Regional Anaesthesia Training During the Pandemic: Before and Beyond. One Teaching Hospital Experience

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"If you are going through hell, keep going."
Attributed to Winston Churchill, 1943

At the time of submitting this paper, the National Health Service (NHS) in the UK - including anaesthetic trainees and trainers - is going through the ‘Recovery’ stage of the COVID-19 Pandemic. Much focus has now been placed on tackling the resultant long waiting lists for elective surgery, including elective orthopaedic surgery. Regional Anaesthesia (RA) trainees are slowly catching up with the training opportunities lost due to deployments and cancelled elective work during the two major waves. RA trainers have welcomed and are adapting to the 2021 RCoA Training Curriculum1, which may have been influenced by the Pandemic and now recommends 3–6 months of RA training as a core training module. Such progress continues despite the emergence of new coronavirus variants, anaesthetic staff shortages due to COVID and stress-related illnesses, and, perhaps, inevitable work/life imbalance re-evaluation amongst the medics.

With this in mind, we feel it right to regularly reflect on ‘the good, the bad and the ugly’ changes that the Pandemic has brought to RA training programmes in our centres.

In our centre, Oxford University Hospitals NHS Foundation Trust (OUHFT), RA training is an important part of the multi-specialty training provided by the Nuffield Department of Anaesthetics (NDA). The NDA, founded in 1937 due to the generosity of Lord Nuffield (William Morris), was the first independent department of anaesthesia in the UK, in Europe, and in the Commonwealth2. Although RA has been practiced and taught in our department for decades, the formal advanced training module in regional anaesthesia (RA ATM) was set up in 2002, learning from already established Obstetric and Airway anaesthesia ATMs. Over the years it has become one of the most popular advanced training modules in the NDA, with no shortage in applicants. From the RA ATM with one advanced trainee in 2003, it has grown to the RA Programme3 which, with careful rota planning, can accommodate up to five subspecialty trainees, internal and external, with various career objectives. Over 60 trainees and fellows have been trained since 2003, with very positive feedback, as confirmed by the recent survey4 (McMahon et al, 2021). We are thus very interested to compare the feedback received from the ‘Before Covid’ (BC-1) and ‘Beyond Covid’ (BC-2) cohorts of our RA trainees.

While the main priority is the provision of 6 months advanced RA training for ‘internal’ specialist registrars in the final two years of their training in the Oxford School of Anaesthesia, we also offer ‘out of programme’ 6–12 months training to ‘external’ fellows from Malta, Australia, Ireland and other countries, with appointments via a competitive interview process. Some fellows have previously completed their anaesthesia training in their countries, while others have had less ‘typical’ career paths. The key to successful training has been and remains a flexible and individual approach to trainees’ learning objectives.

Oxford University Hospital NHS Foundation Trust (OUHFT) is a busy teaching hospital with some 45 theatres on 4 sites and separate on-call rotas for different sites. The ‘base’ site for the RA training is the Nuffield Orthopaedic Centre. The NOC is a tertiary and quaternary referral centre with most theatre lists suitable for training in neuraxial or peripheral nerve blocks. According to our year-long audit of training opportunities at the NOC in 2016/17 - well before COVID-19 ‘BC-1’ stage - over 3,500 blocks were performed during the year in eight theatres. This volume of blocks allowed us to accommodate 4–5 full time trainees during each training period. Operations range from standard hip and knees to complex limb reconstructions, joint revisions, major spine, ortho- and oncoplastic surgery. In fact, complex operations or complex patients are scheduled more often than ‘straightforward’ cases. The ‘down’ side is that they take longer (occasion-ally up to 16–17 hours), require greater operating list time and can potentially be viewed as lost training opportunities for performing blocks. The ‘up’ side is the opportunity to provide high-risk patients with the best RA option, with or without GA, thus raising training experience to a higher level. Additionally, with a high volume of less complex surgical procedures scheduled daily, there is the opportunity for good audits and Quality Improvement Projects (QIPs), such as our recent QIPs on standardised documentation for RA blocks5 or developing a day-case spinal anaesthesia pathway for total hip replacements (McMahon et al, presented at the virtual webinar of the British Society of Orthopaedic Anaesthetists (BSOA) 2020). Complex patients, on the other hand, provide excellent opportunities for problem-based learning discussions (PBLDs) with the potential for presentations/publications, for example a case describing both the anaesthetic and psychological management of a patient with a heart-lung transplant during undergoing major orthopaedic surgery in the period ‘between the two waves’ of the COVID Pandemic6.

In addition to the NOC case mix, there are ample opportunities to perform RA techniques on other OUHFT lists, such as Trauma/Vascular/Emergency/Plastic surgery, albeit while fulfilling the requirement to maintain service lists and on-call commitments. During their clinical days, RA trainees are either directly or indirectly supervised by a Named Clinical Supervisor (NCS) or another Consultant Anaesthetist in the theatre block, the level of responsibility increasing appropriately according to the trainee’s progress. Various workplace-based assessments (WPBAs) are completed during the course of training, and subspecialty qualifications such as EDRA and RA MSc are encouraged.

While practical skill acquisition is key for RA training, there are several non-clinical objectives which may differ depending on the trainee’s needs. We offer opportunities to develop organisational, management, leadership and teaching skills relevant to RA, to perform and complete audits and QIPs, and to submit, present and ultimately publish a variety of projects and studies. On commencing a training block, an individualised training plan is agreed between a trainee and their NCS, with progress reviewed during the interim and final assessments. The NCS and the trainee maintain contact during the training block and often for a few months after, ensuring the completion of various projects.

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Abstracts

From the trainer’s point of view, during the Pandemic and beyond (BC2), the objectives for the RA training have remained the same. The ways to achieve them were far more complicated than during BC1... Reflecting on the past two years as a trainer, the words that come to one’s mind are ‘dedication’, ‘resilience’, ‘resourcefulness’, ‘flexibility’, ‘tiredness’, ‘anxiety’, ‘uncertainty’, ‘frustration’, ‘disruption’, ‘overload’, ‘perseverance’, ‘new normal’... And ‘keep going’ (as per the Churchill’s words above). We know from the 2021 BMA trainees’ survey that majority of trainees (74%) felt that COVID-19 had disrupted their training, many opportunities had been lost and the mental toll had been quite significant. It wouldn’t be surprising if the next GMC Training survey will also capture a significant and long-lasting negative impact of COVID-19 on the trainers’ wellbeing.

It will also be fair to say that all aspects of training in our centre were affected by COVID-19 pandemic to some extend – from skills acquisition to publishing papers. However, the change in the way we had to work and train have also brought new unexpected and excellent opportunities - from presenting lessons learnt from a challenging clinical case done under RA in PPE3 gear to developing new ‘hybrid’ teaching models.

Some stories of the trainees ‘hit by the 1st wave’ of the Pandemic were particularly educational, highlighting the inevitable effect of the great ‘unknown’ that unfolded, as the one by the co-author of this article, a RA Fellow in Oxford at the time the pandemic struck:

‘At this time in 2020, as COVID-19 spread throughout the UK, the deferral of elective orthopaedic and plastics lists greatly reduced opportunities to perform RA. RA fellows and trainees were re-allocated to ICU and emergency theatre rosters to cope with the first surge in COVID-19 admissions. Significantly altered work-practices, frequent changes in PPE/ protocols/SOPs and the overall ‘unknown’ quantity of the pandemic presented a huge challenge for RA training. Nonetheless we adapted and applied our RA experience to trauma and emergency cases, thus avoiding aerosol generating general anaesthesia. This practice applied the joint ESRA/ASRA guidelines7 of late March 2020, recommending RA over GA for patients with COVID-19 to reduce the risk of COVID-19 transmission. RA +/- sedation techniques allowed appropriate cases to continue without the risk of AGPs.

These uncertain and stressful times proved a challenge for the non-clinical aspects of RA training, including maintaining research projects, audits, teaching and even minimum continuing professional development. Keeping up the momentum when educational events and conferences are cancelled proved difficult. With every month that passed, while the uncertainty remained, we got used to working in a changed environment and made the most of the situation we were in. Thus, RA education and research continued, albeit at slower pace, and thankfully some conferences, and the opportunity to present work, resumed in a virtual format. In our experience, in the pressurised COVID-19 environment, adaptability and resilience has been key to ensuring continued RA teaching and research opportunities for trainees and fellows’.

From the trainees’ stories it became clear that not all was ‘doom and gloom’ and that by working together as trainers and trainees, we succeeded in progressing RA training in the most extraordinary challenging times.

As with all procedural-based specialties, skills acquisition in RA training was inevitably affected by the reduction in elective operating during the pandemic. Interestingly, however, change in practices and PPE guidelines during COVID created unique training opportunities. One such case demonstrating this involved learning and teaching US-guided central neuraxial anaesthesia in Force8/10 masks in a severely scoliotic intubated patient, an experience not to be forgotten!

Presenting and publishing One of many challenges was finding the ways how to compensate trainees for reduction in quantity of blocks performed. Perhaps, to accept that the volume of blocks logged will be limited and instead to increase their RA experience in future years; to embrace the opportunity to learn from unique COVID-specific clinical experiences; to submit and present case reports/audits/QIPs at meetings, thus enhancing trainee’s CVs in preparation for subsequent training or consultant post applications. Some 20 paper from Oxford RA trainees have been accepted and presented during the BP-2 phase in Oxford and nationally (BSOA, AAGBI) so far, more to come and full papers being published or ‘work in progress’. Perhaps the principal of ‘when you can’t have the best, have the best of what you can’ is one to be embraced when reflecting on RA training during COVID-19.

Teaching/Management/Leadership During the BC-1 stage the Oxford RA Course (ORAC) with Cadaveric Anatomy run in the past was not only very popular amongst attendees but also offered our RA trainees excellent opportunities for teaching, management and leadership skills. With the return of formal face-to face teaching courses, the ORAC will return to the NDA teaching ‘stage’ in its BC-2 form. In addition, the pandemic has stimulated the development of a new - ‘hybrid’ - teaching model, ‘Oxford Sonoclub’, developed and delivered by subspecialty trainees, with excellent feedback from attendees. This is a wonderful example of the resourcefulness of trainees, impressively adapting to the ‘new normal’. Trainees should be congratulated on taking this project on and ensuring it is sustainable, despite immense challenges.

Reinhold Niebuhr’s famous prayer ‘God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference’ has been inspirational when considering the effects of COVID-19 pandemic on RA training. Written almost 90 years ago, it remains relevant and encouraging when considering the challenge of keeping the RA training ‘ship’ on course during such unprecedented times in anaesthesia training. We believe that the future for RA training in the BC-2 stage of pandemic in Oxford and the UK in general is bright, and by accepting that some challenges (such as a pandemic itself) cannot be changed and by having the courage to change and adapt to the circumstances we are presented with, no matter what ‘unknown’ challenges may lie ahead, we can ensure a continued high standard of both clinical and non-clinical RA training.

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SP24 INFORMED CONSENT FOR REGIONAL ANESTHESIA: WHAT SHOULD WE TELL OUR PATIENTS?

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The physician must be ready, not only to do his duty himself, but also to secure the cooperation of the patient...

Hippocrates The ethics of patient-doctors relationship have been quite complex and somewhat controversial for >2,500 years, starting from the times of the Father of Medicine and his colleagues 1-2. Medical deontology and medico-legal system developments, and other factors greatly influence the informed consent (IC) standards. While we still follow many principles of the Hippocratic Oath and his many imperatives, ‘Do not harm’, in particular, the paradigm of IC has shifted far away from the ‘Conceal everything from your patient’.

Numerous IC guidelines have been updated recently 3-6; clinicians are obliged professionally and medico-legally to follow them. IC becomes even more electrifying for Regional Anaesthetists when we seek our patients’ agreement - for their benefits, of course! - for us to ‘stick’ sharp needles in proximity to their spinal cords and nerves and inject potentially lethal drugs close to their arteries and veins. Some conflict is inevitable, with clinicians finding some guidelines ‘unrealistic, unethical, untenable’ 7. It is just possible that one day there will be another shift from a legal claim-centred to patient-centred IC.

My talk will concentrate on discussing the following regarding IC for RA:
• Types, principles and key points
• Recent landmark publications 1-9
• Risks disclosure for RA: which, when and how
  o General and Specific
  o CNBs and PNBs
  o ‘Large’ print, ‘small’ print and ‘special circumstances’
  o Patient’s recall
  o Situation awareness
• Why anaesthetists may be reluctant to follow guidelines?
• ‘Not documented not done’. Oxford standardised consent labels (pic 1&2). The ‘up the hill, down the hill’ quality improvement ‘battle’ in one busy teaching orthopaedic centre 10-12
  • Can IC harm the anaesthetist?
  • Can IC harm the patient?
  • Lessons from personal experience

REFERENCES

SP25 REGIONAL ANESTHESIA IN PATIENTS WITH NEUROLOGIC DISORDERS: SENSE OR NONSENSE? A PROBLEM BASED LEARNING DISCUSSION

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