WINTER 2012

SEAUK NEWSLETTER

SOCIETY OF EDUCATORS IN ANAESTHESIA

EDITORS' NOTE

Welcome to the winter edition of the SEA UK newsletter! In this instalment we have a number of interesting articles from our trainees. Peter Lang has written a report on his visit to 9th International Scientific Meeting of the Royal College of Obstetricians and Gynaecologists in Athens, after being awarded a SEA UK travel grant in 2011.

SEA UK President, Alison Cooper, has given an account of recent council activities and announces the result of our 'presidential election'. Under her direction the society has developed as a credible professional group having close links with the Royal College of Anaesthetists and other specialist societies.

Alison will be stepping down as President in October 2013 and on behalf of SEA UK members across the country I would like to say "THANK YOU!"

We also include a brief account of the members' survey conducted last year. The results will be used to direct the content of the Annual Scientific Meetings (ASM) and future council activity.

The final two pages of the newsletter are dedicated to the ASM 2013. For the first time in our history, the city of Liverpool will be the host. Simon Mercer has organised what promises to be an interesting and well planned day. Charles Cooper has created a meeting website detailing the programme, abstract submission guidance and registration process. Please visit www.seauk2013.org/1.html

Finally, in the interest of saving paper, the newsletter is being distributed in its electronic format. A limited number of hard copies are available from SEA administrator, Catherine Smith: administrator@seauk.org

Cindy Persad and Claire Joannides

CONTENTS

PRESIDENT'S REPORT

ALISON COOPER

Dear Colleagues,

The nights are now getting dark around 4pm and we are all preparing ourselves for another long dark winter. For most of us working in the NHS the general atmosphere reflects the gloomy nights outside. Nevertheless, good things are still happening and things do get done, with a lot of good will and enthusiasm from individuals.

In October SEAUK council met for its first all day meeting, not only to review current activity, but to try and ensure future plans reflect the feedback from the member's survey. One of the clearest messages from the survey was that we should make available via the website teaching materials, ideas and resources to help with on the job teaching. The website certainly has the functionality to do this and over the next 12 months we hope to move to a member's only area where these resources will be hosted. Council will share our ideas but we are very conscious that you, the members, have lots of good ideas too. Would you be prepared to share via SEAUK? If so, can you please email me so we can all help each other. I heard last year that the NHS had 95 videos of how to wash hands at costs of between £5000 and £50,000. We can save a lot of money and time if we can share what is already available.

We will continue to work collaboratively with other organisations, particularly the Royal College and will support a CPD day, of broad interest to everyone who is involved in Education in April 2013. To book for this, please look at the College website for details of the programme and on-line booking. In addition we will deliver a full day of advanced training for Educational supervisors, aimed at supporting further development within this role and recognising the GMC's intentions to formally accredit the Named Clinical Supervisor and Educational Supervisor. This will be advertised for early 2013, again in collaboration with the college. If you have not seen the GMC document "Recognising and approving trainers: the implementation plan" it is available to download from the GMC website. The GMC is building on the existing standards as set out in "The trainee Doctor" and "Tomorrow's Doctors" and has used the seven areas set out by the Academy of Medical Educators to provide structure. The aim of the GMC in introducing this requirement is to protect and enhance the status of training.

I hope you have all seen the recent contribution to "Bulletin" of five articles from SEAUK, discussing topical educational issues. I would like to thank all the contributors for their hard work in producing such interesting articles and sticking to the deadlines.

I have now been President of SEAUK since 2008 and have decided the time has come to hand over the role early next year, so the ASM in Liverpool will be my last as President. I am very much looking forward to the meeting, which has a very exciting programme and I hope many of you have already booked your study day off and will come and meet up, share ideas and enthusiasm and learn from our distinguished faculty. I am very grateful to Simon Mercer, who has managed to

arrange the meeting despite his many other commitments and I am sure the day will be a great success. As in previous years we have booked space for posters and time for presentations and I hope you and your colleagues will consider submitting an abstract for either a poster or oral presentation. These are often extremely interesting and in the past 2 or 3 years both number and quality have improved. Please do encourage both trainees and SAS colleagues to get involved. We have both prizes and the opportunity to publish the winning abstracts! All details are on the website now!

There are again some vacancies for council next year and I would encourage anyone who is interested to consider standing for election. Everyone on council is very friendly and I have enjoyed my time enormously. I have learnt such a lot and met so many interesting, enthusiastic and knowledgeable colleagues along the way. I shall continue to support SEAUK in every way I can and having been involved since 1999, can appreciate the ways in which the Society and its activities have grown over this time. I am looking forward to attending the meetings with the time to read all the posters and talk to friends and colleagues in a more relaxed fashion!

SEAUK has a very committed and talented bunch of enthusiasts on council who I am sure will ensure the Society continues to flourish but it is nothing without you, the members. Please continue to send us your thoughts, ideas and feedback. I am sure your new President, Dr Teresa Dorman, will welcome your input as much as I have done. Teresa will take over officially next October but handover will start in the spring.

May I say how much I have enjoyed working for SEAUK as President and thank you for the opportunity. May I also thank all my council colleagues, who have been totally supportive throughout my tenure.

My best wishes to all

Alison Cooper

President SEAUK

Alison.cooper@rothgen.nhs.uk

SEA (UK) Travel Grant Award Report

9th International Scientific Meeting of the Royal College of Obstetricians and Gynaecologists September 2011, Athens, Greece

Peter Lang[1], Ranjani Venkat[2], Seosoon Seah[3] and Toh Lick Tan[4]

[1]Foundation Year 2, [2] Anaesthetic SpR, [3] Consultant Anaesthetist [4] Consultant Obstetrician & Gynaecologist, Ealing Hospital, UK

Introduction

I was honoured to be awarded the Greaves-Kumar-Myerson Award by SEA UK to present a poster at the 9th International Scientific Meeting of the RCOG in Athens, Greece. Whilst working as a Foundation Year 2 (FY2) doctor in Obstetrics and Gynaecology in Ealing Hospital, London, I led a project investigating the causes of perinatal maternal critical illness in our district general hospital. We found that, from 2009 to 2010, sepsis, predominantly from the respiratory tract, was the leading cause of maternal critical illness. Compared to patients with postpartum haemorrhage (PPH), septic mothers suffered delays in care, were more likely to require organ support and had a longer length of stay. We recommended better training of all staff in the use of the Modified Early Obstetric Warning System (MEOWS)[1, 2] and in the implementation of the Surviving Sepsis campaign guidelines[3].

Athens

Amidst the chaos of a nation in economic crisis, I arrived, albeit on a flight delayed by over three hours due to airport staff strikes. Over the next few days, my journeys between the hotel and conference centre, as well as through town, would be plagued by similar strikes by bus, train and even taxi drivers. However, my fellow delegates and I somehow managed to attend three full days of fascinating lectures and educational seminars on a multitude of topics. The conference itself was very well-organized and the sessions proceeded seamlessly. At the opening ceremony, we were treated to a beautifully choreographed and somewhat primal dance by the Greek National Opera Ballet, followed by a sumptuous feast of Mediterranean canapés. This was set fittingly against the glorious cultural backdrop of Greece, home to Hippocrates, father of western medicine, and Georgios Papanikolaou, inventor of the "Pap smear" and pioneer in cytopathological detection of early cancer. In contrast, the current critical shortages in medical staff and supplies due to austerity measures served as humbling reminders of the impact of a country's socio-political situation on the ability of its doctors to practise medicine and carry out research.

Sepsis as a significant cause of obstetric critical illness

For the first time since 1956, sepsis has become the leading cause of direct maternal perinatal mortality, overtaking hypertensive disorders of pregnancy and thromboembolic disease, heretofore long-established as the most significant problems.[4] It was encouraging, then, to meet a number of anaesthetic and intensive care colleagues in Athens who likewise had an interest in critically ill pregnant and recently-pregnant mothers. Indeed, I attended an interesting presentation by Dr Caroline Shaw[5], Anaesthetic Registrar in Peterborough, who had singled out for analysis a cohort of obstetric patients admitted to ICU due to sepsis. She also found delays in care due to MEOWS charts not being used systematically or not being acted upon appropriately, as well as problems with communication between different specialties and failure to treat as high-risk those patients requiring

opiate analgesia. There were discussions between obstetric anaesthetists and obstetricians centred on strategies to improve care for critically ill obstetric patients. Suggestions were made to focus on training and education of all staff in early recognition systems, basic resuscitation skills and inter-specialty communication.

LESSONS LEARNT FROM MAJOR TRAUMA

One of the most fascinating and educational lectures was given by the world-renowned Sir Sabaratnam Arulkumaran, President of the International Federation of Obstetrics and Gynaecology (FIGO) and Professor at St George's, London, on "The Future Management of Postpartum Haemorrhage". He drew comparisons to the management of major trauma and reiterated the importance of a systematic approach to assessment and resuscitation, as outlined by the Advanced Trauma Life Support (ATLS) principles[6]. He also emphasized the concept of the 'Golden Hour' within which appropriate, life-saving, damage-control interventions must be promptly carried out.

ISSUES FOR TRAINING

It was somehow reassuring to hear that our obstetric and gynaecology colleagues also faced the problem of balancing compliance with the European Working Time Directive and the shift towards a consultant-led service, against the need to ensure adequate clinical and operative experience for trainees. There were a number of talks on the role of simulation and virtual reality systems in training, as well as suggestions for quality assurance schemes. Attention was also drawn to the decline in experience in female pelvic examination, particularly in medical students. Finally, and rather usefully, an 'Author Workshop' took place, where academics gave seminars on how to design a scientific study or clinical trial, obtaining ethical approval, tips to get successfully published and the insider's view on the peer review process, useful skills applicable to any specialty.

SUMMARY

I thoroughly enjoyed my time at the RCOG conference in Athens. I presented my work in front of an audience of distinguished, knowledgeable academics and clinicians. At the time same time, I learnt a great deal that not only applies to the management of critically ill obstetric patients, but to patients of all specialties. Finally, I was able to experience a small part of the wonderful cultural heritage that this historic city has to offer.

REFERENCES:

1. Lewis G (ed.), 2007 "Saving Mothers' Lives - Reviewing maternal deaths to make motherhood safer: 2003-2005. The Seventh Confidential Enquiry into Maternal Deaths in the United Kingdom." The Confidential Enquiry into Maternal and Child Health (CEMACH), RCOG Press
2. Singh S et al., 2011 "A validation study of the CEMACH recommended modified early obstetric warning system (MEOWS)" Anaesthesia 2012(67) 12-18
3. Dellinger R P et al., 2008 "Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2008" Crit Care Med 36 296-327
4. Lewis G (ed.), 2011 "Saving Mothers' Lives - Reviewing maternal deaths to make motherhood safer: 2006-2008. The Eighth Confidential Enquiry into Maternal Deaths in the United Kingdom." BJOG 118(1) 1-203
5. Shaw C et al., 2011 "The growing burden of sepsis in obstetric critical care admissions and the role of local guidelines in preventing maternal morbidity" Free Communication Presentation, 9th International Scientific Meeting of the RCOG, Athens, Greece
6. American College of Surgeons Committee on Trauma, 2008 "Advanced Trauma Life Support (ATLS) for Doctors" Student Course Manual, American College of Surgeons, Chicago
7. Duchesne J C et al., 2008 "Review of current blood transfusions strategies in a mature level I trauma centre" J Trauma 65(2) 272-6

SEA (UK) Members Survey 2012 Report

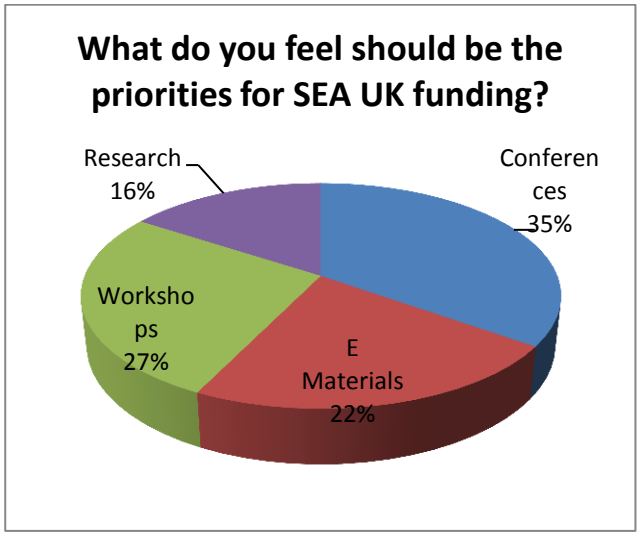
Kirsty Forrest and Charles Cooper

SEA (UK) Council Members

In 2012, SEA (UK) sent out a survey via email to all society members. The following is a brief account of the survey's main findings.
The response rate was 29%.

What do you feel should be the priorities for SEA UK funding?

Conferences	60.2%(53)
E Materials	38.6%(34)
Workshops	46.6%(41)
Research	27.3%(24)

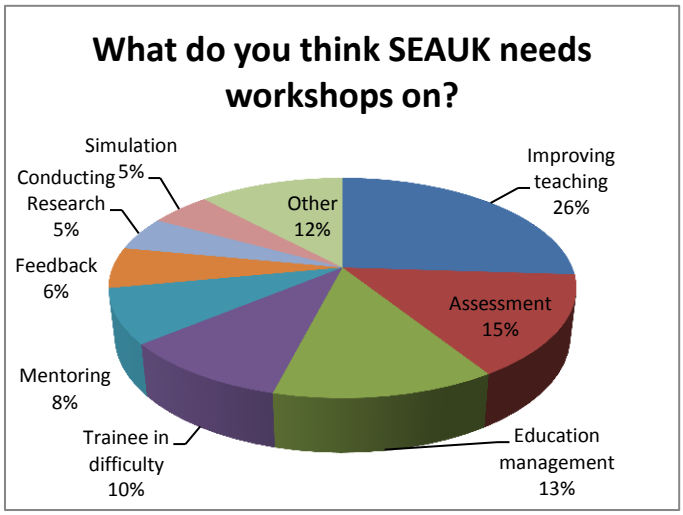


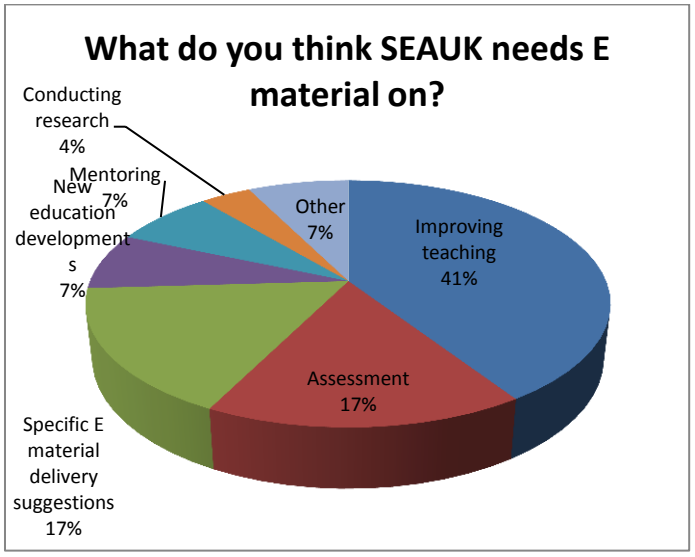
There are possibilities to link with other societies on research questions - would you value this?

Yes	75.0% (66)
No	3.4% (3)
Not sure	21.6% (19)

Would you find it acceptable if subscriptions were raised by £5/year (they are currently £20/year and have been for 5 years), in order to fund these areas?

Yes	83.0% (73)
No	17.0% (15)





FLIPPING THE OPERATING ROOM - EDUCATIONAL INNOVATION AT THE UNIVERSITY OF MICHIGAN

NISHANT SADANA MBBS, FRCA[1] AND KEVIN TREMPER MD, PHD, FRCA[2]

[1] VISITING INSTRUCTOR, [2] ROBERT SWEET PROFESSOR OF ANAESTHESIA AND CHAIR, DEPARTMENT OF ANAESTHESIA, UNIVERSITY OF MICHIGAN

Post-graduate medical education has been historically based on a time-based model with experience gained over time being the primary contributor towards skill acquisition. There has been a shift towards competency based training driven by advances in pedagogical interventions and a desire to streamline post-graduate medical training in the UK. Flipped Teaching is one such intervention that can be useful in achieving the said objectives.

Flipped Learning uses internet technology to enable students to access and assimilate course material before they actually come to class. This enables contact time with the teacher to be spent targeting perceived gaps in the students' knowledge rather than focusing on generic didactics. This concept was introduced by Dr. Mazur working at Harvard University who described using technology to "enable him to coach rather than teach"[1]. Baker[2] introduced the phrase "Guide on the side vs. the Sage on the stage" to the pedagogical lexicon. Salman Khan played a big part in popularising this mode of education with his Khan Academy, currently one of the largest web based educational resources.

Though much more popular within schools, attempts have been made to introduce the concept to higher education. The University of Wisconsin introduced online video presentations for students to review in their computer science course as far back in 2000[3]. In the medical world, the University of Virginia rolled out its new Learning Studio in 2011, which incorporates Flipped Learning in the curriculum[4].

Anaesthesia offers a unique opportunity to introduce Flipped Learning during postgraduate training as we often discuss our cases in advance. The 1:1 ratio between faculty and trainee also facilitates this form of delivery.

My current OOPT at University of Michigan provided an insight into Flipped Learning for anaesthesia trainees. The effort, initiated by Professor Tremper, began in 1996. The scheduling department provided a list of the most common surgical procedures performed by each of the surgical services. These lists were given to senior anaesthesia residents who outlined what they wished their faculty had told them in advance, before starting the case. These outlines were then provided to both the anaesthesia and surgical faculty who provided additions and revisions and were put on the department website. These "operating room tips", contain material for residents to review before they come for their lists the next day. They contain practical tips for setting up the operating theatres (the resident assumes the role of the ODP), theoretical background and relevant readings/references related to the surgery and anesthesia.

The "room tips" function as asynchronous learning resources that enable the resident anesthesiologists to read up and research on aspects of their cases for the following day.

This enables them to focus on experiential learning during the list supervised by their faculty.

This forms an integral part of anaesthesia residency training at the University of Michigan and is unique amongst all the ACGME accredited anaesthesia residency programmes to our knowledge. The UoM Anaesthesia residency programme has been consistently rated as amongst the top five programmes in the USA.

Adoption of similar pedagogical interventions in our own deaneries can promote focused, active learning during teaching lists. Such material can also be quite useful, especially in the training of novice anaesthetists and would be especially suitable for teaching basic sciences in the UK in preparation for FRCA exams.

REFERENCES :

1. Eric Mazur (Feb 1991), *Can We Teach Computers to Teach?*
2. J. Wesley Baker (2000), *The classroom flip: using web course management tools to become the guide by the side*
3. Julie Foertsch, Gregory Moses, John Strikwerda, Mike Litzkow (July 2002), "Reversing the Lecture/Homework Paradigm Using eTEACH Web-based Streaming Video Software", *Journal of Engineering Education*
4. http://uvamagazine.org/features/article/adjusting_the_prescription/#.ULZVc-RlVc0

MEMBERSHIP SEA (UK)

SEA (UK) membership is open to any practicing anaesthetists. You do not need to be very academic or have any educational qualifications. All you need is to be enthusiastic about teaching and keen to meet like minded colleagues.

Membership costs are kept as low as possible and members are entitled to a discount at our annual meeting. They will also be able to access teaching and learning resources via our website.

For application forms please visit www.seauk.org or contact the administrator by emailing Catherine Smith on administrator@seauk.org

CLINICAL SIMULATION FOR MEDICAL STUDENTS - WHY BOTHER?

DAVID LODGE[1] AND SUSIE BAKER[2]
[1]FOUNDATION YEAR 2 DOCTOR, [2]CONSULTANT ANAESTHETIST, DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

August is a daunting time for new Foundation Year 1 (FY1) doctors. Fresh-faced from medical school, they are finally released onto the wards to treat patients. For many, it will be the first time they have assessed and managed acutely unwell patients by themselves.

Clearly, new doctors would benefit from gaining more experience of managing and treating sick patients during their undergraduate education. However, it is unethical for medical students to manage patients alone. So, how can we help to overcome this limitation in undergraduate education in order to create experienced, consciously competent junior doctors?

At Dorset County Hospital, we have introduced clinical simulation to undergraduate training. All final-year medical students at Dorset County Hospital are invited to undertake a simple simulation course, run by the Anaesthetic Department, giving students the opportunity to manage patients within a controlled environment.

THE COURSE

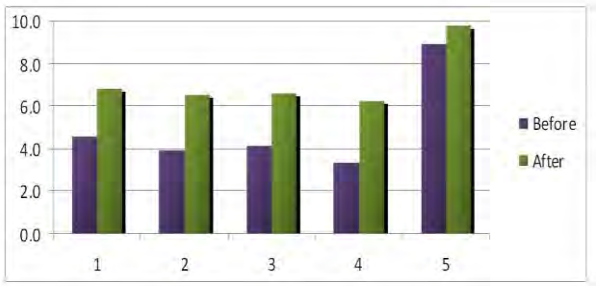
The LAMS (Live Acting Medical Simulation) Course comprises a one-hour lecture, refreshing knowledge on the 'ABCDE' approach to managing patients. The students then undertake a two-hour simulation session, each assessing and managing an unwell 'patient' by themselves. The scenarios are followed with a debriefing and feedback session led by an anaesthetic trainee.

Instead of using a dedicated Simulator Suite, the 'patients' are acted by Foundation Year 1 doctors and the sessions are held on a hospital ward.

Actors are used to increase the realism of the cases. Student-patient interaction is markedly different when the patient is a real person. SimMan® software is used to provide a 'live' patient monitoring screen, adding realism to the case by indicating changes in physiology.

THE RESULTS

Before and after the course we asked students to self-assess their overall knowledge and confidence on a scale of 1-10, when treating acutely unwell patients. Following the course, there was an average improvement of 55% in their knowledge and 76% in their confidence.



On a scale of 1-10, please rate the following:
1) I know how to assess an acutely-unwell patient
2) I am confident in assessing an acutely-unwell patient
3) I know how to manage an acutely-unwell patient
4) I am confident in managing an acutely-unwell patient
5) Simulation is relevant to my education

The fact that this teaching programme resulted in a 55% improvement in knowledge is reassuring, but is by no means a staggering improvement. What we have learnt, however, is that student confidence improves considerably with experience.

We also learnt that medical students recognise the value of simulation in their medical training. Following the course, all students rated simulation as 'highly relevant' to their training.

The faculty (FY1/2 and CT1/2) was also encouraged by the experience. Teaching medical students refreshed their own knowledge and challenged their practice. By acting as nursing staff, they also gained practical experience such as preparing IV fluids and learnt to appreciate the role of other health professionals.

WHAT WE'VE LEARNT

Through simulation, we have recognised the value of experience in improving a medical student's ability to treat acutely unwell patients. Ultimately, releasing appropriately confident doctors into our hospitals in August - doctors with experience of managing sick patients in a controlled environment - can only improve patient care. Furthermore, introducing junior doctors to teaching at an early stage in their training reinforces their own knowledge and influences their practice.

The LAMS course is designed to be transferrable. It doesn't rely on expensive simulators or complex equipment. It simply requires a bed, a few doctor volunteers, and plenty of enthusiasm!

SEA (UK) GRANTS

A SEA (UK) sponsored National Institute of Academic Anaesthesia (NIAA) Research Project Grant for up to £5K intended to help support research of an educational nature that will benefit education in anaesthesia, critical care or pain. Applications for the first round close at noon on the 19th of January 2013.

The Greaves, Kumar and Myerson Awards are three SEA (UK) sponsored NIAA Research and Travel Grants worth £500 each. The research grant may be used to support research relevant to education in all fields of anaesthesia and the travel grant may be awarded to allow the applicant to undertake a visit that would enable the applicant to gain exceptional experience of an educational nature. Application is via the NIAA website.

The Society's Travel and Research Grant provides a grant for £500 to support research and travel in all fields of anaesthesia. The closing dates for these awards are: 1st January, 1st May and 1st September, every year.

For more information regarding the society and the above grants visit www.seauk.org

PARTICIPANT'S PERSPECTIVE ON THE START STUDY AT THE OXSTAR SIMULATION CENTRE, OXFORD

IVAN COLLIN
CORE TRAINEE YEAR 1 ANAESTHETICS, YEOVIL DISTRICT GENERAL HOSPITAL

The StART study is a research study examining the most effective method of training new recruits in anaesthetics. I was fortunate enough to be involved as a participant and wanted to share my experiences with other trainees so that they too may benefit from the trial.

WHO IS IT FOR?

All novice anaesthetic trainees in the Oxford and Severn deaneries are invited to participate. If the study is successful then it may be offered to trainees from other deaneries. Trainees with more than four months anaesthetic experience are not eligible to take part in the study

WHAT DOES IT INVOLVE?

The study runs for approximately three months and participation ends after completion of the Royal College of Anaesthetists Initial Assessment of Competency. You are randomly allocated to either standard training at your base hospital or additional teaching at the OxSTaR simulation centre. The two groups are then brought together at the end of the study for a joint assessment day.
The additional teaching that I was allocated to involves a total of four days at the centre in Oxford delivered in two blocks. There were six CT1's at the teaching days, which allowed for great interaction and small group learning. The first two days were held in August and were aimed at providing a general overview of anaesthetics. We covered the basics of anaesthetic equipment, drugs used in everyday practice, pre-assessment and some simple airway skills. The majority of the teaching was classroom based with a mixture of talks, group discussion and skills stations. A handbook entitled "Introducing Anaesthesia" was provided which proved to be an excellent resource.
The second instalment of two days held in October was almost entirely simulation based. We covered a huge amount of material in such a short space of time. This included revision of the ALS algorithms, anaphylaxis, difficult airway society guidelines for routine and rapid sequence induction, malignant hyperthermia and local anaesthetic toxicity protocols. We each got to lead the scenario on at least two or three occasions and watched all of the others, followed with a group discussion of learning points and issues raised. By the end of it we all felt a lot more confident in managing these critical incidents.

IS THERE AN EXAM?

The final half-day was a chance to show off all the skills we had learnt. There was an ALS style MCQ paper and two simulations; one complicated ALS scenario and a failed intubation during rapid sequence induction. The group allocated to standard training were assessed in the same way.

HOW MUCH DOES IT COST?

The trial is funded by SEA(UK) so participation was free with expenses paid.

WOULD YOU RECOMMEND IT?
I highly recommend getting involved if you have the opportunity. There is a very steep learning curve at the start of anaesthetic training with unfamiliar new equipment, drugs and techniques. The extra teaching and simulation training received at Oxford delivers a lot of crucial information and enables trainees to practice critical incident drills in a "safe" setting. In addition, there is the opportunity to get the IAC 'signed off' and complete workplace-based assessments.

ANAESTHETIC POSTS IN FOUNDATION YEAR 1: A SURVEY OF TRAINEES' OPINIONS WITHIN THE WEST MIDLANDS DEANERY

BENNETT, J.[1], RADFORD, J. C.[1], SURI, I.[2]
[1]FOUNDATION YEAR 2, WEST MIDLANDS DEANERY, [2]CONSULTANT ANAESTHETIST, WARWICK HOSPITAL, SOUTH WARWICKSHIRE FOUNDATION TRUST

INTRODUCTION

The publication of the GMC's 'The New Doctor' in 1997 was the first stepping stone towards a more varied and diverse pre-registration house officer (PRHO) training, with the suggestion of three four-month rotations rather than the traditional six months of surgery and medicine[1]. In response to this, the Royal College of Anaesthetists proposed a four-month rotation in anaesthesia, pain management and intensive care, with the aim of providing practical experience in managing the acutely ill[2].

There has been a great deal of debate about the benefits of such rotations to the foundation doctor, particularly with regard to achieving curriculum aims[3,4] and whether learning to administer an anaesthetic is a worthwhile objective[5]. A survey of foundation year 1 (FY1) doctors in Portsmouth completing a one-month anaesthetic taster showed favourable outcomes in terms of confidence in clinical practice and generic skills[6].

We surveyed the opinions of FY1 doctors in the West Midlands who had completed such a rotation, not only in their confidence of skills, but their overall experience of the post in the setting of the foundation programme.

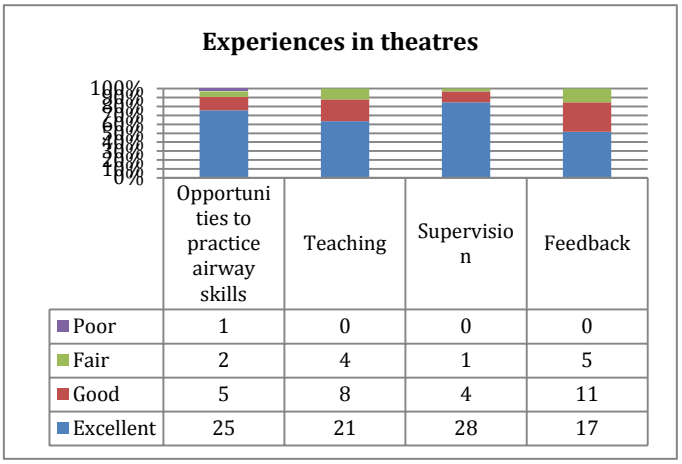
RESULTS

33 responses were received (27%)

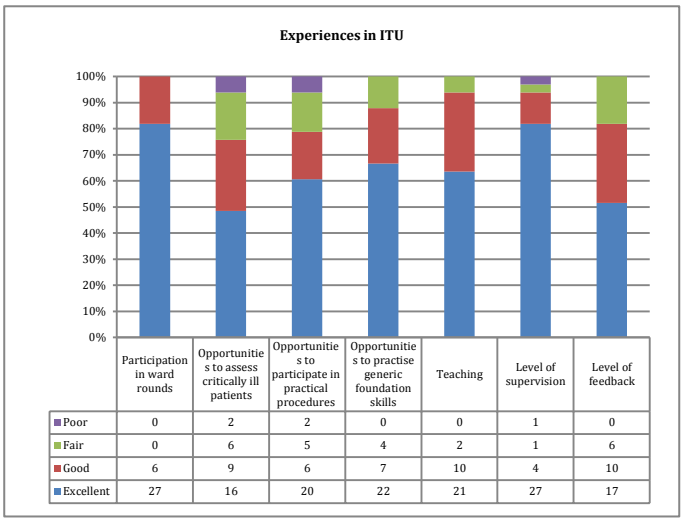
The anaesthetic rotation	Yes	No
Were you considering a career in anaesthetics before the rotation?	**75.8% (25)**	24.2% (8)
Are you considering a career in anaesthetics having completed the rotation?	**81.8% (27)**	18.2% (6)

About the department	Yes	No
Did you clearly know what was expected of you as an FY1?	**78.8% (26)**	21.2% (7)
Did you have a curriculum or set of objectives and outcomes?	**69.7% (23)**	30.3% (10)
Did you receive sufficient departmental and on-the-job teaching during the rotation?	**93.9% (31)**	6.1% (2)

Anaesthetics as part of the Foundation Programme	Yes	No
Was a rotation in anaesthetics useful to your overall foundation training?	**100.0% (33)**	0.0% (0)
Did the rotation increase your confidence in assessing and managing critically ill patients?	**100.0% (33)**	0.0% (0)
Do you feel more confident in your airway skills?	**93.9% (31)**	6.1% (2)
Did you have sufficient opportunities to fulfil e-portfolio requirements?	**100.0% (33)**	0.0% (0)



	Opportunities to practice airway skills	Teaching	Supervision	Feedback
Poor	1	0	0	0
Fair	2	4	1	5
Good	5	8	4	11
Excellent	25	21	28	17



	Participation in ward rounds	Opportunities to assess critically ill patients	Opportunities to participate in practical procedures	Opportunities to practise generic foundation skills	Teaching	Level of supervision	Level of feedback
Poor	0	2	2	0	0	1	0
Fair	0	6	5	4	2	1	6
Good	6	9	6	7	10	4	10
Excellent	27	16	20	22	21	27	17

Discussion

An anaesthetic rotation was viewed as a positive experience by foundation trainees, both as a rotation in its own right and as part of the foundation programme. It was felt to improve confidence in clinical skills, airway skills and management of the acute patient. These are all vital skills for any doctor, regardless of whether a career in anaesthesia is planned or not.

Although there is some overlap between foundation year objectives and those of core anaesthetic trainees, it may be beneficial to develop a more specific FY1 anaesthetic curriculum in order to maximise the skills and knowledge gained in such posts. In addition, having a formal, consistent curriculum or set of objectives

may help to focus teaching, and may help overcome some of the lack of motivation to teach by seniors as discussed by Phillips *et al*[5].

In summary, the combination of positive overall experience, the opportunity to develop generic skills and the ability to meet key curriculum objectives, provides strong evidence for the continued inclusion of anaesthetic posts within the foundation programme in the West Midlands and beyond.

References

1. General Medical Council (1997) *The New Doctor – recommendations on general clinical training*. General Medical Council, London.
2. Norman, J. (1997). Anaesthetic pre-registration house officers. *Anaesthesia*. **52**: 831-2.
3. Higgins, R., Cavendish, S. (2006). Modernising Medical Careers foundation programme curriculum competencies: will all rotations allow the necessary skills to be acquired? The consultants' predictions. *Postgrad. Med. J.* **82**: 684-7.
4. Shippam, W., Warriner, D. (2011). Should foundation year doctors rotate through anaesthetics and critical care? *Br. J. Hosp. Med.* **72**: 358.
5. Phillips, A. J., Kant, A., Chinery, J. P, *et al*. (2007). Foundation doctors in Anaesthesia: should they be taught to administer an anaesthetic? *BMC Med. Ed*. **7**: 48.
6. Mackie, P., Holland, S., Burden, R. J. (2009). The views of Foundation Year 1 doctors in anaesthesia: is this a valuable educational experience? *Anaesthesia*. **64**: 105.

CAN FOUNDATION DOCTORS HAVE INSTRUCTOR POTENTIAL?

CHARLOTTE MARCH
FOUNDATION YEAR 1, ALEXANDRA HOSPITAL, REDDITCH

The Advanced Life Support (ALS) course, created and run by the Resuscitation Council, is a compulsory part of foundation training[1]. In 2011, the 2-day course was attended by 18,208 health care professionals[2]. The course comprises lectures; seminar groups; and practical sessions. Assessment is a continuous process throughout the two days, concluding with a multiple-choice paper and a practical emergency scenario. On completion, course participants gain the ALS qualification and outstanding candidates are invited to become ALS instructors, a prestige bestowed upon 1739 candidates in 2011[2]. The ALS course participants are either newly/re-certifying doctors whose clinical experience ranges from Foundation Year 1 (FY1) doctors to Consultants. It is not therefore surprising that only a handful of candidates identified as having "Instructor Potential" (IP) were FY1 doctors. This article discusses the potential barriers faced by FY1 doctors in becoming an ALS instructor.

When a candidate is identified as showing 'exceptional ability, aptitude and credibility' they may be considered for instructor training[3]. The candidate must firstly be proposed and seconded by two faculty members and then have their overall performance discussed by the whole ALS faculty in relation to the Instructor Potential (IP) appraisal form. The form comprises six sections; MCQ score, communication, enthusiasm, engagement in feedback, interactivity/team working and credibility. Each section is graded as unacceptable, average or outstanding. Potential candidates must achieve a threshold of 'outstanding' in a minimum of four sections to be considered for IP and an 'unacceptable' in any category disqualifies them. The candidate must then complete a three day Generic Instructor Course (GIC) and be observed to teach "satisfactorily" on at least two ALS courses to be awarded full ALS trainer status.

The 'credibility' section can be the stumbling block for FY1 candidates, as they must be deemed to have 'significant clinical experience' and 'occasional exposure to resuscitation and acute care in clinical practice' in order to achieve an acceptable mark in this category. Inevitably FY1 doctors do not have significant clinical experience and often are not involved in medical emergency and cardiac arrest calls. However, most training institutions take the opinion that, by the time the FY1 doctor has completed the instructor training process (mentioned above), they will have gained ample clinical experience. To be deemed 'outstanding' in the other qualifiers is in the hands of the FY1 doctor. Pre-reading the course booklet to gain a good score on the MCQ, together with an enthusiastic attitude and effective application of teamwork skills, stand a candidate in good stead for selection.

As an FY1 doctor who was invited to become an instructor on completing my ALS course, I help illustrate that by being fully prepared, eager to learn and engaging in the course teaching and scenario sessions, FY1 doctors can have instructor potential.

REFERENCES:

1. The Foundation Program Curriculum July 2012, Syllabus, p42, PDF downloadable from: http://www.foundationprogramme.nhs.uk/pages/foundation-doctors
2. Resuscitation Council Newsletter, ALS annual report, Issue 24, Summer 2012, p5
3. Resuscitation Council, ALS instructors guide 2012, Section 8 – Instructor potential

SEAUK

CALL FOR ABSTRACTS

This call is unrestricted however financial prizes will be awarded to Trainees' only

Prizes
Free paper prizes £300 and £150
Poster prize £150

Deadline for submissions
Monday 21 January 2013

Submitting an Abstract – Guidance notes

Your submission must be an educational topic. We are not a forum for purely clinical presentations.
Please indicate if this is for an oral or poster presentation.

Please include:

- Whether the submission is for the free paper or poster prize
- Title, Authors (identifying speaker and grade), Employing institution
- Single A4 sheet. No smaller than Arial Font 10 point.
- Body of abstract max 300 words.
- Introduction/Methods/Results/Discussion or Conclusion
- Max 1 table or graph, Max 3 refs
- Results must be included in the abstract, rather than just "results will be presented"
- Include whether your submission has been previously presented anywhere (this is generally acceptable providing results are still recent)
- Please send a copy to Simon Mercer, Conference Organiser (simonjmercer@hotmail.com) as a Word document.

Free Paper Presentation Guidance

- Maximum of 6 slides
- Presentation should be 7 minutes long.
- You will be stopped at 7minutes.
- 2 minutes for discussion.

Poster Guidance

- Your poster should fit in a space 600mm across by 900mm down (i.e. A1 portrait).
- Velcro will be provided to attach your poster to the stand.
- Posters that do not fit the allocated space may be disqualified.

Opportunity to present at AMEE (Association for Medical Education in Europe) www.amee.org

- We also offer the 1st prize free paper winner the opportunity to choose to submit their work for presentation at the 2013 AMEE conference. This is an international meeting in medical education.
- SEA (UK) will reimburse the cost of your registration (around £450) if you choose to go to this meeting instead of your £300 first prize, should your abstract be accepted by AMEE.
- Please note you will need to submit your abstract to AMEE as per their guidance if you intend to take up this offer.

Society for Education in Anaesthesia (UK)

SEAUK

Annual Scientific Meeting

Monday 4th March 2013

Merseyside Maritime Museum

LIVERPOOL

Educating Anaesthetists "Back To The Shop Floor"

Keynote Speakers

Professor Martin Leuwer
Professor Aidan Byrne
Professor Bryn Baxendale
Dr Ralph MacKinnon

Workshops

Distributed Simulation
Feedback
Trainees Session

Trainees Prize Presentation

For more information visit www.seauk2013.org
or contact administrator@seauk.org