

The gas

The newsletter for all
Anaesthetists in Training

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Susie Thoms & Soumen Sen, Co-editors

Welcome to the Winter edition of The Gas Newsletter

I have experienced a degree of writer's block with this editorial. The first version was swiftly binned after I was contacted by a number of people involved in the ST3 recruitment disaster that has recently occurred.

As your representatives, I can honestly tell you that we were devastated that this happened to our colleagues. We tried to reach as many people as we could locally within our regions and offer direct support, while communicating nationally to address this situation.

Members of RCoA Council, our President, [Dr Fiona Donald](#), and RCoA staff expressed their own strong feelings of sadness, shock and solidarity with trainees.

The RCoA quickly communicated, conveying information they had received, and the [College has worked extremely hard](#) urging ANRO and HEE to find a fair solution for the anaesthetists affected. We have pushed for HEE to conduct a thorough investigation of what happened and they have agreed to do so, with the involvement of the RCoA to represent your interests. We have been blown away by the responses of individual schools and trainers, who have worked hard to secure posts for individuals.

What has been clear is how incredibly passionate the RCoA and Association are, working together to support members in a time of crisis. I have seen the representation network rapidly mobilise and focus on an urgent issue with skill, determination and commitment to our colleagues. The need for an intact, cohesive training representation network has never felt so important to us and we will be working over the next year to ensure that you know who your local representatives are and how you contact them.

Every school has an ATRG ([Anaesthetists in Training Representative Group](#)) representative. We are in the process of updating the RCoA website to show every representative in the country and how to contact them. You can also contact the national Anaesthetist in Training

representatives on trainee@rcoa.ac.uk – we are there and can usually help. We don't want any trainee going through the issues we face alone. Never has the need for peer support been so strong.

On Friday night I worked a night shift with a friend whom I had never actually worked with clinically before. We worked together covering the work load well. We also had 12 hours of mutual support, counselling, chatting, laughing about various things, comparing parenting mishaps and putting the world to rights. It was the longest time I have spent with a friend for a really long time and it struck me as fairly sad.

It is a very strange time to be going through training. The pandemic has caused a perceived and actual distance between us. We work increasingly separately, without our fellow trainee cohort/buddies and somehow we need to try to bring back the support and friendship networks that are vital for our wellbeing. It is also a time of tremendous change within training and within our workplaces and, with that, comes uncertainty, doubt and trepidation.

'Embrace change' is the mantra we hear, but I urge us to do it together, to try and reconnect with the training networks, the friends and the things that have feel more distant for us at the moment. After a rather long time being in training, I can honestly say it has been my friends and colleagues who have pulled me through. Don't underestimate the power of a hug or a five-minute social chat at handover. I think I have hugged more colleagues in the last two months than in the whole year before; it certainly feels important at the moment.

As representatives, we will be trying over the next year to improve our presence, communications and accessibility. We want you to contact your ATRG representatives

with issues you face. We want to hear from you if you are struggling to find your representative or have a problem they cannot help with. Please look at the trainee representation pages on the [College website and use us](#).

As for this edition of *The Gas Newsletter*, we have excellent and interesting articles contributed by our peers, and we really hope you enjoy reading it. Please send any articles to us for future editions – we really want to hear what you are up to.

Keep safe, keep strong and keep in touch.



The *BJA* and *BJAEd* are going digital

The way you access your copy of the *British Journal of Anaesthesia (BJA)* and the *British Journal of Anaesthesia Education (BJAEd)* is changing. Rather than receiving paper copies, members will move to an [online format](#) that includes access to the entire archive of articles.

The change will happen in January 2022 for the *BJA* and July 2022 for the *BJAEd*. [Learn more](#) about the planned changes.

RCoA PODCASTS

Did you know that the RCoA has a podcast channel that has been running for nearly two years with over 35 episodes so far?

Some of our expert speakers include Professor William-Harrop Griffiths, Dr Clare Gerada, and key representatives from the GMC, to name a few.

[You can access the channel here](#) or download the podcasts from [Apple Podcasts](#), [Google Podcasts](#), [Audioboom](#) and [Spotify](#).

The podcasts cover an array of topics from clinical to non-clinical, including wellbeing, guidance, preparing for CCT and beyond.

We are always looking for new content, so if you have any ideas or hot topics that you think should be covered, or are interested in getting involved, please contact Fiona Anderson fanderson@rcoa.ac.uk



Dr Tom Burr

FLASH CARDS

Training theatre teams to prevent unrecognised oesophageal intubation



In August 2020, Glenda Logsdail, a fit and well 61-year-old died tragically of unrecognised oesophageal intubation. It is disheartening to see this still happen, despite all our specialty has done to prevent this potentially avoidable cause of death. This includes the [No trace = Wrong Place](#) campaign which was launched only four years earlier in response to two other deaths. Clearly, we must do more to address this issue.

In response to Glenda's death the College is launching a new campaign to prevent future deaths from unrecognised oesophageal intubation. As part of this campaign we are introducing flash cards as a resource for theatre team training. They contain high-pressure scenarios for the entire multi-professional team to talk through what they would do.

As Anaesthetists in Training we are well placed to introduce this patient safety initiative to our own teams. Each scenario only takes five minutes to run yet they draw on the strengths of more complex simulation-based learning. They raise key themes highlighted in the [Coroner's Report](#) on Glenda's death. These include technical skills like using an A-E approach and understanding the significance of the absent capnography trace. They also address non-technical skills like overcoming fixation error, challenging a more senior anaesthetist and engaging the team.

Why not try a scenario on your next list? You can access them [here](#) to have them readily available on your device. Finally, be sure to visit College [webpage](#) for more information on the campaign.

The College is launching a new campaign to prevent future deaths from unrecognised oesophageal intubation.

Dr Charlotte Soulsby and Dr Lisa Manchanda

SEA-G and the route to COP

Formed in 2018, the Scottish Environmental Anaesthetic Group (SEA-G) is a grassroots organisation of individuals working within anaesthesia across Scotland who strive to improve sustainability and reduce waste within the perioperative journey.

In 2017, Dr Ken Barker championed the Green Theatre Project in Raigmore Hospital, Inverness. This initiative included discouraging the use of desflurane, segregating waste at source, changing disposable equipment such as suction units and warming blankets to reusable alternatives, switching off ventilation and scavenging when not in use. In combination, these efforts not only reduced CO₂ emissions and cut waste but resulted in long-term cost saving for the health board. At the same time, similar smaller projects were running independently in hospitals across Scotland. With the aim of collaborating, sharing ideas, learning and enthusiasm, those involved in each project came together and SEA-G was born.

In November 2021, the 26th United Nations Conference of the Parties (COP26) on climate change [was held in Glasgow](#). It assembled heads of state and climate experts to coordinate action to address the public health threat of climate change. It was the largest international summit ever to be held in the UK. SEA-G presented at COP26, using the platform to demonstrate work achieved in anaesthetic departments across Scotland to reduce the NHS carbon footprint. As COP26 is a zero-waste conference, SEA-G showcased the continuing

work [via a team video](#) and other media. By interacting with other delegates, we hoped to gain new ideas to transform our practice. In addition, there is a virtual Green Zone on the COP26 website.

By presenting at COP26, SEA-G hoped to inspire others to transition towards sustainable healthcare, both in the UK and worldwide. The platform provided by COP26 has publicised continuing projects within our Scottish health boards, fostering engagement between health professionals, sustainability governance and management. This vision is shared by the RCoA with the promotion of sustainable anaesthetic practice.

So what can an anaesthetist do to improve sustainability? You can establish projects to educate clinicians about the environmental implications of using desflurane. Another important issue to highlight is the [carbon footprint of nitrous oxide](#). Engage the support of other individuals in your organisation, seek out your local sustainability officer and collaborate with your health board sustainability governance group. We would love you to join us and follow our work through twitter [@GreenAnaesScot](#) and [online on the route beyond COP26!](#)

GREEN ANAESTHESIA GUIDE
GLOBAL HEALTH CARE → Fifth Largest Carbon Emitter on the Planet

YOU CAN MAKE A DIFFERENCE... HERE'S HOW...

- Avoid desflurane and nitrous oxide
- Use LOW FLOW Anaesthesia
- Use Total Intravenous Anaesthesia
- Use Regional Anaesthesia
- Appropriate waste segregation

Waste Hierarchy

REFUSE
REDUCE
REUSE
RECYCLE
RETHINK
RESEARCH

NEVER DISPOSE OF UNUSED DRUGS DOWN THE SINK

PLAN before you PREPARE

- Consider oral instead of IV analgesia where appropriate
- Need IV fluids and extension lines?
- Need Forced Air Warming Device?
- Need Intermittent Pneumatic Compression Devices (Flowtrons)?
- Think before use - example: avoid excess use of syringes
- Avoid wearing disposable theatre attire if appropriate
- Turn off lights, air conditioners, computers & printers when not used
- Avoid disposable cups & single use plastic bottles
- Education & Raise awareness

Nitrous Oxide
potent greenhouse gas with x300 the effect of CO₂
DESTROYS the ozone layer and hangs around for 114 years

Des the Menace
Desflurane is x3000 as potent as CO₂ in terms of carbon footprint
ONE hour of desflurane use produces the equivalent carbon emissions to driving a car 200 - 400 km

WASTE
Operating theatres produce quarter of all hospital waste
Overprescribing & incorrect disposal of medicines is contaminating our ecosystems and DRINKING WATER
Each operating theatre produces 2300kg of anaesthetic waste per year

40% of this could be reclassified as domestic or recyclable waste

With thanks to Dr Pavan Raju et al, NHS Tayside

Further reading: McGain J, Murat J, Larsson C, Sherman JD. Environmental sustainability in anaesthesia and critical care. British journal of anaesthesia. 2020;125(5):688-92.

Dr Frances Young and Dr William Makuma

Addressing equality, diversity and inclusion for anaesthetists in training

The North West School of Anaesthesia has elected a trainee representative for equality, diversity, and inclusion (EDI) to sit on the Specialty Training Committee. The need for this vital role was identified at the North West's inaugural EDI study day, arranged by trainees to understand and emphasise training concerns.

The GMC has identified a gap in training in both undergraduate and postgraduate settings, leading to differential attainment among trainees, when split by protected characteristics such as age, race and gender.¹ The RCoA has conducted its own research into differential attainment in obtaining the FRCA and demonstrated a gap between white and black and minority ethnic trainees, even when both groups had obtained their primary medical qualification in the UK.² Similar patterns have been identified in successful recruitment, performance at ARCP and GMC referral.³⁻⁴

The EDI representative will aim to bridge this gap by providing better support for all doctors in training with protected characteristics. Understanding this need and how to address it is complex but it is important to ensure that these doctors feel they are appropriately supervised, with training issues being addressed early and by offering a safe space to raise any concerns they may have.

There is also a need to educate the wider medical community. The EDI representative will act as a point of contact for educational supervisors and will provide advice on education around EDI in departments. They will have input into training regarding EDI on post-fellowship study days and educational supervisor study days that already exist in the North West School.

The above strategy will be linked to the Medical Training Initiative programme by coupling with a buddy system currently being piloted. This will aid the smooth integration of trainees and will provide support and advice on any aspects of training that might be required.

The EDI trainee representative will aim to ensure that no trainee be adversely affected or unfairly treated because of personal circumstances, leading to a better and fairer training experience for all anaesthetists in training in the North West.

References

- 1 What is differential attainment? GMC.
- 2 Differential attainment in curricular components of the FRCA: an observational study. RCoA, 2017.
- 3 Woolf K et al. Organisational perspectives on addressing differential attainment in postgraduate medical education: a qualitative study in the UK. *BMJ Open* 2018;8:e021314.
- 4 Progression reports. GMC, 2018.





Dr Rhys Rhidian

Maximising training opportunities in regional anaesthesia

The College's new 2021 curriculum places greater emphasis on training in regional anaesthesia.¹ Anaesthetists in training on the new curriculum will be expected to have a greater regional skillset than those previously, including being able to perform brachial plexus, chest wall, abdominal wall and blocks for lower limb surgery independently by completion of stage 3 training.¹ After recently completing a six-month advanced module in regional anaesthesia, I wanted to share some insight into how to maximise learning opportunities.

First, exposing yourself to doing or observing peripheral nerve blocks as much as possible is desirable. Having some knowledge of which operations and lists in your department tend to have more blocks on them is invaluable. Your department may have even compiled some information on which theatre lists are more 'block heavy'.

Use shared learning opportunities – our institution uses a WhatsApp anaesthetist in training group to alert others of peripheral nerve blocks that are happening in the hospital, that they can either come and perform or observe. I found the figure below a useful graphic to improve my technical skills.²

Hand-eye coordination, essentially improving your needling technique, can be practised using simple models, such as the 'Blue Phantom'. Being confident in both in-plane and out-of-plane needling will be very beneficial when it comes to performing peripheral nerve blocks.

'Image acquisition,' or your skill with using the ultrasound machine, can be practised in a clinical skills lab or in theatre. Having some knowledge of how the ultrasound works and about artefacts such as anisotropy means you can understand better how to improve your image. Use the ultrasound more frequently – either by practising scanning to get more familiar with sonoanatomy or by using it for other procedures such as insertion of arterial lines.

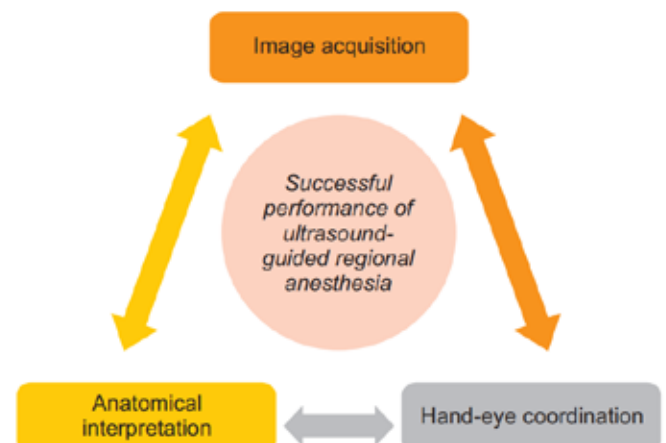
There are plenty of excellent resources out there, which will all help with the 'anatomical interpretation' component. Some resources that I have used include:

- 'Anso' app
- YouTube videos, particularly by Ki Jinn Chin and LSORA
- [NYSORA Compendium of Regional Anesthesia](#)
- A Pocket Guide to Ultrasound Guided Regional Anaesthesia by Townsley et al.³

Many regions also run hand-on regional anaesthesia courses. If you are still feeling keen, you can always pursue advanced training in regional anaesthesia – I would recommend it!

References

- 1 [2021 Curriculum for a CCT in Anaesthetics](#). RCoA, 2021.
- 2 Kim TE, Tsui BCH. Simulation-based ultrasound-guided regional anesthesia curriculum for anesthesiology residents. *KJA* 2019;72(1):13–23.
- 3 Townsley P et al. A Pocket Guide to Ultrasound Guided Regional Anaesthesia. 2nd edition. RA-UK. 2019.





Dr Thomas Coleman

Not another knock at the door

Day after day as medical professionals we are in and out of patient's bed spaces. We can all relate and have experienced the frustrations when someone has pipped you to the post. Your list is due to start in 20 minutes, you have not seen all your patients and the surgeon or nurse or pharmacist or *insert other allied health professional* has got in just before you. Some of us may wait patiently drumming our fingers, thinking we could be doing x, y or z while waiting. Others barge in, make their presence known, cutting the queue or hurrying the other person along.



In the not too distant past, I had the fortune to welcome a child into the world. For those who have been there I am sure you can appreciate the heartwarming emotion but my goodness the bit that comes after is tough. Sleepless nights, endless feeds, managing of reflux or constipation or colic (or whatever name we wish to give it). This was our second, a beautiful baby girl, and we were happy as punch. However, for reasons out of our hands we (or rather my wife and child) had to stay in hospital for a few nights.

I had it easy though. Imagine, you have a new baby and someone knocks on the door. Baby's observations, mum's observations, wound checks, hearing tests, meal times, more observations, breastfeeding advice, baby check, food tray

removed, safeguarding check, cleaner ... and so on and so forth. On one occasion I counted 10 people coming into the room in the space of one hour and this is all on the back of having just given birth and being very sleep deprived.

I am not expecting to move mountains but, from this experience, I definitely think more about the patient's perspective. As a result, the time it takes me to do my postoperative obstetric anaesthetic reviews has gone up significantly. If mum is napping when you get to their room, just let them. What may be just another knock on the patient's door for you might be ruining the only bit of sleep she will get today.

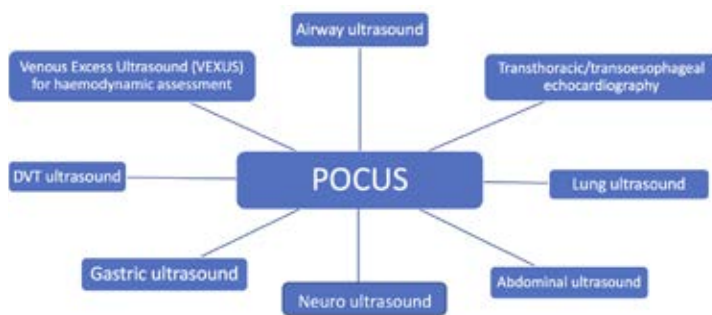


Dr Manoj Wickramasinghe

The future of point of care ultrasound training

Ultrasound has been engrained in anaesthetic practice for a long time, particularly for procedural applications such as venous cannulation and nerve blocks.

There are many applications for ultrasound beyond this use and, with machines becoming increasingly cheaper, better and smaller, it is unsurprising that there has been a huge boom in ultrasound use in anaesthesia and critical care (see below).



A case

- Mrs B presents with shortness of breath and hypotension.
- A bedside echocardiogram shows right-heart strain (Figure 1).
- A lower limb ultrasound identifies a femoral deep vein thrombosis (Figure 2).
- A diagnosis of massive pulmonary embolism is presumed and thrombolysed prior to computed tomography (CT).
- There is a sudden drop in her Glasgow Coma Scale score and she has developed a left-sided hemiplegia.
- A decision is made to intubate her.
- The patient has an anticipated difficult airway and airway ultrasound is done to mark the cricothyroid membrane should front of neck access is required (Figure 3).
- A gastric ultrasound is performed to rule out any significant gastric contents.
- Following intubation, a central line is inserted (with ultrasound guidance) and lung ultrasound is performed to ensure that there is no iatrogenic pneumothorax (Figure 4).
- CT shows an intracranial bleed and an optic nerve ultrasound suggests elevated intracranial pressure (Figure 5) so she is transferred to the neurosurgical unit.

So what is the future of point of care ultrasound (POCUS) training? As machines are becoming increasingly available, it is inevitable that clinicians will perform ultrasound. This is where the Focussed Ultrasound in Intensive Care modular programme comes in, allowing safety through a standardised modular accreditation pathway for multisystem POCUS. New modules are being created and released, with the idea being that practitioners can pick and choose modules that are most appropriate to their clinical practice. Neuro-POCUS, gastric, regional blocks, haemodynamics and transoesophageal echocardiography are all modules that are currently underway or planned for.

As a specialty that has had a close link to ultrasound, we have a central role in the future for POCUS. My idealised vision is a future where handheld ultrasounds are owned by all practitioners, perhaps even rendering the stethoscope obsolete (but that is a debate for a different day!).

Dilated right ventricle

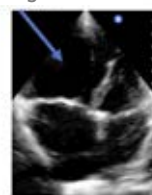


Figure 1

Femoral DVT

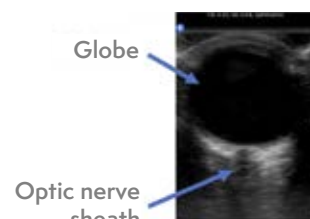


Figure 2



Figure 3

Globe



Optic nerve sheath

Figure 4

Thyroid cartilage

Cricothyroid membrane

Cricoid cartilage

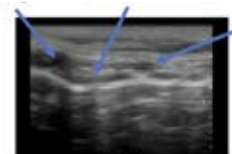


Figure 5



Dr Mina Nasr Arsanious and Dr Ee Jane Lim

Peer-led teaching – a sustainable model for local teaching programmes

As anaesthetists in training (AiT), we found it helpful to supplement regional FRCA teaching with a local programme to better match specific learning needs. Our particular group of AiTs thought that they needed a learning opportunity that allowed them to talk through core concepts in the curriculum, checking their understanding through discussion in a neutral and friendly environment. Following a review of literature, a small-group teaching model in line with self-determination theory of learning was set up.

Teaching model

The three main focuses of self-determination theory are autonomy, competency (or a sense of mastery) and connection. One hour of protected time was secured for core trainees each week with a two-monthly rota arranged. AiTs were given the autonomy to choose a topic of their own choice to deliver during a slot they had picked. The topic was delivered as an interactive small-group discussion with up to eight other AiTs at the same stage of training. Gaps in the teaching rota were filled in by higher-grade AiTs and consultants. AiTs delivering a session were able to liaise with a designated post-FRCA AiT. This enabled them to check their understanding before conducting the session and ensure that due focus and depth were given to the appropriate topics.

Through teaching a topic, the dialogue of the session and in post-session feedback, AiTs gain a sense of mastery over a topic and a feeling of having acquired competence in a subject. Connectivity or community was promoted by having a baking rota to run alongside the teaching rota, helping to create a welcoming and social learning environment.

Results

Feedback was collected pre- and post-programme via Likert scale questionnaires; 100 per cent of AiTs involved felt more confident talking about FRCA-based topics, more prepared for their exams and had an interest in the programme continuing for themselves and future core AiTs. Some 91 per cent of AiTs felt motivated to pursue private study post-programme compared with 48 per cent pre-programme.

Discussion

Supplementing regional teaching with this model of local teaching improves learner autonomy, consolidates knowledge and improves confidence in presenting topics. Its sustainability is built not on relying heavily on constant consultant or senior trainee presence but in building a community around shared learning. This programme is currently being run again with a new cohort of AiTs.



Dr Michael Jarvis

Research for the non-academic anaesthetists in training

For many anaesthetists in training, the recent change by the College to formally include research in the training curriculum is long overdue. For others, this is a step into unknown territory.

The Stage 3 learning outcome for the research and managing data domain of the [2021 anaesthetics curriculum](#) states:

Is research experienced: Has engaged with research; applies the governance involved in research; evaluates and communicates research findings clearly.

So where do you start?

Good Clinical Practice

Good Clinical Practice (GCP) provides a standard for the conduct of research. The National Institute of Health Research provides a [free Introduction to the GCP course](#). This course evidences a number of curriculum objectives and is a mandatory requirement for you to participate in most research studies.

Trainee-led research networks and RAFT

There are currently 21 regional anaesthetic and intensive care trainee-led research networks (TRNs) across the UK ([RAFT map of UK trainee research networks](#)). These trainee-led groups run regional and national multi-centre research and audit projects, journal clubs and educational meetings. Many sub-specialties also have their own TRNs. The Research and Audit Federation of Trainees (RAFT) is a national group representing TRNs that coordinates national trainee-led research projects and

supports access to collaborative projects. Getting involved with TRNs and RAFT is open to everyone and gives many easy opportunities to contribute to regional and national research work as an anaesthetist in training.

National studies and networks

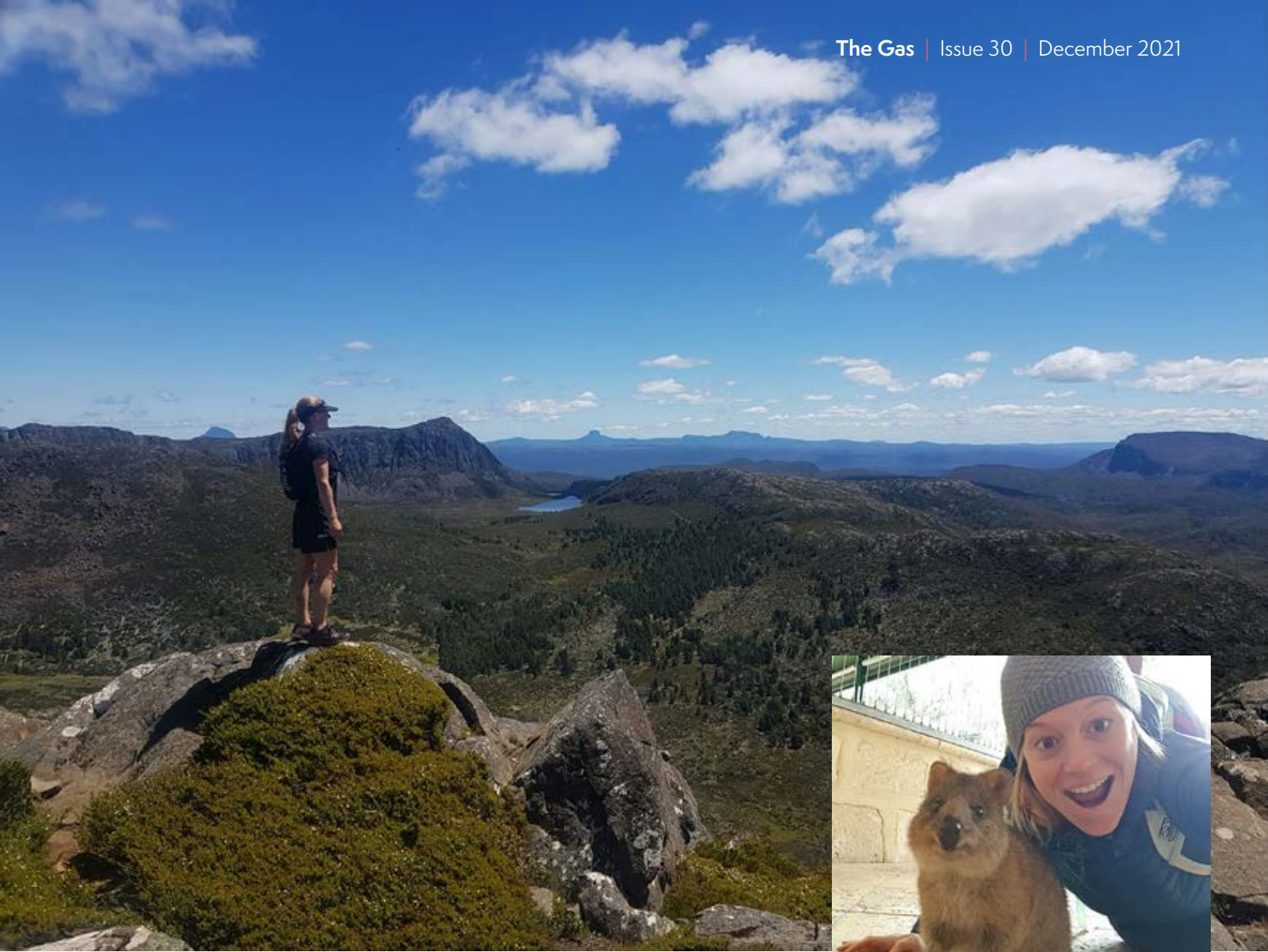
The National Institute of Academic Anaesthesia (NIAA) and the NIHR Clinical Research Network support a number of clinical trials and other studies within the NHS. Trainees can now be formally recognised for their role in NIHR research studies via the [associate principal investigator \(PI\) scheme](#), allowing you to lead a study locally under direct supervision of the consultant PI. This is a great way to evidence your research contribution and curriculum learning outcomes.

So what next?

Complete the GCP course

Visit the TRN and RAFT ([rafttrainees.org](#)) websites, social media and mailing lists to get involved and for upcoming projects, and the RCoA and NIAA websites for national projects. If you find something that appeals to you, why not approach your department research lead with a study of interest? You may be surprised at their enthusiasm and the support they can give!





Dr Amy Teasdale

How Aussi culture shock helped me love the NHS

Securing a Regional Fellowship allowed me an unintentional escape from COVID-19. After hotel quarantine, life was very normal Down Under, yet work was not.

I worked in a public hospital comparable to a large district general hospital in the UK, where it quickly transpired how different the role of the anaesthetist was compared with my NHS experience. Most notably, the anaesthetist was a technician. In the NHS, we engage in patients' perioperative care on many levels as respected decision makers in a way that I did not experience during my OOPT. Initially I couldn't understand how Australia was training anaesthetists in five years. Within just weeks I realised how: the RCoA trains clinicians, leaders, managers and educators. The Australian system (efficiently) trains clinicians. Comparing

my unremarkable CV to an Australian approaching CCT equivalence and the requirement to achieve little beyond clinical competencies demonstrated how well-rounded a consultant the RCoA produces.

I witnessed substandard communication, resulting in skills that anaesthetists could offer being overlooked. Elective theatre lists were not preceded by team briefs or introductions. High-risk parturients appeared on the operating table without warning, after hours on the birthing unit. An archaic hierarchy existed within theatre. The surgeon was evidently

the boss, being the moneymaker in the private sector. An all-too-common situation was observing a consultant give an anaesthetic wholly based on a surgeon's demands, carefully protecting their private working relationship. Examples I witnessed included general anaesthetic for an elective lower limb procedure in a patient with severe respiratory disease for whom my training to date would unquestionably have led me to provide regional anaesthesia. I was told 'just crack on' by supervisors when poorly optimised patients entered the anaesthetic bay, for example a minor surgical patient in fast atrial fibrillation, and anaemic patients for elective major joints. I witnessed both corner-cutting and risk-taking decisions to work quickly or to satisfy surgeons.

A privilege of the Regional Fellow was to attend the neighbouring private hospital and block for multiple lists in one session. Clearly, in this environment, money drives efficiency and productivity, a culture which helpfully transferred to the public hospital. However, there would be patients undergoing general anaesthesia for minor elective cases at 10pm by teams who had started the list at 7am. Financial motivation is huge among clinicians. Anaesthetists in Australia do earn significantly more when compared with NHS salaries, and it is easy to work exclusively in the private sector, which is commonly aspired to.

Of surprising contrast was the low priority of trainee wellbeing. Coming from a school with abundant wellbeing events and access to opportunities for psychological support, I pitied my equivalents. Pastoral support was deficient, lacking formal structure. Educational supervision involved a single training supervisor overseeing 30+ trainees. No trainee on my rota was less than full time, yet on my current NHS rota 6 of 16 trainees are. Equivalent supporting professional activities weren't formalised, despite project work being expected of trainees. I have always experienced time off as being respected as such, whereas, conversely, barriers were broken with work calls to trainees on 'off' days. The role of trainee vs service provider was conflicting, undoubtedly worsened by trainees being employed by the trust rather than by an educational body. For example, senior trainees working a heavy out-of-hours rota also covered countless solo lists because of consultant absences, affecting non-training days. A culture of speaking up was absent. Local trainees felt unable to say no to demands like sudden working pattern changes and extra clinical work without time compensation. I agreed with a UK-trained consultant that 'Australian trainees don't whinge', which I consider a barrier to progress. Such issues may relate to limited geographical choice in where to work upon completion of training, and therefore competition for jobs.

Following a largely negative report, I must emphasise the positives from my OOPT experience, and I willingly encourage every anaesthetist to practice in a new environment. I am a more open-minded, resourceful clinician by means of adapting to new cultures and using equipment, drugs and techniques that hadn't been part of my practice. My regional anaesthesia clinical training was invaluable. Reviewing my logbook, I gave more anaesthetics over a six-month period than I have ever given in a whole training year. I learnt a great deal about improving efficiency in my practice. I wore no FFP3 masks! Key benefits were appreciating the satisfying, respected role of the NHS anaesthetist and practising in a supportive team-orientated environment that wholly prioritises safe patient care.

Having returned to the NHS, I come close to tearing my hair out with obstructions to a patient arriving in theatre before 10am. However, I'll tolerate some systemic flaws knowing that when the patient (eventually) arrives, they will be cared for wholeheartedly by a team that values each other's roles. I've returned to job satisfaction, intrinsic rewards and attending the dearly missed WHO team brief, which now feels like a big 'welcome home' cuddle.





Dr Kimberley Hoyland

THE 'LABOUR BOARD GAME'

A novel way to teach anaesthetists in training about managing the labour ward

Anaesthetists in training are expected to be able to manage the labour ward out of hours at various points in their careers.¹ As a busy and constantly changing environment, filled with a new language of abbreviations, it can be a daunting and challenging prospect.

With experience, it becomes easier to predict the high-risk patients likely to need anaesthetic intervention. However, as a novice to the environment, reading the labour ward board can be difficult and confusing. Teaching tends to be ad hoc, with little in the literature to guide anaesthetists. To address this deficit and to try to make things easier, we designed a local guide to labour ward terminology, abbreviations and the induction of labour process to help guide anaesthetists in training. This was followed by a weekly 'labour ward board game' to play. This evidence-based approach used experiential learning to help develop mental models of pattern recognition for identifying high risk patients.²

Each board game consisted of a model labour ward board based on the department's real template. The anaesthetists in training were sent a board of six patients each week via a group WhatsApp chat, and asked to identify the high-risk patients, as well as what their plans would be (Figure 1). Example scenarios ranged from patients with a simple high body mass index with slow progress to those with more complex bleeding disorders, multiple gestation pregnancies, sepsis and those at risk of postpartum haemorrhage.

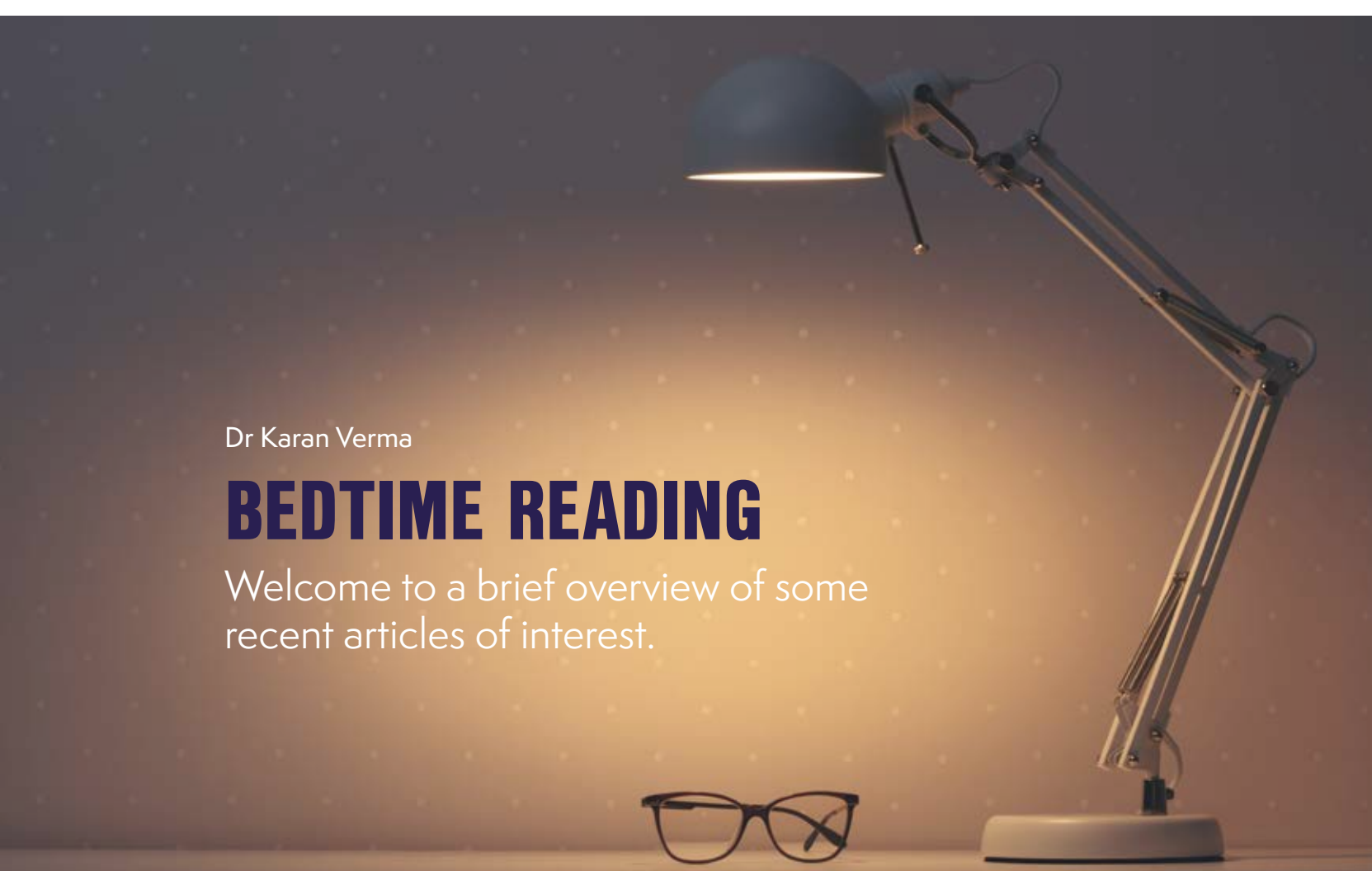
The games were considered a fun way to reinforce learning, with increased confidence in understanding the abbreviations, obstetric thought processes and how to identify high-risk patients. We have refined the labour ward guide and games using input from the obstetric team to ensure that we are using realistic cases. Using WhatsApp groups has proven to be successful in maintaining learning among trainees when face-to-face contact time is limited, and we hope to use this method to ensure that weekly education can be shared regularly.

References

- 1 [2021 Anaesthetics Curriculum](#). RCoA, 2021.
- 2 Walshe N et al. A systematic review to evaluate the comparative effectiveness of educational interventions on health care professionals' situation awareness: implications for training. *BMJ Simul Technol Enhanced Learn* 2019;5:A2.

Figure 1 Example weekly board game

Name	Age	BMI	G/P	Gest	PMH	Labour details	VE 1	VE 2	VE 3	VE 4	ROM	B S	Epi	Oxytocin	Del
Patient 1	44	25	1/0	39+2	IVF	IOL for maternal age Propress at 06:00	05:30 Os closed					1			
Patient 2	21	18	1/0	40+0	nil	From HFH	03:00 3cm				Thin Mec		For		
Patient 3	32	27	2/1	39+4	GDM		23:30 4cm	03:30 4cm	07:30 4cm		SROM 23:30		yes	03:30	
Patient 4	34	30	2/1	38+6	nil	VBAC Prev emLSCS for FTP	02:00 4cm	06:00 5cm			ARM 02:00				
Patient 5	37	32	2/0+1	38+1	nil	DCDA twins PCR 52	04:00 3cm	07:30 5cm			SROM 07:00				



Dr Karan Verma

BEDTIME READING

Welcome to a brief overview of some recent articles of interest.

Effect of laminar airflow ventilation on surgical site infections: a systematic review and meta-analysis

In this Lancet study, laminar airflow ventilation was compared with conventional ventilation to assess their effectiveness in reducing the risk of surgical site infections (SSIs). The authors found 1947 records, of which 12 observational studies compared laminar airflow ventilation with conventional turbulent ventilation in orthopaedic, abdominal and vascular surgery. The available evidence showed no benefit from using laminar airflow in reducing the risk of SSIs in total hip and knee arthroplasties, and abdominal surgery. Decision makers should not regard laminar airflow as a preventive measure to reduce the risk of SSIs.

[READ MORE >](#)

Adherence to the European Society of Cardiology/European Society of Anaesthesiology recommendations on preoperative cardiac testing and association with positive results and cardiac events: a cohort study

This study based at two Swiss hospitals published in the BJA put to test the ESC/ESA recommendations on preoperative cardiac tests for non-cardiac surgery. They sought to test the association between major adverse cardiac events (MACE) and the groups stratified in the recommendations. The authors concluded that discrimination for MACE using the ESC/ESA guidelines algorithms was limited. Over- or underuse of cardiac tests was not consistently associated with cardiovascular events. The addition of age, sex and ASA3 improved discrimination. Readers should tread with caution in ordering and interpreting such tests.

[READ MORE >](#)

Goal-directed fluid therapy in emergency abdominal surgery: a randomised multicentre trial

Danish investigators in this BJA study sought to find the evidence to the current burning topic on intravenous (IV) fluid strategy. They proposed the universal dogma that goal-directed fluid therapy (GDT) titrated to optimal stroke volume would perhaps reduce the risk of major complications as compared with standard fluid therapy (STD) in emergency laparotomy. Some 312 adult patients with abdominal perforation or obstruction were randomised in this multicentric trial. In the STD group, IV fluid was given to ensure a mean arterial pressure greater than 65 mmHg and diuresis greater than 0.5 ml/kg/hour. The authors found no benefit of the GDT-guided regimen on major complications and death after 90 days of follow-up.

[READ MORE >](#)

International consensus on anatomical structures to identify on ultrasound for the performance of basic blocks in ultrasound-guided regional anesthesia

This BMJ consensus aimed to produce standardised recommendations for core (minimum) structures to identify during seven basic blocks. There is no universally agreed set of anatomical structures that must be identified on ultrasound for the performance of ultrasound-guided regional anesthesia (UGRA) techniques. A long list of anatomical structures was refined through serial review by key opinion leaders in UGRA. The list is intended to bolster non-experts using basic UGRA techniques and to standardise teaching and research.

[READ MORE >](#)

Impact of the pericapsular nerve group (PENG) block on postoperative analgesia and functional recovery following total hip arthroplasty: a randomised, observer-masked, controlled trial

This single centre Italian randomised controlled trial in anaesthesia looked at the efficacy of the PENG block following total hip arthroplasty. PENG is a novel block for hip surgery with preserved motor function. A total of 60 patients were randomly allocated equally between groups. The maximum pain score of patients receiving the PENG block was significantly lower than in the control group at all time points. Moreover, this group showed a significant reduction in opioid consumption, better range of hip motion and shorter time to ambulation. Although no significant difference in hospital length of stay was detected, the results look promising.

[READ MORE >](#)

Supraglottic airway, tracheal intubation, and neuromuscular block: will the ménage à trois endure?

This is an extremely interesting editorial in the BJA where the authors contemplate the relationship of tracheal intubation and neuromuscular block and the complexity added to this liaison with the supraglottic airway. 'Ménage à trois' refers to a domestic arrangement of three people. They go on to assert that neuromuscular blockage for surgical conditions does not necessarily call for an endotracheal tube, especially in paediatrics. The editorial presents a small study of 66 paediatric patients for lap inguinal hernia repair. The children who received neuromuscular block had fewer intraoperative complications (12%) than those who did not (45%), even without tracheal intubation. So perhaps there is a need to study supraglottic devices in children with neuromuscular blockade with a larger multicentric trial.

[READ MORE >](#)

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If you have worked on a quality improvement or research project using the Perioperative Quality Improvement Programme (PQIP) data and/or that addresses one of PQIP's top five Priorities, or a project that has focused on sustainability, please submit a poster for your chance to showcase your work.

Full details can be found on our website.

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The College has developed a toolkit that offers patients the information they need to prepare for surgery, including the important steps they can take to improve health and speed up recovery after an operation.

The Fitter Better Sooner toolkit consists of:

- one main leaflet on preparing for surgery
- six specific leaflets on preparing for some of the most common surgical procedures
- an animation which can be shown on tablets, smart phones, laptops and TVs.

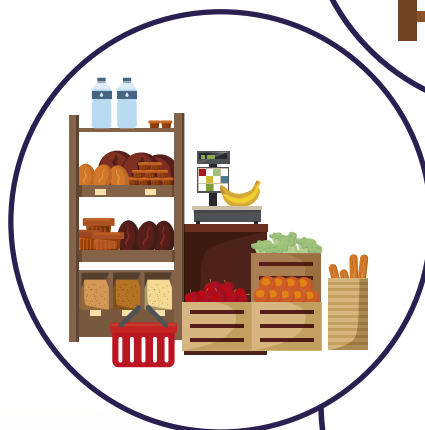
You can view the toolkit here: rcoa.ac.uk/fitterbettersooner

We have also created printable posters, flyers and stickers to help you signpost patients to the toolkit. The animation can be shown on TVs in waiting areas. You can find all these additional resources and instructions on how to download the animation in MP4 format (or request a version in PowerPoint) on our website here:

rcoa.ac.uk/patientinfo/healthcare-professionals

Please share this toolkit with colleagues in both primary and secondary care settings.

It has been shown that people who improve their lifestyle in the run up to surgery are much more likely to keep up these changes after surgery.



The **gas**

The newsletter for all
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