection. Thank you, Kristin.

Janet Barrie

ASM Workshop– Being Human

I was very fortunate to take part in an intimate and very powerful work shop on mental health and suicide prevention. This was led by Sangeeta Mahajan, consultant anesthetist from Guys and St Thomas, trustee of the charity PAPYRUS and a mental health educator and advocate, on a subject obviously very close to her heart. The session was divided into three parts

Physiology of brain development – we discussed the development of the adolescent mind, with the adolescent mind still developing in young people including our trainees. This development leads young people to being high risk for acting on poor judgment, as well as a peak time for psychiatric illness to emerge. This is governed by the dopamine serge and serves to allow adolescents to develop a sense of self.



We then looked at facts through a true and false game. Suicide is commoner in anaesthetists, and trainees, why? High degree of burnout with the moral injury to self-high in highly performing individuals. It is also increasing in females. We discussed risk factors in more detail including societal factors.

So what can we do?

Notice

Ask

We discussed organizational change and support through education. Howe can recognize and help doctors in distress.

In groups of three we then did a simple listening exercise. One person listened and one observed the other member discussing a difficulty or issue. We then fed back how difficult it can be but very important to listen with out interruption and allowing times for silence.

Before closing we watched the following you tube video, Brene Brown - Empathy

https://youtu.be/1Evwgu369Jw

Finally, we rounded up with a personal story from Sangetta and sign posting to resources with the group expressing one thing they would take away and do.

Richard Ramsaran

Papyrus - prevention of young suicide
Help line 0800 068 4141
Text 07786209697
Email pat@papyrus-uk.org
www.papyrus-uk.org
Please also look at the free suicide safety plan

Mental illness and Welfare in Anaesthesia

"Mental illness is not a personal failure"

Prolonged work-related stress without appropriate intervention is a cause for emotional, mental and physical exhaustion among anaesthetist.

Currently mental ill-health in young anaesthetist is major concern in the NHS. Evidence suggests that suicide risk/mental illness varies depending on medical specialty and anaesthetists are considered at greater risk. Many anaesthetists work long hours in isolation and have heavy workloads which can cause severe depression and lead to suicide attempts. Other reason could be easy access and knowledge of potent drugs. More concerning is, only few doctors' reports of being ill or seeks help.

According to BMA's Doctors' Health Matters "Many doctors work long hours and have heavy workloads, which can cause severe depression and lead to suicide attempts" which also claims that doctors are more likely than any other profession to have mental health problems.

NHS 'wake-up call': Six out of seven young hospital doctors are at risk of burning out and many are going without eating or drinking during their shift because pressures on the NHS are putting more strain on working conditions.

The GMC commissioned Horsfall independent report to review cases where doctors have committed suicide while involved with its fitness to practise procedures between 2005 and 2013. From this report significant number of (24%) doctors committed suicide while they are under GMC investigation.

In 2017, Royal College of Anaesthetists published a report on the welfare, morale and experiences of anaesthetists in training, which suggest that poor morale is driving some doctors to quit the profession.

Mental illness can present with various symptoms. It is hard to recognise depression or anxiety in others and as well as in themselves. Depression is often experienced subjectively as "stress", "burnout" with or without anxiety. Poor self-esteem and lack of self-confidence can be symptoms of the illness. It may also preset with physical symptoms such as fatigue, headache, insomnia. Depression can be the cause as well as the result of work problems, relationship difficulties, substance abuse and marriage problems. Mental illness considered stigma in society, doctors tend to deny illness and be poor help-seekers. Denial is particularly prevalent in depression.

Cause for mental illness in anaesthetist is multifactorial. One of commonest factor is work pattern and environment. According to the RCOA welfare report, 78% anaesthetists in training have experienced a detrimental impact to their health as a direct result of their employment and 61% of respondents felt their job negatively affected their mental health.

Rota gaps are perceived to cause major problems in the working pattern of trainees. The analysis of data on trainee rota suggests that anaesthetists in training were asked to fill rota gaps in their employing hospital on an average of six times each month. In some cases, work/life balance was so poor that it resulted in physical and mental health problems, with some taking time out of training to redress the balance and others resigning from training.

Following welfare survey, Royal College of Anaesthetists produced a report with recommendations to junior anaesthetist and decision makers. For individual, they should recognisees any signs and symptoms of illness and seek help sooner. Along with supporting themselves, they should be able to support each other.

The doctors should focus on self-care and support their colleagues in the needy hours. The anaesthetic department should encourage personal and professional development of doctors during work schedules and rota hours. The employing organisation shall prioritise the need of adequate rest and catering facilities for the clinician both during and after on-call periods. A healthy working environment shall be established in which patients' safety and overall department of staff is the priority. There shall be minimal chances of blaming anaesthetist in the untoward events.

Welfare and morale of trainees shall be considered while rewriting anaestehsia CCT curriculum and assessment guideliens. Indices of curriculum delivery across the UK should be collected and reported. RCOA also reassure co-ordinated training between facilities of anaesthesia and ITU. The health authorities should recruit and retain adequate workforce. It is vital to realise that anaestehtist in training need time to train and trainer need time to provide training.

Department of health shall collaborate with other relevant organisations to focus on morale and wellfare strategies of NHS staff. Services such as NHS practitioner health programme shall expand across UK. Appropriate and adequate facilities at workplace will boost in morale of working population. Hence necessary capital funding shall be directed towards the same. The government shall encourage the employers to carryout regular assessment if working environment in which doctors are being trained.

References

WOAG SIG Resource Document 03 Depression and Anxiety 2011.

GMC; Your health matters Practical tips and sources of support.

RCOA; A report on the welfare, morale and experiences anaesthetists in training: the need to listen December 2017.

GMC; Doctors who commit suicide while under GMC fitness to practise investigation, Internal report December 2014.

Dr Shilpa Sannaki

Specialty Trainee

Warwickshire School of Anaesthesia

Life as a 50:50 simulation Teaching Fellow

During my ACCS Anaesthetics training I had the opportunity to become part of the Trent Simulation Faculty and facilitate simulation based teaching to medical students and foundation doctors. I found this type of teaching rewarding and wanted to explore it further and when I found the 50:50 teaching fellow post advertised it appeared to be the perfect opportunity to do just that. I carried out the application via the NHS jobs website and following an interview was delighted to find out that I had been successfully appointed to the post!

University Hospitals Coventry and Warwickshire (UHCW) have several teaching fellow posts – five full time teaching fellows, six 50:50 of which two are simulation fellows. The medical education department at UHCW supports the career development of teaching fellows by funding the higher qualification in education leading Postgraduate Certificate of Medical Education at the University of Warwick.

My weekly work schedule consists of 2 days in anaesthetics and 3 days in medical education. Most of my time is spent working in the simulation centre with the simulation facilitators. We run simulation based teaching courses for final year medical students, foundation doctors, anaesthetic trainees as well as multidisciplinary courses for the anaesthetic, emergency and obstetric departments. The teaching that we deliver to the medical students and foundation doctors involves management of common acute medical and surgical presentations. The anaesthetic simulation scenarios involves critical incidents in theatre and troubleshooting in recovery scenarios. For all the fellows starting this post there is an in house debrief course where we were taught the skills required to debrief scenarios.

The Postgraduate Certificate in Medical Education requires the student to submit a series of assignments based on techniques and methods of teaching. This post gave me perfect opportunity to carry out several peer and senior observations of my teaching. This further encouraged me to reflect on my teaching practice and improve it to continuously. In my role as simulation fellow I have been able to hone my skills in debriefing following observations from other clinical teaching fellows and the simulation facilitators.

As a part of the teaching fellow role, I had the opportunity to be involved with the Warwick Medical School in the role of examiners for their OSCEs and objective structured long case examination record (OSLERs) . We partake in writing and quality assuring questions for the written assessments that the Warwick medical students undertake. This gave me further insight into the assessments at undergraduate level and enabled me to understand the principles of assessment in Medicine.

There are also opportunities to be involved in teaching tutorials and delivering bedside teaching. I am hoping the knowledge gained is useful in preparing for post graduate exams in my own specialty. This may be useful exposure if you have an interest in becoming involved with the education at a future date for example by becoming involved in the Royal College of Anaesthetists examinations. It also was a brilliant opportunity to develop teaching skills for tutorials and small group teaching which can be used in the future with anaesthetic colleagues.

During my anaesthetic days, I have the opportunity to run a solo day case list with local consultant support and a day on a training list. I have been able to consolidate my skills at managing simple cases involving ASA 1 and 2 patients as well as further developing my skills in leadership and timely management of an anaesthetic list.

I would highly recommend a 50:50 teaching fellow job for anyone with an interest in education and simulation! It has been a great opportunity to become involved with a range of different educational activities that have significantly contributed to my professional development.

Dr Ushani Siriwardena MBChB

Clinical Teaching Fellow

University Hospitals Coventry & Warwickshire NHS Trust

Fundamentals of Assessment at Medical School- My Experience as a Clinical Teaching Fellow

Education is a core part of both the trainee and consultant role in anaesthesia. The opportunities to teach in anaesthesia are multiple, but so are the opportunities to get involved in the education of medical students from local universities. I became heavily involved with assessing medical students as part of a clinical teaching fellow job, but what the experience really highlighted was just how many opportunities there are for doctors (both in training and post-CCT) to get involved in the assessment of the doctors of tomorrow.

Assessment in medicine is multifactorial, with multiple choice questions, short answer questions, objective structured clinical examinations (OSCEs), objective structured long examination records (OSLERs), structured oral examinations (SOEs) and long cases utilised. Ensuring these assessments are of a high quality requires multi-disciplinary involvement at all stages.

For written exams there are often opportunities to write questions based on the students' curriculum, usually in well supported workshops. These questions are then reviewed by the medical school assessment leads and compiled into an examination paper. They are then subjected to a quality assurance (QA) process. These 'QA' sessions are often enjoyable meetings where the chosen questions are scrutinised from different angles, by different clinicians from different specialities and varying backgrounds and grades, to ensure they are a fair representative of clinical practice.

The written papers then need standard setting, another collaborate process where each educator independently sets what they think is the pass mark for each question before discussing their decisions with the group. An individual standard setter has to decide what proportion of minimally competent students would answer the question correctly. Based on the proportion for all questions in the paper a pass mark will be calculated. A wide variation in the grades will be discussed during the standard setting meeting. These meetings again require a good representation of clinicians from different specialties and experience.

After the students sit the paper there are opportunities to get involved in marking the short answer questions. Any of these stages of question development could be an avenue into medical assessment for someone interested in the written exam.

However, it is usually with practical exams such as OSCEs, long cases and OSLERs that most people find an avenue into assessment. These are faculty intensive exams that require multiple dedicated examiners from different backgrounds to be first trained in the assessment process, and then examine students from different levels in high stakes (usually summative) exams.

The medical school requires a large bank of trained assessors to be contacted for the multiple exam session run throughout the year, so further volunteers here are always welcome.

So how do you get involved? You don't need to take a year out as a clinical teaching fellow to get your foot in the door of assessment. Instead contact your local exams team (whether they are based at your local medical school or teaching hospital) and enquire about upcoming examiner training sessions. Let your enthusiasm be known. Once you gain experience in one aspect of assessment, and become known to the medical school, other opportunities may also arise.

Dr Alex Tebbett
Clinical Teaching Fellow
University Hospitals Coventry & Warwickshire

2019's Educational Resources Selection -

Trainee Morale
https://www.rcoa.ac.uk/system/files/Welfare-Morale2017.pdf

Mental Health
https://anaesthetists.org/Home/News-opinion/News/Survey-highlights-need-for-improved-mental-health-guidance-support-for-anaesthetists

Trainee Support
https://www.yorksandhumberdeanery.nhs.uk/learner_support/supported_return_to_training

Sustainability in Education
https://www.asme.org.uk/asm2019

Other
https://www.mededworld.org/hardens-blog/reflection-items/July-2019/HARDEN-S-BLOG-News-from-Roanoke--MCQs-are-dead--Le.aspx

We are pleased to announce our 21st ASM!

A date for your diary.