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JULY 2023

Bulletin

The magazine for members of the Royal College of Anaesthetists

A perspective on working with neurodiversity

Page 10

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JULY

Primary FRCA revision course
Online
July–Autumn

Final FRCA revision course
Online
July–Autumn

SEPTEMBER

Joint RCoA, BJA and DAS Webinar
Online
11 September 2023
Free event

After the Final FRCA
Online
13 September 2023

Anaesthetic Updates
RCoA London and Online
27–29 September 2023

OCTOBER

A Career in Anaesthesia
Online
4 October 2023

AaE: Simulation Unplugged
Online
11 October 2023

Anaesthetic Updates
Online
12–13 October 2023

FICM: Striking the Balance
Online
16 October 2023

AaE: An Introduction
RCoA, London
20 October 2023

NOVEMBER

FICM: ICM Clinical Leads Meeting
Online
9 November 2023

RCoA and SSA Joint Winter Scientific meeting
Edinburgh
13–14 November 2023

AaE: ANTs
RCoA, London
17 November 2023

AaE: Teaching and Training in the Workplace
RCoA, London
22–23 November 2023

FPM Annual Meeting
Hybrid, RCoA London and online
28 November 2023

Anaesthesia Research 2023
York
28–29 November 2023

Winter Symposium 2023
Hybrid, RCoA London and Online
30 November–1 December 2023

Royal College of Anaesthetists

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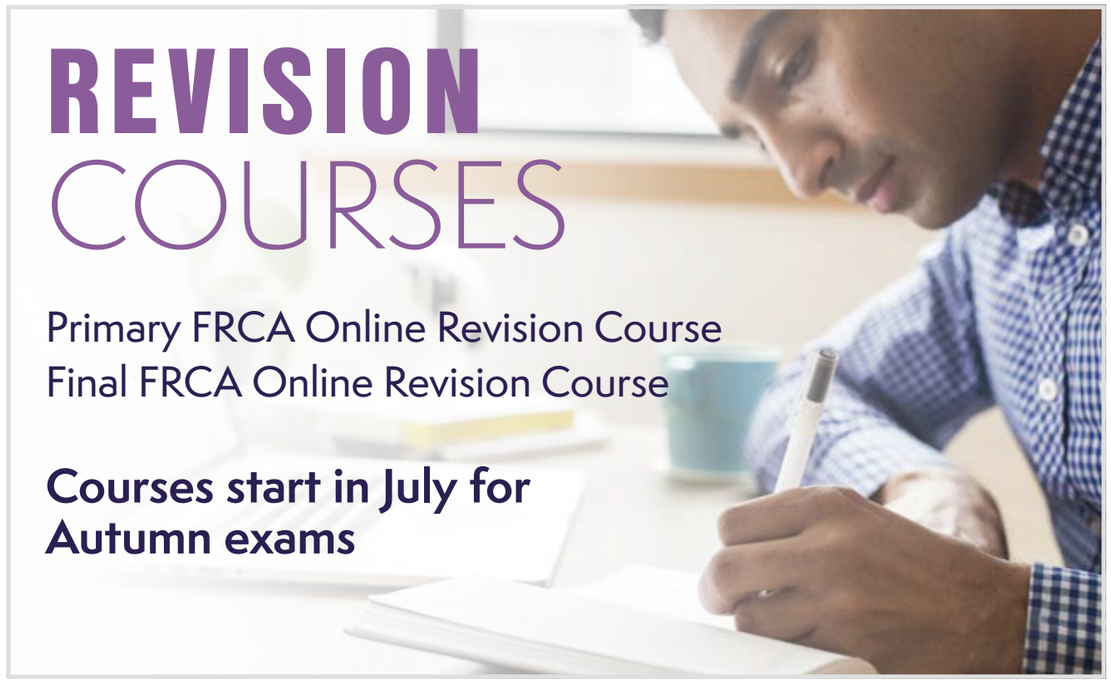
REVISION COURSES



Primary FRCA Online Revision Course
Final FRCA Online Revision Course

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Career in Anaesthesia

4 October 2023 | Online

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

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From the editor

Dr Ramai Santhirapala

Welcome to the July 2023 edition of the *Bulletin*.

As I write this, it is challenging to summarise the state of the UK NHS as anything other than the epitome of uncertainty. Yet many of us, myself included, continue to advocate for a healthcare service so close to our hearts, striving for solutions as we approach the 75th anniversary of the NHS. As someone who comes from an immigrant background, I have personally witnessed sustained periods of uncertainty and instability – and, also, through creative thinking, steadfastness, and perseverance, outcomes beyond any that were imaginable. Observing generations of family, my parents included, undergo the process of building life anew including acculturation, instilled in me from a young age a strong foundation of hope that no situation is insurmountable. This hope is beyond naïve positivity, but rather is borne of a pragmatic optimism resulting from lived experience. As a specialty, we are intelligent, resourceful and innovative – we have 'found a way' countless times.

Understandably, the welfare and morale of those within our specialty have been a particular focus during this time, and you will read more about this in this edition's 'President's View'. While there is no doubt that workforce numbers and conditions (including pay) are crucial aspects of wellbeing, it is heartening to read of impressive initiatives which have had local impact (page 26 and page 40). Further to this, the link between a positive and inclusive workplace and workforce wellbeing is significant. From personal experience, the best way to understand another's experience is to hear it in their own words – 'ask, don't assume'. This premise underpins the 'Guest Editorial' (page 10), which is a brave and open account of living with neurodiversity, discussing the diagnosis of autism later in life and the impact of unconscious biases on an individual.

This transferrable skill of listening to understand is applicable to our patients too. As a keen advocate of championing the patient's voice, I was delighted to read about the College's renewed commitment to patient and public involvement (page 18) and about the brilliantly innovative work on patient information (page 28). Supporting patients as the elective surgery backlog grows, helping them understand the perioperative pathway and what they can do to prepare for surgery are all essential to excellence in patient experience. For most of us, there is no greater satisfaction in our clinical work than a well-prepared patient undergoing surgery who emerges from it pain-free and ready for rehabilitation.

The pace of progress in our specialty continues to astound me, so reading of the early days of the epidural was fascinating (page 50)! Conversely, as artificial intelligence and algorithmic learning are undoubtedly pointing the way forward in healthcare technology, the unusual repurposing of ChatGPT to create 'anaesthesia poetry' will surely bring a smile to your face (page 46).

In short, I know that the current climate of the NHS may seem unrelenting, but I hope you find many opportunities to feel inspired as you read this edition on a tablet, mobile device or (for one last issue) in print. As ever, please feel free to submit articles for future issues of the *Bulletin* to bulletin@rcoa.ac.uk (800 words for a full article or 250 words for a letter). And, of course, I can't leave you without a quote – this time from Nobel Prize winning poet, Joseph Brodsky: 'Creativity is an unending exercise in uncertainty'.

The President's View

LEARNING FROM EACH OTHER

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Dr Fiona Donald
President
president@rcoa.ac.uk

It doesn't seem a moment since I was wishing you all a Happy New Year, and already we are at the halfway point of 2023. The professional highlights of my year so far have been the conversations I've had with many members across the country. I value these conversations, which help me, and colleagues at the College, to understand what you want from your membership, as well as to gauge views on key issues affecting the specialty.

Anaesthesia 2023 in Birmingham

Our flagship annual conference, Anaesthesia 2023, was one such opportunity. We were joined by over 1,400 delegates, both in Birmingham and online, and it was an invigorating experience.

Having specialised in obstetric anaesthesia throughout my career, I was grateful that both Donna Ockenden and Bill Kirkup were able to join us to share their considerable insights on work to address failings in maternity and neonatal care. While the trauma and loss documented in both their presentations was truly harrowing, they prompted useful discussion about the need for obstetric anaesthetists to be an integral and active part of the multidisciplinary team.

This is something we have sought to support through our guidelines and standards. For example, we have ensured that our guidelines for the provision of obstetric anaesthesia services (rcoa.ac.uk/gpas/chapter-9), which we revised earlier this year, are fully aligned with the immediate and essential actions arising from the Ockenden and Kirkup reviews.

Driving quality improvement

The research session included a presentation from Professor Ramani Moonesinghe on the latest findings from our Perioperative Quality Improvement Programme (PQIP). This ongoing study is designed to help improve patient outcomes from major non-cardiac surgery by supporting clinicians to use local data to enhance perioperative care.

There have been some significant improvements in quality of care since the first PQIP report in 2018, which is a remarkable achievement given the impact of the pandemic. The latest report identifies five priorities, which include ensuring all patients receive an individualised risk assessment, effective postoperative pain management and support with eating, drinking and mobilising within 24 hours of surgery.

The value of PQIP lies not only in its robustness as an evidence base, but also in the practical tools and guidance it provides. This includes new online dashboards to provide clinical teams with the most up-to-date postoperative data for PQIP-recruited patients.

You can find out more about the latest findings at our webinar on 11 July. A registration form, along with information about how to get involved with the research, is available on the PQIP website (pqip.org.uk/Content/home).

We have recently conducted two surveys to support our work in lobbying for an increase in ST4 numbers.

Make every contact count with the A-Team Challenge

Anaesthesia 2023 also provided an opportunity to launch new resources to accompany Dennis has an anaesthetic (rcoa.ac.uk/dennis-has-anaesthetic), our Beano comic strip designed to help manage children's preoperative anxiety. The new A-Team Challenge includes a reward chart and stickers to encourage children to prepare for surgery by taking simple steps to eat well, sleep well and stay active.

The resources are designed to help you 'Make Every Contact Count' and our Patient Involvement Lead, Dr Samantha Black, together with Dr Lucy Connolly and Elena Fabbrani, write more about it on page 28.

Many people contributed to the success of Anaesthesia 2023, and I thank our clinical content leads, Dr Toni Brunning, Dr Gunjeet Dua and Dr Claire Mallinson for their excellent curation. I am already looking forward to next year's conference in Glasgow (rcoa.ac.uk/anaesthesia).

Speaking of Scotland, I was grateful for the recent opportunity to attend the Scottish Society of Anaesthetists Spring Meeting in Peebles. It was good to be able to update delegates on the work of the College and answer their questions face to face.

Conversations with College Tutors

Last month, I was in Sheffield for our College Tutors meeting, expertly organised by Dr Sumitra Lahiri and Dr Ruwanmali De Silva. These meetings – attended by over 300 of our representatives – enable us to work collaboratively on all aspects relating to postgraduate training.

Our session on recruitment included discussion of the number of anaesthetists currently unable to secure ST4 posts despite being eligible, which has understandably caused a great deal of upset and concern. We have recently conducted two surveys to support our work in lobbying for an increase in ST4 numbers.

The first survey asks current CT3 anaesthetists in training about their plans once they have completed Stage 1 training, for example whether they are looking to progress to ST4, apply for further experience abroad, apply for an LED post, look to undertake a CESR route or something else. The second asks similar questions of anaesthetists who are now post Core Training/CT3 top up and are currently working in an LED, Trust Grade, Specialty Doctor SAS role or similar.

I'm grateful to College Tutors for their help in collecting this data, which will increase the evidence base about the need for increased training places. While we have been successful in securing some extra places throughout the UK, with more coming next year, these are still not sufficient for the number of doctors requiring them. This issue remains a priority for the College, and we will continue to keep the pressure up and to support those who are not yet in a substantive post.

Addressing differential attainment

Council members Dr Sarah Thornton and Dr Sri Gummaraju led a session on differential attainment. Data from the GMC show significant inequalities in postgraduate medical training for doctors from some ethnic minority backgrounds, Muslim doctors, disabled doctors and those from a lower socioeconomic background. These inequalities are evident in the likelihood of receiving an offer when applying for specialty training and in pass rates for exams.

It is clear that all of us working in medical education need to take action to change this, and to address other persistent inequalities that are having a detrimental impact on individual doctors and the profession as a whole. This is fundamental to the College's core value of justice and fairness, and our work to understand and counter these inequalities includes:

- Undertaking new research to investigate the impact of gender, ethnicity and education background on exam performance. We are also further increasing diversity among our examiners to ensure our examiner pool is representative and inclusive.
- Developing our online training hub (rcoa.ac.uk/training-hub) to make training guidance easily accessible to all and providing training and exam preparation materials for candidates.
- Reviewing and improving our process for responding to requests for reasonable adjustments from candidates.
- Investigating issues relating to equality, diversity, inclusion and representation within the specialty and the College through our Equality Research Project. As a member, you can help us by updating your information in My RCoA (myrcoa.rcoa.ac.uk) so that we can assess diversity trends within our membership.

We are also working in partnership with the Widening Participation Medics Network (wpmedicsnetwork.com) to establish a mentoring scheme – GasReach – to help doctors from underrepresented groups access a career in anaesthesia. We will launch the pilot scheme later this year and will be recruiting members who would like to be mentors. You can read more about GasReach in Dr Colette McCambridge's article on page 38.

Supporting your wellbeing

Our Council Wellbeing Lead, Dr Ramai Santhirapala, led a session on supporting morale and welfare. We have recently published a standardised Departmental Wellbeing Lead job description and person specification (rcoa.ac.uk/news/departmental-wellbeing-lead), in partnership with the Association of Anaesthetists. Our aim is to make it easier for anaesthetic departments and trusts/health boards to support the wellbeing of staff through the appointment of a dedicated lead.

Alongside this, we have created a new wellbeing hub (rcoa.ac.uk/wellbeing-hub) on our website, which features resources to support your individual wellbeing, as well as those to help you embed wellbeing good practice within your department.

In talking about wellbeing, it would be remiss not to mention industrial action and the reasons for it, which are of course intrinsically linked to conditions of work and their effect on morale. As I write this, action by junior doctors in England is ongoing and by the time the *Bulletin* is published, we will know the outcome of the BMA's ballot of consultants. Our focus remains on supporting our members during what is a difficult time, and we have updated our industrial action information and FAQs (rcoa.ac.uk/working-anaesthesia/industrial-action).

NHS 75 and looking ahead to Autumn

The next big event in the College calendar is the Presentation of Diplomates Ceremony on 8 September. I am looking forward to meeting everyone attending this special day of celebration.

Finally, the publication of this issue of the *Bulletin* coincides with the 75th birthday of the NHS. There is much I could say about that within the context of current challenges, but to end on a positive note, I will simply reflect that the NHS continues to be a source of national pride. And that is because of you. It is your dedication and expertise, alongside that of our colleagues across the health service, that is so highly valued by millions of patients, year after year. In that respect, the NHS is no less extraordinary today than it was in 1948.

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Bulletin

of the Royal College of Anaesthetists

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CEO Update

Making the College's assets work for you

In my last update, I mentioned that the College has been addressing some financial challenges.

We are committed through our current five-year plan to manage the College's resources with care, and to 'ensure the College is resourced and equipped to carry out its strategy: now and in the future'. One of our core values is being open and responsive, and in that spirit I am keen to share with you our current financial position, and what we are doing to improve it.

In late 2020, the College's trustees recognised an emerging risk: our planned expenditure would repeatedly exceed our projected income for many years to come without immediate intervention, leading to a steady erosion of the College's cash and assets. This risk had been compounded in the early stages of the COVID-19 pandemic, when large investments in digital services had been required to ensure delivery of the College's core activities during the lockdown.

While end-of-year outturns were sometimes healthier than our budgets had predicted, our long-range financial forecasting was far less optimistic, and it was clear that action needed to be taken to address things proactively, before the risk became a reality.

Following a period of planning and review, the College's trustees and executive staff instigated a Financial Recovery Plan (FRP) which set out a phased approach to cost control, cost recovery and the sourcing of new income. We first reviewed all College activities to see where we could make savings and identified a number of areas that could be delivered more efficiently, or where greater value could be obtained through negotiation of major contracts.

We also confronted some very complex and sensitive issues, including the delivery of a new pay policy and pension scheme for staff that would help us control salary inflation at the College in the medium- to long-term. That process has now concluded and I am hugely grateful to the entire staff team for engaging in the pay policy consultation with such openness and understanding during what I know are difficult times for everyone's personal finances.

I'm pleased to report that, a year into the delivery of the FRP and while we are still carrying a deficit budget, we are substantially ahead of our recovery targets. We will work hard to ensure we hold the gains we have made so far, and deliver our goals in full in the coming months and years.

In the meantime, the process of considering our financial position in such depth has inspired us to look again at the way the College utilises its assets on behalf of its membership and beneficiaries.

We are very aware that the College's assets include a significant amount of property which, whilst working well as a long-term investment, may not provide the best value for our members in the immediate term.

The College is based at Churchill House in Holborn, Central London. Churchill House is an impressive building and an important focal point for members, but it is used infrequently by the majority of our members and, with the advent of hybrid working and events and online, remote delivery of written examinations, has less utility now than it did just a few years ago. The time is right for the College to consider if this asset is being appropriately utilised for its charitable purposes. To that end, trustees will be looking hard in the coming year at the use of Churchill House and the best way to build a College estate that is fit for the future in the service of its members and the specialty.

In the meantime, the staff team is making the most of hybrid working by condensing working space by 50%, and introducing hot-desking to create a busy and energetic place for staff to work and members to visit. This plan

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will also mean we can lease some of our remaining office space, which we hope will generate new income to the College – further supporting our FRP.

The ultimate goal of the FRP is to ensure the College delivers a balanced operational budget with adequate additional funds to enable us to be innovative and progressive. We must not simply deliver profit without purpose – we must deliver a more equitable College.

As a membership body, roughly 57% of our overall income comes from membership subscriptions, 19% from examinations (all of which is ploughed back in to our exams), 10% from events, with the remaining 17% coming from other sources. You, our members, are directly funding a huge share of everything we do and, while that might be very reasonable given that we are a membership body, we have a duty to consider whether this is as balanced as it should be.

The issue with this model is that, in an age of rampant inflation, we find ourselves unable to protect members from the College's rising costs. There is no buffer. The opportunities to invest in new services for our members or to make much needed improvements are limited by our lack of revenue generated from other activities. This is the next phase of the FRP: to seek to generate additional income from sources other than our membership, through fundraising, sponsorships, educational content and international outreach.

The changes in our approach to the College's finances and assets are aimed at creating that much needed financial buffer between what our members pay and our costs, and we are already starting to see the effect of some of this work. This year we will be able to propose to AGM that fee rises will be kept as low as possible, and that there will be a cap on membership subs for Anaesthetists in Training – holding them at the current rate. Our exam fees – on which we do not make a surplus – were due to rise by 7%, but we have been able to reduce this to 5% whilst still being able to invest in additional exams staff to ensure the delivery of secure, high-quality exams. This is a small step, admittedly, but in the right direction, and we hope that more steps will follow soon.

I hope this article goes some way to explaining the depth of care and consideration taken by trustees and staff in the stewardship of the College's assets, as we seek to make them work harder and smarter for you.

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Guest Editorial

A PERSPECTIVE ON WORKING WITH NEURODIVERSITY

Anonymous

In a recent correspondence, I wrote: 'So many ideas flying around in my head (ADHD). I need to pin them down, put them in order (ASD), and get started (ADHD inertia). I'm over the "I'm broken" phase and now feel that my mission before I finally retire is to help others realise they're not broken either'.

Why? A *Bulletin* article entitled 'Equality, diversity and inclusion (EDI): what it means to the College'[1] with no mention of neurodiversity! The College wants to 'develop a dataset of the profile and diversity of their membership and workforce', but without neurodiversity questions I feel excluded!

One in a hundred young people have an autism spectrum disorder (ASD); 10 per cent of these may become high-functioning adults.[2] Between three and six per cent of children have attention deficit hyperactive disorder (ADHD), and for one in seven of these ADHD will continue into adulthood.[3] Also, adults with ASD are more likely to have ADHD![2] Everyone has individual attributes and characteristics. Experience of autism is also unique; this is the power of neurodiversity. Some professions, for example aerospace, screen positively for autistic traits[4] – methodical, attention to detail, ability to hyperfocus, pattern recognition, visual memory, and novel approaches to problem solving. Medicine, particularly anaesthetics, lends itself to the traits of ASD, and as such it's likely that the prevalence there of autistic traits is much higher.[5] Since a 'light-bulb moment', and since sharing my suspicions, five out of twenty SAS doctors and eight out of twenty-seven consultants in my department have confided that they have children with ASD and/or ADHD, and/or that they have suspicions about themselves, thus supporting my hypothesis that the prevalence of autistic tendencies in the medical profession could be as high as 25 per cent!

My childhood wasn't unique. At school, despite appearing sociable, I had few friends and often felt excluded. I was noisy, full of unpredictable energy and bullied for being different. Due to anxiety, I excelled in class but didn't do well at exams, leaving school at the age of 16 with two non-science GCSEs.

After numerous jobs, I passed an entrance exam for nursing aged 21. Training was difficult, but I achieved state registration at my second sitting. Studying O- and A-levels in my late 20s, I achieved mediocre grades. Luckily, aged 30, I was accepted into a London medical school that accepted almost 50 per cent women and 20 per cent mature students – progressive in 1987!

Results were hard-earned and unremarkable, requiring hyperfocus. My sister (a paediatric forensic speech pathologist), diagnosed dyslexia and dyspraxia in the 5th year, after noticing my unconventional visual learning style. Too late for final exam accommodations, but I achieved MBBS aged 36 at my second sitting.

House jobs spent away from home saved my marriage from the stress of chronic sleep deprivation. Inspired by anaesthetists while working as an ITU Nurse, I hoped for an anaesthetic career. The same department gave me the chance. Leaving the over-stimulating bustle of wards to become a junior anaesthetist was a relief. Performance anxiety became manageable, and I felt supported. However, home circumstances meant that after 18 months, the next decade was spent learning experientially as a locum.

After I had failed FRCA primary twice, a trusted mentor helped me obtain an SAS post and promotion to associate specialist on merit. My 'no-nonsense, highly-structured and organised approach' to anaesthetic SAS lead, to service development, to rotas, and to teaching was valued but not always understood. Achieving a DipMEd supported my educational role, and I was considered someone with 'infinite energy' and a 'can do' attitude. Unable to say no for several years, I found myself overwhelmed a decade ago, requiring a lifestyle change.

Now 'retired and returned', I'm a part-time bank associate specialist in a small district general hospital. The 'light bulb moment' came two years ago after chatting with a neighbour about her autistic daughter. In part, she was describing me! After research and self-testing it was clear – I'm autistic! It explains a lot, but not everything! Another conversation with a colleague and more research added ADHD, an auditory processing deficit, and sensory issues to my quirkiness. Over the years, I've been criticised for being:

- 'difficult' or 'confrontational' for speaking up when seeing an injustice or substandard care (ASD)
- 'rude' for interrupting conversations (ADHD), asking direct questions for clarity, or sending concise emails (ASD)
- 'awkward' for asking people to 'show me, not tell me' (APD)
- 'feisty' for having meltdowns when tired, ill or stressed (ASD and ADHD).

No one criticised my work, only the quirkiness of my personality. I have often felt sad and broken!

I'm not broken, I'm ASDie with ADHD! Learning about emotional intelligence, developing a professional 'mask', personal resilience, and self-devised accommodations helped me function.

Failing to meet training milestones because of neurodiversity does not mean a doctor is incapable. However, they may be unable to continue without help. Some become SASs, others find another specialty or leave medicine altogether. Building knowledge and raising awareness about neurodiversity in the profession of anaesthesia could boost retention and help those doctors achieve their potential and realise that they too are not broken.

References

1 Equality, diversity and inclusion (EDI): what it means to the College. *RCoA Bulletin*, January 2023 (https://bit.ly/3nM68AP).

2 Autism and Autism Spectrum Disorder (ASD) for parents and carers. *RCPsych* 2020 (https://bit.ly/42KvdLd).

3 ADHD in adults. *RCPsych* 2021 (https://bit.ly/3nIHWQ2).

4 BBC South West news February 2023 about South West Aerospace in Cornwall.

5 Doherty M. Neurodiversity in practice: autistic anaesthetists can be an asset. *Anaesthesia News*, December 2020 (https://bit.ly/3HUs3N6).

Please see our website for our podcast on neurodiversity in anaesthesia:

rcoa.ac.uk/podcast/neurodiversity-anaesthesia

Faculty of Pain Medicine (FPM)

A career in pain medicine

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The development of the 2021 RCoA curriculum has raised the profile of pain medicine, with pain management embedded as one of the key specialty domains.

Pain medicine has developed, shifting from solo consultant practice to multidisciplinary working and collaborative work with other medical specialties in a variety of settings. This work often includes inpatient, outpatient, and pain-interventional activity.

Doctors who pursue a career in pain medicine have the opportunity to develop specialty interests in the following areas:

- academic pain medicine
- acute pain
- advanced interventional pain medicine/neuromodulation
- cancer pain
- chronic pain
- community pain medicine
- disease specific specialist areas
- paediatric pain medicine
- pain medicine and substance misuse disorder
- medicolegal pain medicine
- rehabilitation pain medicine.

Historically, pain medicine has been hindered by the absence of specialty recognition with the General Medical Council (GMC). The FPM has worked with the GMC to develop a credential in pain medicine which has been approved for implementation, allowing specialty recognition. The special interest area (SIA) in pain medicine within the anaesthetic curriculum is mapped to the credential curriculum. Trainees who complete the SIA in pain medicine and the FFPMRCA will gain their CCT in anaesthesia and the credential in pain medicine. The credential in pain medicine will also be open to consultants considering a career change and to doctors from other specified medical specialties. There will also be a recognition process for credentialing for existing pain medicine consultants.

Like anaesthesia, pain medicine is projected to experience significant workforce challenges. Women account for only 25 per cent of the consultant workforce, despite the flexibility of working and the positive work-life balance that is afforded within the specialty. Annually, there are approximately 28 SIA pain medicine posts in the UK. A career in pain medicine offers a flexibility and variety of clinical work that complements a career in anaesthesia.

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Faculty of Intensive Care Medicine (FICM)

Careers, Recruitment and Workforce Committee

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Critical Staffing matters

Providing safe critical care services is core business for acute hospitals; this is ever more challenging when faced with burgeoning elective surgical pathways, an ageing and more co-morbid population, and new treatment modalities. Maintaining an appropriately trained, motivated workforce is key to this.

The FICM's Careers, Recruitment and Workforce Committee (CRW) has been seeking as much data as possible regarding the staffing of ICUs in the UK. The FICM conducted its annual census, of clinical leads, in 2022. We publish some of the analysis in FICM's Critical Eye publication. The 2023 census will look to strengthen our understanding of the issue all ICUs are faced with. The Scottish Critical Care Delivery Group's detailed census resulted in the Scottish government supporting 16 newly funded intensive care medicine specialty training posts for 2023. A quick snapshot survey of the regional advisors regarding consultant vacancies versus training numbers demonstrates geographical variations that need considering. Details on small and specialist ICUs are being sought. All of this will help with FICM's lobbying for appropriate increases in workforce; this is timely, with NHS England conducting workforce strategy planning meetings that FICM attend and with the government's long-awaited NHS workforce plan.

Regarding supply, the annual national recruitment round has just completed, with 176 StR posts offered across the UK's regions. Huge thanks to Dr Tim Meekings, who, for the last three years, has led the FICM Recruitment team that liaise with the National Recruitment Office for ICM in the West Midlands. There are increasing numbers of doctors pursuing CESR training pathways; FICM has been developing its information resources to support these doctors and their supervisors, and increasing our bank of CESR assessors for applications that come to the GMC.

Intensivists are a heterogenous group. Examples of the varied job plans and routes to the specialist register (via dual/triple CCT or CESR) are being provided on the website by CRW working with FICM StR representatives. Looking after staff wellbeing and assisting those returning to work in critical care has been addressed in the Critical Staffing three-part series. The last of these was published in the autumn of 2022.

The FICM's Careers, Recruitment and Workforce Committee has been seeking as much data as possible regarding the staffing of ICUs in the UK.

SAS Doctors

I have been fortunate to work with Laura Hipple, who is an inspiring SAS colleague from the Royal College of Obstetricians and Gynaecologists (RCOG), through her role at the Academy of Medical Royal Colleges (AoMRC). Laura's reflections of her journey assert that the only limits to progress are the ones in our mind.

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Dr Laura Hipple
Vice-President for Membership and Workforce, Royal College of Obstetricians and Gynaecologists

SAS as leaders: breaking the glass ceiling!

It all started conventionally enough – A-levels, a medical degree, house officer jobs. Nobody in my family was medical, so I had no preconceived ideas about postgraduate career pathways.

During my interview for the regional Obstetrics and Gynaecology training scheme, I was asked how I would combine this career with getting married and having a family. As I wasn't in a relationship at the time, I didn't feel this was a major consideration, and fortunately neither did the other members of the interview panel!

However, having completed the training scheme and obtained my MRCOG, my career then took a different path...

At this time, extra posts were being funded to help reduce working hours for hospital doctors. The unit I was working in knew I had personal reasons for staying – I was no longer single and my partner was not keen to move. The traditional career pathway (research, senior registrar rotation, consultant) wouldn't work now I wanted to get married and start a family.

The 48-hours-per-week staff-grade post created locally offered geographical stability and regular hours – my dream job!

I applied, got the post and started my SAS career in May 1993, initially at 'registrar level', working with a 'named consultant' in every clinic/theatre list. I negotiated a temporary pay cut to release funds for training to obtain a Diploma in Advanced Obstetric Scanning. These scanning skills proved invaluable – training other staff and helping to develop an early pregnancy unit and improving local fertility service provision.

Geographical stability and regular hours continued to be important after my first marriage ended and I juggled full-time work with co-parenting. Moving away and doing rotational jobs with irregular hours simply wasn't feasible. After 10 years in the post and a departmental visit by our college, it was suggested that I should be promoted to an associate specialist position. I was delighted but surprised – why would you pay me more for doing the same job? Because when you retire, we can replace you with a consultant came the reply....

As senior consultant colleagues retired, I became the 'lead clinician' in the clinics I had worked in. Eventually these clinics were coded in my own name and I took on more 'consultant-level' weekday sessions and roles. I became an educational supervisor for foundation and specialty trainees and a clinical supervisor to GP registrars. All these roles were recognised in my job plan in the same way they were for consultant colleagues. I became an SAS tutor and an appraiser. I was local principal investigator for several national research studies.

I was encouraged to apply for a clinical director role, but didn't get the post. This meant I was able to apply for the RCOG SAS/Locally Employed Doctors lead position that had come up at the same time. I was appointed and became the first SAS doctor to sit on RCOG council.

It was a steep learning curve! In this role I also sat on the AoMRC SAS Committee. I had several meetings to attend and national papers and conferences to contribute to. This national work was done in my own time/study leave. I negotiated five days per year professional leave and cut my paid hours by a session per week to help me manage it. I was fortunate to be at a stage in my life/career when I could afford to do this, and the satisfaction I got from the work more than made up for the slight loss in income.

After COVID, and approaching 60 years of age, I decided to reduce my paid hours further, but was persuaded to apply for a new local SAS Lead role alongside my (now shared) SAS tutor role. This gave more opportunities to use the knowledge I had gained nationally to support local SAS doctors. Meanwhile it was suggested that I consider applying for an RCOG vice-president role. I had now been on council for several years, but the encouragement and support of respected senior colleagues was invaluable as I felt a complete fraud! I was honoured to be voted one of the new vice-presidents by fellow council members and took up my position of Vice-President for Membership and Workforce in December 2022.

The post is challenging with another steep learning curve, but also incredibly interesting and rewarding. I have had to fight 'imposter syndrome' and learn the value and insights that 30 years' experience of a different career path can bring to the table.

So, what have I learnt about SAS careers in the last 30 years? That job plans can vary (choose your unit wisely!), that priorities can change over time, that lack of success in one area can open opportunities in another, the value of supportive teamwork and of continually learning, that work is not about money alone, and the importance of understanding what gives you joy at each stage of life.

Please see our website for further information on SAS Doctors:

rcoa.ac.uk/sas

Revalidation for anaesthetists

Continuing Professional Development in the first six months of 2023

Chris Kennedy, RCoA CPD and Revalidation Co-ordinator
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The first six months have been extremely busy in the world of CPD at the College. At the end of May, the Lifelong Learning Platform featured more than 156,000 individual CPD activities which had been added and reflected upon.

Good Medical Practice (https://bit.ly/3MhozqF) talks about the importance of regular reflection on the standards of practice and care which are provided, and this will help a doctor assess whether their learning is adding value to the care of their patients and improving the services in which they work.

Doctors should demonstrate that they are reflective practitioners by reflecting on the learning gained from their CPD and from any changes made as a result, including any further learning needs identified. They should also consider any impact (or expected future impact) on their performance or practice. This is framed in the Lifelong Learning Platform with reflective sections to be completed for review, experience gained and resulting change (sometimes described as 'What? So what? Now what?'); the amount written should be kept proportionate to prompt further verbal reflection during appraisal.

Earlier this year, our external system developers resolved an issue with the Lifelong Learning Platform so that the end date for any CPD activity added now automatically defaults to the start date (although this is still editable) to ensure that the 'filter-by' option for the activity report will function correctly. At this time the word 'optional' was also removed from the end-date field. Any users still experiencing difficulties with the activity report are requested to contact cpd@rcoa.ac.uk.

We also continue to receive a large number of applications for CPD event accreditation (rcoa.ac.uk/cpd-accreditation) – there were more than 420 applications between 1 January and 31 May 2023. These include events organised by the College and faculties and also NHS trusts, regional associations and specialist societies, etc. If you have been to any such event, you are always advised to first search for it in the Lifelong Learning Platform; if it has been accredited by the College you can avoid lots of duplication of effort by associating it with the CPD activity which you create.

All applications undergo a two-stage review process: an administrative check at the College followed by a technical content check by a CPD Assessor (who are all practising clinicians). We are always very keen to hear from new CPD Assessors, and full information is available on our website: rcoa.ac.uk/get-involved/cpd-assessor. We look forward to hearing from you.

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PERIOPERATIVE JOURNAL WATCH

Dr Stuart Connal, Fellow in Perioperative Medicine, North Central London Deanery

Perioperative Journal Watch is written by TRIPOM (trainees with an interest in perioperative medicine – tripom.org) and is a brief distillation of recent important papers and articles on perioperative medicine from across the spectrum of medical publications.

Does melatonin administration reduce the incidence of postoperative delirium in adults? Systematic review and meta-analysis

Postoperative delirium (POD) is associated with increased morbidity and mortality. Melatonin may have a role in prevention of POD. The authors examined the relationship between melatonin administration and POD.

A search of electronic databases from 1990 to 2022 identified 11 eligible studies including 1,244 patients from a range of surgical specialties. The primary outcome was incidence of POD in adults undergoing surgery. The combined odds ratio (OR) of developing POD in the melatonin groups versus control was 0.41 (95% CI 0.21 to 0.80; p=0.01).

The authors conclude there is moderate certainty evidence for melatonin as effective prophylaxis for delirium. However, there was heterogeneity/inconsistency such as melatonin regime, study methodology, tools to diagnose POD, and outcome reporting. Most studies excluded patients with pre-existing cognitive impairment.

POD prevention may require multimodal bundles rather than single interventions, but consensus on how to deliver melatonin and evaluate results will facilitate further work.

http://dx.doi.org/10.1136/bmjopen-2022-069950

'It was a great brain, and I miss it': lay perspectives on postoperative cognitive dysfunction

Postoperative cognitive dysfunction (POCD) – more appropriately classified as perioperative neurocognitive disorders – may occur after surgery and anaesthesia. This qualitative study explored lay perceptions of POCD using thematic analysis of website user comments submitted under an article published by the *Guardian* in April 2022: 'The hidden long-term risks of surgery: "It gives people's brains a hard time".'

Key themes identified by analysis of 84 comments include the subjective and functional impact of symptoms; emotional/psychiatric impact; perception of causes, particularly concerns about general anaesthesia over consciousness-preserving techniques; importance of sharing information, and inadequate preparation and response by healthcare providers.

This qualitative analysis is limited to a narrow sample of voluntarily submitted comments for which demographic or other objective data cannot be ascertained. Public messaging and improved communication may align professional and lay understanding of POCD.

https://doi.org/10.1016/j.bja.2023.02.003

Novel predictors of mortality in emergency bowel surgery: a single-centre cohort study

The National Emergency Laparotomy Audit (NELA) score has previously demonstrated good discrimination and calibration in predicting 30-day mortality, but it includes subjective values such as surgical urgency and anticipated intraoperative findings.

This single-centre cohort study used local NELA data for 1,508 patients from 2013 to 2020 to develop a logistic regression model incorporating risk scores which use only preoperative data (vital signs, routine bloods, frailty assessment) to predict 30-day mortality after emergency bowel surgery.

A novel model combining age, National Early Warning Score (NEWS), Laboratory Decision Tree Early Warning Score (LDTEWS), and Hospital Frailty Risk Score (HFRS) demonstrated good discrimination and calibration (c-statistic 0.827), only slightly outperformed by the NELA score (c-statistic 0.861).

Data available before surgery can be used to predict 30-day mortality in this population, which should inform risk adjustment, resource allocation and shared decision-making.

https://doi.org/10.1111/anae.15966

Feasibility and outcomes of a real-world regional lung-cancer-prehabilitation programme in the UK

Prehab4Cancer (P4C) is a collaboration across Greater Manchester incorporating exercise, nutrition, and psychological assessment and interventions.

The authors studied the feasibility, uptake, and outcomes of the P4C lung cancer service from April 2019 to March 2020. 377 patients with lung cancer planning surgical resection were referred to P4C, of whom 74.3% (n=280/377) attended initial assessment and 47.7% (n=180/377) completed the programme.

Quality of life and functional capacity were assessed at the start and end of prehabilitation. Statistically significant improvements were seen across all domains, including incremental shuttle walk test (ISWT), WHO Disability Assessment Schedule, and European Quality of Life Five Dimensions (EQ-5D).

The authors conclude that P4C offers a framework for developing a multimodal prehabilitation service delivering improved functional performance and high patient uptake. The service has subsequently expanded to include patients with Stage III–IV lung cancer not amenable to surgical resection.

https://doi.org/10.1016/j.bja.2022.05.034

The College is committed to developing a collaborative programme for the delivery of perioperative care across the UK: cpoc.org.uk

PatientsVoices@RCoA

MORE THAN A NEW NAME: a renewed commitment to PPI

At the start of this year the College launched PatientsVoices@RCoA (rcoa.ac.uk/patientinfo/patientsvoices), the new name and brand for what was previously known as the RCoA Lay Committee. This is just one of a number of things that the College is doing to strengthen the patient voice in its work. In this issue I'm talking to Elena Fabbrani, Patient and Public Involvement Manager, about the College's wider work in the area of patient engagement.

We thought we'd have a bit of fun in the last issue, so we turned El and Pauline into avatars!

Pauline Elliott
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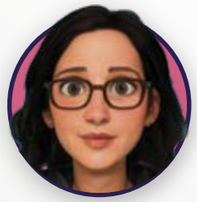

Elena Fabbrani
RCoA Patient and Public Involvement Manager
patientsvoices@rcoa.ac.uk

Hi El, it's great to talk to you. Can you tell me a bit about your role and the renewed commitment to patient and public involvement at the College?

I've been involved with the Lay Committee and the production of patient information for many years. However, last year the College decided that it was time to relook at how it does patient and public involvement (PPI). It decided that this was best done with a dedicated member of staff. That's how my role came about.

The aim of the role is to, in time, develop a dedicated PPI function working across all directorates and supporting impactful patient engagement across a wide range of College projects. To help achieve this, we've set up a network of PPI champions – members of staff who are passionate about patient engagement and who can support and share good practice in their teams. After all, good patient engagement is everybody's responsibility!

Why now? What made the College recognise that it needed to improve the way it engages with patients and their representatives?

I think a number of things contributed to this decision. Externally, there's a changing landscape when it comes to PPI. There's much more focus on active participation, for example in the design of healthcare services. Generally, many organisations are moving away from more traditional and at times tokenistic approaches to patient engagement. Within the anaesthetic community, shared decision-making and the Montgomery ruling have brought to the fore the importance of meaningfully involving patients. Rightly, this ethos is permeating much of what the College does, including how it engages with the diverse patient communities our members look after.

Where does PatientsVoices@RCoA fit into all this?

We knew that a good starting point was to build on the success of the Lay Committee and modernise our approach to PPI. When we surveyed the Lay Committee members in 2020, they told us quite clearly that they wanted to have a stronger voice as a group within the College and that they wanted to be more impactful in representing the views of patients. Hence the decision to change their name and to give them their own identity. So, PatientsVoices@RCoA are a key element of our PPI work.

What are the College's strategic aims around PPI?

I'm really glad you asked that question, because a new name and a shiny logo are great, but they need to be backed up by solid strategic aims. In fact, we already have a strong foundation with the College strategy's Healthier outcomes for all (rcoa.ac.uk/about-college/strategy-vision) strategic theme and the PatientsVoices@RCoA strategy (rcoa.ac.uk/patientsvoicesrcoa-strategy). These give us a very clear direction in terms of using a partnership approach in helping patients achieve better outcomes and strengthening the voice of patients in our work.

These are very worthy but ambitious aims. How is the College going to deliver on these?

We've realised that we need to change the way we think about PPI at an organisational level. Since 1998 we've used the Lay Committee as our primary method of engagement. Doing things differently will require learning new ways of working and having a different mindset about patient engagement. This is why we decided to write a Patient and Public Involvement strategy (rcoa.ac.uk/patients/commitment-ppi), the first for the College. It sets out a roadmap for staff and clinical leads, and shows what good PPI looks like. It builds on the strategic aims which I've already mentioned and turns them into practical things that we can do as an organisation to achieve truly meaningful patient engagement. Importantly the strategy will be translated into key performance indicators for teams in their operational plans, so that we can measure the impact and the delivery of our PPI objectives.

You talked about showing what good PPI looks like. Can you give me some examples of what we might be seeing that's new and different over the coming years?

You can certainly expect increased visibility for PatientsVoices@RCoA. We were delighted that you led the breakout session at Anaesthesia 2023 on digital advances in preoperative assessment, and I'm hoping that in the future you'll be able to host your own events and conferences for the benefit of both our members and the public. You can also expect to see a much more diverse range of patients' voices and lived experiences, as we are looking to collaborate more closely with organisations who can help us reach different sections of the patient community.

Thanks Elena. I'm greatly encouraged by the College's commitment to PPI, and all members of PatientsVoices@RCoA are looking forward to working with you and the College to deliver on these aims over the coming years.

Find out more about the work we do on our website:

rcoa.ac.uk/patientinfo/patientsvoices

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Anaesthesia Clinical Services Accreditation (ACSA)

ROUND TWO
ACSA re-accreditation at Dorset County

'The pessimist complains about the wind; the optimist expects it to change; the realist adjusts the sails.'
[William Arthur Ward]

Round one

Our path towards accreditation started back in 2014. We felt we were a good and forward-thinking department, but the challenge was (a) is it true? and if so (b) could we prove it?

The ACSA process gave us the platform and the tools to provide assurance that we had the policies, and personnel in place, but also highlighted the gaps that had developed over the years. Our original involvement with ACSA and subsequent accreditation in 2018 was a positive experience. ACSA gave the department a common purpose and an opportunity to involve the whole theatre community in reviewing how we work and why we do what we do. We took pride in benchmarking ourselves against nationally agreed standards and opening the department up to external scrutiny. That said, our accreditation in 2018 was not the end of the story.

Next steps

Engagement with ACSA is an ongoing process which is built around a four-year cycle. Since 2018, as with all accredited departments, we have been undertaking compliance checks with the ACSA team to keep us on track with any new standards. In addition, the introduction of the new ACSA Portal web platform (acsa.rcoa.ac.uk/register) enabled us to upload evidence as we worked towards our re-accreditation visit in 2022. The ACSA Portal can be accessed by the departmental ACSA lead and team members, the ACSA team at the College and members of the peer-review team. This is an excellent resource and made the process of preparing for our re-accreditation visit much easier. The Portal also contains 'help notes' and examples from the 'Library of good practice' linked to each standard. It was good to see this information being made more accessible to departments working towards accreditation. If other departments have developed policies, procedures and protocols that have met the ACSA standard, then why reinvent the wheel? Sharing this evidence and learning is one of the significant benefits of the ACSA process.

ACSA and COVID-19

COVID-19 arrived midway through our four-year accreditation cycle. As with all other departments, the pandemic turned our hospital upside down. Many of our normal processes, protocols and policies became redundant, new ways of working flooded in, and elective surgery was put on hold. As

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the pandemic abated, we struggled to remember how our theatres used to run efficiently before COVID-19 as everything seemed harder to do than before.

As a department we had to decide if we used the disruption of the pandemic as an excuse for delaying our ACSA re-accreditation or as a tool to help us put our department back together. I return to the quote at the start of this article, should we 'complain about the wind' (boy, did we complain...), do we wait for 'the wind' to change direction (tempting), or do we readjust the sails we have been left post pandemic, and move forward. Eventually we chose the latter.

Round two

ACSA post pandemic was not easy. We needed to adjust much of the evidence we had previously provided to reflect how we now worked post COVID-19. Our pre-assessment unit (PAU) and perioperative medicine clinic (POM) had been moved off site, our surgical admissions were in a new, less ideal part of the hospital, and theatres had been restructured. A number of staff had moved on, and their replacements were new to the ACSA process. But, as we worked our way through our self-assessment, we found glimpses of how we used to work being reintroduced and that some of our new ways of working were better suited to the ACSA standard. Significantly, the more recently introduced standards, based on the GPAS 'Good department' chapter, were particularly relevant post COVID-19. The focus on departmental wellbeing, leadership, rest facilities and team-based training helped bring a renewed focus on supporting our colleagues.

Is it still worth it?

If ACSA remained a one-off event, it would lose much of its benefit. Our ongoing engagement with quality improvement through ACSA has helped restore our departmental focus. Much of our recent success with improved staffing (obstetrics), maintenance of rest facilities and additional PAU/POM clinic capacity has come through a desire to meet the requirements of ACSA. Also, it is good to know that we are not alone. At the last count, 124 departments are registered with ACSA, 79 are subscribed, 46 are accredited and 17 have now been re-accredited.

Engagement with ACSA requires a whole-departmental effort and the involvement of the wider theatre teams. It remains a pragmatic and achievable goal, but it requires a willingness to be honest as to where you do well and where you could improve. For us, ACSA has helped us to make the positive post-pandemic decision to 'adjust our sails' and start moving the department forward once again.

MEET YOUR NEW COUNCIL MEMBERS

In recent years the College Council has grown the number of co-opted members of Council to include representation from anaesthetists in training, FRCA examinations, defence anaesthesia and regional advisors anaesthesia. Since September 2022, the College Council has welcomed new representatives to support all clinical, professional, and health policy matters. Following on from the four new Council members featured in April's *Bulletin*, you can read more about our new members below.

Self-nominations for election to Council of the College will be opening in **September 2023**. Joining Council provides you with an excellent opportunity to contribute to your College, influence our professional policy, and represent our Members at all stages of their working lives. We are keen to achieve a diverse and representative Council so if you are interested in talking to our current Council members, please email **ceo@rcoa.ac.uk** and we'll put you in touch.

DR ROGER SHARPE
(co-opted member)

Why did you run for Council?

I am a co-opted Council member representing FRCA examinations. I am in my 13th year as an examiner, and was appointed chair of FRCA exams in 2022. I particularly enjoy this role, as it involves working with many stakeholders, including the College Council and Board of Trustees, the exams team, the examiners, and trainee representatives. I came into the role at a time when detailed internal and independent examination reviews were concluding, and I have been working with the above stakeholders to produce an action plan to implement the Exam Review's recommendations over the coming months and years. I recently retired and returned to part-time NHS practice, which has given me more time for this College work.

What do you do outside of work?

In the rest of my spare time I enjoy travelling and cinema. I have recently taken up photography and enjoy the mixture of technical and artistic challenges. I am trying to keep fit by cycling and swimming regularly and am proud to have completed 'Tough-Mudder', raising money for the Carers Trust.

If you didn't work in anaesthesia, what would you do?

If I hadn't been an anaesthetist, I would have liked to be an airline pilot.

COLONEL JAMES RALPH
(co-opted member)

Why did you run for Council?

I am co-opted on to Council as the defence representative in my role as defence consultant advisor (DCA) in anaesthesia and pain. As DCA, I provide advice to the chain of command on current and future manning, education and training, policy, doctrine and capability review as well as clinical assurance of healthcare delivery on operations and analysis of lessons and significant events. As DCA, I am the regional advisor anaesthesia (RAA) for defence anaesthetists. Regular and reserve anaesthetists, both consultants and trainees, work in NHS trusts across the home nations. Issues affecting the workforce within the NHS equally affect defence anaesthetists, and these issues are combined with the unique challenges that maintaining deployable skills and deploying them place on the individuals as well as the host departments and trusts. I hope I can continue to foster the mutually beneficial relationship between defence anaesthetists and their civilian colleagues.

What do you do outside of work?

When not working, I can be found baking bread, or outside trying to defy the ageing process on my bike and running and participating in triathlons.

If you didn't work in anaesthesia, what would you do?

If I had not been successful in securing a place at medical school, I would have studied maths at university. Where that would have taken me – who knows?

DR SIMON FORD
(co-opted member)

Why did you run for Council?

I am honoured to represent the Welsh Anaesthesia Board as a co-opted member of Council. I have always been keen to try and improve training and experience locally, and this has progressed to me being on the Welsh Anaesthesia Board as regional advisor. The broad challenges of healthcare are similar across the UK, but with devolved control of healthcare the solutions or challenges may look slightly different. Supporting the differences and being able to learn from services and solutions from all four home nations is incredibly valuable.

What do you do outside of work?

Outside of work, I enjoy running and coaching the local junior rugby team. You can often find me trying to keep an old camper van running to support trips to the beaches and wilds of West Wales with my wife and teenage son.

If you didn't work in anaesthesia, what would you do?

My childhood dream was to be a pilot, but with the realisation that my navigational skills were terrible, it was never to be. Anaesthetics as a static form of aviation proved safer. An alternative career to anaesthetics would be an independent bike-shop owner – practicality with technical knowledge and always waiting for the next new toy!

DR SIMON MAGUIRE
(co-opted member)

Why did you run for Council?

I have been co-opted onto College Council for one year as the lead RAA. My major nonclinical role has always been around training, having been College tutor, training programme director and RAA in the North West. We have the most amazing team of trainers and trainees in the North West, with fantastic leadership, a great sense of comradeship and egalitarianism which makes my role a real pleasure. I was keen to become lead RAA to have more insight into the functions of Council and push the training agenda forward. College Council is a place of inspiring individuals who are working extremely hard to advance and protect our specialty.

What do you do outside of work?

Outside of work, I pretend that age has no influence on my agility on the squash court or on the need to stop for coffee on longer cycle-rides. I happily follow my film-making wife to watch dubbed films from the 1950s, and I enjoy banter with our four children.

If you didn't work in anaesthesia, what would you do?

If I wasn't an anaesthetist, I would possibly have become a terrible horticulturist with a side-line as a carpenter.

Alessandra Anzante, Employment Lead, RefuAid
Dr Siân Jaggar, Cardiothoracic Anaesthestist, Royal Brompton Hospital
Maria Burke, RCoA Global Partnerships Manager

ONGOING SUPPORT FOR REFUGEE ANAESTHETISTS

World events have seen record numbers forcibly displaced from their homes – currently estimated at 103 million people.[1] According to the Refugee Council, in the 3rd Quarter of 2022, 24,511 applications for asylum were made,[2] an increase of 58.1% on the previous quarter. Government statistics tell us that in 2022 74,751 asylum applications were made (relating to 89,398 people).[3]

A study by Deloitte in 2017 surveying Syrian refugees in Europe[4] found that 38% of respondents were university educated, but that despite this 82% were unemployed. It highlighted language as being one of the biggest barriers to re-entering employment, despite 63% of those surveyed wanting to continue their careers in the professions for which they had trained in their home countries. In the case of anaesthetics (and medicine as a whole), there are significant challenges for them in entering UK practice.

The Refugee Buddy Scheme

In July 2022, the College, in partnership with RefuAid (refuaid.org), began a pilot for matching refugee doctors with UK-based anaesthetists, the aim being to allow these trained doctors to acquire knowledge and experience from qualified doctors in the UK. This might aid their career progression, to the advantage of both the individuals and of the wider NHS.

RefuAid is a charity supporting individuals from forced migration backgrounds and helping them return to their professions in the UK. Based in London and working with refugees nationwide, RefuAid has three central programmes: language, loan, and employment. These are designed to overcome specific obstacles and barriers which adversely affect displaced professionals' ability to return to their careers.

It is difficult to gain specific information about the professional backgrounds of individuals being granted refugee status and therefore with leave to remain in the UK. However, RefuAid currently have 800 doctors registered with them, of whom 16 have indicated that they are anaesthetists or junior doctors hoping to enter our specialty.

We purposely kept the scheme small for the pilot, as we were sure there would be a lot for us to learn. When matching individuals through the scheme, we looked to match Buddies where possible based on:

- previous clinical experience
- cultural background (most buddies appointed were International Medical Graduates with lived experience)
- geographical location (although with the small numbers this was a challenge).

For the pilot we paired eight refugee doctors who have been in contact with their Buddies either in person or online.

Throughout the pilot we asked for feedback from both groups, and in February 2023 we held an in-person event at the College. The day covered the different anaesthesia roles available within the NHS, and there was a GMC-led session outlining registration and CESR processes. The afternoon had a more practical element, with sessions on creating a successful CV and mock interviews for refugee doctors covering not only clinical experience but also governance, education and management. Feedback shows that this session in particular was very well received.

Next steps

Undertaking this pilot has been a valuable learning experience providing many pointers in how to develop and grow the scheme. If you are an anaesthetist from a non-UK background currently working in the UK and you would like to bring your lived experience to this programme, we would love to hear from you. Applications for new refugee Buddies is now open, and the closing date for submissions will be **Sunday 24 September 2023**. Further details can be found on our website here: rcoa.ac.uk/work-us/vacancies.

We will be holding an event at the College at the beginning of the buddying period to allow pairs to meet each other at the start, which we feel will help in developing the buddying relationship. It will also be an opportunity for attendees to gain key information and to put questions to the faculty. We will assist the Buddy partnerships in agreeing how, and how frequently they will communicate with each other. We will also help to pin down any support the pairs may need. We believe that agreeing this from the outset will be advantageous to all the individuals involved.

In addition, we are working with clinical directors to identify clinical attachments that could be taken up by refugee doctors. If you feel that your hospital could accommodate a refugee doctor with such an attachment, please email us at global@rcoa.ac.uk, even if you do not wish to be a Buddy yourself.

We are also pleased to confirm that, with the help of many volunteers, we have launched an International Medical Graduate information section on the RCoA website which can be found here: rcoa.ac.uk/information-for-imgs. We will be continuing to develop this resource, so any feedback or offers of help will be gratefully received.

We are really pleased with how the pilot has gone and the outcomes achieved so far. However, we are also excited to watch the scheme develop in the next 12 months and beyond.

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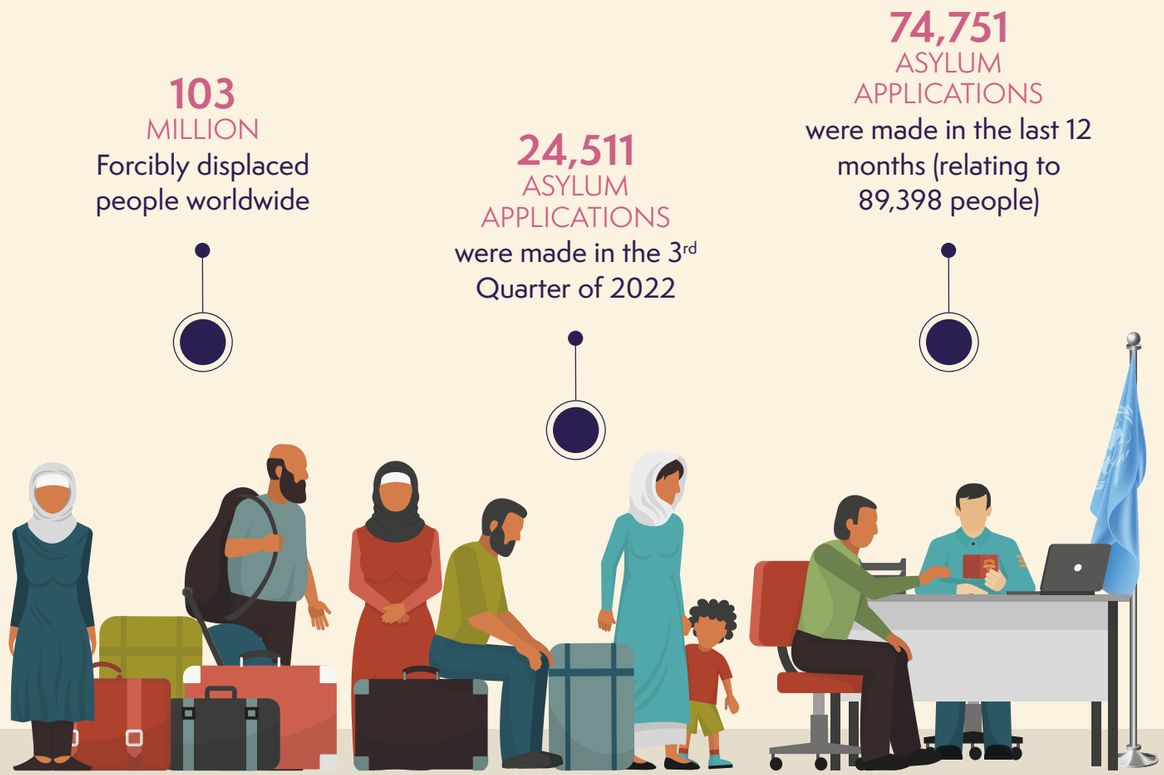

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HEALING GARDENS: a partnership with the Royal Horticultural Society

Being in green spaces and gardening has benefits for our physical, mental and social wellbeing.[1] It seems logical that these should be embedded within our health and social care systems, including acute settings.

In March 2023, three years after its inception, this became a reality at University Hospital Lewisham when we celebrated the opening of the pilot Healing Garden created in partnership with the Royal Horticultural Society (RHS).

Context

During the pandemic I was proud to observe my colleagues come together to develop innovative solutions to our new way of working and was deeply touched by the community response and support. Despite this, the effect it was having on morale and rates of burn-out were visible. As a novice gardener with spades of enthusiasm, I recognised the benefits of green spaces, being in nature and gardening, and wanted to bring that into the healthcare setting.

The process

The process was a multi-pronged team effort with many barriers and failed avenues from which I have learnt a lot. I found like-minded individuals within the hospital and sought out a senior mentor in Michael ('Mick') Jennings, a now retired intensive care consultant, without whom this project would not exist. He brought the garden to the ears of management when they were extremely occupied with the pressing matter of the pandemic.

Information gathering

The first stage was to establish and demonstrate a need for a green space. We created a survey for staff which showed unanimous support for a garden space and explored how it would be used. Recurring themes in the responses were:

- seating areas for lunch/quiet reflection
- wellbeing activities
- growing/harvesting edibles – an active gardening area
- wildlife friendly
- ability to include patient/community groups
- strong desire for staff involvement in creation and maintenance
- commemorative aspect.

Support and interest gathered pace – more than 60 of the 200 staff surveyed signed up to the garden club before we had a space to garden in. We identified a large area of overgrown shrubs and disused lawn and submitted our proposals to management. Liaising with the estates and facilities team we accessed a drawing of the hospital site plans, identified electric cabling which would impact on the garden design, and clarified ownership of the land. People were brought together throughout the hospital; a community was building around the creation of the garden. We visited local community gardens to share ideas on garden design, models of sustainability and future collaborations.

Building resources and partnership

Fundraising efforts commenced. Donations of seeds, cuttings and tools, and offers of manual labour were generously forthcoming from staff, local people and local businesses. Despite the building momentum of support from within the trust and local community, we lacked experience and expertise in designing and establishing a garden, so I contacted the RHS for help. Behind the scenes the RHS Communities Team was looking for a tangible way to support NHS keyworkers through gardening.

Months later, we received the incredible news that the RHS were interested in helping us. This led to a meeting with Andrea Van Sittart, Head of Outreach Development at the RHS, who is the driving force behind this project. With the RHS, we created a promotional video to help secure funding. As an RHS Ambassador, award-winning garden designer Adam Frost generously offered to give his time and expertise to design the garden following consultation with staff, patient and community groups. The RHS ran a fundraising appeal and secured several large donations from generous individuals. Work began in spring 2022, and the first plants were planted in June by NHS staff, community groups and volunteers.

One of the greatest contributions by the RHS has been the ongoing support of Community Development Officer, Alice Cornwell. Alice has been responsible for overseeing the development of a three-year activity programme and working with more than 40 community partner organisations. She runs a weekly garden club for staff and volunteers, and delivers an activity programme online and out in the local community, including yoga, wreath making, terrarium making, houseplant surgery, and wildlife watching.

Many patient groups benefit from the garden – labouring women taking walks, graded exercise for physiotherapy patients, and gardening sessions for people with dementia and their carers. A perinatal support group for women at risk of postnatal depression and psychosis use the garden as a space to run regular activities and a weekly wellbeing walk, helping to connect to their local community. Visitors and staff use the quieter spaces in the garden as somewhere peaceful to sit. The success of the project has led to the expansion of RHS Healing Gardens, and other regional hubs are in development.

More than 1,600 staff, volunteers, patients, and people from the local community have benefited from activities in the garden during the first year of opening, with many more using it informally, and this number continues to grow.

Reference

1 Gardens and Health. *The King's Fund,* 2016.

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AN INNOVATIVE APPROACH TO PATIENT INFORMATION

Over the past months, the patient information team has been busy creating new resources and collaborating with a wide range of partners to create innovative content to help you meet the challenges of preoperative assessment.

Helping you 'make every contact count' with Dennis and the Beano

A child presenting for surgery provides an excellent occasion for health promotion, with the results of the PErioperAtive CHildhood obesitY (PEACHY) study showing that 24% of children presenting for surgery are overweight or obese. It has never been more important to address the physical health of children at every opportunity, 'making every contact count', especially in light of the surgical backlog and our ever-growing waiting lists that we are all too aware of.

Following on from the success of the recent *Dennis has an anaesthetic* initiative (5,229 downloads to date!), we have created the 'A-Team Challenge', with a supplementary reward chart and sticker to help start the conversation with families/children in paediatric pre-assessment in order to help them integrate healthy practices into daily life.

Dennis and friends challenge our young patients to try and eat something healthy with every meal, brush their teeth twice a day, get a good night's sleep and be a bit more active.

Special thanks go to Dr Amy Norrington (South Tees Hospital), who worked closely alongside us to develop these challenges and test them with children and carers at her hospital.

We are also grateful to the Association of Paediatric Anaesthetists for their support with this project.

We have sent a starter pack of challenges, reward charts and stickers to all anaesthetic departments in the UK, but these resources can also be downloaded from our website at: rcoa.ac.uk/dennis-has-anaesthetic

Resources to support patients with preoperative anxiety

We know that patients who are fitter and better prepared will experience better outcomes from surgery. Fitter Better Sooner, our toolkit to help patients make the most of their waiting time before an operation, provides all the steps that they can take to improve their medical conditions and lifestyle. However, we also felt that it was important to help patients prepare their mind, especially those patients who might feel particularly anxious about the procedure. Working with the British Society for Clinical and Academic Hypnosis we have produced new content and relaxation recordings which patients can use ahead of surgery using breathing and guided visualisation techniques. The new resources are available at: rcoa.ac.uk/patientinfo/preparing-your-mind

Trusted Information Creator
Patient Information Forum

RCoA recertified under the Patient Information Forum Trusted Information Creator Kitemark (PIF TICK)

Following our latest assessment, we were delighted that our patient information has been recertified under the PIF TICK, the UK's independently assessed quality mark for trusted health information, demonstrating our commitment to producing high-quality resources for our members and their patients.

To be certified organisations need to demonstrate that they meet the following criteria:

- systems: information is created using a consistent and documented process
- training: staff receive ongoing training and support
- need: resources meet a genuine need
- evidence: information is based on reliable, up-to-date evidence which is communicated clearly
- involving users: users are involved in the development of information
- health inequalities: information is written to meet health, digital literacy, language and accessibility needs of the target audience
- content and design: information is clearly communicated, easy to access and navigate
- feedback: there is a clear process for users to provide feedback
- disseminating: information is promoted to maximise reach
- impact: the impact of information is measured.

Health inequalities is a new criterion for the scheme, and we were successfully able to meet this, not only by striving to making the language in our resources accessible, but also by providing translations (rcoa.ac.uk/patientinfo/translations) in over 20 most-spoken languages in the UK. Recently we have added Ukrainian to our list of languages, and to meet the needs of the Deaf community we now offer translation of our videos in British Sign Language (rcoa.ac.uk/patientinfo/easyread).

Coming up next for patient information

Over the coming months we will be busy reviewing our main series of leaflets to bring the content up to date and to add an element of shared decision-making. Watch this space for the new editions of *You and your anaesthetic* and many more of our popular leaflets!

We have started to plan the review of our risk series, and we are talking to experts on communicating risk about how we can present this information in the most appropriate and up-to-date way. We will be collaborating closely with PatientsVoices@RCoA (rcoa.ac.uk/patientinfo/patientsvoices) on this project and we get invaluable input from them on how patients want to receive information about risk.

We are also working with the ME Association and their network of lived experiences to create a resource for this cohort of patients to fill a gap in the information available to them and to support their discussions and care plans with anaesthetists and healthcare professionals ahead of surgery.

SCAN FOR FURTHER INFO

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Part 2

LESSONS FROM THE CORONER
MDT training – time for action

Mrs Shivalkar was a 78-year-old patient with debilitating co-morbidities, scheduled for elective revision hip-surgery at a stand-alone surgical unit without level-2 or level-3 care facilities. Intraoperatively, significant hypotension was poorly recognised and treated. By the time care was escalated, she had developed severe metabolic acidosis and multi-organ failure leading to her death.

The coroner issued a 'Report to Prevent Future Deaths' (https://bit.ly/3hUoQmM) to the RCoA and the Royal College of Surgeons for action. From our review of the available information, the lessons to be learnt by our specialty were related broadly to risk assessment, remote-site working and team working. My previous article (Part 1) (rcoa.ac.uk/bulletin/january-2023/lessons-coroner) addressed the first two areas, while this follow-up article focuses on team working and the role of multidisciplinary team (MDT) training.

This is a recurring theme in coroners' 'Prevention of Future Deaths' reports to the RCoA. Coroners have repeatedly highlighted concerns over the lack of regular training in emergency drills for the team involved, deskilling of senior staff, poor teamworking and poor non-technical skills, all of which can be improved by regular MDT training.

Teams that work together should train together

MDT training involves procedural teams training together in emergency scenarios and other complex scenarios in a simulated fashion. Ideally the team that actually works together trains together. This can be done in-situ, for example in the theatre where the team works, or it can be done remotely in a simulator with differing levels of fidelity and complexity. This training has a number of roles, including rehearsal of emergency scenarios and drills, systems testing, responding to previous incidents and planning change, improving team working, and improving other aspects of non-technical skills.

Non-technical skills for anaesthesia, including situation awareness, decision-making, task management and team working, are well described by the Anaesthetists' Non-technical Skills (ANTS) framework (https://bit.ly/3pypN84).

The College strongly supports the view that regular multidisciplinary training of teams that work together has an important role to play in safe practice, not just allowing regular rehearsal of emergency drills and testing of systems, but embedding non-technical skills in practice, enabling teams to function well within a flattened hierarchy and promoting a culture that prioritises safety across the team. To support this there are standards for team working and MDT training embedded in GPAS The Good Department (rcoa.ac.uk/gpas/chapter-1#section-3.4) (Standards 3.18–3.27) and assessed in practice through ACSA (www.rcoa.ac.uk/acsa/standards) (Standard 2.5.6.2).

The RCoA is not alone in making recommendations on MDT training and promoting team working. Recent publications, such as the Ockenden Report,[1] NatSSIPs 2[2] and the Association of Anaesthetists guideline 'Implementing human factors in anaesthesia: guidance for clinicians, departments and hospitals'[3] recommend that time and resources should be allocated for MDT training.

Resources to support MDT training

The College is developing resources to support these recommendations and standards. To support a recent patient-safety campaign (rcoa.ac.uk/prevention-future-deaths) we developed Unrecognised oesophageal intubation flash cards (https://bit.ly/RCoA-IntubationFlashCards) to provide teams with short talk-through scenarios that can be easily run through during a busy day in theatre. In response to demand for more, we are developing a pack of flash cards covering a range of emergency situations and an implementation guide that will facilitate the development by departments of their own bespoke cards to meet local needs (https://bit.ly/flashcard-training).

In addition, the College is developing a range of higher-fidelity simulation resources to be shared via the RCoA website, as well as a coordinated approach to simulation training.

At the same time we have cognitive aids such as the Association of Anaesthetists' Quick Reference Handbook (QRH) (https://bit.ly/3VSFJxU) that will increase the success of management of emergency situations known and unknown, and the likelihood of identifying a rare event. However, it is of course essential to train as a team in the use of the QRH ahead of using it in an emergency situation.

Barriers

So the profession has appropriate standards and recommendations in MDT training, and we have a developing pool of resources to support implementation. However, through ACSA Reviews we see that in practice there is great inconsistency in the use of team training both within and between healthcare providers. The predominant reason for this is said to be lack of time for such training, whether low- or high-fidelity, due to the pressure to prioritise delivery of healthcare.

The NatSSIPs implementation survey[4] also stated that the main barriers to embedding NatSSIPs were at organisation level and included time pressures and lack of protected staff time, lack of opportunities for multidisciplinary training, and the increasing focus on productivity and targets, which can conflict with processes designed to ensure safety.

It is understood that the system is under great pressure and resources are stretched, but we ignore this need at the risk of harming patients, especially in this high-pressure environment. MDT training will help us deliver safe care in a complex and pressurised system, but now we need NHS organisations at national and local level to support and enable this training for teams who work together to train together.

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4 NatSSIPs implementation survey. *NHSE* (https://bit.ly/310Xbuz).

The College strongly supports the view that regular multidisciplinary training of teams that work together has an important role to play in safe practice...

You can read Part 1 of this article in the January *Bulletin* which is available from:
rcoa.ac.uk/bulletin/january-2023/lessons-coroner

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Perioperative Allergy Network

Improving allergy services for patients in the perioperative setting

The Perioperative Allergy Network (PAN) was set up under the joint auspices of the British Society of Allergy and Clinical Immunology (BSACI), the British Society for Immunology Clinical Immunology Professional Network (CIPN), and the Association of Anaesthetists. It represents a formal collaboration between UK anaesthetists, allergists and immunologists with an interest in perioperative hypersensitivity and is supported by the Royal Colleges of Anaesthetists, Pathologists and Physicians. It is affiliated with the International Suspected Perioperative Allergic Reactions Group (ISPAR).

Why now, and what need is being met?

The 6th National Audit Project (NAP6)[1] detailed the uniquely complex issues surrounding the diagnosis and investigation of perioperative allergy. The importance of new allergens such as teicoplanin was highlighted, while the risk from better-known allergens including antibiotics, neuromuscular blocking drugs (NMBD), and latex was updated. Key areas for research and quality improvement were described, including the need for novel *in-vivo* and *in-vitro* diagnostic tests, standardised provision of multidisciplinary investigation, pathways for pre-operative delabelling of penicillin allergy, and improvement in allergy training for anaesthetists.

Why collaborate?

The traditional model for investigation of perioperative allergy puts only allergists and clinical immunologists at the end of the referral pathway. There are several reasons why this model might not serve the surgical patient well. Allergists rarely have working experience of anaesthetic practice; as a result important information can be lost or misunderstood. Anaesthetists bring 'theatre perspective' to the case. For example, isolated hypotension following a propofol bolus might be less worrying to an anaesthetist than an allergist. In addition, allergic reactions can be caused by substances not documented on the chart, such as Patent Blue dye or long-acting steroids, and anaesthetists are more likely to anticipate when these have been used. Anaesthetists are perhaps better placed to make recommendations about drug choices for future anaesthesia. Conversely, allergists and immunologists bring vital expertise around the investigation of patients and interpretation of results. Active input from both allergy specialists and anaesthetists is therefore the optimal model for investigating perioperative allergy.

Aims and objectives

The network aims to provide a coordinated national strategy for improving the care of patients with suspected perioperative allergy. Objectives include:

1. **networks and education –** formalising a multidisciplinary network with shared educational and clinical interests
2. **service provision and accountability –** defining accreditation standards and the role of anaesthetic allergy leads and updating protocols for investigation, including those for high-risk challenge testing
3. **development of a national patient safety system –** a centralised, digital access point for both the referral of cases and dissemination of subsequent investigations
4. **audit and research –** promoting and facilitating research and quality improvement through multidisciplinary collaboration.

Structure and function

Much of the proposed infrastructure already exists in various forms. PAN aims to formalise this and reduce variation across the UK, improving the flow and quality of perioperative hypersensitivity investigation. The proposed structure will comprise:

1. local allergy leads in every UK anaesthetic department, who will:
   - act as a contact point for referrals to the regional centre, providing continuity of care and improving the quality of referrals
   - ensure the anaesthetic department is updated on current teaching and standards.
2. regional perioperative allergy service, with joint input from allergists/immunologists and anaesthetists in delivering specialist allergy testing. In some centres, this will include high-risk challenge testing
3. a PAN Steering Committee – who will ensure that the network delivers its stated aims, facilitating a joined-up approach to patient care. Additional roles envisaged are:
   - provision of multidisciplinary educational events and embedding of allergy training for all career stages
   - setting accreditation standards and generating and supporting research
   - updating existing perioperative hypersensitivity investigation algorithms and protocols.

What has been achieved so far?

The network now has more than 120 members. Our first network event was a multidicisplinary seminar held in London in May; future events are planned including a webinar on perioperative penicillin allergy delabelling in November 2023. The network has produced two key documents since its inception. The first was a statement in response to the MHRA withdrawal[2] of pholcodine-containing products (https://bit.ly/4331Cgl), in which we recommend against screening patients for prior pholcodine use. Screening has no practical benefit for patients and prior use of pholcodine does not warrant avoidance of an NMBA where one is clinically indicated. The second is an addendum to the recently updated Resuscitation Council UK guideline on management of anaphylaxis. The network, in collaboration with other stakeholders, has developed an algorithm specifically for use by anaesthetists, in which the use of intravenous epinephrine is emphasised as the first-line choice for patients under the care of an anaesthetist.

To join the network, visit our webpage (https://bit.ly/3WvRqLf) and complete a brief form detailing your scope of practice and geographical area. You will then be added to an email distribution list and updated about network events.

References

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Euthanasia: 'no opinion', is not neutral and a valid expression of some truths

'You always own the option of having no opinion. Things you can't control are not asking to be judged by you. Leave them alone.'

Marcus Aurelius (121–180 CE)

For the record: I am a full-time NHS consultant in pain medicine and anaesthesia, and the sole provider of 'interventional pain procedures' to my local hospice, where I have a weekly session to see inpatients, outpatients and discuss complex pain problems in the end, and not-so-end, of life scenarios. I am also a former dean of the Faculty of Pain Medicine.

Discussions have started within the RCoA on whether the College, and its faculties, should take a stand on the issue of 'assisted dying'.

They should not. Not pro, anti, or neutral (this last stance is multifaceted and arguably not 'neutral' at all).

It is not for a college to have a 'view' on all topics. This is a societal issue – although some doctors have strong opinions in the pro and anti camps, these should remain personal views. Religion, ethics, morals, societal norms and acceptances, are where any decisions will be made. We can only offer technical advice, and this is not a technical debate.

Many have grave doubts about what is euphemistically termed 'assisted dying' but is, at its core, simply 'killing'. The word is usually avoided by the pro camp or qualified with 'mercy'. It is not aiming to reduce the final burdens of suffering, but to finish them. Managing them is not always done well, and the support that should be available is not always there. But to accept that this is an argument to 'kill off the problem' quickly...? That is a very different proposition. It is a fundamental shift in the responsibilities that doctors accept – from medical school to retirement – that they would be responsible for the active termination of life, whether directly or indirectly.

The magnitude of this change should not be underestimated.

But let us consider the role of professional organisations in this debate.

The Royal College of Physicians (RCP) changed from 'no opinion' to 'neutral' in 2019.[1] Less than 20% responded to the survey, and of these 43% opposed a change in the law, 32% were in favour, and 25% were neutral. From these results they adopted 'neutrality'. Its council voted by 36 to 1 to change position,[2] later issuing a statement: '... the RCP clarifies that it does not support a change in the law to permit assisted dying...' [3] This highlights the problem of a 'neutral' stance.

The Royal College of General Practitioners opposes a change in the law. With a 13.5% turnout in 2019,[4] 47% were against a change and 40% in favour; its council voted 44 against, 13 in favour, and five abstaining.

The British Medical Association changed from against to neutral in 2021.[5] With less than 20% of its members taking part,[6] 40% were in favour of a change in the law, 33% opposed and 6% undecided.

The Royal College of Surgeons of England recently changed their stance, from opposed to neutral, on a survey with a 19% response rate.[7]

The Royal College of Psychiatrists also opposes a change.[8]

The Association for Palliative Medicine – perhaps the only professional medical organisation that might legitimately consider the issue to be within their remit – is opposed.[9]

Looking at these figures, it is impossible to have any confidence that the will of the members is, or can be, reflected in any of these stances. It will disenfranchise many over an issue that – I hope I am pointing out – should not have a collegiate view.

Some argue that fellows and associates would have little involvement, but that is clearly rubbish. Those working in intensive care are commonly involved in end-of-life decisions. Pain is commonly given as a reason for expediting the end of life, and requests to help with complex pain problems are bread and butter to many of us. These would be core to termination decisions. Those working solely in anaesthesia will be asked to provide expertise in respect of patients who cannot eat or drink – if not in the form of an individual, then of some committee supported, at least nominally, by the College.

Before any changes in the law, will all current or potential anaesthetists be comfortable about any position?

The arguments for pro- and anti-change are well-trodden, but the arguments around 'no opinion' and 'neutral' are often conflated. A neutral position indicates an indifference to the outcome whether the current state or a change, but that is manifestly untrue. Those looking for a change will take neutrality as the implied acceptance of the outcome they wish. This has immense political significance.

Individuals who wish to campaign are free to do so.

If the law changes, we will have to form judgements and professional standards that adhere to and support the law, but the law has not changed.

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Fire safety and evacuation simulation training

At Newham University Hospital there were extensive refurbishments taking place in order to make the theatre complex compliant with current fire-safety regulations. As well as this, there have been a number of fires in intensive care units in the UK over the past decade requiring full-scale staff and patient evacuation.

We realised that we were unsure ourselves of how we would manage such a situation, and so we looked up whether there were fire-safety guidelines specifically for anaesthetists. We came across the recent Association of Anaesthetists fire-safety and emergency evacuation guidelines, published in May 2021 (https://bit.ly/427Op5X). One of the key recommendations was that all healthcare workers should have 'practical walk-through and/or simulated evacuation training' at least every two years.

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The fire had originated in the coffee room at the end of the corridor, but the door had been unsafely wedged open, so the fire was spreading rapidly towards the operating theatre.

We had never undertaken simulation training involving an emergency patient evacuation during our careers so far. So we went about organising such simulation training for the whole theatre multidisciplinary team at Newham Hospital, including scrub nurses, anaesthetic practitioners, anaesthetists and surgeons. Very fortuitously for us, there is a monthly education, governance and audit day at Newham for the entire theatre department. We therefore decided to run the simulation during one of these days, as everyone would be collected in one place.

We enlisted the help of the fire-safety wardens and the simulation team in order to write and run the scenario. It consisted of a recently paralysed patient who was intubated and being ventilated, with an open abdomen mid-operation, when the fire alarm begins to sound. The fire had originated in the coffee room at the end of the corridor, but the door had been unsafely wedged open, so the fire was spreading rapidly towards the operating theatre. This meant that the team had to urgently undertake a horizontal evacuation of the patient down the corridor, followed later by a vertical evacuation down the stairs, as the fire continued to spread. They then found the lifts out of order, with a portable stretcher left nearby, forcing the team to use this to transfer the patient downstairs to an ambulance waiting outside.

We ran the scenario twice due to large numbers attending the session. We required an empty theatre complex plus a set of stairs that would be unused by other people at the time of the simulation. Fortunately, this was available at the Bart's Health Orthopaedic Centre on site at Newham, which had no lists running because all the staff were attending the governance day. The simulation team kindly provided all the necessary equipment, including a mannequin with a monitor displaying observations that were controllable via a tablet/computer.

There were several learning points highlighted during the debrief; a key point was that there was only one patient-evacuation aid between four operating theatres in the orthopaedic centre. We are therefore in the process of working with the fire-safety team to purchase more of these for Newham to cover the possibility that all of the operating theatres needed to be simultaneously evacuated.

Other benefits for the staff who participated included simulation-participation certificates and renewal of their fire-safety module as part of the trust statutory and mandatory training.

We surveyed all of the participants before and after the training, with the responses showing universally improved confidence in being able to respond to a fire alarm and manage an emergency patient evacuation. There was also marked improvement in staff members' knowledge of the areas highlighted in the Association of Anaesthetists guidance, such as where to find manual fire-call points, patient-evacuation aids, fire action-plan cards and oxygen shut-off valves in their clinical areas.

Moving forward, we are sourcing more 'fit-for-purpose' evacuation aids for Newham hospital with the help of the fire-safety team. We are planning to run further sessions of the simulation training, and to ensure that it becomes established to take place at least annually at Newham. The involvement of the communications team has resulted in the word being spread throughout Bart's Health trust via the intranet, as well as the publicising of our project further afield in order to hopefully inspire other healthcare workers to set up similar practical training in their hospitals and trusts.

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GASREACH

Examples of widening participation backgrounds

- Attend a school with low progression into higher education.
- The first generation of their family to consider higher education.
- From an under-represented ethnic group.
- From a low socio-economic group.
- Have a disability.
- Are a care leaver.
- Are a carer.

The need for a diverse workforce

It is understood that in healthcare having a diverse workforce that reflects the population they care for can have better outcomes for patients, improve staff retention, and can positively improve staff morale.

Traditionally, medicine has been a career dominated by those from socioeconomically advantaged backgrounds.[1] Despite this, there have been progressive changes in this stereotype in recent times – for the last 25 years more than 50% of medical students have been female, and in 2017 59% of those accepted into medical school were women.[2] In contrast to this, there is currently a disproportionately low number of doctors who come from lower socioeconomic backgrounds. Data from 2015 shows that only 14% of new medical students were from lower socioeconomic groups, yet these groups represent 56% of the population.[3,4] The RCoA has pledged to develop equality, diversity, and inclusion within the specialty of anaesthesia.

Improving diversity in postgraduate training

'Widening Participation' (WP) is a government initiative designed to encourage more students from under-represented groups to apply to train in medicine, and thus make the workforce more reflective of its community and more understanding of the needs of its patients in the future. All UK medical schools are now mandated to offer specific programmes dedicated to widening access to medical studies. While schemes which promote diversity in aspiring medical students are widespread, there are relatively few initiatives which look at diversity in postgraduate and subspecialty training.

The Widening Participation Medics Network (WPMN) was set up in 2020 with the aim of building a supportive community of junior doctors who can offer advice to both current and prospective medical students from under-represented groups. Founded by Dr Jade Scott-Blagrove, WPMN already supports students from 37 out of 41 medical schools.

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Data from 2015 shows that only 14% of new medical students were from lower socioeconomic groups, yet these groups represent 56% of the population.

WPMN has since looked to expand the support it provides beyond students' graduation. This has been done through the introduction of subspecialty-specific mentor schemes. Mentors can offer guidance, insight and specialist knowledge to their mentees that is incomparably better than that which can be found online. This support is particularly valuable to WP mentees who are likely to be working in professional circles that aren't necessarily relatable, often leading to instances of imposter syndrome and feelings of isolation in the workplace.

The first of these schemes was RadReach, initiated in 2021.[5] This is a collaboration between the Royal College of Radiologists and WPMN, aiming to increase applicants from a WP background to radiology and oncology through mentorship schemes. The scheme uses a formal matching process to pair mentors and mentees, with the aim of ensuring the greatest level of coherence in the process. All mentors receive appropriate training prior to commencement of their mentorship role. The scheme has received excellent feedback, with several mentees achieving high interview scores and first-choice offers.

Introducing GasReach

'GasReach' is an exciting new scheme, with WPMN working in collaboration with the RCoA. This scheme will mirror the format of the successful 'RadReach' programme. GasReach will not only aim to inspire doctors from WP backgrounds to consider a career in anaesthesia, but will also provide them with guidance and support during the application process.

The pilot scheme will be launched later this year and will initially last one year. Mentees will be aspiring future applicants to anaesthesia from a WP background.

We will be looking to recruit enthusiastic individuals who would like to be mentors for this pilot. Mentors must be in training, post-fellowship, and able to meet the time commitments. They will be expected to meet with their mentee a number of times in the year to discuss topics such as careers and applications, and to provide interview advice and pastoral support if required. Mentors will undergo training and will be supported throughout the scheme by a steering group comprised of RCoA and WPMN members.

If you are interested in becoming a mentor, please visit the RCoA website for more information.

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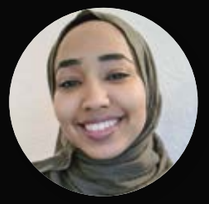

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Schwartz Round in action: my experience

In recent years, 'mental health awareness' and 'wellbeing' have been hot topics in almost all facets of life. It goes without saying that I was pleased to see this ethos entering into the mainstream. However, a recent incident while on call left me questioning whether this ethos had translated into my workplace.

In the early hours of an August morning, a cardiac arrest call came through on my bleep. I arrived to find chest compressions being performed on an 11-week-old baby. I was immediately filled with dread, anxiety, and confusion. As with many district general hospitals with limited paediatric service, the vast majority of sick children are diverted elsewhere, so I was not expecting to see a child. I remember feeling totally out of my depth. It had been a while since I'd dealt with paediatric patients, and I'd certainly never participated in a real paediatric arrest. Once the immediate shock subsided, I assumed the default position and took over the airway. It was at that point that I could see and feel the baby up close. I'd seen this colour in a child before, and knew this wasn't going to end well. As I held that baby's face, ventilating him, I became conscious of my racing thoughts: 'Am I doing this right?'... 'I think I'm going to cry'... 'No one else is crying, get a grip'... 'Thank goodness the registrar is here'... 'This baby is not going to make it'...

Soon enough, the decision was made to stop further resuscitation. The registrar ushered me out the room, mentioning that we should debrief, but it was time to hand over to the day team. I went home with my mind racing, feeling overwhelmed and exhausted. Naturally, I returned to work as normal, wondering when *I* would feel back to normal.

Fast forward to October. I was given the opportunity to help develop a wellbeing service within our anaesthetic department. As part of this service, the team decided to establish a Schwartz Round and pilot it in one of our audit meetings. I offered to share my experience at the cardiac arrest, thinking that perhaps it would be a good starting point for discussion and, selfishly, an opportunity for me to offload.

Schwartz Rounds have been utilised in various healthcare settings across the US and UK over the past 10 years. The Schwartz Round programme is an initiative of the Schwartz Center, founded by the family of Ken Schwartz, an American lawyer who received treatment for cancer in 1994. Schwartz felt it was important for caregivers to share their experiences in order to feel supported and thus to be better caregivers.[1] This forum, which involves clinical and non-clinical staff from different departments coming together regularly to reflect on challenges at work, has been shown to improve communication and compassion between healthcare workers, to reduce hierarchies, and to reduce feelings of stress and isolation.[1,2]

While Schwartz Rounds are normally multidisciplinary, our round in contrast was contained within our anaesthetic department and, for practical reasons, facilitated by one of our consultants. However, I felt it allowed for a more familiar and intimate environment to be vulnerable in compared to other larger rounds I've attended. For the first time since the incident, the registrar and I were able to openly and candidly express how we felt about what had happened. For me, it was an incredibly cathartic and healing experience. I felt heard and validated in a way I was not expecting. The reactions from my colleagues made me feel like I was not alone. I was starting to feel closure. The operating department practitioner and outreach nurse who attended the arrest were also invited to share their perspective: I was incredibly touched by their accounts and took it for granted that they too felt out of their depth and were looking for someone to process the event with. Further discussion ensued around dealing with death and trauma from the pandemic, which many colleagues still carry the emotional burden of. The feedback from my colleagues indicated that there was a clear need for this space within the department.

Schwartz Rounds will by no means solve the epidemic of stress and poor mental health within the medical profession, but incorporating a simple intervention to optimise wellbeing in the workplace and improve patient care is a no-brainer in my opinion. No amount of resilience training or self-care can replace the empathy, solidarity, and connection felt in that room. I have felt the fruits of it, and I hope to see more anaesthetic departments establishing something similar so that more of us can also reap those fruits.

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THE PREOPERATIVE ASSESSMENT NON-MEDICAL LEAD NETWORK

I started working part-time for GIRFT (Getting it Right First Time) as a POA (Preoperative Assessment) national advisor in September 2022. Most POA non-medical leads will recognise that you are often working in a silo in a POA department. While we have a number of expert multidisciplinary-team (MDT) professionals who feed into and out of the department, the core 'everyday' team are predominantly non-medical staff.

It's an area that has seen significant variation across the country, but for many POA will be the sole job for the staff who work there. The reason? They absolutely LOVE IT! Highly skilled and hugely rewarding, this area brings a huge amount of satisfaction and unity to identify potential challenges for our patients undergoing elective surgery, and is an opportunity to help educate and inform on perioperative risk.

Post pandemic, we have seen pivotal changes to the perioperative pathway with a focus on early assessment and optimisation for patients 'while they wait'.[1] Working for GIRFT and NHS England (NHSE) colleagues, specifically in elective recovery, has brought a new dimension to my role and, I hope, skills of influence, engagement and innovation to help drive forward the importance of all POA clinics, everywhere.

The non-medical lead POA network was created in November 2022, with its main aims and objectives being:

- to create a group for non-medical leads working within POA that feeds into the national networks and membership bodies promoting perioperative care/medicine and that is driven by clinical experts
- to share and promote best practice, learning and case-studies
- to link staff together to help streamline pathways across providers, systems and regions so they have access to peer support
- to help reduce variation and promote standardisation where possible
- to build upon existing transformation and service improvements within POA services.

Six months in, there are more than 150 non-medical leads on this online network. The average Teams meeting monthly attendance is around 50–60, spanning across a diverse non-medical healthcare professional group but with engagement and emails from many more. The things that I didn't expect, but that became obvious after the first meeting, were probably the most important things that I have learnt: leadership, enthusiasm, passion, civility, kindness, and a safe space for discussion on daily challenges. Most of us have a common goal in healthcare: patient safety, doing the best we can and valuing each other in an often challenging environment. For the first time, non-medical leads of POA departments have a voice and a platform to share their challenges and expertise with others in similar roles. The network has brought excitement, creativity and relief! We have met each other and have shared a purpose and fondness for where we work and what we do. There isn't a week goes by without a request to forward the invite or an 'ask' to share a protocol, and so, the POA community continues to grow. We were extremely grateful to receive some funding from NHSE to enable us to have regional non-medical champions within POA to work alongside our medical colleagues, and I've never met such a group of fantastic individuals. They are eager, proud and bursting with enthusiasm to help create sustainable change.

The challenge ahead is hard. Demands on service, rapid transformation, and new guidance to implement and explore are coming at POA departments thick and fast. Both medical and non-medical leads, along with executives, operational managers, the royal colleges, associations of professional bodies and, most importantly, our patients are exploring new ways of working of which POA is an integral part. There is a commitment to changing processes and doing the best for our patients while they wait during that journey to surgery.

Optimisation, early screening, workforce, digital enablement, patient co-design, scheduling and booking are at the forefront of transformation across provider, system and region. Excellent examples of primary and secondary care partnerships are highlighted and shared when reviewing patient pathways. Engagement at every level, both clinical and non-clinical, is progressing towards common goals and aspirations and a real 'can do' approach.

There has never been a more exciting time in my career to be a POA advocate and advisor alongside those exceptional leaders who have a wealth of process and pathway expertise. They are showing they have a huge ability to not only inform, but also to help transform the elective recovery journey. I'm extremely grateful, and proud to have this network up and running. To review this work and the previous presentation and agendas, please register or login to the FutureNHS platform and search 'Pre-Operative Assessment - Getting It Right First Time' (future.nhs.uk/GIRFTNational/view?objectID=40854352).

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SHARING LEARNING FROM THE QUALITY NETWORK

The College's Quality Network (QN) was formed to share learning, develop quality improvement (QI) knowledge, and encourage local improvement work (rcoa.ac.uk/qi). It is comprised of regional leads, who are aligned with the schools of anaesthesia, and local leads who are based within the hospitals of each region.

The College's Quality Improvement Working Group wanted to make a fresh assessment of the QN to take stock of our progress and plan future work. A short national survey, to understand implementation of an important safety initiative, was felt to be an effective way to re-invigorate members and generate learning for future projects.

Prep Stop Block[1] (PSB) (rcoa.ac.uk/news/salg/psb) was created in 2021 to enhance the message of 'Stop Before You Block' (SBYB) and standardise national regional anaesthetic practice, aiming to reduce the incidence of inadvertent wrong-side block. It was launched with a training package and supporting resources. This new standardised operating procedure applies to all departments undertaking regional anaesthesia.

A short survey was designed and sent to local leads with the intention of conducting a rapid scan for information and resources. We hoped that generating results quickly would demonstrate benefit to members and allow the sharing of learning with minimal delay.

The survey requested information on the improvement measures and resources used to implement PSB. In addition, we sought details regarding methods that had worked well and the challenges faced. Comments were also collected from the regional and local leads to gather feedback on the QN and communication within it.

How is the Network working?

The QN consists of 25 regions, and 13 of these participated, resulting in responses from 62 hospitals. This represents 44% of the hospitals within participating regions and a national response rate of 24%.

Feedback from regional leads shed light on communication with local hospitals, with some describing difficulty in identifying their local leads. Conversely, this process was straightforward when leads had established contacts within the region. This highlighted the impact of these relationships on information transfer through the Network.

The project has also helped us to consider the most efficient methods of data collection, how we best support regional leads with their work (particularly in large geographical regions), and how we account for all hospitals that deliver anaesthesia services in future projects.

How has PSB been implemented?

The most common measures implemented by hospitals were:

- displaying the official PSB poster (24% of all interventions)
- presentation at departmental meetings (20%)
- training of other theatre staff (11%)
- audit (11%).

Video resources were described being used seven times (7%), demonstrating the value of multimedia resources in reinforcing practice.

Of the successful measures reported, 38% shared the themes of empowering or encouraging operating department practitioners and multidisciplinary team learning with theatre staff. Regular education, in the form of teaching and audit presentations, teaching at staff induction and 'tea trolley training', accounted for 23% of measures that worked well.

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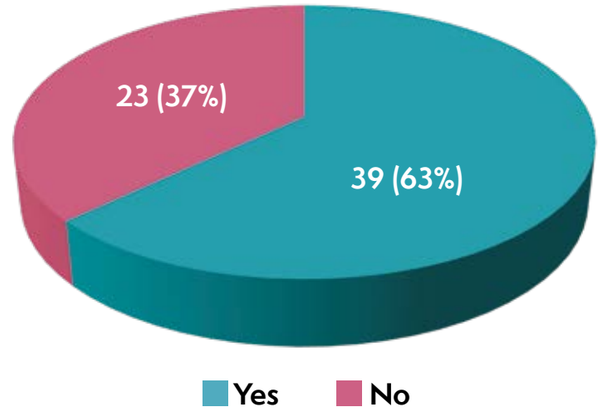
Figure 1 Have PSB improvement measures been implemented?



Of the 23 hospitals not using PSB, eight (13%) were using SBYB. Five of these felt it was working well and did not plan to implement PSB. Overall, 24% were not using PSB or SBYB

The themes of the challenges faced while implementing PSB were:

- anaesthetic staff – including lack of staff motivation or clinicians preferring SBYB
- theatre staff – staff feeling unempowered or being unaware of PSB
- system challenges – including overcomplication with additional paperwork
- human factors – including list or staff changes and distractions in the anaesthetic room.

What next?

Overall, this project has given us lots to reflect upon. Much of the learning is centred upon the people within the wider Network and how we foster connections, improve communication and facilitate resource sharing. It also emphasises the role of QI in testing, listening and adapting processes in order to engage staff and improve patient safety.

PSB is a national campaign, delivered with supporting resources. Key messages from the project showed the value of regular multidisciplinary teaching in educating and empowering staff and reducing the impact of system or human factors. Despite a strong national steer on implementation and resources, there are many examples of local variations in approach and many departments who have not implemented it at all. We hope that sharing resources and learning will also help those who are yet to start.

Finally, thank you to all the local and regional QI leads and to the College staff who contributed to this project.
To read the full report or to find out about the QN, please visit the College website (rcoa.ac.uk/prep-stop-block-survey).

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‘SO WHAT IF CHATGPT WROTE IT?’

Artificial intelligence (AI) continues to innovate the ways humans interact with information and technology, and Chat Generative Pre-trained Transformer (ChatGPT) is the latest iteration freely available on the internet. Trained using transformer architecture, it generates human-like text by sifting through terabytes of data and billions of written works from internet sources[1] – many from familiar authors– to create human-like answers to prompts or questions.

As an experiment, I prompted ChatGPT to write this article, and it produced a not-terrible piece of work – although Reader, you will be reassured to know that this publication is man-made.

For your enjoyment, here is an example of a prompt related to anaesthesia:

Write about general anaesthesia in the style of Shakespeare...

‘In the realm of medicine, where healers doth reside,
There lay a patient, in need of surgical guide.
The anaesthesiologist, with a learned hand,
Prepared the potion, to make pain’s grip disband.
General anaesthesia, the drug of sleep,
Shall make the patient, in peaceful slumber steep.
The patient lay, upon the surgical bed,
As the anaesthesiologist’s potion was administered, as gentle as a feather shed.
The world around him, did fade away,
And he felt himself, in dreamless sleep to stay.
While surgeons worked, with skill and care,
The patient knew not, nor did he the pain bear.
When he did wake, the surgery complete,
He felt no pain, nor any wound’s heat.
The anaesthesiologist, with a smile so fair,
Said “all is well, thy pain is now repair”.
The patient thanked them, with grateful heart,
For the anaesthesia, that did play a crucial part.
And so, he left the hospital, with renewed life,
For the anaesthesia, brought him ease amidst the strife.’

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Although entertaining, and with nuance of the original poet, such work lacks a certain je ne sais quoi – it is a dispassionate mimicry of human artistry

There are issues with using AI for more serious purposes. AI can be prone to bias inherent in the data it was trained with, and a lack of transparency and credibility about that training makes it difficult to tell how AI draws conclusions. It’s a sober caution that ChatGPT can make false or contradictory statements, confabulate citations to support false contentions (also known as ‘hallucinations’), and misremember details.[2]

However, the painful truth is that algorithm biases are of humanity’s own making: they’re often similar to the mistakes we’re capable of making ourselves. AI is a nascent technology of great promise, but also one of great ethical challenges. There are serious concerns that ChatGPT may entrench and exponentially compound discrimination, regurgitate prejudicial statements, and violate social norms. The EU Agency for Fundamental Rights (FRA) has warned that ChatGPT could cause harm, and recommends safety and accountability mechanisms to mitigate bias and discrimination.[2] Responsible AI creators recognise that learning from people ‘in the wild’ is not straightforward.

Similar ethical challenges also arise when doctors utilise ChatGPT without critical awareness to create reflective pieces, academic articles, or other clinical reports. The title of this article may very well then be a legitimate question posed by the creator of such work to editors and readers. Whether using AI to write is an unethical misuse of technology, an unsettling but unavoidable change to the way we produce literature, or a clever way to reduce friction for exploring ideas, the ramifications require consideration. Such digital transformation changes knowledge acquisition, and requires research in order to identify and implement policies to protect against abuse of Generative AI. ChatGPT alone is unlikely to be a method to cheat one’s way to greatness, but what might individuals lose in offloading such efforts?

Reassuringly, the expert consensus is that – when properly safeguarded – AI can enhance productivity, and reframe our purposes and focus on skills that complement rather than compete with them.[3,4] Surprisingly, tasks that we consider the pinnacle of human intellect, eg, chess, are often executed easily by a computer. However, humans eclipse AI when it comes to seemingly effortless functions, such as recognising a cat, catching a ball, or acting on the complex and subtle human behaviours we value as part of providing care to patients.[4]

Ultimately, the impact of AI on our purpose and actualisation will depend on how we choose to integrate it. The RCoA acknowledges that AI will play an increasing and transformative role in the provision of anaesthesia,[5] with the potential to find new meaning in a world where AI and human intelligence work in harmony. For now at least, ChatGPT will not cede the creative and daring exploits of anaesthetists or *Bulletin* authors.

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DR RALPH S VAUGHAN

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Pask Certificate of Honour 1990
1940–2023

Ralph was born in Morriston, Swansea and qualified in 1966. He found his calling in anaesthetics. His first posts were as SHO and later registrar in south-east Essex. Ralph returned to his beloved homeland and joined the department in Cardiff working under Bill Mushin. From early in his career, Ralph had involvement with the Association of Anaesthetists, being honorary secretary to the then Junior Anaesthetists Group from 1969–1972. With his appointment as a consultant, he continued his links, becoming the guru behind the trade exhibition at the Annual Scientific Meetings. Election to Council of the Association allowed Ralph to bring his unique slant onto many important issues, and he was elected to the office of honorary secretary from 1992–1994. His value to the Association was further recognised by his subsequent appointment as vice-president. Ralph was elected to Council of the RCoA, where he rose to be vice-president in 1999. During his time on Council, he held several key roles, including chairman of the Examinations Committee. Few people have been so successful in working in the two bodies for the unity of anaesthesia – and I suspect even fewer have served as vice-presidents of both.

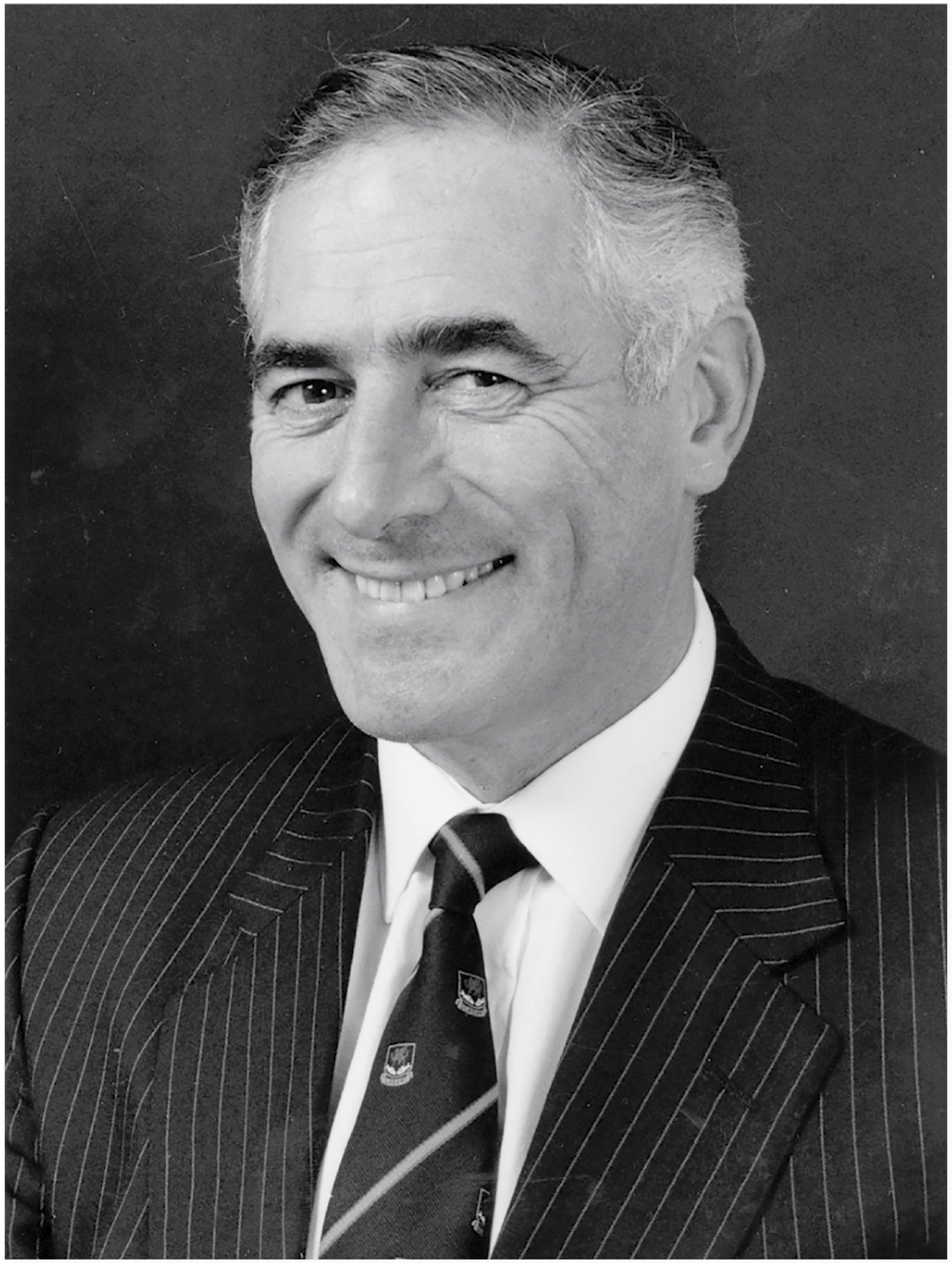
Most of Ralph's research revolved around practical airway management. He was a founder member of the Difficult Airway Society (DAS) with Adrian Pearce, and also the first chairman of this society. His seminar on difficult airways is still running today and is the longest-running Association seminar. His fellow lecturers would try to beat his feedback scores by introducing videos and interactive technology, enthusiasm, and educational fads, but Ralph's seemingly casual, off-the-cuff style always won the day. In recognition of his ability to hold an audience, the Ralph Vaughan Cup was designated by the Difficult Airway Society for the best oral presentation by a UK/Irish trainee. He inspired and taught on the Cardiff three-day DAME (Difficult Airway Management Education) course. Many current international airway experts refined their airway teaching skills on this course. In addition, he co-authored more than 80 peer-reviewed papers and many books. In 2010, he was Awarded the DAS MacEwan Medal in recognition of his enormous contributions.

As a clinical anaesthetist, Ralph had always been able to combine his excellent technical abilities (regional and airway) with compassion for his patients and a trusting relationship with his surgical colleagues. If only all anaesthetists could be so endowed we would have a much easier job convincing others of our merits; he inspired a generation of colleagues to behave in a similar fashion. After an initial retirement that many colleagues felt was premature, he returned to the department in a part-time temporary position. His wisdom for consultants and sheer enthusiasm for teaching trainees was always appreciated.

In retirement, he chaired the Radyr and Morganstown Association Community Council. He made a huge contribution to Radyr life, including involvement in starting the first Welsh-speaking nursery. For his family, he was a wonderful loving and supportive husband, father and dadcu (grandfather), and they considered that they were very blessed to have had him. His passing has left a huge void in their lives that will never be filled. He leaves his wife of 56 years, Marilyn, two daughters, and four grandchildren. Throughout his career, Ralph was always supported by his wife Marilyn 'both in sickness and in health', and our sympathies go out to her and the whole family. Others of us have lost a dear and caring friend, and anaesthesia has lost one of its gentlemen and its strongest supporters.

Mark Stacey

Acknowledgements
Mike Harmer (https://bit.ly/3nDmxYb).
Suzanne Vaughan – eulogy



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AS WE WERE

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The epidural

Two prefixes separate the same procedure: *peri*dural in French means *epi*dural in English. Physiologically, the French word is the more accurate.

Our first child arrived in 1968, delivered in a London hospital. My wife was nominally under the care of a consultant, but in reality the obstetric senior registrar oversaw her delivery.

She had attended antenatal classes, and was primed to request analgesia when her contractions became distressing. Entonox was a non-starter for her – she had an ether-induction for a childhood tonsillectomy and had retained a terror of an anaesthetic mask being placed on her face ever since.

When that time arrived, the midwife administered 75mg of pethidine: within fifteen minutes my wife began to hallucinate. Our daughter was born without any additional analgesia.

For her second delivery, in the same London hospital, my wife refused to have pethidine, and our second daughter was delivered without analgesia.

When, in 1975, she became pregnant for a fourth time, I had been an anaesthetic trainee for three years and had a fellowship examination behind me. Ultrasonography had now arrived into obstetric antenatal medicine, and my wife duly had her abdomen painted with olive oil and scanned. The machine was not yet sufficiently precise to be able to determine the sex of the foetus, but our son was born in January 1976. The grainy photograph of his intra-uterine life remains as a memento in a photo album.

During my training I rotated through several of the sub-disciplines which were gaining in strength and status, one of which was the ever-growing role of the epidural for labour, both normal and compromised. The driving force for this was Dr Andrew Doughty from Kingston-upon-Thames.

In 1976 commercially pre-packed epidural kits were not available: reusable 10cc glass syringes, air filled, were inserted to demonstrate a loss of resistance and so locate the epidural space. Dr Doughty placed great emphasis on specific positioning of the epiduralist's hands to minimise dural puncture. Nonetheless I witnessed an air encephalogram caused by clumsy fingers injecting 10ccs of air subdurally. The parturient immediately assumed an opisthotonos position. Her headache lasted for more than a week.

Knowing my wife's aversion to face masks and pethidine, I convinced her to have an epidural for what was anticipated to be a straightforward delivery: the one problem this idea threw up was that there was no one in the anaesthetic department other than myself who had any lumbar epidural experience. Single-shot caudal epidurals were relatively common.

Please see the heritage and archive information on our website:

rcoa.ac.uk/heritage

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Ultrasonography had now arrived into obstetric antenatal medicine, and my wife duly had her abdomen painted with olive oil and scanned.

At this time, intra-dural anaesthesia *per se* and a procedure with any likelihood of entering the subdural space was viewed as problematical as UK spinal anaesthesia was still under the cloud generated by the Wooley and Roe case in 1947. Disposable single-use medical plastics were just becoming available and were eventually to revolutionise anaesthetic practice in its totality, for example, endotracheal tubes and epidural catheters.

To my surprise the obstetric senior registrar volunteered to provide my wife with a single-shot lumbar epidural: he quickly added that for an obstetrician to insert an epidural in Rhodesia, his country of birth and where he had initially practised, was quite normal, there being a paucity of anaesthetists. The injection of 15mls 1% lignocaine was successful in providing the multiparous parturient with a minimally uncomfortable birth.

Obstetric anaesthesia continued to grow: it did so via single-use J Alfred Lee Tuohy needles with Huber points, plastic catheters, programmable infusion pumps, and new anaesthetic drugs plus the synthetic opioid fentanyl. Ultrasonic devices now aid needle positioning for many local blocks.

Obstetricians also changed their practice: by 1980 forceps deliveries had effectively vanished, and caesarean sections ruled, frequently completed after an in-situ epidural top up.

English obstetric anaesthetic practice has remained fairly uniform, notwithstanding learned journals printing negative articles and a vocal defence of 'natural' childbirth: both decry the effectiveness of the analgesia provided.

I have seen two variations on the loss-of-resistance technique. Firstly, when in Sweden an anaesthetist took a 20ml syringe containing 2% lignocaine, positioned the needle between two lower-vertebral processes and with the palm of his right hand pushed the syringe into the patient in a non-stop movement. This was deemed acceptable as the regional professor of anaesthetics electively produced a total spinal so as to teach his juniors how to treat this situation. The second variation occurred in 2004 when anaesthetists from Eastern Europe flew into the UK, worked non-stop for two weeks and then returned home. One of these 'flying doctors' eschewed the loss-of-resistance technique, preferring the 'hanging drop' method. I felt that his approach was considerably safer than the Nordic variant.

Peri/epidural obstetric anaesthesia is now, rightly, considered part of the normal delivery package: long may it continue!

NEW TO THE COLLEGE

The following appointments/re-appointments were approved (re-appointments marked with an asterisk).

December 2022

Regional Adviser Anaesthesia

Kent, Surrey & Sussex

Dr Visweswar Nataraj

Deputy Regional Adviser Anaesthesia

North Central London

Dr Sarah Barnett

March 2023

Deputy Regional Advisers Anaesthesia

Kent, Surrey & Sussex

Dr Alison Chalmers

West of Scotland

Dr Shashi Timalapur

To note recommendations made to the GMC for approval, that CCTs/CESR (CP)s be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in Anaesthesia, or Anaesthesia with Intensive Care Medicine or Pre-Hospital Emergency Medicine where highlighted.

November 2022

Severn

Charlotte Earnshaw

February 2023

East Midlands

Yuvraj Kukreja

Imperial

Nicole Pamela Greenshields
Alexander James Walls
Nisha Bhudia
Roshni Manek

Kent, Surrey & Sussex

Richard Paul Sumner Stead
Thomas Clewley

Mersey

Grant Craig Harris

North Central London

Jaishel Patel
Sam Curtis
Thomas Christopher McCretton
Victoria Rose Buswell
Zoe Anna Brummell FICM

North of Scotland

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Shin Hann Chia
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Severn
Inthu Kangesan FICM
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Victoria Anne Bennett FICM
Jessica Sophie Catharine W Johnston

South Yorkshire
Daiva Woolley

Wales
Kiroless Saba
Matthew Short
David Robert George
Farzad Saadat
Thomas Roberts

Warwickshire
Arif Aleem Qureshi

West of Scotland
Duncan Thomas Young FICM
Kathryn Norman

West Yorkshire
Kate Mary Wilkinson FICM

March 2023

Barts & The London
Pooja Shah

East & North Yorkshire
Paul Richard Sellens FICM

East of England
Romit Samanta FICM

Kent, Surrey & Sussex
Andrew Edward Skinner
Anna Thomas
Emily Walton
Katharine Mary O'Rourke

Mersey
Claire Catherine Anne Davies

North Central London
Rachel Anna Coathup
Tawhida Hussain FICM

North West
Sarah Rehman

Northern
Han Ying Lim

Oxford
Maria Dolores Rivero-Bosch

South East
Alexander James Stilwell

South East Scotland
Frances Ann McConaghie
John Andrew Livesey FICM

St George's
Azra Osama Fahid Zyada

Wales
Barrie Philip Robertson
Ifan Lloyd Lewis FICM
Rachel Scale
Rebecca Catherine Jackson

Appointment of Fellows to consultant and similar posts

The College congratulates the following fellows on their consultant appointments:

Dr Andrew Bretherick, University of Edinburgh

Dr Emira Kursumovic, Royal United Hospitals Bath

Dr Ifan Lewis, University Hospital of Wales, Cardiff

Dr Victoria Ormerod, North Bristol NHS Trust

Dr Ajay Sathyanarayana, Worcestershire Acute NHS Trust

Dr Sara Scott, Queen Elizabeth Hospital, Gateshead

Dr Elizabeth Turnbull, Northumbria Healthcare Trust

Bulletin | Issue 137 | July 2023

LETTERS TO THE EDITOR

If you would like to submit a letter to the editor please email **bulletin@rcoa.ac.uk**

Dear Editor,

We read with interest the article by Drs Apps and Patil: 'Cardiotocography: a concern for the anaesthetist' (RCoA *Bulletin* 136, April 2023). While we fully agree that basic knowledge and an appreciation of cardiotocography (CTG) form an important part of the obstetric anaesthetic assessment, we dispute the following.

The authors propose that with the national shortage of midwives, anaesthetists can provide an additional layer of safety via CTG interpretation. NICE stipulates that continuous CTG monitoring is required in patients receiving central neuraxial blockade.[1] Anaesthetists would not be able to both provide this while simultaneously siting the epidural and (perhaps more importantly) provide post-procedural monitoring. There are many ways to support our midwifery colleagues, however CTG monitoring and shouldering of diagnostic responsibilities should not form part of this.

While CTG interpretation may enable more effective discussions between anaesthetic and obstetric teams during emergencies, 'panic' anaesthesia as suggested by the authors is best minimised through targeted training and simulation, rather than through anaesthetists' ability to interpret CTGs.

Finally, we strongly believe that anaesthetists already are a vital part of the labour ward multidisciplinary team. Our ability to provide safe perioperative care for complex patients, manage life-threatening emergencies and transform patients' birth experiences places us far beyond being just a 'technical specialty'. The ability to interpret CTGs, although useful, would not be required to add 'further credibility to our specialty'.

Dr Chao-Ying Kowa
Dr Maggie Xiaokun Zou

Reference

1 Fetal monitoring in labour; NICE Guideline 229. *NICE*, 2022 (nice.org.uk/guidance/ng229).

Editorial Board Trainee Membership

The *British Journal of Anaesthesia* is recruiting for an additional trainee member to the editorial board of *BJA Education*. The role includes overseeing the production of high-quality monthly podcasts and other enhanced technology material, and contributing to the social media activities of the journal. Applicants should be in possession of the FRCA or equivalent and the appointment will be for a three-year term to commence in January 2024. Please note that these are non-commissioning editorial roles.

The successful applicant will benefit from:

- regular interaction with other editors, gaining insight into the commissioning, proposal review, and peer-review processes
- opportunities to review submitted manuscripts and develop these skills with a mentor within the board
- networking opportunities with the editors working in several continents
- contributing to a high-quality CPD journal with a large international readership.

The duties of the trainee/podcast editors are:

1 to contribute to the recording and editing of high-quality monthly podcasts in collaboration with authors of articles for *BJA Education*
2 to assist the editors in maintaining and increasing the profile and impact of *BJA Education* on social media, eg Twitter @BJAJournals
3 to attend and contribute to the two editorial board meetings held at the RCoA in March and October each year and the two editorial teleconferences held in January and July each year
4 to assist the editors by providing input into the peer review of proposed and submitted articles planning of future developments and journal content.

You can view the job description and person specification for this role here: https://bit.ly/BJAEd-Podcast

Applications, in the form of a covering letter and a brief CV (maximum two sides of A4) should be sent to admin@bja-education.org **by 31 August 2023**. The EiC and current trainee/podcast editors are also happy to be contacted via admin@bja-education.org for informal discussions about the role before the application deadline.

The selection process for shortlisted candidates will involve a short presentation and interview to be held at the RCoA in Red Lion Square the **week commencing 11 September 2023**.

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Editorial Board Membership Vacancies

The *British Journal of Anaesthesia* invites applications for membership of the Editorial Board of *BJA Education* to commence in 2024. The appointments will be for a five-year term in the first instance, renewable for a further five years subject to performance.

To be eligible, applicants should be engaged in a substantive academic or clinical position, with significant clinical experience in one or more fields of anaesthesia, in or outside of the UK.

Applications from individuals with general and subspecialty interests are invited, but we particularly welcome those with specific expertise in paediatric anaesthesia, intensive care, general anaesthesia and basic sciences to complement the experience of the current Editorial Board.

Applicants should have experience of the editorial process for medical journals and in the preparation and submission of high-quality articles for publication.

This role requires significant commitment to the development of the Journal and we will expect appointed editors to be able to commit to:

1 commissioning and overseeing the submission and review of at least five articles per year
2 attending and contributing to the three editorial board meetings each year
3 assisting the Editor-in-Chief by providing editorial expertise and reviewing articles submitted for publication
4 ensuring that all editorial tasks and deadlines are met promptly to ensure timely publication of the journal.

You can view the job description and person specification for this role on the *BJA Education* website: https://bit.ly/BJAEd-Editorial

If you are committed, enthusiastic and willing to join a highly performing team to further develop *BJA Education*, please send your application (in the form of a covering letter detailing what contributions you would bring to the journal (one side A4 maximum) and a brief CV (four sides A4 maximum) that includes a list of publications in the past five years) to the Editor-in-Chief, Professor Jonathan Thompson, at admin@bja-education.org by **9:00am on Thursday 31 August 2023**. We plan that interviews will be held **week commencing 11 September 2023** either remotely or face-to-face at the RCoA in Red Lion Square.

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Registered Office: Department of Anaesthesia, University of Liverpool, Duncan Building, Daulby Street, Liverpool L69 3GA.

RCoA Ethics Committee Chair

The RCoA is looking to appoint a new Chair of the Ethics Committee. Medicolegal and ethical dilemmas in clinical practice are increasingly common. Sitting as a link between the RCoA and the wider profession, the Chair, in conjunction with the Ethics Committee will identify and provide independent critical analysis to the RCoA on matters of ethics of particular concern to anaesthetists and pain specialists and the public they serve.

The role is for a fixed term of three years, renewable for a second three years subject to performance. There is no funding attached to support this role.

If you believe that you are the right person for this role, please take a look at the job description and submit an abbreviated focused CV (maximum two pages) and a 650-word statement which addresses the person specification (rcoa.ac.uk/vacancies). Please send your CV and statement to clinicalquality@rcoa.ac.uk **by 29 September 2023**.

In your submission, please state at the beginning of your statement, your name, College Reference Number and current RCoA membership category.

We are expecting a lot of interest in this important role. Our current expectation is that we will shortlist and interview in October.

Deaths

With sadness, we record the death of those listed below.

Dr Derek F J Appleton, Hope Valley
Dr John Beddard, Hampshire
Dr John Hurdley, Birmingham
Dr Hugh D Jones, Devon
Dr Maithrie M Rajapakse, Sri Lanka
Dr John F Searle, Exeter
Dr Rosalind M Ward, Berkhamsted
Dr Sean A White, Bristol

To submit a Lives of the Fellows form for publication on our website (rcoa.ac.uk/lives-fellows-biography-listings), please contact archives@rcoa.ac.uk

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†**Source:** GMC *Fitness to Practise Report*, January 2023.
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Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

Book your place at rcoa.ac.uk/events

Hybrid event

Winter Symposium

RCoA, London and online

30 November to 1 December 2023

Joint Winter Scientific Meeting

13-14 November 2023 | Edinburgh

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